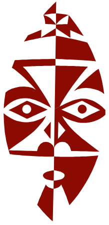

Chapter 2

Lessons Learned in Program Preparation and Implementation

1. Why is this chapter important?

The MAP approach is experimental and based on learning-while-doing. The past three years of project preparation and implementation have generated valuable lessons of experience. General lessons for future MAP projects and for enhancing the implementation of existing programs are provided in this chapter. Lessons on individual aspects are presented in the chapters that follow.

2. What are the most important elements of successful programs?

The initial experience with the MAP program, as well as investment projects generally, suggest the following aspects of preparation will help determine overall success:

- **Ownership/Champions**—The program has the commitment of all the major stakeholders in a country and continuing leadership from "champions"—institutions or individuals in the public and private sectors and civil society determined to make it work. Mechanisms are established to permit champions who supported program preparation to remain involved during implementation;
- **Capacity to Implement**—There are people and organizations with the ability to implement the program effectively, especially to scale up existing programs, or who can acquire the necessary skills to deal with higher levels of activities;
- **Clarity of Objectives**—The program has very clear goals that people understand and accept: win the war against HIV/AIDS by mobilizing every part of society to expand and improve prevention, care and support and mitigation programs;
- **Quality of Design**—The project activities identified will move the program toward its goals, and the roles and responsibilities of each implementing participant and their relationship to one another are clearly articulated;
- **Stakeholder Involvement**—The people groups, and institutions who benefit, who provide the services and who manage the project and the resources are all engaged in the preparation (and implementation) of the program; and
- **Readiness**—Important elements of the program are ready to be implemented as soon as the funds are available.

Experience suggests there are also several aspects of program implementation that will also contribute to successful outcomes (See also Chapter 25 on supervision):

- **Flexibility and adaptation**—The program is adjusted and "reworked" continuously to meet changing circumstances. The original design is a guide, not a blueprint;
- **Focus on the goals**—The objectives are always kept in mind when making decisions: how will this action help us achieve our purpose?

- **Monitoring and evaluation**—A good M&E system is essential to tell us how well the program is doing, where it is going and how it needs to be adjusted; and
- **Stakeholder involvement**—Involving the stakeholders is no less important in implementation than in the design. There must be an openness to innovation and non-traditional partners
- **Intense supervision** — The complexity, scope and "learning by doing" nature of the MAP approach requires more intense supervision both by countries and donors
- **Harmonization** – The more that donors agree to harmonize their procedures and work within a common framework, whether it is adopting the "Three Ones"[6] or actually "pooling" of funds, the better is the chance of achieving the most effective and efficient use of available resources and ensuring rapid action and result based management.

3. What are the specific lessons from the initial MAP projects that can help new operations and recommendations?

Experience with the initial MAP operations has generated useful lessons of what works and what can be improved. Consultations with National Aids Councils, NAC Secretariats, donors, technical organizations, governments, NGOs, the private sector and foundations have identified important lessons for the "next generation" of HIV/AIDS projects.

- The fundamentals are sound: the basic concept, design and structure of the MAP are appropriate. The MAP approach has already begun generating results. There has been an expanded effort and more resources for prevention, mitigation, care and treatment of HIV/AIDS, stronger partnerships, funds channeled directly to communities, faster project preparation and stronger implementation capacity. Basic strengths of the MAP approach include:
  - Reliance on existing programs
  - Flexible design adapted to local conditions
  - Mechanisms to channel support directly to civil society and communities
  - Multi-sectoral approach
  - Focus on partnerships
  - Speed of preparation
- Preparation and implementation need to be better in some basic ways. While the basics are in place and provide a good foundation for development of new operations, several aspects are not working well. Each bullet below identifies areas where MAP Projects can be designed and carried out better (roughly in order of their place in project processing):
  - Stakeholder involvement
  - Understanding the fundamental social factors
  - Thinking and acting differently
  - Getting started well
  - Scaling up and building capacity
  - Managing and monitoring the overall program
  - Sharing good practice, and
  - Working more effectively together.

