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AIDS Community Response Initiative for West Africa

(Nigeria, Benin, Togo, Ghana and Ivory Coast)

*A Regional Initiative for Capacity-Building of
Community-Based and Non-Government Organizations
for Community Outreach & Response to the AIDS crisis*

Submitted By

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Executive Summary

Africare is requesting \$18,709,860 in support of a five-year AIDS Community Response Initiative for West Africa (ACRI). The goal of this Initiative is to reduce the transmission and impact of HIV/AIDS in the coastal region of five adjacent countries of West Africa—Nigeria, Benin, Togo, Ghana and Ivory Coast. The east-west axis of the target region will extend approximately from Lagos, Nigeria to the western border of Ivory Coast. The region has a total population of about 165 million people and the HIV prevalence ranges from 3.2% in Benin to 12% in Ivory Coast.

The region was selected due to its mixture of high levels of HIV prevalence as seen in Ivory Coast and Togo, the rapidity in which HIV is spreading in the lower prevalence countries (Nigeria, Ghana and Benin) and the potentially ominous impact on the region of the mounting explosion of HIV in Nigeria, now the second-ranked country in Africa in terms of the absolute number of HIV-infected people. Because of the continuous movement of the region's population—in Ivory Coast one-third of the population originates from outside the country—the AIDS crisis represents a regional problem and requires a regional response. Africare has strong presence in this area and is therefore well positioned to contribute significantly to the AIDS effort.

The target group for the Initiative is communities whether defined by geography or affiliation such as common profession, religion, culture, age group, gender, sports activity, military encampment, cross-border public officers, entertainment groups, HIV/AIDS status or other grouping. What is known is that in African society, community is binding, powerful and respected. Yet, prevention efforts more often than not focus largely on the individual to the exclusion of community and messages are communicated at the national level through mass media versus community dialogue. While these efforts have resulted in high levels of AIDS awareness and knowledge in the region, what is known is that behavior change that prevents sexual transmission of the AIDS virus has not occurred. Community-level input is needed to address the problem of AIDS. These messages were echoed throughout the region in meetings held from mid November to mid December 1999, between Africare's proposal design team and key stakeholders working on AIDS.

Moreover, it is known that in this region communities cut across national borders and that AIDS not only attacks individuals, but it also weakens communities. Community norms, practices, attitudes and beliefs define, permit, block and/or sanction courses of action and perspectives that help drive the epidemic and are underutilized resources to be applied to reducing the transmission and impact of AIDS.

Through this Initiative, Africare will focus on AIDS and community response and will address the following main objectives. Africare will encourage communities to deal directly and

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pro-actively with the AIDS crisis; will strengthen the capacity of community-based organizations (CBOs) and non-governmental organizations (NGOs) to more effectively face the tremendous challenge of AIDS; and will scale up to the regional level a response to AIDS by communities. This will result in decreased transmission, reduced stigma, increased community support of orphans and other victims of AIDS and extended community survival mechanisms.

Achievements in development gained in Africa over the past three decades are being swallowed up by AIDS and at the same time AIDS-related problems are compounding at a crisis level. To mobilize additional resources, ensure accountability and increase sustainability, Africare will be in the role of project manager and facilitator and will partner with local governments and organizations that conduct AIDS activities. Africare is a US-based non-government, development assistance organization founded in 1971 and currently supports health, agriculture, environment, democracy & governance programs in 28 African countries.

Africare will bring a well-established presence in the target region, long-term experience working in Africa on AIDS and CBO and NGO capacity building and strong commitment to weaken the disastrous path of this epidemic.

The project will operate out of a regional office and five country project offices located in each of the target countries. On site staff will be host country nationals and external experts in AIDS programming, CBO and NGO capacity building, participatory community development and monitoring and evaluation. A large component of the Initiative will be to strengthen the capacity of CBOs and NGOs to carry out a more effective and sustainable response to AIDS.

Through a well-defined capacity-building program, selected CBOs and NGOs in the region will participate in an organization-specific strategy to build their AIDS programming and institutional capacities. Clear and concise indicators will be applied to measure CBO and NGO progress. Training in participatory community development will take place and community and opinion leaders will be encouraged to become AIDS advocates. The program will also manage a seed-grant component to empower selected and needy CBOs and NGOs to implement creative, community-based and directed activities.

In addition, activities will be carried out to promote cross-fertilization of ideas, skills and information across the region, including joint review & planning and study tours. Common monitoring and evaluation systems will be developed for regional application. Meetings with key stakeholders at the regional level will be organized to inform them of community concerns, problems and solutions related to AIDS, to promote partnership and collaboration and to mobilize regional sources of funding.

The crisis of AIDS in Africa, now and in the foreseeable future, is at an emergency level. Africare has assessed the AIDS problem, needs and resources in the target region. Africare also has weighed this information against the strengths that Africare possesses and the lessons learned

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about AIDS. The AIDS Community Response Initiative represents a solid, appropriate and achievable effort to tackle the crisis more effectively and in a sustainable manner.

I - BACKGROUND AND PROBLEM STATEMENT.

Of the 33.6 million people now infected with HIV worldwide, 23.3 million of them are in Sub-Saharan Africa - nearly 70 percent of the worldwide total of people living with HIV/AIDS. In 1999 alone, 2.5 million people worldwide died as a result of the AIDS virus, making it the world's fourth-biggest cause of death, and the spread of the epidemic continues unabated. Africa is also home to 90 percent of the world's 11 million AIDS orphans. AIDS is now the leading cause of death in sub-Saharan Africa with 13.7 million Africans already having died as a consequence of the epidemic.

The HIV/AIDS epidemic is at a severe crisis level in Africa. Dr. Peter Piot, executive director of UNAIDS stated, *"visibly, the epidemic is eroding the social fabric of many communities. In its demographic, social and economic impact, the epidemic has become more devastating than war, in a continent where war and conflict appear to be endemic"*. He added, *"the time is now to declare AIDS in Africa a state of emergency, requiring emergency type efforts and resources"*. Speaking at the Lusaka conference on AIDS in Africa in September 1999, a World Bank official stated that, *"HIV is now the single greatest threat to future economic development in Africa"*. World Bank President James Wolfensohn has described AIDS as a *"major development challenge, if not the most important development challenge confronting us in Africa today"*. At the macro-economic level, the World Bank estimates that African countries with high HIV prevalence will lose one percent of GDP growth per capita annually. Recent studies showed that for a number of companies in Africa profits decreased significantly (up to 20 percent) as a direct result of AIDS. Absenteeism, recruitment and training of replacement employees, higher costs of employee benefits and a reduced pool of skilled labor affect companies' profitability and viability. In Ghana, as in many African countries, the increasing number of cases has put severe stress on the health sector. A recent Korle-bu hospital study estimates that the in-hospital life time cost of treating an AIDS patient is approximately \$60. Ghana's health budget is less than \$5 per capita.

The problem of AIDS along the West Africa coastal corridor linking Nigeria, Benin, Togo, Ghana and Ivory Coast (with a combined total population of about 165 million) is as dynamic, mobile and expansive as the commerce and population movement that drives and defines this region. The AIDS epidemic has seriously penetrated Ivory Coast and Togo and now is picking up speed in Nigeria, Ghana and Benin—places that were once described as low prevalence countries. Because of continuous population movement, close geographic proximity and high population density in the coastal region, HIV moves easily across the national borders of these countries.

The country-specific rates of AIDS infection in the five target countries range from a low of 3.2 in Benin to a high of 12 percent in Ivory Coast. In Nigeria, based on three successive surveys (91-99), the HIV prevalence rates were seen to rise from 1.8 percent to 5.4 percent. In urban centers such as Abidjan, Ivory Coast the infection rates are higher than for the country as a whole (16.2 percent in Abidjan). In Nigeria, because the total population is so large (over 120 million), the country now ranks as second in Africa in terms of the absolute number of people infected with HIV. There are a total of 3.5 million persons living with HIV/AIDS in the five countries. Of that number, 1.4 million are AIDS cases (1997). The progressive increase shown in Ghana by the number of HIV cases reported in the last three years equaling the number reported in the ten prior years is a cause for concern.

Generally, people in the region have heard about the disease AIDS and have received information (most commonly via mass media) about how the virus passes and how transmission can be prevented. Unfortunately, AIDS awareness and knowledge do not easily translate to belief in one's vulnerability and changed behavior.

Community norms, practices, attitudes and beliefs define, permit, block and/or sanction courses of action and perspectives that help drive the epidemic and are an underutilized resource to be applied to reducing the transmission and impact of AIDS. UNICEF was one of the first to use social mobilization in an effort to reduce infant mortality. In the early 1980s UNICEF began acting as a catalyst to form strategic alliances around universal child immunization. The targets for mobilization were everyone from women, parents, and children to health workers, teachers and political leaders. By mobilizing multiple sectors, from the client to the influential leaders, a world-wide movement was created that increased immunization coverage from 20 to 80% in six years. In Zambia, The Salvation Army's community based program in HIV/AIDS has found that behavior change occurred 90% of the time in relation to ritual cleansing practices when families and communities were targeted as opposed to 50% when individuals were targeted.

Cheryl Walter in "*Community Organizing and Community Building for Health*" by Meredith Minkler, Ed. States the following in regards to community building practice: "*First, it places community, not the community organizer at the center of practice....Second, thinking of community as multidimensional, involving people and organizations at many levels, consciousness, actions, and context, allows us to model greater complexity...Third, if we perceive community not as an existing unit that needs to be organized differently but as a dynamic and emergent whole embodying varying degrees of communityness that is continually being built or created, then the building of community will be one of the central concerns and activities of community practice... Fourth, community practice then becomes less an intervention or coming between and more an interchange, where each of us is changed through coming together.*"

Much of AIDS programming is focused on individual-based AIDS awareness education

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that involves national-level mass media campaigns. Although these efforts have been successful in increasing AIDS awareness and knowledge, corresponding behavior change has not resulted. Community-level responses are needed to more effectively address behavior change related to reduction in transmission of the AIDS virus or mitigation of the impact of the AIDS crisis. Community-level responses have been effective in many of Africare's programs addressing food security at the household level. Existing and new groups within the community are identified, formed. Training and mentoring of these groups is provided with the goal being for the communities to gain autonomy in identifying and solving their problems around food security. The Hearth Model approach uses existing community resources in the treatment of malnutrition. The behaviors to be addressed need to involve not only individual-based behaviors but also focus on community-based behaviors that can bring leverage on individual behavior in a sustainable mutually reinforcing manner.

Lack of financial resources is not the only barrier that limits response to the AIDS crisis. When individuals and communities do not feel that AIDS—prevention, care and support and mitigation of impact—is their problem, their priority and an issue over which they have power to act, the epidemic spreads easily. Moreover, reluctance to talk openly about AIDS, sex and the underlying factors that drive this epidemic severely restricts the ability to respond to the AIDS crisis. Stigmatization towards people living with HIV/AIDS sequesters not only the people who are facing the disease head on, but relieves communities of their potential to act from a position of strength in facing the AIDS crisis.

1.1. General Response to the AIDS Crisis.

Global resources to address the AIDS crisis remain scarce. Approximately \$165 million dollars was allocated in 1997 for AIDS prevention in sub-Saharan Africa. In speaking at the recent meeting of the UN Security Council, World Bank President James Wolfensohn stated that *between 1-2.3 billion dollars was needed each year for AIDS prevention in Africa.*

All the five countries have established National AIDS Control Programs (NACPs) and developed strategic plans to tackle the problem of HIV/AIDS. There are several community based organizations and NGOs that are active in HIV/AIDS prevention programs. Recently the First Lady of Ghana launched a national campaign to promote AIDS education at all levels and a government committed to create a special fund for supporting community level initiatives.

Several CBOs and NGOs have come together to form consortia or networks to mobilize resources for advocacy and for sharing information. Associations and networks of persons living with HIV are coming to being. Many community-based organizations, such as motorcycle taxi associations in Benin and Togo, possess strong willingness to undertake AIDS activities and bring a substantial constituency with significant influence. These associations have limited experience in responding to AIDS and there is a clear need to strengthen their capacity. In Ivory

Coast, a country where one-third of the residents are from outside the country, cultural associations representing various immigrant groups present another example of community groups that are well positioned to respond to AIDS. AFRICASO, a network of African-based AIDS services organizations and the Society for Women Against AIDS in Africa (SWAA) are highly regarded voices for community organizations involved in AIDS in Africa. GHANET in Ghana has created the forum for partners of HIV/AIDS prevention to network and mobilize resources. Most of these voluntary groups lack institutional and financial capacity to do effective work.

For example, in Uganda through the effort of CBOs, NGOs and government, the HIV infection rate among pregnant women in towns has decreased from 37 percent to approximately 15 percent and among Ugandan youth, the age of onset of sexual intercourse has been delayed by two years. This evidence shows that concerted efforts by national and community leaders have measurable effects.

Despite such limited initiatives and successes, the ability of national AIDS control program as well as state and district level AIDS programs to carry out their responsibilities is severely restricted by the lack of technical and institutional capacity as well as funding. There is a limited level of purpose built among CBOs and NGOs and little shared vision region-wide.

In Africa, engaging communities in response to AIDS is essential. This is true because community is the foundation, strength and orientation of African society. Community serves as one of the most important entry points and agents in responding to AIDS.

The AIDS Community Response Initiative for West Africa (ACRI) will confront the problem of AIDS by building upon strengths and resources of African communities. A similar vision to the one presented in this proposal is echoed in a statement by the Community AIDS Movement in Africa delivered at the December 6 -7, 1999 meeting of the International Partnership Against AIDS in Africa called by United Nations Secretary General Kofi Annan. The statement read: *"There is an urgent need to make a significant move to address priorities defined by communities and to support us in our efforts to empower and accompany our communities in their development and response to HIV/AIDS. Community leaders believe strongly that there is a need to review and implement new funding schemes that can support the development of a sustainable response from the community sector. These include:*

- * *direct funding support to African-based non-governmental organizations and networks,*
- * *building the capacity of Africa-based non-governmental organizations to better manage and implement their programs,*
- * *supporting the development of Africa-based human resources that provide tangible benefits to the local community above those that support a strengthening of already strong non-African interests."*

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Building response to AIDS through civil society is needed because the problem of AIDS must be addressed jointly by communities, government, and the private sector. Community-based organizations and non-governmental organizations tend to have greater flexibility and the ability to respond rapidly, however, these groups do not often have the opportunity to share experiences and lessons learned. Working regionally, as described in this proposal, will generate greater sharing of resources and programming expertise. There are strong historical, cultural, linguistic and economic ties between these five contiguous countries. For example the Ewes are found living in the coastal corridors of these countries and share the same culture. This provides an opportunity of developing similar messages in the same language thereby easing communication and minimizing cultural hurdles. In addition, the West African regional community has developed several avenues of collaboration in the political, economic and social areas that is making south to south interaction more constructive and leading the path to various forms of integration. This Initiative fits this agenda.

1.2. Africare: Capabilities Statement.

Africare is a US-based NGO founded in 1971. Africare's extensive development activities in the continent make it the largest U.S.-based organization focused exclusively on improving the condition of African communities. In each of the 28 countries where Africare works, its development programs build on the concept of self-help. Working closely with people, community organizations and governments, Africare designs, operates and facilitates projects in primary health care, HIV/AIDS, capacity-building of civil society, environmental management, democracy and governance, agricultural production and emergency humanitarian aid. Currently, Africare has more than 150 projects dispersed across all regions of Africa that range in size from \$1,000 to \$7,000,000.

Africare has well-established country field offices in three of the five countries (Nigeria, Benin and Ghana) that comprise the three major target areas for the West Africa Regional AIDS Initiative. In Ivory Coast, Africare has a long history of project involvement. At present, Africare shares offices with a partner NGO, with supervision from Africare's country field office in Burkina Faso. Africare does not have a field office or activities in Togo, although professional contacts are established.

1.3. Africare's HIV/AIDS Experience.

At present, Africare is involved in an overall strategic planning process. One of the major goals of this process is to redefine the mission and program priorities of Africare based on current realities in Africa. During the strategic planning process Africare staff identified HIV/AIDS as a top priority for their work in Africa.

Over the past twelve years, Africare has devoted more than \$5 million in program resources to assist partners in Africa to combat the AIDS epidemic. The first Africare initiative was in 1987 in Nigeria and Rwanda, where Africare supported the establishment of national AIDS programs. In Nigeria, Africare worked with Federal and State Ministries of Health, International NGOs, Nigerian universities and local NGOs to organize and carry out a series of successful national, zonal and state level planning and prevention activities. These began with a national policy workshop that involved senior policy and technical representatives and the Ministries of Health and Education of each state and Federal Capital Territory, to educate and motivate leaders toward the implementation of AIDS and drug abuse prevention campaigns in every state. The national workshop was followed by a series of zonal workshops to strengthen state government health professional skills in preparing training curricula, visual aides and state plans for their programs aimed at behavior change. Under a subsequent program, Africare strengthened local non-governmental organization (NGO) capabilities to plan, design, seek funding for, and implement community-based HIV/AIDS prevention activities. Africare is presently supporting an AIDS orphans program through local NGOs in Rivers State, Nigeria.

In Rwanda, Africare supplied critical material support for the establishment of the national AIDS program office. In Ivory Coast, Africare helped to establish counseling and information centers for Liberian refugees and displaced persons. Through the West and Central Africa Family Health and AIDS Prevention Project funded by USAID, Africare is coordinating the work of local NGOs involved in preventing AIDS transmission along the migrant routes between Burkina Faso and Ivory Coast. These NGOs are focusing on outreach work to sex workers, long-distance truck drivers and plantation workers at eight sites between Burkina Faso and Côte d'Ivoire.

With funding from the William H. Gates Foundation, Africare has launched a three-year HIV/AIDS regional initiative in Zambia, Zimbabwe, Malawi, and South Africa. The overall goal is to identify, draw upon and disseminate best practices of existing programs to strengthen the capacity of community-based groups to educate, counsel and support adolescents, young adults and their families, in reproductive health and HIV/AIDS prevention. A key achievement has been validation of the project's basic strategy of building upon existing community-based initiatives to improve the quality of their activities, extend their reach, to replicate the most effective approaches, and to strengthen their sustainability. Africare/Tanzania conducted a project on the island of Zanzibar to strengthen CBOs and NGOs working in AIDS. The objectives of this project were to build the capacity of community organizations working in HIV/AIDS/STD prevention and to encourage collaboration among these organizations. Africare currently carries out HIV/AIDS activities in conjunction with its child survival projects in Benin and Tanzania.

Africare is using the progress and results of these initial efforts to leverage added support from a variety of multi-laterals, bi-laterals, foundations, corporations and other entities. Africare

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through this Initiative will confront the problem of AIDS by building response to AIDS through civil society. Under the AIDS Community Response Initiative, the job of Africare and its partners will be to assist target country CBOs and NGOs and the communities that they represent in developing their capacity to more effectively fight the AIDS epidemic.

Some of the *Lessons learned* are:

- the importance of fostering a shared purpose in working with communities;
- the power of working in organized communities;
- the strength of a cultural empowerment approach;
- gender-sensitive approaches are needed to work with communities;
- given the adequate support, local initiatives are the best means to address local prevailing reproductive health problems; and
- partnerships and collaboration at the community, regional and national levels are powerful in mobilizing communities.

1.4. Africare's Capacity Building Experience.

During the last several years Africare has increased programming emphasis on institutional development of African rural associations, NGOs and civil society in general. A non-exhaustive list of recent and/or on-going activities include:

- in Benin, Africare is implementing a highly successful civil society organization strengthening project funded by USAID.
- in Guinea, Africare implemented a USAID project to develop community level organizations in Faranah and Kankan Regions that carried out participatory workshops resulting in the auto-diagnostic by NGOs and local area associations of their strengths and weaknesses and the elaboration of a plan to address their needs. Participatory training financed by USAID and the Government of Guinea resulted in increased professionalism in NGOs, the creation of regional self-coordinating structures and increased partnerships. This pioneering work has shaped the national debate on NGO strengthening needs, the role of NGOs in civil society and development in Guinea.
- In Nigeria, Africare's NGO component of the Nigeria AIDS Prevention Project in Lagos, Cross River and Kano states helped to: train staff of Nigerian NGOs; provide NGOs with technical and material assistance; strengthen their abilities to design, finance, manage, implement, evaluate, support and sustain AIDS prevention activities; and provide seed grants to selected Nigerian NGOs for well planned AIDS prevention projects.
- In Burundi, Africare has been implementing a USAID financed activity to strengthen local NGOs in Bujumbura, Gitega and McKamba Provinces.
- in South Africa, a USAID-funded governance training program enabled elected officials and other policy makers (from any political party) with practical training and technical assistance

- in many of Africare's Child Survival programs, Africare partners with local NGOs. For example, in Benin's USAID centrally-funded Child Survival program, Africare is partnering with ABPF, the local NGO affiliate of International Planned Parenthood Federation.

II - PROJECT DESCRIPTION.

