SP DISCUSSION PAPER NO. 0211

Supporting and Expanding Community-Based HIV/AIDS Prevention and Care Responses: A Report on Save the Children (US) Malawi COPE Project

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May 2002

Social Protection
LABOR MARKETS, PENSIONS, SOCIAL ASSISTANCE
THE WORLD BANK

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A Report on Save the Children (US) Malawi COPE Project

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Acknowledgement:

While this report was prepared by Susan S. Hunter, Ph.D., it relies heavily on the fine work and documentation prepared by Save the Children/Malawi's COPE Program staff and other Malawi Field Office professionals, on the excellent work of the COPE Program's many reviewers, including Jill Donahue and John Williamson, Namposya Serpell, Lloyd Feinberg, and the Horizon Project's Eka Esa Williams and her team, and on instructive comments received from World Bank reviewers in response to a first draft prepared in June 2002.

Abstract

In 1995, Save the Children/US- Malawi introduced a small pilot project called COPE-Community-based Options for Protection and Empowerment, to provide direct services to prevent and mitigate the impact of HIV/AIDS on children, families and communities in 1district. Over the past six years, the program has evolved and expanded to four districts, covering 9% of the national population. The goal of COPE is to mobilize sustainable community action utilizing existing indigenous social infrastructures and a three tier structure - District AIDS Coordinating Committees (DACCs), Community AIDS Committees (CACs) and Village AIDS Committees (VACs). The program is multisectoral and involves partnerships with government, business communities, local leaders, other NGOs/CBOs and religious organizations.

Program success includes: the ability of communities to identify the most vulnerable members and provide them with care and support; the DACC/CAC/VAC structures mobilized MK1.5 million during the 5 year period; 295 VACs formed; health centers in COPE focus communities reporting substantial drop in cases of STD infections; and a drop in school drop-out rates of orphans. Frequently cited benefits by participating communities include: community-cohesiveness, increased awareness of HIV/AIDS and its consequences, involvement, participation and empowerment to deal with orphans and PLWHAS in their midst; peace of mind for HIV+ parents in the knowledge that when they die, the community will take care of their surviving children.

Challenges for COPE include: lack of resources to go to national scale; donor support often unreliable, unrealistic and inconsistent in terms of timeframe and resource availability. Some of the lessons learned are: prevention messages can be conveyed effectively using care and support focused responses; community members who are directly affected need to be equally involved in all program processes; multisectoral approach the most effective to address multiple and interrelated impacts of HIV/AIDS; and lastly not least no single approach is appropriate for all communities, hence the need for flexibility and relevance in HIV/AIDS programming.

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LIST OF ACRONYMS

ADC	Area Development Committee
ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
CAC	Community AIDS Committee
CARE	Cooperation for Assistance and Relief Everywhere
CBCC	Community-based Child Care
CBLC	Community-Based Learning Center
CBO	Community-Based Organization
CHAPS	Community Health Partnerships
CHAM	Christian Health Association of Malawi
COPE	Community-based Options for Protection and Empowerment
DAC	District AIDS Coordinator
DACC	District AIDS Coordinating Committee
DCOF	Displaced Children and Orphans Fund
DDC	District Development Committee
DHS	Demographic and Health Survey
DDF	District Development Fund
ECM	Episcopal Conference of Malawi
HACI	Hope for African Children Initiative (Gates Foundation)
HBC	Home Based Care
LIFE	Local Income and Food Enhancement
MAHAP	Malawi HIV/AIDS Partnership
MASAF	Malawi Social Action Fund
MoGYCS	Ministry of Gender, Youth and Community Services
MoH	Ministry of Health
NAC	National AIDS Commission
NSNP	National Safety Net Program
NGO	Non-Governmental Organization
OVC	Orphans and other Vulnerable Children
PAC	Political Action Committee
PMTCT	Prevention of Mother to Child Transmission
PVO	Private Voluntary Organization
SC/US	Save the Children Federation/US
SCF/UK	Save the Children Fund/UK
SWAA	Society for Women and AIDS in Africa
TA	Traditional Authority
TFT	Training for Transformation
TSC	Technical Subcommittee
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAC	Village AIDS Committee
VCT	Voluntary Counseling and Testing
WVI	World Vision International

EXECUTIVE SUMMARY

In 1995, Save the Children/US's COPE Project (Community-Based Options for Protection and Empowerment) began in Malawi as a tiny experiment in providing direct services to mitigate the impact of HIV/AIDS on communities. Building on its own experience and that of other Malawi programs, COPE quickly evolved into a program aimed at mobilizing and harnessing community strengths and resources to deal with HIV/AIDS prevention and care. Over the past six years, with funding from USAID's Displaced Children and Orphan's Fund, the COPE model in Malawi has been carefully developed and slowly expanded to cover 9% of the national population.

Like its neighbors in Eastern and Southern Africa, Malawi is severely affected by HIV/AIDS. The growing number of orphans is one of the pandemic's most visible and troubling impacts. These children's health, development, education and social integration are already seriously compromised, and as their numbers increase, the problems will become much worse.

Malawi's National AIDS Commission launched the National HIV/AIDS Strategic Framework for 2000 to 2004 in October of 1999. Community mobilization and capacity building are a key implementation strategy, with implementation activities decentralized to the District Assembly and its District AIDS Coordinating Committee (DACC). The COPE program, which builds on government's district and local AIDS Committee structure, is an integral part of the Malawi's response to HIV/AIDS at all levels.

Through COPE, communities are assisted in developing a sustainable "package" of services for HIV/AIDS prevention, care and mitigation that addresses the needs of AIDS-affected families holistically, including those of orphans and other vulnerable children. COPE's success is due in part to its inclusion of assistance for a whole range of responses on the HIV/AIDS prevention-to-care continuum, so that villages are not forced to artificially separate prevention from care, the infected from the uninfected, adults from children, or males from females in their responses. Project evaluations show that communities with COPE training better understand the relationship of their behavior to factors causing spread of HIV, are less likely to blame their problems on external causes, and more likely to initiate internal responses to their own problems.

After developing basic capacities of leadership and organization, COPE-assisted Villages AIDS Committees initiate support for orphans and their guardians, home care services for the chronically ill, prevention programs, services for young people, and economic and food security programs through their sub-committees. In this way, villages develop a whole range of services to protect and support orphans and other vulnerable children starting before they are orphaned and continuing through their life cycle. The capacity of the village as a whole is improved through the COPE model so that AIDS-affected children and families are not isolated or stigmatized.

There are many measures of COPE's success, but the most important is that communities themselves are asking for COPE and starting their own COPE initiatives before they are approached for mobilization. COPE is demand driven because it is modeled on traditional, community-based multi-sectoral strategies developed in response to the HIV/AIDS epidemic in Malawi. Demand for COPE is growing because it strengthens community safety nets and enables the community to deal with the effects of the epidemic. It also increases demand for basic services in health and education, and links to resources that support development of safe water, sanitation, and infrastructure. Begun in rural Malawi, COPE is now being adapted to urban settings. Project data suggest that COPE is cost effective and has considerable impact on service population's health, social capacity, and economic well being.

During 2000 and 2001, SC/US trained four other PVOs in the COPE model of community mobilization, and proposed to the Malawi government and its PVO/NGO partners that a national implementing partnership be formed to replicate the COPE model on a widespread basis. The Malawi HIV/AIDS Partnership (MAHAP), endorsed by the government as the implementing arm of the National Strategic Framework, is a PVO/NGO association dedicated to achieving national coverage with high quality, effective and efficient community-based prevention, care, treatment, impact mitigation and advocacy interventions by 2005. SC/US, through its COPE/Malawi Program, will serve as coordinating partner for the MAHAP, and has also been designated as the lead partner in Malawi for the core partners funded by the Hope for African Children initiative (HACI). Major planning and systems building for both groups began in the last quarter of 2001.

COPE does not stand alone, but takes its place among a range of community-based projects initiated in the region since the late 1980's. Built on indigenous coping mechanisms developed in AIDS-affected countries since the late 1980s, the COPE model's success warrants widespread replication by Save the Children, partners and other sponsors. In 2000, Save the Children's Field Offices in Ethiopia and Mozambique began positioning themselves to replicate COPE in urban and rural settings by 2001. The Ethiopian project aims to cover 10% of the most affected population of that country within five years. Within two years, SC/US-Mozambique with Alliance partners from the UK and Norway hope to start projects that will cover the vulnerable populations of Mozambique's three high risk corridors: Gaza, Beira and Nacala.

However, when the size of COPE's service population and those of projects like it is put against the extensive need for community-based HIV/AIDS projects all across Sub-Saharan Africa, it is clear that they form only a small microcosm of effective intervention. Full-scale replication in Malawi relies on coordination and development of better interfaces among organizations with technical skills and organizations with the resources to overcome the constraints of abiding individual and institutional poverty.

Box 1: Summary of the Save the Children's COPE/Malawi Project

Founded: 1955

COPE 1: 1995-1996	1 district	Namwera Phase 1: 9 villages; Phase 2: 96 villages Limited services
COPE 2: 1997-2001	4 districts	Catchment area population 894,128, 9% of Malawi Full range of services
COPE 3: 2002-2005	6 districts	Catchment area goal: 15% of Malawi Full range of services, VCT and PMTCT

Strategic Objective: "To mobilize sustainable community action to mitigate the impact of HIV/AIDS. COPE facilitates the development of effective multi-sectoral responses, uniting government and non-governmental organization personnel, religious leaders, business persons, and concerned community members in efforts to address the needs of children and families affected by the HIV/AIDS pandemic. COPE seeks to accomplish this goal through strengthening capacities of communities, community institutions and organizations, and government offices and personnel" (Opoku and Kachiza, 2000: 9).
Mobilization Techniques: Training for Transformation, group discussions, interviews
Community-Based Service Provision by Local Groups

1. Community Leadership Development. Training enables Village AIDS Committee (VAC) members to understand the needs of their communities and respond more effectively by organizing and leading task-oriented groups within their villages;

2. Identification, Targeting and Monitoring the Vulnerable. Typically, VACs enumerate the households within their village, identify families and children most in need of assistance, and target resources and services to the most needy. They also monitor their well being, and tailor assistance to changing family needs;

3. Planning. VAC responses are planned on the basis of their orphan registrations. For example, villages with younger orphan populations are concerned about providing early childhood education and monitoring, while villagers with older children were organizing vocational training.

4. Provision of Services. VACs organize services for the vulnerable, including *agricultural development* (communal fields, agricultural inputs, extension training), *business and income generation* (micro-credit and savings, business training, assistance in marketing), *education* (early childhood development and assistance for primary and secondary schooling), *health* (home care for PLHAs, referrals for adults and children in need of care, training in growth monitoring and nutrition), and *psychosocial assistance* (integration, home visiting, cluster foster care, security and protection, counseling of guardians and children, succession planning); *prevention* (behavioral change and IEC communication, life skills, peer education, condom distribution); *activities for youth* (prevention, empowerment, and participation in decision-making and in providing services for the chronically ill and for orphans and other vulnerable children).. Where relief assistance (food, clothing, school fees) is provided, it is organized through another agency so that it does not destroy COPE's community empowerment and volunteer mobilization efforts.

