Document of
The World Bank

Report No.: 31746

PROJECT PERFORMANCE ASSESSMENT REPORT

CHAD

POPULATION AND AIDS CONTROL PROJECT
(CREDIT NO. 2692)

March 7, 2005

Sector, Thematic and Global Evaluation Group
Operations Evaluation Department

Currency Equivalents (annual averages)

Currency Unit = FCFA

Exchange Rate Effective August 2004	Exchange Rate Effective December 31, 2001	Exchange Rate Effective March 1st, 1995
531 CFA Francs = US$1.00	744 CFA Francs = US$1.00	514 CFA Francs = US$1.00
US$0.1883 = 100 CFA Francs	US$0.1344 = 100 CFA Francs	US$0.1946 = 100 CFA Francs

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AMASOT	*Association pour le Marketing Social au Tchad* (Social Marketing Association of Chad
ARV	anti-retroviral
ASTBEF	*Association Tchadienne pour le Bien-Etre Familiale (*Chadian Association for Family Well-being)
CERPOD	*Centre de Recherche sur la Population pour le Développement (*Center for Research on Population and Development)
CNLS	*Comité National de Lutte contre le SIDA* (National AIDS Committee)
CNPRH	*Commission Nationale de Population et des Ressources Humaines* (National Population and Human Resources Commission)
CPR	contraceptive prevalence rate
CPPRH	*Commission Préfectorale de Population et des Ressources Humaines* (Prefectoral Commission on Population and Human Resources)
CTLS	*Comité Technique de Lutte Contre le SIDA* (Technical Committee for AIDS Control)
DHS	demographic and health survey
FOSAP	*Fonds de Soutien aux Activités en matière de Population* (Social Fund)
HCPRH	*Haut Conseil de la Population et des Ressources Humaines* (High Council on Population and Human Resources)
HIV	Human Immunodeficiency Virus
ICR	Implementation Completion Report
IEC	information, education, and communication
KAP	knowledge, attitudes, and practices
KfW	Kreditanstalt Für Wiederaufbau
M&E	monitoring and evaluation
MASACOT	Project Social Marketing Unit
MCH	Maternal and child health
MoPC	Ministry of Planning and Cooperation
MoPH	Ministry of Public Health
MTR	Mid-term review
NGO	nongovernmental organization
OED	Operations Evaluation Department
PAIP	*Programme d'Action et d'Investissement Prioritaire en matière de Population* (Program for Priority Actions and Investment in Population)
PCT	project coordination team
PLWHA	people living with HIV/AIDS
PNLS	*Programme National de Lutte Contre le SIDA* (National Program of AIDS Control)
PPAR	Project Performance Assessment Report
PPLS	*Projet population et Lutte contre le SIDA (*Population and AIDS Control Project)
PRSP	Poverty Reduction Strategy Paper
STD	sexually transmitted disease
TB	tuberculosis
TOR	terms of reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

Fiscal Year:

Government: January 1—December 31

Director-General, Operations Evaluation	:	Mr. Gregory K. Ingram
Director, Operations Evaluation Department	:	Mr. Ajay Chhibber
Manager, Sector, Thematic and Global Evaluation Group	:	Mr. Alain Barbu
Task Manager	:	Ms Denise Vaillancourt

OED Mission: Enhancing development effectiveness through excellence and independence in evaluation.

About this Report

The Operations Evaluation Department assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, OED annually assesses about 25 percent of the Bank's lending operations. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons. The projects, topics, and analytical approaches selected for assessment support larger evaluation studies.

A Project Performance Assessment Report (PPAR) is based on a review of the Implementation Completion Report (a self-evaluation by the responsible Bank department) and fieldwork conducted by OED. To prepare PPARs, OED staff examine project files and other documents, interview operational staff, and in most cases visit the borrowing country for onsite discussions with project staff and beneficiaries. The PPAR thereby seeks to validate and augment the information provided in the ICR, as well as examine issues of special interest to broader OED studies.

Each PPAR is subject to a peer review process and OED management approval. Once cleared internally, the PPAR is reviewed by the responsible Bank department and amended as necessary. The completed PPAR is then sent to the borrower for review; the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

About the OED Rating System

The time-tested evaluation methods used by OED are suited to the broad range of the World Bank's work. The methods offer both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. OED evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (more information is available on the OED website: http://worldbank.org/oed/eta-mainpage.html).