2.1. Goal and Objectives.

GOAL: REDUCTION IN HIV/AIDS INCIDENCE

Objectives and Sub-Objectives	
1. To build community response to the AIDS Crisis and develop CBOs / NGO abilities in AIDS prevention in West Africa	
1.1	To promote partnership, collaboration and dialogue in the community and among stakeholders to share vision and objectives in responding to AIDS.
1.2	To strengthen the organizational capacities of partner CBOs & NGOs that focuses on problem solving about AIDS by the community and community empowerment.
1.3	To reinforce the technical capacity of partner CBOs and NGOs in AIDS programs for increased sustainability of AIDS activities.
1.4	To promote community managed and financed AIDS activities
2. To enhance the regional response to AIDS in West Africa	
2.1	To promote cross-fertilization of ideas, skills and strategies among key stakeholders for AIDS prevention
2.2	To promote the mobilization of regional resources for community activities
3. To influence policy making	
3.1	To build a community of purpose among community-based actors responding to the AIDS crisis
3.2	To promote an enabling environment for community-based response to the AIDS crisis

Table 1 : ACRI's objectives and sub-objectives

2.2. Strategies to Address the Problem.

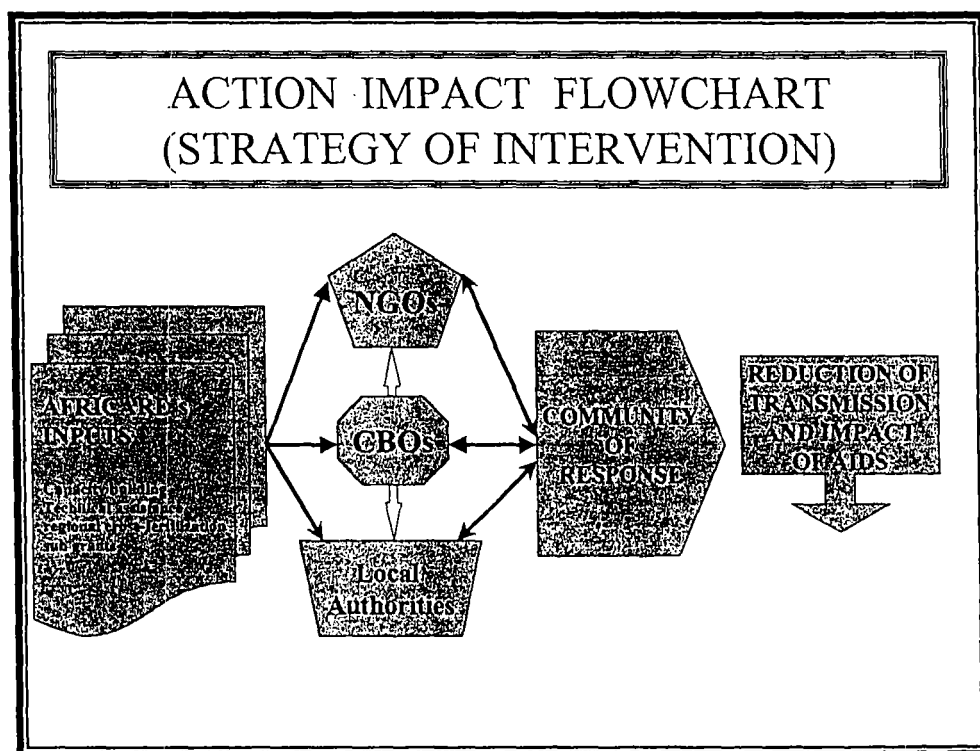


diagram 2 : Africare's strategy of intervention

2.2.1. Target group.

“The *AIDS Community Response Initiative* will start from the grassroots with its scope of activity evolving naturally in harmony with CBOs and NGOs interests and initiative, toward regional horizontal linkages and a shared sense of purpose”. Building community response to the AIDS epidemic will require promoting an enabling environment for the AIDS epidemic, building capacity of actors and promoting linkages and synergy between actors toward a regional community of purpose.

The specific **target groups** for this Initiative are the CBOs, NGOs, and other community groups. The broad target group for the Initiative will be communities. These organizations will be diverse in their nature and have a broad base within their community. They will include those CBOs already involved in AIDS activities and those that have the potential and interest to become key agents in responding to AIDS. They will be the operational focal points for the Initiative because they represent communities and serve as the infrastructure through which communities dialogue, analyze, plan and act. CBOs and NGOs also serve as the infrastructure through which prevention outreach and AIDS-related services are delivered.

The organizations will be selected and involved in the activities after an initial diagnosis using methodologies developed by Africare in its highly successful civil society organizations strengthening project “BINGOS”. The criteria include reputation in the community, internal governance, representation of the community in its membership, dedication and sincerity to its mission. Exceptionally, the Initiative will work directly with grassroots local governance committees such as the Unit Committees in the case of Ghana, where they act as a CBO. Otherwise, CBO/NGO partnership with such structures will be favored. From the baseline diagnosis indicators of progress will be followed for each organization partner and used to adjust the collaboration with these organizations.

2.2.2. Geographic focus.

The geographic focus for the project will be the coastal region that spans across five countries of West Africa—Ivory Coast, Ghana, Togo, Benin and Nigeria. This region comprises a natural socioeconomic hub reinforced by the contiguous ocean coast, close geographic proximity between countries, sea ports that serve as collective gateways, high population density, active trade and trucking routes, vibrant urban, government and employment centers, shared languages, cultures and ethnic groups that traverse national boundaries, constant population movement and common problems such as AIDS. Communities in rural and urban settings will be included under the Initiative. In addition, the project’s geographic target is based on the level of HIV infection across the region and the epidemic’s growing momentum.

Africare established a country office in **Benin** in 1993. In addition to a USAID-funded child survival project in the Oueme Department of Benin, Africare undertook BINGOS (Beninese Indigenous Non-Governmental Organization Strengthening Project)—a \$4 million three-year activity funded by USAID and focused on capacity-building of non-governmental organizations with programs in health, family planning and governance in 1994.

The Initiative’s purpose is to strengthen civil society by creating a critical mass of effective, well managed and honestly run NGOs that are able to implement grassroots self-help activities. Due to the success of this project, funding for BINGOS was renewed through activities expanded to cover all of Benin. Through BINGOS, mentoring and training activities are carried out in areas such as management, staff and board development, finance, program development, feasibility studies, proposal writing, budgeting, evaluation and implementation. In addition, the BINGOS project has managed a small grants program. Over 100 NGOs and intermediary CBOs have participated in the project. The framework and lessons learned from this project will be applied to the Initiative.

Africare’s project activities in **Nigeria** that began in 1987, have included family health, child survival, AIDS, literacy, water, agriculture, river blindness control, income generation, and institutional strengthening.

Although Africare has been involved in **Ghana** since 1989, it is only in early 1998 that it established its office in Accra. Two projects that Africare is supporting in Ghana include a USAID funded child survival project and a privately funded integrated community development initiative with components of rural electrification, income and skill generation, and improved education. Both projects are geared towards outreach capacity building and community participation. Africare collaborated with two urban-based local NGOs to undertake an HIV/AIDS prevention project using music as entry point for the prevention effort. This project was funded by WorldSpace and was implemented as a Millennium Eve event.

Africare's project activities in **Ivory Coast** that began in 1991, have included Family Planning and Vegetable Production.

Given that Africare has a long-standing, well established and highly respected presence in four of the five countries (Nigeria, Benin, Ghana and Ivory Coast), these countries were selected as a good place to begin and to achieve maximum results.

2.2.3. Building a critical mass of synergy zones.

Within the Coastal West Africa Region *the Initiative will focus its effort in local governance areas, where a synergy of actions and actors to include communities, NGOs, CBOs and leaders can be achieved for greater impact.* These focus areas are referred to by the Initiative as **Synergy Zones**. The Synergy Zone is characterized by having legislated political and administrative autonomy, being governed by democratically elected leaders, and being perceived by government and civil society as a local hub of social and economic development, possessing its own development plan.

For example, in Ghana, the Synergy Zone is the District, with a population generally from 70,000 - 100,000 persons, an elected District Assembly, its own development and operations budget, and with local administration of a number of social services. In Benin, the Synergy Zone is the Commune with a population of approximately 60,000 persons, a locally elected board and mayor, legislated financial autonomy, its own development plan, and budget. Synergy Zones for the other three countries will follow along similar lines.

Table 2 : ACRI Targets

Country	Phase I		Phase II		Total	
	Synergy Zones	CBO/NGO partners	Synergy Zones	CBO/NGO Partners	Synergy Zones	CBO/NGO Partners
Cote d'Ivoire	8	40	8	64	16	104
Ghana	8	40	8	64	16	104
Togo	4	20	4	36	8	56
Benin	8	40	8	64	16	104
Nigeria	8	40	8	64	16	104
ACRI Total	36	180	36	292	72	472

By focusing efforts within a selected number of local governance areas, the Initiative will benefit from and reinforce the local self-development dynamic and decentralized democratic governance. Within each of the selected Synergy Zones about 5 different community organization and NGO partners will be identified. They will be strengthened and partnerships promoted between organizations and structures with complementary roles and spheres of actions.

The Initiative will promote the emergence of a critical mass of CBOs and NGOs within these synergy zones, their example inciting emulation, their number serving as the core and catalyst for the movement of community response to the AIDS crisis. The force of the critical mass will create momentum towards changing the way communities respond to the epidemic and the way other actors, such as Government and its financial partners, orient their efforts and resources. The number will vary according to Country. In the case of Ghana, for example, there are 41 Districts in the 5 administrative Regions that will be included in the Initiative. Of these, the Initiative will work with eight in the first two years. Others will be added in consecutive years up to a total of one third.

2.2.4. Objective1: Building community response to the AIDS Crisis and developing

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CBOs and NGOs abilities in AIDS prevention in West Africa.

Strengthening CBO and NGO institutional capacity, the Initiative will use an organizational development approach, stressing progress of the organization in obtaining goals set together with the Initiative team after a participatory base-line organizational diagnostic. Strategic planning will be emphasized as a tool for organizations toward self-empowerment and sustainable programming. Methodologies and tools developed by Africare in its BINGOS Project will be employed to the best advantage.

Areas of institutional capacity strengthening will include:

- Financial management;
- Administrative management;
- Strategic planning;
- Fund raising and resource mobilization;
- Democratic governance of civil society organizations;
- AIDS programming; and
- Project design, implementation, monitoring and evaluation

Strengthening CBO capabilities in AIDS Programming will be developed through a variety of means—sharing of information, resources, lessons learned and best practices, training and workshops, skill-building in participatory community development, message and materials development and cross-fertilization of ideas and skills through networking, site-visits, exchanges and study tours. Moreover, emphasis will be placed on developing AIDS programming that goes beyond AIDS awareness education and accentuates the role of community in responding to AIDS. Partner CBOs and NGOs will be encouraged to look within as well as outside their organizations for opportunities to address the AIDS epidemic.

Through capacity building in AIDS programming, CBOs and NGOs will strengthen their ability to:

- promote AIDS risk assessment and behavior change,
- sensitize and energize community leaders,
- promote greater access to and use of condoms,
- source, develop and disseminate IEC materials and activities,
- promote and/or provide socioeconomic support to people living with HIV/AIDS, their families & AIDS orphans and to reduce their stigmatization,
- mobilize local resources for increased sustainability of AIDS activities,
- collect, analyze, apply & disseminate information on HIV/AIDS and STIs, and
- encourage community participation in responding to the AIDS crisis.

Strategic sub-granting as a strengthening mechanism, the Initiative will not attempt to fund the community response to AIDS. It will however use sub-grants as a tool to support the process of building capacity and community level experience as well as to mitigate marginal financial constraints to promoting an enabling environment. Activities and

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opportunities for building regional community of purpose will benefit from sub-grant consideration. Sub-grants will support activities such as:

- pilot and operational support activities;
- leveraging of resources;
- building constituency;
- specific organizational and institutional capacity building objectives;
- enabling partnerships and conditions for synergy; and
- connecting CBOs/ NGOs through the Internet.

Sub-grants will be made for amounts of \$100 to \$10,000 with possibility of renewal or higher awards for activities of special merit. Approximately 30 sub-grants will be awarded *per year in each Country*. CBO and NGO partners will be strengthened in fund raising and will actively seek community and external sources of financing for activities outside of the regular budget.

Outcomes of CBO/NGO Strengthening. The program of CBO/NGO strengthening measures will impulse directly into communities a heightened awareness of the AIDS crisis and positive behavioral change leading to reduced transmission of HIV/AIDS (fewer sexual partners, use of condoms..). Dealing with AIDS will enter into public and private discussions which will be increasingly informed and proactive -- AIDS stigma will decrease. Individual outcomes will include: Compassion, solidarity and support to PLHAs as well as capacity of PLHA organizations to serve their members will increase; support and concern for AIDS orphans and AIDS victim's families will be heightened; a sense of community security from a common understanding and ethic about protection will build increased hope for the future in the face of mounting tragedy of the AIDS crisis; and communities will be more proactive in ensuring the availability, access and use of condoms.

2.2.5. Objective 2: Enhancing the regional response to AIDS in West Africa.

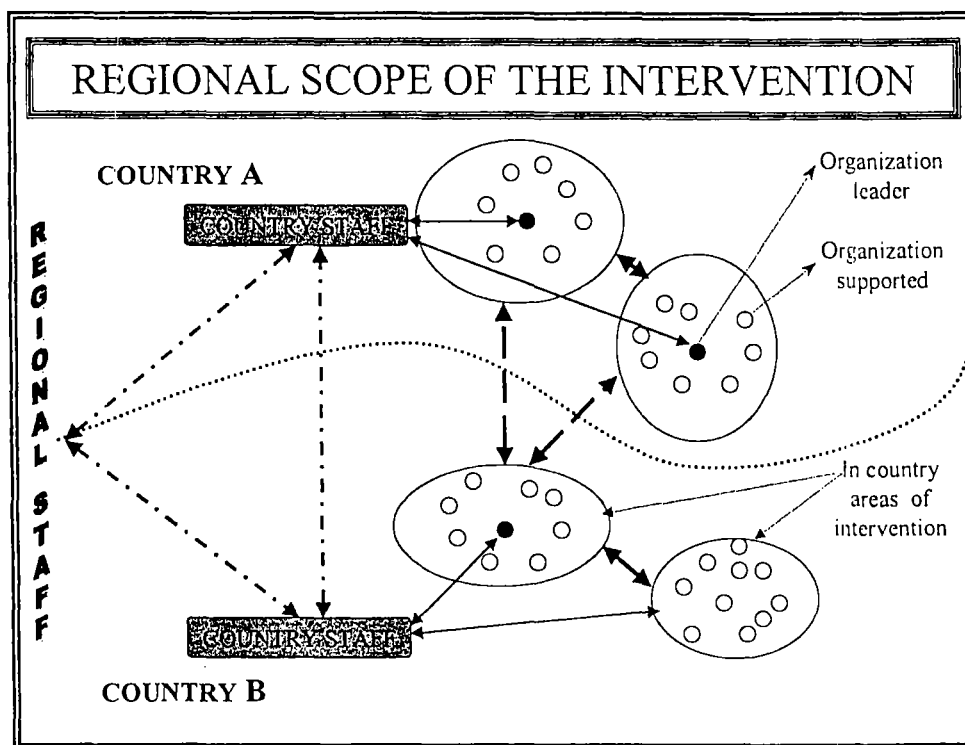


diagram 3 : Africare's regional scope of intervention

The regional nature of the AIDS epidemic requires regional as well as local solutions. Within the West Africa Coastal Region an opportunity exists to enhance horizontal linkages and shared vision between community-based actors creating a regional community of purpose. This objective will be achieved through a variety of mechanisms.

Cross-fertilization of ideas and skills will be carried out through numerous activities among regional stakeholders. Cross-border and regional meetings will be organized among key stakeholders. Cross-border study tours will be arranged. An information clearinghouse will be established or enhanced for use by CBOs and NGOs responding to AIDS in this region and other interested parties. A web site will be established that will feature documents of interest to the CBOs and NGOs, newsletters reporting on the activities of the CBOs and NGOs, profiles of activities carried out under the Initiative and other relevant information and tools. A regional pool of resource persons will be cultivated and enhanced to promote indigenous expertise and experience. Operational research and results sharing by universities and research institutions will be promoted. The initiative will facilitate community to community and south to south solutions to problems.

Building community of purpose among CBOs and NGOs, the outcome of which will be a shared vision region-wide. This community of purpose is not only defined by members' shared goals and values, but includes their solidarity and willingness to help each other and

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to come together to promote their common objectives, despite ethnic or national boundaries. Direct contact between CBOs within and outside of national boundaries will be promoted. Existing networks will be enhanced to the extent that their membership includes a significant number of community-based actors.

The Initiative will support workshops to develop regional leadership and shared vision. These contacts will converge toward a regional strategic planning exercise for community-based actors sponsored by the Initiative. Furthermore, the Initiative will promote adoption of a code of ethical and professional behavior for CBOs and NGOs involved in AIDS activities throughout the region.

Mobilization of regional resources for community-based actions as well as regional coordination and collaboration will involve working with civil society AIDS networks, governments and other institutions. In particular, the Initiative will encourage advocacy efforts targeting regional institutions and fora for the purpose of increasing financial support for community-based activities region-wide. Regional public and private funding sources will be cataloged followed by an effort to identify and develop more effective and accessible funding mechanisms, to permit CBOs and NGOs to access regional funding sources.

Building advocacy and communication capacity of the CBOs and NGOs has been set apart for special emphasis due to its capital importance in promoting an enabling environment for community-based AIDS activities as well as for developing cross-border community to community cooperation.

2.2.6. Objective 3: Promoting an enabling environment for community lead change.

The Initiative will promote an enabling environment for community-lead change and action. The promotion of local public awareness and political will enable CBOs and NGOs to develop AIDS programs with an administrative support. As noted earlier in the document, communities have been for the most part marginalized in the fight against AIDS in favor of vertical programs targeting individuals and mass media and social marketing campaigns. Through promoting national recognition of the community role and the importance of their contribution in responding to the AIDS epidemic, local, national and regional resource allocation to them should improve. Likewise, government and their partners will understand the opportunity for greater impact of actions by facilitating community to community horizontal partnerships. CBOs and NGOS must create favorable public opinion and lobby decision makers to bring about this change. Special emphasis will be given to strengthening CBO and NGO partners, and other community leaders to empower them to accomplish this objective.

2.3. The Initiative Team and Implementation Approach.

Geographic Organization - from the grassroots up:

The centerpiece of the implementation approach is the transfer of capacity to
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Community-based Organizations responding locally to the AIDS epidemic within a local governance area (Synergy Zone). To facilitate this process and insure its grassroots presence, the Initiative will put in place Community Capacity Transfer Facilitators (CCTF). These multi-disciplinary agents will mentor and coach CBOs, provide on site advising, and coordinate Initiative technical and resource inputs to these local partners. Each CCTF will be responsible for 1-2 Synergy Zones and based within one of those Zones.

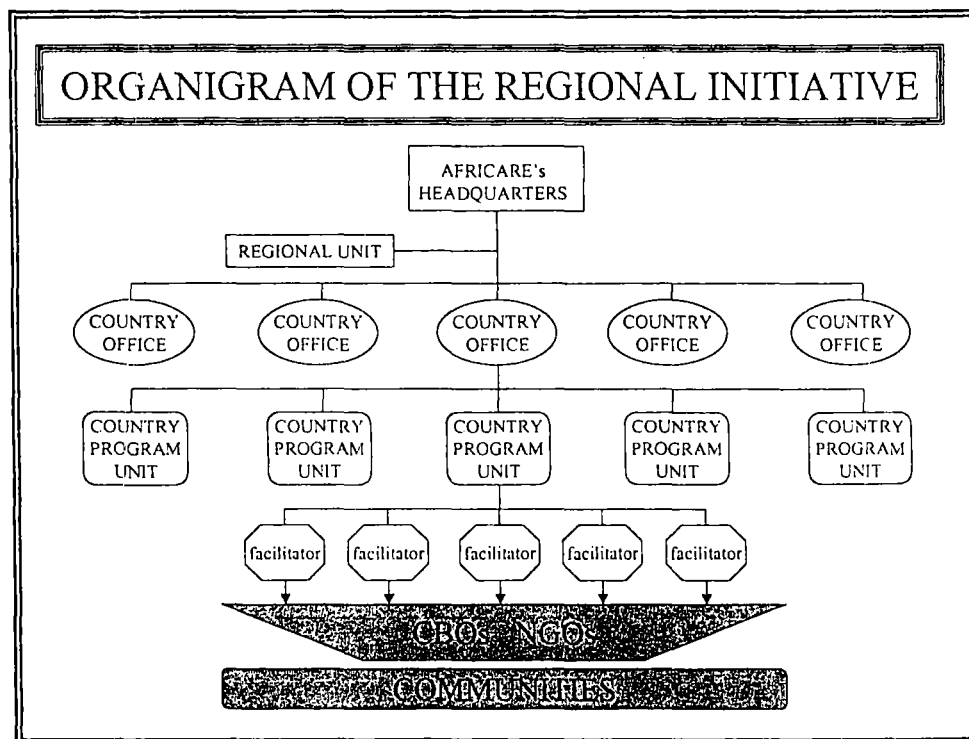


diagram 4 : Africare's organigram for the regional intervention

They will be supported by the Initiative country-program Coordinator and three specialists:

- a CBO/NGO Capacity Building Specialist
- a Sub-Grant Manager
- a Monitoring and Evaluation/MIS Specialist

Each specialist has defined roles of technical support to the CCTFs and for the overall implementation. These four persons together with the CCTFs make up the Country Technical Team. They will be supported by shared and full-time administrative and logistical staff (accountant, secretary, and drivers) according to each Africare Field Office situation.

The Africare Country Representative and his/her team will provide implementation, administrative and financial oversight in addition to institutional support as is the case with all Africare projects. The Initiative Country Team will be housed within the Africare Field Office where possible to reduce costs and facilitate communication.

The Initiative will be implemented as autonomous Country-level projects with

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coordination, facilitation and technical backstopping provided by a Regional Coordination Team. The Regional Team is composed of the Regional Coordinator, the Regional MIS Specialist and a Secretarial/document preparation assistant.

The Role of the Regional Team is:

- ☐ quality assurance (monitoring and evaluation, assessment of human resource inputs and methodology, identifying Country Team training needs and opportunities...)
- ☐ capitalization of experiences (capturing, documenting and sharing of country developed experiences and lessons, researching and diffusing of external experiences and innovations...)
- ☐ links/liaison with regional and international institutions (sharing information, identifying resources, coordination)
- ☐ joint management (joint review and planning, joint training, tracking of global expenditures...)

The Regional Team will be based in the Africare Ghana Country Field Office located in Accra. Accra is central to the region, offers good communication infrastructure and excellent regional transportation links. The Regional Team will have logistical and administrative autonomy but will cost share with the Ghana Field Office.

