World Bank Global HIV/AIDS Program

HIV/AIDS - *Getting Results*

These reports describe activities, challenges and lessons learned during the World Bank's HI/AIDS work with countries and other partners.

An effective, well-coordinated response to HIV in Djibouti

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A Grant from the World Bank provided a strong impetus to Djibouti's national HIV response in 2003. Clear objectives and priorities, effective government action and commitment, and close cooperation among the key donors and government organizations have contributed to strong results in the national response to HIV. The Global Fund cites Djibouti as a "best practice" example of donor coordination and harmonization and UNICEF recognizes the outreach to young people and community interventions as best practices.

Initiating Djibouti's HIV response

In 2002, Djibouti's HIV prevalence was estimated at three percent for the whole population, but higher than five percent among people aged 20-35 years, and surveys showed that rates had risen dramatically in some groups. The tuberculosis rate was the second highest in the world, and malaria was spreading rapidly. These diseases were fueled by rapid urbanization, and large population movements from trade, migrants and refugees, and in the case of HIV, low literacy, the presence of military bases and a major trade corridor with Ethiopia, an active sex trade, low age of sexual debut among young men and teenage boys, and extensive use of khat by men. The situation was made more difficult by high poverty and unemployment levels.

The Government of Djibouti requested World Bank support in mounting a concerted effort to prevent further spread of these infectious diseases, and to provide treatment and care to infected and affected people. The Government met the eligibility criteria for the Multicountry HIV/AIDS Program for the Africa Region (MAP), including developing a strategic approach to HIV, establishing a high-level HIV/AIDS coordinating body, and agreeing to channel funds to nongovernmental organizations and the private sector for HIV prevention activities.

Designing the Program: Clear Objectives and Activities

In 2003, the Djibouti HIV/AIDS, Malaria and Tuberculosis Control Project became effective, providing US$12 million in grant funds.

There are **three main objectives**:

- To prevent HIV infection by contributing to changes in behavior among the Djiboutian population, especially among high-risk groups, particularly young people using social communication and peer-education to reach young men and women, and multisectoral, civil society, and community initiatives.
- To provide care, support, and treatment to people with HIV in Djibouti, expanding access to treatment for opportunistic illnesses and sexually transmitted infections (STIs), and mitigating the impact of HIV and AIDS on infected and affected persons.
- To treat and control the spread of malaria and tuberculosis.

Figure: AIDS Posters on a building in Djibouti

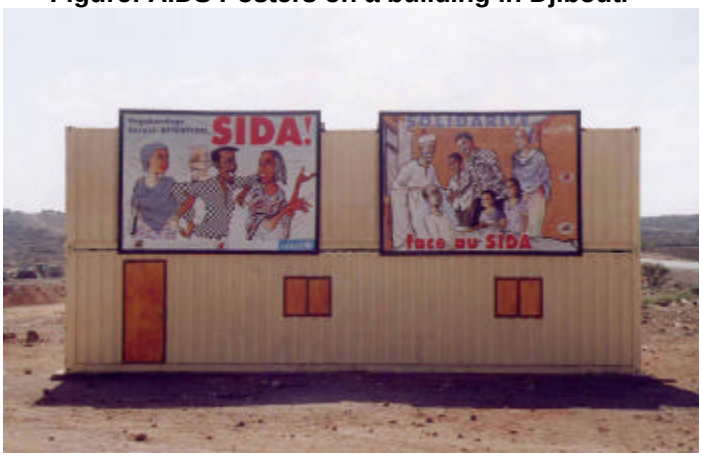


Photo by Dominique Ganteille, www.alovelyworld.com

The project supports **four key areas of action** to achieve the objectives:

- Strengthening the public health sector response to HIV and AIDS, other STIs and malaria and tuberculosis, including through voluntary counseling and testing (VCT) for HIV and treating opportunistic illnesses; diagnosis and case management of STIs; distributing condoms; improving screening and treatment for tuberculosis; strengthening detection, prevention, and response to malaria; and strengthening the health system.