Relevance of Objectives: The extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). *Possible ratings:* High, Substantial, Modest, Negligible.

Efficacy: The extent to which the project's objectives were achieved, or expected to be achieved, taking into account their relative importance. *Possible ratings:* High, Substantial, Modest, Negligible.

Efficiency: The extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. *Possible ratings:* High, Substantial, Modest, Negligible. This rating is not generally applied to adjustment operations.

Sustainability: The resilience to risk of net benefits flows over time. *Possible ratings:* Highly Likely, Likely, Unlikely, Highly Unlikely, Not Evaluable.

Institutional Development Impact: The extent to which a project improves the ability of a country or region to make more efficient, equitable and sustainable use of its human, financial, and natural resources through: (a) better definition, stability, transparency, enforceability, and predictability of institutional arrangements and/or (b) better alignment of the mission and capacity of an organization with its mandate, which derives from these institutional arrangements. Institutional Development Impact includes both intended and unintended effects of a project. *Possible ratings:* High, Substantial, Modest, Negligible.

Outcome: The extent to which the project's major relevant objectives were achieved, or are expected to be achieved, efficiently. *Possible ratings:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry and supported implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of the project). *Possible ratings:* Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower assumed ownership and responsibility to ensure quality of preparation and implementation, and complied with covenants and agreements, towards the achievement of development objectives and sustainability. Possible ratings: Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Contents

This report was prepared by Denise Vaillancourt, who assessed the project in February 2004. The report was edited by William B. Hurlbut, and Pilar Barquero provided administrative support.

Boxes

Tables

Figures

Principal Ratings

	*ICR **	*PPAR*
Outcome	Satisfactory	Moderately Satisfactory
Sustainability	Likely	Likely
Institutional Development Impact	Modest	Substantial
Bank Performance	Satisfactory	Satisfactory
Borrower Performance	Satisfactory	Satisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible operational division of the Bank.

Key Staff Responsible

Project	*Task Manager/Leader*	*Sector Manager*	*Country Director*
Appraisal	Eva Jarawan	David Berk	Francisco Aguirre-Sacasa
Completion	Michele L. Lioy	Arvil Van Adams	Robert Calderisi

Preface

This is the Project Performance Assessment Report (PPAR) for the First Population and AIDS Control Project in Chad. This project was financed through IDA Credit No. 2692 in the amount of US$20.4 million equivalent (13.9 million SDR) with a planned government and community contributions of US$1.3 million and US$1.0 million, respectively, and projected cofinancing by KfW and UNFPA in the respective amounts of US$4.4 million and US$0.1 million for a total cost of US$27.2 million. The credit was approved on March 23, 1995, became effective on September 8, 1995, and closed on December 31, 2001, after a six-month extension. The credit was fully disbursed.

The findings of this assessment are based on an Operations Evaluation Department (OED) mission to Chad in February 2004. The mission met in N'Djamena with: authorities and staff of the Ministry of Plan, Development and Cooperation (including the Project Coordination Team); the Ministry of Public Health; other public sector agencies implementing population and HIV/AIDS activities; the Social Marketing Association (AMASOT); the Social Fund (FOSAP); representatives of civil society; and key donors supporting population and HIV/AIDS activities in Chad. The mission also visited the cities (and prefectures) of Mongo (Guéra), Mao (Kanem), Bongor (Mayo-Kebbi), and Moundou (Logone Occidental), interviewing public sector and civil society actors and beneficiaries and visiting selected facilities, research/academic institutions, and community-based projects. Key documentary sources consulted include: (a) World Bank project files; and (b) project-related reporting and evaluation, epidemiological data, studies and research on population and HIV/AIDS, much of it generated in Chad.

This PPAR is one of six conducted on the "first generation" of the Bank's HIV/AIDS projects, as background for a larger OED evaluation of the development effectiveness of World Bank's assistance for fighting the AIDS epidemic. In light of that purpose, relatively more material has been presented in this "enhanced" PPAR than is the OED standard.

The OED mission gratefully acknowledges all those who made time for interviews and provided documents and information.

Following standard OED procedures, copies of the draft PPAR will be sent to the relevant government officials and agencies for their review and comments. Comments received are incorporated into the PPAR and presented in Annex F.

