Project Name	Gambia, The-Gambia HIV/AIDS Rapid... Response Project (HARRP)
Region	Africa Regional Office
Sector	HIV/AIDS
Project ID	GMPE60329
Borrower(s)	GOV. OF THE GAMBIA
Implementing Agency	Address TBD
Environment Category	C
Date PID Prepared	October 18, 2000
Projected Appraisal Date	November 12, 2000
Projected Board Date	January 16, 2001

1. Country and Sector Background
Relation to Country Assistance StrategyThe last Country Assistance Strategy (CAS) for The Gambia (Report No. 18361 GM) was prepared in August 1998 and discussed by the Board of Directors on September 10, 1998. Although the HIV/AIDS epidemic was still in its very early stages in the country at that time, the CAS did mention the need for HIV/AIDS prevention. The CAS also mentioned the threat of the sexually transmitted diseases or infections (STIs), which are an important co-factor in the spread of HIV/AIDS in the early stages of an epidemic. Last but not least, the CAS stressed the importance of addressing major public health concerns through preventive rather than curative measures. The instrument that was envisioned in the CAS to tackle the issue of HIV/AIDS prevention (and its linkage to reproductive health outcomes) was a Population Policy LIL. Initial preparatory work for the Population Policy LIL operation has subsequently been subsumed into this larger HIV/AIDS Rapid Response Project. The preemptive nature of this HIV/AIDS project and its objective to both organize and increase the response against the HIV/AIDS epidemic are well in line with the overall social and human capital development strategies that are spelled out in the CAS. Moreover, the proposed operation is fully consistent with the overarching objective of Bank Group assistance which is to achieve a sustainable reduction in poverty.Epidemiologic Situation and Government ResponseHIV was first diagnosed in The Gambia in 1986. In 1988 the first sero-prevalence survey was undertaken and found a consolidated HIV prevalence of 1.8% among adults (people 15 years old and above), consisting of 1.7% HIV-2 infection and 0.1% HIV-1 infection. This survey was repeated in 1991 at which time survey data showed an increase of HIV-1 infection from 0.1% to 0.5%, whereas HIV-2 infection was stable at 1.7%. From 1993 to 1995 a study undertaken among antenatal mothers showed similar prevalence rates. Additionally, specific studies of a very high risk group, commercial sex workers (CSW), reflected a similar trend. While HIV-2 remained relatively stable among CSWs at 2.1%, HIV-1 infection increased in this group from 2.1% in 1989 to 8.1% in 1993. Unfortunately there are no prevalence data available from 1995 to 1999. However, indirect indicators show a steady increase in the number of HIV cases as well as an increase in HIV prevalence among blood donors (reaching a consolidated level of 3.5% for

HIV-1 and HIV-2 in one center in 1999). The predominant means of HIV transmission in The Gambia is heterosexual. The extent of mother-to-child transmission, contaminated blood products, needle sharing, and from men having sex with men, is not known.The Government launched in 1992 a program to fight the epidemic, prepared a five-year HIV/AIDS prevention, treatment and care plan, created the National AIDS Control Program, and also held resource mobilization meetings to fund the program, with modest success. Nevertheless, a number of activities have been promoted, principally by UN agencies and NGOs in conjunction with the Government, to prevent and mitigate the spread of HIV/AIDS. These activities include limited information, education and communication (IEC) activities, condom promotion, dissemination and use of HIV test kits, and sentinel surveillance activities. Today a number of high government officials are seized with the problem and dangers stemming from the HIV/AIDS epidemic, are more vocal about these dangers, and recognize the risks to Gambia's future development if a major and well-coordinated effort is not launched quickly to stem its spread. The Government as a whole is now conscious of the need to curtail the spread of the virus before it reaches an explosive dimension, as has occurred in a number of other SSA countries.Government HIV/AIDS StrategyWhile HIV/AIDS is referenced in a number of Government strategy documents, there is not yet a medium (5 year) or longer-term strategic document which: (a) clearly articulates Government's priorities in containing HIV/AIDS; (b) consolidates the various discussions of HIV/AIDS in the strategy documents for the sectors; and (c) puts forward a detailed Plan of Action based on a consolidated overall strategy against the HIV/AIDS epidemic.A strategic document is being developed, and will be reviewed and adopted by the new institutional structure to be put in place under the new HIV/AIDS Rapid Response Project (HARRP). The Gambian Government and civil society recognize that HIV/AIDS is a complex multi-faceted and multi-sectoral problem that requires a long-term sustained response from all sectors of government and society. The policy and strategic framawork will involve a process of planning and program development at bith the national dans Divisional levels. This process will engage national and regional government institutions, the major regional sector NGOs, religious organizations, associations, PLWHAs, and others key stakeholders. The Government expects that is it develops this comprehensive, multi-sectoral five year strategy and plan of action, and then receives the support of the international community, the people and institutions of The Gambia will have the capacity to contain the spread of the epidemic and its enormous burden on society and the economy.