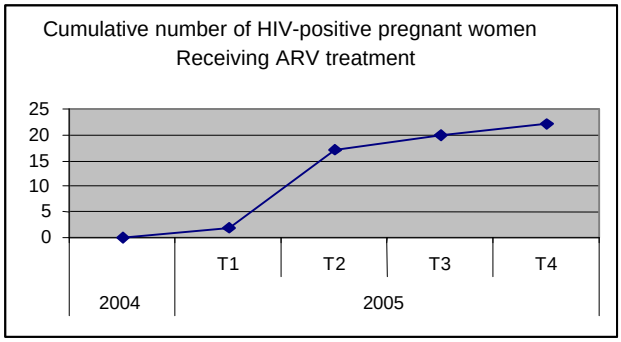
- Multisectoral responses to reinforce health education, counseling, and prevention activities through eleven ministries, especially targeting groups most at-risk and vulnerable to infection such as men in uniform, youth, women, sex workers, truckers, and dock workers.
- Reinforcing the community response through strengthening community-based associations and NGOs so that they can implement essential activities to reduce vulnerability to HIV, tuberculosis and malaria and mitigate the impact of the HIV epidemic.
- Supporting the national coordinating structure for the three diseases, including the Interministerial Committee of eleven ministries (which is chaired by the Prime Minister), the Technical Intersectoral Committee, and the Executive Secretariat, as well as strengthening public, private, and nongovernmental institutions.

Progress to date: Strong results in a short time

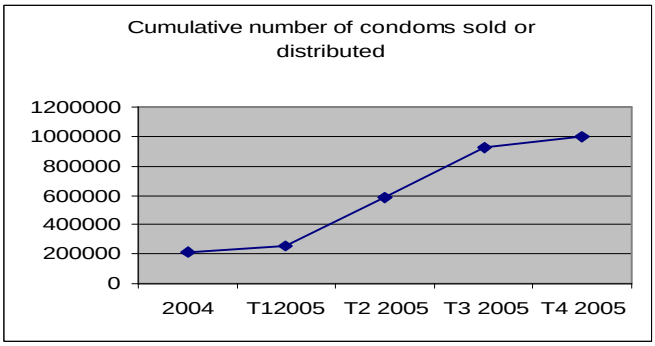
The project helped launch a national HIV response, which had been almost non-existent except for a few sporadic and limited initiatives. Backed by strong political support, and with wide participation of government agencies and many non-government groups, progress has been very good. Mid-way through the project period, many targets have already been met or exceeded. Results reported here are as of the end of 2005, unless otherwise noted.

Health Sector Response

- Comprehensive integrated care including clinical, nutritional, social, and psychological care has been provided to 620 persons with HIV.
- When the project was being designed, there was a debate about whether it was feasible to provide antiretroviral (ARV) treatment. After starting with a small pilot treatment program for 200 people in 2004, treatment access is being scaled up. By May 2006, 425 people were receiving treatment with ARV drugs, based on clinical eligibility criteria. There are plans for much more rapid expansion in 2006 and 2007, using additional funding from the Global Fund to Fight AIDS, TB and Malaria.
- Social support is being provided to 80% of the families of people with HIV, reaching a total of more than 3,000 beneficiaries. Decisions on whether a family needs help, and what level and kind of help, are based on a social and economic assessment using well established criteria, and are validated by social surveyors.
- At the ten prenatal care clinics in which HIV VCT is offered, 99% of pregnant women are accepting testing, and all those who test HIV positive are offered treatment free of charge to reduce the risk of HIV transmission to their babies, and then ARV treatment to maintain their own health, as needed.



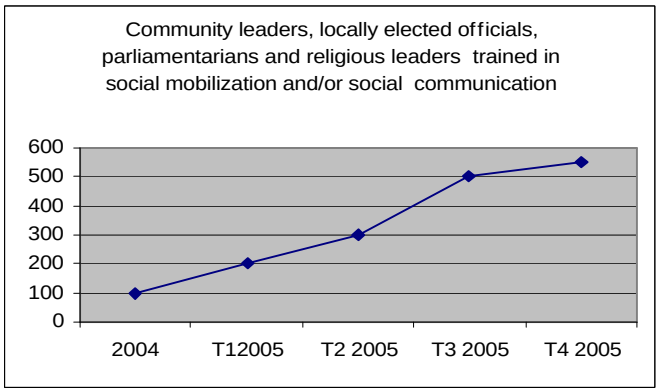
- The number of people treated for STIs almost doubled from 1,338 in 2004 to 2,593 in 2005, well above the target of treating 2,000 people in 2005.
- Starting from scratch, a widespread condom distribution network has been set up that now has over 350 sales points, and distributed more than one million condoms in the past year, a huge increase from only 30,000 condoms distributed at the national level in the year before the project.