5. Resource Development. VAC resource development activities are of three types: *fund raising and small grants administration* (within the community, from businesses and donors); *increased productivity* (pooled labor, vocational training, business skills), *generating demand* for basic services (health, education, agriculture) through advocacy.

Services by COPE - Assistance with initial organization; training in leadership and provision of specific services; support for development and maintenance of service structure
Benefit Distribution: Community decides what services are needed and develops criteria for targeting assistance to most needy; services depend on community resources and ability to raise funds
Obstacles in Implementation: "Doing for" instead of "doing with"; donor support for rapid replication
Replicability: COPE serving 9% of vulnerable communities in Malawi by 2001 with continued expansion planned for 2002-2005; national expansion through partnership planned in Malawi by 2005; SC/US to replicate in Ethiopia and Mozambique by SC/US and other Save Alliance partners; standardized manuals and training prepared to facilitate replication.

I. HIV/AIDS IN MALAWI: THE NATIONAL RESPONSE

A. The Development Challenge in Malawi

Malawi is ranked among the 15 poorest countries in the world and has an estimated GNP per capita of $ 210[1]. Approximately 85% of the population lives in rural areas, and 60% in absolute poverty. The population of Malawi is now estimated at 10 million, but with an annual growth rate of 2.0%[2] and a 2000 contraceptive prevalence rate of 26%[3], it is expected to double by 2015. Approximately half of the population is under 15 years of age, and over half of the population is illiterate.

Malawi's health indicators are among the worst in the world, and many have become worse over the last decade according to the 2000 DHS. With the impact of HIV, adult mortality has increased, and life expectancy at birth is now estimated at 39.5 years. Today, HIV/AIDS is the leading cause of death amongst the most productive age group of 15-49 year olds, and the DHS estimated that it increased mortality among women by 74% and men by 76% during the 1990s[4]. AIDS accounts for over 70% of all inpatient hospital admissions[5], and consumes a growing percentage of the national budget due to lost productivity and increased costs in all public and private sectors.

The under five mortality rate, however, dropped from 234 per 1000 live births in 1992 to 189 per 1000 live births in 2000 DHS[6]. The improvement, while welcome, is difficult to explain. Vaccination rates have declined from 82% to 70%, recognition and treatment of acute respiratory infections is poorer, and 49% of children under 5 are malnourished. However, use of ORS and exclusive breastfeeding has increased. During the same period, maternal mortality had risen from 620 per 100,000 live births in 1992 to 1,120 per 100,000 live births in 2000, an increase attributed in part to HIV/AIDS by the DHS.

B. HIV/AIDS in Malawi

HIV began spreading silently in Malawi during the early 1980s under the previous regime, which limited discussions on sexuality and HIV/AIDS. Today, Malawi has the eighth highest HIV prevalence rate in the world. HIV/AIDS is one of the most important development challenges facing the country. Malawi's estimated HIV prevalence rate among 15-49 year olds rose from 13.8% in 1996 to 15% in 1997 and to 16.4% in 1998. The infection rate among antenatal clinic attenders was 20% in 2001[7]. In 1998, 46% of all new HIV infections were in the 15 – 24 age group, and there is evidence that HIV infection in younger females aged 15-24 is 4 to 6 times higher than the infection rate in

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[1] ***State of the World's Children***, UNICEF, New York: 2000
[2] 1998 Population Census of Malawi
[3] 2000 Malawi Demographic and Health Survey
[4] 2000 Malawi Demographic and Health Survey
[5] Malawi's National Response to HIV/AIDS for 2000-2004, NAC 2000
[6] 2000 Malawi Demographic and Health Survey
[7] Malawi National AIDS Control Program, Sentinel Surveillance Report 2001

their male counterparts. Within a decade HIV prevalence among pregnant women attending antenatal clinics in Blantyre rose from 3% in 1986 to almost 35% in 1996[8]. In 1998, HIV rates were estimated at 26% in urban centers[9] where 20% of the population lives. Variation among rural, semi-urban and urban areas is wide in all districts, but the highest prevalence is in the southern region.

The National AIDS Commission (NAC) estimates that over 265,000 Malawians died of HIV/AIDS since the first AIDS case was diagnosed in 1985 through 1998[10], and that about 800,000 adults and children were living with HIV/AIDS at the end of 2001[11]. The NAC expects that annual AIDS cases will peak at 70,000 during the current decade[12]. It is estimated that 21.5% of children under 15 in Malawi have lost either one or both parents to all causes of death, and that at least 390,000 of them have been orphaned as a result of HIV/AIDS[13]. Orphans of AIDS and other causes are at the highest risk of malnutrition, poor access to health, lack of schooling opportunities, early marriages, neglect, sexual and physical abuse and diminished self-esteem, with resultant fading hope for their future. Most home based care patients live with their children, yet the needs of children are rarely addressed by HBC volunteers. Parents report that they most commonly worry about the future of their children and receive no support in discussing the future with their children.[14]

HIV/AIDS in Malawi is structured by gender inequality, poverty, low access to basic services such as health, water and education, stigma, and silence. In 1999, an estimated 250 Malawians became infected with HIV each day, according to the National AIDS Commission. Of these, 60% were women and girls, with infection rates much higher among younger women than men due to patterns of sexual exposure and age differentials in mating patterns. Female infection rates are increasing despite the fact that far fewer unmarried women practice multiple partner behavior, 1 in 20 women compared to 1 in 4 men. Some 18% of married men report sexual behavior outside of marriage compared to 1% of married women. While condom use outside of marriage increased slightly from the 1996 to 2000 DHS, it actually declined in married relationships. According to repeat surveys commissioned by UNICEF/Malawi, 44% of primary and 66% of secondary school youths were sexually active, and 80% of these are girls. In 1998, 46% of new HIV infections occurred in young people aged 15 - 24 years old.

These patterns are related to lack of knowledge of the causes of HIV infection and effective prevention behavior. While the 2000 DHS reports a large increase in knowledge – for example, the proportion of men who know that use of condoms prevents HIV transmission rose from 47 to 71% -- the increase in knowledge among women is much smaller. Only 55% of women queried in 2000 knew that condom use could prevent

[8] Kaluwa et al 1996, NACP, Malawi
[9] NACP, Malawi, Sentinel Surveillance Report 2001
[10] Malawi's National Response to HIV/AIDS for 2000-2004, NAC 2000
[11] World Health Organization, Epidemiological Fact Sheet, Malawi, 2000 Update
[12] Malawi National AIDS Control Program, National Strategic Framework 2000-2004
[13] Malawi National AIDS Control Program, National Strategic Framework, 2000-2004
[14] Assessment of Home Based Care Services in Malawi. March 2000, Umoyo Network

HIV transmission, up from 23% in 1996. Women also have much lower knowledge of and access to testing. Only 9% of all women interviewed by DHS had an HIV test, compared to 15% of men. While access is low for both sexes, some 70% of men and women who have not been tested say that they want to test, and two-thirds (women) to three quarters (men) know where they can be tested. The DHS did not inquire why testing had not been done, but they report that testing is associated with urban residence, sexual activity, and level of schooling.

The relative infection rates of men and women reflect overall deficiencies in women's status. According to the 2000 DHS, only 49% of women are literate, compared to 72% of men. Women have much lower exposure to all forms of mass media. The DHS reports that fully 46% of women have no access to any forms of mass media, compared to 26% of men. Women are much less likely to work for cash; most work in agriculture and receive no payment at all. Men control women's spending, even on personal items like health care. More than 65% of Malawian women interviewed for the 2000 DHS say they have no say in their own health care, large household purchases, and daily household purchases, but make these decisions jointly with someone else, usually a husband. Thirty-six percent of the women interviewed believe a husband may beat his wife for a variety of reasons, including refusal of sex. This proportion is higher in rural areas than urban, and declines with increasing education of the woman. However, 68% of all women believe that a wife has the right to refuse sex to her husband if she knows he is having sexual relations with another women or if he has a sexually transmitted infection. Some 11% of women and 8% of men reported having had some type of STI in the 12 months prior to the DHS interview.

C. Impact Mitigation: The National Response

In October of 1999, Malawi's National AIDS Commission launched the National HIV/AIDS Strategic Framework for 2000 to 2004. The product of a participatory national dialogue that included broad input into strategy development, the framework and its associated Agenda for Action and HIV/AIDS Implementation Plan "realistically address the country's HIV/AIDS epidemic, giving attention to the social, economic, cultural, political, and biomedical factors that influence the epidemic's course and its impacts."[15]

The Framework is categorized into nine priority program areas, within which community mobilization and capacity building are a key implementation strategy. According to the National Strategic Framework, implementation activities are to be decentralized to the District Assembly, which will develop HIV/AIDS prevention, care and impact mitigation plans through the District AIDS Coordinating Committee (DACC). DACC plans are included in District Development Plans. Coordinating bodies can also conduct policy review, coordinate service delivery, integrate their findings and activities into local development plans, monitor and evaluate program implementation, review program quality, and provide training. The NGO community is a full partner with government in

[15] Williamson and Donahue, 2001: 3

strategy development as well as in the provision of social services (including health, education, social work) and community development activities.

This approach continues Malawi's commitment to decentralized HIV/AIDS planning and action through district authorities begun in 1994. In 1994, the National AIDS Control Program, recognizing the need to mobilize a collaborative response to HIV/AIDS by all segments of society, developed the concept of a national network of AIDS committees. Support was provided by UNICEF so that DACCs could organize a Community AIDS Committee (CAC) for each of its health catchment areas. In turn, each CAC was to mobilize a Village AIDS Committee (VAC) in every village in its jurisdiction. Committees at district and community levels included representation from government ministries, nongovernmental organization (NGOs), religious bodies, and the private sector. At each level, every committee was to have four technical subcommittees (high-risk groups, home-based care, orphans, and youth). However, resources were provided for only a limited time, and the mobilization process in many districts did not progress much below the district level.

Most District AIDS Coordinating Committees were formed before 1997, but "since 1997 DACC as a structure in most districts has become weak while sub-committees like District Orphan Technical Sub-Committees (DOTSC) and District Youth Technical Sub-committees (DYTSC) have become more active and organized"[16]. Where DACCs had tried to include community groups and NGOs, membership was large, but the majority of members of most DACCs were from government departments. NGOs were represented in 20 districts, CBOs in 15 districts, and religious organizations in 21 districts.[17] In Thyolo, Mchinji and Mzuzu Urban Districts, the District Orphan Care Committee (DOCC) did not report to the DACC, but directly to the District Development Committee. DACCs without financial support from the government, UNICEF, or an NGO lacked training and had poor leadership. Only half of the DACCs had received some training in HIV/AIDS, orphan care guidelines, functions, formation of CACs, leadership, resource mobilization, training and partnership development. UNICEF funded almost 83% of DACC training, and Save the Children 14.3% through COPE.[18]

The existence and strength of CACs depends on active DACCs, and the existence of a health center to act as a focal point for activity. In some cases, DACCs and CACs were thought to be unnecessary because already existing Primary Health Care Committees or home care and orphan support groups under religious organizations and NGOs were sufficient.[19] In these cases, the catchment area of CACs was originally supposed to be the health center catchment area, but committees sponsored outside of the DACC/CAC/VAC structure covered other areas. Weak CACs lacked supervision and motivation, resources, strong leadership, and financial management skills[20].