Summary

The objectives of the Population and AIDS Control Project (Credit No. 2692 of 13.9 million SDR) were to advance the onset of fertility decline by increasing the modern contraceptive prevalence rate (CPR) from 1 percent in 1990 to 10 percent by 2000, and to slow the spread of HIV infection by promoting behavioral change. The project was managed and implemented efficiently overall; and the credit was fully disbursed. Implementation, however, was constrained by the lack of Government counterpart financing and weak capacity of public sector implementing agencies.

In 1992 Chad was one of the few Sahelian countries that did not have a population policy. However, deteriorating socioeconomic conditions and analysis of population issues, supported by the World Bank, prompted in 1994 the preparation of a national population policy and the repeal of the 1920 law which prohibited contraceptives. Population program efforts were constrained by poor coverage and quality of family planning and weak capacity for the coordination of activities and for the collection and analysis of data. Strong disincentives for decreasing fertility included high levels of poverty and high dependence on children to supplement family income and provide old age social security, and very high infant and child mortality.

The first cases of AIDS were reported in 1986, with a total accumulation of 2,866 reported cases by 1994, 97 percent of which were attributed to heterosexual transmission. Government's earliest response under its short-term plan (1988-89) and first medium-term plan (1990-93) for AIDS control focused on program start-up, capacity-building, surveillance and prevention activities. Denial and stigma within the Government and in society at large were pervasive.

Population. Project assistance did not succeed in raising the modern CPR to 10 percent. By the project's end, CPR was estimated at 2 percent. Available data indicate that the total fertility rate in Chad has remained constant over the life of the project at around 6.6 children. At the time of the project's mid-term review, the Bank and the Borrower acknowledged that the objectives were, in retrospect, not realistic and would not be achieved. UNFPA hired consultants to set new targets on the basis of the DHS data, but their work progressed slowly and the project objectives were not amended.

HIV/AIDS. Epidemiological and behavioral surveillance was improved under the project and helped document the seriousness and scope of the epidemic. The project was successful in establishing a social marketing program that has increased the availability of condoms in Chad at an affordable price. Against a target of 14 million, a total of 19.9 million condoms were sold, of which about 3 million are estimated to have been sold in neighboring countries. While condoms were taboo at the start of the project, they are now sold openly in shops, market stands, inns and hotels across the country. There is considerably less stigma today associated with the purchase and use of condoms. The project has mobilized and financed a wide response from civil society organizations, and a response from various sectors in the public sector at central and decentralized levels.

The project has succeeded in increasing awareness and knowledge of HIV/AIDS and in inciting safer behavior. The most significant improvements in awareness and behavior are found among women, rural residents, and the poorest income quintiles with consequent reductions in disparities between men and women, urban and rural residents and the poorest and richest segments of the population. Condom use has increased among men and women, although levels are still relatively low. In the absence of baseline data, it is difficult to evaluate the extent to which the project has slowed the spread of HIV infection. Available data reveal that HIV prevalence has risen over the past decade in the general population and that it may have stabilized among pregnant women using prenatal services in urban areas. However, the HIV prevalence rate does not yield insights into the change in the rate of new infection.

Ratings. This project is judged to have had a moderately satisfactory outcome overall, based on an unsatisfactory outcome of the population objective and a satisfactory outcome of the HIV/AIDS objective. Institutional development is rated as substantial; and sustainability of project efforts is likely. Both Bank and Borrower performance was satisfactory.

LESSONS

- The Bank can be instrumental in stimulating government commitment with regard to population and HIV/AIDS through policy dialogue, advocacy, technical support and lending, but that support is insufficient to consolidate and sustain the commitment. Other factors that are critical to raising and sustaining Government commitment are the relevance of the objective (determined by the availability of local evidence and data) and the degree of mobilization of civil society.
- The stimulation and nurturing of broad-based national commitment requires continuous and multiple efforts, given population mobility and turnover in public sector positions.
- Even in the context of a multisectoral approach to the achievement of HIV/AIDS and population objectives, the role of the health sector is pivotal.
- The absence of baseline data for key indicators and of a monitoring and evaluation plan undermines opportunities to track and fine-tune the performance and impact of national population and HIV/AIDS efforts.
- Intensive information campaigns in the early years of the project followed by the recruitment of intermediary NGOs to build capacity onsite and to stimulate the formation of new associations, proved to be very effective in engaging civil society in population and HIV/AIDS activities.