At Africare's Washington, D.C. Headquarters, the Initiative will be backstopped by the Africare Health Unit and HIV/AIDS Director. In addition, the Africare Regional Director and Program Manager will contribute 5% of their time to backstopping the project.

2.3.1. Implementation Approach.

The ACRI will be implemented in four major movements: building the foundation for collaboration, the first group of partners and corresponding program, the second group of partners and corresponding program, and the transversal phase of regionalization/sustainability.

Building the foundation: There can be no underestimation of the importance of putting in place the right people with adequate orientation to form the project team, developing harmonious relationships and informing institutional partners, communities and the general public of the nature of the Initiative and its strategy. This will be the focus of the first six months of the project, with public information and institutional relation cultivation extending throughout the project life.

Phase One and Two: there are two phased groups of Synergy Zones and CBO/NGO partners. The targets for each phase are featured in 2.2.3. and in Table 2. "ACRI Targets". The phased grouping will allow a concentration of resources and ensure greater success. Resources developed within the first phased group will be used to amplify the transfer of capacity to the second phased group and beyond the Initiative Synergy Zones. Each phase will require a two year cycle. The first phased group will benefit from ongoing, though

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reduced, support as the second phase is brought on board.

Converging efforts and actions towards regional and sustainable actions will be integral movement with increased intensity as the Initiative progresses in building local capacity and response. The second half of the five-year Initiative will see activities focusing wholly on this dimension.

2.4 First Year Activities

Adequate resources will be devoted to recruiting orienting and enhancing the capacities of the Initiative team. Once in place the Initiative local teams will work closely with the respective National AIDS Program Coordination Teams and their institutional partners (UNAIDS, WHO, World Bank, bi-lateral development assistance agencies) as well as civil society representatives and administrative and elected officials to build understanding and trust. A first step in working together will be to identify the initial Synergy Zones.

Organizations with special capabilities, exceptional dedication and openness will be identified within Synergy Zones. The staff will conduct an inventory of CBOs and NGOs within the Synergy Zones. Using a survey questionnaire, data will be collected on each of the groups that reflect its objectives, membership, location, length of existence, financial stability, organizational management, strengths and weaknesses. These, generally more structured, intermediary CBOs and NGOs will be designated as resource organizations and will be endowed with additional resources such as documentation libraries, internet connections, audio-visual equipment that will serve the surrounding CBOs and NGOs. Where such capacity can be cultivated, intermediary CBOs and NGOs will be provided special training to act as community-based organizational mentors. The **organizational mentors** will amplify Initiative staff outreach and continue transferring capacities to community organizations at the end of the project.

Local partner selection will entail participatory situational community assessments and organization evaluations. This process will be initiated during the second quarter of the first year. Detailed country-by-country implementation plans will be completed once baseline surveys and assessments have been completed and shared with stakeholders. CBO strengthening activities including sub-granting will begin in the fourth quarter in parallel with activities directed at creating the enabling environment for community-based AIDS activities. A baseline study will be conducted to determine initial situation and to develop indicators for future evaluation of ACRI impact. The process of sharing of all assessment and study results will inform partners, allow significant feedback and allow community ownership of activities and results. The end product of this first project implementation step will be the elaboration of a *detailed implementation plan*.

Work Plan for Year One West Africa Regional AIDS Initiative

Activity	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Regional staff recruited, oriented and posted	X			
Regional office established	X			
Government protocol completed and Memorandum of Understanding signed for regional office	X			
Vehicles, other equipment and supplies for all offices ordered	X			
Contacts and meetings with key stakeholders, NGOs and CBOs begins or is renewed	X	X	X	X
Headquarters backstopping staff oriented	X			
Planning by regional staff	X	X	X	X
Preparation of information brochure on Initiative completed and distributed		X		
Visits by regional staff to target countries		X	X	X
Staff for country offices hired		X		
Country offices established		X	X	
Strategic planning meeting including regional & country program staff & HQ project program mgr. (travel to field by HQ project program manager once a year to attend one meeting)		X	X	X
Monitoring and evaluation staff hold strategic planning meetings and develop instruments & systems		X	X	X
Identification of country-specific geographic area to be targeted in each country		X		

Activity	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Baseline survey conducted in each country		X	X	X
Contact and assessment of potential partners	X	X	X	X
Sharing findings of baseline surveys with stakeholders		X	X	X
Detailed implementation plan prepared				X
First year work plan finalized with annual benchmarks			X	
Official launching of Initiative			X	
General information meeting for CBOs and NGOs held in each country			X	
NGO resource centers identified and partnerships formed		X	X	X
CBOs and NGOs identified following described procedures		X	X	X
Quarterly reports prepared	X	X	X	X
Work plan for Year Two prepared				X

2.6. Monitoring and Evaluation of Initiative.

The four most important functions of the AIDS Community Response Initiative's (ACRI) monitoring and evaluation strategy are the following:

- to assess the input, process, result and impact of the project in relation to the proposed objectives
- to use the information collected through monitoring and evaluation to refine or redirect project activities to meet quality assurance expectations
- to dialogue with project beneficiaries regarding objectives and progress and
- to assist CBOs to develop and implement stronger monitoring and evaluation capabilities.

Monitoring and evaluation will be exercised at three levels: 1) Initiative level; 2) CBOs/NGOs level; and 3) community level. There will be an emphasis on strengthening the capacity of partner CBOs and NGOs to conduct self-diagnosis on a continuous basis. They will receive training in setting goals and objectives, developing indicators, monitoring and participatory evaluation of their activities and use the findings to further improve their performance. They will also be trained on how to conduct participatory community baseline surveys and assessments on their respective constituencies of progress towards achieving targeted objectives. The Initiative will develop community-based, user friendly process and benchmark tools, and use checklists.

The key components of monitoring and evaluation in this Initiative will include:

- conducting baseline assessments of CBOs, NGOs and constituencies (baseline information collected at the time of project start-up will include knowledge, behavior and practice (KBC) of the CBOs and NGOs as it relates to HIV/AIDS, organization, management and community outreach);
- routine tracking of resources and performances;
- assisting partners to develop work plans and activity schedules;
- conducting scheduled reviews and planning sessions with all stake holders;
- monthly, quarterly and annual progress reports;
- mid-term and final evaluations (evaluations will be conducted at the levels of CBOs/NGOs and the target constituencies. The evaluations will be participatory in nature and will be conducted two times during the life of the project. One at mid-term and another at completion of the project).
- dissemination and use of material and regional information/data for the benefit of all stakeholders

Joint process and objective indicators will be elaborated in the first year to ensure that monitoring and evaluations are consistent and action oriented. This will allow for comparison of results across the five countries.

Although formal evaluations will be conducted (with the participation of external evaluators, project staff, representatives from CBOs and NGOs, community and opinion leaders, beneficiaries of AIDS programs and other key stakeholders at the community and regional levels), peer evaluations will be given special attention as a tool of not only assessing success, failure and constraints but also as a tool for learning from each other. Partner organizations will be invited to share their experiences, performance results and lessons learned in an annual review and lessons learned workshop.

The project's monitoring and evaluation team will consist of a regional monitoring and evaluation officer and five country-level monitoring and evaluation officers, located in each of the five target countries. The key activities of the monitoring and evaluation team will be designing and adapting monitoring and evaluation instruments and systems, developing a monitoring and evaluation system that could be used as a common tool in the region, conducting training sessions on monitoring and evaluation, collecting, receiving and analyzing information, accessing progress and achievements, reporting on findings and making recommendations.

The monitoring and evaluation team is responsible to collect resources and document experiences that will be available in a manner and language that is appropriate to the grass roots groups that the Initiative is targeting.

APPENDIX A : *Acronyms*

ABPF	<i>Association Béninoise de la Promotion Familiale</i>
AIDS	Acquired Immune Deficiency Syndrome
AFRICASO.....	Africa-based AIDS Service Organization
ATPF	<i>Association Togolese de la Promotion Familiale</i>
ACRI	AIDS Community Response Initiative
BINGOS.....	Beninese Indigenous Non-Governmental Organization Strengthening Project
CBO	Community-based Organization
CCTF	Community Capacity Transfer Facilitators
GDP	Gross Domestic Product
GTZ.....	German Technical Assistance
GHANET	Ghana AIDS Network
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
ICASO	International Coalition of AIDS Service Organizations
IEC	Information, Education and Communication
ICW.....	International Community of Women Living with HIV/AIDS
KBP.....	Knowledge, Behavior and Practice
MIS	Management Information System
MOH	Ministry of Health
NACP.....	National AIDS Control Program
NGO.....	Non-governmental Organization
PA	Program Advisor
PHC.....	Primary Health Care
PM.....	Program Manager
PNLS.....	<i>Programme National de Lutte contre le SIDA</i>
NACP	National AIDS Control Program
SWAA.....	Society for Women Against AIDS In Africa
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN.....	United Nations
UNAIDS	United Nations AIDS Coordination Unit
UNICEF	United Nations Children's Fund
UNDP.....	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WHO.....	World Health Organization

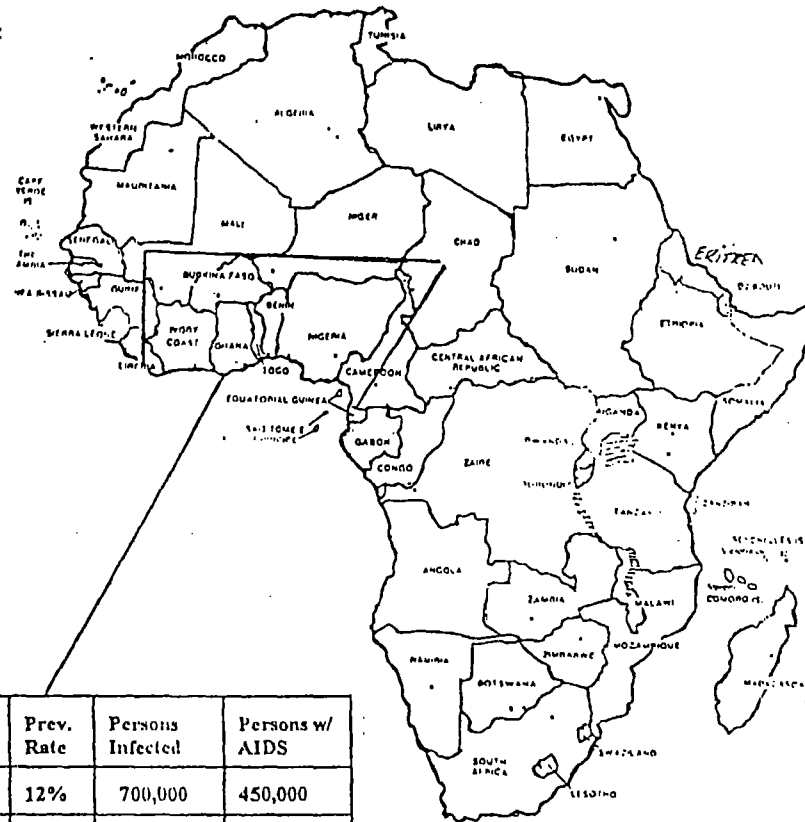
APPENDIX B

OBJECTIVES AND SUBOBJECTIVES	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
OBJECTIVE #1: TO BUILD COMMUNITY RESPONSE TO THE AIDS CRISIS AND DEVELOP CBO/NGO ABILITIES IN AIDS PREVENTION IN WEST AFRICA			
SUBOBJECTIVE 1.1 To promote partnership, collaboration & dialogue in the community & among stakeholders to share vision and objectives in responding to AIDS	# of meetings held, # of stakeholders participating to meetings, # of joint activities held by the stakeholders, # of partnerships formed and collaboration taken place,	CBO and NGO reports project reports	Dialogue among partners, CBOs, NGOs and community leaders needs promotion
SUBOBJECTIVE 1.2 To strengthen the organizational capacities of partner CBOs and NGOs that focuses on problem solving about AIDS by the community and community empowerment	# of training session held & persons trained, # of AIDS activities developed, # of persons informed on AIDS prevention,	pre and post training tests, Initial and continuous competencies assessment Supervision reports, CBO/NGO/project reports	Training of staff organization on technical subjects on AIDS is needed and accepted by them
SUBOBJECTIVE 1.3 To reinforce technical capacity of partner CBOs and NGOs in AIDS programs for increased sustainability of AIDS activities	# of partners with an organizational diagnosis, % of recommendations of the diagnosis applied by the partners, # of training session held & persons trained, % of organizations trained with a annual plan, % activities planned & realized by organization	pre and post training tests, Initial and continuous competencies assessment Supervision reports, CBO/NGO/project reports	Training of staff organization on organizational development & good governance is needed & admitted by them
SUBOBJECTIVE 1.4 To promote community managed and financed AIDS activities	% of organizations with a sub-grant from the regional program for AIDS activities, CBO/NGO fund raising plan elaborated/applied Budgeting of CBO/NGO activities in local government budget, % of grants used as initially planned, % organizations with grants from partners, increase in local contribution	CBO/NGO/project reports, (financial, supervision, monitoring and evaluation reports)	Community managed and financed activities exist and need to be promoted

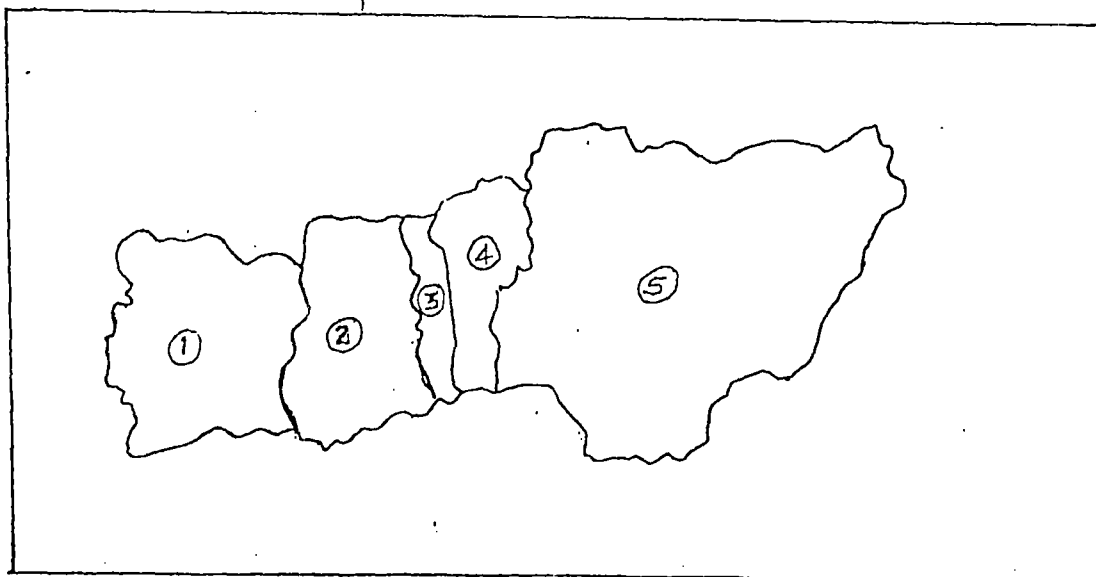
OBJECTIVES AND SUBOBJECTIVES	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
OBJECTIVE #2: TO ENHANCE A REGIONAL RESPONSE TO AIDS IN WEST AFRICA			
SUBOBJECTIVE 2.1 To promote cross fertilization of ideas, skills and strategies among key stakeholders for AIDS prevention	Annual number of in country and regional meetings held among key stakeholders, Number of key stakeholders participating in cross fertilization activities, Number of cross border study tours yearly held, Number of organizations accessing clearinghouse for information,	CBO/NGO/project reports, (periodic & occasional) effective information obtained by each organization from the regional system (study, tools, methodology...) evidence of studies carried out and results shared	Regional cross fertilization among CBOs/NGOs and key stakeholders needs to be encouraged
SUBOBJECTIVE 2.2 To promote the mobilization of regional resources for community activities	Increased number of partners funding regional community-based activities Number of CBOs/NGOs having access to regional funds for community-based activities Number of activities held advocating to finance regional community-based activities	Agreements btw partners CBO/NGO/project reports, (periodic & occasional)	Regional & in country resources are available for AIDS activities and could be oriented to the community level
OBJECTIVE #3: TO INFLUENCE POLICY MAKING			
SUBOBJECTIVE 3.1 To build a community of purpose among community-based actors responding to the AIDS crisis	Number of tools/solutions adopted from country to country, Number of community to community visits, Regionwide adoption of professional and ethical code for AIDS/CBOs and NGOs, Development and regional dissemination of a training manual	CBO/NGO/project reports, (periodic & occasional) ethical code developed and sent to each organization regional representativeness of the organizations active and involved in the program	A community of purpose among key stakeholders & CBOs/NGOs needs to be encouraged

OBJECTIVES AND SUBOBJECTIVES	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
SUBOBJECTIVE 3.2 To promote an enabling environment for community-based response to the AIDS crisis	# of AIDS sessions held or supported by leaders by intervention site, # of advocacy sessions on community response to AIDS by intervention site, # positive public statements & actions taken by community leaders and authorities, public recognition at local-regional and state levels leading towards policy change	pre and post training tests, # of promotion tools created for AIDS advocacy, CBO/NGO/project reports Official speeches reports & policy documents	Participation by community and opinion leaders is important in responding to AIDS Community leaders and opinion leaders need to become AIDS advocates

APPENDIX C



	Target Countries	Population	Prev. Rate	Persons Infected	Persons w/ AIDS
1	Ivory Coast	14.2 million	12%	700,000	450,000
2	Ghana	18 million	4.5%	210,000	180,000
3	Togo	4.3 million	3.3%	170,000	140,000
4	Benin	5.8 million	3.7%	54,000	16,000
5	Nigeria	118 million	5.4%	2,300,000	590,000
	Total	165 million	-	3.4 million	1.4 million



APPENDIX D

Africare
AIDS Community Response Initiative for West Africa (ACRI)

Budget

Cost Center	Description	Year One	Year Two	Year Three	Year Four	Year Five	Total
1	HQ Staff Salaries	\$32,500	\$34,125	\$35,831	\$37,623	\$39,504	\$179,583
2	Regional Team Salaries	\$114,500	\$123,088	\$132,319	\$142,243	\$152,911	\$665,061
3	Country Team Salaries	\$701,004	\$753,579	\$810,098	\$870,856	\$936,170	\$4,071,707
5	Fringe Benefits	\$287,463	\$308,694	\$331,501	\$356,001	\$382,320	\$1,665,979
6	Housing & Recruitment	\$144,540	\$107,866	\$128,067	\$115,822	\$120,100	\$616,395
7	Travel & Per Diem	\$409,800	\$400,520	\$459,731	\$422,361	\$483,496	\$2,175,908
8	Training & Workshops	\$267,300	\$347,300	\$338,300	\$338,300	\$283,050	\$1,574,250
9	Other Direct Cost	\$181,630	\$160,280	\$165,373	\$170,720	\$176,334	\$854,337
10	Equipment	\$668,875	\$23,625	\$24,806	\$26,047	\$27,349	\$770,702
11	Supplies	\$77,818	\$75,700	\$76,960	\$77,783	\$79,172	\$387,433
12	Subgrants	\$0	\$750,000	\$750,000	\$750,000	\$375,000	\$2,625,000
	Total Direct Costs	\$2,885,430	\$3,084,777	\$3,252,987	\$3,307,755	\$3,055,406	\$15,586,354
	Indirect Costs @ 20.04%	\$578,240	\$618,189	\$651,899	\$662,874	\$612,303	\$3,123,505
	Total Expenses	\$3,463,670	\$3,702,966	\$3,904,885	\$3,970,630	\$3,667,709	\$18,709,860

Africare ACRI Budget Notes

1. HQ salaries include 5% for the Senior Vice President, 30% time of the HQ-based AIDS Director and 15% for the Regional health Program Manager who are responsible for HQ level supervision and maintaining US institutional relations and 10% of Regional Director for overseeing all HQ financial/ personnel/administrative management support as well as general program coordination.
2. Regional Team Salaries include the expatriate Regional Program Advisor and Regional Monitoring and Evaluation/Management Information Systems Support Officer supported by a locally recruited Secretary/document preparation assistant and driver(all based in Accra).
3. Country Team Salaries include for each Country, the locally recruited:
 - ◆ Country Team Coordinator
 - ◆ CBO/NGO Capacity Building Specialist
 - ◆ Monitoring & Evaluation/MIS Officer
 - ◆ Sub-Grant Manager
 - ◆ (8X) Community Capacity Transfer Facilitators
 - ◆ Shared and full-time administrative, financial & logistical support staff
(Accountant, secretary, logistician, drivers, guards,...)And the expatriate:
 - ◆ Africare Country Representative (at 30% of time)
 - ◆ Country Program Administrative Officer (at 30% of time)
4. Fringe Benefits are paid on expatriate staff salaries at approximately 45% of gross salary for medical and travel/emergency medical evacuation assurance, social security/workman's compensation, pension plan contributions; and for local staff at approximately 30% of gross salary for medical insurance, social security, and other locally legislated benefits.
5. Housing and Recruitment expenses include:
 - ◆ local housing rent and maintenance for the 2 expatriate Regional Advisors
 - ◆ 30% support of the Country representative & Admin Officer housing costs
 - ◆ first year purchase of modest furnishings for the Regional Advisors
 - ◆ Direct expenses of recruitment: advertising, interview lodging/per diem
 - ◆ Expenses of fielding the Regional Advisors: moving allowances, travel medical costs, shipping storage of personal effects.
6. Travel and Per diem expenses include:
 - ◆ Local vehicle operation, maintenance and repair,
 - ◆ occasional local airfare,

- ◆ local per diem & lodging cost for in country travel by the Country Team,
 - ◆ international airfare for the Regional Team and a % of these cost for the Country Representative/Admin officer,
 - ◆ per diem for international travel such as AIDS conferences.
7. Training and workshops expenses cover lodging and meal costs of training events for CBO/NGO partners and other partners, training support equipment (projectors, video equipment, flipchart stands, digital cameras, etc). ACRI consultants include technical specialists for short term contracts to advise and train on the baseline studies and final evaluations and to provide specific technical inputs as identified by the Regional and / or Country Teams over the course of the project. These are both locally recruited specialists (a total of 150 person/days per Country Program) and internationally recruited specialists (a total of 85 person/days per Country Program).
 8. Other Direct Costs include:
 - a 30% average cost sharing of local Office Rent and Maintenance,
 - direct communication costs (telephone, internet services, express and local mail services, etc)
 - program auditing fees
 - vehicle insurance
 - shipping freight charges for equipment purchases
 - foreign exchange losses
 - local bank fees
 - local customs processing fees (Africare is exempt from import duties and taxes in most of its operations)
 9. Equipment includes:
 - 3 4x4 9-place passenger vehicles per country program,
 - an all terrain motorcycle for each Community Capacity Transfer Facilitator (36 total)
 - computers and computer support equipment/ country program,
 - a photocopier/ country program,
 - office furnishings for each country program
 - fax machine and other miscellaneous support equipment (calculators, phones, etc)/country program.
 10. Supplies expense include offices supplies and printing and duplication costs.
 11. Sub-Grants as discussed in the ACRI Proposal include three categories:
 - Institutional Support Grants @ \$2,500 avg x 15/year/country program
 - Seed Grants @ \$8,000 avg x 10/year/country program
 - Resource organization development grants @ \$10,000 avg /year/ country program
 12. Africare's Indirect Cost Rate (Overhead) is an annual audited rate, currently at 20.04%.

