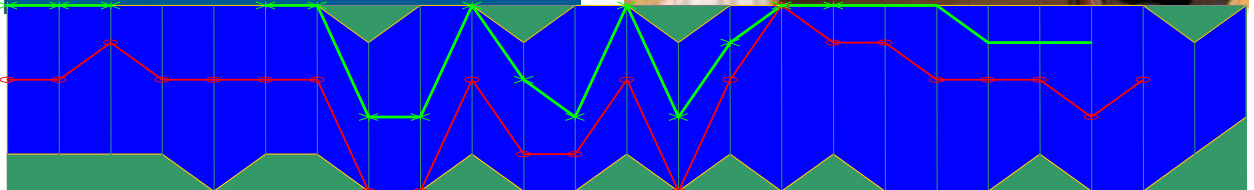
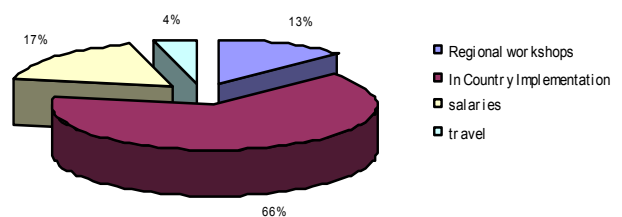


Evaluation of the UNAIDS/UNITAR **AIDS** Competence Programme



ACP Scale-up Costs for 50 countries (USD)



A COMMUNITY COMPETENCE BUILDING PROCESS JOINTLY DESIGNED AND IMPLEMENTED BY BRITISH PETROLEUM, THE SALVATION ARMY, THE WORLD BANK INSTITUTE, OTHER DONORS, LOCAL AUTHORITIES, CIVIL SOCIETY AND COMMUNITIES WORLDWIDE.

June, 2005

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Definitions as used in this report:

1. AIDS Competence Programme (ACP): the ACP is a Community Competence Building Programme. It consists of a series of processes and knowledge management (KM) assets developed with the private sector, which, if well adapted and implemented, lead to the ability of communities to achieve AIDS competence. It can either be referred to as a programme or as a process, depending on the level of operations of the party adopting it. **These KM assets and information exchange media** are collectively referred to as **tools** in this report.

2. AIDS Competence: AIDS Competent Communities are those that : (i) recognize the reality of HIV and AIDS; (ii) build capacity to respond to HIV and AIDS; (iii) exchange and share knowledge and skills; (iv) reduce vulnerability and risks; and (v)live to their full potential.

3. AIDS Competence Programme tools and processes: tools include River Diagram, Step Diagram, Self-Assessment Framework, e-Workspace, e-Forum; **processes include:** facilitation, knowledge-sharing processes including those used in community meetings, seminars and workshops, partnership building, etc.

4. Communities: in this evaluation communities are assumed to include political, social, geographical and cultural groupings that get together to implement the AIDS Competence Programme within different geographical boundaries. This includes business networks, Civil Society, Villages, Local Authorities, health networks, and professional organizations, and stakeholder groupings, among others.

5. Local Authorities: depending on the level in which authority is shared between the central government and smaller administrative arms in provinces, districts, cities, town and rural areas, 'Local Authority' refers to the smallest entity of government or relevant local appointed/elected institution with the capacity to coordinate all sectors, and to interact with civil society in urban and suburban settings. It is recognized by local actors to have such a convening power as well as the political, technical and financial authority to make decisions, plan and implement programmes in the city/relevant territorial entity. Local Authorities played a particularly strong role in the initial phase of the AIDS Competence Programme, and stand to do even more in its subsequent initiatives.

6. Stakeholders: the various groups directly involved, and having an interest in the quality, administration, management, and implementation of the AIDS Competence Programme. These include the donors, technical assistants, programme managers, local authorities, governmental and nongovernmental organizations, programme facilitators, and lay participants and third party beneficiaries.

7. Programme partners: in this report, this refers to the various organizations and individuals involved in the management , finance or technical development of the AIDS Competence programme, including UNAIDS, UNITAR, British Petroleum, The Salvation Army, World Bank Institute and others currently joining in these capacities, including The Aga Khan Development Network, and the Constellation for AIDS Competence.

8. Community ownership: the placing of responsibility, authority and accountability for programmes at community level, allowing them to decide how to design, implement and assess their own programmes based on their needs.

9. Community empowerment: when communities have genuine power in decision-making bodies.

10. Community participation: process through which communities influence and share control of the AIDS Competence Programme's initiatives, decisions and resources that affect them.

11. Capacity building: the development of sustainable skills, organizational structures, resources and commitment to health improvement in health and other sectors, in order to prolong and multiply health gains many times over.

12. Principles of development programmes: the universally desired goals of communities which include participation, sustainability, equity, empowerment, ownership, multidisciplinary collaboration, capacity building.

13. Community elements: the characteristics of a community that help it to maximize benefits from any development programme. Attainment of elements leads to the achievement of community development principles. Elements include communal resources, cohesion, unity, trust, camaraderie, communication channels, information sharing, common values, power, altruism, communal services, community confidence, and resource networks.

14. Effectiveness: the extent to which the programme achieved its objectives, including those expected by different stakeholders during the current timeframe, and the extent to which the programme reached its target group.

15. Efficiency: the extent to which the results achieved by the programme still justify the costs incurred.

16. Impact: at this stage of the AIDS Competence Programme, 'impact' refers to the extent to which the general objectives set for the programme are expected to translate into an improvement of the HIV and AIDS situation in communities. Some communities can already measure or estimate impact.

17. Outcomes: the extent of change in targeted communities' attitudes, values, behaviour, or conditions regarding programme and community standards. This is known by comparing conditions just before implementation of the programme (baseline data) and after the programme/interventions. Depending on the nature of the intervention and the theory of change guiding it, changes can be immediate, intermediate, final, and longer term outcomes. Outcomes also depend on the partner and their mandate, as well as the community objective. In HIV and AIDS terminology, outcomes include changes in attitude towards people living with HIV, increase in knowledge, increase in participation rates, etc.

18. Sustainability: the likelihood that the AIDS Competence Programme benefits will be maintained locally after withdrawal of external support and funding.

19. Reach: the distance, area over which and number of people to whom the AIDS Competence Programme or its various processes and assets have spread and are effective.

20. Coverage: distance, area, and number of people to whom the AIDS Competence Programme has spread, with or without outcomes, but with the potential to produce some qualitative gains.

Abbreviations

ACP	The AIDS Competence Programme
AIMF	International Association of Francophone Mayors
AMICAALL	Alliance of Mayors and Municipal leaders on HIV/AIDS in Africa
AusAID	Australian Assistance in Development
BCC	Behaviour Change Communication
BP	British Petroleum plc
CCRA	Section Council of Cities and Regions in Africa
CIFAL	French acronym for International Training Centre for Local Authorities/Actors: Centre International de Formation des Autorités/ Acteurs Locaux
CITYNET	The Regional Network of Local Authorities for the Management of Human Settlements
CRD	UNAIDS Country and Regional Support Department
CRIS	UNAIDS Country Response Information System
CSW	Commercial Sex Workers
DCP	UNITAR's Decentralized Cooperation Programme
DFID	Department for International Development, United Kingdom
DRI	The District Response Initiative of the World Health Organization, 1996-2000
e-Workspace	UNAIDS electronic information exchange workspace
FHI	Family Health International
FLACMA	Latin American Federation of Municipalities and Cities
GMS	Greater Mekong sub-Region: Thailand, Vietnam, Laos, China, Myanmar, Cambodia
GTZ	Abbreviation for the German technical cooperation : Deutsche Gesellschaft für technische Zusammenarbeit,
HCD	Human Capacity Development
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
ICLEI	International Council for Local Environmental Initiatives (ICLEI)
ICRC	International Committee of the Red Cross
ICT	Information and Communication Technologies
IEC	Information, Education and Communication
JICA	Japanese International Co-operation Agency
KIT	Royal Tropical Institute of the Netherlands
MDG	Millennium Development Goals
MSM	Men who have sex with men
NCA	Kirkens Nørdjhelp
NGO	Nongovernmental Organization
NORAD	Norwegian Agency for International Development
PDM	Partnership for Municipal Development
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission (others refer to 'PMTCT' as 'PPTCT', that is, 'Parent' in place of 'Mother.')
PPP	Public-Private Partnership
PwC	PricewaterhouseCoopers plc.
SMS	Short Messaging Service using mobile phones
TND	UNAIDS Technical Network Development unit
UCLG	United Cities and Local Governments
UDICOSA	Uganda District and Council Speakers Association
UNAIDS	The Joint United Nations Programme on HIV/AIDS, whose Cosponsors include The United Nations High Commission for Refugees (UNHCR), United Nations Children's Fund (UNICEF), World Food Programme (WFP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), International Labour Organization (ILO), The United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO), and the World Bank.
UN-HABITAT	United Nations Human Settlements Programme
UNITAR	The United Nations Institute for Training and Research.
UCLA	University of California, Los Angeles
USAID	United States Agency for International Development
WACLAC	World Association of Cities and Local Authorities

Executive Summary

i. Introduction

During the last twenty years of responding to HIV, common lessons have been learned. Countries now acknowledge that HIV affects other sectors besides the health sector. Organizations and communities generally agree that the social environment has a crucial effect on the individual's behaviour and the population's health status. Whole communities and not just individuals are therefore to be considered while designing health programmes. Most successful responses to HIV have begun at the local/community level. Policy reviews have therefore recommended greater community ownership¹ of systems that deliver health services to the public. However, not all has gone well regarding local responses to HIV. Successful local responses have rarely been shared internationally. Inadequate communication, monitoring and reporting systems, and poor accountability have made it difficult to effectively provide communities with resources to share their experiences with each other directly and promptly. Innovative processes and public-private partnerships (PPP) promoting systematic information exchange and donor facilitation² of community ownership are needed. One successful project using innovative methods to build community capacity is the Mekong region STD/HIV/AIDS project led by UNICEF, Govt. of Netherlands and five governments in the Mekong region. The AIDS Competence Programme³ developed under the Mekong project seeks to promote community ownership through facilitation and use of innovative knowledge management assets.

ii. Objectives and issues addressed

This evaluation does not re-investigate the lessons and conclusions already acknowledged and documented during the past decades. It begins from the perspective that⁴: (a) community ownership improves planning and performance of AIDS programmes, leading to improved population and individual health status; (b) governments and civil society can play a significant role in promoting community ownership; and (c) The joint United Nations Programme on HIV/AIDS (UNAIDS), including UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO, and the World Bank, can play a significant role in developing the agenda for community ownership of programmes. This evaluation measures the effectiveness and efficiency of the AIDS Competence Programme's process and outcomes. The evaluation's approach relies both on methods used in AIDS programme evaluations, and accepted sociological evaluation methods that define community capacity or the individual capacity (i.e., economic, social, pedagogical and politically related outcomes). The AIDS Competence Programme's potential to achieve impact is also examined. It should be noted that the evaluation of specific community interventions where the AIDS Competence Programme is used, e.g., in prevention of mother-to-child transmission⁵ programmes, and the evaluation of the global AIDS Competence Programme follow significantly different approaches, as outlined later in this report.

¹ Community Ownership, that is, the placing of accountability, authority, and responsibility for processes and products at the community level.

² Coordinating rather than leading a programme so that communities are encouraged to participate

³ This evaluation has later recommended that the ACP be renamed 'The AIDS Competence Process.'

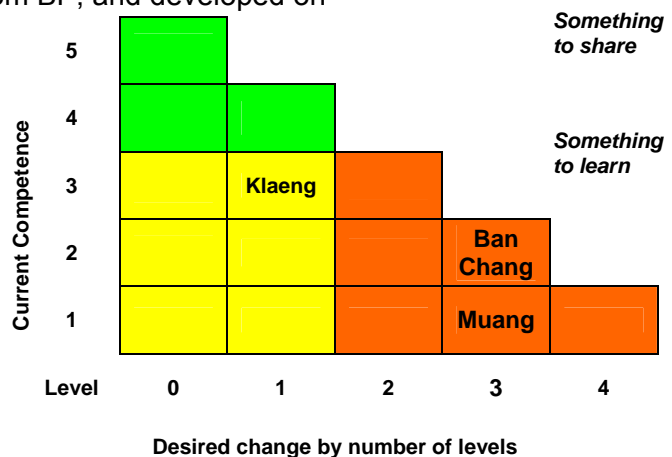
⁴ See references, No. 3, 17, 18, 28, 43, 44 and 49 in ANNEX I

⁵ Prevention of Mother -to-Child Transmission of HIV/AIDS, or Parent-to Child Transmission of HIV/AIDS.

iii. Background of the AIDS Competence Programme

UNAIDS partnered with the United Nations Institute for Training and Research (UNITAR), British Petroleum (BP), the Salvation Army, the World Bank Institute and a number of nongovernmental organizations and Local Authorities to launch the initial phase of the AIDS Competence Programme between February 2003 and June 2004. Partners joining later included the Aga Khan Development Network. Some managers from the initial phase formed the 'Constellation for AIDS Competence,' a not-for-profit organization to promote the AIDS Competence Programme agenda. When implementing the AIDS Competence Programme⁶ communities use the Self-Assessment Framework (see Annex C) to define their needs (weaknesses) and strengths in different areas. These areas include HIV and AIDS acknowledgement and recognition, care and prevention, access to treatment, inclusion, identifying and addressing vulnerability, learning and transfer, measuring change, adapting their responses, ways of working and mobilizing resources. Communities then map out their strengths in each of the areas using a River Diagram and update changes over time (see p.66). Communities also map out their: (i) current levels of competence (y-axis); and (ii) desired levels of change in particular practices (x-axis) onto a 'Step/ Stairs Diagram' (shown below) which is shared between different communities. Through the Stairs Diagram, communities identify those strong communities through whom they could acquire or share certain strengths. To enable systematic and timely information exchange, communities are connected through an electronic (Internet) workspace (see p.64) moderated by UNAIDS. The e-Workspace remained partially idle after the initial phase since the moderator was not supported, despite growing community needs. It was completely revived in June 2005 following an initiative of the Constellation for AIDS Competence, and is now fully active. The e-Workspace is both a store and a forum for knowledge exchange. Communities can request training from an expert who either trains communities or their trainers directly. Communities may also meet through seminars, workshops and other forums. When well implemented, the AIDS Competence Programme can be effective in monitoring both private and public sector programmes and addressing Millennium Development Goals, and principles/elements of community capacity building⁷. The AIDS Competence Programme's Knowledge Management Assets were adapted from BP, and developed on the knowledge base of UNAIDS, WHO and partners. The Salvation Army provided guidance on Human Capacity Development (HCD), while local authorities, the private sector and academic institutions also contributed. Work by the WHO District Response Initiative (1996-2000) and the Royal Tropical Institute of the Netherlands (KIT) (Local responses toolkit) informed the AIDS Competence Programme's development process.

Fig. 1 The Step Diagram.
Learning and Transfer in Thai communities
 ACP tools : River Diagram p.66
 Self-Assessment Framework p.54, eWorkspace p 64.



⁶ This evaluation has later recommended that the AIDS Competence Programme be renamed 'The AIDS Competence Process.'

⁷ Principles of community programmes include participation, sustainability, equity, empowerment, ownership, multi-disciplinary collaboration, capacity building... Elements of capacity building includes wealth, cohesion, unity, trust ...

'...Any kind of training, especially at the local level is really what will work ...due to the training we conducting with CIFAL, last year we had not one single case of vertical (Parent-To-Child) transmis. in Curitiba, (Brazil)...' Dr. Deisi Kustra, President, World Family Organization, March, 200

iv. Methodology

The methodology for this evaluation is outlined in the annex section as ANNEX A and ANNEXD. It consists of a desk review, interviews whose respondents were selected through random and snowball sampling—sample sizes ($n \geq 50$), and a technical analysis phase. In some Thai sites, translators/ facilitators were relied upon. The evaluation considered diverse partner interests, varying uses of the AIDS Competence Programme, differences within and between communities using the Programme, and the many interventions in which it is being used.

v. Findings

The AIDS Competence Programme process facilitates community efforts rather than directs them. It introduces new methodologies rather than a new type of programme. As a support mechanism that multiplies the effect of existing programmes, the AIDS Competence Programme can be implemented without changing strategic, financial, or operational policy, as it is in harmony with existing (multisectoral) programme methods and community needs. The Programme tools are applicable in a variety of interventions including behaviour change communication, prevention of mother-to-child transmission, promoting confidential voluntary counselling and testing, and Capacity Building. The AIDS Competence Programme Knowledge Management and sharing tools⁸ and processes could boost the development, monitoring, and implementation of community programmes if customized to address community needs. The AIDS Competence Programme Knowledge Management assets (tools) and processes are strong and relevant across different sectors, countries and time periods if supported by timely collection of raw scientific data. The Programme promotes community ownership of AIDS programmes and promotes the principles and desired elements in communities. It is also able to address Millennium Development Goals, and still relevant to the public and private sector.

(a) End-user satisfaction: a vast majority of interviewed AIDS Competence Programme users (between 83% and 87%) are satisfied and confident that the Programme achieves impact within communities, based on the experiential outcomes that they see or perceive within their communities. Thirteen percent named areas they would like to be improved, while 2% did not think the AIDS Competence Programme would have any impact; 62% of all who found the AIDS Competence Programme useful were estimated as likely to share it effectively.

Effectiveness⁹

(b) Outcomes: Many communities did not rigorously measure outcomes since they assumed that periodic monitoring using the self-assessment framework and AIDS Competence Programme tools was adequate. The following outcomes are based on locally validated community self-assessments by seven communities from North Eastern Thailand using Early 2003 data as baseline data and March 2005 data as current data. The results are averaged for all communities but not weighted since community populations are almost the same:

⁸ River Diagram, Step Diagram, Self-Assessment Framework, e-Workspace, e-Forum... processes include knowledge sharing processes including those used in community meetings, seminars and workshops, partnership building, etc.

⁹ The extent to which the programme achieved its objectives and reached its target group.

Fig. 2 Outcomes from Seven Communities In North Eastern Thailand

OUTCOME	BASELINE * (2003)	CURRENT (2005) *
Knowledge and acknowledgement of HIV/AIDS	46%	77%
Positive Attitudes Towards People Living with HIV/AIDS	51%	80%
Women Participation and Support in AIDS Work	45%	80%
Resource Mobilization	42%	71%
Identification and addressing of Risks and Vulnerabilities	49%	86%
Treatment Availability for People Living with HIV/AIDS	37%	71%

* Based on 0-low-0% while 5-100%, High

(c) Multisectoral / multidisciplinary collaboration: a mix of national and local governments (37%), donors, multinational corporations (25%), civil society (25%), and academic institutions were using, sharing the AIDS Competence Programme and implementing its processes by March 2005 in nearly 30 countries. There were differences in partners' interests and preferred methods for programme implementation.

(d) Community empowerment¹⁰, participation¹¹, ownership and inclusion: communities expressed interest and committed some resources before managers worked with them. Community participation in Thailand increased by 114% from pre-implementation rates. Some practitioners felt that there was an inadequate definition and treatment of gender roles and the impact of women and girls' participation on community programme performance. The AIDS Competence Programme lacked a comprehensive programme plan at the partner level due to its initial research and development nature. There was no listing of planned activities that would logically lead to expected future outcomes and impact, upon which evaluators would later benchmark performance. There were therefore no baseline indicators to evaluate programme processes, and no internal means of verification. It was explained that this stage of the ACP was conceived as a phase for researching and developing a universally acceptable set of assessment and information exchange tools.

(e) Community cohesion¹²: an evaluation in Thailand reported that cohesion (unity, trust and camaraderie) in implementing community programmes had improved significantly—43% of respondents reported increased unity and support of each other since the inception of the AIDS Competence Programme.

(f) Reach¹³ and coverage¹⁴: communities and stakeholders from different sectors in nearly 30 countries (80% developing countries) have successfully implemented the AIDS Competence Programme, nationally or locally. The UN system in Eritrea successfully implemented the Programme, encouraging the private sector and UN offices in other countries to emulate. The total reach of the programme now exceeds 1 million people¹⁵. Earlier assessments in Thailand revealed that 71% of respondents had shared strengths gained from the AIDS Competence Programme within their own countries, while 29 % had shared with others outside the country.

¹⁰ When communities have genuine power in decision-making bodies.

¹¹ Process through which communities influence and share control the AIDS Competence Programme's initiatives, decisions and resources that affect them.

¹² Cohesion here includes the notion of social capital and the desired community elements of unity, trust.

¹³ The limits within which the ACP can be effective; based on quality of information passed, quality of methods by which it is passed, the degree of retention, and the ability to pass it around to other people while still achieving results for the programme.

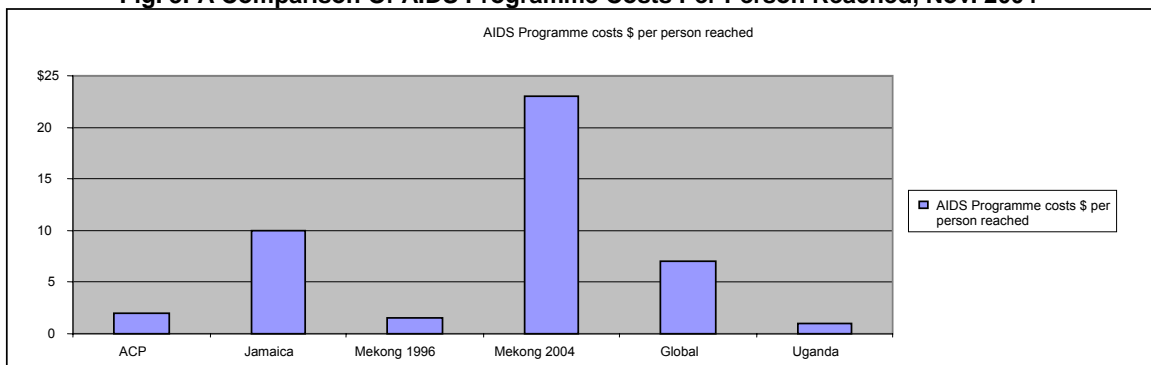
¹⁴ Distance, area, and number of people that have in any way come into contact with the ACP.

¹⁵ For calculations of Reach, please see Methodology ANNEX A under: *Calculating Reach-Case Study of Madagascar*.

(g) Information exchange, knowledge management tools and electronic discussions: most communities are still implementing and using the AIDS Competence Programme tools and processes. Programme Knowledge Assets and processes are easily available to, transferable and customizable by communities, who request follow-up. There were no complaints regarding the River and Step diagrams once understood. The Self-Assessment framework has been ‘customized’ successfully in Brazil, Thailand, Eritrea, Kenya, Madagascar, Uganda and other countries. The number of e-Workspace participants grew into the thousands by end August 2004. Based on an internal AIDS Competence Programme evaluation of electronic discussions it was found that 74% of respondents had read and contributed to the discussion postings, 13% had only read, while another 13% did not participate in the electronic discussions. Participants in countries using high and low internet connection speeds felt *included* and accessed the e-Workspace and e-Forum without difficulty.

(h) Efficiency¹⁶: costs: total programme costs during the initial phase were US\$ 630 000. Of these, direct costs amounted to approximately US\$ 300 000¹⁷. Based primarily on reach, the AIDS Competence Programme was found to be highly cost-effective when compared to other programmes since it has extended to many sites in nearly 30 countries at relatively minimal costs and is spreading without additional funding.