Multisectoral response

- Contrary to the original plan to engage eleven ministries in the national HIV response gradually over the two years, all eleven ministries started in the first year. All eleven ministries have developed yearly plans that are being implemented, although with different degrees of achievements. The ministries for Youth, Education, Communication, Women and Welfare Affairs are the most active. In June 2006, the Parliament ratified a new law prepared by the Ministry of Justice to stipulate the legal rights of persons infected with HIV in order to prevent stigma and discrimination.
- Awareness and education campaigns are progressing well. Since the start of the project, a total of about 1,000 awareness sessions have been conducted, and 550 community leaders, locally elected officials, parliamentarians and religious leaders have been trained in social mobilization

and/or social communication about HIV, more than double the original target of 200.



- The number of public centers offering HIV VCT has increased from 8 to 12, and the number of people tested has been rising steadily. Uptake of VCT at the military and police clinics has been limited due to sensitivity and confidentiality concerns, however.

Reaching out through peer educators

The original goal was to train 300 peer educators who would then work with various high risk and vulnerable groups. An information toolkit was designed for each of the eight vulnerable groups -- truckers, dock workers, commercial sex workers, young people at school, young people out-of-school, khat chewers, men in uniform, and young girls in difficulty. Initially, there was some reluctance to support the peer education approach, but the early success and acceptability of the approach provided a strong impetus. To date, about 1,261 people have been trained as peer educators – more than four times the original target.

The various efforts to inform and educate the population are showing clear results: a survey in 2005 found that 69% of the population aged 15-49 years could name three methods of protection against HIV infection. This is an enormous improvement over the baseline of only 20% and well on the way to the end of project target of 90%.

Community-based response

- The community-based component was carefully planned. Rigorous criteria for selecting subprojects were developed, to ensure that they respond to the needs identified. For example, the criteria include previous experience in managing community-based projects, experience with a particular vulnerable group (not necessarily regarding AIDS), and proximity to the vulnerable groups. A manual describing the criteria and procedures was developed and distributed, for easy reference by all implementers.
- Six large NGOs were selected to work with and help smaller community-based associations (CBAs) to develop sound proposals. Each of the six has responsibility for a particular geographic area of the country, and/or a particular risk group. This helps avoid gaps and duplication, and makes it easier to share information about what works well.
- In the first year, 30 subprojects were approved, 75 in the second year, and 156 in the third year. Projects have been successfully implemented in all districts of the country. One very successful project operates in the "P.K.12" truck stop, where an NGO has trained peer educators to empower sex workers to persuade their clients to use condoms, along with condom social marketing campaigns and ensuring easy availability of condoms. Building on this success, USAID provided micro-credits for vulnerable women in the area of P.K.12 to enable them to earn livelihoods in ways other than sex work, and to help alleviate poverty. Other projects include outreach to sex workers in Djibouti-ville and to dock workers and truckers using peer-educators, as well as distribution of food to affected needy families.

Reaching young people

Young people are an important target group for HIV prevention efforts, and a variety of channels have been used to reach out to them. Twelve "*Information Points for Youth*" (IPY) have been set up at youth centers, where 12 "animators" and 20 female instructors are available to answer questions and talk about HIV. With the help of trained peer educators, in just two years, more than 25,000 young people have taken part in information and chatting sessions to raise awareness about HIV through IPYs.

However, IPYs attracted mainly young boys and only a few girls. So, in collaboration with the Ministry of Women, the project established 8 "Audio Listening Cells" for young girls, where information is provided in a more discreet environment. These cells have served 1,440 girls each year.

The animators and instructors have also worked in other information and education sites for young people. Education and prevention sessions in schools and other educational establishments have reached about 18,000 students. In addition, 12,000 notebooks and 3,000 handbooks containing informational messages targeted to young people have been distributed. A network of "Health Clubs" has been created in high schools and other academic establishments, and a social communication program on HIV and AIDS set up for the Health Club instructors and peer educators.