Gregory K. Ingram
Director-General
Operations Evaluation

1. Background and Context

1.1 This is the sixth of a series of PPARs that are being undertaken on the "first generation" of completed Bank-financed HIV/AIDS projects, as background for a larger OED evaluation of the development effectiveness of the World Bank's AIDS assistance.[1] In light of that purpose, relatively more material has been presented in this "enhanced" PPAR than is the OED standard. This project was chosen for assessment to provide the main study with lessons and insight on the experience of the Bank's HIV/AIDS assistance to a West African country, prior to the design and approval of the MAP.[2]

1.2 **General Context.**[3] Chad is one of the poorest countries in the world with an estimated four-fifths of its population of 8.1 million living on less than a dollar a day, and half of the population living on less than 50 cents per day. More than 50 percent of Chadians over the age of 15 are illiterate and only about 30 percent of the population has access to potable water. Epidemic and endemic diseases are prevalent in all regions of the country and there is only one doctor for every 29,000 inhabitants. Infant and child mortality were estimated at 102.6 and 194.3, respectively, and maternal mortality was estimated at 827 per 100,000 live births in 2000.[4] Life expectancy is estimated at 50 years. Gender disparities are acute and highly correlated to poverty in Chad.

1.3 Chad is a vast territory (over 1.2 million square kilometers) with only about 550 kilometers of paved road. Geographic isolation and high transport costs undermine the viability of economic activity and constrain access to basic social services and information. Development efforts are further challenged by the broad cultural diversity of the country with about 200 ethnic groups and 120 distinct languages. Following decades of civil war, a democratization process has taken hold since the mid-1990s, but political stability remains fragile.

1.4 Chad's recent macroeconomic performance has been satisfactory with an increase in the rate of real growth of GDP from an average of 3.1 percent for the period 1997-2000 to 8.5 percent in 2001, 9.7 percent in 2002 and 11.2 percent in 2003, largely due to investments in the Chad-Cameroon pipeline, completed in early 2003. With full production achieved in 2004, it is estimated that some US$100 million in oil revenues

1. The other projects assessed to date include the Kenya Sexually Transmitted Infections Project, the Zimbabwe Sexually Transmitted Infections Prevention and Care Project, the First India National AIDS Control Project, the first and second Brazil AIDS and Sexually Transmitted Disease Control Projects, and the Kingdom of Cambodia Disease Control and Health Development Project.

2. The first Multi-Country HIV/AIDS Program (MAP), a horizontal Adaptable Program Loan (APL) for Africa Region's intensified assistance to the fight against HIV/AIDS, in the amount of US$500 million, was approved on September 12, 2000. MAP II for an additional US$500 million was approved on December 20, 2001.

3. Data and information cited in this section are drawn from Chad's Poverty Reduction Strategy Paper (PRSP) of October 7, 2003, and from the World Bank's Country Assistance Strategy (CAS) for Chad of November 12, 2003.

4. Ministère de la Santé et des Affaires Sociales et Banque Mondiale, March 2004.

will be generated this year, a portion of which is supposed to be earmarked for expenditures in priority sectors.[5]

1.5 **Population.** The first population census estimated Chad's population to be about 6.2 million in April 1993 and growing at an annual rate of 2.5 percent. The total fertility rate was estimated at 5.7 live births per women, lower than the average of 6.6 for Sub-Saharan Africa. The population of N'Djamena increased fivefold between 1960 and 1990.

1.6 In 1992 Chad was one of the few Sahelian countries that did not have a population policy, in part because of the large size of the country and low population density. However, deteriorating socioeconomic conditions and analysis of population issues increased Government awareness of population growth as a development issue, and prompted two key actions: (a) the preparation of a national population policy and the creation of institutions for its oversight and management; and (b) the repeal of the 1920 law which prohibited the importation, distribution and use of contraceptives. In 1994, the Government of Chad adopted its Declaration of Population Policy (DPP), which outlined national priorities and strategies in population and family planning (see Box 1).

Box 1. 1994 Population Policy Objectives:

A Summary

- Improve coverage and access to basic health and nutrition services (including reproductive health services) and education services
- Decrease annual population growth from 2.5 percent to 2 percent by 2005
- Strengthen understanding of the relationship between population and development
- Promote women's rights, social status and participation in development
- Promote and ensure the rights and well-being of children and youth.