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[16] Banda, 1999: 9
[17] Banda, 1999: 10
[18] Banda, 1999: 11
[19] Banda, 1999: 11
[20] Banda, 1999: 12

Table 1. DACC/CAC/VAC Responsibilities

Level	Responsibility
District AIDS Coordinating Committee - DAC	• Coordinate all HIV/AIDS activities in the district • Conduct assessment and map activities, service providers, and resources in the district • Monitor and evaluate all HIV/AIDS activities in the district through the technical sub-committees (TSCs: prevention, youth, home care, orphans) • Supervise the TSCs in training CAC TSCs to train the VACs to implement village activities • Link the DACC TSCs and CACs to funding sources and material donations
Community AIDS Committee - CAC	• Define the geographic service area • Coordinate all HIV/AIDS activities in that area • Conduct assessment and map activities, service providers, and resources in the community • Monitor and evaluate all HIV/AIDS activities in that area through the TSCs • Link the CAC TSCs and VACs to funding sources and material donations, either through the DACC or independently • Report the needs and concerns of the VACs to the DACC • Implement community-based activities that benefit the whole service area
Village AIDS Committee - VAC	• Define the village and geographic service area of the VAC • Implement and monitor activities in that area • Conduct assessment and map activities, service providers, and resources in the village • Identify problems and report them to the CAC • Conduct community-based fund-raising activities

Source: The COPE Model, SC/US Malawi Field Office, 2001

D. Policy for Children

Malawi was the first country in the region to create a National Orphans Task Force (NOTF). The body was established in 1991 within the Ministry of Gender, Youth and Community Services (MoGYCS), and includes national and district government representatives from the MoGYCS, the Ministry of Health (MoH) through the NAC, key NGOs and CBOs, major religious bodies in Malawi, and representatives of key UN agencies. Members of the National Task Force, in consultation with advisors from the Ugandan government and NGOs, developed "Policy Guidelines for the Care of Orphans in Malawi and Coordination of Assistance for Orphans" in 1992. At that time, the legal sub-committee of the National Orphan Task Force was chaired by COPE. Malawi was a pioneer in this regard; few if any other countries have specific orphan program and coordination guidelines. Simple and brief, the guidelines are used by the government to advise groups interested in developing orphan care programs. These guidelines have

been updated and revised over the years, and in 1998 were developed into Malawi's draft National Orphan Care policy and due to be adopted in 2002.

SC/US is still a member of NOTF, which coordinates programs for orphans and other vulnerable children implemented by the DACCs, CACs, and VACs, and organizes multisectoral planning that includes NGOs and religious groups. While Malawi's national orphan care system is officially the responsibility of the MoGYCS, district and local committees are coordinated by the NAC. The District Social Welfare Officers are members of the Orphan Technical Sub-committee. The MoGYCS, through the NOTF, is also responsible for administration and review of Acts of Parliament designed to protect the welfare of children, including the Adoption Act, the Children and Young Persons Act, the Affiliation Act, the Maintenance of Married Women Act, and the Wills and Inheritance Act. In addition, it monitors foster care and adoption services, residential institutions for children, and administration of short term assistance and relief. The District Social Welfare Officers have legal jurisdiction over any NGO providing services to children, and also supervise institutional care, foster placement and adoption, tracing relatives and placement of abandoned children, and children who have problems with the law.

Malawi's National Orphan Care Guidelines

1. **Community based approaches** to orphan care are primary. The government will coordinate service providers to support and enable communities
2. **Formal foster care** will be expanded as the second source of care.
3. **Institutional care is the last resort**, although temporary care may be needed for children awaiting placement.
4. **Hospitals should record next of kin** so relatives can be traced if children are abandoned.
5. **Birth and death registration should be revitalized** to monitor orphans
6. **Government will protect the property rights of orphans**, and these should be widely publicized.
7. **Self help groups should be developed** to assist families with counseling and other needs.
8. **NGOs are encouraged to set up systems of community based care** in consultation with the government.
9. **The needs of all orphans should be included regardless of cause of death, religion or gender.**
10. **The National Task Force will continuously plan**, monitor and revise programmes and policies
11. **Government will solicit donor support** for resources for capacity building.
12. The **Ministry of Women, Youth and Community Services is the lead government body** on these issues.

In 2001, Malawi's first national study of Child Violence was coordinated by COPE as a leading member of the Children and Violence Task Force, and the formation of the Wills and Inheritance Core Group was initiated by SC/US study findings on wills and inheritance in Malawi. The government has taken over responsibility of advocating for the rights of children and widowers and is now considering revamping the entire act as opposed to making amendments. In 2002, a Gender Law Review was initiated to review and coordinate national law affecting women's rights and make recommendations on their improvement.

II. DESCRIPTION OF THE COPE PROGRAM IN MALAWI

A. Changes in COPE's Implementation Strategies

COPE's objectives and implementation strategies have changed significantly in response to frequent evaluations and self-assessments focused on operational and implementation issues.[21] Frequent evaluation has contributed to the programs' implementation success because program development has been deliberately iterative, continuously building on prior learning.

In the 1995 Phase 1 pilot, staff attempted direct implementation of activities "to improve the immediate conditions and long-term prospects for the care and healthy development of children affected by AIDS in three areas of Mangochi District, promoting sound policy development alongside implementation of viable program interventions that can be adopted at the national level."[22] Staff designed and implemented a range of interventions to mitigate the economic, psychosocial, education, and health impacts of the HIV/AID epidemic on a pilot basis in 9 semi-urban villages in Mangochi Boma. Critical evaluation after nine months suggested that direct implementation by staff was not cost effective, and that sustainable activities aimed at the economic, health and psychosocial effects of HIV/AIDS depended on full community participation.

In the second phase of COPE 1, the project reinvented itself as an outside change agent assisting with community mobilization, capacity building, and empowerment. Implementation was integrated into the government's established AIDS committee structure. The initial objective of the project, "to mobilize and strengthen community action to address the needs of children and families affected by HIV/AIDS", was expanded to include improving the cost effectiveness of activities, enhancing their sustainability, and increasing their scale.

From their experience in COPE 1, Phase 1, Save the Children recognized that the national DACC/CAC/VAC structure could "serve as an effective vehicle through which a community can galvanize collection action and marshal resources".[23] Starting with Phase 2 of COPE 1 and throughout COPE 2 and the most recent project transition phase, this system has been key to developing, replicating, and maintaining a district-administered system of community-based care. "Active participation and leadership by government employees from all levels, and particularly from field level, is a crucial element of the program's sustainability strategy".[24] In its transition phase, COPE 2's community mobilization strategies still rely on existing structures, but in urban areas, mechanisms for collaboration with NGOs, religious groups and the business community independent of the DACC/CAC/VAC structure are being more fully explored. The project is now able to more fully articulate its strategic objective and approach to implementation:

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[21] Chilongozi, 1999; Donahue and Williamson, 1996, 1998, 1999; Feinberg, Serpell, and Williamson, 1999, Williams et al., 2000; Williamson and Donahue, 2001

[22] Williams et al., 2000: 2

[23] Opoku and Kachiza, 2000: 9

[24] Opoku and Kachiza, 2000: 10

The strategic objective of COPE is to mobilize sustainable community action to mitigate the impact of HIV/AIDS. COPE facilitates the development of effective multi-sectoral responses, uniting government and non-governmental organization personnel, religious leaders, business persons, and concerned community members in efforts to address the needs of children and families affected by the HIV/AIDS pandemic. COPE seeks to accomplish this goal through strengthening capacities of communities, community institutions and organizations, and government offices and personnel.[25]

Table 2: Changes in the COPE Program in Malawi

COPE I, Phase 1 1995	**COPE I, Phase 2 1995-1996**	**COPE 2 1997-2000**	**Transition Jan-Dec 2001**	**COPE/Malawi 2002-2005**
SC/US changing focus from refugees to HIV/AIDS, has little experience with community mobilization	Project evaluation indicates that implementation approach is too expensive, slow and not sustainable	SC/US has much more mobilization experience with HIV/AIDS programs in Malawi communities	Partners seeking SC/US expertise and training in COPE model; national NGO implementing partnership established	SC/US coordinating national NGO implementing partnership with HACI partners as the core
Phase 1 pilot implemented directly by staff after they conduct a needs assessment in target communities	Phase 2 Project implemented through government AIDS Committee structure; SC/US focuses on mobilizing and strengthening the committees' own ability to implement programs; With expanded capacity building at DACC/CAC/VAC levels, assumption of greater responsibility is possible;	SC/US mobilizes DACC and trains it to mobilize and train CACs to mobilize VACs Training for Transformation adopted Specific training for TSCs developed (home care, OVC, youth, resource development) MIS developed	Intensified interventions, standardized training documents and training programs; provision of drugs and supplies in home care program; MIS being refined and expanded to include impact indicators; service population and beneficiary group estimates	Community mobilization program using COPE model augmented by partner best practices; common MIS expanded to collect more baseline impact and process data; costing mechanisms instituted
COPE 1 Phase 1 phase down was abrupt; with no community participation	DACCs/CACs/VACs are not phased down, but trained to carry out expanded activities in COPE 2	Phase down period extended to ensure community readiness	The need to build and maintain the AIDS committee structure within the national HIV/AIDS prevention, care and impact mitigation system is critical	While inputs into established communities can be reduced as their capacity is increased, quality assurance and skills updates will be needed

[25] Opoku and Kachiza, 2000: 9

During 2000 and 2001, SC/US trained four other PVOs in the COPE model of community mobilization. In response to the growing demand, SC/US proposed to the government and its PVO/NGO partners that a national implementing partnership be formed to replicate the COPE model on a widespread basis. The Malawi HIV/AIDS Partnership (MAHAP) was initiated in September 2001 as an association of PVOs and NGOs dedicated to the goal of achieving national coverage with high quality, effective and efficient community-based prevention, care, treatment, impact mitigation and advocacy interventions in Malawi by 2005. To date, 15 PVOs and NGOs have signed the MAHAP Terms of Reference. SC/US, through its COPE/Malawi Program, will serve as coordinating partner for the MAHAP, and has also been designated as the lead partner in Malawi for the core partners funded by the Hope for African Children initiative (HACI). Major planning and systems building for both groups began in the last quarter of 2001.

B. COPE Mobilization Techniques

COPE has developed a community mobilization manual and technical subcommittee trainers' guides for each constituent technical subcommittee (TSCs include orphans, youth, home-based care, community resource mobilization, and prevention). These are used by DACCS to train their own subcommittees and to assist CACs in training CAC subcommittees. CAC members support, in turn, the training of VAC sub-committee members. Training curricula, materials and approaches are regularly updated to reflect changes in national policy and are adapted to variations in Malawi's communities, the basic content of training materials and curricula are standardized among districts. Training programs are developed in collaboration with DACCs, CACs, and VACs, and with the relevant line Ministries (e.g., MoH and NAC for home care, MoGYCS for orphan care), and are pilot tested and revised before they are adopted.