Fig. 3: A Comparison Of AIDS Programme Costs Per Person Reached, Nov. 2004



Cost-effectiveness—efficiency varies from US\$ 0.10 to US\$ 2.00 per person reached (>1 Million). Costs/reach may become negligible as AIDS Competence Programme methods and knowledge spread in communities. Costs per Satisfied User¹⁸ likely to spread the process currently vary between US\$ 1.00 to US\$ 4.50.

(i) Sustainability¹⁹: initial AIDS Competence Programme partners continued to mobilize human resources and to use and share Programme tools and processes, after the lapse of the funding phase. A network comprised of the managers, facilitators and technical professionals of the AIDS Competence Programme formed a non-profit organization to promote its agenda: The *Constellation for AIDS Competence*.

¹⁶ The extent to which the results achieved by the programme still justify the costs incurred.

¹⁷ Direct Costs are those that are related and essential to the performance and continuation of the programme, and not those of related goods and services.

¹⁸ ‘Satisfied User’ considers only those who are confident that the ACP is achieving outcomes and is capable of achieving results (62% of ‘Reach’)

¹⁹ The likelihood that the ACP benefits will be maintained locally after withdrawal of external support and funding

(j) Impact: the main role of the AIDS Competence Programme is to strengthen the AIDS-related sociological elements within communities, which would result in better performing AIDS programmes. Different communities in many countries prioritize desired AIDS-related competencies, varying from participation of people living with HIV to resource mobilization. Implementing communities face different economic, social and political conditions, while community facilitators have different skills levels. It is therefore difficult to measure impact fairly or effectively. Again, it is still too early to assess general impact of the AIDS Competence Programme on Community HIV and AIDS conditions. However, using historical control groups, Curitiba Municipality's (Brazil) health section reports that last year (2004), there was 'not a single case' of parent (mother)-to-Child transmission of HIV. One medical doctor interviewed fully credits the training received through the AIDS Competence Programme's City AIDS programme conducted by CIFAL.

vi. Discussion

The AIDS Competence Programme's aims and objectives are sound in relation to the collective UNAIDS agenda and concordant with UNAIDS' Policy. The approach is effective when communities customize the tools and processes and when all stakeholders' mandates are clarified. The AIDS Competence Programme approach is highly cost-effective, given the fact that the Programme has been implemented in a variety of sites in about 30 countries and that with time the knowledge spreads without need for further funding. Some users debate whether the AIDS Competence Programme promotes advocacy and service quality. Some feel that the standards used for self-assessment by most communities are not adequate to give scientifically valid results. However, it is also argued that self-assessment improves community ownership. The AIDS Competence Programme/process would cost about US\$ 2.3 million to scale up in 50 developing countries over three to four years. Nationally, it would cost between US\$ 75 000 and US\$ 100 000. However, this costing has been done on the assumption that 10 subregional training of trainer workshops are held, while the 50 countries are granted US\$ 30 000 each to train community facilitators from remote areas. Out of this latter figure US\$ 5000 is used to coordinate the e-workspace; US\$ 500 000 is set aside for salaries and travelling expenses of two or three programme managers (one should be a knowledge management specialist).

vii. Recommendations

Due to differences in stakeholder roles, available AIDS Competence Programme methodologies and communal heterogeneity, specific recommendations have been addressed to each group of stakeholders.

Recommendations to donors, country offices and other partners

1. Efforts by communities to build competence in tackling multisectoral development problems through processes such as the AIDS Competence Programme and responding to HIV and AIDS should continue to be encouraged, strengthened, and scaled up.
2. Efforts should be made to continue to build the institutional relationship between UNAIDS and UNITAR, both within and beyond the AIDS Competence Programme, since it has proved fruitful so far. UNITAR's network and experience in training and knowledge generation at local and global levels could be a valuable resource in the scaling up of local health responses and the sharing of this knowledge internationally; which conforms to the general health and development sector aims. Similarly, other existing and evolving institutional partnerships ought to be maintained and promoted as far as their aims conform to the goals envisaged by the collective global response to AIDS.

3. The AIDS Competence Programme should be endorsed for use by other partners. The importance of transfer, exchange, and sharing of local responses should be recognized, promoted and supported.

4. For the AIDS Competence Programme to be even more successful in terms of reach, outcomes and impact, implementing partners' field offices ought to provide technical support and follow-up on communities' progress.

Communities and facilitators

5. Emphasis should be placed on the collection of baseline scientific/epidemiological data by prospective implementers of the AIDS Competence Programme. This would be useful in measuring outcomes and projecting impact.

6. The Internet should continue to be used as a cost-effective and sustainable tool for information exchange, even during lapses in funding, since it ensures continuity. At the local level, the Mobile (cell) phone and SMS texting may be considered as another effective option for instantaneous transfer of ideas, information and knowledge between remote communities.

Recommendations to programme managers

7. Efforts should be made to make donors, communities and other stakeholders better able to understand the AIDS Competence Programme and integrate it with existing community, national, and global AIDS and community-development programmes. For example, the process of facilitating rather than directing community responses to AIDS, which is a key component of the AIDS Competence Programme, is not well understood by all stakeholders. Communities are responsible for selecting and addressing competencies.

8. AIDS Competence Programme managers should make facilitators and communities understand and include gender roles, especially the importance of women and girls' participation, within the AIDS Competence Programme's design and implementation processes.

9. Regarding capacity building, AIDS Competence Programme objectives involving financial resource leveraging should be clarified from the definition of resource mobilization, which also includes technical, communal and human resource mobilization. Many stakeholders confuse this to mean that relatively poor communities are expected to mobilize their own financial resources.

10. Managers should directly assess ACP's implementation, address barriers to successful evaluations, encourage and perform routine surveillance activities and population based evaluations for outcomes and impact (seroprevalence, transmission, life years saved, etc.) evaluations.

1. Background and context

The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) reported that by December 2004 there were about 40 million people living with HIV. Few countries are reversing the trends of HIV infection. Annual incidence has increased in most countries and has generally been on the rise since 1990. Common characteristics are evident in countries where annual incidence has fallen as a result of successful programmes to address HIV. People within these countries have been motivated to respond to HIV intrinsically, progressively, together, and have worked to sustain their efforts towards fighting the pandemic. In fact, while HIV incidence has risen within the last two decades, there has been a universal convergence in methodologies and concepts employed to respond to it. Today, several key developments have been accepted as principles, assumptions or ways forward in the response to AIDS¹.

1. HIV is not only a health sector problem but also a multisectoral problem requiring a population rather than an individual approach to health promotion.

2. The social environment has been acknowledged to have a significant effect on individual and population health status.

3. From a global monitoring and evaluation as well as public service delivery perspective, health and related service systems are changing in favour of greater community ownership, leading to improved programme planning and performance, and therefore improvements in health status. Work by the WHO² through the District Response Initiative (DRI 1996–2000) and with partners UNAIDS and GTZ between 1996–1998 highlighted the existing gaps between the health sector and communities and the benefits of local responses. This previous work demonstrates that many countries are ready to implement the AIDS Competence Programme approach. The WHO further emphasizes the need to bridge health service delivery systems and communities in order to learn from the past 20 years of responding to the AIDS epidemic. This also helps to mobilize and utilize all resources available towards responding to AIDS³.

4. Governments and nongovernmental organizations have shown through their influence on, and collaboration with communities that they could play a huge role in assuring community ownership of HIV programmes. UNAIDS can play a meaningful role in developing this agenda.

5. Regarding the implementation of public-health policy, Local Authorities have the potential to ensure an enabling environment that reduces HIV- and AIDS-related risks. This potential has remained vastly untapped. In many countries, AIDS dramatically jeopardizes the quality of life of citizens and challenges the sustainable development of families, rural villages, towns, districts, cities and regions. Where public-health systems are devolved to the municipal or village level in any national administration, the local representative, such as Mayor or Councillor is ultimately responsible for the quality of life of citizens. From this perspective, emphasis could be placed on the role of civic leaders (mayor, municipal council leader) and the local government as an effective interface between local communities and public health services.

¹ Johns Hopkins University School of Public Health (June 2000) Resource Guide to concepts and methods in Community Based and Collaborative Problem Solving and UNAIDS Update 2004

² World Health Organization

³ WHO (2003), Partnership Work, The Health Service –Community Interface for the Prevention, Care and Treatment of HIV/AIDS, WHO Consultation Report, 5-6 Dec. 2002, Geneva, Switzerland.

Several evaluations of different preventative interventions within programmes (including behaviour change, knowledge and information dissemination and condom use) have led to the finding that there is greater impact from programmes that register higher degrees of collective psychological and sociological engagement; gains resulting from within communities rather than those imposed upon the individual and collective community will. Consequently, community mobilization, which promotes community ownership of projects, has steadily grown in importance in the response to HIV. A number of impact studies since 1991 have confirmed that most knowledge sharing and similar prevention programmes can achieve impact on HIV in terms of risk reduction, increased access to care, increased use of preventative methods and reduction in infection as well as prevalence rates if well implemented.

The AIDS Competence Programme promotes community ownership. The Programme defines ideal *AIDS Competence* as a situation where communities acknowledge and recognize the reality of HIV, act from strength to build capacity to respond to HIV, exchange and share knowledge and skills, reduce vulnerability to risks, and live to their full potential. Its focus is both on health promotion and disease prevention and treatment. This evaluation of the AIDS Competence Programme is part of a participatory process designed to investigate the efficiency of the Programme. It investigates the history, planning, processes and preliminary results within the AIDS Competence Programme using a logical framework, unified standards approach and several accepted analytic techniques from different disciplines. Desired qualitative and quantitative standards⁴ for community AIDS and general development programmes are measured against the original and updated objectives of the AIDS Competence Programme in a manner that fairly informs and addresses the evaluation needs of all stakeholders. This draft report presents, in a summarized form, the findings from the evaluation. Besides the response to AIDS, the AIDS Competence Programme addresses community development principles (e.g., sustainability of programmes) and the desired elements within communities (e.g., unity, shared resources, and common values). This evaluation assumes that the more communities grow in these principles and elements, the more competent they become in responding to AIDS. Change in AIDS competence is monitored through the AIDS Competence Programme's Self Assessment methodologies. A major component of the Programme was implemented and coordinated by Local Authorities and Local Actors. The word 'Communities' in this report also refers to Local Actors, or those involved in implementing the AIDS Competence Programme at the local as opposed to the national level.

2. History of the AIDS Competence Programme: converging perspectives

This section presents the chronology of the AIDS Competence Programme, beginning with the different developments within donor organizations and community needs which prompted its inception. It then summarizes the benefits of the Programme and challenges facing the Programme.

The AIDS Competence Programme is built on the principle that while effective individual responses to AIDS is the end goal, it cannot achieve desired results without competent

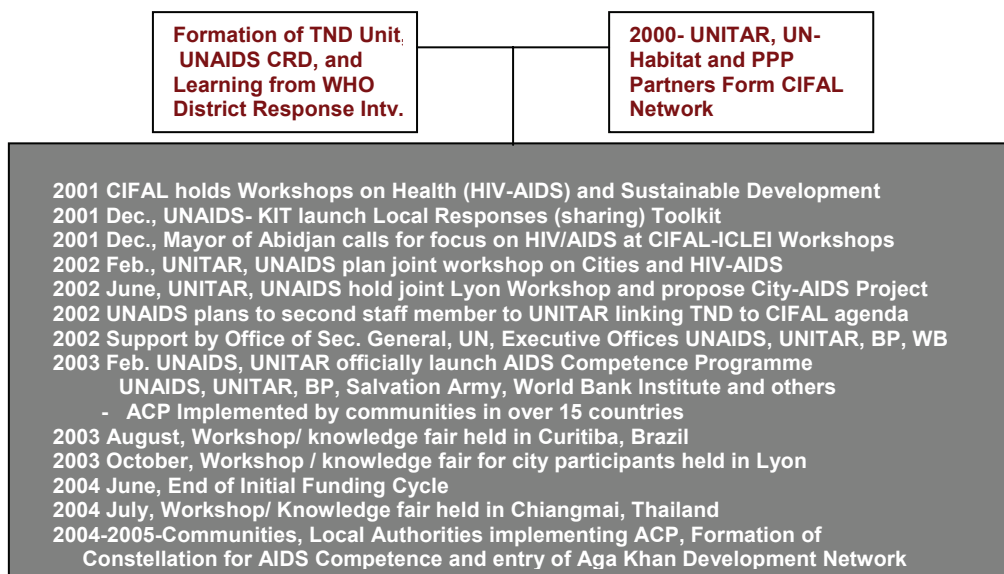
⁴ Standards measured include levels of achievement for community development principles: multidisciplinary collaboration, empowerment, participation, capacity building, sustainable development and equity. Also, notions of evidence-based decision-making and accountability, including donor and government decision-makers' needs from the evaluation have been measured.

communities that can reinforce, adapt, and spread this response. The communities' needs, available knowledge, and the many advantages of sharing this knowledge globally were strong reasons behind the programme's inception. The programme recognized the value of community ownership in improving programme planning and performance. UNAIDS, UNITAR, BP, the Salvation Army and the World Bank Institute merged in the knowledge that the goals of sustainable development, private sector aims and the response to AIDS offer common challenges hence leveraging resources would ensure better results. Different sectors and programmes over the past twenty years recognize community ownership as key to programme performance and have recommended community ownership strategies using concepts such as Community Empowerment, Community Competence, Community Mobilization, and Community Capacity Building. The AIDS Competence Process includes aspects of all of these different strategies.

2.1 The Joint United Nations Programme on HIV/AIDS (UNAIDS)

The Joint United Nations Programme on HIV/AIDS (UNAIDS), is the world's main advocate for action on the AIDS pandemic. It leads, strengthens, expands and supports an expanded response to the pandemic. This response is aimed at preventing transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV, and mitigating the impact of the epidemic. UNAIDS was formed in 1995, and its ten cosponsors are The High Commission for Refugees (UNHCR), UN Children's Fund (UNICEF), World Food Programme (WFP), UN Development Programme (UNDP), UN Population Fund (UNFPA), UN Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the UN Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO), and the World Bank.

Fig. 4 Chronology of the AIDS Competence Programme



Work by the WHO, especially through the District Response Initiative between 1996 and 2000 in Burkina Faso, Ghana, Uganda and Zambia, and work in collaboration with UNAIDS between 1996 and 1998 informed the need to learn from local responses and to provide a public health service-community interface. The Technical Network Development Unit of UNAIDS partnered with communities and Chiangmai University in Thailand, the Royal Tropical Institute of the Netherlands (KIT), a number of developing countries and other partners to implement a Local Response to the HIV/AIDS agenda

and enable sharing. In December 2001, a toolkit for sharing experiences was launched. The toolkit included a range of short documents providing practical examples and guidelines on how to perform activities aimed at promoting AIDS competence at community, district, and national levels. The toolkit focused on the use of simple methods and practical guidelines. Communities defined the practices that would be included in the tool's format. Communities would then contribute their experiences into a shared and toolbox (knowledge storage / management asset). With the University of Chiangmai's Faculty of Education, UNAIDS supported the Aids Education Programme, a multi-site, multi-disciplinary programme that led to participatory learning, capacity building, community transfer of knowledge, and experiences. The programme provided linkages between local responses, advocacy and development.

A training manual was developed for communities. It was planned that information would be shared through workshops, electronic media, networking, theatre, exchange visits, and information management tools. The initial phase of one such project with KIT was planned for between December 2001 and December 2002. The second phase focused on building human capacity through the training manual and scaling up the use of the tools, in collaboration with the Salvation Army. Much of the initial work was performed in communities in Chiangmai, Thailand, and East and Southern Africa. Later, Chiangmai (Thailand) AIDS Education Programme was to benefit from the Salvation Army's expertise in Human Capacity Development (HCD), networks in Africa and other partnerships with UNAIDS. During this stage serious discussions began with other partners to build a tool that would enhance human and community capacity to manage, assess, share, and use knowledge. These community initiatives and best practices would be translated into recommendations, which would be relied on at the global level to formulate policies and strategies. These global initiatives would also be transformed into results at country level. Thus, the cycle of knowledge generation from individuals to families to communities and then to districts would continue. By the time partnership discussions began with UNITAR, it was apparent that more expertise was needed in the area of Knowledge Management, and it was at this juncture that, recognizing BP's global leadership in this area, a British Petroleum (BP)-based knowledge management expert was sought. UNAIDS and UNITAR sought the company's assistance towards the development of a broader framework that used across communities, sectors, and programmes. To date, wide ranging partnerships have emerged out of the AIDS Competence and related Programmes.

2.2 The United Nations Institute for Training and Research (UNITAR)

The United Nations Institute for Training and Research (UNITAR) was established in 1965 as an autonomous body within the United Nations with the purpose of enhancing the effectiveness of the organization through appropriate training and research. UNITAR's programmes are established under two main clusters of activity: (i) training in international affairs management; and (ii) capacity-building in economic and social development and environment. UNITAR conducts about 150 programmes, seminars, conferences and workshops each year across five continents, targeted at more than 7500 participants. Simultaneously, the Institute has developed an original approach focusing on network maximization and intensification with partners inside and outside the United Nations System. UNITAR is the training arm of various United Nations Agencies, as well as Secretariats for international legal instruments. UNITAR strategically contributes to the creation and transfer of knowledge within these networks (more information about UNITAR on Partnerships is provided in Annex H).

Recognizing the growing influence and need for local authorities (decentralized government arms at the local/community level) due to increased urbanization, UNITAR

mandated its Decentralized Cooperation Programme (DCP) to form the CIFAL Network (International Training Centre for Local Authorities/Actors-the name is derived from its French Acronym) which was initiated in 2000 as a Public-Private Partnership including UN-HABITAT, the World Association of Cities and Local Authorities (WACLAC), the nongovernmental organization Global Ecovillage Network, and Veolia Environnement, one of the water management sector's leading companies. Since 2000 the CIFAL Network has provided training in different sectors and continents. To date the CIFAL network has extended to 11 International Training Centers for Local Authorities/Actors throughout the world. These centres are used for capacity building and knowledge sharing between local and regional authorities, civil society, private sector and international organizations to enhance local public services and quality of life for citizens.

As part of the UNITAR/DCP strategy, CITY-AIDS was formed under its humanitarian department to support a global network for increasing the competence of local government leaders and local actors in dealing with AIDS. It aims to facilitate learning from local responses and sharing of good practices by local governments and city networks worldwide. CITY-AIDS proposes to strengthen the capacity of local authorities and local actors in cities to respond to AIDS by self-assessing and improving their capabilities, learning from the lessons of other cities, and sharing their progress nationally and through local government networks (UCLG, FLACMA, PDM, CCRA, CITYNET, AIMF) (more information about other partners is available in Partnership ANNEX H).

2.3 Activities leading to the joint implementation of AIDS Competence Programme

In early 2001, several meetings were held between the UN and local authorities in Europe seeking ways to help rebuild the municipalities of Kosovo after the war. The number of ideas and lessons shared by participating cities was so impressive that it prompted the UN office in New York to recommend a similar knowledge and skill sharing strategy between the UN system, local authorities, and the private sector. Prior to the Johannesburg Conference on Sustainable Development, it was recommended that UNITAR work with the private sector and UN-HABITAT to promote the agenda of sharing knowledge and information between cities as a basis for sustainable development. Together with the International Council for Local Environmental Initiatives (ICLEI), a nongovernmental organization working with local authorities to promote sustainable development, a number of workshops were held in 2001. It was during the second day of one of these workshops in December 2001 that the mayor of Abidjan remarked that as mayor of a country plagued with the AIDS epidemic, he found it disturbing that the workshop focused purely on concepts of sustainable development while a threat as serious as AIDS was crippling any chances of growth and sustainable development in some regions. He remarked that as mayor he did not know what to do with his staff, who were succumbing to the epidemic, let alone knowing where to bury his citizens. This was an expectedly touching remark, prompting a series of discussions between the senior staff of UNITAR and UNAIDS representatives.

Fig. 5: UNITAR: CIFAL Training Centres Around The World, October 2004



In February 2002, UNITAR and UNAIDS representatives planned to hold one joint event before the Johannesburg Summit on Sustainable Development. This event was held in the French city of Lyon in June 2002. A special workshop on 'Sustainable Development and Public Health' was held within the event. It was here that a programme named 'CITY-AIDS' was proposed, to include the issue of AIDS in Sustainable Development. UNAIDS and UNITAR signed a Memorandum of Understanding, and similar arrangements were made between UNITAR and the World Bank Institute and other partners, including The Salvation Army. A leading global knowledge management expert was seconded from BP and UNAIDS to set up the AIDS Competence Programme which was to be based at UNITAR, Geneva. Statements of Support were received from the Office of the Secretary-General UN, and the Executive Directors of UNAIDS, UNITAR, BP and the World Bank. The programme was officially launched in February 2003.

2.4 An example of partner collaboration through AIDS Competence Knowledge Fairs

In 2003 and 2004 a series of workshops known as the AIDS Competence Knowledge Fairs were held in Curitiba, Brazil; Lyon, France; and Chiangmai in Thailand. These workshops brought together hundreds of people from many organizations. Participants of the Chiangmai knowledge Fair on 8 and 9 July 2004 included over 140 individuals from nongovernmental organizations, Local Authorities, UN agencies, and other organizations from 30 countries worldwide. This event was organized by UNAIDS and UNITAR AIDS Competence Programme in collaboration with the AIDS Education Programme from the University of Chiangmai, the Salvation Army, and the World Bank Leadership Programme. Financial Support was received from the French Ministries of Foreign Affairs and the Thai Ministry of Public Health. Using a similar format as earlier workshops, participants completed the Self-Assessment framework, (see Annex C).

Countries where **self-assessments** have been carried out widely include: Brazil (12 cities), Burkina Faso (24 nongovernmental organizations, Ouagadougou), Democratic Republic of Congo, East Timor, France, Guinea, India, Italy, Rwanda, Somalia, South Africa, Spain, Sweden, Thailand, Trinidad, Uganda, Ukraine, and Zambia. Many business groups have carried out these self-assessments, including The Coca Cola Company, British Petroleum, Nation Media Group, Group Bolloré, and The Brazil

Business Council. NORAD, the Norfund, UN agencies, The International Red Cross and others had either expressed a strong interest or used the self-assessment tools by March 2005. UNAIDS and UNITAR Secretariats have also performed their self-assessments. Thailand is one country where the self-assessments have been performed to a level that could inform an outcome evaluation.

Other processes of this and other workshops included:

- **Facilitation;** now used in Brazil, Thailand, Zambia, Rwanda, Eritrea, Kenya, Madagascar, Togo and Guinea.) Philippines, Uganda and Mali have requested help in the building of national facilitation teams.
- **Knowledge Exchange;** representatives from thirteen heterogeneous⁵ cities met in Lyon in October 2003 to share good practices and experiences. Representatives were from cities in some of the above-mentioned countries. The River Diagram was used as a tool for knowledge exchange.
- **Knowledge Assets:** after sharing experiences, the universal principles are identified and the knowledge is captured as a set of referenced principles and recommendations.
- **Continued dialogue and Sharing:** is enabled through electronic means by use of the e-Workspace an electronic knowledge exchange store managed from UNAIDS, with the internet as a backbone. Communities use a 'Stairs/ Step Diagram' representing those with something to learn and something to share within a specific area. Another tool used is a '**People Connector.**' The latter is a classified human resource directory similar to the 'Yellow Pages', which allows individuals to volunteer their skills to those who need them.