1.7 Receptivity to the notion of controlling family size was very weak in Chad. First, extremely high levels of poverty in Chad prompted couples to have many children as a means of supplementing family income and providing social security in their old age. Second, civil conflict was another deterrent to limiting family size in the face of continued tensions among ethnic groups. Third, infant and child mortality were very high (estimated, respectively, at 132 and 222 per thousand in 1993[6]), inciting high fertility levels as women tried to compensate for the loss of children. Furthermore, religious leaders have had a very strong influence on Chadian society and many took a position against the use of modern contraception.

1.8 At the time of project preparation the Ministry of Plan and Cooperation (MoPC) was responsible for population policy implementation and oversight, with the Ministry of Public Health (MoPH) having primary responsibility for family planning. Within MoPC a Population Division (*Division de la Population)* was created to facilitate the coordination of population policy implementation and a Directorate of Statistics and of Economic

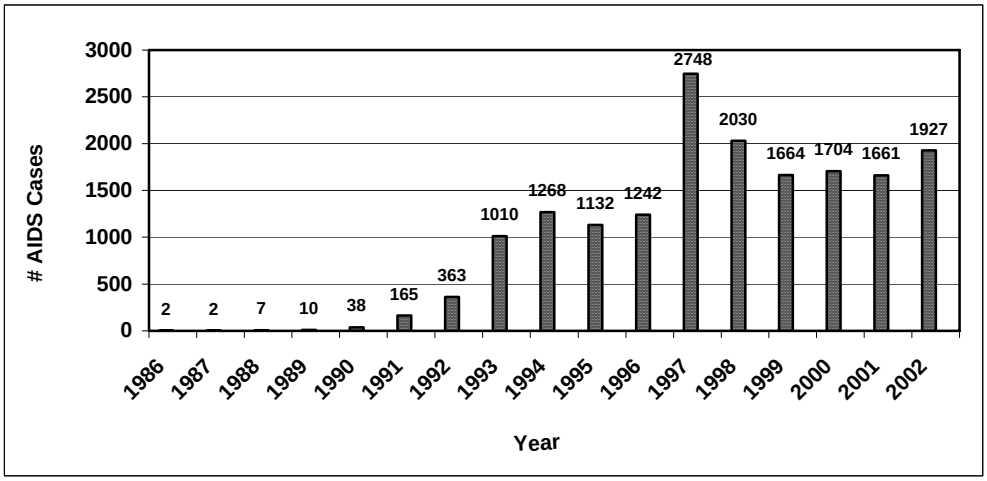
5. Priority sectors include: health, social affairs, education, infrastructure, rural development, and environment and water resources.

6. Ministry of Health statistics.

Studies[7] was responsible for demographic research and analysis. Given the multi-sectoral nature of the population agenda, a high-level council on population *(Haut Conseil de la Population et des Ressources Humaines , HCPRH),* chaired by the President of the Republic, was set up to define the general orientations of population policy and to adopt recommendations of an inter-ministerial population committee *(Comission Nationale pour la Population et les Ressources Humaines, CNPRH),* chaired by the Minister of Plan and Cooperation. The mandate of the *CNPRH* was to prepare policy and coordinate its implementation. The main issues constraining population program efforts in 1994 were (a) poor coverage and quality of family planning information and services[8]; (b) limited demand for these services; and (c) weak capacity for the planning and coordination of population activities and for the collection and analysis of social and demographic data through research, studies and surveys (World Bank 1995).

1.9 **Health and HIV/AIDS.** The leading causes of illness and death in Chad (infectious and parasitic diseases,[9] pregnancy-related conditions, and malnutrition) are all preventable and amenable to the effective delivery of a basic package of health services (including communicable disease control and family planning). Health system performance in the early 1990s suffered from low coverage, poor access, limited and inefficiently allocated resources, lack of qualified health personnel, lack of strategic management capacity and an overly centralized organization. An indicator of the health sector's inadequate performance in Chad is the extremely low child immunization coverage of 3 percent in the early 1990s (World Bank 1992).