In every district, COPE works within the DACC/CAC/VAC system to mobilize community based responses and include traditional and political leadership at all levels. To mobilize communities, COPE/Malawi staff first builds rapport at district level and helps to activate or reactivate the DACC. Together, DACC and the COPE staff then build rapport at community level, facilitate workshops to form and orient CACs, which they assist to form and orient VACs. An early COPE survey showed that people were willing to participate not only because they had a sense of moral obligation and reciprocal altruism, but also because the scope of the AIDS crisis was unprecedented and immediate. While they hoped for outside assistance, the problems they faced as members of AIDS-affected communities were so immediate that they recognized that they had to act whether or not they received external assistance.[26]

To build commitment, COPE's staff present data and materials about the impact of HIV/AIDS and utilize participatory methods of discussion and assessment to encourage realization of the impact of HIV/AIDS at each level. The COPE mobilization manual contains specific suggestions and exercises aimed at building committee expertise and confidence, specific instructions for assessment and mapping exercises, and sample

[26] Williams et al, 2000

action plans to stimulate committee planning. The manual also helps staff and committee members build their skills in communications and public relations, mobilization and sensitization, community entry and diagnosis, advocacy and negotiation, networking, leadership and supervision, and in economic opportunities development.

COPE's guiding principles of community mobilization state that:[27]

1. Sustainability of social change is more likely if the individuals and communities most affected own the process and content of communication;
2. Communication for social change should be empowering, horizontal (versus top-down), gives a voice to previously unheard members of the community and is biased towards local content and ownership;
3. Communities should be the agents of their own change.
4. Emphasis should shift from persuasion and the transmission of information from the outside technical experts, to support for dialogue, debate and negotiation on issues that resonate with members of the community.

COPE staff and community volunteers learn that mobilization is "a systematic and gradual development approach, which respects peoples' cultural values and norms, initiated either by the community itself and/or external agents with the purpose of identifying HIV/AIDS prevention, care and mitigation problems and possible ways to address them through establishment and /or strengthening of existing community-based and managed social structures."[28] Community mobilization involves a commitment of at least two years and includes[29]:

1. Developing an ongoing dialogue between community members regarding HIV/AIDS issues;
2. Creating or strengthening community organizations aimed at improving the situation of HIV/AIDS;
3. Assisting in creating an environment in which individuals can empower themselves to address their own and community's health need;
4. Promoting community members' participation in ways that recognize diversity and equity, particularly of those who are most affected by HIV/AIDS;
5. Working in partnership with community members in all phases of the project to create locally appropriate responses to HIV/AIDS issues;
6. Identifying and supporting the creative potential of the communities, to develop a variety of strategies and approaches to improve the HIV/AIDS situation;
7. Committing enough time to work with communities, or with partners who work with them, to accomplish full empowerment.

When COPE begins work with a community, it facilitates a three-day 'Tigwirizane' (Training For Transformation) workshop at the community level with newly formed CACs and VACs to:

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[27] COPE Program Mobilization Manual, 2001
[28] COPE Program Mobilization Manual, 2001
[29] COPE Program Mobilization Manual, 2001

1. To raise awareness of HIV/AIDS and its impact;
2. To stimulate community action toward taking ownership of HIV/AIDS-related problems;
3. To encourage the development of multi-sectoral programs at community and village levels to alleviate their impact.

The TFT workshop is one step in the community mobilization process and plays a vital role in setting the stage for community transformation. It has proven so valuable that every committee will receive refresher training in 2002. Other community mobilization tools used in COPE mobilization include participatory rapid assessment; participatory rural appraisal, Stepping Stones, participatory learning and action, focus group discussions, a capacity building inventory, and transect walks.

A 1999 COPE II evaluation found that "systematic resource mapping and problem definition is not transparent in the CACs and VACs and was often limited to HIV/AIDS".[30] COPE community training now incorporates resource mapping and problem identification exercises that help the community identify their problems and gain a sense of their prevalence; complete a resource inventory; register the chronically ill, orphans, and other vulnerable children; and conduct a needs assessment of these target groups and HIV/AIDS-affected households.

As committee members at each level gain experience, staff assistance on basic activities is reduced and focused on introduction of new services. The function of each TSCs is explained and community members with appropriate skills and experience are urged to form the core of the TSC and share their expertise with other volunteers. TSC members recruit additional members until they have a sufficient number of share tasks easily (about 20 to 30). After elections are held for officer positions, their 5 to 7-day technical orientation and training begins. COPE mobilizers find that the hardest TSC to form initially is prevention, but once the importance of its activities is explained, it is possible to recruit members. Youth TSCs often include many prevention activities in their work, especially AIDS dramas and condom distribution.

C. The DACC/CAC/VAC Structure

District AIDS Coordinating Committees (DACCs). District AIDS Coordinating Committees DACCs play a critical role in the COPE Malawi program (Table 3). They plan and monitor geographic coverage, develop the community mobilization skills of CAC members, assist them to mobilize VACs, and support them in their work. They train CAC subcommittees and help them train VAC subcommittees. They compile VAC and CAC MIS data on a quarterly basis. Following initial DACC mobilization and training, COPE's District office staff continue to facilitate the work of DACC members and often accompany DACC members on visits to CACs and VACs..

[30] Feinberg et al., 1999: 6.

Table 3: DACC/CAC/VAC Composition and Roles

District Level Authorities	Community Level Authorities	Village Level Authorities
District Commissioner District Assembly District Development Committee (DDC) **District AIDS Coordinating Committee includes the** District AIDS Coordinator District Health Officer District Social Welfare Officer District Youth Officer It may include other District Officers (community development, education, agriculture) It also includes religious leaders, NGO and CBO leaders, and business people	Traditional Authority Members of Parliament and other political leaders Group village headmen, village chiefs, elders and clan heads Area Development Committee (TA, village headmen, government extension workers) **Community AIDS Committee may includes any of the above authorities and the** Health Center officer in Charge Government officers and extension workers Religious leaders Teachers and headmasters Private/mission hospital managers CBOs Members of local business community (shop owners, estate owners)	Village Chief Chief Counselors Village clan heads Chief's spouse Village AIDS Committee may include any of the above authorities and the Health Surveillance Assistant Traditional healers and birth attendants Government officers and extension workers Religious leaders Teachers and headmasters Children and adults affected by HIV/AIDS
Mobilization process followed by COPE staff		
COPE staff helps District AIDS Coordinator (DAC) Build leadership support Establish/revitalize DACC Conduct District Assessment COPE staff assists DACC to: Develop its membership, structure and sub-committees Map the district Prioritize needs and develop action plan Train subcommittees, CACs and VACs Implement programs Monitor and evaluate Revise action plan	COPE staff supports DACC to Build CAC leadership support Establish/revitalize CACs Conduct Community Assessment DACC assists CAC to: Develop its membership, structure and sub-committees Map the community Prioritize needs and develop action plan Train subcommittees and VACs Implement programs Monitor and evaluate Revising action plan	COPE staff supports CAC to Build leadership support Establish/revitalize VACs Conduct Village Assessment COPE staff assists CAC to: Develop its membership, structure and sub-committees Map the village Prioritize needs and develop action plan Train subcommittees Implement programs Monitor and evaluate Revising action plan

Source: COPE Community Mobilization Handbook, Book Two, Draft April 2001

DACCs have a pivotal role in the new national HIV/AIDS prevention and care program, which is decentralized to the district level. They report to the District Assembly, and are charged with stimulating and coordinating implementation of HIV/AIDS programs in their districts, in collaboration with NGOs and CBOs. They have the responsibility to raise funds and allocate resources according to their plan's established priorities, and report on their implementation progress to their District Development Committees (DDCs).

COPE supports the DACCs in its districts of operation through capacity building at the district, community and village levels and with organizational and technical assistance. In COPE districts, DACC representatives are active, well informed, and distinguished community volunteers committed to HIV/AIDS prevention and care. They recognize the contributions of COPE to the success of district programs, and have good relationships with COPE staff, who were very respectful of their needs and time. [31].

Community AIDS Committees. CAC members are well informed, articulate, well organized and stalwart considering their span of control, which is the largest in the system.[32] DACCs, for example, have at most 6 to 8 CACs reporting to them, while CACs range in size from 50 to 298 villages. VAC responsibility also varies according to village size, but not as much as CACs. The disproportionate responsibility of the CACs arises from the definition of a CAC catchment area either as a Traditional Authority (TA) or as the catchment area of a health center, which is a subset of a TA. CAC areas have mutually exclusive boundaries, and are planned by DACCs to cover the entire district.

COPE staff assists the DACC to train CAC members in a systematic process of village mobilization that includes sensitization, discussion and TFT. It also encourages exchange visits among CACs and their subcommittees to get new ideas on prevention strategies, care programs and mobilization strategies. Experienced CACs are generating new ideas about mobilization, including use of the Community Health Surveillance Assistants, women's groups and other CBOs. CACs in several districts have indicated that if their access to transportation was improved (i.e., if they had bicycles), they could reach more villages faster and more frequently to monitor activities.[33]

VACs say CAC members should come from different background (government, private sector, different religions and affiliations), have good leadership skills, be transparent in their business affairs, respect divergent views, have experience in charity and volunteer work; represent their communities well, and be familiar with HVI/AIDS issues and motivated to deal with them.[34]

Village AIDS Committees. The most successful VACs involve the entire communities in their activities, are transparent in their activities and use of resources, and

[31] Hunter, 2001
[32] Hunter, 2001
[33] Hunter 2001.
[34] Williams et al., 2000

have a palpable feeling of excitement about their work.[35] The least successful were newer, insecure in their mobilization strategies and conflict resolution skills, and not yet fully accepted by their communities. Other factors in addition to experience account for difference in effectiveness of the VACs, including whether the VAC has yet received Training for Transformation (TfT). The importance of TfT in helping volunteers develop basic skills and lay a solid foundation for their work cannot be exaggerated.[36] Some variation in VAC effectiveness arose from the strength of local leadership and its backing for VAC projects. On the whole, village committees are extremely active and their efforts were bearing fruit, even in those villages where VACs were new and struggling. There was a real sense of accomplishment at all levels when village committees achieve their goals, and local celebrations of these achievements are held to reinforce motivation of the volunteers.[37]

For a VAC to succeed, it must have the support of its headmen or group headmen (attending meetings, designating land and resources for VAC projects, assisting with problem resolution), promote participation of everyone in the community, ensure that their members participate in planned activities, and take decisive action.[38] The decision-making processes and criteria used to allocate donated resources must be transparent and inclusive: "community groups that are able to mobilize the entire community's involvement in carrying out activities become the most dynamic and are able to sustain motivation over the long run. A group that assumes responsibility for addressing problems on behalf of its community is likely to burn itself out."[39]

COPE staff work with CAC and DAC members to develop conscious strategies for entry into the community with respect for the intrinsically gradual nature of development processes. Where their initial approaches were not successful, they were able to analyze the reasons for their difficulties and create fresh ways of making contact. As an example, Muslim Yao communities in Nkota-kota rebuffed their approaches until staff realized that these communities were different from Yao in Mangochi and could be approached only through the imam.[40]

AIDS committees at all levels were diverse in membership and skill base, representing the variation in their constituent communities. In 2000, an SC/US gender assessment of programming in Mangochi District found that more men than women participated on VACs, but that women occupied only 30% of the executive positions but did most of the actual work. Data is now being collected on the gender composition of committees, subcommittees, and beneficiaries (OVCs and the chronically ill, including PLHAs) as the first stage in developing a strategy to build gender equity within the context of national replication. The Malawi branch of the

[35] Williams et al., 2000; Hunter, 2001
[36] Williams, et al., 2000; Hunter 2001
[37] Hunter, 2001
[38] Williams et al., 2000: 8
[39] Donahue and Williamson, 1999: 2
[40] Hunter, 2001

Society for Women and AIDS (SWAA) will be collaborating in strategy development.