3. Description of the key components of the AIDS Competence Programme

This section presents the different methods and processes that form components of the AIDS Competence Programme in relation to existing strategies in local and global HIV- and AIDS-intervention programmes and provides a brief description for each of these methods.

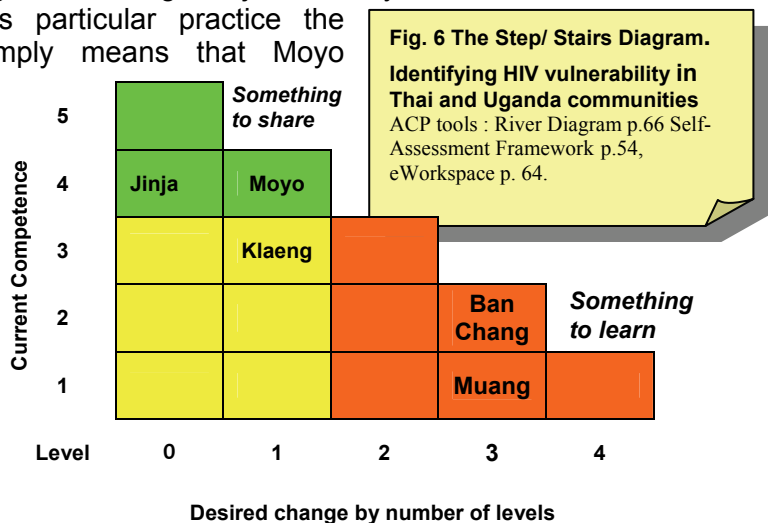
The AIDS Competence Programme introduces a community self-assessment tool and knowledge management process, which was developed in a similar fashion to the UNAIDS TND /KIT toolbox described in the 'History' section of this report. A Peer Assist session in Chiang Mai, Thailand led to the realization of the importance of such a tool. The original tool was a set of 16 practices which might contribute to communities becoming AIDS Competent, together with ideas for a set of five steps which would tend towards AIDS Competence in each practice. The tool was initially used in five principal countries, while providing support to other countries wishing to use the Self Assessment Framework/Matrix for AIDS competence. These countries were Thailand, Uganda, Zambia, Guinea, and Brazil. During the ensuing three months, the wording of the matrix was changed considerably to suit communities' needs, and its final framework consisted of ten practices and five progressive levels of achievement related to each practice.

3.1 AIDS Competence Programme Knowledge Management Assets/Information Exchange Tools

The **Self-Assessment Framework** (see Annex C) provides a valid basis for comparison and for learning between different countries, organizations, and communities. Community levels of achievement in many practices can be measured.

⁵ Different culturally, socioeconomically and politically

Ten common practices are: acknowledgement and recognition, inclusion, care and prevention, access to treatment, identification and addressing of vulnerability, learning and transfer, measurement of change, adaptation and response, ways of working, and resource mobilization. These practices may be shortened to five main objectives and standards that may be used to monitor progress within communities for AIDS Competence and to evaluate the performance of community AIDS programmes. These objectives are outlined in the subsequent section of this report. Communities then plot dots to match these 10 (or more) practices to their levels, forming a horizontal zigzag shaped line, above which another line showing their expected levels of achievement is plotted. The final graph resembles a river, hence the name **'River (of life) Diagram'**⁶ (see Annex G). Communities then award themselves marks between one (or zero representing low or lack of competence, and Five, representing high competence.) Communities can compare their River Diagrams with others. Through this process, they find out which other communities are best placed to provide or receive help from them in particular areas. Communities also map their levels of competence in particular areas into a **'Step/Stairs Diagram'** shown here. The *Stairs Diagram* uses the same competence levels as the *River of Life* and labels them vertically from one to five. The horizontal labels of the Step diagram are zero to four showing the number of levels by which each community would like to improve. Generally the communities in green boxes on the top of the stairs, are those with something to share, while those at the bottom red boxes have something to learn regarding, in this hypothetical example, the identification of factors that make communities more vulnerable to HIV infection. In this hypothetical example, Muang, and Ban Chang communities from North Eastern Thailand could learn how to identify factors promoting HIV risks efficiently from either Jinja City or Moyo community of Uganda. Though Jinja and Moyo are each at the same competence level (4) in this particular practice the horizontal difference in boxes simply means that Moyo community would like to improve by one competence level while Jinja is comfortable with its current level. This sharing continues for other practices and each has something to learn and share. For example, communities which are particularly strong at increasing community knowledge while weak in measuring change or mobilizing resources can share ideas and resources with stronger and weaker communities in these respective areas.



The process of exchanging this information at a local or global level in real time is facilitated through a common e-Workspace (see page 64), e-Forum (an electronic forum dedicated to the exchange of AIDS Competence Programme-related information within the e-Workspace) and other electronic forms of global communication relying on the internet to store and exchange information either directly or moderated by an implementing partner (in this case UNAIDS). Training for community facilitators is done through face-to-face meetings at the local level, while updated knowledge and materials are continually shared electronically. By using these processes, communities are also able to develop sustainable skills; organizational structures, resources, and commitment to respond systematically and effectively to the particular AIDS issues

⁶ 'River of life' is the expression adapted from the Salvation Army, who related the River Diagram to their belief that the human being has the capacity to respond to different situations in life, once facilitated.

facing them. Communities also improve programme planning and performance, outcomes, impact and the health situation. Other business and development areas also benefit from the use of the AIDS Competence Programme's tools.

3.2 AIDS Competence Programme strategies and options

The AIDS Competence Programme methodology offers a range of options for improving the community's role in the response to AIDS. Because the Programme is implemented by heterogeneous (with social, cultural, economic, political, and legal differences) and constantly changing communities, and because its tools are used by different types of programmes, there is no one method that will work for all settings. The AIDS Competence Programme shares several strategies with other programmes designed to respond to AIDS:

(a) Information and Communication Technology (ICT) and Knowledge Sharing (IEC strategies),

- Providing an Information Technology-enabled environment (e-Workspace) for the exchange of experiences within and between countries, in the form of an online directory and collaborative platform for all willing participants.
- Supporting the flow of knowledge through partnering groups that have something to share and those that want to learn and through building on each other's knowledge and developing policies from lessons learned.

(b) Training of Trainers

- Training different community leaders and trainers to assess their levels of AIDS Competence, set improvement targets, monitor their response and progress, share experiences, and learn efficiently from the best existing sources.

(c) Community Competence Building

(which includes all concepts and principles of community mobilization and development from the public and private sectors.)

- Providing support to the establishment and operation of facilitation teams
- Promoting local ownership of the responses to AIDS in order to learn from local experience and transfer lessons to their organizations.

3.3 The AIDS Competence implementation process

The AIDS Competence Programme provides a facilitative process through which communities come to believe in their capacity to respond and become empowered/inspired to act as a group. In 2003, there were at least eight countries where one or more key organizations had initiated the self-assessment for AIDS Competence. The Programme, if well adapted, addresses most of the Millennium Development Goals. The management team travelled to seven of countries to implement the process, including Brazil, France, Guinea, Norway, Thailand, Uganda, and Zambia. Strategies employed by the programme include the following.

(a) Facilitation and Training of Trainers

The programme managers train facilitation teams who sustain the flow of knowledge by learning from local responses and translating the lessons into organizational practice. This facilitation has been fostered by the Salvation Army. National facilitation teams met in June in Zambia and established the Africa facilitation network with a view to expanding the process throughout Africa. Countries interested in establishing national facilitation teams included the Philippines, Madagascar, Mali, and Uganda.

(b) Community Capacity/Competence Building: Self-Assessments

Communities self-assess and compare their levels of performance in many areas of HIV and AIDS using the 'River of Life' diagram as a competence-assessment tool. They then share knowledge, skills, and experiences with other communities. Developing countries that have completed the self-assessments include Brazil (12 cities), Burkina Faso (24 nongovernmental organizations, Ouagadougou), the Democratic Republic of the Congo, East Timor, Guinea (UN Theme Group, nongovernmental organizations and sub-districts), and India (Bombay) among others.

(c) Knowledge assessment, management, and exchange

Through this component, cities and organizations have met to share successful practices and experience. In October 2003, 13 three-person teams from different cities represented by met in Lyon to share good practices and experiences learned from Local Responses to AIDS. Each team comprised of a senior municipal officer, a representative of a local nongovernmental organization, and a person living with HIV.

(d) Information and communication technology: e-Workspace

To sustain and reinforce the knowledge exchange process, the participants are connected through modern information technology, principally via the Internet. A number of e-Workspaces exist to support different topics, and a total of over 1500 participants had visited the e-Workspace by October 2004 (please see sample of e-Workspace on Annex).

Each country and community is left to tailor their own AIDS programme based on their AIDS priorities. Countries such as Madagascar and Uganda planned more general programmes which included most major aspects of the response to AIDS: Behaviour Change Communication through mass media campaigns, condom marketing and promotion, peer to peer learning, and counselling. These countries developed clear logical frameworks for their programmes and would be in a position to assess the impact of the AIDS Competence Programme.

4. Rationale for the evaluation

This section presents reasons why this evaluation was necessary, the programmatic differences between AIDS Competence Programme and other programmes and which approaches the evaluation chose. It further describes why the evaluation chose these approaches, and what the AIDS Competence Programme as well as the evaluation adds to global programmes and other evaluations respectively.

The present evaluation is of a formative nature, which seeks to improve implementation of the AIDS Competence Programme even further. It therefore focuses on processes and outcomes. An attempt to evaluate the impact of the whole AIDS Competence Programme and community interventions adopts a futuristic methodology that asks: 'Based on credible outcomes from the AIDS Competence Programme, would this programme have a future effect ($p < x\%$)?'⁷. The evaluation takes the greatest possible care to be fair, inclusive, and informative, and to include the participation of all stakeholder groups, including donors, programme managers, and communities. The evaluation considers needs and objectives of all stakeholders prior to recommendations.

The AIDS Competence Programme reached the end of its initial funding cycle, which was between January 2003 and June 2004. An evaluation of the AIDS Competence

⁷ Based only on the ACP processes implemented by communities, if separated from existing community interventions.

Programme was requested at a UNAIDS Programme Coordinating Board meeting in June 2004. This resulting evaluation measures the effectiveness and efficiency of the AIDS Competence Programme process and outcomes. The evaluation attempts to include all stakeholder groups in prioritizing what to measure, how to measure it, and how to inform about the findings, as recommended for community health programme evaluations. This involves the setting of standards for evaluation and means of measurement with each stakeholder. The different options are then unified by selecting indicators that are universally acceptable, and which would be considered to fairly judge each stakeholder. Two major ways of perceiving the AIDS Competence Programme are addressed by this evaluation. This is significant because they have traditionally been the cause of differences in opinion between stakeholders (practitioners and decision-makers) in community-development programmes:

(i) The extent to which the AIDS Competence Programme adds value to the beneficiary communities, based on the principles of empowerment, participation (ownership), multidisciplinary collaboration, capacity building, equity, and sustainable development.

(ii) The need to inform donors, managers, and all decision-makers using evidence-based and inclusive concepts of transparency and accountability as well as other process, outcome, and impact measurements. The evaluation also seeks to include any omissions during the programme planning stage that may have undermined the cooperation, coordination, and communication process within and outside the AIDS Competence Programme, and which is within the scope of the evaluation to address.

4.1 Distinguishing characteristics and value added of this evaluation

This evaluation considers:

(1) Heterogeneity and dynamism of communities: communities that are different in kind and nature, including cultural, social, economic, and political differences, have implemented the programme. These communities are constantly changing.

(2) Different levels and subjects of evaluation: each of the partners and stakeholders is evaluated for process, outcomes and probability of impact in future. This is understandably a cumbersome process which calls for a unique yet practical evaluation approach and design. This design has therefore stressed unification of objectives and standards of measurement.

(3) Baseline differences in practitioners' competence: globally, practitioners of varying skill and experience have implemented and continue to implement components and variants of the AIDS Competence Programme. Social, economic and political factors within different contexts have been considered. To an acceptable degree, communities' self-assessed outcomes validated by experienced local facilitators have been analyzed, sorted for global relevance, and reported in this evaluation.

(4) Multiple standards of evaluation, lack of programmatic point of reference for indicators: The AIDS Competence Programme addresses community ownership, empowerment, participation, sustainability, and capacity building, whose measurement during evaluations has traditionally been in conflict with the core issues of propriety, scientific measurement, feasibility, politics and other issues. It also reports on efficiency, which is a question of effective financial, human, and technical resource use. It also considers the interests of each stakeholder, which would determine future support or lack of it. This was not done during the programme planning stage.

(5) Need for innovation, information and scientific soundness: There was a view that the evaluation at this stage could only be a priori rather than a posteriori⁸, but this evaluation has managed to address both views despite methodological and normative (ethical) constraints. The evaluation has attempted to measure probability alongside plausibility (comparable to verifiable changes) and adequacy (quality and processes). However, this evaluation suggests a method for estimating expected impact within the short term through static or dynamic models.

4.2 The AIDS Competence Programme evaluation also distinguishes itself by addressing issues not yet addressed by previous programme reports.

Among these are:

(1) The evaluation informs donors and other decision makers on the costs, effectiveness, and efficiency levels of the AIDS Competence Programme including present and, when possible, future components and their potential impacts. The AIDS Competence Programme evaluation is the result of an internal administrative requirement. (It was stipulated in the Memorandum of Understanding between UNITAR and UNAIDS in February 2003 and by extension, other stakeholders.)

(2) The evaluation provides additional and more generally acceptable standards of measurement (for feasibility, normative, scientific measures of process, and outcome). In communities where it is possible, the present and future impact of the Programme which has not been included in other evaluations, and which would be generally more acceptable to all groups has been considered (see Annex E on key questions).

(3) The evaluation introduces a framework and potential model for future evaluation of global and local community projects and programmes that are implemented within cultural, social, political, and economically heterogeneous settings.

(4) A significant part of the evaluation's methodology is a Logical Framework that brings the evaluative process back into the design of the project. This feature of the methodology will assist in clarifying stakeholder roles and will allow the evaluators to trace the inherent risks of the programme and the implementation of AIDS Competence Processes chronologically. If possible it is recommended that communities intending to implement the process perform an initial/ baseline data collection to enable them to compare changes in scientific data (outcomes and impact) periodically.

(5) Another introduction is a model/ comparison table that assists in the generation of questions that are relevant to all stakeholders helping them to carry out interviews. These questions could be associated to indicators of measurement that would be universally acceptable.

(6) The major global challenges existing today are covered by the Millennium Development Goals (MDGs) and stipulated in the United Nations Millennium Declaration of September 2000. For more information on Millennium Development Goals, please visit: <http://www.developmentgoals.org>. The AIDS Competence Programme is a unique programme (providing a series of assets and processes) that can make substantial contributions to most of the Millennium Development Goals. It was also formulated as a Public-Private Partnership to address the eighth Millennium Development Goal which calls for stakeholders to 'Develop a global partnership for development' that strengthens the role of the private sector information and communication technologies and is open to

⁸ i.e. A priori: without prior investigation or experience, based on general knowledge or accepted logical truths about community programmes. Opposite—a posteriori: after investigating or experiencing changes brought about by the ACP within communities from their perspective.

every stakeholder in global and local development. The AIDS Competence Programme's methodology principally originates from the private sector, particularly from British Petroleum, a leader in knowledge management. The Salvation Army is a strong contributor of processes for Human Capacity Development. The differences in what to measure, methods to use and types of variables to measure in each of these are enormous. The evaluation methodology could therefore be a model for referral by future programmes.

5. Findings

The first part of this section summarizes findings from a review of AIDS Competence Programme documents alongside findings from key informants while the second part presents a review of related literature as benchmark for programme structure, costs, and effectiveness comparison. Where necessary, earlier AIDS Competence Programme data which may have minimally provided a portion of this data has been validated by enlarging the sample size from about 10 to 50 (and in some cases entire communities). Original research has been used to come up with efficiency measures and benchmarks.

The AIDS Competence Programme provides a knowledge management and sharing process that could boost the development, monitoring, and implementation of community programmes. It could also strengthen existing interventions within countries and globally. In particular, development programmes could borrow from the following.

(1) The autonomous monitoring nature of the knowledge management tools and methodologies: Communities perform their own monitoring, making future evaluation simpler and less time taking.

(2) The AIDS Competence Programme's methodology comprehensively addresses and benefits from the needs and knowledge within the practicing communities by allowing them ownership of the programme.

(3) The AIDS Competence Programme tools, which are relevant across sectors, countries, and communities. They enhance the pragmatism, innovation, and resourcefulness of the different stakeholder groups.

(4) Its ability to enable different organizations and communities, nationally and internationally, to share knowledge and skills in real time and in a systematic, measurable way.

(5) The AIDS Competence Programme's provision of a robust, useful, and practical methodology that can be implemented across different sectors and is therefore attractive to different types of partners. Methodology is useful both for business and development partners.

(6) The AIDS Competence Programme process, which adequately provides for and promotes all the principles and elements of community capacity building while relating them to the global and local response to AIDS.

5.1 AIDS Competence Programme results

(a) End-user satisfaction: about 85% of those questioned and recorded are completely satisfied with every aspect of the AIDS Competence Programme. Other findings were that 33% of interviewees were 'Very Confident' that the Programme had helped reduce HIV and AIDS in the community, 50 % of interviewees were 'Confident' while 17% were 'Not Confident.' Samples sizes ($n \geq 50$) here needed to be enlarged and validated through interviews. Following a similar pattern to earlier interviews, 87% of those

interviewed found the knowledge assets introduced by the AIDS Competence Programme useful to varying degrees: Very Useful 25% and Useful 37% (These two groups comprising of 62% are the most likely to transfer it to other people and communities), Somewhat Useful 25%, and 13% had not used the Knowledge Assets. Enlarging and validating (n) again, only about 14% had not used the Knowledge Assets and were not confident that the Programme would meet all desired goals of reducing HIV vulnerability and risk. Communities are happy with the tools and robust methodology but would like more leeway to customize tools according to their respective needs. They request that the tools be made more flexible.

Effectiveness:⁹ Sample size (n) for qualitative evaluation questions is 50. The number of respondents varies per question or issue. To measure processes and outcomes such as current and potential reach, whole communities have been considered. Almost half of communities interviewed are already reporting impact. However some of these have not been validated scientifically.

(b) Community HIV and AIDS outcomes: Many communities did not rigorously measure HIV and AIDS outcomes since they thought that compiling and filling the self-assessment framework (see Annex C) over time was adequate. Thailand is one of the countries with communities which have carried out self-assessments to the level of informing an outcome evaluation. Seventeen communities in Bangkok and a further 13 in Eastern and North Eastern Provinces carried out self assessments and used the river diagram between 2003 and 2005. In total, around 40 Thai communities have carried out self-assessments through the PPLLR project (Project of Participatory Learning from Local Responses in Thailand). In Bangkok, 18% of participants reported improved attitudes towards people living with HIV/AIDS. 56% reported being involved in community AIDS activities. The pre and post programme evaluation reported an increase of 114% in this number.

Fig. 7 Outcomes From Seven Communities In North Eastern Thailand

OUTCOME	BASELINE (2003) *	CURRENT (2005) *
Knowledge and acknowledgement of HIV and AIDS	46%	77%
Positive Attitudes Towards People Living with HIV	51%	80%
Women Participation and Support in AIDS Work	45%	80%
Resource Mobilization	42%	71%
Identification and addressing of Risks and Vulnerabilities	49%	86%
Treatment Availability for People Living with HIV	37%	71%

* Based on 0-low-0% while 5-100%, High

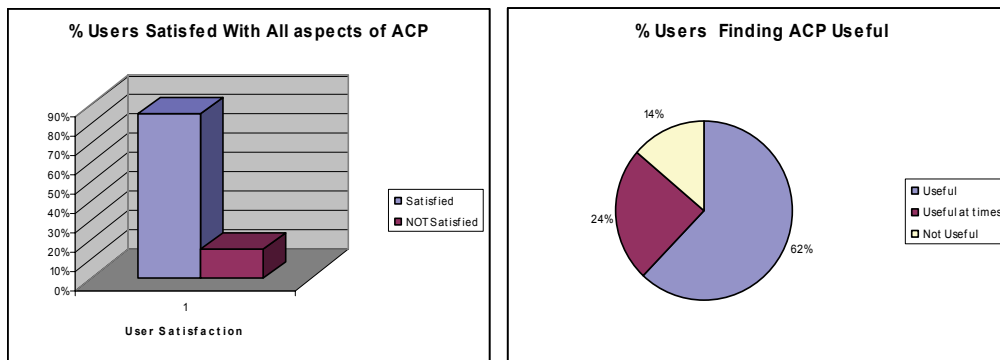
Among the Thai communities considered for this evaluation are Ban Dung, Kham Pia, Chong Mek, Muang Suang, NaPasaeng, Kheelek, and Moo Mon, in Eastern and North Eastern Thailand. The reported outcomes are based on community self-assessments performed in collaboration with the Chiangmai University. Results were generally positive. NaPasaeng community though reported a drop in community work with youth and men who have sex with men (MSM). Chong Mek also reported a drop in levels of working with men who have sex with men. Kheelek community reported no change in community work with Commercial Sex Workers. No reasons were provided for these conditions. No raw data were provided. There was no explanation as to how these were arrived at. It is assumed that these were based on experiential standards. However, the outcomes were validated by a locally based and former UNAIDS professional attached to the University of Chiangmai.

⁹ The extent to which the programme achieved its objectives and reached its target group.

Another positive point is that these were self-evaluations that promoted community ownership, and which reflected on communities' willingness and ability to measure change. Also, it is worth noting that in some areas where percentage change was low, the baseline data already reflected high, or close to 100% competence. A weakness in baseline and current community comparisons is that whole communities have been considered and not weighted according to the number of people they represent. However, community populations do not vary significantly enough to influence results.

(c) Multisectoral and multidisciplinary collaboration: the many leading multinational businesses that had expressed an interest in the AIDS Competence Programme tools by October 2004 included British Petroleum, Coca Cola Company, Groupe Bolloré, and the Brazil Business Council on AIDS. Donor groups included NORAD, Norfund, and other donors. In some countries UN Agencies, Media Houses, Schools, hospitals, industrial manufacturers, leading musicians, government representatives, Local, municipal authority heads, rural community representatives and people living with HIV, medical professionals, and others have attended some of the Programme workshops.

Fig.8. Confidence That The AIDS Competence Programme Is Achieving Positive Outcomes And Will Achieve Impact In Communities Implementing It (Please Refer To Annex On ACP Questions)



Governmental organizations represented 37% of all participants. Nongovernmental Organizations represented were 25%; Educational Institutions were 13% while others were 25%. At the global level, there were five officially signed agreements between AIDS Competence Programme partners by the end of June 2004. In Thailand for example, Chiangmai University's AIDS Education Programme, which uses the AIDS Competence process, has collaborated with WHO, AusAID, JICA, UNICEF, FHI, NCA, BP, and The Salvation Army, among others.

(d) Community empowerment¹⁰, participation¹¹, ownership and inclusion: communities expressed interest and committed some resources before managers worked with them. The Internet communication bandwidth (speed) was compatible with all global zones. Stakeholder inclusion was a key requirement of the ACP process. Some communities in very poor rural settings still have problems reaching service providers or mobilizing basic resources- it is debated whether the AIDS Competence Programme builds community competence in advocacy. Community participation in development programmes in Thailand increased by 114% from pre-implementation rates. Some practitioners felt that there was an inadequate definition and treatment of gender roles and the impact of women and girls' participation on community programme performance. The AIDS Competence Programme lacked a comprehensive programme plan at the partner level due to its initial research and development nature. There was no listing of planned activities that would logically lead to expected future outcomes and

¹⁰ When communities have genuine power in decision-making bodies.