Success factors

Several key factors have contributed to the successful implementation of the project. However, it is important to note that the measure of progress thus far is limited to process and output indicators. A number of surveys are planned at the end of 2006 to assess the impact of the program.

The project design was based on a rigorous situation analysis.

The National Strategic Plan and the design of the project and its interventions were based on evidence from the situation analysis, which helped identify the epidemiologic patterns, the most vulnerable groups, specific risk behaviors, and the information and support that people needed. For example, a sero-prevalence survey was conducted on a nationally representative sample of 2,488 persons, which established a robust baseline among the general population and identified the prevalence in the different age groups e.g., 3.3 percent in women, 2.5 percent in men, and 5.9 percent in the age group 15 to 34 years. Focus groups and interviews with sero-positive people and their families revealed, among other things, that many people needed nutritional support.

National commitment and institutional capacity are strong.

There has been consistent, high level political commitment to the project. The President of Djibouti, the Prime Minister and the Health Minister have provided visible support, for example, in the inauguration of "National AIDS Week" each year. The Minister of Health was shown on TV being tested for HIV in order to promote VCT.

Despite the weak institutional capacity and lack of human resources at the national level, a strong Executive Secretariat was established with competent and dedicated staff. The Government mobilized long and short term international consultants whenever needed to build national institutional and management capacity for the program.

Prevention is coupled with a comprehensive, integrated package of care and treatment services.

In addition to preventive interventions such as education and information, social marketing, condom promotion and VCT, the project provides an integrated package of care including medical, nutritional, economic, psychological and social support to infected people and their families.

The different aspects of the package complement each other. This is critically important, as the lack of any of these aspects may have jeopardized the results. For example, focusing on prevention only would exclude the infected population; promoting VCT would be much less effective without also offering treatment; and while infected people need access to medical treatment, they, and their affected families often need psychological and social support as well. As access to treatment expands, interest in testing for HIV also seems to be increasing.

Interventions in health facilities are linked to community interventions.

Community-based associations that know the communities and culture are subcontracted to deliver some of the support elements of the integrated package of care. One innovation has been to hire and train people from the community as "social/psychological companions" to support people with AIDS and to be a link between the care provided at home and in health facilities. They provide counseling to patients, help them to understand and follow the treatment regimen, and follow up on patients who "drop out", helping to ensure high adherence.

Effective multi-sectoral response and wide mobilization

Another key success factor is the mobilization and involvement of all relevant government sectors, not only the Ministry of Health. This has enabled a broad, integrated national response, with many different information channels reinforcing messages and helping reach many different groups in society.

The engagement of the ministries responsible for communication, police, youth, and women and family welfare has been particularly important. The activities implemented by the Ministry of Youth were extremely effective in actively engaging and reaching out to thousands of young people (see box on *Reaching Young People*). Engaging religious leaders in this Moslem country is a continuing challenge, however.

Community-based interventions are based on identified need and focus on results.

Three factors have helped ensure the effectiveness of the community-based interventions.

To ensure proper targeting, a social mapping exercise was carried out across the whole country to identify who the vulnerable and high risk groups were, their size, and where they live. For example, the mapping identified truckers operating along the road corridor, dock workers, and sex workers and where they worked.

To mitigate the weak capacity of the community-based associations (CBAs), six well-established "umbrella" NGOs were hired to help mobilize and strengthen the capacity of numerous CBAs. The CBAs have strong local ties and a deep understanding of the culture and social networks, and have played a key role in delivering the help, support and services that families need,

reaching out into communities and diverse groups across the whole country.

To ensure effective implementation, community projects are selected using rigorous criteria that ensure that they meet identified needs, and are implemented under annual performance-based contracts with CBAs. Each CBA defines the results it will seek to achieve during the year, such as "deliver food each week to 25 households". The CBA submits a simple progress report each quarter, which the umbrella NGO verifies. Funding is released according to the results achieved; for example, a subproject that achieves only half of the planned target for the quarter will only receive half the funding. Each community project is funded for one year, and only those that prove successful are invited to submit a proposal for the following year. About half of the community-based associations that implemented projects in the first year were considered to have achieved good enough results to warrant continued funding.