2. Objectives

This Project is a country program within the context of the $500.0 million Multi-Country HIV/AIDS Program for the Africa Region (MAP) approved by the Board on September 12, 2000. In line with the purpose of the MAP and in collaboration with other members of the International Partnership Against AIDS in Africa (IPAA), the overarching purpose of this HIV/AIDS Rapid Response Project (HARRP) is to assist the Government of The Gambia stem the growth of human immuno-deficiency virus (HIV) infection by helping to: (a) maintain the current low levels of the epidemic; (b) reduce its spread and mitigate its effects; and (c) increase access to prevention services as well as treatment, care, and support for those infected and affected by HIV/AIDS. This will be achieved through the provision of HIV/AIDS prevention, care, and treatment services at all levels (national, regional, and local) as well as in a number of sectors.

3. Rationale for Bank's Involvement

The Multi-country HIV/AIDS Program for the Africa Region places HIV/AIDS at the center of the development agenda for work in the region. For the individual country, but also for neighboring countries and communities, the curtailment of the spread of HIV is pivotal if human development and overall development goals are to be achieved. HIV/AIDS prevention is cross-sectoral and the Bank has experience in financing selected sectors in The Gambia, each of which has a key role to play in carrying forward an HIV/AIDS prevention program (agriculture, education, health, the private sector). Further, the Bank has embarked with the Government and the IMF on a Poverty Reduction Strategy exercise, and this effort will take HIV/AIDS concerns into account. With its IPAA partners, the Bank has experience in the design of HIV/AIDS rapid response programs in other countries, and in supporting successful programs in West Africa. Of significance for The Gambia because it is encircled by Senegal, is the Senegal program, where the HIV prevalence rate is and has been kept at 2.2%. IDA is one of the UNAIDS partners in a position to make a multi-year commitment to the long-term Gambian effort to avert a HIV disaster.

4. Description

The Multi-country HIV/AIDS Program for the Africa Region (MAP) provides the framework and the basic concept for the HARRP. The four MAP elements for eligibility, namely satisfactory evidence of a strategic approach to HIV/AIDS (demonstrated by having a participatory strategic planning process underway); a high level HIV/AIDS coordinating body; Government agreement to use appropriate implementation arrangements; and Government agreement to use and fund multiple implementation agencies, have been integrated into the project design. HARRP will support the development of a national medium term strategy and plan of action, concentrating on prevention. It will assist the National AIDS Commission and Secretariat to fulfill its mandate. Concurrently it will build on and increasingly accelerate coverage of existing programs, as well as improve the institutional capacity of those entities involved, both public and private. Finally, the intention is to continuously track and evaluate activities and to reassess them on an annual basis, in terms of effectiveness, but also in terms of resource availability should other partners decide to participate.Synergies with Existing HIV/AIDS ActivitiesHARRP will build on activities already underway at various stages of implementation, including those financed by the IDA-Participatory Health, Population and Nutrition Project (PHPNP), approved in March 1998. Of particular note are the recently approved STI and HIV management manuals developed by the DOSH and a technical advisory group. These manuals use the syndromic management approach and are consistent with UNAIDS guidelines, providing the basic framework for a national approach for prevention, treatment and care. PHPNP also supported revision of the mid-wifery curriculum and improvements in primary and secondary health facilities. Under a complementary health project financed by the African Development Bank (AfDB), a national public laboratory will provide essential testing support for reproductive health activities.Another program which is to be expanded with the help of the HARRP is the "Stepping Stones" effort. This community level, empowerment and participatory learning and action approach uses infertility prevention as the acceptable pathway to discuss STIs and HIV prevention issues with local villages in an Islamic context. Several local organizations including Action Aid, The Gambia Family Planning Association, the German