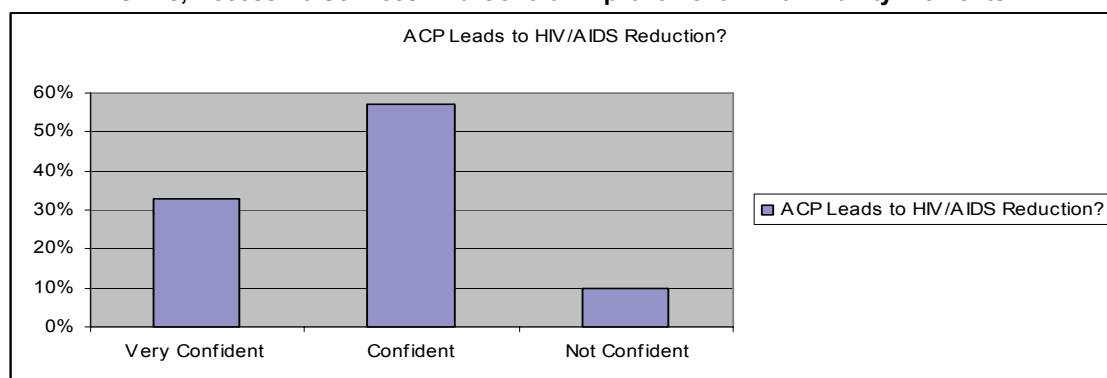
¹¹ Process through which communities influence and share control the AIDS Competence Programme's initiatives, decisions and resources that affect them.

impact, upon which evaluators would later benchmark performance. There were therefore no baseline indicators to evaluate programme processes, and no internal means of verification. It was explained that this stage of the ACP was conceived as a phase for researching and developing a universally acceptable set of assessment and information exchange tools.

(e) Community cohesion: an evaluation in Thailand reported that cohesion (in terms of unity and camaraderie), was improved significantly, as 43% of respondents in Thailand reported increased unity and support of each other since the inception of the AIDS Competence Programme. This cohesion was brought about by increased trust in each other, representative nongovernmental organizations, Partner Managers and belief in the ability of the Programme process and knowledge management tools to build community competence. These findings relied on experiential measures by those who have lived within the communities, rather than equally valid scientific measurements such as those proposed by the World Bank operations evaluation department (see World Bank references).

(f) Reach¹² and coverage¹³: low- and middle-income countries that have completed the self assessments are nearly 30 and included Burkina Faso (24 NGOs, Ouagadougou), DR Congo, East Timor, Guinea (UN Theme Group, NGOs and sub-districts), India, Rwanda, (Districts and NGOs) and South Africa, (Durban). Others include Brazil (12 cities), Thailand (17 sub-districts, Bangkok), Trinidad (port of Spain), Uganda *associations of PWA, Jinja), Togo (ICRC), Madagascar (National AIDS Programme), Kenya (The Aga Khan business and development network) and Zambia (9 UN organizations, NGO and government). Other countries that have used the tool include France (Lyon), Spain, Ukraine, Italy, and Sweden. The reach of the programme continues to increase. The UN system in Eritrea also implemented the AIDS Competence Programme successfully, influencing decisions by the private sector and by the UN offices in other countries to implement it. The total reach of the programme has long passed the 1 million figure. The potential population that the programme could target at its current state runs into tens of millions, but in order to capture a true picture during the evaluation, only coverage, reach and direct costs are used to measure efficiency among implementing populations.

Fig. 9 Percentage Of Respondents Confident That ACP Builds Competence And Leads To Reduction In HIV/AIDS Within Communities. Confidence Based On Visible Outcomes Regarding Behaviour, Skills, Access To Services And General Improvement In Community Elements.



¹² The limits within which the ACP can be effective ; based on quality of information passed, quality of methods by which it is passed, the degree of retention and the ability to pass it around to other people, while still achieving results for the programme.

¹³ Distance, area and number of people that have in any way come into contact with the ACP.

In many countries the AIDS Competence Programme has developed an extremely valuable strategy by targeting existing development-business partnerships. For instance, the Programme has collaborated with the Aga-Khan Development Network in Kenya which controls interests in East Africa's largest business and development organizations—including a media house (The Nation Media Group) which serves over 90 million people daily, the Aga Khan group of schools, hospitals, hotels—all of which are spread out in major urban areas of East Africa. The AIDS Competence Programme also benefits from a number of e-Workspaces branched from UNAIDS main website. They have facilitated the spread of the AIDS Competence Programme tools and methodologies. Based on a previous study, 71% of respondents had shared strengths gained from the AIDS Competence Programme with others within their own countries, while 29 % had shared these with others from outside the country. Again, the sample size was low. In subsequent telephone interviews, the proportion of people who had shared experiences with others remained 100%, while a GIS mapping of the expansion of the Programme's coverage shows that it is spreading steadily among communities.

(g) Information exchange, Knowledge Management Tools and Electronic discussions: the Knowledge Assets of the AIDS Competence Programme are easily available and transferable within communities. They can also be useful for future expansion of the programme. After the completion of the first funding cycle, the tool has continued to spread among communities. However, the e-Workspace should not have been left to go idle, as it has hindered the continuing collection of information and the sharing of knowledge at a higher pace despite the relatively low cost of maintenance e-Workspaces became principal modes of quick interactions and the number of direct participants went into the thousands by end August 2004. Based on an internal AIDS Competence Programme evaluation of electronic discussions, 74% of respondents had both read and contributed to the discussion postings, 13% had only read, while a similar percentage did not participate at all in the electronic discussions. The e-Workspace remained partially idle as the moderator was not supported after initial phase ended, despite need from the communities. The e-Forum remained completely idle. In June 2005 the e-Workspace and e-Forum were completely revived following an initiative of the Constellation for AIDS Competence, and is now fully active, with hundreds of new users per week registering. Most communities are still implementing and using the Programme tools and processes. There were no complaints regarding the River and Step diagrams once understood. The Self-Assessment framework has been 'customized' successfully in Brazil, Thailand, Eritrea, Kenya, Madagascar, Uganda and other countries.

(h). Financial Efficiency¹⁴ and feasibility and related results

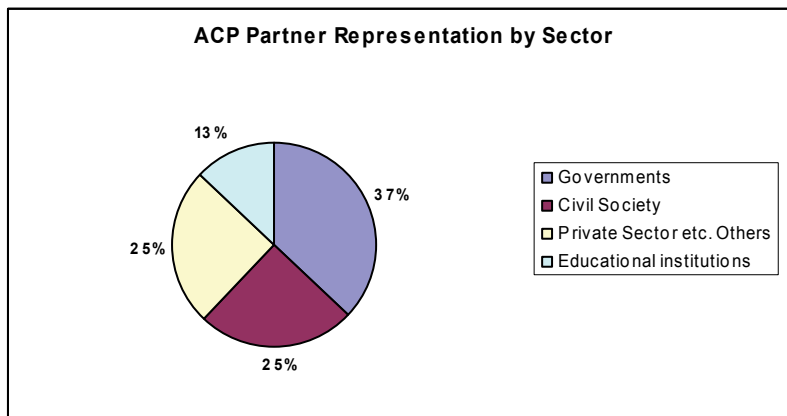
Costing: Costing methodology used conforms to standard project costing guidelines. The AIDS Competence Programme is highly cost-effective if benchmarked against the more cost-effective global and community programmes. Impact studies remain to be carried out which may change the level of effectiveness, but they are unlikely to vary it by more than a few dollars per health improvement measured.

Costs: The full costs of the programmes, including headquarter-based staff salaries and all contributions through UNAIDS and UNITAR, amounted to US\$ 650 000. From UNAIDS and UNITAR's contributions (This refers to the funding that the AIDS Competence Programme received from UNAIDS and UNITAR, including cities and organs that donated through the two organizations.), direct costs¹⁵ are estimated to be US\$ 300 000.

¹⁴ The extent to which the results achieved by the programme still justify the costs incurred

¹⁵ Direct Costs are those that are related and essential to the performance and continuation of the programme, and not those of related goods and services.

Fig. 10 Percentage Composition Of ACP Partners By Sector, October 2004. (This Changed To Include More Private Sector And City Participants In The First Quarter Of 2005.)



Cost-effectiveness: effectiveness here refers to reach, coverage, and end-user satisfaction; impact studies should now be carried out by each community. Currently, efficiency varies between US\$ 0.30 to US\$ 2.00 per person reached and tends towards zero over time. Variations would be due to differences within communities implementing the AIDS Competence Programme. The Programme is also implemented in some industrialized countries where the costs of living are among the highest in the world. This has increased the AIDS Competence Programme costs significantly. Admittedly, the programme costs would never be negative, but they may end up being negligible as the methodology and knowledge spreads across communities. Costs per satisfied user who is likely to spread the process currently vary between US\$ 1.00 to US\$ 4.50. Satisfied users are the 62% who, based on several responses on confidence of achieving outcomes and impact, and also through scientific theories of behaviour, would share the AIDS Competence Programme tools and processes effectively (see methodology Annex A, on Madagascar case study on measuring reach).

Based on past projects and methodology, a threshold of 30 000 adult participants was estimated as a figure that, if achieved, would list AIDS Competence Programme among the more cost-effective (based on reach) projects at US\$ 10 per adult reached. Based on UNFPA's estimation of average fertility rate for developing countries, (at 3.1 children per woman-between 4.5 and 6 in most of these countries), adults that participate in this programme are expected to transmit their knowledge to at least three children, and at least one other adult with a reasonable level of effectiveness. This brings the calculated cost per person reached at between US\$ 2.00 and US\$ 2.50. The actual cost per person reached (effectively) could be anywhere between US\$ 0.10 and US\$ 3.00, but the above cost could still be considered prudent. This cost per person tends towards zero over time as an increasing number of people are reached, and the programme extends its coverage. By April 2005, it was estimated to be under US\$ 1.00 per person reached.

The multiplicity of education and communication technologies used (internet, public forums, training of trainers, institutional, multisectoral participation—including media, school teachers, nurses, lay participants and leaders) and the fact that the AIDS Competence Programme has been implemented in nearly 30 countries already, means that the reach is expected to be over one million currently. (Measures by ITU¹⁶ on

¹⁶ International Telecommunications Union, United Nations lead agency for Coordinating Global Telecommunications

information exchange can be applied here e.g., based on how many share the newspaper, make telephone calls or exchange e-mails per day.) At this coverage figure, the AIDS Competence Programme already ranks among the more effective community and other development programmes so far.

Compared to other similar large-scale programmes (i.e., those implemented countrywide, in multicultural, multisectoral settings, or multiprocess programmes) that use Information, Training, Education and Communication strategies, AIDS Competence Programme processes are still found more adaptable to existing interventions at lower costs. Programmes that may be compared to the AIDS Competence Programme, to varying degrees, include the ICT and HIV/AIDS Preventive Education in the Cross-Border Areas of the Greater Mekong subregion (GMS countries: Cambodia, China, Laos People's democratic Republic, Thailand and Viet Nam.) GMS project partners were the Asian Development Bank, UNESCO 2003-2004, which cost US\$ 1.8 million and was expected to reach a total of 80 000 people in two to three years. Cost per person reached was found to be US\$ 23. The Mekong Project 2003 involved ICT use, capacity building, including training for trainers, and the use of ICT for knowledge sharing. Other similar projects and associated costs per person reached include an earlier Mekong Programme (1996) which eventually reached 14 million people at less than US\$ 1 each, and a Government of Jamaica/JICA, UNESCO programme that cost US\$ 20 per person reached between February 2004 and 2005. The figure is expected to decrease to around US\$ 1 in five years as more people are reached by the programme.

(i) Sustainability¹⁷: groups have shown commitment through: (i) resource mobilization (financial resources raised in relation to the programme by one partner since the end of funding in June 2003 amount to over US\$ 300 000, while another partner has obtained human resources, institutional partnerships, and potential coverage of the programme that could spread out to communities covering a further projected 45 million people if well followed up); (ii) continued use of knowledge management and sharing tools within their internal and external programmes; and/or (3) adaptation and use of methodologies for their own internal programmes.

Special mention ought to be made of a new partner, the Aga Khan Development Network and Business concerns, whose direct community, business, and civil society network has been extremely valuable in shaping the lives of hundreds of millions globally over the past decades, and whose contribution stands to add immense value to the AIDS Competence Programme. For instance, in one subregion alone, the network owns leading schools, hospitals, finance institutions, hotels, industries, and supports nongovernmental organizations, and other organizations serving over 90 million people each day. A network comprised of the original managers, facilitators, and technical professionals in the initial funding phase of the AIDS Competence Programme has also developed through the Constellation for AIDS Competence, and this degree of commitment is being transferred to communities currently. Those interviewed within communities increasingly request follow-up opportunities and declare interest in facilitating more sessions in order to enlarge the network. More Private Sector partners are joining the process.

(j) Measures of impact and expected Impact: the main role of the AIDS Competence Programme is to strengthen the AIDS-related sociological elements within communities that would result in better performing AIDS programmes. *Different* communities in many *different* countries prioritize *different* AIDS-related competencies, varying from participation of women and girls, men who have sex with men sex workers, to resource

¹⁷ The likelihood that the ACP benefits will be maintained locally after withdrawal of external support and funding.

mobilization. Again, implementers have varying skills and live under different social, economic and political conditions. As such, it would be difficult to measure impact either fairly or effectively (for more information see methodology Annex A).

Impact estimations will be different according to:

- (1) The community implementing the AIDS Competence Programme (with its socioeconomic, health, legal, and political settings).
- (2) Time of implementation (before, during or after a different programme, before new scientific developments, etc).
- (3) Type of intervention (behaviour change communication, prevention of mother-to-child transmission). Once baseline and other data are available, it is easy to input into a model or build a community specific impact measurement model based built along the methodology of existing models.
- (4) The role of the AIDS Competence Programme; whether it is a stand-alone or a supporting programme for existing interventions.

Impact results were already available for Curitiba in Brazil and a number of Thai Communities. In Curitiba, Brazil, a municipal doctor, who is also the president of the World Family Organization, reports that in 2004 there was not a single case of mother-to-child transmission of HIV, an improvement for which she credits the training received within the AIDS Competence Programme/CITY-AIDS programme conducted by CIFAL. In Brazil, the AIDS Competence Programme's cost per infection/case averted was estimated to be about US\$ 10, which may be considered low. This may be benchmarked against a similar figure from an evaluation of prevention of mother-to-child transmission programmes in sub-Saharan Africa by UNICEF (2002), where costs per case averted were found to be around US\$ 25; however this cost-effectiveness analysis factored in the provision of Nevirapine and Zidovudine (antiretroviral drugs), caesarean births and other costs.

In Curitiba, generally, there has also been a reduction in the number of new infections from an initial figure of about 600 to about 500 new infections annually. However, these have not been validated scientifically to be purely a result of the AIDS Competence Programme, and it is unlikely that this is the case. For the rest of the communities, data gathering and impact projections were recommended. Impact estimations would be different according to: (i) community implementing the AIDS Competence Programme, (due to differences in socioeconomic, health, legal and political settings); (ii) time of implementation (before or after a complementary programme, AIDS campaign, new scientific development); and (iii) type of intervention—behaviour change communication, prevention of mother-to-child transmission etc.. Once baseline and other data are available, it is simple to type it onto an existing scientific/epidemiological estimation model or to build a community-specific impact measurement model based on slight variations of the methodology of existing models e.g., AVERT, SCHOOL, prevention of mother-to-child transmission models. Users with little experience in modelling can develop estimates of intervention impact using such models as AVERT (search here for features of AVERT Model: <http://www.iaen.org/mtng/avert/sld009.htm>). Such models provide estimates of the impact of intervention results for at least one of the most common forms of transmission. For parent-to-child transmission programmes, the PMTCT/Spectrum model by the Futures Group could be recommended. Similarly, UNAIDS School model may be used to estimate the impact of school/ knowledge dissemination programmes for young people. The models have their own advantages and disadvantages. The basic probability equation for AVERT is:

$$P = 1 - \left\{ p \sum_{i=1}^4 w_i [1 - r_{gi} (1 - fe)]^n + (1 - p) \right\}^m$$

Where: (p) is HIV prevalence among sexual partners, (m) is average number of sexual partners, (n) is average number of sexual acts with a given partner, (f) is proportion of sexual encounters in which condoms are used, (e) is efficacy of condoms which is assumed constant, (wi) is prevalence of sexually transmitted infections in population and (r_{gi}) is HIV transmissibility. For some results and data using the AVERT model, please search <http://www.iaen.org/mtng/avert/index.htm>.

Inferences from Uganda

The AIDS Competence Programme can be used to support people living with HIV, to strengthen counselling sessions, to decrease mother-to-child transmission of HIV, increase the use of preventative modes, and contribute to other wide ranging HIV interventions. It can help bring together the two parallel structures (national and community) responding to AIDS in the country through a multisectoral approach and ensure that all district stakeholders and different types of businesses are included in future workshops. This wider involvement would lead to better results in the sub-counties and villages, where the smallest versions of Local Authorities and Communities are found. It would also ensure that all important stakeholders are included. For instance, a popular musician alone could reach up to 10 000 people within one hour, a feat only ten conferences over one year would achieve. The mayors of Kampala, Jinja, and Nkokonjeru Town Council found the AIDS Competence Programme useful. In the latter area, a small semi-urban town council, the immediate reach was 400 people, and it has spread to 3500. While there are resource shortfalls, such as the lack of testing kits and clinical officers, the programme stands to reach a total of nearly 55 000 from communities surrounding the tiny town if the Nkokonjeru community would surpass these difficulties urgently. When communities know where to be tested and even know their HIV-status, it is much easier to design and implement interventions. But cases of small rural communities that do not receive funding are not rare in low-income countries. Despite representation at the highest continental local authority body, this township still does not have clinical testing kits or an adequate number of clinical officers. Through the AIDS Competence Programme, it is possible for the town to find a global community that would like to share or donate equipment. The lingering question is whether the trend would be repeated in all communities in need. Questions of financial resource mobilization, due to the economic inequality prevailing in the world and the sheer amount of resources needed, would still need to be solved at the macro level, even as community efforts continue to gain ground.

Rate of sharing and spread

In one part of Thailand alone, (Bangkok), there were 6000 participants in sessions where AIDS Competence Programme methodology was used. In these communities AIDS did not rank among the community's priority problems or needs, based on a number of development and health problems. Evaluation found that 18% of participants reported improved attitudes towards people living with HIV and 56% reported being involved in community AIDS activities. The pre- and post-programme evaluation reported an increase of 114% in this number.

Among the questions that remain to be asked are the number of people who changed their sexual behaviour and attitudes due to the programme, the percentage change in condom use, and the increase in knowledge about HIV and AIDS. However, based on the modest 65 000 and 200 000 number (higher threshold- it is now estimated that the number is way above 1 million for reach) for the AIDS Competence Programme's reach and coverage respectively, it would not be imprudent to draw positive conclusions and

recommendations on the AIDS Competence Programme as a programme at this stage of the evaluation.

Strengths of the AIDS Competence Programme process

1. The autonomous monitoring nature of the knowledge management tools and methodologies: communities perform their own monitoring, thereby easing the process of future evaluation.
2. The fact that the AIDS Competence Programme methodology comprehensively addresses and benefits from the needs and knowledge within the practicing communities by allowing them ownership of the programme.
3. The pragmatism, innovation, and resourcefulness of the different stakeholder groups, further enhanced by the AIDS Competence Programme tools' relevance across sectors, countries, and communities.
4. The Programme's ability to enable different organizations and communities nationally and internationally to share knowledge and skills in real time and in a systematic, measurable way.
5. Provision of a robust, useful, and practical methodology that can be implemented across different sectors, and are hence attractive to different types of partners. The methodology is useful both for business or development partners.
6. The AIDS Competence Programme process adequately provides for and promotes all the principles and elements of community capacity building while relating them to the global and local response to AIDS.

Weaknesses of the AIDS Competence Programme process

A minor weakness of the initial phase of the AIDS Competence Programme, and also one that affects many programmes is that due to the Research and Development nature of the initial phase, the need for a logical implementation plan was not a priority. The process, tools, and ideas were so much in demand by communities and practitioners that the need for more thorough planning was overlooked. For instance, partners were not analyzed for their strengths, weaknesses, resources, and mandates. This exposed the AIDS Competence Programme to potential problems with internal and external communication (especially with potential decision makers), coordination, and cooperation.

Existing needs addressed by the AIDS Competence Programme

Formation of the AIDS Competence Programme was heavily influenced by the following realizations.

1. The strength and higher success rates of local responses to AIDS. In countries where community networks play a significant and globally visible role such as in Uganda and in the greater Mekong region of Asia success is more apparent.
2. The need to learn from and target communities more effectively responding to AIDS and the realization that communities performed better when facilitated rather than when directed.
3. The need to build human capacity to respond to AIDS.
4. The need to share information, skills, and knowledge between, within, and across local and global communities.
5. Finally, the AIDS Competence Programme was also conceived as a possible answer to many of the existing challenges in the area of HIV prevention, treatment, care and support: Prevention, care, and treatment programmes for HIV are currently facing serious challenges: poor countries do not have resources to adequately respond to

AIDS. Those countries which can afford to devote resources to responding to the epidemic face challenges in reach and coverage. International support has been fragmented and difficult to coordinate, undermining the efforts of multisectoral partners and often leading to duplication and inefficiency. Any programme that encourages the systematic and timely sharing of information, knowledge, skills, and resources through traditional and modern communication channels would therefore be highly welcome. Such a programme would need to be in direct touch with communities and should ultimately be owned by these communities.

Some benefits of the AIDS Competence Programme

1. The Programme allows communities to self-assess their progress towards achieving their objectives while building their capacity to respond to AIDS.
2. It complements other existing community programmes, through which they may transfer knowledge and skills and become more competent in addressing other developmental issues. A number of impact studies since 1991 have confirmed that most knowledge sharing and similar prevention programmes can achieve impact if well implemented.
3. Nongovernmental organizations in these countries have also facilitated the ability of these communities to effectively own programmes. UNAIDS can play a meaningful role in developing this agenda through the provision of leadership and advocacy, especially since the AIDS Competence Programme contributes to some of UNAIDS' core objectives, namely:
 - providing and sharing strategic information to guide efforts against AIDS worldwide,
 - tracking, monitoring and evaluating the HIV/AIDS pandemic and responses to it,
 - providing civil society engagement and partnership development, and mobilizing resources to support an effective response to AIDS within different sectors in communities.
4. The Programme addresses most of the challenges facing global community programmes and is transferable across sectors.
5. The Programme's objectives are coherent with existing UNAIDS and other stakeholder policies.

Challenges facing the AIDS Competence Programme

1. The proposed strategies for implementation of the programme differ considerably from donor to donor depending on mandates, objectives, and their perceived needs.
2. The lack of a strong logical framework at the global partner level has undermined efforts at coordinating, communicating, and implementing the programme. It is not clear how implementation and impact of duties are to be divided among partners and between global partners and communities. Feasibility standards (e.g., accountability) are therefore not simple to set.
3. Means of Verification (indicators) and their sources need to be improved.
4. There is no single, consistent form of communication that ensures continuity of the knowledge sharing process between lapses in donor funding (such as a continually running e-Workspace).
5. Frequent lack of raw data to objectively support community self-assessments and address stakeholders' evaluation questions. Gender roles in community development are not adequately addressed, but some communities have taken the initiative to ensure equitable gender inclusion.