D. Community-Based Service Provision

HIV/AIDS has multiple, interrelated negative impacts on households and communities. In order to effectively combat spread of the disease and improve coping responses, community-based programs must provide an array of services that match these impacts. In Malawi, COPE Village AIDS Committees have multisectoral representation, receive training in a broad array of prevention, care and impact mitigation programs, and can therefore provide a broad range of services to their communities:

1. **Community Leadership Development**. Training enables VAC members to understand the needs of their communities and respond more effectively by organizing and leading task-oriented groups within their villages;
2. **Identification, Targeting and Monitoring the Vulnerable**. Typically, VACs enumerate the households within their village, identify families and children most in need of assistance, and target resources and services to the most needy. They also monitor their well being, and tailor assistance to changing family needs;
3. **Planning**. VAC responses are planned on the basis of their registrations of OVCs and the chronically ill. For example, villages with younger OVC populations are concerned about providing early childhood education and child protection, while villages with older children were organizing vocational training and support for secondary school fees.
4. **Provision of Services**. VACs organize services for OVCs and other vulnerable community members, including *agricultural development* (communal fields, agricultural inputs, extension training), *business and income generation* (micro-finance, credit and savings, marketing, business management training), *education* (early childhood development and assistance for primary and secondary schooling), *health* (home care for the chronically including PLHAs, referrals for children and adults in need of care, training in growth monitoring and nutrition), *psychosocial assistance* (integration of children, home visiting, assistance with household chores, cluster foster care, child security and protection, counseling of guardians and children, succession planning); *prevention* (behavioral change and IEC communication, life skills, peer education, condom distribution); *activities for youth* (prevention, empowerment, and participation in decision-making and in providing services for the chronically ill and for orphans and other vulnerable children). Where *relief assistance* (food, clothing, school fees) is provided, it is organized through another agency so that it does not destroy COPE's community empowerment and volunteer mobilization system;
5. **Resource Development**. VAC resource development activities are of three types: *fund raising and small grants administration* (within the community, from businesses and donors); *increased productivity* (pooled labor, vocational

training, business skills), and *generating demand for basic services* (health, education, agriculture) through advocacy.

In its most recent phase, COPE is strengthening its programming and training as follows:

Child protection. COPE trains VAC orphan committee members to identify, monitor and protect vulnerable children and families using standard approaches. Committees are taught to integrate the registration process with service provision to protect the privacy and dignity of beneficiaries and avoid stigmatization. Care for OVCs is now being extended to children before they are orphaned through home based care committees because this improves outcomes for orphans when parents die. It is improving psychosocial care (counseling and succession planning using memory books), initiating systems to protect children against violence and abuse, sensitizing teachers about children's problems, and promoting community-based child care (CBCCs) to provide early childhood education, socialization and protection, and nutrition supplementation. Nine communities have initiated CBCCs, several with no prompting from the CAC or DACC, although material assistance and training is provided afterwards. Several communities with CBCCs in temporary shelters are making bricks to construct more permanent structures in anticipation of MASAF assistance for cement and metal roofing.[41] Care for street children, not a feature of COPE's mobilization in largely rural districts, is now being included in Lilongwe's strategic planning.

Home Care for the Chronically Ill and PLHAs. COPE is increasing training for home care givers and improving its quality with the aim of increasing the frequency and quality of care. It is piloting home based care kits, improving links with TB control and strengthening referral systems. In 2000, an assessment of all home care programs in Malawi found that patients needed material assistance (food, drugs, bedding, soap), and help with household chores; that all HBC providers were poorly trained and supervised; that referrals were low; and that there was little coordination with national treatment and prevention programs in TB and HIV. Acceptance of home based care volunteers by the community was low and volunteer enthusiasm was flagging because while volunteers were trained, their lack of even the simplest supplies limited their ability to assist. Although groups were raising money for supplies on their own, the cost of drugs and other materials was well beyond their grasp.

After the national training curriculum was revised by the MoH and piloted in four districts, COPE volunteers were retrained. A system of direct supervision and support of volunteers was instituted because the MoH had insufficient staff to supervise the care givers properly. In 2001, COPE began a pilot test home based care kits containing pain killers, vitamins, Fansidar and other simple medications and ointments, soap and disinfectants, ORS, lotions, bandages, gloves, and condoms. Volunteers in COPE VACs with chronically ill patients (about half) were trained using standard guidelines for drug administration and maintain drug registers/inventories in addition to their records on patient visits. The ability of the care givers to provide concrete assistance not only improved their outcomes but also increased their acceptance by villagers.

[41] Hunter 2001; Williamson and Donahue, 2001

In response to a review of the pilot in 2002, ways of making the kits sustainable are being tested, including turning them into revolving drug funds. Some villages had already instituted payment because the general lack of drugs made for any type of illness made it impossible for them to refuse help to villagers with non-chronic illnesses. Volunteers have received additional training in referrals to improve recognition of medical complications. Referrals from hospitals to home care committees has also improved as the quality of care has improved.[42]

Prevention. COPE is collaborating with the government to train peer educators in the youth groups to provide more effective prevention messages, an approach that will be replicated in other districts by the government. COPE is training facilitators within the communities to conduct HIV/AIDS prevention discussion groups, including prevention of infection for home based care providers. It is improving condom access, promoting voluntary counseling and testing, and increasing links with traditional healers and counselors.

Economic and Food Security. COPE is widening the access of communities to the private sector and to lending institutions. It has developed a small grants program, and is expanding community apprenticeships and vocational skills training. COPE II is linking with agricultural projects to improve agricultural inputs and short term food supplementation for home based care patients. It is also collaborating with relief agencies for distribution of food but all relief assistance is organized through collaborating agencies so that it does not destroy COPE's community empowerment and volunteer mobilization system

Microfinance and Credit. Because COPE had dropped its microfinance component in 1995, a review team recommended that COPE explore closer operational links with microfinance programs, like the Foundation for International Community Assistance (FINCA).[43] In March 1999, COPE's Economic Opportunity Officers were trained in community resource mobilization. At that time, community- and village-level AIDS committees had experienced initial success in mobilizing their internal resources. COPE staff members had been able to create links between communities and agricultural extension help or inputs that greatly enhanced community group fundraising for more vulnerable members of their village. Yet, committees seemed to be reaching the limits of those resources. They needed assistance to identify and mobilize additional resources that remained untapped within their community and to gain access to new external sources of assistance. Although COPE met with FINCA, no partnership has yet been achieved.[44]

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[42] Hunter, 2001
[43] Williamson and Donahue, 2001; Donahue, 1999.
[44] Williamson and Donahue, 2001

E. COPE Staff

The program's staffing has changed over the life of the project, but has stabilized over the past few years as follows:

Central Office Staff. COPE's central office staff currently include a Project Officer, responsible for all aspects of program management, an Assistant Project Officer, responsible for coordinating activities of the District Offices, a Monitoring and Evaluation Officer (since 2001), responsible for maintenance of the MIS system, and a Home Based Care Officer (since 2001). Project accounting is the role of SC/US's program accountants, and other administrative services are also provide by SC/US staff. While the central COPE staff is small, it receives considerable support from SC/US regional and global advisors to meet the technical and developmental needs of the program.

District Staff. COPE has a District Officer and an Economic Opportunity Officer (since 2000) in each district of operation, who are assisted by a secretary. In all of the districts, these staff members are very articulate, highly qualified, maintain very good relationships with local volunteers and government representatives, and are well informed about HIV/AIDS. COPE district staff are highly committed to meaningful community development. Many had worked in other development organizations, and were very proud of and stimulated by the success of COPE compared to other approaches. They also possessed a sense of humility and humor about their endeavors. Their reports of regular meetings with DACCs, CACs, and VACs were supported by the nature of their interaction with those groups, which is friendly and familiar.[45]

All COPE staff members work very long and flexible hours, especially in Lilongwe where community volunteers organize many of their events on the weekends and after normal working hours. None of them seemed to mind the demands on their time, and were fresh and composed about their work. It seems, however, that the heavy demands on staff time require that the district economic opportunity officers work on the whole range of development and training tasks. This suggests that staff might be more effective and better utilized by the addition of a competent associate district officer for general development work, freeing economic opportunities officers for specific tasks in their area of expertise.[46]

F. Monitoring and Evaluation

Since 2000, the COPE program has placed more emphasis on the development of a management information system (MIS) that produces data to monitor two aspects of the program:

1. Development of the DACC/CAC/VACC system's capacity (formation of committees and subcommittees, provision of training), and

[45] Hunter, 2001
[46] Hunter 2001

2. Program outputs (provision of services by village committees, resource development).

Monitoring and evaluation is fully participatory. VACs gather data on their vulnerable populations and beneficiaries, and maintain records on their services and activities. This data is collected and reviewed with them monthly by CACs, who consolidate it at the community level. DACCs consolidate CAC data on a quarterly basis. All groups are trained in data collection methods and also to use the data in monitoring and planning. The program's monitoring system also captures some additional information on the program's success (spontaneous development of CACs and VACs, requests for training from other NGOs).

Until 2000, most of COPE's reviewers criticized the program's poor monitoring and evaluation system, and advocated for the importance of "documenting the potential contributions of the COPE program to the improvement of quality of life of participating communities, especially children, is critical."[47] However, it was not until the beginning of 2001 that COPE began to develop data on its impact on children and families with a "baseline" survey of the four districts where COPE has been operating.

In addition, development of information on the project's costs and benefits has not been systematic. The project appears to be delivering very high benefits at an extremely low cost, but this subject needs more creative evaluation techniques that look at the outcomes using cost benefit, cost effectiveness, or return on investment models. A retrospective evaluation of these aspects of the program, initiated in the beginning of 2002, will serve as the basis for regular tracking system in the future.

G. Integration and Sustainability

Because they are community-based, most COPE II services and functions are already integrated into local structures through the DACC/CACC/VAC structure, and are an integral part of national, district and local services delivery. COPE structures also include representatives of other government sectors such as agriculture and education, and services and training are often provided in collaboration with local government officers. Progress toward integration is greater in areas where the COPE program has been implemented for a longer period of time.

Current and prospective MAHAP partners are also integrating COPE services into national structures. Community Health Partnership (CHAPS) providers all implement their programs in collaboration with District Health Officers and other local partners. The Christian Health Association of Malawi (CHAM) provides an estimated 47% of health services in Malawi through its hospitals, health centers, and clinics, and collaborates with District, community and village committees in its HIV/AIDS programs. Umoyo NGO Network's local, national, and international partners collaborate with local public and private organizations to integrate services into local delivery systems. These efforts will intensify through introduction of COPE over a wider geographic area, and at

[47] Feinberg et al., 1999: 6

the same time, distribution of services will improve as they are realized through community-based mechanisms. Under Malawi's new Strategic Framework for HIV/AIDS, the NAC started to provide financial support for DACC activities in 2001, including mobilization of CACs and VACs, an activity which UNICEF also supports. The Malawi government and selected NGOs pay the salary of public sector DACC members.