[6] *One agreed HIV-AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority, with a broad based multi-sectoral mandate; and One agreed country level Monitoring and Evaluation System.*

(i) **Genuine stakeholder involvement in both preparation and implementation is fundamental to effective programs.** This is not just theory or theology; it is demonstrably true—programs are more effective when people living with AIDS, caretakers, health professionals, program managers, suppliers, civil society members and others touched by the disease are actively engaged in deciding what is to be done and ensuring that it is done. In practical terms, it means their participation in project planning (such as seminars on the "logical framework"), consultations on specific programs, involvement in the preparation of the Project Operations Manual, implementation of the monitoring and evaluation system and serving as watchdogs to ensure services are delivered. To date, there has been more rhetoric than substance on community engagement in particular. Genuine stakeholder participation is less time consuming than dealing with programs that fail because of its absence.

(ii) **Good social analysis is a prerequisite for behavioral change.** HIV/AIDS is a social disease, spread (and controlled) by behavior. A good social analysis is needed early in the project cycle of implementing agencies to identify the specific social conditions, values and norms that contribute to the spread of HIV/AIDS and affect its treatment and mitigation. Social analysis is not yet a routine part of preparation, but should be, especially for specific programs in prevention, care and mitigation and for monitoring and evaluation.

(iii) **Management of HIV/AIDS programs calls for exceptional measures.** It is not business as usual. The initial response to the MAP program in many countries has been to treat these projects as any other, when the urgency of the problem and its devastation call for unconventional responses. However, the National AIDS Counsels (NAC) and the Secretariats (NAS) have been more effective where they see themselves as guides, facilitators and coordinators rather than traditional project "control" and implementation bureaucracies. Implementation of key aspects, including financial management, procurement, monitoring and evaluation and selected service delivery, have usually been more effective when they are "contracted" rather than done "in house." This may be particularly important in getting started, using respected outside agencies to initiate an assessment of impacts and drafting an initial work plan.

(iv) **Start well, end well.** Experience suggests that projects succeed when implementation begins promptly as soon as funds become available. This helps show results quickly and builds and sustains commitment. The initial MAP projects have generally started slowly, with a loss of momentum and enthusiasm. This suggests completion of several preparatory activities before Credit funds are available as indicated in the Box 2.1;

Box 2.1: Elements of Good Preparation

a) Preparation of the operational manuals and first year program,

b) Piloting of expansion activities through retroactive financing or other means,

c) First year performance targets,

d) Developing mechanisms for advocacy "champions" to stay engaged during implementation,

e) Assigning key responsibilities to the agencies already engaged, especially the Health Ministry, and

f) Launching assessments of the impact of HIV/AIDS within ministries and beginning program development at the earliest stage. It may be possible to get started quickly by using project preparation funds (such as PHRD Grants), the IDA Project Preparation Facility (PPF) or a government's own resources that may be reimbursed under the project (retroactive financing).

(v) **Scaling up existing programs and building capacity for HIV/AIDS activities have been tougher than originally expected.** The two major objectives for phase one of the MAP program are to (i) scale up existing HIV/AIDS programs and (ii) build capacity where needed to implement them, both in the public sector and civil society. This has been harder than envisaged. Capacity building needed for scaling up has two distinct components; (i) enhancing skills; and (ii) increasing the quantity of existing skills and institutional infrastructure. Donors are often more prepared to finance (i) rather than (ii).