Please see Annex H for a review of the approaches adapted and challenges facing Partners.

5.2 Literature review

This section presents literature related to costs for past and present programmes comparable to the AIDS Competence Programme and compares them using a table. A separate section has been annexed to compare impact related literature.

Interpretation for Figure 9. By comparing the cost-per-person reached (effectively targeted) by community programmes related through their intervention methodologies, it is possible to use these as benchmarks for comparison. However, these heterogeneous/different communities earn different incomes, both across and within countries and over time. The cost of living and therefore the cost of implementing the programme is different, whether one separates direct from indirect or fixed from variable costs. The comparison is therefore validated by: (i) using a single currency; or (ii) calculating Gross Domestic Product as a pointer to the costs of living in that country or community during that period (higher cost of living will lead to higher programme costs); or (iii) another possibility is the use of a COLI (Cost of Living Index); one is then able to judge the most cost-effective programmes. It is good to note that countries with high prevalence (15% and above) should not be judged alongside countries with low prevalence (5% and below) since the cost of a programme also varies (by US\$ 7 to US\$ 10) according to many other factors within these two types of countries. Unifying the costs in this way enables ranking of programmes according to efficiency. Judged in this way, the most cost-effective programmes according to the table are the Mekong region STD/HIV/AIDS project, the AIDS Competence Programme, and the Uganda National AIDS Programme. As expected, the least cost-effective are ICT and HIV/AIDS Preventive Education in the Cross-Border Areas of the Greater Mekong Subregion (GMS) and the Education Sector Capacity-building for HIV/AIDS Response in Jamaica (see figure 9).

6. Discussion

(i) Soundness of AIDS Competence Programme aims and objectives in relation to the collective UNAIDS agenda

The Programme objectives offer ways of implementing the UNAIDS agenda and coming up with effective outcomes. The UNAIDS agenda addresses: leadership and advocacy for effective action on AIDS; strategic information to guide efforts against AIDS worldwide; tracking, monitoring, and evaluation of the epidemic and of responses to it; and civil society engagement and partnership development, Mobilization of resources to support an effective response. The main AIDS Competence Programme objectives are outlined in the self-assessment framework, but five are proposed as sufficiently inclusive. They include: to exchange and share knowledge and skills in a systematic way; acknowledge and respond to AIDS; reduce vulnerability and risks and build capacity to respond to AIDS; build capacity to respond to AIDS; and that through these, communities live to their full potential.

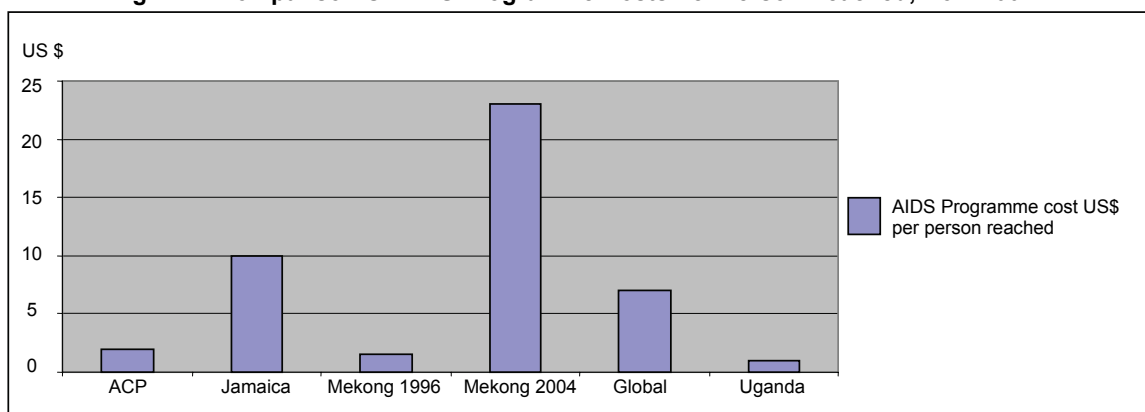
The AIDS Competence Programme is clearly designed¹⁸ to complement the joint UNAIDS agenda. The objective of the AIDS Competence Programme is to achieve AIDS competence within communities which self-assess and implement the AIDS Competence Process. 'AIDS Competent' Communities are those that achieve the Programme's objectives. The aims and objectives of the Programme are sound in relation to the UNAIDS agenda. They also are coherent with existing UNAIDS policy.

¹⁸ Please see ACP self-assessment framework available at <http://www.unitar.org/acp/OurResourcesFin.htm>

ii) Soundness of AIDS Competence Programme approach

General views provided on the AIDS Competence Programme indicate that most stakeholders agreed on almost all aspects of the Programme. They provided their objectives of interest, and perceptions on a series of wide-ranging issues. Partners provided suggestions for the way forward and are engaged in negotiations on a number of issues. It is important to note that the AIDS Competence approach may be viewed from both the global donor and community perspective. Also, the AIDS Competence Programme can be viewed from a development as well as HIV/AIDS donor perspective. All views introduce potential differences in priorities, needs, and short-term/ immediate interests. As equal partners for instance, the World Bank would stress community capacity building while UNAIDS would stress reduction in HIV prevalence, according to their mandates. UNITAR may stress pedagogical outcomes while the Salvation Army may stress increase in human capacities. BP may stress short- and long-term results related to products and services. Communities may stress all or any of these but would expect HIV/AIDS impact to accrue over the shortest period of time possible while allowing more time for community competence building. Again, when asked to evaluate results, communities and facilitators provide views limited to the ACP programmes, processes and abilities that they are aware of. If generalized, these views may either improve greatly or sharply misinform.

Fig. 11 A Comparison Of AIDS Programme Costs Per Person Reached, Nov. 2004



To further illustrate, a UNICEF representative in the field and one at the agency's New York headquarters would also see things differently. The one based at the headquarters would want to see a community that is capable of addressing both infant and maternal mortality, parent-to-child transmission of HIV, and malnutrition problems simultaneously. This one would be willing to accord more time to the community project with a view to achieving results sustainable in all of the agency's programmatic areas. The field officer, who is in constant touch with suffering families on a daily basis, would, after a year without improved impact results, reason that the programme was of such little impact because there were few results in each of the specific areas that were of interest to the field officer and the communities. This is no different from the situation currently facing multinational company Chief Executive Officers, who need to achieve value-added results to increase company stock value, sometimes at the cost of more sustainable long term projects. The AIDS Competence Programme approach is cost-effective, useful across sectors, relatively robust, promotes community ownership, builds community competence, promotes community development principles and elements, and is capable of sustaining itself and spreading without much coordination. However, it currently is weak in stressing the collection of scientific data. The variety of processes and tools used makes it difficult to classify or compare the AIDS Competence Programme to mainstream AIDS programmes. In comparison to other cost effective

programmes, that rely on similar methods and processes the AIDS Competence Programme has the advantage of promoting community ownership, self-assessment, reducing costs over time and universally relevant methodology as well as tools.

Some implementing partners and stakeholders would rightfully demand solid and time-specific results in specific areas such as HIV risk reduction and knowledge increase within communities in a matter of months (it has been proven by other community programmes that this is possible), while others would rightfully await results for overall Community Competence over a number of years. Programme managers need to recognize that each new partner/stakeholder, while obviously adding a new advantage to the programme, would have operational mandates that might dictate the strategies they would use and not use to implement programmes. In the partnership building process all partners' needs should be reconciled with the needs of the AIDS Competence Programme. Some partners would, for instance stress on working only with local authorities or community-based organizations. This has several implications on future reach, evaluation standards, etc. The structure of the Programme is theoretically sound but needs to give more stress to HIV risk, prevalence and vulnerability reduction that can be ascertained through scientific measurement. Currently, it is assumed that community reports suffice. Implementing communities need to focus on results which assure the earliest possible positive epidemiological changes within communities. The implementation process could be strengthened by designing logical programmes which include activities, outcomes, processes, and goals that relate each partner's agenda to the AIDS Competence Programme's agenda even if they come from different sectors or have different visions and ways of operating. The relationship between the different ways in which the Programme can be used and implemented is not very easily grasped by all, even while its components are praised by participants within communities.

This leads to potential gaps in coverage. A more thorough and logical design would enable fluid communication between stakeholders. There should be outcome assessments in some implementing communities and organizations at least once every year in order to measure the effectiveness of the programme in achieving the overall objectives of the global response to AIDS. Based on this evaluation, there is credible evidence to prove that the AIDS Competence Programme approach is effective. In implementing and achieving its stated objectives, the AIDS Competence programme was effective. Communities should now focus on achieving impact and provide means of verification, a process that would boost the AIDS Competence Programme as it is transferred to new communities.

(iii) Debate on whether the AIDS Competence Programme currently achieves 'AIDS Competence' at community level

The theoretical structure and vision of the Programme would achieve 'gold standards' as far as global and local community capacity building projects and programmes are concerned. Nevertheless, there ought to be an explicit requirement for the scientific verification of AIDS-related outcomes and results, so that donors may be able to compare the feasibility of programmes across different implementing partners. This means that communities should interpret the change measurement requirement within the Self-Assessment framework as an expectation to scientifically collect baseline and periodic data related to HIV and AIDS epidemiology, attitudes, and skills before implementing the Programme processes. Positive results in the response to AIDS are driven as much by the need to obtain quick and efficient results as by the process of programme implementation. In some regions AIDS is no longer an epidemic but a pandemic. Again, scarce resources call for allocation to programmes that stress an effective and quick reduction in suffering.

Users (please note that these users are not conversant with all the aspects of the AIDS Competence Programme) debate whether the self-assessment tool's (see Annex C) five levels of competence actually represent stages of increase in competence. This is partly because some communities score highly on objectives that they had not previously addressed. To address these concerns, this evaluation has suggested that in cases where they are not used, scientific data be collected to later validate community self-assessments periodically. It is also important to collect the views of individual community members using participative formats such as the community member response form provided in Annex D of this report. Some users debate whether the Programme should be used to encourage discussions or for assessment. Another debate involves whether the Programme has increased the ability of communities in advocacy based on whether they are able to access resources, treatment and other services. Initial outcome reports from Thailand indicate that communities have increased their ability to mobilize resources. This, coupled with growing participation, public-private partnerships, empowerment and inclusion, may indicate to a certain degree, that communities are improving advocacy. However, this statement still needs to be supported through indicators of communal access to resources, services, treatment etc. In conclusion, it should be noted that an important contribution of the self-assessment tool is that it promotes community ownership, which in any case leads to improved planning and performance. The tool should be used before, during and after the implementation of projects. Other tools including the e-Workspace, e-Forum and people connector should be used to maintain linkages with resources, and obtain information.

iv) Cost of AIDS Competence Programme to donors and other stakeholders: this question remains to be answered since it depends on the communities, countries and geographical areas that choose or are chosen to implement the programme or its components. Each programme is designed by the communities and according to their needs, living conditions and available resources.

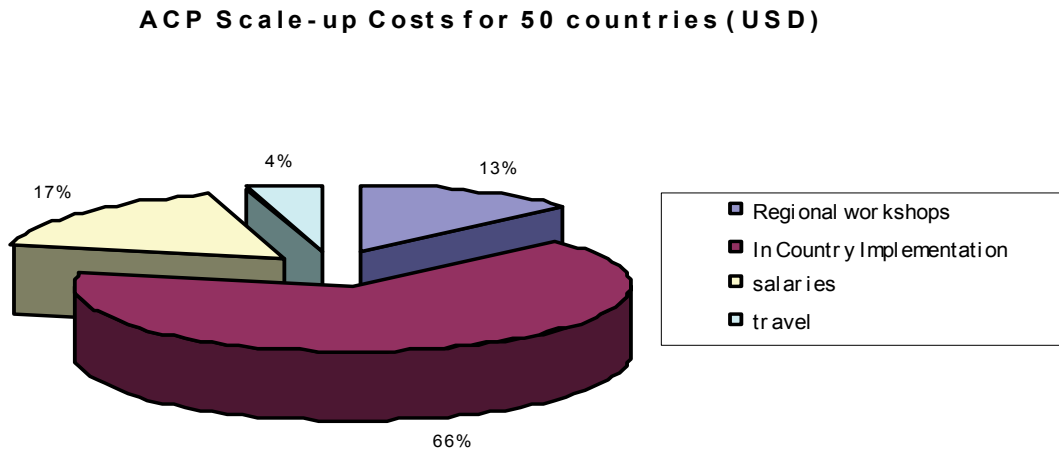
Fig. 12 Comparative Table For Programme Costs vs. Reach

PROGRAMME TIMEFRAME	PROGRAMME MANAGERS	OBJECTIVES	TARGET POPULATION SIZE OR REACH	TOTAL PROGRAMME COSTS US\$	COST PER PERSON	PER CAPITA GDP (PURCHASING POWER PARITY)
THE AIDS COMPETENCE PROGRAMME JANUARY 2003–JUNE 2004	UNAIDS-UNITAR, BP, WORLD BANK, Salvation Army, Private Sector, Schools, Local Governments, UN Agency Country Offices	1) Information and Communication Technologies 2) Training for Trainers. 3) Community Capacity Building 4) Information and Knowledge Exchange	Estimated between 65 000 to 200 000 first year	US\$ 650 000	between US\$ 0.10–US\$ 2.00	Consider Average GDP 2003-2004 in France, Guinea, Switzerland, Uganda, Thailand, Cote-d'Ivoire and rest of countries where ACP has been implemented- It is much higher compared to all other projects below since industrialized countries have been included.
ICT and HIV/AIDS Preventive Education in the Cross-Border Areas of the Greater Mekong Sub region (GMS) JANUARY 2003 –JUNE 2004	Asian Development Bank, UNESCO, SEAMEO	1)develop ICT learning materials 2) build the capacities of teachers, health workers, and other stakeholders for HIV preventive education; 3) Expand the use of ICT intervention HIV preventive education; 4) deliver ICT-based interventions to isolated, marginalized, and vulnerable populations.	TARGET 8000 High School STUDENTS, ESTIMATED REACH /x10 (80 000)	US\$ 1 850 000	US\$ 23	Consider average GDP 2003-2004 between Cambodia, China, (Yunnan Province), Laos, Thailand and Vietnam

UNAIDS

The Mekong region STD/HIV/AIDS project in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam 1996–1999	Govt. of Netherlands, UNICEF/UNAIDS, 6 National Governments. Community-Based Organization, MASS ORGs NGOs	1) To reduce the rates of transmission of HIV in Mekong countries by focusing on vulnerable groups 2) To build the capacity of government agencies, NGOs, mass orgs. communities and UNICEF country offices to design, test, implement, monitor and evaluate HIV/AIDS interventions within communities. 3) To seek more vigorous promotion of the Convention on the Rights of the child, particularly as it relates to the right to health and the protection of children and youth from exploitation through commercial sex work.	Over 14 million	US\$ 6 500 000	between US\$ 0.30– US\$ 1.00	Consider average GDP 1996–2004 between Cambodia, China, (Yunnan Province), Myanmar, Laos, Thailand and Vietnam
Education Sector Capacity-building for HIV and AIDS Response in Jamaica February 2004– February 2005	Government of Jamaica, UNESCO, Japan International Cooperation Agency	1) Establishment of an HIV/AIDS Response Team 2) Teacher education materials development 3) Development of a cadre of HIV/AIDS trainers 4) Piloting school-level instructional materials	30 000 trained within the Jamaica Education Sector.	US\$ 707 300	US\$ 20 first year, tending towards US\$ 1.00 over 5 years	Jamaica \$3900
Global Country AIDS Programmes	World Bank ACT Africa Study	General			US\$ 3.00– US\$ 12 per Capita. Depends on prevalence	
Uganda National AIDS Programme Late 1980s to present	Uganda Government and Partners	Prevention programme stressing abstinence, behaviour change and condom use	Uganda Population over 15	over US\$ 12 million annually	Under US\$ 1.00 (Annual cost per person under 15)	Uganda \$1400

For the AIDS Competence Programme to be implemented by existing national programmes, it would cost between US\$ 75 000 and US\$ 100 000 depending on purchasing power, whether cost-saving mechanisms, among other economic, social and financial factors are used. However, similar global facilitation can be easily provided through a group of two to five global staff members and a number of country-based staff in countries where UNAIDS or other donors/networks are already implementing community-based programmes or seeking multisectoral partnerships, especially in the Private Sector. The staff may also be from partnering agencies, organizations or communities that have implemented the AIDS Competence Programme successfully. For the AIDS Competence Process to be fully inculcated into communities and National AIDS Control Programmes, it would cost donors in the region of US\$ 2.3 million over three to four years including direct and indirect costs. There is still room for implementing cost-saving measures. This costing has been done on the assumption that at least 10 subregional training workshops (training of trainers' sessions) are held, at an average cost of US\$ 30 000 where representatives (mostly from donor field offices) of the countries within the region attend, and then impart this knowledge to others within the country. An in-country follow-up of at least 50 countries over three to four years by global programme managers and knowledge management experts then follows. US\$ 400 000 is set aside for the salaries of three global programme managers (one of whom would be a knowledge management specialist), while US\$ 75 000 is set aside for their travel.

Fig. 13 Distribution of AIDS Competence Programme scale up costs

Fifty country offices are granted an average of US\$ 30 000 out of which US\$ 25 000 would be used to conduct training sessions on the AIDS Competence Programme process and methodology within remote communities that can not yet be reached by traditional means of communication or the Internet. A further US\$ 5000 would be used to create and maintain an Internet link and a local administrator over 24 months. These figures may yet be reduced through cost-saving mechanisms and economies of scale. Such mechanisms include initial training of local facilitators by country field offices through regional training workshops shared by other countries, and follow-up using the e-workspace and forums.

7. Recommendations

This section outlines some of the recommendations arising from this evaluation. Due to the varying roles, implementation methods, mandates and objectives of each stakeholder, the recommendations have been addressed to specific stakeholders.

The AIDS Competence Programme provides a knowledge management and sharing process that could assist in the development, monitoring and implementation of community programmes. It could also strengthen existing interventions within countries and globally. Borrowing from the Programme's knowledge assets and processes could prove useful to communities. The processes of the AIDS Competence Programme need to be understood globally. The Programme process facilitates community efforts rather than directs them. It introduces a new methodology rather than a new type of programme. It is a supporting mechanism that multiplies the effect of existing programmes. It can be implemented in countries without the need to change strategic, financial or operational policy, because it fits into the existing programme needs, especially for those multisectoral community programmes that need improved IEC, Knowledge Sharing or Training. The AIDS Competence Programme can be operationalized within donors' or other interested parties' existing programmes.

Recommendations to partners and donors

1. Efforts by communities in building competence to tackle multisectoral development problems and responding to AIDS should continue to be encouraged, strengthened, and scaled up since economically, socially and politically strengthened communities are more effective in the response to AIDS. The AIDS Competence Programme facilitates community competence building.

2. Efforts should be made to continue to build the institutional relationship between UNAIDS and UNITAR, both within and beyond the AIDS Competence Programme, since it has proved fruitful so far. UNITAR's network and experience in training and knowledge generation at the local and global level could be a valuable resource in the scaling up of local health responses and the sharing of this knowledge internationally, an aim which conforms to the general health and development sector aims. Similarly, other existing and evolving institutional partnerships ought to be maintained and promoted as far as their aims conform to the goals envisaged by the collective global response to AIDS.

3. The AIDS Competence Programme should be endorsed for use by other partners and should stress the need for impact results related to the global AIDS response agenda. The importance of the transfer, exchange and sharing of local responses should be adequately recognized, promoted, and supported. Partners who support or promote the uptake of the Programme may earn valuable partnerships in future especially as innovative public-private partnerships emerge in pursuit of Millennium Development Goals¹⁹.

4. For the AIDS Competence Programme to be more effective at the community level, it should be supported not only through funding, but by provision of technical knowledge management assistance to communities through donor country offices or field personnel. Communities should be continually engaged through the communication options supplied by the Programme, especially the e-Workspace. Such support would also ensure/ independently monitor if communities are progressing towards AIDS competence, hence save summative evaluation costs in the long run. Since the methodology is sound and may in future be adopted by many organizations, 'owning' or supporting the Programme early may be a source of 'development capital' (i.e., partnerships, innovative ideas, etc.) that may strengthen existing partnerships while attracting new and valuable ones. This is especially important as innovative public-private partnerships emerge in pursuit of the Millennium Development Goals.

5. Partnerships should be formed beginning with those partners who share direct mandates and progressing to those that have more indirectly related missions. In the long run, this improves efficiency in programme implementation, and reduces costs. Each partner welcomed into a development or business programme comes with their own mandates, methods and preferences which may be in conflict with others. Each new implementing partner ought to be evaluated for strengths and weaknesses, resources and mandates that they could bring to the programme.

6. To minimize the possibility of liabilities in each new partnership, (especially multisectoral partnerships), implementing partners should prioritize expected results and agree as early as possible on those that should be measured, as well as the timeframes and resources to be contributed by each.

Recommendations to specific communities:

1. Communities that are planning to implement the AIDS Competence Programme should perform HIV- and AIDS-specific data collection before or at beginning of the programme/ processes to be able later to compare changes in HIV and AIDS conditions including knowledge, skills, attitudes and access to treatment. This would further assist in impact projection and evaluation e.g., infections and deaths averted or life years gained. Focus should be placed on collection of baseline scientific/ epidemiological data by prospective implementers, which may be useful in measuring outcomes and

¹⁹ Millennium Development Goals.

projecting impact. Preparations should be made for impact studies, while more outcome studies should be carried out especially in and/or by communities that have developed or implemented the AIDS Competence Process for over two years. These include, among others, those in Zambia; Thailand; and Lyon, France.

2. The internet should continue to be used as a sustainable tool for information exchange, even during lapses in funding, since it ensures continuity, while its advantages ensure sustainability of programmes and the capture of useful knowledge. Inter-communal learning should be promoted and global partners should institute solid mechanisms such as the AIDS Competence Programme, in order to learn from them. If possible, partners, communities and donors taking up the Programme should prioritize and dissociate the Internet usage budget from programme budgets. Conversely, one founding organization should take charge of the main e-Workspace and include it as a day-to-day component of its existing activities. At the local level, the Mobile (cell) phone and SMS texting may be considered as another effective option for transfer of ideas and knowledge between remote communities.

3. Efforts should now be made to prepare to conduct evaluative AIDS impact studies within the different communities undertaking the AIDS Competence Programme. These efforts should be spearheaded by the countries and communities that implemented the Programme. Efforts should be made to reconcile communities' differences in objectives for evaluation in future by using a standard methodology. This may be done through the formulation of different indicators within the evaluation model/framework, to allow for unified evaluations at the community level. This ensures that donor, manager and community interests are accounted for by impact evaluations.

The outcomes that may be needed to validate these impacts include, but are not limited to: changes in behaviour and attitudes; changes in sexually transmitted infection prevalence; reduction in HIV transmission and prevalence; percentage increase in knowledge; percentage reduction in risk; percentage increased use of HIV preventative methods; percentage increased level of treatment and care; percentage reduction in parent-to-child transmission of HIV, and other community specific measures (please see Annex on community outcomes for more indicators). However, evaluation of the AIDS Competence Programme must take account of not only scientific measures, but also normative, experiential and other measures such as those mentioned in this report's findings. Future outcome and impact measures should also include measures of access to treatment and services, quality of access to services and products (e.g., adherence, correct treatment, constant availability, etc.).