A focused strategy for sustainability and integration of MAHAP services will be developed by partners in 2002, including benchmark activities and indicators. Through MAHAP, progress toward widespread sustainability and integration will be monitored. Partners must develop and implement mechanisms for program maintenance after the project is completed. As Malawi's government proceeds with decentralization, COPE/Malawi will advocate, through the Ministry of Local Government, for increased resources to the DACCs.

COPE's community-based approaches have important implications for sustainability:

1. **Services can be provided flexibly and responsively**. Community-based HIV/AIDS projects can address the needs of PLHAs and orphans and other vulnerable children simultaneously and vary the activities for each population according to local size and vulnerability. This improves effectiveness and creates significant economies, although it makes it harder to estimate cost effectiveness;
2. **Services are fairly targeted**. Most VACs target services and benefits efficiently, transparently and fairly according to the availability of resources, without enormously complicated bureaucratic review procedures. If they do not, services are not sustained and VACs lose support;
3. **Beneficiaries are or will become service providers**. The beneficiaries of HIV/AIDS projects can become empowered service providers, able to take on roles and provide services that under-resourced State health, education and social welfare systems cannot provide;
4. **Service delivery adds subsidiary value**. Training and organization have subsidiary benefits unrecognized in traditional cost analysis because they build strengths for development that are not directly related to HIV/AIDS care or prevention. Changes in the community increase members' acceptance and uptake of development programs and inputs in agriculture, education, health and other areas;
5. **Direct and subsidiary benefits are realized in the next generation.** Children and young people are empowered to take charge, participate, and reason with adults about prevention of HIV transmission. Children are gaining skills and benefiting from the changes in organization and infrastructure initiated by adults. This improves the knowledge and responsibility of next generation, reduces stigma, and helps to sustain reduced HIV incidence. COPE will attempt to evaluate the impacts of young people's participate on incidence in the next project phase;

6. **Valuable services are sustained**. Once empowered, service delivery continues even when external support is removed if services are valuable to the community.

III. COPE'S IMPACTS AND SUCCESSES

COPE has widened its catchment populations to an estimated 9% of Malawi's population[48], and through periodic evaluation, has continued to improve the quality of volunteer services and adapt its strategy for mobilization to urban settings. While development of a sophisticated project monitoring and evaluation system has been late in coming, numerous evaluations and self assessments of COPE have provided valuable information on COPE's impact and success. These findings are summarized below in four areas, including COPE's impact on attitudes, on village organization and activity, on health, education and socioeconomic status, and on resource flows.

A. The Impact of COPE on Attitudes

A recently published retrospective review of COPE's first phase[49] found that communities involved in the COPE project had three characteristics not shared by those without COPE:

1. Communities that Understand HIV/AIDS. The COPE intervention helped villagers with COPE-trained Village AIDS Committees (VACs) better understand the link between HIV/AIDS and growing problems of chronic illness and orphans and their own behaviors.

2. Communities that Do Not Blame Others. Respondents in non-VAC villages blamed the spread of HIV on outsiders. Villagers with COPE-trained VACs "do not blame others for the situation or expect to have others deal with the problem; they realize this is a community problem that they have to deal with through local effort and external support."[50]

3. Communities that Find their Own Solutions. The health committees of non-VAC villages focussed on sanitation and immunization, viewing HIV/AIDS, care for orphans, other vulnerable children, and the chronically ill (including PLHAs) as the responsibility of the family. Respondents in VAC villages "emphasized the community's responsibility to provide care and support to those affected or infected by HIV/AIDS".[51]

B. The Impact of COPE on Village Activity and Organization

COPE training improves the situation of participating villages by:

1. Creating new skills within the community;
2. Stimulating new activities and services;

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[48] Coverage of 12% reported previously (Hunter, 2001, Williamson and Donahue, 2001) was due to an error in calculating base population statistics

[49] Williams et al., 2000

[50] Williams et al., 2000: ii.

[51] Williams et al., 2000: iii.

3. Increasing the volume of new and old activities, while at the same time increasing their productivity and improving their quality;
4. Increasing the availability of goods and materials;
5. Increasing the interaction of community members among themselves and with outsiders;
6. Increasing resources flows within the community and with outsiders.

Goods and services that were previously unavailable within communities are now available largely through the work of villagers themselves. They undertake a broad range of activities, including " emotional and material support to orphans, the sick, and their caregivers; [fostering] the social integration of orphans; ...income-generating activities to benefits orphans and PLHA; and [helping] caregivers with household chores, such as doing laundry, providing water, and fetching firewood."[52] As a result of COPE activities, villagers are maintaining chronically ill adults and vulnerable children at home with the support of village structures.

COPE evaluations also show that COPE opens up new roles for women and young people, unleashing their energy for village prevention and care activities. Youth subcommittees are well-organized, active, have regular meetings, keep good records and are committed to providing care as well as prevention services. They provide support to orphans and other vulnerable children and help to integrate them into the social life of the community. They also assist with home based care. Evaluators concluded that their lack of resources limited their activities, and that they had tremendous untapped potential for social growth and change. There is some evidence in Malawi as in Uganda that young people are leading behavior change to prevent AIDS in their communities[53].

COPE training enabled motivated individuals to provide services to themselves and their neighbors and continue their work even after project support was gone and there were no external resources to support their efforts. This occurred even when the morale of home care subcommittees was very low because there are so many sick people who need care.[54] COPE-trained participants replicated project activities on their own, even during the earliest phases of the project. In June 1998, one year after COPE pulled out, leaving 16 VACs mobilized, CACs mobilized another 5 VACs with very little assistance, and the membership of the original VACs increased.[55] Regular reports of spontaneous replication have been received ever since.[56]

C. The Impact of COPE on Health, Education and Socioeconomic Status

The lack of baseline data on the health, education, and other measures of socioeconomic status for COPE's service populations has made it impossible to measure COPE's impact on the well-being of the children, women and men it serves. COPE has maintained

[52] Williams et al., 2000: iii
[53] NAC National HIV Prevalence Estimates, 2001, p. 6
[54] Williams et al, 2001
[55] Donahue and Williamson, 1998: 4
[56] Williamson and Donahue, 2001; Hunter, 2001

records of services provided, but has no baseline data to demonstrate impact. To partially address this problem, it collected baseline data in the first quarter of 2001. Baseline data will also be collected in the first quarter of 2002, prior to the start of the HACI project. COPE's impact on increasing the availability and accessibility of services suggests that it may contribute to reducing morbidity and mortality and extending the life of people with HIV/AIDS, thereby reducing orphan rates.

Indirect evidence from previous evaluations suggests that COPE has positive impacts on participants' health and well being. Some 36% of target households participated in income generation and gardening, and were able to supplement their diets with more protein and could buy essentials like salt, soap, sugar, clothing, and school supplies for children in their households[57]. Care for chronically ill persons had been improved in 95 of 100 of COPE 1's target households, reducing chance of infection and improving quality of life for the ill and their care givers both. Additional data will be collected to evaluate 2001 and 2002 pilots. In Phase 1, 39 children had been referred to under 5 clinics and 45 to the hospital, suggesting positive outcomes for their health. This data will also be updated in the new evaluations.

In a recent program review, District Health Officers reported increased capacity for home care referrals of AIDS-related cases and other chronically ill patients, realizing system wide efficiencies, reductions in expenditures, and alleviating over crowding in hospitals where patients are often bedded on the floor in crowded wards. The impoverishment of families who must leave their homes and work in order to provide care and food to hospitalized patients was diminished. Quality of care for patients also improved as a result.[58] The involvement of high risk groups such as youth and commercial sex workers in the provision of care for vulnerable children and PLHA fosters the well being and social integration of both, in addition to strengthening the program's links between prevention and care.

D. The Impact of COPE on Resource Flows

A 2001 review of COPE's more recent phases concurred, finding that AIDS committees at all levels take responsibility for identifying their own problems and needs, finding solutions, and developing resources to implement them.[59] COPE's "community mobilization and capacity building have resulted in higher levels of social capital in HIV/AIDS-affected villages, ... relationships that serve as assets and resources, which in turn enable residents to undertake collective action for mutual benefit. Increasing evidence shows that such social cohesion is critical for poverty alleviation and sustainable human and economic development. Harnessing and building on social capital have contributed to community capacity to create more resilient safety nets for families

[57] Donahue and Williamson, 1996: 13
[58] Hunter, 2001
[59] Williamson and Donahue, 2001: 8

affected by HIV/AIDS."[60] The following are cited as evidence of increases in social capital due to the COPE program[61]:

1. VACs mobilize funds by writing successful grant proposals, soliciting donations, doing piecework, selling produce from communal gardens, and other charity walks and events. DACCs, CACs, and VACs have raised more than $20,000 for community programs;
2. VACs also mobilize resource people and institutions within their own communities;
3. VACs resolve their own governance problems;
4. VACs gain the participation of the community at large including in-kind donations of labor and materials to care and prevention programs;
5. VACs in non-COPE villages mobilize themselves following the COPE model;
6. Young people are competent participants in community prevention and care programs;
7. DACCs and CACs are mobilizing external resources for VACs from donors, gaining capital and material investments from outside organizations including the World Bank-supported Malawi Social Action Fund and the Southern Africa Root Crops Research Network;
8. DACCs are seeking links with other programs to increase community competency, like literacy programs.

A 1999 workshop comparing COPE/Malawi and Project Concern International's Orphans and Vulnerable Children Program in Zambia concluded that communities and districts trained to identify their own problems and solutions through community-based methodologies find they have more capacity to handle orphans and other children due to the HIV/AIDS pandemic[62].

During COPE's first phase, Donahue and Williamson estimated that COPE interventions cost $478 per target household and $162 per individual in those households. Using these figures, they estimated that the total cost to serve 10% of all orphans in Malawi would be at $8 to 12 million per year.[63] While this estimate of a "per beneficiary" cost is very useful, it was developed using data from COPE 1's pilot phase, when it could be assumed that costs would be at their highest because few economies of scale had been reached. Second, their denominator was target households and individuals. If the benefits of COPE are understood to go beyond targeted households because it effects all households in the community positively, the per beneficiary cost is much lower. COPE AIDS committees often attract more capacity building, material, and financial resources into a community, and create additional resources through their productive activities. In addition to cash, resources of additional value are created and attracted in many other ways.[64]

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[60] Williamson and Donahue, 2001: 8
[61] Williamson and Donahue, 2001: 9-10
[62] Chilongozi, 1999
[63] Donahue and Williamson, 1996
[64] Williamson and Donahue, 2001: 26-30

As noted above, a retrospective study of project costs and benefits was initiated in January 2002 to address this important gap in project evaluation. It will follow established guidelines in HIV/AIDS program costing.[65] The study will examine the impact of COPE on resource flows into and out of communities, and among households within communities. For example, a VAC's activities and resources should reduce the amount of direct inter-household transfers by providing goods and services to extended family members that are then not required of non-target households, effecting a savings to them. Presence of a VAC should also stabilize economic and social activities considerably, which has direct and indirect benefits for everyone in the community. VAC activities bring in microcredit, available to all community members, and improve markets and marketing skills of community members, and the VAC can improve the infrastructure and services available to all community members, including agricultural extension, health, and education.