There is a strong focus on results, backed by rigorous monitoring and evaluation.

Specific, quantitative targets were defined for project activities. A rigorous monitoring and evaluation system was set up to track progress systematically towards the targets. Regular reporting on progress has helped keep a strong focus on the targets and results. The focus on results was also built into the project in other ways; for example, the way that community-based activities are funded on the basis of results, as described above.

In preparation for the mid-term review of the project, several surveys are being planned, including one that will examine the coverage, quality and effectiveness of the activities implemented by community-based associations, and one that will assess their cost effectiveness. A nationally representative survey will assess knowledge, attitudes and practices related to HIV, and another survey will estimate HIV prevalence. An institutional analysis will look at whether the current implementation structure – the Executive Secretariat, the system of ministry focal points, the umbrella NGOs, and district health offices – effectively meets the needs of Djibouti's HIV response, and whether and how it might be improved.

Innovative approaches and adult support help in reaching young people.

Given the sensitivity of talking about sexuality and AIDS, it was important to get the support of community leaders before launching the youth program, particularly for the peer educators. The community support worked, in turn, as a source of motivation for the young people involved in the program. The "Information Points for Youth" and the "Audio-Listening Cells" enabled a large number of young people to acquire information on HIV and AIDS and get condoms readily, and in a discreet way.

The project got a "jumpstart" from an existing health project.

Djibouti had begun implementing a World-Bank funded health project the year before the HIV project began. The HIV project took advantage of the health project fiduciary staff, procedures and mechanisms that were already established, and got off to a very quick start in implementing activities.

Similarly, when Djibouti secured a grant in 2005 from the Global Fund to Fight AIDS, Tuberculosis and Malaria, implementation was able to begin immediately, using the structures and processes set up under the World Bank-funded project. A pilot for providing ARV treatment had been done in 2004, and scaled up to offer twice the number of people access to ARV treatment in 2005. This enabled the Global Fund grant to be used to finance an existing program that was already in the process of being scaled up, and to show results very quickly.

Scaling up in harmonized partnership with the Global Fund

Djibouti's grant from the Global Fund is enabling a significant expansion in the national program to care for people living with HIV and their families, and to prevent infections, especially among the most vulnerable groups. The initial two-year grant is $7.3 million, with the possibility of an additional $4.6 million, based on grant performance. The Global Fund agreed to use the existing national authority as the grant recipient, to channel the funds through the existing structures and processes, and to rely on the existing national HIV monitoring and evaluation system. From the start, all three organizations – the World Bank, Global Fund and national program authority – were committed to working together in a fully cooperative, harmonized way. This commitment, mutual respect and close interaction have made it possible to resolve potential conflicts and differences quickly.

For the community response component, there is a single set of criteria and one unified process for funding sub-projects implemented by NGOs. For monitoring and evalution, a single set of indicators was agreed upon with discussion and compromise, making it possible for the national program to produce one report to all development partners, and avoid duplicative or customized reporting for different funding agencies. This donor harmonization is efficient and time-saving. To enable each funding agency to report on the results which its funding has helped achieve, there is a clear mapping of how and where each funding source is used, for example, one source of funds is used for activities inside the capital city, while another source is used for activities along the main corridor road. A tool that helps

promote transparency and complementarity of program financing is a unified "General Project Implementation Plan" that shows all the program activities planned for the year, by quarter, and by financing agency, including the World Bank, the Global Fund, the French Development Agency and others. The plan is sent regularly to all donors contributing support to the national program.

Djibouti is a fine example of the “Three Ones” principles being put into practice. There is a single national authority. All donors support one multisectoral national program. And progress is tracked through a single national monitoring and evaluation system. This makes rational and efficient use of scarce resources – one of the scarcest being the valuable time of the people available to manage, coordinate and implement the program. This excellent harmonization has helped achieve impressive results in a very short time.

Further information

For more information on the Djibouti HIV/AIDS, Malaria and Tuberculosis Control project, please go to www.worldbank.org, select “Projects” in the search window at the top of the page, and search for “Djibouti AIDS”

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Map of Djibouti, Showing Location and Neighboring Countries