4. Communities should customize the knowledge management tools offered by the AIDS Competence Programme in order to assess the areas that they find of most relevance. Before implementation of particular processes and use of tools, they should be made to thoroughly understand the various uses of the AIDS Competence Programme's tools and methodologies and not just those that are being implemented by them (e.g., for self-assessment, sharing, competence building, communication etc, within prevention of mother-to-child transmission, sex workers, behaviour change communication, treatment, support, other development programmes not directly related to HIV prevention or treatment.) This will enable them to understand the AIDS Competence Programme better, share more effectively and give more informed critiques.

5. Communities should learn how to project and later evaluate impact, as they currently project desired outcomes. If this is not plausible, they could be taught how to input data on some of the existing impact evaluation/projection models, based on their experiential knowledge of community needs and abilities. This should in all cases be accompanied by baseline data. These impacts would later be validated independently and professionally.

Recommendations to Programme Managers (all, including UN, civil society and private sector representatives)

1. Programme Managers in the AIDS Competence Programme should make facilitators and communities understand and include gender roles, especially the importance of women and girls' participation, within the Programme's design and implementation processes. Increased participation by girls and women in AIDS programmes leads to improved results.

2. Financial resource mobilization is a rigorous and complex issue, especially for community programmes in general. Communities should continue to play a role in capacity building by designing robust programmes, sharing skills, and building a collective commitment to promote health. As a way of building community capacity, objectives involving financial resource mobilization are undermined by existing global economic inequalities and the large amount of resources needed. While financial resource mobilization may yet need to be solved at the macro level, communities should continue to play a role in mobilizing technical, human and other resources. They should also design robust programmes, share skills, and build a collective commitment to promote health.

3. Efforts should be made to make donors, communities and other stakeholders better able to understand the Programme and integrate it with other existing community, national, and global AIDS and community development programmes. For example, the process of facilitation, which is a key component of the AIDS Competence Programme, is not well understood by all stakeholders. It should be emphasized that the type of results expected of Managers in the AIDS Competence Programme are not the same kind of results expected from communities, even though the managers could facilitate the process of evaluating and reporting these results.

4. The AIDS Competence Programme should be re-designed at the Managing Partner/global level to include a logical and time-specific framework clearly linking stakeholders, resources, problems, activities, desired outcomes, impacts, and their means of verification. This will enable better communication and implementation of the Programme, as well as facilitate evaluations. This recommendation assumes that communities have their own logical frameworks, activities, and programme implementation plans.

5. Programme Managers should make an effort to provide the global AIDS Competence Programme/HIV and AIDS partners with community-relevant and desirable indicators. Communities should work towards these results and make them relevant to partners' special needs in the domains of health, education and general development.

6. Programme Managers in the AIDS Competence Programme should promote an understanding and inclusion of gender roles within the Programme's design and process among facilitators and communities. Attainment of gender equality promotes positive community AIDS programmes, and is also an indicator of changing community attitudes. A few of the communities that began implementing the AIDS Competence Programme in 2003 have realized this, especially in North Eastern Thailand (see Annex G on community outcomes).

7. Efforts should be made to make donors, communities and other stakeholders better able to understand the Programme and integrate it with other existing community, national, and global HIV and AIDS goals. For example, the process of facilitation, which

is a key component of the AIDS Competence Programme, does not seem to be well understood by all stakeholders. It should be emphasized that the kind of results expected from Managers in the AIDS Competence Programme, though they have overall reporting responsibility to the Programme donors, are not the same kind of results that could be expected from communities, even though the managers could facilitate the process of evaluating and reporting these results.

8. Managers in the AIDS Competence Programme could also provide a toolbox or best practices compendium that allows communities to directly share their methodologies and other experiences.

9. AIDS Competence Programme workshops should ensure adequate representation of community representatives at the sessions. Increased participation of people living with HIV is also necessary. Failure to include representation directly from communities leads to significant leakages within the knowledge-sharing process; knowledge may not be shared with communities or have direct recognition, the support of governments or the private sector. In countries such as Uganda, having a well-developed rural community network in all 56 districts, the participation of at least 15 people per district would be the minimum required for an optimal outcome for the AIDS Competence Programme right from the national to the community level.

10. Subject to policy considerations, managers could consider re-naming the AIDS Competence Programme as the 'AIDS Competence Process'. Currently, any country, local authority, organization, or community can adapt the processes into their existing programmes.

11. While communities continue to play a role in capacity building by designing robust programmes, sharing skills, and building a collective commitment to promote health serious efforts at the macro level (government and global) should continue to identify them and provide them with financial assistance. The heavy, rigorous and complex burden of financial resource mobilization should not be left completely to communities. The existing global economic inequalities in welfare gains, wealth creation and health standards make it incredibly difficult for most low-income country communities to develop the capacity to secure their own financial resources.

12. Programme Managers should continue to promote the use of the Internet as a sustainable tool for information exchange, even during lapses in funding, since it ensures continuity and is a cost-effective medium for exchange of information. Budgeting should ensure continuity of the e-Workspace and e-Forum, and if possible, include them separately partners' core administrative programmes. At the local level, the Mobile (cell) phone, currently the most widely used interactive-communication medium in low-income countries and across income and social levels should also be considered by the AIDS Competence Programme as a useful information exchange medium (e.g., use of Short Message Texts.)

13. Managers should directly assess implementation of the AIDS Competence Programme, address barriers to successful evaluations, encourage and perform routine surveillance activities and population based evaluations for outcomes and impact (seroprevalence, transmission, life years saved, etc.) evaluations.

Recommendations to Governments

Governments, especially those of low- and middle-income countries, should continue to promote the spread of HIV- and AIDS-related programmes beyond the health, education, social and cultural sectors into industry/ business and other sectors. Communities that demonstrate progressive competence ought to be encouraged and the sharing of experiences with others facilitated by government. National programmes should consider adopting some of the AIDS Competence Programme processes into their existing strategies, programmes, and projects, while customizing them to local needs.

2. National programmes should consider providing Technical Monitoring and Evaluation assistance to communities using AIDS Competence Programme processes to encourage timely and objective impact assessments.

3. National programmes should encourage internal and cross-border sharing of knowledge through processes provided by the AIDS Competence Programme and consider adapting them within their own interventions.

Recommendations to Civil Society (including nongovernmental, faith-based and family organizations)

1. Civil Society should consider adopting some of the AIDS Competence Programme processes into their existing strategies, programmes, and projects, while customizing them to local needs.

2. Civil Society, through their direct work with communities, local authorities and governments should seek to ensure that the AIDS Competence Programme process is well understood by all partners and consider providing assistance in monitoring and evaluation.

3. Civil Society should encourage internal and cross-border sharing of knowledge through processes provided by the AIDS Competence Programme and consider adapting them within their own interventions.

4. Civil society should support government efforts to ensure that the response to AIDS obtains new partners from all sectors.

Recommendation to Evaluators

The current evaluation adopts more of a formative nature, but can be used to make policy decisions. It measures the whole AIDS Competence Programme by bringing together all its components and comparing them against other community projects. The objective of its approach was unity. The compared projects are those that involve information dissemination and knowledge sharing. The evaluation is preoccupied with outcome and process measures which are generally common (universal) within community programmes, particularly reach, and end user satisfaction. Apart from the studies carried out in Thailand, Brazil and the analyses in this paper, future impact evaluations should be summative, focus on specific impacts on HIV and AIDS p<x% (separate components of the AIDS Competence Programmes from existing conditions, in order to ascertain how much of the impact was due to the Programme alone and not pre-existing factors or inter-communal differences.)

ANNEXES

ANNEX A: Methodology

Methodology

Methods adapted for this evaluation therefore include:

Desk review: A review was made of directly and indirectly related literature, audio-visual materials.

Interviews: There were face-to-face meetings, telephone interviews, and electronic interviews (Random and Snowball Sampling [sample size n = 50]), but in most cases, the views of communities, organizations and a much higher number of people/communities has been taken into account.

Technical Analysis: The evaluation was of a consultative nature, with a large team, a facilitating evaluator, large number of informants and focal points from among the partners and participating communities. Advice from many parties involved was sought before and during the drafting of the report.

The Logical Framework Approach was used to evaluate stakeholder groups, prioritize needs and interests, solve problems, find alternatives, and create means of verification.

Innovative design and accepted scientific methodology was used to generate and compare desired and acceptable programme standards to programme objectives. This methodology was also used to come up with indicators that answered most stakeholder needs (see AIDS Competence Programme Evaluation model at the ANNEX section of this report).

Accepted economic analysis, financial, and accounting methodology and techniques were used to estimate and compare costs and then to come up with boundaries for this type of evaluation. A wide array of literature was reviewed to support each step of the evaluation and a number of past programmes were reviewed as benchmarks for comparison. A number of ensuing steps have been elaborated in the methodology section in the main part of this report.

Technique for evaluating managing and funding stakeholders (process evaluation):

A number of Monitoring and Evaluation techniques were used to evaluate the AIDS Competence Programme. However, in order to: (a) clarify and manage the process; and (b) address earlier planning and implementation anomalies, the techniques have been synchronized through the Logical Framework Approach. This an effective management tool for programme planning, implementation, monitoring and evaluation. It makes communication and coordination of the AIDS Competence Programme simpler. It is target group oriented and participatory. The lack of a logical design at the research and implementation stage of the programme meant that there was a lack of official indicators and means of verification. This was however a mild problem as stakeholders provided adequate responses to enable the use of existent and programme specific measures that are universally desirable and acceptable. An example of the step-by-step methodology used follows:

Step 1: Direct and Indirect Stakeholder Analysis

1. Direct and Indirect Stakeholder Analysis (Groups: population groups, public and private-sector organizations, civil-sector organizations, religious organizations, political organizations and other stakeholders.) The table below provides a summary of whom and what were investigated.

Advantages and purpose of Stakeholder Analysis

1. The analysis of stakeholders has built a comprehensive picture of stakeholders' preferred strategies and methodologies for implementation of the AIDS Competence Programme. It has also clarified areas of agreement and disagreement and will inform a unifying approach.
2. The analysis enabled the communication of ways in which the stakeholders have contributed to the implementation, risks and feasibility of the AIDS Competence Programme.
3. The analysis identified the potential, interests, and limitations for consideration during the evaluation and redesign stage.
4. The stakeholder analysis promotes internal and external cooperation, coordination and communication of the programme to increase its chances of being well implemented or understood by all.

STAKEHOLDER ANALYSIS TABLE

Groups	Interests	Perceived Problems	Resources and Mandates
UNITAR, Practitioners, UNAIDS, World Bank, Salvation Army, Aga Khan Development Network, Community and Lay Practitioners, British Petroleum plc Civil sector organizations, Governments, religious and other organizations, political organization,	Objects of Interest of each group in relation to the AIDS Competence Programme, its evaluation and implementation.	Planning omissions, and their implications and developments within the initial AIDS Competence Programme phase. Areas of disagreement	<i>Resources:</i> Past and possible future contributions towards support of, or opposition to the AIDS Competence Programme or its components. (Financial, non-financial, tangible or intangible support or opposition) <i>Mandates:</i> As per Memos, legal authority, objective statements. and organizational missions

Step 2: Problem Analysis

Problems here are defined as existing negative situations and not as the absence of desired situations or future/ possible problems. Problem analysis included:

- Systematically evaluating realities on the ground in different AIDS Competence Programme sites before, during and after project implementation (implementing, beneficiary or planning stakeholders were involved in this process).
- The core problems solved by the AIDS Competence Programme (existing problems tackled by the Programme within the implementing communities).
- Problems of measurement (different proposals for what to measure)
 - (a) Measuring facilitator performance
 - (b) Measuring community progress towards 'Competence' by asking relevant questions within specific communities as described below.

Step 3: Analysis of objectives²⁰

The Objectives of the AIDS Competence Programme that were evaluated in this evaluation included those described as characteristics of AIDS Competent Communities:

- 1) Recognize the reality of HIV and AIDS
- 2) Exchange and share knowledge and skill in a systematic way
- 3) Reduce vulnerability and risks
- 4) Live to their full potential
- 5) Build capacity to respond to AIDS.

Findings from Stakeholder Reviews

The stakeholder review process identified differences in Stakeholders' interpretation of the definition of 'AIDS Competence', due to changing interpretations of the definition based on their own differing needs. These differences are not faults or mistakes. They however led to differences in perceived priorities for measurement based on what the evaluation could focus upon, whether it would evaluate process and quality, verifiable outcomes or impact.

The process also identified differences in stakeholders' opinions on how exclusive the partnerships should be. One approach favours an unlimited multisectoral community partnership process where the key AIDS Competence Programme partners should work together with communities and any interested stakeholder from the public and private sector anywhere in the world. Proponents of this approach view the AIDS Competence Programme as a means of achieving success in not only responding to AIDS, but also in overall sustainable development programmes.

A second approach favours a pre-specification/limitation of the type of partners to those with a wide, internationally recognized reach, specific desired resources and highly experienced structures .e.g., local authorities and the international private sector. This approach also envisions the AIDS Competence Programme as a large programme, but part of a wider sustainable development programme, that shares tools and resources within a larger decentralized cooperation framework.

Both approaches consider the AIDS Competence Programme as a means of achieving sustainable development, as a major step towards the wider Millennium Development Goals, as well as a tool for community mobilization programmes. However, depending on organizational mandates and missions, their approaches are different.

²⁰ Please see reference list: r1-r5 for more on the Logical Framework Approach for planning, implementing, monitoring, evaluating and communicating programmes.

'Which approach is better?'

There is no logical 'Yes' or 'No' answer to the question of which approach is preferable, but each approach has its strengths and weaknesses in different settings. Stakeholders proposed indicators that they felt were best to evaluate the AIDS Competence Programme, based on their interests, perceived priorities and needs. Key proposals regarding methodology were received from the Aga Khan Foundation and various stakeholders, and an evaluation framework was used to unify each of the objects of interest (i.e., what to measure.)

Step 4: Analysis/ Choice of Alternative Programmes

There are few communities in the world that have not implemented a participatory project, supported by either their governments, nongovernmental organizations, Private Sector or the UN System. The AIDS Competence Programme has several components: ICT and knowledge sharing; training; and community competence building (which includes all concepts and principles of community development from the public and private sectors). Again, the AIDS Competence Programme, as mentioned before, is implemented by heterogeneous (social, cultural, economic, political, legal heterogeneity etc) and dynamic communities. Again, several donors may already exist in communities where the AIDS Competence Programme was implemented.

What are some of the comparable programmes, processes, strategies or interventions to the AIDS Competence Programme? There is a question of what alternative programmes could be used to compare against aspects of the AIDS Competence Programme. Finding an alternative community for comparing impact results (what the World Bank²¹ evaluation team would call 'counterfactuals') would balance upon:

- 1) Comparing either against communities with similar pre-intervention characteristics where similar projects have been implemented, or communities where no interventions have been attempted.
- 2) Analysing alternative projects based on qualitative inputs, processes and outcomes of projects and weighting evaluation results. Here the AIDS Competence Programme has the distinct advantage of a well conceived, top-of-the-range process and tools that autonomously maximize end user satisfaction while maximizing reach. It is argued that if the quality is excellent, then quantity only serves to increase returns from the project, and the impact is then bound to be higher.

The current evaluation was able to measure the whole AIDS Competence Programme component against other community projects based on entire populations within community programmes that deal with information dissemination and knowledge sharing. The evaluation was primarily preoccupied with outcome and process measures which are generally common (universal) within community programmes, particularly with the measures of reach and end user satisfaction.

²¹ World Bank, 2003, Community-Driven Development, A study Methodology, Operations and Evaluation Department, July 2003 page 18.

However, future impact evaluations may need to separate components of the AIDS Competence Programme in order to find out how much of the impact was due to the Programme alone and not pre-existing factors and inter-communal differences.

Based on the above argument, for the present evaluation, alternative programmes would be those that encouraged information dissemination and communication, as well as training of trainers.

A list of qualified alternative projects for comparison at the community/intervention level is indexed in the draft report.

Step 5: Use of Logical Framework Approach and choice of indicators to evaluate activity (process, quality), output (outcomes), objectives, goals, resources, and mandates.

Process of Consensus Building

A number of techniques were used to arrive at consensus where differences in opinion existed:

- (a) prioritization
- (b) selection of 'best' decision
- (c) brainstorming and other decision aids
- (d) temporary settlements on proposed focal problems to work with, but with a review of alternatives for a later date.

Where differences in opinion were strong between stakeholders, they were encouraged to name or second representatives of other stakeholder groups who share their respective views but are not necessarily in complete disagreement with each other. Where differences persisted, each was encouraged to provide alternatives, and a comparison was made between them, relying on existing literature for guidance.

Technique for Field Evaluation

A different set of process, outcome and possible impact evaluation questions was addressed to the communities. These were reached through mixing the stakeholder review process and activity report review to agree on interpretations of objectives and needs from the AIDS Competence Programme and the evaluation. A mix of globally acceptable and desired standards relevant to the Programme was then reached. These standards are used as benchmarks to judge the AIDS Competence Programme process. The respondents were community practitioners—both lay and facilitators. Questions were structured according to communities' reported level of competence, from low to high on the Self assessment framework.

(For sample questions See Annex D: AIDS Competence Programme evaluation questions and community response form.)

Calculating reach—case study of Madagascar

The reach of the AIDS Competence Programme in one country can be illustrated by studying the case of Madagascar, where the Programme has been used effectively to strengthen the National HIV/AIDS strategy. Madagascar began implementing the AIDS Competence Programme in 20 districts in 2004, as a supportive intervention to its existing strategies. It was aimed that by the end of 2004, at least 30% of youth would have sufficient levels of AIDS Competence. (Madagascar has a population of 17.5 million, 44% of whom are below the age of 14 years). Also targeted were parliamentarians, local authority heads (mayors), religious leaders, and other opinion leaders. Among other aims in Madagascar were that general public attitude towards people living with HIV would have evolved positively, and 500 people living with HIV would have received suitable antiretroviral treatment. Also, 50% of the national territory would have condoms and treatment for sexually transmitted infections constantly available. The total population covered by the AIDS Competence Programme interventions within the national programme in 2004 is around 70% of Madagascar's population, based on the above aims. This amounts to an estimated 11.9 million people.

However, only the population above age 15 and below 65-years old is considered, since: (a) they are the more likely to influence and be influenced by changes in social behaviour; and (b) data on percentage of population in this age group is available for most countries. For Madagascar, this age group is 52% of the population, with the number of females being directly proportional to that of males. The total coverage considered is therefore reduced to 6.2 million.

The next task is to calculate reach. This would be influenced by the percentage of people who have seen or believe in the AIDS Competence Programme's impact to increase knowledge, skills, change attitudes, and would confidently state that it would have an impact based on this. This percentage ranges from 52% in some communities and countries to around 85% in others. Based on scientific theory (Social Cognitive Theory, Theory of Planned Behaviour and Social Support theory) these are also the people most likely to take the AIDS Competence Programme seriously and share its information with others effectively for support purposes (see Clanz and Rimer, 1995). They are also the more likely to change their behaviour.

In cases where not all community members can be available for comment, their representatives or facilitators e.g., counsellors at a clinic, teachers, clinical officers or elected municipal leaders can represent them. The risks of misrepresentation, though still present, are considerably reduced if only specific facilitators that have repeated interactions with specific community members are relied upon. From the above process, if 30% of those interviewed in Madagascar are assumed to share the view that the AIDS Competence Programme process and outcomes have been useful to them, can name at least one outcome that it has had, and have shared it with at least two people, then reach could be estimated to be 30% of the coverage. i.e., in this case 30% of 6.2 million, which is 1.86 million people in Madagascar.

A key way to measure outcomes (change in attitude, skills) and project impact would be to measure changes in gender roles. Measuring the position and status of girls and women in a community, is a key indicator to measure impact and substantial changes in mindset and behaviour (see Clanz and Underwood, 2003 <http://www.jhuccp.org/pubs/cp/102/102.pdf>).

Estimating intervention-specific reach

In countries where only specific workshops have been held, the above way of calculation i.e., from the country figures, down to the most possible specific figures is not applicable. Such countries, e.g., Togo (2005), where one or two organizations are spearheading community efforts, would need to calculate the rate of spread of the AIDS Competence Process knowledge, processes and tools, for example, using Thai figures of the rate of sharing as benchmarks. Thailand is a good country to choose from because:

- (a) AIDS is considered among the least of developmental problems, in comparison to drug use and others, therefore the proportion of those sharing may be lower than in other countries;
- (b) Thailand informed the research and development stage as well as the first process evaluation of the AIDS Competence Programme (see activity report); and
- (c) Data is available, and is reasonably credible; Thai communities have been dedicated to measuring general change.

For more definitive steps at calculating workshop, community and intervention specific types of reach, please visit www.RE-AIM.org 'Steps for Calculating and Reporting Reach' or search directly at: http://www.re-aim.org/2003/calc_reach.html .

Calculating HIV outcomes

While best left to the individual communities and their evaluators to report outcomes, methodology and calculations should be based on universally acceptable principles.

A few outcomes among those reported in this paper are:

- (a) Percentage change in knowledge levels, for example, number of people who can name at least three ways of contracting HIV
- (b) Change in percentage of people living with HIV accessing treatment.
- (c) Change in number of personnel skilled to provide certain intervention requirements.
- (d) Change in the rate of participation of women and girls in community activities.

Important Note: It should be noted that the evaluation of specific interventions where the AIDS Competence Programme is used, such as Voluntary Counselling and Testing programmes, Behaviour Change Communications among others, and the evaluation of the AIDS Competence Programme follow

significantly different approaches. For more on the evaluation of specific interventions, please see the following publication, among others: Kamenga, Coates and Rehle, *Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries*:

<http://www.fhi.org/en/HIVAIDS/pub/Archive/evalchap/index.htm> .

Measuring and Projecting Impact

Here again, it must be noted that evaluating the general AIDS Competence Programme process, outcomes, and impact is very different than evaluating the outcomes, and impacts of specific AIDS Competence Programme interventions within communities. Impact estimations are different according to:

(1) The community implementing the AIDS Competence Programme (with its socioeconomic, health, legal, and political settings).

(2) Time of implementation (before, during or after a different programme, before new scientific developments, etc.).

(3) Type of intervention (Behaviour Change Communication, prevention of mother-to-child transmission. Once baseline and other data are available, it is easy to input into a model or build a community specific impact measurement model based built along the methodology of existing models.

(4) The role of the AIDS Competence Programme; whether it is a stand-alone or a supporting programme for existing interventions.

Impact results were already available for Curitiba in Brazil and a number of Thai Communities. In Curitiba, Brazil, the municipal doctor, who is also the president of the World Family Organization, reports that in 2004 there was not a single case of parent-to-child transmission of HIV, an improvement for which she credits the training received within the AIDS Competence Programme/CITY-AIDS programme conducted by CIFAL. In Curitiba, generally, there has also been a reduction in the number of new infections from an initial figure of about 600 to about 500 new infections annually. In Brazil, the AIDS Competence Programme's cost per infection/case averted was estimated to be about US\$ 10, which may be considered low. This may be benchmarked against a similar figure (US\$ 8 to US\$ 12) from Kenya, which was considered low in 1996, following a specific prevention programme for brothel-based sex workers. One should also consider that the present value of the 1996 figure in Kenya currently is probably over US\$ 30 per case averted (see annex A). Again, it should be noted that specific impact results from Kenya, which are used here to compare the Curitiba results, are a special kind of intervention. This is because work with brothel-based sex workers is highly targeted and leads to significant differences in cost per case averted when compared to other programmes. It also, like prevention of mother-to-child transmission, has special costs considerations. Thai results were also positive, but specifics are yet to be released by communities.