While it is important to estimate the cost of community-based projects, it might be more realistic to assess them using a measure of return on investment over time. COPE is put in place to improve community organization and services, and these accumulate over time. Each improvement will have positive effects on improving adult and child health and reducing HIV transmission as well as increasing economic opportunities and improving the quality of life of community members. The VAC's ability to make improvements also improves over time as member experience grows. In the next project phase, COPE will measure some of these long-term effects. Finally, if young people's committees are successful in improving understanding of the causes of HIV transmission and reducing transmission, their contributions to reducing HIV prevalence in the next generation should be measured.

[65] UNAIDS 1998 and 2000

Table 4. Achievements of COPE/Malawi, 1995 - 2001

Topic	COPE 1 1995-1996	COPE 2 and Transition 1997-June, 2001
Duration	Phase 1: 1 year 5 months Phase 2: 7 months	4 years
Accomplishments	1 DACC 1 CAC 16 VACs +5 post project 249 youth clubs 458 trained care givers 15 home care trainers	4 DACCs 20 CACs 208 VACs 440 youth clubs w/7,416 orphans/OVC participating 2,495 trained care givers 9 Community Based Child Care Centers
Persons/ Households Served	1,201 orphans registered 276 orphans assisted with materials, food, medicine 56 home care patients assisted with materials, food, medicine	3,000 orphans registered 2,865 orphans assisted with materials, food, medicine 2,763 home care patients assisted with materials, food, medicine
Improvements in Health and Quality of LIfe	Care for chronically ill persons had been improved in 95 of 100 target households, reducing chance of infection and improving quality of life for the ill and their care givers both. $472 raised by CACs and VACs 1 CAC trained in market chain analysis 10 CACs trained in resource mobilization 39 children referred to under 5 clinics and 45 to the hospital	722 VACs with community gardens 100 VACs linked to agricultural extension system 20 people trained on cassava grating machine 4,200 households linked to SARRNET cassava and sweet potato program 33,500 reached by HIV/AIDS prevention campaigns 17,935 condoms distributed by VACs $20,000 raised by DACs and CACs 11 VAC groups linked to microfinance institutions 9 CACs trained in market chain analysis 140 people trained in business management 29 CAC and DACC members trained in revolving credit and savings 55 VAC, CAC and DACC members trained in market chain analysis 130 individuals trained in resource mobilization (Oct-Dec only) 271 patients referred to hospital
Budget	$538,000	$1.1 million
Estimated Cost per Beneficiary	$478 per target household; $162 per target individual[66]	No estimates made

[66] Donahue and Williamson, 1996

IV. COPE'S CHALLENGES

A. Poverty, Underdevelopment, Costs, and Sustainability

COPE and other community-based HIV/AIDS projects in Sub-Saharan Africa have been organized in "HIV/AIDS-rich" and "resource poor" communities because they are the most in need of care. The nature of these settings is important because it determines the number and needs of children and families receiving assistance (high), and the nature of the families providing care (poor, fragmented, in poor health). These settings are also by nature resource-poor, with low employment, limited access to health care and schools, transportation, electricity, agricultural inputs and the like. Although AIDS makes it even more difficult, maintenance, growth and sustainability of community-based projects in these settings has proven a major challenge to development workers since the 1920s.

Malawi's extreme poverty makes it more difficult and costly to implement program interventions because many communities lack even the most basic resources for day-to-day survival. While COPE has shown that volunteer capacity building and resource mobilization is not impossible in poor communities, it is much more difficult and a relatively large investment of time is required to receive even the most modest results. The popular "big walks" and other fund raising drives often net less than US$10 equivalent, and local philanthropic resources and private business are far fewer in number to support fund raising efforts than they are in wealthier communities.

At least 50% of the program's volunteers are illiterate, and have never been exposed to any kind of training before they participate in a COPE training program. Home based care volunteers struggle to learn how to maintain a simple patient register. Provision of services is also affected by constraints on availability of basic services in health, education and other sectors. For example, because the Malawi health system is functioning with roughly half of the personnel it needs, supervision of home care volunteers must be done by project personnel. Basic drugs are unavailable in hospitals and health centers, making it difficult for home care volunteers to restrict the use of their supply kits to the chronically ill.

Constraints of this nature lengthen the time it takes to train participating communities and prepare them to be self-sufficient and able to sustain their efforts following program withdrawal. In 2001, HACI and MAHAP partners will be studying this issue and devising a strategy for integration and sustainability that systematically addresses these questions. COPE is also attempting to link its communities with Malawi's National Safety Net Program to widen community resource availability without destroying the volunteer spirit.

B. Working Within Government Structures

COPE's successes in working within the government of Malawi's DACC/CAC/VAC system are many, including "an increased role of the district in coordination of HIV/AIDS activities; increased access to funds through advocacy of district personnel

from DACC; a high commitment to HIV/AIDS mitigation on the part of some DACC members."[67] However, before the system functioned effectively, capacity of all levels of the system had to be built. The challenges of working with the structure include the high expenses associated with activities involving large numbers of volunteers; a low level of commitment on the part of some DACC members in part due to other time commitments; and instability due to frequent transfer of district level personnel.[68] COPE must also guard against diversion of its resources to other programs.

In its current phase, COPE/Malawi has reoriented each DACC in COPE's districts of operation "on the importance of its role in terms of coordination and resource mobilization" and reviewed lessons learned to improve DACCs' coordinating ability.[69] SC/US supported a full time District AIDS Coordinator (DAC) in Lilongwe District "with the hope that the government will recognize the increased effectiveness of district level AIDS planning when a full-time position is assigned for that purpose."[70] Full time DACs are part of the national AIDS control strategy but were not funded until the most recent National HIV/AIDS Strategic Framework was adopted.

COPE reviewers also noted that while the "government DACC/CAC/VAC structure [is] a viable model with great potential for sustainability...the model is not viable if the DACCS are not able to communicate with and therefore serve the needs of the CACs and VACs."[71] Stronger two-way communication was needed between levels of the system, to be achieved by having members from different levels attend one another's meetings. DACCs also needed to be in more regular contact with CACs, and CACs with VACs for organization, on-going support, supervision, and technical assistance, but were hindered by lack of transportation. COPE II provided vehicles to each of the four districts and bicycles to each CAC to address this problem.

C. CAC Span of Control

The CACs' large span of control as it was originally defined is a barrier to successful fulfillment of their management responsibilities in the DACC/CACC/VAC system. Even the most successful and long established CAC (Namwera Community AIDS Committee, or NACC) had reached only one-third of the villages for which they were responsible (34 of 112). CACs are the most stressed part of the DACC/ CAC/VAC system, and most threatened by burn out. However, CAC members were stoical, and even seemed a bit insulted when they were queried about the enormity of their responsibilities.[72]

The impossible demand presented by the CAC's workload is likely to have one of two outcomes: they will achieve project goals slowly if at all or they will collapse under the weight of their task. The former is more likely than the latter, because CAC members

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[67] Opoku and Kachiza, 2000: 9
[68] Opoku and Kachiza, 2000: 9
[69] Opoku and Kachiza, 2000: 10
[70] Opoku and Kachiza, 2000: 10
[71] Williams, 2000
[72] Hunter, 2001

were highly committed. This is a real weakness in an otherwise strong system, because CACs have critical responsibilities in developing and sustaining the system. When the system was initially designed, it is doubtful that the demands for on-going communication with and support to a large number of VACs was adequately anticipated. This problem is aggravated in areas where village formation is accelerated by rapid population growth.

COPE is currently studying the allocation of responsibility within the system, but there are some indications that volunteers are resolving this issue themselves by fission. COPE is encouraging this solution, because accelerated implementation and smooth functioning of the system can only be achieved if CAC catchment areas are reduced, perhaps to 30 to 40 villages. This is particularly true if quality is to be maintained and new services introduced.

D. Developing Mechanisms for Hand Over

In COPE's oldest district of operation, hand over of responsibility for COPE operations to Mangochi's CHAPS project was begun in 2001 and will be completed before the end of 2002. Since CHAPS is managed by the District Health Office, the hand over will improve integration of COPE with other health services. At the same time, SC/US will be able to keep close watch on the process because CHAPS is supported by Save in Mangochi District. SC/US anticipates that hand over of COPE in Dedza District to another NGO will be possible in 2002. Both processes present a major challenge to the COPE structure as well as a major opportunity for learning that will improve national implementation by MAHAP. SC/US will begin mobilization in two additional districts as its responsibility is reduced in districts where hand over is achieved, although it intends to maintain a COPE officer in each district for a year after hand over is complete in order to follow up on the process and ensure that services are sustained.

In Mangochi, COPE also experimented with collaborative project implementation by fostering development of a new CAC by World Vision. Implementation by World Vision has been brief because it has been confined to COPE's basic community mobilization program. While World Vision weaned support from this CAC and its six VACs in September 2001 after only nine months of development, most of these CAC members felt confident of their ability to sustain their endeavors. However, they felt they had several weaknesses, including lack of office management skills and insufficient training in fund raising skills. They also wanted training as trainers so they could be more effective in all their village work. World Vision added a 3-day training in proposal writing although it had not been part of the initial plan. This CAC also indicated that it was not satisfied with its monitoring and evaluation system because lack of transportation limited their ability to visit and work with their VACs, however they hoped to maintain quality and work with the villages as problems arose. The CAC maintains monthly plans for their own activities and also monitors VAC monthly plans.

Although the confidence of this CAC is laudable, it will be important to maintain contact with this group to help them through the transition and ensure that they are able to carry

on. District staff felt it takes two years of orientation and support for a CAC to achieve sustainability, and suggested that the DACC provide special attention and support to this CAC as it becomes independent. COPE staff will undoubtedly pay particular attention to this phase out and to the CHAP hand over in Mangochi as they transpire so they can identify problems and help NGOs, the DACC, CACs and VACs with the transition. This information will be invaluable as SC/US supports other partners in developing their COPE acumen. COPE could also convene an annual meeting of all CACs in the district to review accomplishments, share techniques and strategies, and learn new approaches.

E. Involvement of Religious Leaders

While they are official part of the DACC/CAC/VAC system, religious leaders have tended to remain separate from the system for several reasons. Perhaps the most important is their wariness at being involved with HIV/AIDS prevention strategies that include promotion of condom use. Secondly, many of Malawi's major religious institutions include HIV/AIDS prevention and care activities within their own programs. The Christian Health Association of Malawi (CHAM), for example, is not only providing behavioral change programs, but also provides voluntary counseling and testing and piloting programs for prevention of mother to child transmission, and antiretroviral treatment. The development arm of the Episcopal Church of Malawi (ECM) is also active in HIV/AIDS prevention, care and impact mitigation through community mobilization. However, both groups are interested in the wider replication of COPE, and have been participating in the development of MAHAP. In addition, the Political Action Committee, a coordinating body for Malawi's major religious groups, is part of the new HACI/Malawi partnership, and has received funding to increase the understanding and participation of religious leaders.