The greatest challenge in the MAP approach is to fund on a sustained basis the increase in the quantity of African skills that already exists and the expansion of the institutional infrastructure, including incremental operating costs and logistics. Scaling up can be accelerated if the preparation process: (i) assesses the quality of existing programs; (ii) selects programs for support in the first year in a transparent process; and (iii) the NAS is empowered to approve programs quickly. Capacity building can also be accelerated if NASs contract with experienced local technical resource organizations to deliver training and if public sector agencies establish an AIDS coordination unit responsible for training. Capacity building and capacity enhancement is a continuous, never-ending process that needs full time attention. Civil society organizations need: (i) two to three year funding commitments to invest in "scaling up" their level of operations; and (ii) funding for administration and management as well as incremental operating costs such as personnel, equipment and materials and appropriate transportation.

Monitoring and evaluation systems are the key to effective implementation. In an experimental and learning process, a good M&E system is essential. You can't learn if you don't know where you are starting from and check periodically how you're doing against what you had planned. Most MAP projects do not yet have an effective system to measure progress and evaluate results. All of them should have them. (See Chapter 23). In addition, employing field investigators to visit a sample of beneficiary organizations to assess the efficiency, effectiveness and transparency of program implementation has proven useful in assessing impact and in publicizing the MAP program both nationally and internationally.

(vi) Successful programs draw on the experience of others, benefiting from collaboration about "good practices." "Knowledge management" about what works and why can facilitate effective program implementation, scaling up and capacity building. The experience and knowledge gained within a country and across countries can be shared by the creation (and external funding) of national Technical Resource Groups and specialized organizations, animated by the NASs and UNAIDS Theme Groups. The challenge is not to create new knowledge but to share existing, relevant knowledge more effectively among program coordinators and implementers, all of whom are overloaded with work and information.

(vii) Partnerships matter: hang together or hang alone. Combating HIV/AIDS effectively can only be done by genuine collaboration—within government, between the public and private sectors and civil society, among citizens and with and among donors and specialized international agencies. Partnership involves sharing power and responsibility during program design and implementation, not always easy for organizations used to being dominant in their fields. (See Chapter 8 on Partnerships).

(viii) The value of multiple efforts. Lessons from the private sector, especially companies dealing with consumers, teach that changing behavior requires that multiple messages, with different content, be sent through various media, with diverse sponsorship in order to affect the way individuals, families and communities act. In short, winning the war against HIV/AIDS requires multiple efforts. Young people about to embark on their first sexual encounters are a key target group of HIV/AIDS program. Changing their behavior is challenging and these people need to be reached through many different mechanisms – parents, peers, churches, schools, local government, cultural organizations, mass media of all kinds, etc. Sending messages to youth through all these mechanisms is not duplication, which is wasteful, but multiple efforts, which is effective.

(ix) The MAP is demand –driven; this has resulted in more emphasis by implementing agencies on prevention and mitigation than on treatment. While this may change now that prices for ARVs have fallen sharply, it is now clear that treatment programs will require a massive international effort, especially to scale up programs as rapidly as required. To give an encouragement to treatment and to test different implementation models, the World Bank is providing US$ 60 million in grants to partnerships of the public health sector and civil society in three African countries as

well as to WHO and UNECA for specialized support and knowledge sharing. In Burkina Fasco, the partnership will focus on organizations of people living with AIDS, in Ghana with the private sector and in Mozambique with non-government organizations, including faith-based organizations.

(x) **The welcome reduction in the prices of ARVs means that substantially larger numbers of AIDS patients will receive treatment.** However, as drug prices have come down, the other costs associated with treatment – medical and support personnel, non-ARVs drugs, biological monitoring, etc. – have largely remained constant (See Table 2.1 below). Many of these treatment costs are local, not foreign, operating costs rather than investment, salaries rather than commodities – all areas that many donors traditionally have avoided funding, especially on a long term basis. While the MAP will finance all costs associated with treatment, this needs to be the norm among donors rather than the exception.

Table 2.1

Cost Category	Lowest Cost Scenario (US$)	High Cost Scenario (US$)
ARV Drugs	140	1,000
Other Drugs	80	80
Biological Monitoring	150	400
Personnel	200	200
Equipment	50	50
Total Cost	620	1,730