For the rest of the communities, data gathering and impact estimations were recommended. Impact estimations would be different according to: (i) community implementing the AIDS Competence Programme, (due to differences in socioeconomic, health, legal and political settings); (ii) time of implementation (before or after a complementary programme, AIDS campaign, new scientific developments or other intervention); and (iii) type of intervention—behaviour change communication, prevention of mother-to-child transmission. Once baseline and other data is available, it

is simple to type it onto an existing scientific/epidemiological estimation model or to build a community-specific impact measurement model based on slight variations of the methodology of existing models e.g., AVERT, SCHOOL, prevention of mother-to-child transmission models. The underlying methodology in these models is simply a formula estimating the impact of community interventions by relating changes in community competence e.g., knowledge, access to antiretrovirals and other types of treatment, number of Caesarean births, to baseline data and expected measures in change that are used to create the formula. The reality of such estimations heavily depends on the validity of such formulae. The AVERT model has been tested for validity. Users with little experience in modelling can develop estimates of intervention impact using this model (search here for features of AVERT model:

<http://www.iaen.org/mtng/avert/sld009.htm>). Such models provide estimates of the impact of intervention results for at least one of the most common forms of transmission. For parent to child transmission programmes, the MTCT/Spectrum model by the Futures Group could be recommended. Similarly, UNAIDS School model may be used to estimate the impact of school/knowledge dissemination programmes for young people. The models have their own advantages and disadvantages. The basic probability equation for AVERT is:

$$P = 1 - \left\{ p \sum_{i=1}^4 w_i [1 - r_{gi} (1 - fe)]^n + (1 - p) \right\}^m$$

Where:

(p) is HIV prevalence among sexual partners, (m) is average number of sexual partners, (n) is average number of sexual acts with a given partner, (f) is proportion of sexual encounters in which condoms are used, (e) is efficacy of condoms which is assumed constant, (wi) is prevalence of sexually transmitted infections in population and (r_{gi}) is HIV transmissibility. For some results and data using the AVERT model, please search here: (<http://www.iaen.org/mtng/avert/index.htm>).

When a community has specific data for changes or improvements in any of these, the expected impact in the reduction of HIV transmission can then be estimated. Also, when only one of few sets of data is available, the rest of the variables²² may be held constant to find out the effect that one variable may have on the overall reduction in transmission and lives saved.

For the AIDS Competence Programme's impact evaluation, data is currently expected from communities in Thailand. However, based on experiential estimations and supported a priori information on the relationship between knowledge increases, change of attitude and reduction in transmission, the impact is expected to be high. This is especially if the above figures from Thailand on changes in attitude towards people living with HIV and increased participation are relied upon to reflect changes in behaviour and increased knowledge of HIV and AIDS within communities over time. These changes have an impact on number, frequency of sexual partners and use of condoms. Another factor to consider is how credible this data is. However, its credibility is high, as it has been collected and validated by local epidemiologists with international experience, including university and former UNAIDS personnel.

²² Data that changes according to the characteristic of the subject being reviewed, e.g. HIV prevalence among male and female pupils, male and female adults, pregnant women, commercial sex workers, truck drivers, ...

ANNEX B: Literature review (impact evaluations to guide communities)

Following is a list of impact studies that would guide the impact measurement for the AIDS Competence Programme, as adapted from the University of Leeds Health database:

1. Mercer, M A, Gates, N, Holley, M, Malunga, L and Arnold, R. (1996) Rapid KABP survey for evaluation of NGO HIV/AIDS prevention projects. *AIDS Education and Prevention* 8, 143-154.

Target Group/Country Rural subsistence communities, SAVE THE CHILDREN FUND, ZIMBABWE.

Intervention Methodology A community outreach by an existing network of village community workers and farm health workers visited rural areas and commercial farms in Zimbabwe. They held a two-day educational/ training session on HIV and AIDS, which community representatives and government extension workers also attended. The objective of the programme was to achieve knowledge of at least three HIV transmission methods and three preventative behaviour change methods among 80% of families.

Evaluation Method A baseline study of a sample of 1176 people had been carried out. A final study of 641 people aged between 18 and 45 years selected through cluster sampling followed. These were interviewed in 2 of the 3 project areas with a community size of about 22 500. The sample was separated into two groups, one of 429 people who knew at least one source of information used in the project and 212 people who had not named any project information source but had named mass media as the source of information on AIDS.

Impact Achieved 85% of the respondents named three modes for preventing transmission. There was an increase from 31% (baseline) to 65% (post-test) in persons spontaneously mentioning the use of condoms as a means of preventing AIDS (The study does not provide a significance test. Among people reached by project staff, there were a higher ($p < 0.01$) percentage of people reporting knowledge of at least three transmission mechanisms and knowledge of a family member with HIV. Little information is provided about the baseline study in which interviewers had received less training and the questions had been worded differently than the post-test. The study had actually been designed to validate a rapid appraisal rather than an evaluation. The self-reported exposure to project staff is also not reliable as a control.

2. Schopper, D., Doussantousse, S., Ayiga, N., Ezatirale, G., Idro, W.J., and Homsy, J. Village-Based AIDS Prevention in a Rural District in Uganda. *Health Policy and Planning* (2): 171-180, 1995.

Target Group/Country Ugandans ages 15–49 in the Moyo district.

Intervention Methodology Thirty community educators were recruited from every parish in the district and trained to conduct information sessions at the village level. An illustrated AIDS information leaflet whose content was based on findings from a KAP study supported their educational work.

Evaluation Method A baseline study was carried out in February-March 1991 on a cluster sample of men (n = 733) and women (n = 753) aged 15 to 49 years from the District. After 18 months in September-October 1992 the impact of the programme was measured through a second survey of 1744 individuals 9874 women, 870 men. There were no controls.

Impact Achieved During the first five months of the information campaign (September 1991 to January 1992) an estimated 50 000 people attended the information sessions at the village. 45 000 pamphlets and 40 000 condoms were distributed; 60% had participated in an information session, and 42% had received the pamphlet. Knowledge about condoms increased from 26% to 63% in women and 57% to 91% in men ($p < 0.000001$); and condom use in casual sex increased from 6% to 33% in women ($p = 0.12$) and 27% to 48% in men ($p = 0.06$). **Authors claim that this is the first ever documented example of the impact of a village-based AIDS intervention in Africa.** The main problem in interpreting the information is the lack of control. Another perspective argues that the impact achieved was due to exposure of the community to other educational activities.

3. Ngugi, E and Plummer, F. (1991) Prostitutes teaching prostitutes in Nairobi. In: Anonymous AIDS prevention through health promotion: facing sensitive issues, pp. 51-55. Geneva, Amsterdam: World Health Organization [WHO], Royal Tropical Institute]. Target group/Country Commercial Sex Workers in Nairobi, Kenya

Evaluation Method A cohort study had followed 595 Commercial Sex Workers since January 1985 with data-collection on all Commercial Sex Workers carried out in January, May and November 1986. For purposes of analysis the cohort members were retrospectively divided into three 1) 91 who received their health education through both community meetings and individual sessions at which the results of serological tests for HIV infection were discussed; 2) 67 who only attended community meetings; and 3) 205 who had received no intervention. Condoms were distributed free of charge to all Commercial Sex Workers who had requested them and their use was measured through the reported number clients in the preceding week using condoms and a semi-quantitative estimation of condom use (never/occasional/often/always).

Impact Achieved At the start of the study, 61% of the Commercial Sex Workers were infected with HIV and only 10%, 7%, and 7% of Commercial Sex Workers in Groups 1, 2, and 3, respectively, reported some use of condoms. After six months in the programme, this statistic had increased to 80%, 70%, and 58%, respectively. The mean frequency of condom use was 38.7%, 34.6%, and 25.6% of sexual encounters in Group 1, 2, and 3 women. Any condom use resulted in a three-fold reduction in risk of seroconversion. 20 of 28 women who were not condom users seroconverted compared with 23 of 50 condom users. Stepwise logistic regression confirmed that group discussion was the factor most significantly associated with condom use. Note that the authors stated that their reason for using this rather complex model was that they felt that a randomised clinical trial would have been unethical. It is difficult to establish from the paper whether the Group 3 were part of the original cohort of 506 followed up since Jan 1985 or an additional group of women outside this group. It is assumed that they were part of the original group. **Note: this is the classic study that first showed that health education could have an impact on seroconversion. An economic analysis of the programme suggests that the cost of the programme is between US\$ 8 to US\$ 12 per case of HIV transmission prevented, which is low.**

ANNEX C: THE AIDS COMPETENCE PROGRAMME SELF-ASSESSMENT FRAMEWORK

	1 BASIC	2	3	4	5 HIGH
Acknowledgement and Recognition	We know the basic facts about HIV/AIDS, how it spreads and its effects.	We recognise that HIV/AIDS is more than a health problem alone.	We recognise that HIV/AIDS is affecting us as a group/ community and we discuss it amongst ourselves. Some of us get tested.	We acknowledge openly our concerns and challenges of HIV/AIDS. We seek others for mutual support and learning.	We go for testing consciously. We recognise our own strength to deal with the challenges and anticipate a better future.
Inclusion	We don't involve those affected by the problem.	We co-operate with some people who are useful to resolve common issues.	We in our separate groups meet to resolve common issues (e.g. PLWA, youth, women).	Separate groups share common goals and define each member's contribution.	Because we work together on HIV/AIDS we can address and resolve other challenges facing us.
Care and prevention	We relay externally provided messages about care and prevention.	We look after those unable to care for themselves (sick, orphans, elderly). We discuss the need to change behaviours.	We take action because we need to and we have a process to care for others long term.	As a community we initiate care and prevention activities, and work in partnership with external services.	Through care we see changes in behaviour which improve the quality of life for all.
Access to Treatment	Other than existing medicines, treatment is not available to us.	Some of us get access to treatment.	We can get treatment for infections but not ARVs.	We know how and where to access ARVs.	ARV drugs are available to all who need them, are successful procured and effectively used.
Identify and address vulnerability	We are aware of the general factors of vulnerability and the risks affecting us.	We have identified our areas of vulnerability and risk. (e.g. using mapping as a tool)	We have a clear approach to address vulnerability and risk, and we have assessed the impact of the approach.	We implement our approach using accessible resources and capacities.	We are addressing vulnerability in other aspects of the life of our group.
Learning and transfer	We learn from our actions.	We share learning from our successes but not our mistakes. We adopt good practice from outside.	We are willing to try out and adapt what works elsewhere. We share willingly with those who ask.	We learn, share and apply what we learn regularly, and seek people with relevant experience to help us.	We continuously learn how we can respond better to HIV/AIDS and share it with those we think will benefit.
Measuring change	We are changing because we believe it is the right thing to do but do not measure the impact.	We begin consciously to self measure.	We occasionally measure our own group's change and set targets for improvement.	We measure our change continuously and can demonstrate measurable improvement.	We invite others ideas about how to measure change and share learning and results.
Adapting our Response	We see no need to adapt, because we are doing something useful.	We are changing our response as a result of external influences and groups.	We are aware of the change around us and we take the decision to adapt because we need to.	We recognise that we continually need to adapt.	We see implications for the future and adapt to meet them.
Ways of working	We wait for others to tell us what to do and provide the resources to do so.	We work as individuals, attempting to control the situation, even when we feel helpless.	We work as teams to solve problems as we recognise them. If someone needs help we share what we can.	We find our own solutions and access help from others where we can.	We believe in our own and others capacity to succeed. We share ways of working that help others succeed.
Mobilising resources	We know what we want to achieve but don't have the means to do it.	We can demonstrate some progress by our own resources.	We have prepared project proposals and identified sources of support.	We access resources to address the problems of our community, because others want to support us.	We use our own resources, access other resources to achieve more and have planned for the future.

ANNEX D: EVALUATION FRAMEWORK/ Model

Insert programme objectives on the y-axis (vertically) and insert the associated standard/ measure that each stakeholder wants/ prefers on the x-axis (horizontally). Reference each column and each row i.e each box. For example reference calculations, methodology or information.

	S	T	A	N	D	A	R	D	S
O		Step 1 1. What are the stakeholders' strengths, weaknesses, mandates and resources? (2) Are the programme objectives (a) The same as in the beginning? (b) The same for all stakeholders? (3) What data existed at the beginning of the programme?	Step 2 What donors, communities, programme managers and other stakeholders want to learn from the evaluation	Step 3 Step 3 QUALITATIVE evaluation based on community programme principles and elements (World Bank, UNITAR, Communities, etc)	Step 4 Step 4 QUANTITATIVE MEASURES based on UNAIDS and other donors' objectives.	Step 5 Step 5 PRIORITIZE, BUILD CONSENSUS AND TURN INTO INTERVIEW QUESTION DEPENDING ON: 1. Who is being addressed, 2. Assumptions of the evaluation 3. Main objectives of evaluation	Step 6 Step 6 Transform question into acceptable (PROCESS, OUTCOME OR IMPACT INDICATOR and show calculation)	Step 7 Step 7 Validate, produce report, receive comments and review	Means of Verification for each step
B	Desired AIDS COMPETENCE PROGRAMME OBJECTIVES/ STANDARDS								REFERENCES for each step of the evaluation (as indicated from p.65-67 of this report): e.g for this row, ref. would include ref. no 21, e. Judd et al (2001), other refs.: 2, 3, 9, 15, 17, 18, 33, 36, R7 Annex C. For easier referencing, quote chapter and name each box in matrix e.g. (1, 3) or chess board format e.g. A3
J	RECOGNIZE THE REALITY OF HIV AIDS	e.g. Strengths, Weaknesses, Mandates: As per Memos, legal authority, objective statements. and organizational missions Planning: omissions? Changes	e.g. Is the programme capable of achieving impact? How much does it cost? How many lives have been, or will be saved? What problems are there with the tools?	e.g. Capacity Building (skills), Information Exchange Best Practices.	e.g. (a) % Increase in HIV/AIDS knowledge, (b) % Increase in reach, (c) Cost vs. Reach	e.g. Question Theme: could be on (1. High level: testing or counselling, 2. Mid level: AIDS as a multi-dimensional problem 3. Low level: Ways in which AIDS is spread.	e.g. (a) Thailand figures would work here (b) general: if number of participants = x, then x + increase in x (j) x (X) 100 = Y. Current Reach = Y (X) 12 / number of months since workshop X projected timing (Assuming no mass media campaigns result from workshop, etc)	VARIES WITH SPECIFIC COMMUNITY (equations - Reference 1 + equations from references m1 and m2)	Ref no. (General) 1, 2, 6, 8, 10, R1, (costing) ref. 11 chapter 16, , m1, m2, 16, R6.... Reach Annex A, ref M3.
E	BUILD CAPACITY TO RESPOND TO HIV/AIDS	e.g. Resources: Past and future contributions towards support or opposition to the ACP or its components. (Financial, non-fin., tangible or intangible support or opposition)	e.g. Has the community become more capable of achieving positive results?	Participation, sustainability, empowerment, multi-disciplinary collaboration, capacity building (resources, structure)	Cost vs. User satisfaction (or utility of ACP to the end user), monetary value of partnerships built/ mobilized resources		% Respondents who think service quality was sufficient.		Refs. No. 1, 3, 5, 6, 8, 9, 11, 12, 13, 14, 16, 19, 20, 26, 27, 48, 54 ...

C	EXCHANGE AND SHARE KNOWLEDGE AND SKILLS	Tools and Methods: Use of ICT, Training Methods, Trainers' and Facilitators' adequacy, Knowledge Management Assets, Participant Comprehension		Multidisciplinary Collaboration, Capacity Building (skills, structure)	Cost vs. Reach (coverage)	e.g. Have you shared your knowledge from the ACP with anybody? Or, How many Children do you have-do you speak to them about HIV/AIDS? 1. What are those factors within your community that lead to high risk of HIV spreading? (Alcohol and drugs, Commercial Sex work, child exploitation, PMTCT?) 2. Is your community doing anything to address the problems of risks and vulnerabilities? (a) If yes, what is your community doing...if not, why is it not doing anything? (c) Is anything planned? 3. As part of addressing risk and vulnerability to HIV/AIDS, does your community does address issues beyond health and knowledge sharing	m3, 9, 13, 22, 33,50, 54, 55, ...Interview transcripts, Annex A, Annex C, Annex F, Annex G.
T	REDUCE VULNERABILITY and RISKS		What can be said about Behaviour Change outcomes, condom use, inclusion of women and girls, inclusion of PLWHA, Has the community become more competent in terms of advocacy ? Has the community	Sustainability, Empowerment,	Increase in knowledge, Reduced vulnerability: increased abstinence, faithfulness to one partner... no. Of infections averted ?	4, 6, 8, 9, 11, 12, 14, 16, 19, 22, 26, , 28, 31, 32, 40, 47, 53, M1, M2, R6, Annex G.	
E	LIVE TO THEIR FULL POTENTIAL			Equity, Sustainable development, empowerment, participation, Capacity Building: commitment to health improvement.)	Cost vs. Utility, cost. vs reach	29, 4, 30, 48, 49, 51, 52, 1, 2, 7, 10, Annex G	
S	Support /References for each step e.g. interviews, transcripts, costing forms, field participative Missions etc.	Over 50 Interviews including with with Dr. Tomaro, Lamboray, Nuttali, Diez, Mugisa, Boisard, Kamar, Sabiti, Pimenta, Duongsaa, CSW Uganda, Musician	UNAIDS, UNITAR, Community manager and Practitioner representatives.	Digital video of session in Lyon		55, Transcripts, interviews	

ANNEX E: ACP EVALUATION QUESTIONS (for different levels of competence) AND COMMUNITY MEMBER RESPONSE FORM
ACP EVALUATION : COMMUNITY and FACILITATOR QUESTIONNAIRE – TELEPHONE INTERVIEW

<p>ACP OBJECTIVE: To achieve AIDS competence within communities which implement the AC Process. <i>'AIDS Competent' Communities</i> are those that:</p>	<p>SAMPLE INTERVIEW QUESTIONS: (Varies depending on communities' own reports of their competence levels). Universally acceptable and desirable standards used to arrive at these questions. Please see MS Excel file on evaluation framework and ACP process.</p>	<p>Quantitative and Qualitative Standards</p>
<p>RECOGNIZE THE REALITY OF HIV AIDS (Capacity Building (skills), Information Exchange Best Practices.)</p>	<p>1. Do you know of three ways that the HIV virus can spread? 2. Does your community or any part of it meet to discuss HIV/AIDS, or do any members go for HIV Tests? 3. Do you think your community is strong enough to assume control and leadership of the fight against HIV/AIDS and achieve impact? (a) What are the strong aspects within your community that you think would be useful in the fight against HIV/AIDS? (b) What areas would your community need outside assistance in order to perform well?</p>	<p>Capacity Building (skills), Information Exchange Best Practices. (a) Has there been an improvement or fall in : % change in HIV/AIDS knowledge, Access to treatment, skills, attitudes (b) Cost vs. Reach</p>
<p>BUILD CAPACITY TO RESPOND TO HIV/AIDS</p>	<p>1. Since the ACP began in your community do you find it easier or harder to: a) Interact? b) Trust each other while interacting? b) Raise funds c) Organize any community event d) Find technical assistance when you need it? 2. Suggest ways to make the ACP more relevant and useful to your community.</p>	<p>Cost vs. User satisfaction (or utility of ACP to the end user), monetary value of partnerships built/ mobilized resources, (Participation, sustainability, empowerment, multi-disciplinary collaboration, capacity building (resources, structure) Cost vs. User satisfaction (or utility of ACP to the end user), monetary value of partnerships built/ mobilized resources.)</p>
<p>EXCHANGE AND SHARE KNOWLEDGE AND SKILLS IN A SYSTEMATIC MANNER</p>	<p>1. Do you have children or young people under your care e.g. students? 2. Have you spoken to anybody about HIV/AIDS since you participated in the ACP? If yes, how many people? 3. Has any other group referred to your methods and data that you used at your ACP session to perform their work? 4. Has participating in the ACP attained any other results that you were not expecting?</p>	<p>Multidisciplinary Collaboration, Empowerment, Capacity Building (skills, system structure). Cost vs. Reach (coverage). Total membership of local community organizations as % of population</p>

UNAIDS

<p>REDUCE VULNERABILITY AND RISKS</p>	<p>1. What are those factors within your community that lead to high risk of HIV spreading? (Alcohol and drugs, Commercial Sex work, child exploitation, PMTCT?)</p> <p>2. Is your community doing anything to address the problems of risks and vulnerabilities? (a) If yes, what is your community doing...if not, why is it not doing anything? (c) Is anything planned?</p> <p>3. As part of addressing risk and vulnerability to HIV/AIDS, does your community address issues beyond health and knowledge sharing (e.g. economic, social, political, cultural and human rights issues?)</p> <p>(For actively competent communities in this objective- level 4 and 5)</p>	<p>Sustainability, Empowerment, How many people have changed their attitude towards people living with HIV/AIDS</p>
<p>LIVE TO THEIR FULL POTENTIAL</p>	<p>1. Were you satisfied by the ACP workshop/ seminar in your community?</p> <p>-What about it did you like most?</p> <p>-Dislike most?</p>	<p>Equity, Sustainable development, empowerment, participation, capacity Building: commitment to health improvement.</p> <p>Cost vs. Utility, Cost vs. reach</p>

Other possible questions / indicators

Participation , Multidisciplinary Collaboration and Service Quality Indicators

Some questions may require time-series measurement

EXAMPLES OF INDICATORS

Community participation Indicators

Structure

- What level of participation in decision-making does this represent (using one of the well known schemes detailing hierarchies of participation .e.g. World Bank, UN-Habitat)
- How much consultation took place, and with whom, in defining this set of rules

Process

- Attendance/ participation rate of community members at meetings, steering groups, etc
- Agency opinion about how power is distributed between providers and residents
- the range of methods used to record levels of end user satisfaction and which interests were consulted in setting up these arrangements
- **Residents' opinion about how power is distributed between providers and residents**

Community Participation - outcomes

- Participating members' opinions about the extent to which their views have effect on specific outcomes at defined levels of community operation (on the same scale as above)
- % of members who know about the laid down participation arrangements
- % of members who can name community representatives/ councillors
- Number of visits to the AIDS Competence Programme website or E-Workspace, number of e-mail addresses opened
- Total membership of local community organizations as % of population
- Community members' views on the positive/negative effects for them of being active participants

MULTI-DISCIPLINARY COLLABORATION INDICATORS

Structure

- How many formal service agreement 'contracts' exist between agencies?
- What % of the local authority spend goes into pooled budgets
- In what % of Job Descriptions is interagency working an explicit requirement (as a % of time spent or in some other way)
- For what % of jobs do Performance Indicators explicitly specify interagency/ community activity?