WE HAVE LEARNED
TIME AND AGAIN
THAT PEOPLE CANNOT
BE FORCED TO LIVE
TOGETHER IN
TRANQUILITY.
THEY HAVE TO
UNDERSTAND AND
VALUE THE DIVERSITY
IN THEIR MIDST AND
IN THEIR WORLD.
THAT MEANS OVERCOM-
ING FEAR AND
IGNORANCE.

world of difference. ... And because future conflicts may well be between people rather than between states, national and international institutions will need to accommodate much more diversity and difference—and to open many more avenues for constructive participation.”

The UNDP report envisions a “new role for the United Nations,” with an emphasis on “peacemaking and peacebuilding,” not just peacekeeping. It also envisions a standing United Nations military force, presumably capable of moving rapidly to douse ethnic brushfires and other simmering conflicts before they escalate beyond control.

President Clinton should take this cue to shift the United States’ role from being perceived as the world’s police to that of promoting a broad-based international *peacebuilding* initiative. The first stage would be a Rio-type summit at which

world leaders and institutions would agree to a strategy and means for identifying potential ethno-cultural hot spots and addressing them through neutral mediation.

The United Nations and regional bodies such as the Organization of African Unity and the European Community are groping for ways in which they can act more dynamically and effectively—yet diplomatically—to preempt conflict “between people.”

Such an initiative might also enlist respected former national leaders who have a demonstrated talent for building consensus among putative enemies. President Jimmy (Camp David) Carter is one role model, who has chaperoned peaceful change in Nicaragua and elsewhere. Former Zambian President Kenneth D. Kaunda, who fostered a durable national identity in a country speaking 73 languages, is another. Kaunda is following Carter’s path and establishing a foundation to support his personal commitment to peace and the art of making it.

The failure of recent peace ventures in Bosnia and Somalia is no excuse for discounting this approach as hopelessly idealistic. Typically, honest brokers like Cyrus Vance and David Owen arrive too late and

without the support of a credible international mandate. If they and other skilled mediators could have appeared on the scene well before Yugoslavia’s “leaders” pushed the self-destruct button, hundreds of thousands of innocent people might have been spared misery and death.

In Liberia, if something could have been done years ago to strengthen a more genuine sense of shared nationhood and destiny, thousands of slaughtered civilians might be alive today. At the very least, had there been an international early-warning system that could have detected the Liberian catastrophe in the embryo stage, we might not be shaking our heads at the most recent massacre of women and children.

Something, we are convinced, *could* have been done to avoid the holocausts in Liberia, in Bosnia, in Angola and in Somalia. It is crucial that we find out what that something is, bottle it and begin applying it as widely as possible. Otherwise, as we are beginning to realize in Somalia, no number of United Nations blue berets may be enough to restore sustainable peace once blood is on the floor.

We have learned time and again that people cannot be forced to live together in tranquility. They have to understand and value the diversity in their midst and in their world. That means overcoming fear and ignorance, which often are deliberately encouraged by political and ethnic leaders.

Ironically, we may find the greatest hope in the least likely places. Many Serbs have remained in Muslim-dominated Sarajevo, in defiance of ethnic cleansing. It is an ember which Bosnians cannot allow to die.

And there is South Africa. If any nation on earth is capable of showing us how to live together, it may well be this benighted and beloved land. Apartheid has brought out the worst in many South Africans, but it also has brought out the best in many others. More to the point, the majority of South Africans—white and black—appear to have decided that they have only two options: either share the country as equals or resort to a full-fledged race war.

We may never have to confront such a sobering choice. But the rapidly changing racial and ethnic demographics in this country could have consequences in the next century which we might prefer not to contemplate. How we deal with our increasing diversity, and whether we learn to draw strength from it, will ultimately define us as a nation.

C. Payne Lucas is president of Africare, a Washington, D.C.-based development organization. Kevin Lowther serves as the agency’s regional director for Southern Africa. Both were officials at the Peace Corps in the 1960s.

WASHINGTON, D.C. (Aug. 2, 1993)

Coping With Diversity

By C. PAYNE LUCAS AND KEVIN G. LOWTHER

We dedicate this article to the late John T. Walker, first African-American bishop of the Episcopal Diocese of Washington, D.C., who spent his life pursuing peace, justice and interracial harmony.

Back in the late 1970s, we flirted with trying to start a syndicated newspaper column. We were going to call it “In Black and White”—Lucas is African-American, Lowther of European ancestry—and focus on issues of race and culture in American society. The idea died on the drawing board, in part because we naively concluded that Americans were finally learning to live with each other. There seemed less urgency—or media market—for commentary that would guide us through the thickets of ethnic, religious and cultural diversity.

It seems we were premature to abandon our collaboration. Race, ethnicity, religion and culture have become increasingly complex and divisive factors in American life. And in the world at large, from Yugoslavia to Sri Lanka to South Africa, we have seen one nation after another ravaged by these same powerful forces.

If we were to launch “In Black and White” today, we would have to broaden

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its scope far beyond the American racial divide. We would have to give it a new name—"Making a World of Difference" might do—and a new objective: to help Americans and their leaders better understand and deal with diversity at home and abroad.

In the current issue of *Foreign Affairs*, Professor Samuel P. Huntington, of Harvard University's Institute for Strategic Studies, writes of an incipient "clash of civilizations" in which the West will have to reconcile itself to non-Western peoples "whose power approaches that of the West but whose values and interests differ significantly. ... It will ... require the West to develop a more profound understanding of the basic religious and philosophical assumptions underlying other civilizations."

Considering that we ourselves are not yet reconciled to one another, this task is daunting at best. However, with U.S. soldiers already serving in two ethnic danger zones—Somalia and Macedonia—we ought to give closer attention to people and cultures who used to be tucked safely away on the pages of *National Geographic*.

There may be a handful of Americans who understand Somali society and culture. There may be slightly more who could identify Macedonia on a blank outline map of Europe. Most of us, however, are grossly ignorant of the civilizations in Professor Huntington's world (which, incidentally, virtually excludes Africa, to judge by his sole and passing reference to its "possibly" being considered a civilization).

Here, then, is our maiden—and perhaps only—edition of "Making a World of Difference." Our central thesis is that every leader, from President Clinton, to Nelson Mandela, to Boutros-Ghali, to the PTA chair in your ethnically changing neighborhood will succeed or fail to the degree that he or she can manage diversity.

We live in a world in which centuries-old enmities can come back to life in Bosnia as if cryogenically preserved for generations; we live in a world in which immigrants and the displaced now account for one in every 50 human beings; we live in a world in which ethnicity, race, religion and culture are the dominant sources of conflict, not ideology, economics or even the naked desire for power.

These forces are at work close to home. In Arlington, Va., police needed four hours to quell a recent brawl among about 60 Latino and black men; in the New York area, authorities have arrested several Muslim fundamentalists seemingly committed to blowing up Manhattan, building by building; and in Los Angeles, the FBI is alleging that several white men were planning to attack a black church congregation to ignite a race war.

We and the world are in collective denial that these divisions are a fundamental challenge to human order and concord. We delude ourselves into believing that they are merely localized eruptions on the body politic, that they can be contained or swept under the carpet.

This leads to talk of extraditing a militant Muslim sheik to Egypt, coaxing Mexico to take 600 Chinese boat people detained by the U.S. Coast Guard or trying to gerrymander the Bosnian map to keep the ethnic peace.

It also has led to a dangerously wishful faith in the alchemy of democratization. Free elections may sometimes aggravate rather than sublimate differences between groups who have managed, under more autocratic government, to live together in relative harmony. For the West to promote democracy without addressing this unpleasant reality is like giving someone a rowboat, but no oars, and urging them to venture into turbulent waters.

Most Americans probably share the conceit that democracy is inherently good. This is what we are taught from an early age. But how many have *learned* this truth in a practical way? How many of us, in our lives and thoughts, have tried to articulate our national identity in terms of our increasingly multicultural, multiethnic and multiracial character?

There was a time, in the early decades of American independence, when whites and blacks alike were preoccupied with deciding whether this new-world democracy was to be purely European, or whether the mounting free black population meant that we would be, in the term much-used then, "amalgamated."

There were many whites and some blacks who thought we would be well rid of each other. But black leaders of the day were readier to acknowledge that this was a practical impossibility. More to the point, they were more concerned with asserting blacks' claim to be as truly American as anyone else.

The debate over our national identity remains unresolved, and indeed largely unremarked. In 1816, a year of pronounced racial tension and a rumored invasion of black revolutionists from Haiti, it was Topic A. Today, it surfaces episodically in discussions of quotas in the work place, immigration law and granting asylum to someone else's huddled masses.

It is ironic that we have been settled and enriched by many waves of immigration, becoming the world's most diverse society, yet seem unable to distill from this experience the wisdom and sensitivity to cope with both our own and other peoples' ethnic and cultural tensions.

Fortunately, all is not reduced to fear and loathing along the world's human fault lines, whether they run through Cicero, Ill., or the blood-soaked African bush. There is good reason to believe that people of varied backgrounds can coexist, if given the chance. Knowledge and leadership are key.

One of the more enduring myths of American sociology is that racial or ethnic integration of formerly homogeneous (read white) neighborhoods inevitably triggers decline of the community and of the value of property.

Some years ago, one of us studied the history of neighborhood changes of this type and found that the "incur-sion," normally of upwardly mobile black families into all-white areas, usually led ultimately to *improved* housing values. It was unprincipled real estate speculators, preying on white fears, who often encouraged panic selling, then profited by raising prices for incoming black families.

He encountered numerous examples of stable interracial communities throughout the country. Where block associations and community organizations existed to allay false concerns and provide a means to defend against unscrupulous real estate agents, neighborhoods were able to deal rationally with change and to assimilate a more diverse population.

What has occurred in Bosnia-Herzegovina is all the more tragic because Muslims and Serbs seemingly had put ancient animosities behind them and learned to live together, often in the same neighborhoods. Until, that is, so-called national leaders introduced the higher cause of "ethnic cleansing."

The international community, chagrined and impotent, almost seems to be sitting back, waiting for this process to run its course in Bosnia and elsewhere. But then what? Is anyone giving serious consideration to the consequences of economically driven immigration throughout the world? Or to defusing ethnic time bombs ticking in Europe, the former Soviet Union, Kashmir, Angola or here among homegrown white supremacists?

The United Nations Development Programme, in its just-released Human Development Report for 1993, states: "Our world is still a

**THE FAILURE OF
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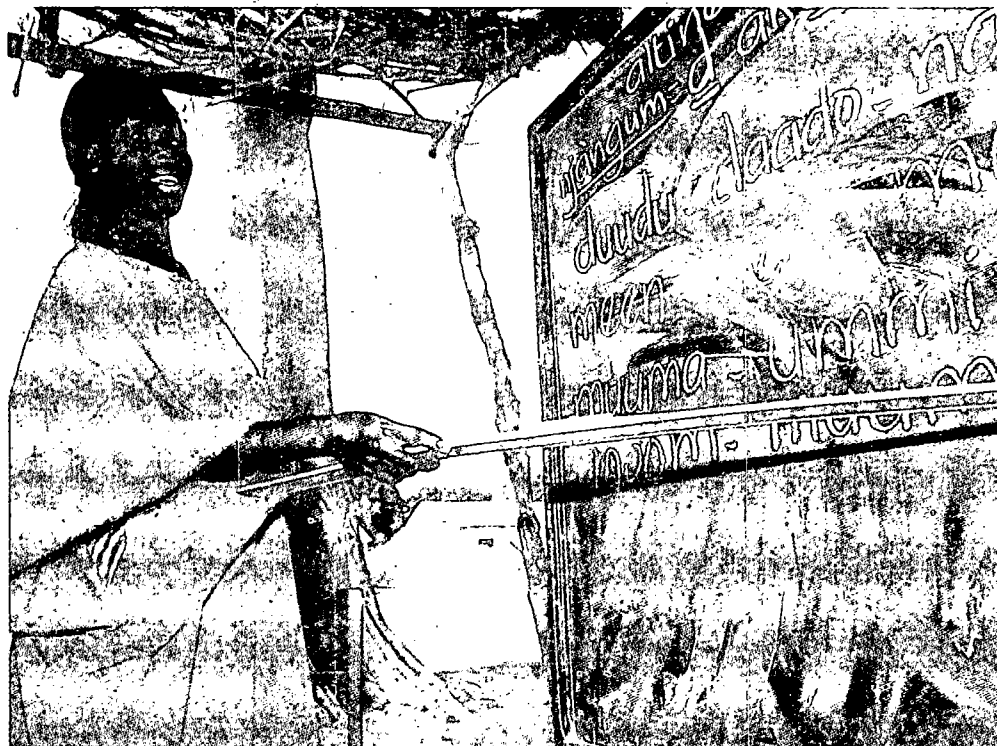


PHOTO BY NEILA MCINNIS

"I REGARD AFRICARE AS ONE OF AMERICA'S GREATEST GIFTS TO AFRICA. YOUR WORK, IN EVERY CORNER OF OUR GREAT CONTINENT, HAS SUSTAINED OUR OWN COMMITMENT TO BUILDING A STRONG AND FREE AFRICA."

— NELSON R. MANDELA
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA
HONORARY CHAIRMAN OF AFRICARE

WHAT IS AFRICARE?

Africare helps Africa. A private, nonprofit organization, founded in 1971, Africare celebrates more than a quarter-century of assistance to families and communities Africa-wide. Areas of assistance include food, water, the environment, health and emergency humanitarian aid. Africare also supports projects in private-sector development and governance.

WHY WAS AFRICARE FOUNDED?

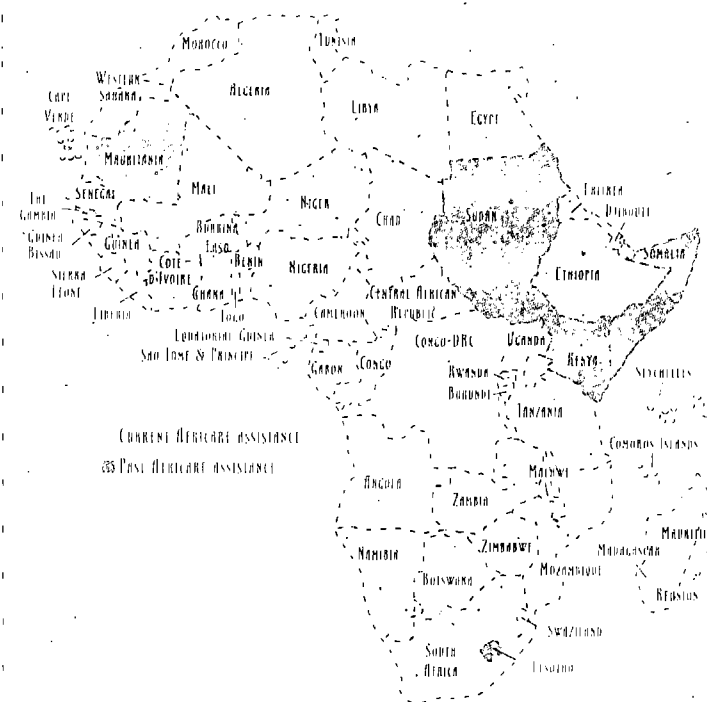
In 1971, West Africa was in the midst of one of the most severe droughts in its history. People and animals were dying. Crops could not grow. Thousands of villagers fled their homes in search of water. Relief agencies responded with food, medicine, equipment and personnel.

Many African leaders foresaw that, once the moment of crisis had passed, they would have to develop long-term plans to strengthen their rural sector and protect their environment. Only in this way, they understood, could they withstand future crises and go on to attain a better quality of life.

To provide the needed long-term help, to assist in emergencies and to educate Americans about Africa — African and American leaders and development specialists founded Africare.

WORKPLACE GIVING

Africare is a member of the International Service Agencies workplace-giving federation (CFC code #0303).



(April 1999)

WHAT HELP HAS AFRICARE GIVEN?

During its first years, Africare concentrated on helping to alleviate the effects of severe drought in West Africa. By the mid-1970s, Africare had shifted its emphasis to development projects in the areas of food, water, the environment and health — expanding in the late 1980s to private-sector development and governance. Africare also gives rapid humanitarian aid in times of crisis, from the Ethiopian drought of 1985 to the more recent warfare in Angola, Liberia, Rwanda and Sierra Leone.

HOW MANY PROJECTS DOES AFRICARE SUPPORT?

Africare now supports more than 150 assistance projects in Africa. Some are as small and simple as the digging of a village well, while others are as large and complex as child survival and maternal health on a regional scale. The projects range in budget from a few thousand to several million dollars.

WHERE DOES AFRICARE WORK?

Africare specializes in Africa and works in all of the major regions of the continent. Since its establishment, Africare has helped people in 35 African nations. Today, the organization is assisting 28 nations: Angola, Benin, Burkina Faso,



PHOTO BY SHEILA MCKINNON

Burundi, the Central African Republic, Chad, Cote d'Ivoire, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Liberia, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Uganda, Zambia and Zimbabwe (see map).

Africare has its headquarters in Washington, D.C., with field offices in 27 African countries.

HOW DOES AFRICARE WORK?

Africare projects are *African* projects. Responding to local initiatives, Africare cooperates closely with African planners, field experts, village leaders and workers — complementing rather than preempting local resources and skills. In its development projects, Africare marshals only the technical counsel and funds that may be necessary to sustain and encourage African efforts at the national and grassroots levels. In its emergency relief,

Africare also responds to the priorities voiced by Africans. Africare and African project managers carefully monitor all financial assistance.

WHO SUPPORTS AFRICARE?

Support comes from charitable foundations, multinational corporations and small businesses, the religious community, other private organizations, the U.S. government, foreign governments, international agencies and thousands of individuals.

Africare is a member of International Service Agencies (ISA), a part of the Combined Federal Campaign and many corporate as well as state and local government workplace drives.

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Overview of Africare *with Focus on Health Sector Activities*

Overview

Africare works in Africa. A private, US-based, nonprofit organization, founded in 1971, Africare works with families and communities Africa-wide, with health, agricultures, water, environmental protection and emergency assistance.

Africare celebrated its 25th Anniversary at the 1996 Africare Bishop John T. Walker Memorial Dinner held on October 17, 1996, in Washington. The event also honored former President Jimmy Carter, who like Africare has demonstrated a lifelong commitment to global stability as a foundation for peace and prosperity. The Africare Dinner provides unique opportunities to recognize outstanding individuals' contributions to global stability and to support Africare's needed programs. In the past Africare has recognized H.E. President Nelson Mandela (currently the Honorary Chairman of Africare), Reverend Leon Sullivan, Archbishop Desmond Tutu, Sargent Shriver and several African Heads of State.

Africare was founded by Africans and African-Americans on the principle that true development is self-development. When Africare was founded, the Sahel region of West Africa was experiencing its worst drought in recent history. Headquartered in Washington, D.C. Africare supports activities in 28 countries of Africa: Angola, Benin, Burkina Faso, Burundi, Central Africa Republic, Chad, Cote d'Ivoire, Egypt, Eritrea, Ethiopia, Ghana, Guinea-Bissau, Guinea, Liberia, Malawi, Mali, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Tanzania, Uganda, Zambia and Zimbabwe.

Africare's goal is to improve the quality of life in Africa. Africare staff work closely with host government agencies and communities to design and support programs in health, water resources development, food production, protection of the environment and natural resources, emergency relief and integrated rural development. Additionally, Africare has made important contributions toward better health care, including successful initiatives in community health, child survival, pharmaceutical management, control of river blindness (onchocerciasis), family planning, AIDS prevention and literacy for health.

Africare receives its support from a variety of sources, including thousands of individual donors, charitable foundations, corporations, small businesses, churches, the U.S. Agency for International Development, other international development assistance and bilateral institutions such as the United Nations' agencies. Africare's current annual development assistance program totals more than \$25 million.

Africare Country Representatives work with host governments to identify and design projects. Africare is currently supporting more than 200 projects, ranging from \$1,000 to \$8 million, in 26 countries. Cash and in-kind support for these projects is provided by host governments, and also by donor agencies through grants, contracts and contributions to Africare. In each country where Africare works, its programs build on the development objectives of host government agencies and reinforce the self-help efforts of rural communities. Africare's framework for development assistance in each country is set forth by a Country Agreement signed centrally with the host government. The Agreement summarizes development priorities to be addressed, and sets forth the terms of reference for Africare's official presence and collaboration.