Figure 1. Reported AIDS Cases 1986 – 2002



Source: MoPH/PNLS Epidemiological Data

7. Direction de la Statistique des Études Économiques et Démographiques – DSEED.

8. Weak capacity was due both to a lack of qualified health personnel and to a lack of prioritization of family planning information and services within the minimum package of services.

9. Diarrhea, tuberculosis, malaria, trypanosomiaisis, onchocerciaisis, meningitis, cholera, measles, STDs/AIDS.

1.10 The first cases of AIDS were reported in 1986, with a total accumulation of 2,866 reported cases by 1994 (Figure 1). At the time of project preparation, adult prevalence for HIV[10] was estimated by MoPH at 3 percent with the highest rates in the south and west of the country.[11] Ninety-seven percent of reported AIDS cases were estimated to have been caused by sexual transmission, a result of multiple partners, lack of education and information, and difficult access to condoms.[12] Poverty, conflict, and successive droughts have contributed to this phenomenon by encouraging significant migration and commercial sex.

Box 2. Second Medium-Term Plan for AIDS Control – Strategic Orientations (1995-1999)

Prevention of:

a. sexual transmission
b. transmission through unsafe blood
c. mother-to-child transmission

Mitigation of:

a. the health impact of sero-positive patients with or without AIDS
b. the social impact of AIDS on patients and their families
c. the impact on public expenditure, especially for the health sector
d. the impoverishing effects of the disease through income-génération activities.

1.11 In 1988, the Government set up an institutional framework for the fight against HIV/AIDS,[13] and prepared and launched a short-term plan for AIDS control covering the period 1988-89, followed by the first medium-term plan covering the period 1990-93. Early activities focused on program start-up, capacity building, early surveillance activities,[14] and prevention for the general public, and for prostitutes, youth, and the military. A second medium-term plan, prepared during project preparation, accorded highest priority to prevention (see Box 2), at a cost of about US$9 million (excluding social marketing and social fund).

1.12 Despite the institutional and policy framework established for HIV/AIDS by the Government of Chad, there was still widespread denial and stigma within Government and in society at large. Many interviews reveal that HIV/AIDS was not referred to by its name, but instead referred to as “the sickness” or “the syndrome.” There was reported to be widespread denial among Government officials at central and decentralized levels of administration, many stating that this was a creation of donors. Religious leaders were also reported to be strongly resistant in the early 1990s to the promotion of condoms and

10. The percent of adults infected with HIV at a given time.

11. In 1993, 88 percent of all reported cases came from Ndjamena and Moundou.

12. Mother-to-child transmission was also acknowledged as a means of infection, with some 4,800 children estimated to be infected in 1994, along with the transfusion of unsafe blood supplies (World Bank 1995).

13. Consisting of: (a) the National AIDS Committee (Comité National de Lutte contre le SIDA, CNLS), chaired by the Minister of Health and composed of six ministers, responsible for oversight of all HIV/AIDS control activities, (b) the Technical Committee for AIDS Control (Comité Technique de Lutte Contre le SIDA, CTLS), chaired by the Director General of Health, and (c) the National AIDS Control Program (Programme National de Lutte Contre le SIDA, PNLS) within MoPH, responsible for day-to-day implementation and follow-up of AIDS activities.

14. Surveillance activities included seroprevalence surveys in selected prefectures (Abéché, Sarh, Moundou, Bongor and Ndjamena) and limited surveillance of pregnant women, blood donors and TB patients.

interventions with commercial sex workers, which they considered to be in conflict with religious principles. Strongly influenced by religious and traditional leaders, and lacking basic facts about HIV/AIDS and how to prevent its transmission, Chadian society at large exhibited great discomfort with discussion of the disease itself and with ways and means of controlling it. Societal resistance to early HIV/AIDS control efforts was reported by many of those interviewed, who cited billboards set up in major cities being torn down and destruction of equipment after information and social marketing campaigns.