Gambia Family Planning Program, the Worldwide Evangelisation for Christ, the Medical Research Council and the DOSH have undertaken a collaborative effort to pilot the approach. They have now developed the methodology and manuals and tested it in several communities. This "Stepping Stones" approach has been partly evaluated and found successful.Other relevant acuvwes include neruung priority health indicators and me allocation of resources a the health sector. HARRP is designed to direct resources made available from Government, the donor community, and other partners, to a mufti-sectoral HIV/AIDS prevention, treatment and care strategy and action plan. The emphasis will be on interventions which can be implemented rapidly, targeting high risk and other target groups, working as much or more outside the public sector, with communities and NGOs.The Project The proposed project will have four components: 1) capacity building and policy development; 2) mufti-sectoral responses to prevention care and support; 3) health-sector responses to STI/HIV management, including prevention and care; and 4) HIV/AIDS Fund (H Fund) community initiatives.Component 1: Capacity Building and Policy Development. This component will aim at strengthening Gambia's capacity to cope with the spread of HIV/AIDS by supporting the work of the multisectoral National HIV/AIDS Commission (NAC), its Secretariat (NAS), and Divisional/Municipal AIDS Committees (DACs), in development of an interim and subsequently final national HIV/AIDS strategy and Action Plan, and in providing the institutional capacity to carry out the Plan. Six sub-components address the following areas: (a) National Strategy and Action Plan; (b) HARRP Coordination and Administration; (c) Advocacy Training, and Technical Support Activities; (d) Surveillance and Mapping, (e) Operational Research and Pilot Testing, and (f) Monitoring and Evaluation.Component 2: Multi-sectoral Responses for Prevention, Care and Treatment Support. This component will be principally to improve the capacity of Government Departments to respond to the HIV/AIDS epidemic, emphasizing prevention, through a)provision to their staffs, of HIV/AIDS education, training, condoms, and other support, to encourage HIV/AIDS avoidance behavior, and b) Departmental capacity to help their specific external partners such as PTAs, farmers associations, village health committees to confront effectively HIV/AIDS prevention, care, and treatment. Interested line Departments either have or will appoint HIV/AIDS focal persons to carry out Departmental plans for these purposes, with support from HARRP. Currently the Departments of Education, Agriculture, Defense, Interior, Youth, Tourism, Community Development and Health have plans and will be HARRP participants.Component 3: Health Sector Responses to STI/HIV Management. The Department of State for Health and Social Welfare (DOSH) will be able to carry out all of the activities described above by participating line Departments. In addition, the DOSH and more broadly the health community, have special responsibilities for STI/HIV prevention and management. This sector therefore warrants a separate Component, making provision for prevention, treatment and care from a health sector perspective, whether public or private. It builds on work now contained in the STI and HIV management manuals recently adopted by the DOSH, as well as other reproductive health activities. DOSH will not be able to undertake all of the health sector specific tasks at once, nor do it without assistance from other non-public health care providers. It will prioritize which aspects, where, when and how quickly it can implement and scale up these management packages. A preliminary draft of the DOSH Plan will be refined, but the basic elements are: a) voluntary counseling and testing: b) care for the asymptomatic patient: outpatient care at primary