Africare's agricultural assistance emphasizes food production and the elevation of people from subsistence crop farming and livestock rearing to cash earning activities. Projects enable villagers to produce and sell surpluses beyond their family needs, not only the cereal food grains they raise during the rainy season, but also the irrigated dry season crops made possible by gravity flow systems, or by water pumped from wells, rivers and ponds. Emphasis is placed on working with groups at the community level such as cooperatives and today, particularly, groups of women. Another important aspect of Africare's agricultural work is agribusiness support, where extension staff also introduce and teach small business management practices such as bookkeeping and accounting, amortization of equipment, food processing, storage and marketing. Environmental protection and natural resource management efforts supported by Africare include reforestation projects, sand dune stabilization, the establishment of village woodlots, the promotion of amenity plantings, soil conservation, alley cropping, live fencing, planting of forage crops and other agro-forestry activities.

Africare's water activities have focused on the construction of hand-dug, concrete-lined, wide-diameter wells to provide water for human use, livestock watering and vegetable gardening. In places where springs abound, Africare has assisted in developing springs so that they can be improved to increase yields and protected from contamination. To support agricultural production, small-scale gravity-flow water systems and irrigation dams have been provided.

Although Africare is principally a long-term development assistance agency, it also has responded in very critical ways to **emergencies** in Africa that have displaced people and have required relief and emergency assistance. Africare responded to human needs during the long Sahelian drought of the late 1960s and early 1970s. Africare also has provided support to refugee assistance efforts in Central African Republic, Côte d'Ivoire, Ethiopia, Liberia, Malawi, Mozambique, Rwanda, Somalia, Zambia and Zimbabwe to persons displaced by drought and civil war.

Africare's **health and population programs** have emphasized a primary health care approach, promoting the health of entire communities, especially mothers and children, and preventing illness. Some of the interventions have included promotion of childhood and maternal immunization, control of diarrhoeal diseases through the use of oral rehydration therapy and improved water/sanitation, improved reproductive health, including recognition and treatment of sexually transmitted infections (STIs), prevention and control of AIDS, improved recognition and treatment of respiratory infections, improving drug supply systems and training of health workers. These programs have been designed and implemented in close collaboration with Ministries of Health, local non-governmental and community-based organizations and other international agencies.

In the last several years, Africare has been involved in an effort to control river blindness (onchocerciasis), particularly in Nigeria and Chad. In this effort, Africare has collaborated with USAID, the Carter Center, World Bank and the World Health Organization (WHO).

Africare also has recently begun to focus on malaria prevention and control and is serving as the local coordinating agency for the implementation of the Africa Integrated Malaria Initiative (AIMI) in Benin, in collaboration with USAID, Benin's Ministry of Health, Centers for Disease Control and Prevention (CDC) and USAID-funded BASICS.

Africare's **Food for Development Program** was started in August 1988 after a feasibility study concluded that Africare could incorporate food aid resources into its development. Africare's use of food aid resources is not based on food distribution. Instead, food resources are monetized and commodities sold to local traders and analyses

are conducted to ensure that local production and markets are not harmed. Africare's first food security program was established in Guinea-Bissau, where rice was monetized in the commercial sector to generate local currency for a Sustainable Rural Initiatives project. Africare now has food security programs, with the goal of improving agricultural production and household nutrition as well as improving the capacity of local communities to address their own food security, in several countries, including Chad, Eritrea, Guinea-Bissau, Guinea, Mali, Mozambique and Uganda.

Africare's **Development Education and Constituency Development Program** has educated American communities, particularly African-American, on Africa and Africa's development needs. Since Africare's inception in 1971, this program has been an integral part of its work. The broad goal is to mobilize and foster increased cooperation and coordination among a broad-based coalition of American, African and international organizations, institutions and individuals committed to the progress and empowerment of Africa and the African peoples.

A new initiative funded by the Ford and Carnegie Foundations in 1996 is the **National Summit on Africa**, a vehicle designed to raise the level of recognition Africa receives in the United States through a range of highly visible, well-publicized, and widely attended activities held across the country. The Summit's role will be to serve as a catalyst for, and facilitator of, discussion and debate about U.S. relations with Africa.

Africare Health Sector Initiatives

Child Survival and Community-based Health Programs

Africare's health sector work began at its inception in 1971, in Niger. Africare's first health program trained community-based health care providers and strengthened the delivery of health care services in the remote Diffa Department, on the Chadian border near Lake Chad. Africare has extensive experience working in Child Survival/Primary Health Care projects since the late 1970s. *Benin, Burkina Faso, Central African Republic, Ghana, Guinea, Eritrea, Ethiopia, Malawi, Mali, Niger, Nigeria and Tanzania* have all benefitted from such projects in the last 13 years. During the present a new child survival program is being initiated in *Uganda*.

Current child survival project activities include:

- *Benin*: improved malaria prevention (through the use of insecticide-treated nets) and case management; promotion of family planning and improvement of commodities management; AIDS prevention and control; STIs prevention, identification and case management

- ▶ **Ghana:** strengthening district-level management; promotion of EPI; promotion of oral rehydration therapy; reinforcement of a cost recovery program; promotion of school health (through de-worming and micro-nutrient supplementation)
- ▶ **Guinea:** improved district-level management and establishment of community health centers; support to immunization programs; improved diarrheal disease control; prevention of malnutrition and growth promotion; promotion of family planning
- ▶ **Malawi:** reinforcement of district-level management; improved maternal health; breast feeding promotion; diarrheal disease control
- ▶ **Mali:** strengthen of community-based health centers; health education based on working with traditional channels of communication; growth and nutrition promotion; immunizations; family planning promotion
- ▶ **Tanzania:** nutrition and food security promotion; malaria prevention and case management; STIs/AIDS prevention and control

In addition, community-based primary health care programs are being implemented in *Angola, Mali, Mozambique and Senegal*.

Reproductive Health/Family Planning

Africare's work in reproductive health and family planning has involved support to the national programs and local non-governmental organizations in *Nigeria, The Gambia, Cape Verde, Guinea-Bissau, Mauritania, and Senegal*.

- ▶ Africare's largest such program was in *Nigeria* where, in 1984, Africare entered into an agreement to assist State Ministries of Health in surveying and identifying clinics to receive supplementary equipment sets in order to strengthen their capacity to provide family health services including child spacing. Africare since then has been responsible to source, purchase, ship and aid in the distribution of more than 1300 sets of equipment to rural health facilities in the country. As an outgrowth of clinic supply activities under the Nigeria family planning program, Africare assisted seven State Ministries of Health to design and conduct more than 1,000 person-weeks of in-service training from 1986 through 1988 to more than 500 physicians, nurses and nurse midwives, on family planning initiatives. Also, in collaboration with the Center for Development and Population Activities (CEDPA) in Washington, D.C., and with State Ministries of Health, Africare identified and arranged one-month management training in the US for 10 Nigerian women in family planning, mid-level management positions. Africare's most recent national population initiative in Nigeria was in collaboration with the Federal Ministry of Health of Nigeria, the 30 State Ministries of Health and

Johns Hopkins University, under the National Policy Component of Nigeria's Family Health Services Program.

- ▶ In *The Gambia*, Africare technically and materially assisted the Gambia Family Planning Association to strengthen its family planning commodity ordering, receipt, storage, management and distribution facilities and systems, including provisions for cost-recovery.
- ▶ In *Cape Verde, Guinea-Bissau* and *Mauritania*, under separate projects, Africare has again supplied equipment sets and medical supplies for the strengthening of rural clinics to incorporate child spacing as a part of family health services.
- ▶ Under a family planning project in *Senegal*, building upon Africare's experience in earlier project settings, Africare is strengthening the family planning training, outreach, service delivery and support program of SANFAM (*Santé de la Famille Sénégalaise*), a local non-governmental organization (non-governmental organization (NGO)). This project focuses on developing quality assurance standards for family planning service provision in the public and private sectors of Senegal.

AIDS/STIs Prevention and Control

In the past several years, Africare also has begun to support national efforts in Africa to combat the AIDS epidemic.

- ▶ The first such Africare initiative was in *Rwanda*, in response to a request from the Ministry of Health, where Africare was able to provide critical material support for the establishment of the national AIDS program office. In Kigali, Africare helped the Biryogo Health Center to upgrade its facilities so that AIDS patients can receive better services, more confidential health consultations, and more private care.
- ▶ Since 1988, Africare has been collaborating with the Federal and State Ministries of Health in *Nigeria* in support of efforts to plan and implement programs for the prevention of drug abuse and AIDS. In February 1988, Africare helped to sponsor and conduct a national workshop, for senior officials and technical staff from state-level Ministries of Health and of Education. The workshop focused on design and dissemination of health staff training and patient education materials on AIDS prevention, emphasizing avoidance of accidental AIDS virus transmission through contaminated clinical instruments and blood, and on educating the public on protection through awareness and avoidance of high-risk practices.
- ▶ In *Côte d'Ivoire*, Africare has assisted in establishing counseling and information centers for Liberian refugees and displaced persons. Although AIDS education has

been a focus in the Côte d'Ivoire, efforts have been limited to urban areas. Africare's project was the first initiative focusing on rural populations.

- ▶ Africare was funded by the World AIDS Foundation and the Pharmaceuticals Manufacturers' Association to undertake an AIDS/STDs prevention and control project in *Ethiopia*. The project is being implemented in collaboration with the religious and school communities, farmers' associations, health facilities and children.
- ▶ Through the West and Central Africa Family Health and AIDS Prevention Project funded by USAID, Africare is coordinating the work of local NGOs involved in preventing AIDS transmission along the migrant routes between *Burkina Faso* and *Côte d'Ivoire*. Most educational activities focus on truck drivers and other transport workers, seasonal farm workers and commercial sex workers.
- ▶ In Southern Africa (*Malawi, Zambia, Zimbabwe* and *South Africa*), Africare is launching a three-year regional initiative that will identify, draw upon and disseminate best practices of existing programs to strengthen the capacity of community-based groups to educate, counsel and support adolescents and young adults, and their families, in reproductive health, family planning and HIV/AIDS prevention.

Pharmaceutical & Medical Supply Management

In *The Gambia, Sierra Leone, Imo and Sokoto States of Nigeria, Ghana and Ethiopia* Africare worked centrally and peripherally with Ministries of Health to help plan, design and implement **improved systems to purchase, manage and distribute basic medicines for rural health care**. These projects involved tackling major problems related to poor storage, lack of information on pharmaceutical need and use, in some instances irrational pharmaceutical use, weaknesses in distribution and delivery, inadequate supply and frequent stock outs, inadequate stock control mechanisms, and absence of clear policy and procedure guidelines on pharmaceutical services.

- ▶ In 1982 in *The Gambia*, after three months of Africare technical assistance and training, the Government established a national pharmaceutical management program. In 1995, under a contract with Medical Care Development International, Africare provided technical assistance for The Gambia Health Sector Requirement Study (Pharmaceutical Component) under an African Development Bank loan program.
- ▶ In *Sierra Leone* in 1987, building upon the systems developed in The Gambia, and with the benefit of one year of Africare technical, training and material assistance, the Sierra Leone Ministry of Health was able to develop and demonstrate its improved systems at Central Medical Stores and three district-

wide primary health care zones. From 1987 to present, the Sierra Leone Ministry of Health with periodic Africare technical support and assistance from other organizations, has successfully continued the work. With UNICEF material, financial and technical assistance it is expanding the systems to the remaining nine districts of the country. In January 1991, Africare was contracted by UNICEF to evaluate the national essential drug program in Sierra Leone and make recommendations for its further improvement, and in February/March 1992, under a contract with Medical Care Development International, Africare provided technical assistance for the analysis of essential drugs program needs under an African Development Bank loan program to strengthen the country's health care infrastructure.

- ▶ In *Imo* and *Sokoto States, Nigeria*, Africare in 1987/88 assisted the Ministries of Health to develop general policies, procedures and plans for the pharmaceutical component of their Health and Population Program Loan Applications to the World Bank. Africare, under contract with the Imo State Ministry of Health, is following up by providing technical assistance for the implementation of the program. Cost-recovery and sustainability are key aspects of the Sierra Leone and Nigeria systems.
- ▶ Similar programs of assistance have been provided by Africare to the Ministries of Health in *Ghana* in collaboration with the World Bank loan-funded health and population program, and in *Ethiopia*. As a first step in the Ghana project, Ghanaian mid-level program managers were brought to Sierra Leone and received orientation and training on the systems in place. In Ethiopia, the project is supporting an improved drug supply management system for Region 14 (Addis Ababa) and is helping the central government in the development of a national drug management manual.

River Blindness Control

In the area of *River Blindness Control*, Africare is implementing community-based distribution of ivermectin (Mectizan) in five highly infected states in *Nigeria*, and six prefectures in *Chad*. Nigeria contains fully one third of all known cases of river blindness in the world, and the disease is a major barrier to development in the affected locales. The drug for treating the disease is produced by Merck & Co. and is available free of cost to treat river blindness.

Africare, in collaboration with host Ministries of Health and with funding from USAID, the Public Welfare Foundation, the River Blindness Foundation and Donation of Ivermectin (Mectizan) by Merck & Co. of USA, has instituted a variety of intervention strategies for the annual distribution of ivermectin in these two countries. To date more

than 2 million people have benefitted from the treatment and more than 2000 Community-based Distributors have been trained. The emphasis has been on the identification and integration of perceived replicable and sustainable strategies into the prevailing primary health care structure of both host Countries (Nigeria and Chad).

The activities of each control program include a preliminary design of field studies and operations research activities to identify and treat endemic foci, an evaluation of the effect and a determination of cost-effective strategies. To date, each of the programs has achieved a measure of success stemming from the horizontal organizational structure put in place with the involvement of local health personnel in community-based activities.

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AFRICARE



1998 ANNUAL REPORT

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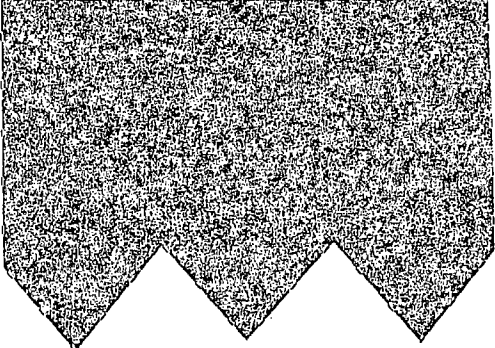
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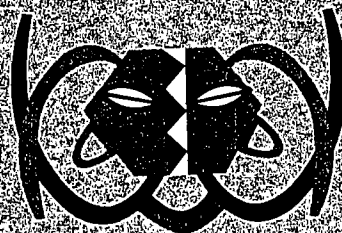
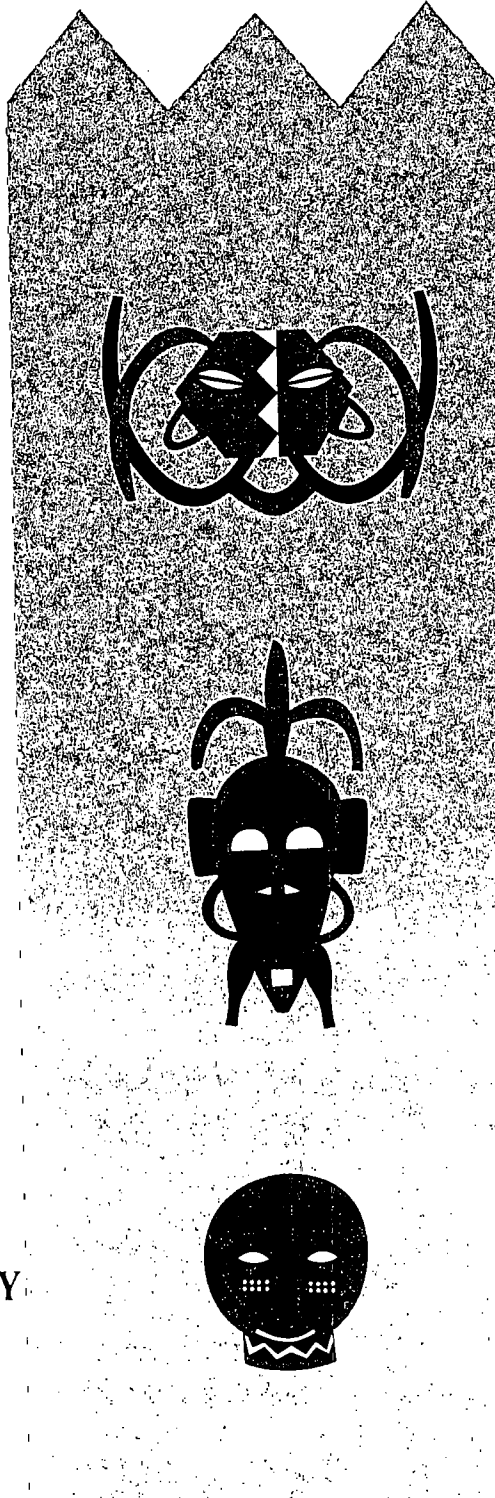
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Africare is a private, nonprofit organization, dedicated to improving the quality of life in rural Africa. For 28 years, Africare has provided assistance in five principal areas: food, water, the environment, health and emergency humanitarian aid. More recently, Africare has supported projects in private-sector development and governance. In the United States, Africare focuses on building understanding of African development through public education and promotional outreach.

Communities in 35 nations Africa-wide have benefited from direct Africare assistance since 1971, when the organization was founded. Today, Africare supports more than 150 projects in 28 African countries. Africare has its headquarters in Washington, D.C., with field offices in 27 nations of Africa.

Africare is a charitable institution under Section 501(c)(3) of the Internal Revenue Code. Africare's financial support comes from charitable foundations, multinational corporations and small businesses, the religious community, other private organizations, the U.S. government, foreign governments, international agencies and thousands of individuals. Africare is a member of International Service Agencies (ISA), a part of the Combined Federal Campaign and many corporate as well as state and local government workplace drives. Gifts to Africare are tax-deductible to the extent provided by law.

(April 1999)

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food, water, the environment, health and
emergency humanitarian aid as well as
private-sector development and governance.

Confirmed
9/2/99

August 18, 1999

Ms. Sandra L. Thurman
Director
Office of National AIDS Policy
736 Jackson Place, N.W.
Washington, DC 20502

Dear Ms. Thurman:

Sandy

I am pleased to invite you to attend the 1999 Africare Bishop John T. Walker Memorial Dinner as our guest.

The Dinner will take place on Monday evening, September 27, at the Hilton Washington Hotel here in Washington, D.C.

This is the largest annual event for Africa in the United States. We expect more than 2,500 guests from all sectors — corporate, governmental, international and philanthropic — having to do with Africa.

We will honor the Mozambican social activist, Graça Machel. The Honorable Albert Gore and Mrs. Gore are the Honorary Patrons of the 1999 event. As National Chair, we have Edward E. Whitacre, Jr., Chairman and CEO of SBC Communications Inc. Finally, we will welcome heads of state and ministerial-level representatives of numerous African nations. Event proceeds will benefit Africare's humanitarian assistance to more than 28 countries Africa-wide.

The evening will begin with a reception from 6:00 to 7:00; directly following the reception will be a seated dinner and the program of speeches and entertainment, to end at about 10:00 p.m. The formal invitation is enclosed.

To respond, either send us the reply card (enclosed with the invitation) or call the Africare Dinner Office at (202) 328-5367. If possible, please let us have your response by September 3. With best wishes,

Sincerely,

C. Payne Lucas

C. Payne Lucas
President

declined

9/21/99



In honor of

Graca Machel

Recipient, 1999 Bishop John T. Walker
Distinguished Humanitarian Service Award

and

The African Diplomatic Corps

Africare

requests the pleasure of your company

at a reception

on Sunday, September 26

from 5:00 to 7:00 p.m.

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440 R Street, N.W.

Washington, D.C.

R.S.V.P.

(202) 328-5372

Informal attire or
National dress

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called, declined
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May 17, 2000

Hon. Sandra Thurman, Director
National AIDS Policy
The White House
736 Jackson Place, NW
Washington, DC 20503

Dear Hon. Thurman:

This is a follow-up to our brief meeting in Atlanta last April at the International Conference on HIV/AIDS & Malaria in Africa. I am writing to request a meeting with you at your earliest convenience. You may recall that we were introduced by Mr. C. Payne Lucas, President of Africare just before your keynote address at the luncheon on April 14, 2000.

We gave you a copy of our proposal on AIDS Community Response Initiative for West Africa (Nigeria, Benin, Togo, Ghana and Ivory Coast). You invited me to the White House and I promised to get in touch with you to answer any questions you may have and to get your reaction to this initiative.

The enclosed proposal is currently under review by the Bill and Melinda Gates Foundation. We have been asked to submit letters of support from key agencies and stakeholders. We hope you will feel comfortable in writing such a letter and to indicate how our proposal fits within the context of the White House's HIV/AIDS Initiatives.

I look forward to hearing from you soon on the day and time you are available to meet.

Thank you for your consideration.

Best regards,

Clarence S. Hall, Dr.P.H.
Director of HIV/AIDS

AIDS Community Response Initiative for West Africa

(Nigeria, Benin, Togo, Ghana and Ivory Coast)

*A Regional Initiative for Capacity-Building of
Community-Based and Non-Government Organizations
for Community Outreach & Response to the AIDS crisis*

Submitted By

**Africare/Washington
440 R Street N.W.
Washington, D.C. 20001**

April 2000

**Contact: Yolonda Richardson, Senior Vice President
Tel: (202) 462-3614* Fax: (202) 387-1034 * [e-mail:africare@africare.org](mailto:africare@africare.org)**

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Executive Summary

Africare is requesting \$18,709,860 in support of a five-year AIDS Community Response Initiative for West Africa (ACRI). The goal of this Initiative is to reduce the transmission and impact of HIV/AIDS in the coastal region of five adjacent countries of West Africa—Nigeria, Benin, Togo, Ghana and Ivory Coast. The east-west axis of the target region will extend approximately from Lagos, Nigeria to the western border of Ivory Coast. The region has a total population of about 165 million people and the HIV prevalence ranges from 3.2% in Benin to 12% in Ivory Coast.