1.13 **Previous Bank Support.** The Bank's first support to Chad's health sector was through a US$7 million health component under the Social Development Action Project, approved in June 1991,[15] which sought to improve basic social services in the city of N'Djamena and in the southern region of Tandjilé (the only region not covered by donor support).[16] The Bank's engagement in human development in Chad was intensified in 1992 with the preparation and discussion of an in-depth analysis of the population, health and nutrition sectors.[17] This report highlighted the negative consequences of high fertility on the health of mothers and children, on poverty at the household level, and on the socio-economic development prospects of the country at large.[18] With regard to health, the report recommended steps to improve the quality, coverage and cost-effectiveness of health services through decentralization, capacity building and the control of key diseases, highlighting AIDS, in particular.[19]

1.14 This dialogue culminated in the preparation of a proposed Health and Population project, which was ultimately split into two projects: (a) the Health and Safe Motherhood Project, approved in June 1994, the Bank's first freestanding health sector investment;[20] and (b) the Population and AIDS Control project, the subject of this review. The decision to split support into two projects was based on a number of factors. First, the population component was not sufficiently prepared in relation to the rest of the original project

15. Credit 2156-CD in the amount of SDR 10.4 million (US$13.4 million equivalent) was approved on June 14, 1990, and made effective on April 14, 1991. A supplemental credit (Credit No. 21561-CD) in the amount of SDR 6.8 million (US$9.8 million equivalent) was approved on November 10, 1994, and made effective on September 6, 1995. Both credits were closed on April 30, 1998.

16. The Bank's final evaluation report (World Bank 1998) acknowledged this component's success in improving utilization of health facilities, but also noted that the project did not fully achieve its objectives to expand infrastructure and to develop sustainable institutional capacity.

17. World Bank Report No. IDP-122, "Population, Health and Nutrition Sector Report," December 1992.

18. It called for action to slow down population growth through: (a) the establishment of a government coordinating body for population policy development and the creation of a population unit for program development and coordination; (b) the development of a national family planning strategy and action plan to increase access to family planning services, with an emphasis on child spacing; and (c) intensified information, education and communication (IEC) by promoting a multi-media approach and involving NGOs.

19. This report noted that the scale and urgency of HIV/AIDS were growing rapidly and were possibly grossly underestimated. At that time the rates of infection of HIV, according to sentinel site data, were 1.6% in Moundou, 0.5% in Sarh and 0.2% in N'djaména. Low awareness, inadequate skills of health personnel and shortage of resources and logistical support all were cited as important impediments to program effectiveness.

20. Credit 2626-CD in the amount of SDR 31.1 million (US$18.5 million equivalent), provided support to three components aimed at: (a) strengthening central MoPH capapcity to support regional health services; (b) improving health, nutrition and family planning services in Guéra and Tandjilé regions; and (c) developing and implementing a national drug policy. 2/24/95, closing 6/30/01.

concept at the time of its appraisal,[21] and there was incentive both not to delay the health operation and not to compromise on the quality of the population component. Second, it was considered critical to address the spread of HIV/AIDS, which was recognized as a threat to Chad's economic and social development prospects.[22] The rationale for combining population and AIDS efforts under one operation was to exploit synergies of efforts in the provision of family planning and HIV/AIDS services and information for behavior change, and in the social marketing of commodities. Third, a combined health and population project was thought to be too complex for the limited management capacity of MoPH. Given the multi-sectoral approach of population and HIV/AIDS, the management of this project was placed under the auspices of the MoPC.

1.15 **Support by Other Donors** to population and AIDS in the early 1990s fell short of needs. Population support was provided primarily by UNFPA (US$3.5 million for the population census, policy formulation, and family planning program management) and USAID (US$8.5 million for maternal and child health and family planning [MCH/FP] service delivery in two regions, and provision of contraceptives). Other support to MCH/FP was provided by donors in the context of basic health services support[23]. A major gap in the financing of contraceptives was imminent with the planned withdrawal of USAID from Chad in 1995. Donors provided about US$4.3 million to support implementation of Chad's first short-term (1988-89) and medium-term (1990-93) HIV/AIDS plans. WHO's Global Programme on AIDS (GPA) was the main source of financial and technical assistance, with support also being provided by UNDP, USAID, France and the European Union (World Bank 1995).

21. Slow progress in the preparation of the population component is largely attributable to the weak capacity of the demographic unit within MoPC.

22. Building on the analysis of the Population, Health and Nutrition Report (World Bank 1992), the Regional AIDS Strategy for the Sahel (World Bank January 1995) provided updates on the progression of the HIV/AIDS epidemic in Chad and guidance for Bank support, most notably: strengthening and expansion of communication; expanding clinical management, epidemiological surveillance and laboratory capacity; support for NGO and community initiatives; support for multisectoral interventions; and policy analysis, research, monitoring and evaluation.