level; c) care for the symptomatic patient; d) care for the terminally ill patient: home care and regular home visits by nurses; e) care for the bereaved family.Two other aspects need highlighting with respect to the health sector:First, blood supply is important and blood supply system enhancement is being partly addressed under the PHPNP. In this regard the stated policy goal of The Gambia is that blood supplies be controlled and assured as safe. Donor mobilization is being financed under the PHPNP along with a readiness to cover preparation of a plan for a national blood transfusion service, identify the necessary equipment to complement what is being done under existing AfDB and IDA financing, what would be needed in terms of blood bags and reagents, and training of laboratory technicians. The objective would be to ensure that blood for transfusion and blood products do not transmit HIV and other STIs.Second, there is need for specialized training in HIV/AIDS hazardous materials handling and provision of medical supplies to health workers so as to prevent HIV virus transmission. Health workers represent a particularly vulnerable group because of their routine contact with hazardous materials, they are the front line in treatment, and need to be confident their personal safety is taken into account so that they actively promote testing and treatment of PLWHAs.Component 4. HIV/AIDS Fund-Community Initiatives. The HIV/AIDS Fund (H Fund) will be a separate financing mechanism to provide resources to support community, civil society, worker associations, and "establishment or primary unit" initiatives (" establishments or primary units" are businesses, military camps, prisons, refugee camps, religious groups, trade associations, sports clubs and the like). It will therefore support both "community-based" and "community-involved" activities. The H Fund will be roughly half of the HARRP Credit, be established by and report to the NAC, through the NAS. An initial allocation will be made to the five Divisions (and two municipalities) on a population density basis, so that there is proportionate sharing and an indicative planning amount from which to begin work. Basically there will be three types of proposals put forward by eligible applicants for approval: 1) large scale activities (National or Division coverage) which will require substantial experience, and institutional capacity, and for which entities will be pre-qualified (Category A); 2) medium-small scale activities which will require considerably lesser standards of capacity, with such organizations ranging from NGOs, CBOs, PLWHAs associations, other groups and establishments (Category B); and 3) communities on their own behalf. Category B entities and communities will be able to obtain modest grant assistance from the HARRP for local consultant support to help in preparing proposals and organizational training, if need be.Using participatory group discussion techniques, a CBO assessment was done in July 1999 by ActionAid, the Department of Community Development and Women's Bureau covering ActionAid nationwide areas of operation. Based on criteria that included CBO self-assessment, extension worker assessment, and those of the assessment organizers, CBOs were assessed as strong, moderate or weak. An expansion of this assessment to cover non-ActionAid areas is being undertaken by the Local Initiative Fund and shared with the HARRP. A preliminary assessment of larger NGOs has also been done, based on questionnaire and interview responses. Thus there is a basis on which to go forward in determining institutional capacity with major groups of likely H Fund applicants.Various institutional options were considered, including contracting the Gambia Social Development Fund financed by the African Development Bank, channeling resources to the decentralization rural development structures established by the European Development Fund

and which use multi-disciplinary facilitation teams (MDFT), or utilizing the Local Initiative Fund (LIF) approved in 1998. After due consideration the Gambian Government determined its preference would be to use multiple channels for developing and presenting proposals, and rely on Divisional/municipal AIDS Committees and the NAS to process applications for approval and monitor H Fund activities. The existing mechanisms did not appear to be the " right fit" for HARRP, either because they had other priorities, were credit providers only, were more infrastructure-oriented, had long appraisal or developmental timelines, or already had too much to do with their current plans and programs. The H Fund system will be demand driven and thus allow for the full gamut of potential users and other institutions to access resources..A menu of eligible activities, an "HIV/AIDS Activity Positive List", will be further defined in an IDA approved, H Fund Operations Manual. Assuming a qualified applicant puts forward a proposal consistent with the menu/positive list, it would be presumed to be eligible for financing. Broadly speaking H Fund activities would be aimed at the following areas: (a) Information education and communication/behavioral change communications (IEC/BCC) campaigns; (b) Support to high-risk groups; (c) Youth-related activities ; (d) Condom supply and dissemination.(a) IEC/BCC campaigns. Activities would be geared at the general community and/or small groups, and encompass public awareness and information campaign/programs. This would include TV and radio access, videos radio cassettes to reach villagers, songs, plays, road signs to convey simple messages, and other indigenous channels for message delivery. The draft 1999 IEC Communications Strategy prepared by the Department of State for Health can provide a basis for the IEC/BCC menu until a separate HARRP menu is finalized.(b) Support to high-risk groups (and priority target groups). Possible activities for H Fund financing for high risk groups would include BCC, promotion of condom use and condom availability, provision for STI diagnosis, treatment of STIs and TB, and care. High risk groups include commercial sex workers and their clients, long distance transport workers, migrant workers, hustlers in tourist areas known as "bumsters", refugees and displaced people, prisoners, the military, and those already infected. For a particular subset of this group, namely PLWHAs, sub-activities could include financing support groups, NGOs, and community organizations to reach families and individuals with coping mechanisms that provide a package of home-based care supplies (ex. gloves, plastic sheets) and essential drugs (ex. aspirin, calamine lotion) to symptomatic and terminally ill patients and their dependents, as well as medical treatment, shelter, food supplementation, and care to HIV parents, students, and orphans, as well as income generating activities for PLWHAs.(c) Youth-related activities. This sub-component would target the youth, defined as aged 15-24, and empower them to better tackle the threat of HIV/AIDS and STIs. Activities would focus on: (i) youth-specific information, education and communication as well as behavioral change communication (IEC/BCC) programs; and (ii) Family Life Education programs for in-school and out-of-school adolescents. H Fund financing would cover innovative approaches such as peer-education programs, purchase of FLE materials for peer education, youth clubs, youth-specific meeting places, and other means. FLE programs in schools would encourage referral of adolescents to H Fund supported services in the areas of voluntary counseling and testing (VCT), STI treatment, and condom access. Parent and teacher associations (PTAs) could be financed to play active roles in fostering a "culture of care" in schools and the school as one of the main community based

organizations countering AIDS.(d) Condom supply, access and distribution. IEC/BCC messages without means to carry out actions would not produce the desired results. Therefore availability, accessibility, and a steady supply of condoms would be essential, facilitated, and financed under the H Fund, in conjunction with, or separate from, other H Fund-financed activities.