The region was selected due to its mixture of high levels of HIV prevalence as seen in Ivory Coast and Togo, the rapidity in which HIV is spreading in the lower prevalence countries (Nigeria, Ghana and Benin) and the potentially ominous impact on the region of the mounting explosion of HIV in Nigeria, now the second-ranked country in Africa in terms of the absolute number of HIV-infected people. Because of the continuous movement of the region's population—in Ivory Coast one-third of the population originates from outside the country—the AIDS crisis represents a regional problem and requires a regional response. Africare has strong presence in this area and is therefore well positioned to contribute significantly to the AIDS effort.

The target group for the Initiative is communities whether defined by geography or affiliation such as common profession, religion, culture, age group, gender, sports activity, military encampment, cross-border public officers, entertainment groups, HIV/AIDS status or other grouping. What is known is that in African society, community is binding, powerful and respected. Yet, prevention efforts more often than not focus largely on the individual to the exclusion of community and messages are communicated at the national level through mass media versus community dialogue. While these efforts have resulted in high levels of AIDS awareness and knowledge in the region, what is known is that behavior change that prevents sexual transmission of the AIDS virus has not occurred. Community-level input is needed to address the problem of AIDS. These messages were echoed throughout the region in meetings held from mid November to mid December 1999, between Africare's proposal design team and key stakeholders working on AIDS.

Moreover, it is known that in this region communities cut across national borders and that AIDS not only attacks individuals, but it also weakens communities. Community norms, practices, attitudes and beliefs define, permit, block and/or sanction courses of action and perspectives that help drive the epidemic and are underutilized resources to be applied to reducing the transmission and impact of AIDS.

Through this Initiative, Africare will focus on AIDS and community response and will address the following main objectives. Africare will encourage communities to deal directly and

Africare AIDS Community Response Initiative for West Africa – April 2000

pro-actively with the AIDS crisis; will strengthen the capacity of community-based organizations (CBOs) and non-governmental organizations (NGOs) to more effectively face the tremendous challenge of AIDS; and will scale up to the regional level a response to AIDS by communities. This will result in decreased transmission, reduced stigma, increased community support of orphans and other victims of AIDS and extended community survival mechanisms.

Achievements in development gained in Africa over the past three decades are being swallowed up by AIDS and at the same time AIDS-related problems are compounding at a crisis level. To mobilize additional resources, ensure accountability and increase sustainability, Africare will be in the role of project manager and facilitator and will partner with local governments and organizations that conduct AIDS activities. Africare is a US-based non-government, development assistance organization founded in 1971 and currently supports health, agriculture, environment, democracy & governance programs in 28 African countries.

Africare will bring a well-established presence in the target region, long-term experience working in Africa on AIDS and CBO and NGO capacity building and strong commitment to weaken the disastrous path of this epidemic.

The project will operate out of a regional office and five country project offices located in each of the target countries. On site staff will be host country nationals and external experts in AIDS programming, CBO and NGO capacity building, participatory community development and monitoring and evaluation. A large component of the Initiative will be to strengthen the capacity of CBOs and NGOs to carry out a more effective and sustainable response to AIDS.

Through a well-defined capacity-building program, selected CBOs and NGOs in the region will participate in an organization-specific strategy to build their AIDS programming and institutional capacities. Clear and concise indicators will be applied to measure CBO and NGO progress. Training in participatory community development will take place and community and opinion leaders will be encouraged to become AIDS advocates. The program will also manage a seed-grant component to empower selected and needy CBOs and NGOs to implement creative, community-based and directed activities.

In addition, activities will be carried out to promote cross-fertilization of ideas, skills and information across the region, including joint review & planning and study tours. Common monitoring and evaluation systems will be developed for regional application. Meetings with key stakeholders at the regional level will be organized to inform them of community concerns, problems and solutions related to AIDS, to promote partnership and collaboration and to mobilize regional sources of funding.

The crisis of AIDS in Africa, now and in the foreseeable future, is at an emergency level. Africare has assessed the AIDS problem, needs and resources in the target region. Africare also has weighed this information against the strengths that Africare possesses and the lessons learned

Africare AIDS Community Response Initiative for West Africa – April 2000

about AIDS. The AIDS Community Response Initiative represents a solid, appropriate and achievable effort to tackle the crisis more effectively and in a sustainable manner.

I - BACKGROUND AND PROBLEM STATEMENT.

Of the 33.6 million people now infected with HIV worldwide, 23.3 million of them are in Sub-Saharan Africa - nearly 70 percent of the worldwide total of people living with HIV/AIDS. In 1999 alone, 2.5 million people worldwide died as a result of the AIDS virus, making it the world's fourth-biggest cause of death, and the spread of the epidemic continues unabated. Africa is also home to 90 percent of the world's 11 million AIDS orphans. AIDS is now the leading cause of death in sub-Saharan Africa with 13.7 million Africans already having died as a consequence of the epidemic.

The HIV/AIDS epidemic is at a severe crisis level in Africa. Dr. Peter Piot, executive director of UNAIDS stated, *"visibly, the epidemic is eroding the social fabric of many communities. In its demographic, social and economic impact, the epidemic has become more devastating than war, in a continent where war and conflict appear to be endemic"*. He added, *"the time is now to declare AIDS in Africa a state of emergency, requiring emergency type efforts and resources"*. Speaking at the Lusaka conference on AIDS in Africa in September 1999, a World Bank official stated that, *"HIV is now the single greatest threat to future economic development in Africa"*. World Bank President James Wolfensohn has described AIDS as a *"major development challenge, if not the most important development challenge confronting us in Africa today"*. At the macro-economic level, the World Bank estimates that African countries with high HIV prevalence will lose one percent of GDP growth per capita annually. Recent studies showed that for a number of companies in Africa profits decreased significantly (up to 20 percent) as a direct result of AIDS. Absenteeism, recruitment and training of replacement employees, higher costs of employee benefits and a reduced pool of skilled labor affect companies' profitability and viability. In Ghana, as in many African countries, the increasing number of cases has put severe stress on the health sector. A recent Korle-bu hospital study estimates that the in-hospital life time cost of treating an AIDS patient is approximately \$60. Ghana's health budget is less than \$5 per capita.

The problem of AIDS along the West Africa coastal corridor linking Nigeria, Benin, Togo, Ghana and Ivory Coast (with a combined total population of about 165 million) is as dynamic, mobile and expansive as the commerce and population movement that drives and defines this region. The AIDS epidemic has seriously penetrated Ivory Coast and Togo and now is picking up speed in Nigeria, Ghana and Benin—places that were once described as low prevalence countries. Because of continuous population movement, close geographic proximity and high population density in the coastal region, HIV moves easily across the national borders of these countries.

The country-specific rates of AIDS infection in the five target countries range from a low of 3.2 in Benin to a high of 12 percent in Ivory Coast. In Nigeria, based on three successive surveys (91-99), the HIV prevalence rates were seen to rise from 1.8 percent to 5.4 percent. In urban centers such as Abidjan, Ivory Coast the infection rates are higher than for the country as a whole (16.2 percent in Abidjan). In Nigeria, because the total population is so large (over 120 million), the country now ranks as second in Africa in terms of the absolute number of people infected with HIV. There are a total of 3.5 million persons living with HIV/AIDS in the five countries. Of that number, 1.4 million are AIDS cases (1997). The progressive increase shown in Ghana by the number of HIV cases reported in the last three years equaling the number reported in the ten prior years is a cause for concern.

Generally, people in the region have heard about the disease AIDS and have received information (most commonly via mass media) about how the virus passes and how transmission can be prevented. Unfortunately, AIDS awareness and knowledge do not easily translate to belief in one's vulnerability and changed behavior.

Community norms, practices, attitudes and beliefs define, permit, block and/or sanction courses of action and perspectives that help drive the epidemic and are an underutilized resource to be applied to reducing the transmission and impact of AIDS. UNICEF was one of the first to use social mobilization in an effort to reduce infant mortality. In the early 1980s UNICEF began acting as a catalyst to form strategic alliances around universal child immunization. The targets for mobilization were everyone from women, parents, and children to health workers, teachers and political leaders. By mobilizing multiple sectors, from the client to the influential leaders, a world-wide movement was created that increased immunization coverage from 20 to 80% in six years. In Zambia, The Salvation Army's community based program in HIV/AIDS has found that behavior change occurred 90% of the time in relation to ritual cleansing practices when families and communities were targeted as opposed to 50% when individuals were targeted.

Cheryl Walter in "*Community Organizing and Community Building for Health*" by Meredith Minkler, Ed. States the following in regards to community building practice: "*First, it places community, not the community organizer at the center of practice....Second, thinking of community as multidimensional, involving people and organizations at many levels, consciousness, actions, and context, allows us to model greater complexity...Third, if we perceive community not as an existing unit that needs to be organized differently but as a dynamic and emergent whole embodying varying degrees of communityness that is continually being built or created, then the building of community will be one of the central concerns and activities of community practice... Fourth, community practice then becomes less an intervention or coming between and more an interchange, where each of us is changed through coming together.*"

Much of AIDS programming is focused on individual-based AIDS awareness education

Africare AIDS Community Response Initiative for West Africa – April 2000

that involves national-level mass media campaigns. Although these efforts have been successful in increasing AIDS awareness and knowledge, corresponding behavior change has not resulted. Community-level responses are needed to more effectively address behavior change related to reduction in transmission of the AIDS virus or mitigation of the impact of the AIDS crisis. Community-level responses have been effective in many of Africare's programs addressing food security at the household level. Existing and new groups within the community are identified, formed. Training and mentoring of these groups is provided with the goal being for the communities to gain autonomy in identifying and solving their problems around food security. The Hearth Model approach uses existing community resources in the treatment of malnutrition. The behaviors to be addressed need to involve not only individual-based behaviors but also focus on community-based behaviors that can bring leverage on individual behavior in a sustainable mutually reinforcing manner.

Lack of financial resources is not the only barrier that limits response to the AIDS crisis. When individuals and communities do not feel that AIDS—prevention, care and support and mitigation of impact—is their problem, their priority and an issue over which they have power to act, the epidemic spreads easily. Moreover, reluctance to talk openly about AIDS, sex and the underlying factors that drive this epidemic severely restricts the ability to respond to the AIDS crisis. Stigmatization towards people living with HIV/AIDS sequesters not only the people who are facing the disease head on, but relieves communities of their potential to act from a position of strength in facing the AIDS crisis.

1.1. General Response to the AIDS Crisis.

Global resources to address the AIDS crisis remain scarce. Approximately \$165 million dollars was allocated in 1997 for AIDS prevention in sub-Saharan Africa. In speaking at the recent meeting of the UN Security Council, World Bank President James Wolfensohn stated that *between 1-2.3 billion dollars was needed each year for AIDS prevention in Africa.*

All the five countries have established National AIDS Control Programs (NACPs) and developed strategic plans to tackle the problem of HIV/AIDS. There are several community based organizations and NGOs that are active in HIV/AIDS prevention programs. Recently the First Lady of Ghana launched a national campaign to promote AIDS education at all levels and a government committed to create a special fund for supporting community level initiatives.

Several CBOs and NGOs have come together to form consortia or networks to mobilize resources for advocacy and for sharing information. Associations and networks of persons living with HIV are coming to being. Many community-based organizations, such as motorcycle taxi associations in Benin and Togo, possess strong willingness to undertake AIDS activities and bring a substantial constituency with significant influence. These associations have limited experience in responding to AIDS and there is a clear need to strengthen their capacity. In Ivory

Coast, a country where one-third of the residents are from outside the country, cultural associations representing various immigrant groups present another example of community groups that are well positioned to respond to AIDS. AFRICASO, a network of African-based AIDS services organizations and the Society for Women Against AIDS in Africa (SWAA) are highly regarded voices for community organizations involved in AIDS in Africa. GHANET in Ghana has created the forum for partners of HIV/AIDS prevention to network and mobilize resources. Most of these voluntary groups lack institutional and financial capacity to do effective work.

For example, in Uganda through the effort of CBOs, NGOs and government, the HIV infection rate among pregnant women in towns has decreased from 37 percent to approximately 15 percent and among Ugandan youth, the age of onset of sexual intercourse has been delayed by two years. This evidence shows that concerted efforts by national and community leaders have measurable effects.

Despite such limited initiatives and successes, the ability of national AIDS control program as well as state and district level AIDS programs to carry out their responsibilities is severely restricted by the lack of technical and institutional capacity as well as funding. There is a limited level of purpose built among CBOs and NGOs and little shared vision region-wide.

In Africa, engaging communities in response to AIDS is essential. This is true because community is the foundation, strength and orientation of African society. Community serves as one of the most important entry points and agents in responding to AIDS.

The AIDS Community Response Initiative for West Africa (ACRI) will confront the problem of AIDS by building upon strengths and resources of African communities. A similar vision to the one presented in this proposal is echoed in a statement by the Community AIDS Movement in Africa delivered at the December 6 -7, 1999 meeting of the International Partnership Against AIDS in Africa called by United Nations Secretary General Kofi Annan. The statement read: *"There is an urgent need to make a significant move to address priorities defined by communities and to support us in our efforts to empower and accompany our communities in their development and response to HIV/AIDS. Community leaders believe strongly that there is a need to review and implement new funding schemes that can support the development of a sustainable response from the community sector. These include:*

- * *direct funding support to African-based non-governmental organizations and networks,*
- * *building the capacity of Africa-based non-governmental organizations to better manage and implement their programs,*
- * *supporting the development of Africa-based human resources that provide tangible benefits to the local community above those that support a strengthening of already strong non-African interests."*

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Building response to AIDS through civil society is needed because the problem of AIDS must be addressed jointly by communities, government, and the private sector. Community-based organizations and non-governmental organizations tend to have greater flexibility and the ability to respond rapidly, however, these groups do not often have the opportunity to share experiences and lessons learned. Working regionally, as described in this proposal, will generate greater sharing of resources and programming expertise. There are strong historical, cultural, linguistic and economic ties between these five contiguous countries. For example the Ewes are found living in the coastal corridors of these countries and share the same culture. This provides an opportunity of developing similar messages in the same language thereby easing communication and minimizing cultural hurdles. In addition, the West African regional community has developed several avenues of collaboration in the political, economic and social areas that is making south to south interaction more constructive and leading the path to various forms of integration. This Initiative fits this agenda.

1.2. Africare: Capabilities Statement.

Africare is a US-based NGO founded in 1971. Africare's extensive development activities in the continent make it the largest U.S.-based organization focused exclusively on improving the condition of African communities. In each of the 28 countries where Africare works, its development programs build on the concept of self-help. Working closely with people, community organizations and governments, Africare designs, operates and facilitates projects in primary health care, HIV/AIDS, capacity-building of civil society, environmental management, democracy and governance, agricultural production and emergency humanitarian aid. Currently, Africare has more than 150 projects dispersed across all regions of Africa that range in size from \$1,000 to \$7,000,000.

Africare has well-established country field offices in three of the five countries (Nigeria, Benin and Ghana) that comprise the three major target areas for the West Africa Regional AIDS Initiative. In Ivory Coast, Africare has a long history of project involvement. At present, Africare shares offices with a partner NGO, with supervision from Africare's country field office in Burkina Faso. Africare does not have a field office or activities in Togo, although professional contacts are established.

1.3. Africare's HIV/AIDS Experience.

At present, Africare is involved in an overall strategic planning process. One of the major goals of this process is to redefine the mission and program priorities of Africare based on current realities in Africa. During the strategic planning process Africare staff identified HIV/AIDS as a top priority for their work in Africa.

Over the past twelve years, Africare has devoted more than \$5 million in program resources to assist partners in Africa to combat the AIDS epidemic. The first Africare initiative was in 1987 in Nigeria and Rwanda, where Africare supported the establishment of national AIDS programs. In Nigeria, Africare worked with Federal and State Ministries of Health, International NGOs, Nigerian universities and local NGOs to organize and carry out a series of successful national, zonal and state level planning and prevention activities. These began with a national policy workshop that involved senior policy and technical representatives and the Ministries of Health and Education of each state and Federal Capital Territory, to educate and motivate leaders toward the implementation of AIDS and drug abuse prevention campaigns in every state. The national workshop was followed by a series of zonal workshops to strengthen state government health professional skills in preparing training curricula, visual aides and state plans for their programs aimed at behavior change. Under a subsequent program, Africare strengthened local non-governmental organization (NGO) capabilities to plan, design, seek funding for, and implement community-based HIV/AIDS prevention activities. Africare is presently supporting an AIDS orphans program through local NGOs in Rivers State, Nigeria.

In Rwanda, Africare supplied critical material support for the establishment of the national AIDS program office. In Ivory Coast, Africare helped to establish counseling and information centers for Liberian refugees and displaced persons. Through the West and Central Africa Family Health and AIDS Prevention Project funded by USAID, Africare is coordinating the work of local NGOs involved in preventing AIDS transmission along the migrant routes between Burkina Faso and Ivory Coast. These NGOs are focusing on outreach work to sex workers, long-distance truck drivers and plantation workers at eight sites between Burkina Faso and Côte d'Ivoire.

With funding from the William H. Gates Foundation, Africare has launched a three-year HIV/AIDS regional initiative in Zambia, Zimbabwe, Malawi, and South Africa. The overall goal is to identify, draw upon and disseminate best practices of existing programs to strengthen the capacity of community-based groups to educate, counsel and support adolescents, young adults and their families, in reproductive health and HIV/AIDS prevention. A key achievement has been validation of the project's basic strategy of building upon existing community-based initiatives to improve the quality of their activities, extend their reach, to replicate the most effective approaches, and to strengthen their sustainability. Africare/Tanzania conducted a project on the island of Zanzibar to strengthen CBOs and NGOs working in AIDS. The objectives of this project were to build the capacity of community organizations working in HIV/AIDS/STD prevention and to encourage collaboration among these organizations. Africare currently carries out HIV/AIDS activities in conjunction with its child survival projects in Benin and Tanzania.

Africare is using the progress and results of these initial efforts to leverage added support from a variety of multi-laterals, bi-laterals, foundations, corporations and other entities. Africare

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through this Initiative will confront the problem of AIDS by building response to AIDS through civil society. Under the AIDS Community Response Initiative, the job of Africare and its partners will be to assist target country CBOs and NGOs and the communities that they represent in developing their capacity to more effectively fight the AIDS epidemic.

Some of the *Lessons learned* are:

- the importance of fostering a shared purpose in working with communities;
- the power of working in organized communities;
- the strength of a cultural empowerment approach;
- gender-sensitive approaches are needed to work with communities;
- given the adequate support, local initiatives are the best means to address local prevailing reproductive health problems; and
- partnerships and collaboration at the community, regional and national levels are powerful in mobilizing communities.

1.4. Africare's Capacity Building Experience.

During the last several years Africare has increased programming emphasis on institutional development of African rural associations, NGOs and civil society in general. A non-exhaustive list of recent and/or on-going activities include:

- in Benin, Africare is implementing a highly successful civil society organization strengthening project funded by USAID.
- in Guinea, Africare implemented a USAID project to develop community level organizations in Faranah and Kankan Regions that carried out participatory workshops resulting in the auto-diagnostic by NGOs and local area associations of their strengths and weaknesses and the elaboration of a plan to address their needs. Participatory training financed by USAID and the Government of Guinea resulted in increased professionalism in NGOs, the creation of regional self-coordinating structures and increased partnerships. This pioneering work has shaped the national debate on NGO strengthening needs, the role of NGOs in civil society and development in Guinea.
- In Nigeria, Africare's NGO component of the Nigeria AIDS Prevention Project in Lagos, Cross River and Kano states helped to: train staff of Nigerian NGOs; provide NGOs with technical and material assistance; strengthen their abilities to design, finance, manage, implement, evaluate, support and sustain AIDS prevention activities; and provide seed grants to selected Nigerian NGOs for well planned AIDS prevention projects.
- In Burundi, Africare has been implementing a USAID financed activity to strengthen local NGOs in Bujumbura, Gitega and McKamba Provinces.
- in South Africa, a USAID-funded governance training program enabled elected officials and other policy makers (from any political party) with practical training and technical assistance

- in many of Africare's Child Survival programs, Africare partners with local NGOs. For example, in Benin's USAID centrally-funded Child Survival program, Africare is partnering with ABPF, the local NGO affiliate of International Planned Parenthood Federation.

II - PROJECT DESCRIPTION.