F. COPE as a Learning System

For COPE to achieve its vision of sustainable community-based HIV/AIDS programming. DACCs, CACs, and VACs must have the tools to evaluate their work and the capacity to utilize data to monitor and assess the success of their activities, judge the impact on local populations, and adjust their planning and strategies accordingly. DACCs, CACs and VACs helped develop the new monitoring and evaluation system instituted in 1999, and have all received training on its collection and use. Continued refinement of that system to improve COPE as a learning system and to improve COPE's ability to respond to donor's requests for documentation of long term impact remains a challenge. Innovative means of measurement that are not costly and are simple enough for the community to use will be a product of growing experience with COPE's new MIS system in the next project phase.

G. The Need to Build Broader Partnerships

The resources of the COPE have been limited because COPE was never intended to be a service delivery program, and reviewers have recommended that it avoid this role:

> COPE has faced pressures to become a service and resource provider. It can and should help find ways to ensure that AIDS committees are able to obtain the resources they need to meet the needs of the most vulnerable community members. To an extent, COPE may need to be a conduit for some resources... However, such functions could easily come to consume the majority of COPE's resources and the time and effort of its staff, and COPE should avoid that outcome. COPE must continue to expand and to strengthen community action.[73]

However, at the same time, the unmet need of AIDS committees and their constituents for basic resources is enormous. According to one review, "the gap between what communities are doing and the needs of the children and other vulnerable residents is still very large, and to think that community resources alone will be able to bridge it is not reasonable."[74] In resource-scarce settings, COPE and similar community-based organizations must collaborate with existing groups to improve the overall quantity and organization of resource flows into the community.

COPE's 1998 mid-term review suggested that "through linkages with other organizations, COPE could significantly increase the scale of responses to the problems of vulnerable children and families in Malawi"[75]. As a result, COPE began some partnerships with existing institutions and organizations outside of the DACC/CAC/VAC structure in its current district of operations. This strategy is particularly important in urban Lilongwe where work schedules limit participation in new organizations. COPE will help these groups to "enhance their activities and provide training resources for home-based care, orphan care, and resource mobilization."[76] The materials and training will be the same as that provided to DACCs/CACs/VACs, but provided in different settings to accommodate the work schedules and styles of alternative partners.

COPE also partnered with ADRA to develop a home care program in Blantyre and is providing training, monitoring and evaluation. Funding was made to ADRA after their proposal underwent considerable refinement and implementation will begin in 2001. COPE partners with SAARNET to obtain additional inputs into its food security interventions.

While COPE has explored some of the possibilities for partnership, most of COPE's focus has been on its own internal development. As COPE moves into its next phase (2002 to 2005), this orientation is rapidly changing. SC/US has become the leader through the COPE program of a national implementing partnership of NGOs called the Malawi HIV/AIDS Partnership. Through MAHAP, COPE is partnering with other NGOs to expand implementation of community-based HIV/AIDS prevention and care programs modeled on COPE to all of Malawi's districts.

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[73] Williamson and Donahue, 2001: vii.
[74] Williamson and Donahue, 2001: vii.
[75] Donahue and Williamson, 1998
[76] Opoku and Kachiza, 2000: 11

With the development of MAHAP, the partnering of DACCs, CACs, and VACs with other national programs can become more systematic. For example, some COPE VACs were successful in obtaining funds from the World Bank funded Malawi Social Action Fund (MASAF). MAHAP can explore how the this link can be developed country-wide. Malawi is also developing a Social Safety Net Program that is currently investigating ways to deliver resources to the country's very poor in communities nationwide, and MAHAP-mobilized communities may be ideal vehicles for this program. The World Food Program is a member of MAHAP and is working with NGOs in selected districts to implement a program to supply food to PLHAs through community home-based care programs.

V. LESSONS LEARNED FROM COPE IN MALAWI

A. COPE's Strengths

The core of COPE's programming strength arises in its early realization that the development of strong and competent communities would be key to its success and that mobilization and facilitation would be more important than direct implementation. Modest program resources were leveraged by supporting and mobilizing existing structures rather than by superimposing additional structures for direct service delivery. This belief in the importance of enabling communities to do their own planning, set their own priorities, and do their own work not only prescribes the project structure and approach, but sets the tone for all of the program's work with communities.

COPE's iterative development process has ensured adaptive program growth. Frequent self-review and external evaluation helped ensure that the program responded to changing circumstances, identified and corrected internal weaknesses and programmatic shortcomings, and incorporated learning from programs in Malawi and other countries.

While community capacity building was aimed at developing competencies for HIV/AIDS prevention, care, and impact mitigation, valuable social capital was built that has had unanticipated positive benefits for the COPE program itself and has much broader implications for overall development of COPE-trained communities. Communities can directly convince other communities to adopt the program or can lead by example. Training is provided or augmented by experienced community leaders, so that the stimulus for change is immediately demonstrated and internalized much more readily than if it came from an outside source.

Integration into existing national structures and strategies was essential because the program could build on existing developments and receive the support of local, district and national government officers, so that COPE benefits directly from the Malawi government's previous efforts. While the Malawi government's direct support for the DACC/CAC/VAC structure may have diminished through the 1990's,[77] government officers at district and local levels contribute a great deal to COPE program growth through their participation on AIDS Committees, by facilitating access to parallel programs and resources, and by using their expertise to build community capacity.

The DACC/CAC/VAC system has also been critical to project replication and growth because it provides a ready-made, government-sanctioned structure for supervision, training, and development. While COPE had to invest resources in revitalizing or creating these committees, the template had been established for cooperative, interlocked, HIV/AIDS prevention and care programs. COPE has never worked in a vacuum, but gains strength from established expectations and relationships, even where they are weak or flimsy.

[77] Williamson and Donahue, 2001: ix.

COPE's collaboration with and contribution to national HIV/AIDS programming has improved the government's opinion of COPE and Save the Children. As the program moves to the next stage, this contribution to national programming has been recognized through government support to MAHAP, which will increase the orderly interface of government and NGO programming countrywide.

Finally, COPE is holistic. The wide array of COPE's multi-sectoral HIV/AIDS interventions can encompass the concerns of a wide range of community members. This encourages the participation of people whose concern about HIV/AIDS may be secondary or equal to their concerns about such issues as children's education and nutrition, or business and service development within communities. The subcommittee structure also tacitly acknowledges the importance of traditionally undervalued community members, including the role of women in care giving and the role of young people in prevention and care.

B. COPE's Weaknesses

COPE's attractiveness to communities may prove to be one of its major weaknesses. Many participating villagers are so happy with the results of COPE that they mobilize neighboring non-COPE villages so that they can share in the benefits. VAC members understand that since COPE changes come from within, starting additional villages off will not jeopardize their access to resources. In many cases, residents of neighboring villages saw COPE-related activities and requested training from the CAC to start work. Some start projects with no initial training, a sign of how strong demand is for the program. This is an indication that in the next phase of COPE, management must look at its ability to respond more quickly to community demand by improving distribution of committee workloads and introducing other innovations that increase the breadth and impact of training and mobilization.

The need to respond to demand from communities and donors to expand the range of services COPE provides has also slowed project implementation and the ability of communities to become self-sufficient. New mechanisms for adding services and improving the quality of existing services must be explored. Also, reviewers feel that COPE must expand its ability to capture resources for development:

However, community demand and increasing pressure from the HIV/AIDS pandemic on COPE to expand services and mobilize more resources may constitute an unrealistic demand on a system that was not constructed with these purposes in mind. While "finding ways to channel material and financial support to and through community structures ... in ways that reinforce community ownership and responsibility is very important,"[78] it may be an impossible task given the developmental challenges of the system in which COPE is embedded.

[78] Williamson and Donahue, 2001: 26

Lack of full-scale monitoring and evaluation systems has limited COPE's development as a learning system. Baseline surveys and community-based management information systems are now being implemented that can document the impact of COPE and support arguments for continued investment in their success.

C. Lessons Learned

COPE/Malawi has identified a series of lessons learned from their initial years of program implementation that are useful in replication:

Community Mobilization

1. High quality community mobilization and training is important to begin successful projects and to improve and expand services;
2. Training for community organization should be standardized;
3. Training for Transformation is essential to build community ownership and project sustainability;
4. Political and traditional leaders should be involved from the start;
5. Disadvantaged committee members are as important as advantaged members in committee implementation;
6. Committees must involve individuals from all sectors;
7. Youth can be successfully engaged and their energies and resources harnessed in providing services, an invaluable result in terms of sustaining long term declines in HIV transmission and care;
8. Transparency, communication, and feedback are key at all levels of the implementation hierarchy, and require project attention and investment;
9. Strong committees stay close to and are trusted by the communities they represent.
10. Community mobilization takes time. There is a positive relationship between time spent with the community early in the mobilization process and the potential for sustainability of mobilization;
11. A thorough community assessment is needed to identify existing strengths and gaps;
12. The mobilization process builds on responses to strengthen, not replace, existing initiatives;
13. "Strategic" material assistance (e.g., bicycles) must be provided to motivate and sustain volunteers;
14. Response to resource deficits in communities is essential to project success, and a driving force in sustaining community motivation and participation.

Program Content

1. Prevention activities should be incorporated from the beginning;
2. The quality of home based care can be improved with standardized training and provision of home care kits.

Program Evaluation

1. Qualitative information is as critical as quantitative information to represent community perception of the program, but the latter are necessary to maintain donor support;
2. Monitoring and evaluation should be participatory;
3. Programs must develop approaches to documenting long term impact.

A January 1999 USAID/DCOF review of COPE highlighted several other key lessons learned:[79]

1. The project's success was critical in reinforcing the Malawi government's commitment to community-based epidemic management and care for orphans and other vulnerable children;
2. Sustained training and support was essential for economic security and income generating activities initiated in participating communities;
3. Food security was closely related to project success;
4. A community-based management information system was needed for project monitoring and evaluation;
5. Continued donor input is required in maintaining and fine-tuning community-based projects, or the essential hierarchical infrastructure on which these projects rely collapses and responses are not sustained.

[79] Donahue and Williamson, 1999

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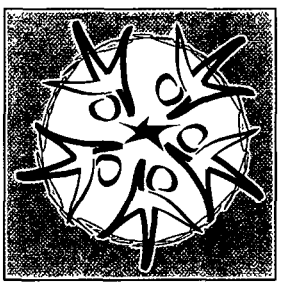

Summary Findings

In 1995, Save the Children/US- Malawi introduced a small pilot project called COPE-Community-based Options for Protection and Empowerment, to provide direct services to prevent and mitigate the impact of HIV/AIDS on children, families and communities in 1district. Over the past six years, the program has evolved and expanded to four districts, covering 9% of the national population. The goal of COPE is to mobilize sustainable community action utilizing existing indigenous social infrastructures and a three tier structure — District AIDS Coordinating Committees (DACCs), Community AIDS Committees (CACs) and Village AIDS Committees (VACs). The program is multisectoral and involves partnerships with government, business communities, local leaders, other NGOs/CBOs and religious organizations. Program success and challenges included.

HUMAN DEVELOPMENT NETWORK