5. Financing

Total	(US$m)
GOVERNMENT	
IBRD	
IDA	
Total Project Cost	15.0

6. Implementation

The National AIDS Commission (NAC) will have broad-based, public and private, multi-partisan membership. NAC will be the high level body charged with developing the national HIV/AIDS strategy and action plan, and following through with overseeing its implementation. It will be the oversight body for the HARRP, meeting at least quarterly to receive briefings and reports from the National HIV/AIDS Secretariat (NAS) and also other Rapid Response partners. On an annual basis it will report to the National Assembly on the status of HIV/AIDS, and steps taken to prevent its spread. The NAS would be expected to report quarterly to the NAC on progress in carrying out all components, results achieved, and knowledge of the state of HIV/AIDS prevalence in The Gambia. Like the NAC, the DACs (or municipal equivalents) will have roughly equal membership from a) Government (line departments and local governments) on the one hand, and b) NGOs, women's groups, the private sector and PLWHAs, on the other (PLWHAs must be represented in each case). DAC committees will convene monthly to focus on the proposals submitted under the H Fund as well as discuss the status of HIV/AIDS prevention, treatment and care in their area.

7. Sustainability

The sustainability of the HARRP will largely depend on the degree of ownership by the various concerned entities at national, regional, and local levels, their implementation capacity, their ability to organize for specific sub-project activities, and the reliability of their access to funds. The process at community level will be demand-driven; sustainability at that level will be promoted by targeting priorities identified by the beneficiary group. The incorporation by line Departments of their own action plans, directed at internal and external target groups will create ongoing support and awareness of the HIV virus problem and appropriate behavior. The focus on capacity building, training, performance monitoring and evaluation will further enhance sustainability.

8. Lessons learned from past operations in the country/sector

Stakeholder Consultation: Key stakeholders, particularly those with an important role in implementation, should be involved from project identification, through preparation and appraisal, and throughout implementation. The project has been prepared with both implementors and donor agencies in as consultative a manner as possible in the short time available.Procurement: Provision has been made for procurement

support. A procurement agency would not be appropriate for this project in view of the limited procurement under International Competitive Bidding (ICB) procedures. Financial Management: Particularly given the new structures, it is important to have both sound financial management and clear accountability for both the Government and external financing. Stress has been put on this during preparation and it is reflected in agreement to employ a financial management firm.Coordinating Body vs. Managing or Implementing Agency: Experience in other contexts has shown the danger of a "so-called" coordinating body overstepping its role and attempting to undertake implementation. This results in numerous implementation problems, and turf conflict. Both the Government of The Gambia and IDA have kept this issue at the forefront of discussions on the establishment ofthe National AIDS Secretariat; it will have coordinating and administration functions, but not implement programs.Additional lessons learned from IDA financed projects in the Gambia and Bank activities elsewhere, and which guided HARRP development include: (i) where there is limited resources and HIV/AIDS prevalence is low, a focused approach is more likely to be successful; (ii) high level official--and continuing--commitment to the fight against HIV/AIDS, is essential; (iii) large scale condom promotion and marketing should result in large increases in condom use; (iv) HIV/AIDS is not a "health sector" problem alone, but requires a multi-sector effort ; (v) NGOs, CBOs and the private sector/establishments should play significant roles in HIV prevention.

9. Program of Targeted Intervention (PTI) N

10. Environment Aspects (including any public consultation)
Issues : This project will not generate any adverse environmental effects.

11. Contact Point:

Task Manager
Richard M. Seifman
The World Bank
1818 H Street, NW
Washington D.C. 20433
Telephone: (202) 458-2897
Fax: (202) 473-8216

12. For information on other project related documents contact:
The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-5454
Fax: (202) 522-1500
Web: http:// www.worldbank.org/infoshop

Note: This is information on an evolving project. Certain components may not be necessarily included in the final project.

This PID was processed by the InfoShop during the week ending October 20, 2000.