2.1. Goal and Objectives.

GOAL: REDUCTION IN HIV/AIDS INCIDENCE

Objectives and Sub-Objectives	
1. To build community response to the AIDS Crisis and develop CBOs / NGO abilities in AIDS prevention in West Africa	
1.1	To promote partnership, collaboration and dialogue in the community and among stakeholders to share vision and objectives in responding to AIDS.
1.2	To strengthen the organizational capacities of partner CBOs & NGOs that focuses on problem solving about AIDS by the community and community empowerment.
1.3	To reinforce the technical capacity of partner CBOs and NGOs in AIDS programs for increased sustainability of AIDS activities.
1.4	To promote community managed and financed AIDS activities
2. To enhance the regional response to AIDS in West Africa	
2.1	To promote cross-fertilization of ideas, skills and strategies among key stakeholders for AIDS prevention
2.2	To promote the mobilization of regional resources for community activities
3. To influence policy making	
3.1	To build a community of purpose among community-based actors responding to the AIDS crisis
3.2	To promote an enabling environment for community-based response to the AIDS crisis

Table 1 : ACRI's objectives and sub-objectives

2.2. Strategies to Address the Problem.

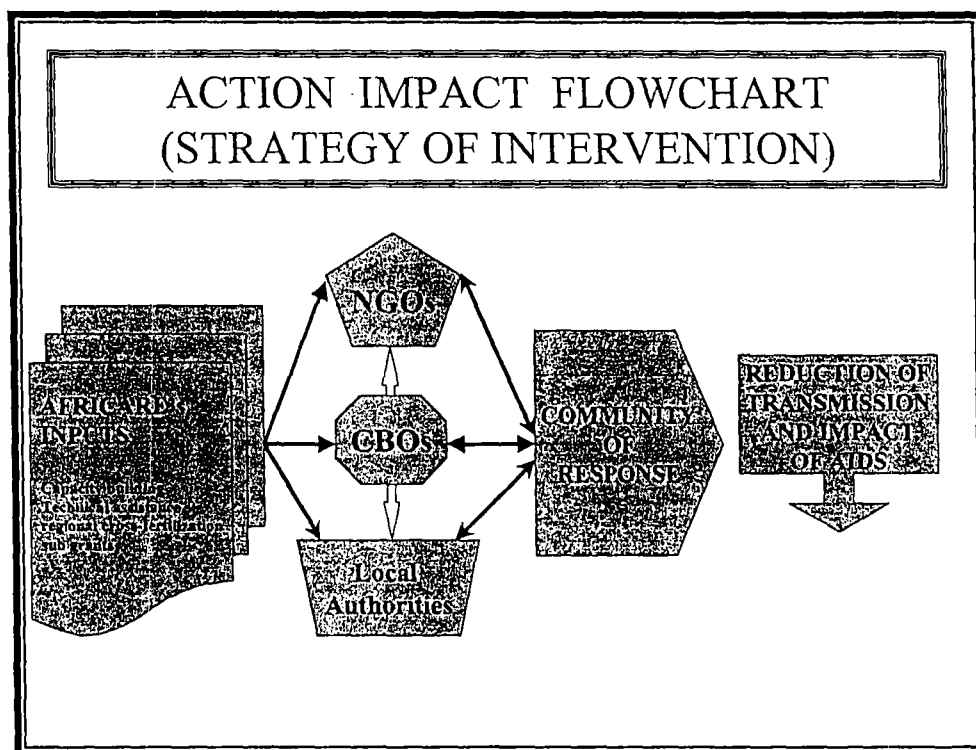


diagram 2 : Africare's strategy of intervention

2.2.1. Target group.

“The *AIDS Community Response Initiative* will start from the grassroots with its scope of activity evolving naturally in harmony with CBOs and NGOs interests and initiative, toward regional horizontal linkages and a shared sense of purpose”. Building community response to the AIDS epidemic will require promoting an enabling environment for the AIDS epidemic, building capacity of actors and promoting linkages and synergy between actors toward a regional community of purpose.

The specific **target groups** for this Initiative are the CBOs, NGOs, and other community groups. The broad target group for the Initiative will be communities. These organizations will be diverse in their nature and have a broad base within their community. They will include those CBOs already involved in AIDS activities and those that have the potential and interest to become key agents in responding to AIDS. They will be the operational focal points for the Initiative because they represent communities and serve as the infrastructure through which communities dialogue, analyze, plan and act. CBOs and NGOs also serve as the infrastructure through which prevention outreach and AIDS-related services are delivered.

The organizations will be selected and involved in the activities after an initial diagnosis using methodologies developed by Africare in its highly successful civil society organizations strengthening project “BINGOS”. The criteria include reputation in the community, internal governance, representation of the community in its membership, dedication and sincerity to its mission. Exceptionally, the Initiative will work directly with grassroots local governance committees such as the Unit Committees in the case of Ghana, where they act as a CBO. Otherwise, CBO/NGO partnership with such structures will be favored. From the baseline diagnosis indicators of progress will be followed for each organization partner and used to adjust the collaboration with these organizations.

2.2.2. Geographic focus.

The geographic focus for the project will be the coastal region that spans across five countries of West Africa—Ivory Coast, Ghana, Togo, Benin and Nigeria. This region comprises a natural socioeconomic hub reinforced by the contiguous ocean coast, close geographic proximity between countries, sea ports that serve as collective gateways, high population density, active trade and trucking routes, vibrant urban, government and employment centers, shared languages, cultures and ethnic groups that traverse national boundaries, constant population movement and common problems such as AIDS. Communities in rural and urban settings will be included under the Initiative. In addition, the project’s geographic target is based on the level of HIV infection across the region and the epidemic’s growing momentum.

Africare established a country office in **Benin** in 1993. In addition to a USAID-funded child survival project in the Oueme Department of Benin, Africare undertook BINGOS (Beninese Indigenous Non-Governmental Organization Strengthening Project)—a \$4 million three-year activity funded by USAID and focused on capacity-building of non-governmental organizations with programs in health, family planning and governance in 1994.

The Initiative’s purpose is to strengthen civil society by creating a critical mass of effective, well managed and honestly run NGOs that are able to implement grassroots self-help activities. Due to the success of this project, funding for BINGOS was renewed through activities expanded to cover all of Benin. Through BINGOS, mentoring and training activities are carried out in areas such as management, staff and board development, finance, program development, feasibility studies, proposal writing, budgeting, evaluation and implementation. In addition, the BINGOS project has managed a small grants program. Over 100 NGOs and intermediary CBOs have participated in the project. The framework and lessons learned from this project will be applied to the Initiative.

Africare’s project activities in **Nigeria** that began in 1987, have included family health, child survival, AIDS, literacy, water, agriculture, river blindness control, income generation, and institutional strengthening.

Although Africare has been involved in **Ghana** since 1989, it is only in early 1998 that it established its office in Accra. Two projects that Africare is supporting in Ghana include a USAID funded child survival project and a privately funded integrated community development initiative with components of rural electrification, income and skill generation, and improved education. Both projects are geared towards outreach capacity building and community participation. Africare collaborated with two urban-based local NGOs to undertake an HIV/AIDS prevention project using music as entry point for the prevention effort. This project was funded by WorldSpace and was implemented as a Millennium Eve event.

Africare's project activities in **Ivory Coast** that began in 1991, have included Family Planning and Vegetable Production.

Given that Africare has a long-standing, well established and highly respected presence in four of the five countries (Nigeria, Benin, Ghana and Ivory Coast), these countries were selected as a good place to begin and to achieve maximum results.

2.2.3. Building a critical mass of synergy zones.

Within the Coastal West Africa Region *the Initiative will focus its effort in local governance areas, where a synergy of actions and actors to include communities, NGOs, CBOs and leaders can be achieved for greater impact.* These focus areas are referred to by the Initiative as Synergy Zones. The Synergy Zone is characterized by having legislated political and administrative autonomy, being governed by democratically elected leaders, and being perceived by government and civil society as a local hub of social and economic development, possessing its own development plan.

For example, in Ghana, the Synergy Zone is the District, with a population generally from 70,000 - 100,000 persons, an elected District Assembly, its own development and operations budget, and with local administration of a number of social services. In Benin, the Synergy Zone is the Commune with a population of approximately 60,000 persons, a locally elected board and mayor, legislated financial autonomy, its own development plan, and budget. Synergy Zones for the other three countries will follow along similar lines.

Table 2 : ACRI Targets

Country	Phase I		Phase II		Total	
	Synergy Zones	CBO/NGO partners	Synergy Zones	CBO/NGO Partners	Synergy Zones	CBO/NGO Partners
Cote d'Ivoire	8	40	8	64	16	104
Ghana	8	40	8	64	16	104
Togo	4	20	4	36	8	56
Benin	8	40	8	64	16	104
Nigeria	8	40	8	64	16	104
ACRI Total	36	180	36	292	72	472

By focusing efforts within a selected number of local governance areas, the Initiative will benefit from and reinforce the local self-development dynamic and decentralized democratic governance. Within each of the selected Synergy Zones about 5 different community organization and NGO partners will be identified. They will be strengthened and partnerships promoted between organizations and structures with complementary roles and spheres of actions.

The Initiative will promote the emergence of a critical mass of CBOs and NGOs within these synergy zones, their example inciting emulation, their number serving as the core and catalyst for the movement of community response to the AIDS crisis. The force of the critical mass will create momentum towards changing the way communities respond to the epidemic and the way other actors, such as Government and its financial partners, orient their efforts and resources. The number will vary according to Country. In the case of Ghana, for example, there are 41 Districts in the 5 administrative Regions that will be included in the Initiative. Of these, the Initiative will work with eight in the first two years. Others will be added in consecutive years up to a total of one third.

2.2.4. Objective1: Building community response to the AIDS Crisis and developing

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CBOs and NGOs abilities in AIDS prevention in West Africa.

Strengthening CBO and NGO institutional capacity, the Initiative will use an organizational development approach, stressing progress of the organization in obtaining goals set together with the Initiative team after a participatory base-line organizational diagnostic. Strategic planning will be emphasized as a tool for organizations toward self-empowerment and sustainable programming. Methodologies and tools developed by Africare in its BINGOS Project will be employed to the best advantage.

Areas of institutional capacity strengthening will include:

- Financial management;
- Administrative management;
- Strategic planning;
- Fund raising and resource mobilization;
- Democratic governance of civil society organizations;
- AIDS programming; and
- Project design, implementation, monitoring and evaluation

Strengthening CBO capabilities in AIDS Programming will be developed through a variety of means—sharing of information, resources, lessons learned and best practices, training and workshops, skill-building in participatory community development, message and materials development and cross-fertilization of ideas and skills through networking, site-visits, exchanges and study tours. Moreover, emphasis will be placed on developing AIDS programming that goes beyond AIDS awareness education and accentuates the role of community in responding to AIDS. Partner CBOs and NGOs will be encouraged to look within as well as outside their organizations for opportunities to address the AIDS epidemic.

Through capacity building in AIDS programming, CBOs and NGOs will strengthen their ability to:

- promote AIDS risk assessment and behavior change,
- sensitize and energize community leaders,
- promote greater access to and use of condoms,
- source, develop and disseminate IEC materials and activities,
- promote and/or provide socioeconomic support to people living with HIV/AIDS, their families & AIDS orphans and to reduce their stigmatization,
- mobilize local resources for increased sustainability of AIDS activities,
- collect, analyze, apply & disseminate information on HIV/AIDS and STIs, and
- encourage community participation in responding to the AIDS crisis.

Strategic sub-granting as a strengthening mechanism, the Initiative will not attempt to fund the community response to AIDS. It will however use sub-grants as a tool to support the process of building capacity and community level experience as well as to mitigate marginal financial constraints to promoting an enabling environment. Activities and

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opportunities for building regional community of purpose will benefit from sub-grant consideration. Sub-grants will support activities such as:

- pilot and operational support activities;
- leveraging of resources;
- building constituency;
- specific organizational and institutional capacity building objectives;
- enabling partnerships and conditions for synergy; and
- connecting CBOs/ NGOs through the Internet.

Sub-grants will be made for amounts of \$100 to \$10,000 with possibility of renewal or higher awards for activities of special merit. Approximately 30 sub-grants will be awarded *per year in each Country*. CBO and NGO partners will be strengthened in fund raising and will actively seek community and external sources of financing for activities outside of the regular budget.

Outcomes of CBO/NGO Strengthening. The program of CBO/NGO strengthening measures will impulse directly into communities a heightened awareness of the AIDS crisis and positive behavioral change leading to reduced transmission of HIV/AIDS (fewer sexual partners, use of condoms..). Dealing with AIDS will enter into public and private discussions which will be increasingly informed and proactive -- AIDS stigma will decrease. Individual outcomes will include: Compassion, solidarity and support to PLHAs as well as capacity of PLHA organizations to serve their members will increase; support and concern for AIDS orphans and AIDS victim's families will be heightened; a sense of community security from a common understanding and ethic about protection will build increased hope for the future in the face of mounting tragedy of the AIDS crisis; and communities will be more proactive in ensuring the availability, access and use of condoms.

2.2.5. Objective 2: Enhancing the regional response to AIDS in West Africa.

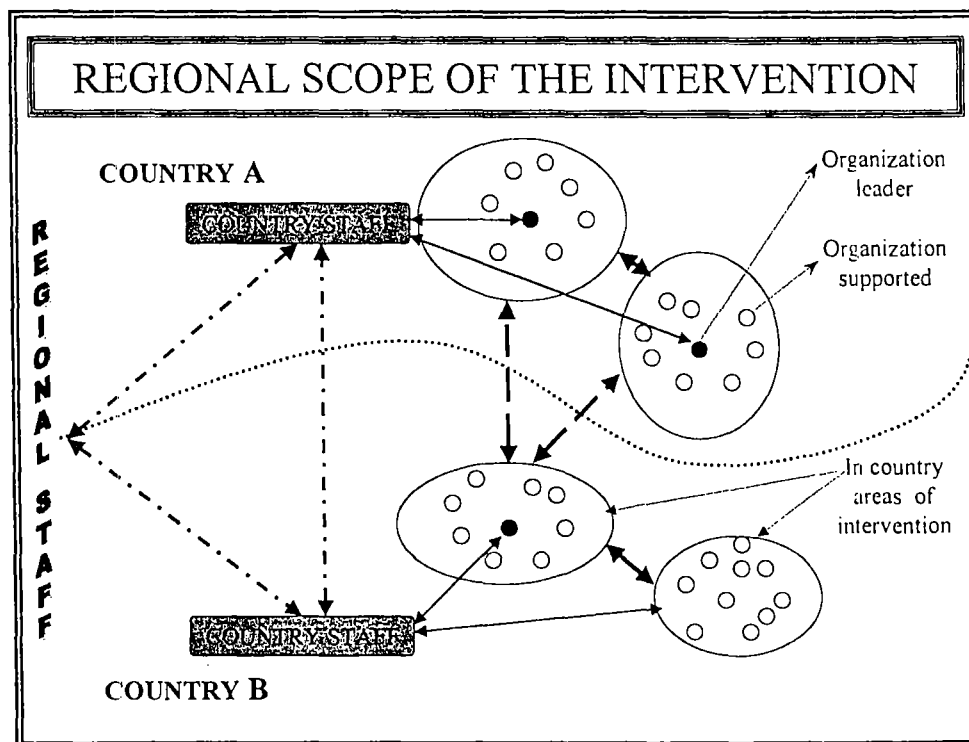


diagram 3 : Africare's regional scope of intervention

The regional nature of the AIDS epidemic requires regional as well as local solutions. Within the West Africa Coastal Region an opportunity exists to enhance horizontal linkages and shared vision between community-based actors creating a regional community of purpose. This objective will be achieved through a variety of mechanisms.

Cross-fertilization of ideas and skills will be carried out through numerous activities among regional stakeholders. Cross-border and regional meetings will be organized among key stakeholders. Cross-border study tours will be arranged. An information clearinghouse will be established or enhanced for use by CBOs and NGOs responding to AIDS in this region and other interested parties. A web site will be established that will feature documents of interest to the CBOs and NGOs, newsletters reporting on the activities of the CBOs and NGOs, profiles of activities carried out under the Initiative and other relevant information and tools. A regional pool of resource persons will be cultivated and enhanced to promote indigenous expertise and experience. Operational research and results sharing by universities and research institutions will be promoted. The initiative will facilitate community to community and south to south solutions to problems.

Building community of purpose among CBOs and NGOs, the outcome of which will be a shared vision region-wide. This community of purpose is not only defined by members' shared goals and values, but includes their solidarity and willingness to help each other and

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to come together to promote their common objectives, despite ethnic or national boundaries. Direct contact between CBOs within and outside of national boundaries will be promoted. Existing networks will be enhanced to the extent that their membership includes a significant number of community-based actors.

The Initiative will support workshops to develop regional leadership and shared vision. These contacts will converge toward a regional strategic planning exercise for community-based actors sponsored by the Initiative. Furthermore, the Initiative will promote adoption of a code of ethical and professional behavior for CBOs and NGOs involved in AIDS activities throughout the region.

Mobilization of regional resources for community-based actions as well as regional coordination and collaboration will involve working with civil society AIDS networks, governments and other institutions. In particular, the Initiative will encourage advocacy efforts targeting regional institutions and fora for the purpose of increasing financial support for community-based activities region-wide. Regional public and private funding sources will be cataloged followed by an effort to identify and develop more effective and accessible funding mechanisms, to permit CBOs and NGOs to access regional funding sources.

Building advocacy and communication capacity of the CBOs and NGOs has been set apart for special emphasis due to its capital importance in promoting an enabling environment for community-based AIDS activities as well as for developing cross-border community to community cooperation.

2.2.6. Objective 3: Promoting an enabling environment for community lead change.

The Initiative will promote an enabling environment for community-lead change and action. The promotion of local public awareness and political will enable CBOs and NGOs to develop AIDS programs with an administrative support. As noted earlier in the document, communities have been for the most part marginalized in the fight against AIDS in favor of vertical programs targeting individuals and mass media and social marketing campaigns. Through promoting national recognition of the community role and the importance of their contribution in responding to the AIDS epidemic, local, national and regional resource allocation to them should improve. Likewise, government and their partners will understand the opportunity for greater impact of actions by facilitating community to community horizontal partnerships. CBOs and NGOS must create favorable public opinion and lobby decision makers to bring about this change. Special emphasis will be given to strengthening CBO and NGO partners, and other community leaders to empower them to accomplish this objective.

2.3. The Initiative Team and Implementation Approach.

Geographic Organization - from the grassroots up:

The centerpiece of the implementation approach is the transfer of capacity to
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Community-based Organizations responding locally to the AIDS epidemic within a local governance area (Synergy Zone). To facilitate this process and insure its grassroots presence, the Initiative will put in place Community Capacity Transfer Facilitators (CCTF). These multi-disciplinary agents will mentor and coach CBOs, provide on site advising, and coordinate Initiative technical and resource inputs to these local partners. Each CCTF will be responsible for 1-2 Synergy Zones and based within one of those Zones.

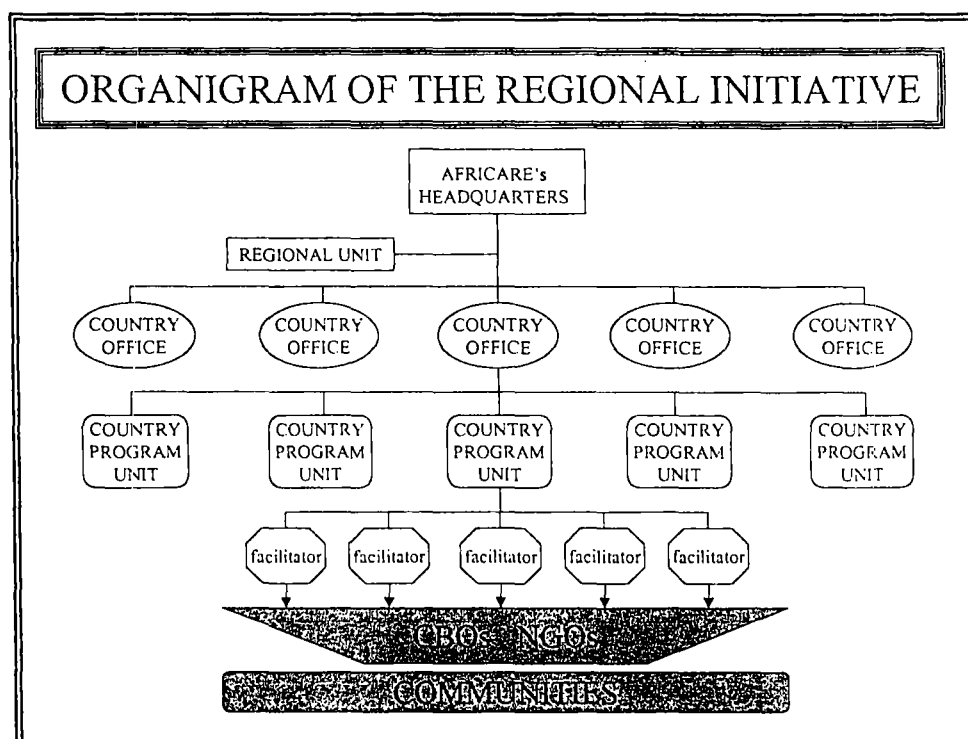


diagram 4 : Africare's organigram for the regional intervention

They will be supported by the Initiative country-program Coordinator and three specialists:

- a CBO/NGO Capacity Building Specialist
- a Sub-Grant Manager
- a Monitoring and Evaluation/MIS Specialist

Each specialist has defined roles of technical support to the CCTFs and for the overall implementation. These four persons together with the CCTFs make up the Country Technical Team. They will be supported by shared and full-time administrative and logistical staff (accountant, secretary, and drivers) according to each Africare Field Office situation.

The Africare Country Representative and his/her team will provide implementation, administrative and financial oversight in addition to institutional support as is the case with all Africare projects. The Initiative Country Team will be housed within the Africare Field Office where possible to reduce costs and facilitate communication.

The Initiative will be implemented as autonomous Country-level projects with

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coordination, facilitation and technical backstopping provided by a Regional Coordination Team. The Regional Team is composed of the Regional Coordinator, the Regional MIS Specialist and a Secretarial/document preparation assistant.

The Role of the Regional Team is:

- ☐ quality assurance (monitoring and evaluation, assessment of human resource inputs and methodology, identifying Country Team training needs and opportunities...)
- ☐ capitalization of experiences (capturing, documenting and sharing of country developed experiences and lessons, researching and diffusing of external experiences and innovations...)
- ☐ links/liaison with regional and international institutions (sharing information, identifying resources, coordination)
- ☐ joint management (joint review and planning, joint training, tracking of global expenditures...)

The Regional Team will be based in the Africare Ghana Country Field Office located in Accra. Accra is central to the region, offers good communication infrastructure and excellent regional transportation links. The Regional Team will have logistical and administrative autonomy but will cost share with the Ghana Field Office.

At Africare's Washington, D.C. Headquarters, the Initiative will be backstopped by the Africare Health Unit and HIV/AIDS Director. In addition, the Africare Regional Director and Program Manager will contribute 5% of their time to backstopping the project.

2.3.1. Implementation Approach.

The ACRI will be implemented in four major movements: building the foundation for collaboration, the first group of partners and corresponding program, the second group of partners and corresponding program, and the transversal phase of regionalization/sustainability.

Building the foundation: There can be no underestimation of the importance of putting in place the right people with adequate orientation to form the project team, developing harmonious relationships and informing institutional partners, communities and the general public of the nature of the Initiative and its strategy. This will be the focus of the first six months of the project, with public information and institutional relation cultivation extending throughout the project life.