Process

- Level of staff understanding of other agencies' aims/responsibilities/procedures, etc.
- What is the volume of post/telephonic/electronic communication between multi/sectoral partners
- % of management and community members who have had short secondments to other agencies
- Opinion of the impediments to better partnership working
- Opinion on the additional burdens, if any, imposed by more partnership working (Leeuw, 2001)

Outcomes

- Staff assessment of the changes in the organization, culture and practices of their particular agency as a result of more partnership working (World Bank 2001)
- Staff assessment of whether they have derived personal gains and/or disbenefits from more partnership working (for example more job satisfaction, ability to work more creatively around problems, etc.)
- Assessments made by 'third parties' including frontline helping bodies such as Councillors, Donor agencies, Community AIDS bodies etc. about whether or not there is better partnership working

UNAIDS

ACP FACILITATIVE / SERVICE QUALITY INDICATORS

Structure

What is formally laid down about service quality (UNAIDS, UNITAR, Government, Community targets, etc.)
How much consultation took place, and with whom, in defining these standards of training or service quality

Process

- Communities' knowledge and understanding of these standards

Outcomes according to both agencies and residents

- Residents' opinions about the changing quality of services and whether they are meeting the standards laid down.

**AIDS COMPETENCE PROGRAMME
Participatory Community Evaluation: Lay member Response Form (translated in several languages)**

Please write your own brief comments and thoughts on each of the community principles below with reference to the situation in your own community. For the queries 'Current Strength' and '12 Month Change' please write a number between 1 and 5, representing 'Total Absence' to 'Very High':
(1) TOTAL ABSENCE (2) WEAK (3) AVERAGE (4) HIGH (5) VERY HIGH

Element	Explanations	Community Members' Comments
<p>Selflessness: Current Strength: 12 Month Change:</p>	<p>The proportion of, and degree to which, individuals are ready to sacrifice benefits to themselves for the benefit of the community as a whole (<i>seen through degrees of generosity, individual humility, communal pride, mutual supportiveness, loyalty, concern, camaraderie, sister/brotherhood</i>).</p>	
<p>Common Values: Current Strength: 12 Month Change:</p>	<p>The degree to which members of the community share values, especially the idea that they belong to a common entity that is above the interest of members within it.</p>	

<p>Communal Services: Current Strength: 12 Month Change:</p>	<p>. Human settlements facilities and services (<i>such as roads, markets, potable water, access to education, health services, Cyber Cafes</i>), their upkeep (<i>dependable maintenance and repair</i>), sustainability, and the degree to which all community members have access to them.</p>	
<p>Communications: Current Strength: 12 Month Change:</p>	<p>. Within a community, and between itself and outside, communication includes roads, electronic methods (eg <i>telephone, radio, TV, Internet</i>), printed media (<i>newspapers, magazines, books</i>), networks, mutually understandable languages, literacy and the willingness and ability to communicate (<i>which implies tact, diplomacy, willingness to listen as well as to talk</i>) in general.</p>	
<p>Confidence: Current Strength: 12 Month Change:</p>	<p>How much confidence is shared among the community as a whole? e.g. an understanding and belief that the community can achieve whatever it wishes to do in the fight against HIV/AIDS.</p>	
<p>Community Environment: Current Strength: 12 Month Change:</p>	<p>. This environment includes (1) political (<i>including the values and attitudes of the national leaders, laws and legislation</i>) and (2) administrative (<i>attitudes of civil servants and technicians, as well as Governmental regulations and procedures</i>) elements. The legal environment.</p>	
<p>Information on HIV/AIDS: Current Strength: 12 Month Change:</p>	<p>Besides receiving and sharing information on HIV/AIDS, is the community able to analyze and use this information, process it for what is directly relevant to its situation and that of local families? What is the level of awareness, knowledge and wisdom found among key individuals and within the group as a whole?</p>	

<p>ACP Intervention and methodologies: Current Strength: 12 Month Change:</p>	<p>How effective has the ACP been in mobilizing, training, raising awareness and stimulating the community? Do outside or internal sources of funds increase the level of dependency and weaken the community, or do they challenge the community to act and therefore become stronger?</p>	
<p>Leadership: Current Strength: 12 Month Change:</p>	<p>Please give your thoughts about the skills, willingness, and charisma of your leaders. Do they follow the decisions and desires of the community as a whole?</p>	
<p>Networking: Current Strength: 12 Month Change:</p>	<p>What is the extent to which community members, especially leaders, know persons (and their agencies or organizations) who can provide useful resources that will strengthen the community as a whole?</p>	
<p>Organization: Current Strength: 12 Month Change:</p>	<p>The degree to which different members of the community have a role in supporting the community (in contrast to being a mere collection of separate individuals), including community structures, procedures, decision making processes, effectiveness, division of labour and complementarity of roles and functions</p>	
<p>Political Power: Current Strength: 12 Month Change:</p>	<p>The degree to which the community can participate in national and district decision making. Are decisions or concerns of the community taken seriously by the authorities?</p>	
<p>Skills: Current Strength: 12 Month Change:</p>	<p>The ability of individuals, that will contribute to the organization of the community and the ability of it to get things done that it wants to get done, technical skills, management skills, organizational skills, mobilization skills.</p>	

<p>Trust: Current Strength: 12 Month Change:</p>	<p>. The degree to which members of the community trust each other, especially their leaders and community servants.</p>	
<p>Unity: Current Strength: 12 Month Change:</p>	<p>Despite divisions, <i>(religious, class, status, income, age, gender, ethnicity, clans)</i>, please comment on the degree to which community members are willing to tolerate the differences and variations among each other and are willing to cooperate and work together. Is there a sense of a common purpose or vision, shared values?</p>	
<p>Wealth: Current Strength: 12 Month Change:</p>	<p>. The degree to which the community as a whole <i>(in contrast to individuals within it)</i> has control over actual and potential resources , and the production and distribution of scarce and useful goods and services, monetary and non monetary <i>(including donated labour, land, equipment, supplies, knowledge, skills)</i>.</p>	

Adapted from Bartle, P. (2004) The Sociology of Communities. Victoria, Canada, Camosun Imaging, <http://www.scn.org/cmp/>

INITIALS _____ COMMUNITY/ ORGANIZATION: _____
 CITY AND COUNTRY _____ DATE _____

ANNEX F: FINANCIAL INFORMATION AND E-WORKSPACE SAMPLE

logged in as: [Chris Alando](#) [[Log out](#)] **e-Workspace Sample**

English

[Send feedback](#) Language: English (choose from the list)

My e-Workspaces Other e-Workspaces:

My e-Workspaces

ACP Knowledge Fair
 CRIS Support (public e-Workspace)
 Learning about eWs (public e-Workspace)
 Local Responses to HIV/AIDS

What's new

Subject

- Version 2.1
- Technical Information
- Russian UserGuide for Workshop
- Initial CRIS v.21 Russian UG (draft)
- Research Data Model
- Project Data Model
- Indicator Data Model
- Training exercises
- Curacao Training
- XP
- Network Installation
- document.pif
- Training Presentation (unspecified)
- (unspecified)

e-Workspace	List	Modified
CRIS Support	Userguide	3/1/2005 6:12:00 PM
CRIS Support	Documentation	2/1/2005 12:39:00 PM
CRIS Support	Version 2.1	3/10/2005 4:34:00 PM
CRIS Support	Version 2.1	3/1/2005 5:40:00 PM
CRIS Support	Technical Information	2/15/2005 5:21:00 PM
CRIS Support	Technical Information	2/15/2005 5:20:00 PM
CRIS Support	Technical Information	2/15/2005 5:20:00 PM
CRIS Support	Documentation	2/9/2005 11:53:00 AM
CRIS Support	CRIS Training	2/8/2005 9:04:00 PM
CRIS Support	Technical Information	2/1/2005 12:40:00 PM
CRIS Support	Technical Information	2/1/2005 12:39:00 PM
Local Responses to HIV/AIDS	-	1/27/2005 12:18:00 PM
CRIS Support	Documentation	1/25/2005 4:04:00 PM
ACP Knowledge Fair	-	1/7/2005 11:08:00 PM
ACP Knowledge Fair	-	1/7/2005 11:08:00 PM

I want to...

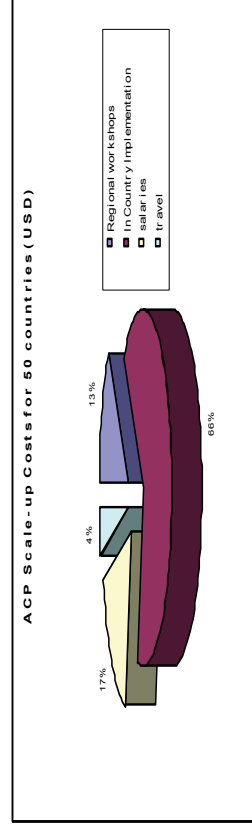
- [Request new e-Workspace](#)
- [Change e-Workspace navigation](#)

FINANCIAL INFORMATION: Please note that countries within regions could merge and some of these countries into single workshops, thereby saving costs. Other cost-saving and efficiency increasing measures exist, but are best agreed between partners. Total cost of coordinating and achieving global AIDS Competence Programme expansion based on these costs would be US\$ 2.3–US\$ 2.5 million over 3.5 years (**all figures in US\$**).

A) AIDS Competence Programme distribution of Initial Phase spending (Viewed as a stand-alone programme)			
Administrative/ Global programme formulation and management costs (Indirect Costs)	300 000		
Implementation costs including support, technical meetings, training and fundraising (Direct Costs)	315 000		
Communications Costs (Direct Costs)	15 000		
Total initial Phase (excluding BP costs)	630 000		
*Purchasing Power Parity			
B) AIDS Competence Programme projected in-country costs (spending based on a country 'x' with GDP / capita (PPP*) of between US\$ 700 and US\$ 1500 per capita. (Viewed as a support programme for existing interventions). Figures based on earlier programme manager estimations.			
Support to country AIDS response groups and their partners			50 000
Technical meetings and learning from action (these could be pooled and shared by countries within a region. Averaging for 25 countries, this could save US\$ 600 000)			30 000
Communication and Fundraising (These could be subsidized by forming partnerships with Mass media organizations.)			15 000
Programme Support costs			5000
Total expected in-country costs			100 000

Second Scenario for 50 countries:

Activity	Costs US\$ (2.3 million)
Regional workshops@30,000	300,000
In Country Implementation	1500000
Salaries for 2 or 3	400000
Travel	100000



ANNEX H: Partnerships



The Joint United Nations Programme on HIV/AIDS (UNAIDS):

The Joint United Nations Programme on HIV/AIDS, **UNAIDS**, is the world's main advocate for action on the HIV/AIDS pandemic. It leads, strengthens, expands and supports an expanded response to the pandemic. This response is aimed at preventing transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and mitigating the impact of the epidemic. The UNAIDS was formed in 1995, and its ten Cosponsors include, UNICEF, the World Health Organization (WHO) and the World Bank.



UNITAR

The United Nations Institute for Training and Research

The United Nations Institute for Training and Research (UNITAR) was established in 1965 as an autonomous body within the United Nations with the purpose of enhancing the effectiveness of the Organization through appropriate training and research. UNITAR's programmes are established under two main clusters of activity: (1) Training in international affairs management, and (2) Capacity building in economic and social development and environment. UNITAR conducts about 150 programmes, seminars, conferences and workshops each year across 5 continents, targeted to more than 7500 participants. Simultaneously, the Institute has developed an original network maximization and intensification approach with partners inside and outside the United Nations System. UNITAR is the training arm of various United Nations Agencies, as well as Secretariats for international legal instruments (such as the United Nations Convention on Climate Change).



British Petroleum (BP): BP is a leading stakeholder in the oil industry and among the largest energy companies, providing its global consumers with fuel used for transportation, energy for heat and light, retail services and petrochemicals products that are used in day to day life. The company is also known for its operational excellence and its knowledge management expertise.



The Salvation Army: The Salvation Army is a part of the Christian Church, with different practices and way of government. It was founded in 1865, and works in all continents in the world. The Salvation Army is known for its belief in the human capacity to respond to any situation once facilitated, and is now a recognized leader in Human Capacity Development.



THE WORLD BANK

The World Bank Institute: The World Bank Institute is the capacity development arm of the World Bank. It assists countries to share and apply global and local knowledge in response to development challenges. The Institute works in partnership and networks policymakers, academics, and development practitioners everywhere, and helps in the application of knowledge to development challenges. The Institute's capacity development programs are designed to build skills among groups of individuals involved in performing tasks in order to strengthen the organizations in which they work, and the sociopolitical environment in which they operate.

Other organizations that have implemented the AIDS Competence Programme's processes to different levels inside countries include the United Nations System, The Aga Khan Development Network, Business Corporations, among many others.

AGA KHAN DEVELOPMENT NETWORK

The Aga Khan Development Network:

The Aga Khan Development Network (AKDN) focuses on health, education, culture, rural development, institution building and the promotion of economic development. It improves the welfare of the poor and provides them with opportunities. The Network works equally with people of all origin and faith. The network is physically present in about 25 countries in Africa, Asia, Europe and the Americas.

The Constellation for AIDS Competence: The Constellation for AIDS Competence is a non-profit organization registered in Belgium. It comprises most of the original managers, facilitators and technical professionals in the initial funding phase of the AIDS Competence Programme, drawn from various disciplines and areas of the globe. The Constellation aims to link people and organizations committed to AIDS Competence. The Constellation further aims to facilitate the local ownership of responses to AIDS, so that it is recognized, included in strategic frameworks, funded and implemented nationwide. The Constellation has recently been registered as an association in Belgium, and has opened a satellite office in Chiangmai, Thailand.

Value added by partners, proposals for the future and challenges facing partners

UNAIDS is recognized as an effective pillar for the global response to AIDS, through the provision of leadership and advocacy, strategic information, monitoring and evaluation, and mobilization of resources to support effective responses.

- 1) UNAIDS active engagement of civil society and experience in global and community partnership development was another value added to the AIDS Competence Programme. UNAIDS partnerships included ten organizations within the UN system, governments, civil society, and communities.
- 2) The Salvation Army is the oldest among the original partners in terms of community experience. It provides extensive human capacity building and community information exchange experience. Its strong belief in the ability of communities to inform, learn from, and respond effectively to AIDS has formed the basis of the AIDS Competence Programme.
- 3) British Petroleum contributed well acclaimed technical expertise in Knowledge Management (KM), knowledge generation and sharing that could be used for HIV and AIDS and other development or private sector programmes. The AIDS Competence Programme tools assist in meeting community and Millennium Development Goals. BP is physically present in a majority of countries globally.

- 4) UNITAR is experienced in partnership building with local authorities and leading players in the global private sector. UNITAR has extensive experience in resource mobilization. It has extensive experience in training and research and is a leading UN organization in terms of information generation and dissemination.
- 5) The Constellation for AIDS Competence comprises most of the original ACP planning and implementing managers.
- 6) The World Bank has the experience of having implemented hundreds of development programmes globally and learning from them. It could also inform future evaluations significantly. The World Bank Institute shares development and training mandates and a close working relationship with both UNAIDS and UNITAR and thousands of institutions globally.
- 7) The Aga Khan Development Network provides a network of leading business and development institutions from almost all economic sectors spread out within 25 strategic countries.

UNITAR

Based on the Type II initiative for training and capacity building of local authorities for sustainable urbanization presented at the Johannesburg Summit in 2002, UNITAR's Decentralized Cooperation Programme has developed public-private partnerships to provide training to local authorities and actors enhancing their capacities to implement the Millennium Development Goals at the local level.

The UNITAR CITY-AIDS Project, in cooperation with UNAIDS, aims at developing the capacities of City Managers, senior municipal officials and local actors to create an effective response to HIV/AIDS through developing and sharing knowledge. The project is founded on the core methodology of participatory and facilitation approaches to build AIDS-competence in Cities worldwide. Individuals, communities and institutions are competent when they are learning from local responses to HIV/AIDS, and applying such knowledge in their response to HIV/AIDS, when they are able to measure their own progress in fighting the epidemic, set improvement targets and share their knowledge.

In the spirit of public-private partnerships, all UNITAR/DCP workshops associate both local authorities and local actors (such as communities - including affected people, civil society organizations, private sector), as well as international organizations. In order to enhance training activities' effectiveness, local authorities are involved at two levels: the decision-making level (Mayors, governors, local elected officials) and the technical level (technical directors - health/HIV/AIDS secretaries or coordinators in the case of CITY-AIDS). Training and knowledge sharing activities are being implemented through the CIFAL Network. Based on strong partnerships with Emory University, Morehouse University, CDC and UNAIDS on one hand; with WHO and UNAIDS on the other hand, CIFAL Atlanta (USA) and CIFAL Lyon (France) are taking the lead in developing the CIFAL Leadership Initiative for AIDS Competence in Cities as a global programme and network.

The Constellation for AIDS Competence

The Constellation for AIDS Competence has already signed an agreement with the Aga Khan Development Network. Its representatives have carried out an AIDS Competence Workshop in Kenya, with a whole range of business and development networks associated with the Aga Khan network, and the International Red Cross in Togo. Many more countries and organizations have expressed an interest in collaborating with the Constellation.

The Challenges Facing Partners

The stakeholder review process has identified minor differences in:

Stakeholders' interpretation of the definition of 'AIDS Competence.' (The differences are due to changing interpretations of the definitions based on their own differing mandates and are therefore neither faults, mistakes, nor arising from these objectives.) These differences result in further differences in perceived priorities for measurement (for this evaluation) based on the following points of view:

(a) That evaluations could focus mainly on AIDS Competence Programme managers' and facilitators' point of view and mainly evaluate the stakeholders' achievement, due to the pre-existing monitoring or self-assessing nature of the Programme tools.

(b) That evaluation should focus mainly on performance measurement in relation to progressive community achievements and improvements due to the AIDS Competence Programme.

It is possible for this and future evaluations to measure, to varying degrees, both alternatives. A number of useful methodologies have been proposed and annexed as technical notes accompanying this report. Stakeholders are encouraged to propose their own methodology for participatory consideration and unification of standards to measure during each evaluation.

The proposed strategies for implementation of the programme differ considerably:

1. One approach favours an unlimited multisectoral community partnership process where the key AIDS Competence Programme stakeholders should work together with communities and any interested stakeholder. Proponents of this approach view the Programme as a means of achieving success in not only AIDS, but also overall sustainable development programmes.

2. Another approach favours a pre-specification/ limitation of the type of partners to those with a wide reach, specific resources targeted, and high experienced structures e.g. local authorities and the private sector leaders. This approach also envisions the AIDS Competence Programme as a large programme, but part of a wider sustainable development programme, that shares tools and resources within a larger decentralized cooperation framework.

Both approaches consider the AIDS Competence Programme as a means of achieving sustainable development, as a major step towards the wider Millennium Development Goals, as well as a great tool for community mobilization programmes. There are few communities in the world that have not implemented a participatory project, either supported by their governments, nongovernmental organizations, Private Sector, or the UN System. The AIDS Competence Programme has several components- ICT and knowledge sharing, Training, Community Competence Building (which includes all concepts and principles of community development from the public and private sectors). Again, the AIDS Competence Programme, as mentioned before, is implemented by heterogeneous (social, cultural, economic, political, legal heterogeneity) and dynamic communities. Again, several donors may already be existing in communities where the AIDS Competence Programme was implemented. The question in finding an alternative community for comparing impact results (what the World Bank²³ evaluation team would call 'counterfactuals') would therefore rely on:

3. Comparisons with either communities with similar pre-intervention characteristics where similar projects have been implemented or communities where no interventions have been attempted.

Analysis of alternative projects based on qualitative inputs, processes, and outcomes of projects and weighting evaluation results against other programme's results as benchmarks. Here AIDS Competence Programme has the distinct advantage of a well-conceived, top-of-the-range process and tools that autonomously maximize end user satisfaction while

²³ World Bank, 2003, Community-Driven Development, A study Methodology, Operations and Evaluation Department, July 2003 page 18.

maximizing reach. It is argued that if the quality is excellent, then quantity only serves to increase returns from the project and the impact is bound to be higher. Based on the above argument, for the present evaluation, alternative programmes would be those that encouraged information dissemination and communication, as well as training of trainers (see Annex A, for list of comparative impact evaluations).

ANNEX I: References

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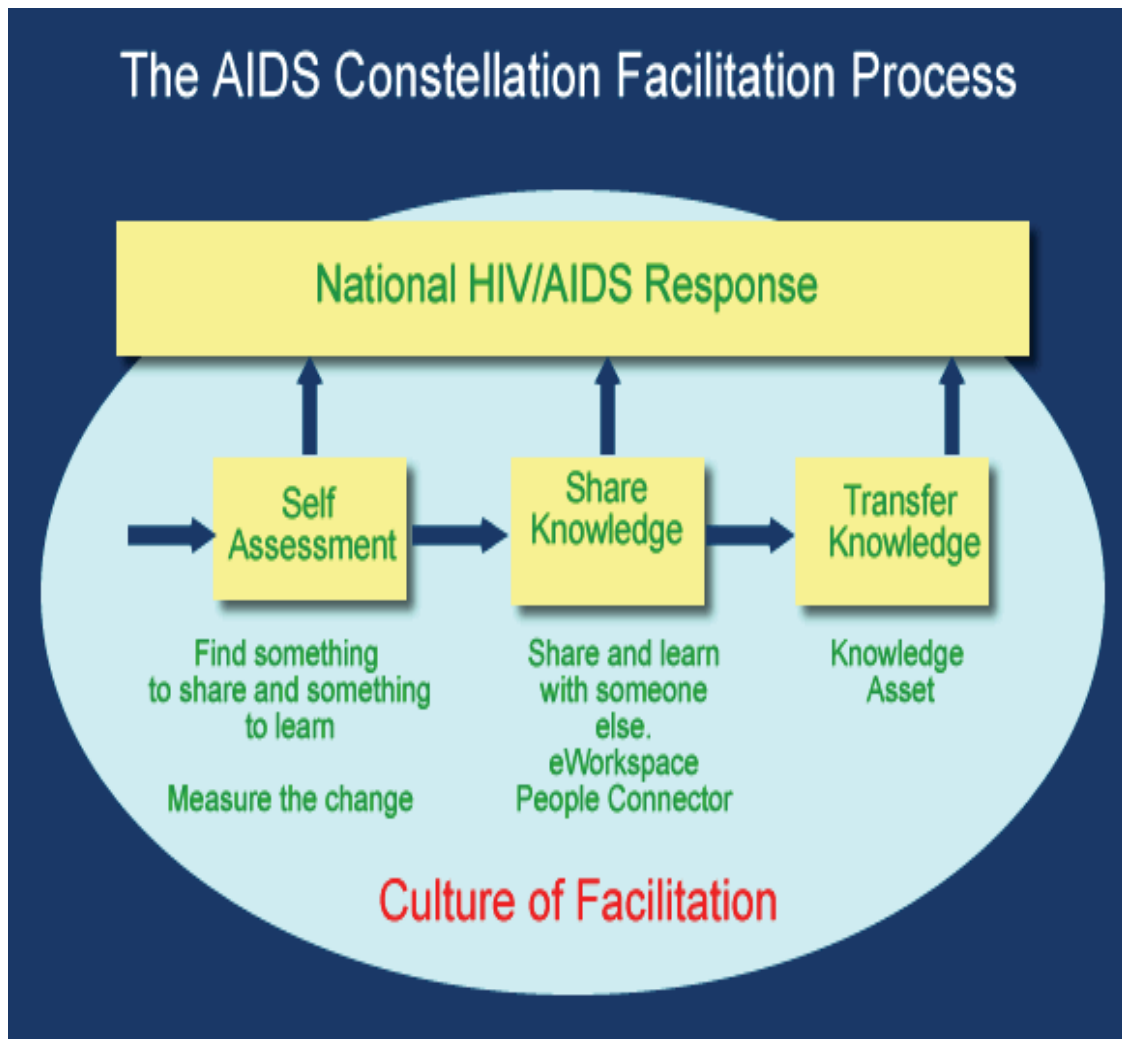
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