Phase One and Two: there are two phased groups of Synergy Zones and CBO/NGO partners. The targets for each phase are featured in 2.2.3. and in Table 2. "ACRI Targets". The phased grouping will allow a concentration of resources and ensure greater success. Resources developed within the first phased group will be used to amplify the transfer of capacity to the second phased group and beyond the Initiative Synergy Zones. Each phase will require a two year cycle. The first phased group will benefit from ongoing, though

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reduced, support as the second phase is brought on board.

Converging efforts and actions towards regional and sustainable actions will be integral movement with increased intensity as the Initiative progresses in building local capacity and response. The second half of the five-year Initiative will see activities focusing wholly on this dimension.

2.4 First Year Activities

Adequate resources will be devoted to recruiting orienting and enhancing the capacities of the Initiative team. Once in place the Initiative local teams will work closely with the respective National AIDS Program Coordination Teams and their institutional partners (UNAIDS, WHO, World Bank, bi-lateral development assistance agencies) as well as civil society representatives and administrative and elected officials to build understanding and trust. A first step in working together will be to identify the initial Synergy Zones.

Organizations with special capabilities, exceptional dedication and openness will be identified within Synergy Zones. The staff will conduct an inventory of CBOs and NGOs within the Synergy Zones. Using a survey questionnaire, data will be collected on each of the groups that reflect its objectives, membership, location, length of existence, financial stability, organizational management, strengths and weaknesses. These, generally more structured, intermediary CBOs and NGOs will be designated as resource organizations and will be endowed with additional resources such as documentation libraries, internet connections, audio-visual equipment that will serve the surrounding CBOs and NGOs. Where such capacity can be cultivated, intermediary CBOs and NGOs will be provided special training to act as community-based organizational mentors. The **organizational mentors** will amplify Initiative staff outreach and continue transferring capacities to community organizations at the end of the project.

Local partner selection will entail participatory situational community assessments and organization evaluations. This process will be initiated during the second quarter of the first year. Detailed country-by-country implementation plans will be completed once baseline surveys and assessments have been completed and shared with stakeholders. CBO strengthening activities including sub-granting will begin in the fourth quarter in parallel with activities directed at creating the enabling environment for community-based AIDS activities. A baseline study will be conducted to determine initial situation and to develop indicators for future evaluation of ACRI impact. The process of sharing of all assessment and study results will inform partners, allow significant feedback and allow community ownership of activities and results. The end product of this first project implementation step will be the elaboration of a *detailed implementation plan*.

Work Plan for Year One
West Africa Regional AIDS Initiative

Activity	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Regional staff recruited, oriented and posted	X			
Regional office established	X			
Government protocol completed and Memorandum of Understanding signed for regional office	X			
Vehicles, other equipment and supplies for all offices ordered	X			
Contacts and meetings with key stakeholders, NGOs and CBOs begins or is renewed	X	X	X	X
Headquarters backstopping staff oriented	X			
Planning by regional staff	X	X	X	X
Preparation of information brochure on Initiative completed and distributed		X		
Visits by regional staff to target countries		X	X	X
Staff for country offices hired		X		
Country offices established		X	X	
Strategic planning meeting including regional & country program staff & HQ project program mgr. (travel to field by HQ project program manager once a year to attend one meeting)		X	X	X
Monitoring and evaluation staff hold strategic planning meetings and develop instruments & systems		X	X	X
Identification of country-specific geographic area to be targeted in each country		X		

Activity	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Baseline survey conducted in each country		X	X	X
Contact and assessment of potential partners	X	X	X	X
Sharing findings of baseline surveys with stakeholders		X	X	X
Detailed implementation plan prepared				X
First year work plan finalized with annual benchmarks			X	
Official launching of Initiative			X	
General information meeting for CBOs and NGOs held in each country			X	
NGO resource centers identified and partnerships formed		X	X	X
CBOs and NGOs identified following described procedures		X	X	X
Quarterly reports prepared	X	X	X	X
Work plan for Year Two prepared				X

2.6. Monitoring and Evaluation of Initiative.

The four most important functions of the AIDS Community Response Initiative's (ACRI) monitoring and evaluation strategy are the following:

- to assess the input, process, result and impact of the project in relation to the proposed objectives
- to use the information collected through monitoring and evaluation to refine or redirect project activities to meet quality assurance expectations
- to dialogue with project beneficiaries regarding objectives and progress and
- to assist CBOs to develop and implement stronger monitoring and evaluation capabilities.

Monitoring and evaluation will be exercised at three levels: 1) Initiative level; 2) CBOs/NGOs level; and 3) community level. There will be an emphasis on strengthening the capacity of partner CBOs and NGOs to conduct self-diagnosis on a continuous basis. They will receive training in setting goals and objectives, developing indicators, monitoring and participatory evaluation of their activities and use the findings to further improve their performance. They will also be trained on how to conduct participatory community baseline surveys and assessments on their respective constituencies of progress towards achieving targeted objectives. The Initiative will develop community-based, user friendly process and benchmark tools, and use checklists.

The key components of monitoring and evaluation in this Initiative will include:

- conducting baseline assessments of CBOs, NGOs and constituencies (baseline information collected at the time of project start-up will include knowledge, behavior and practice (KBC) of the CBOs and NGOs as it relates to HIV/AIDS, organization, management and community outreach);
- routine tracking of resources and performances;
- assisting partners to develop work plans and activity schedules;
- conducting scheduled reviews and planning sessions with all stake holders;
- monthly, quarterly and annual progress reports;
- mid-term and final evaluations (evaluations will be conducted at the levels of CBOs/NGOs and the target constituencies. The evaluations will be participatory in nature and will be conducted two times during the life of the project. One at mid-term and another at completion of the project).
- dissemination and use of material and regional information/data for the benefit of all stakeholders

Joint process and objective indicators will be elaborated in the first year to ensure that monitoring and evaluations are consistent and action oriented. This will allow for comparison of results across the five countries.

Although formal evaluations will be conducted (with the participation of external evaluators, project staff, representatives from CBOs and NGOs, community and opinion leaders, beneficiaries of AIDS programs and other key stakeholders at the community and regional levels), peer evaluations will be given special attention as a tool of not only assessing success, failure and constraints but also as a tool for learning from each other. Partner organizations will be invited to share their experiences, performance results and lessons learned in an annual review and lessons learned workshop.

The project's monitoring and evaluation team will consist of a regional monitoring and evaluation officer and five country-level monitoring and evaluation officers, located in each of the five target countries. The key activities of the monitoring and evaluation team will be designing and adapting monitoring and evaluation instruments and systems, developing a monitoring and evaluation system that could be used as a common tool in the region, conducting training sessions on monitoring and evaluation, collecting, receiving and analyzing information, accessing progress and achievements, reporting on findings and making recommendations.

The monitoring and evaluation team is responsible to collect resources and document experiences that will be available in a manner and language that is appropriate to the grass roots groups that the Initiative is targeting.

APPENDIX A : *Acronyms*

ABPF	<i>Association Béninoise de la Promotion Familiale</i>
AIDS	Acquired Immune Deficiency Syndrome
AFRICASO	Africa-based AIDS Service Organization
ATPF	<i>Association Togolese de la Promotion Familiale</i>
ACRI	AIDS Community Response Initiative
BINGOS	Beninese Indigenous Non-Governmental Organization Strengthening Project
CBO	Community-based Organization
CCTF	Community Capacity Transfer Facilitators
GDP	Gross Domestic Product
GTZ	German Technical Assistance
GHANET	Ghana AIDS Network
HIS	Health Information System
HIV	Human Immuno-deficiency Virus
ICASO	International Coalition of AIDS Service Organizations
IEC	Information, Education and Communication
ICW	International Community of Women Living with HIV/AIDS
KBP	Knowledge, Behavior and Practice
MIS	Management Information System
MOH	Ministry of Health
NACP	National AIDS Control Program
NGO	Non-governmental Organization
PA	Program Advisor
PHC	Primary Health Care
PM	Program Manager
PNLS	<i>Programme National de Lutte contre le SIDA</i>
NACP	National AIDS Control Program
SWAA	Society for Women Against AIDS In Africa
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	United Nations AIDS Coordination Unit
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
WHO	World Health Organization

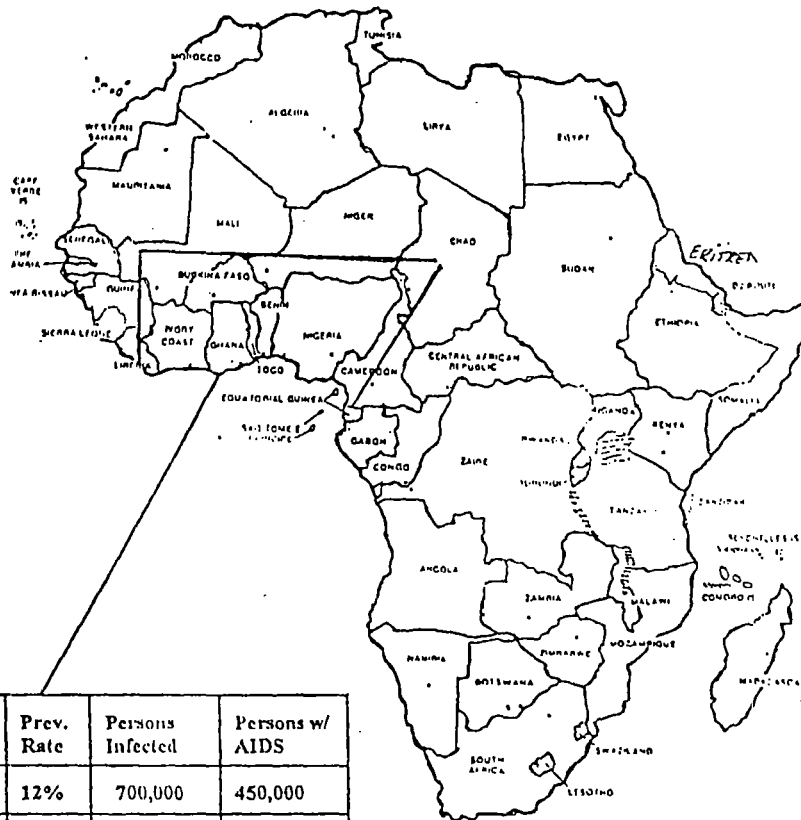
APPENDIX B

OBJECTIVES AND SUBOBJECTIVES	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
OBJECTIVE #1: TO BUILD COMMUNITY RESPONSE TO THE AIDS CRISIS AND DEVELOP CBO/NGO ABILITIES IN AIDS PREVENTION IN WEST AFRICA			
SUBOBJECTIVE 1.1 To promote partnership, collaboration & dialogue in the community & among stakeholders to share vision and objectives in responding to AIDS	# of meetings held, # of stakeholders participating to meetings, # of joint activities held by the stakeholders, # of partnerships formed and collaboration taken place,	CBO and NGO reports project reports	Dialogue among partners, CBOs, NGOs and community leaders needs promotion
SUBOBJECTIVE 1.2 To strengthen the organizational capacities of partner CBOs and NGOs that focuses on problem solving about AIDS by the community and community empowerment	# of training session held & persons trained, # of AIDS activities developed, # of persons informed on AIDS prevention,	pre and post training tests, Initial and continuous competencies assessment Supervision reports, CBO/NGO/project reports	Training of staff organization on technical subjects on AIDS is needed and accepted by them
SUBOBJECTIVE 1.3 To reinforce technical capacity of partner CBOs and NGOs in AIDS programs for increased sustainability of AIDS activities	# of partners with an organizational diagnosis, % of recommendations of the diagnosis applied by the partners, # of training session held & persons trained, % of organizations trained with a annual plan, % activities planned & realized by organization	pre and post training tests, Initial and continuous competencies assessment Supervision reports, CBO/NGO/project reports	Training of staff organization on organizational development & good governance is needed & admitted by them
SUBOBJECTIVE 1.4 To promote community managed and financed AIDS activities	% of organizations with a sub-grant from the regional program for AIDS activities, CBO/NGO fund raising plan elaborated/applied Budgeting of CBO/NGO activities in local government budget, % of grants used as initially planned, % organizations with grants from partners, increase in local contribution	CBO/NGO/project reports, (financial, supervision, monitoring and evaluation reports)	Community managed and financed activities exist and need to be promoted

OBJECTIVES AND SUBOBJECTIVES	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
OBJECTIVE # 2: TO ENHANCE A REGIONAL RESPONSE TO AIDS IN WEST AFRICA			
SUBOBJECTIVE 2.1 To promote cross fertilization of ideas, skills and strategies among key stakeholders for AIDS prevention	Annual number of in country and regional meetings held among key stakeholders, Number of key stakeholders participating in cross fertilization activities, Number of cross border study tours yearly held, Number of organizations accessing clearinghouse for information,	CBO/NGO/project reports, (periodic & occasional) effective information obtained by each organization from the regional system (study, tools, methodology...) evidence of studies carried out and results shared	Regional cross fertilization among CBOs/NGOs and key stakeholders needs to be encouraged
SUBOBJECTIVE 2.2 To promote the mobilization of regional resources for community activities	Increased number of partners funding regional community-based activities Number of CBOs/NGOs having access to regional funds for community-based activities Number of activities held advocating to finance regional community-based activities	Agreements btw partners CBO/NGO/project reports, (periodic & occasional)	Regional & in country resources are available for AIDS activities and could be oriented to the community level
OBJECTIVE # 3: TO INFLUENCE POLICY MAKING			
SUBOBJECTIVE 3.1 To build a community of purpose among community-based actors responding to the AIDS crisis	Number of tools/solutions adopted from country to country, Number of community to community visits, Regionwide adoption of professional and ethical code for AIDS/CBOs and NGOs, Development and regional dissemination of a training manual	CBO/NGO/project reports, (periodic & occasional) ethical code developed and sent to each organization regional representativeness of the organizations active and involved in the program	A community of purpose among key stakeholders & CBOs/NGOs needs to be encouraged

OBJECTIVES AND SUBOBJECTIVES	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
SUBOBJECTIVE 3.2 To promote an enabling environment for community-based response to the AIDS crisis	# of AIDS sessions held or supported by leaders by intervention site, # of advocacy sessions on community response to AIDS by intervention site, # positive public statements & actions taken by community leaders and authorities, public recognition at local-regional and state levels leading towards policy change	pre and post training tests, # of promotion tools created for AIDS advocacy, CBO/NGO/project reports Official speeches reports & policy documents	Participation by community and opinion leaders is important in responding to AIDS Community leaders and opinion leaders need to become AIDS advocates

APPENDIX C



	Target Countries	Population	Prev. Rate	Persons Infected	Persons w/ AIDS
1	Ivory Coast	14.2 million	12%	700,000	450,000
2	Ghana	18 million	4.5%	210,000	180,000
3	Togo	4.3 million	3.3%	170,000	140,000
4	Benin	5.8 million	3.7%	54,000	16,000
5	Nigeria	118 million	5.4%	2,300,000	590,000
	Total	165 million	-	3.4 million	1.4 million



APPENDIX D

Africare
AIDS Community Response Initiative for West Africa (ACRI)

Budget

Cost Center	Description	Year One	Year Two	Year Three	Year Four	Year Five	Total
1	HQ Staff Salaries	\$32,500	\$34,125	\$35,831	\$37,623	\$39,504	\$179,583
2	Regional Team Salaries	\$114,500	\$123,088	\$132,319	\$142,243	\$152,911	\$665,061
3	Country Team Salaries	\$701,004	\$753,579	\$810,098	\$870,856	\$936,170	\$4,071,707
5	Fringe Benefits	\$287,463	\$308,694	\$331,501	\$356,001	\$382,320	\$1,665,979
6	Housing & Recruitment	\$144,540	\$107,866	\$128,067	\$115,822	\$120,100	\$616,395
7	Travel & Per Diem	\$409,800	\$400,520	\$459,731	\$422,361	\$483,496	\$2,175,908
8	Training & Workshops	\$267,300	\$347,300	\$338,300	\$338,300	\$283,050	\$1,574,250
9	Other Direct Cost	\$181,630	\$160,280	\$165,373	\$170,720	\$176,334	\$854,337
10	Equipment	\$668,875	\$23,625	\$24,806	\$26,047	\$27,349	\$770,702
11	Supplies	\$77,818	\$75,700	\$76,960	\$77,783	\$79,172	\$387,433
12	Subgrants	\$0	\$750,000	\$750,000	\$750,000	\$375,000	\$2,625,000
	Total Direct Costs	\$2,885,430	\$3,084,777	\$3,252,987	\$3,307,755	\$3,055,406	\$15,586,354
	Indirect Costs @ 20.04%	\$578,240	\$618,189	\$651,899	\$662,874	\$612,303	\$3,123,505
	Total Expenses	\$3,463,670	\$3,702,966	\$3,904,885	\$3,970,630	\$3,667,709	\$18,709,860

Africare

ACRI Budget Notes

1. HQ salaries include 5% for the Senior Vice President, 30% time of the HQ-based AIDS Director and 15% for the Regional health Program Manager who are responsible for HQ level supervision and maintaining US institutional relations and 10% of Regional Director for overseeing all HQ financial/ personnel/administrative management support as well as general program coordination.
2. Regional Team Salaries include the expatriate Regional Program Advisor and Regional Monitoring and Evaluation/Management Information Systems Support Officer supported by a locally recruited Secretary/document preparation assistant and driver(all based in Accra).
3. Country Team Salaries include for each Country, the locally recruited:
 - ◆ Country Team Coordinator
 - ◆ CBO/NGO Capacity Building Specialist
 - ◆ Monitoring & Evaluation/MIS Officer
 - ◆ Sub-Grant Manager
 - ◆ (8X) Community Capacity Transfer Facilitators
 - ◆ Shared and full-time administrative, financial & logistical support staff
(Accountant, secretary, logistician, drivers, guards,...)And the expatriate:
 - ◆ Africare Country Representative (at 30% of time)
 - ◆ Country Program Administrative Officer (at 30% of time)
4. Fringe Benefits are paid on expatriate staff salaries at approximately 45% of gross salary for medical and travel/emergency medical evacuation assurance, social security/workman's compensation, pension plan contributions; and for local staff at approximately 30% of gross salary for medical insurance, social security, and other locally legislated benefits.
5. Housing and Recruitment expenses include:
 - ◆ local housing rent and maintenance for the 2 expatriate Regional Advisors
 - ◆ 30% support of the Country representative & Admin Officer housing costs
 - ◆ first year purchase of modest furnishings for the Regional Advisors
 - ◆ Direct expenses of recruitment: advertising, interview lodging/per diem
 - ◆ Expenses of fielding the Regional Advisors: moving allowances, travel medical costs, shipping storage of personal effects.
6. Travel and Per diem expenses include:
 - ◆ Local vehicle operation, maintenance and repair,
 - ◆ occasional local airfare,

- ◆ local per diem & lodging cost for in country travel by the Country Team,
 - ◆ international airfare for the Regional Team and a % of these cost for the Country Representative/Admin officer,
 - ◆ per diem for international travel such as AIDS conferences.
7. Training and workshops expenses cover lodging and meal costs of training events for CBO/NGO partners and other partners, training support equipment (projectors, video equipment, flipchart stands, digital cameras, etc). ACRI consultants include technical specialists for short term contracts to advise and train on the baseline studies and final evaluations and to provide specific technical inputs as identified by the Regional and / or Country Teams over the course of the project. These are both locally recruited specialists (a total of 150 person/days per Country Program) and internationally recruited specialists (a total of 85 person/days per Country Program).
 8. Other Direct Costs include:
 - a 30% average cost sharing of local Office Rent and Maintenance,
 - direct communication costs (telephone, internet services, express and local mail services, etc)
 - program auditing fees
 - vehicle insurance
 - shipping freight charges for equipment purchases
 - foreign exchange losses
 - local bank fees
 - local customs processing fees (Africare is exempt from import duties and taxes in most of its operations)
 9. Equipment includes:
 - 3 4x4 9-place passenger vehicles per country program,
 - an all terrain motorcycle for each Community Capacity Transfer Facilitator (36 total)
 - computers and computer support equipment/ country program,
 - a photocopier/ country program,
 - office furnishings for each country program
 - fax machine and other miscellaneous support equipment (calculators, phones, etc)/country program.
 10. Supplies expense include offices supplies and printing and duplication costs.
 11. Sub-Grants as discussed in the ACRI Proposal include three categories:
 - Institutional Support Grants @ \$2,500 avg x 15/year/country program
 - Seed Grants @ \$8,000 avg x 10/year/country program
 - Resource organization development grants @ \$10,000 avg /year/ country program
 12. Africare's Indirect Cost Rate (Overhead) is an annual audited rate, currently at 20.04%.

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May 17, 2000

Hon. Sandra Thurman, Director
National AIDS Policy
The White House
736 Jackson Place, NW
Washington, DC 20503

Dear Hon. Thurman:

This is a follow-up to our brief meeting in Atlanta last April at the International Conference on HIV/AIDS & Malaria in Africa. I am writing to request a meeting with you at your earliest convenience. You may recall that we were introduced by Mr. C. Payne Lucas, President of Africare just before your keynote address at the luncheon on April 14, 2000.

We gave you a copy of our proposal on AIDS Community Response Initiative for West Africa (Nigeria, Benin, Togo, Ghana and Ivory Coast). You invited me to the White House and I promised to get in touch with you to answer any questions you may have and to get your reaction to this initiative.

The enclosed proposal is currently under review by the Bill and Melinda Gates Foundation. We have been asked to submit letters of support from key agencies and stakeholders along with our final draft. We hope you will feel comfortable in writing such a letter and to indicate how our proposal fits within the context of the White House's HIV/AIDS Initiatives.

I look forward to hearing from you soon on the day and time you are available to meet.

Thank you for your consideration.

Sincerely,

Clarence S. Hall, Dr.P.H.
Director of HIV/AIDS