23. WHO, UNICEF, Swiss Tropical Institute, European Union, France, Switzerland. In addition, the International Planned Parenthood Federation (IPPF) provided support to its local affiliate in Chad, the Association for Family Well-being (ASTBEF).

2. Objectives and Design

2.1 The Population and AIDS Control Project was financed through an IDA credit of US$20.4 million equivalent[24], approved on March 23, 1995, and a planned government contribution of US$1.3 million. In addition, cofinancing by KfW and UNFPA in the respective amounts of US$4.4 million and US$0.1 million, brought the total estimated project cost to US$27.2 million. This first free-standing population and AIDS project in Chad became effective on September 8, 1995.

2.2 **Objectives and Components.** The project was designed to assist the Government in implementing its long-term strategy in population and family planning and its medium-term plan 1995-99 (MPT 2) for AIDS control. Its overall objectives were to advance the onset of fertility decline by increasing the use of modern methods of contraception (from 1 percent in 1990 to 10 percent by 2000), and slow the spread of HIV infection by promoting behavioral change. Project assistance was channeled through four components aimed at: (a) strengthening of national capacity to implement the population policy; (b) strengthening of national capacity to contain the spread of HIV/AIDS/STDs; (c) establishment of a social marketing program for condoms; and (d) promoting the participation of the nongovernmental sector in population, family planning, and HIV/AIDS/STD programs. See Annex C for a presentation of project components.

2.3 **Implementation Arrangements.** The MoPC was responsible for overall project coordination, management and oversight. To this end a project coordination team (PCT) was established and placed under the direct supervision of the General Directorate of the MoPC. The PCT was responsible for the day-to-day coordination of project activities, administrative and financial matters, and for the coordination of monitoring and evaluation. It was also responsible for maintaining an effective dialogue with key donors and agencies in the population and health sectors. The PCT consisted of a project coordinator appointed by Government, local contractual staff (including a project administrator, an accountant, the FOSAP administrator, and support staff), and a long-term international specialist in epidemiology and program management. In addition to the cost of these staff, the project financed short-term technical assistance in procurement, accounting and audits, training, logistical support, and operational costs.

2.4 The management of project activities was assigned to institutional structures with respect to their traditional mandates. The population policy component was to be managed by the Division of Population at the MoPC; and the HIV/AIDS component was assigned to the PNLS within the MoPH. Management and implementation arrangements for the social marketing and social fund components are presented below.

2.5 *Social Marketing.* Responsibility for the management and implementation of the social marketing component was given to ASTBEF and (initially to) an international firm specialized in social marketing, together under the general supervision of MoPC and in collaboration with the *PNLS/*MoPH (for technical aspects). Transfer of skills was the main objective of this technical assistance, which was to be provided on a permanent

24. All US$ amounts represent the US$ equivalent of SDRs or other currencies.

basis during the first three years of the project, and through short-term assistance for the remaining two years of the project. The Government, World Bank, and KfW signed an agreement to support this program. KfW was to finance the first three years of the program and IDA the remaining two years; they shared the expenses of an auditor.

2.6 *Social Fund.* The PCT was given responsibility for management of the social fund, with a social fund administrator included among its core staff. Funds were to be made available for subprojects prepared and implemented by: (a) NGOs and civil society organizations; (b) selected sector ministries (health, education, defense, justice, social affairs, communications, and interior); and (c) decentralized, multisectoral entities responsible for population and HIV/AIDS.[25] The social fund was designed to finance 80 percent of the subproject costs, the remaining 20 percent to be provided as counterpart from the implementing organizations.[26] A procedures manual and contract prototypes were developed and agreed by the borrower and IDA, providing for IDA review of contracts larger than CFAF 30 million (about US$60,000) before signature. Under the "resource projects" experienced NGOs were given a geographical zone to operate in, within which they would (a) provide capacity-building support to local associations that would prepare/implement subprojects; and (b) stimulate the development of new associations and additional subprojects to further strengthen civil society. The role of these experienced NGOs was limited to technical assistance and capacity building; they neither signed contracts with the implementing agencies nor disbursed funds, these tasks being the responsibility of the social fund.

2.7 **Monitoring and Evaluation** of project performance was the responsibility of the implementing units, in line with indicators specified in national policies and strategic documents on population and HIV/AIDS, under the overall coordination of the PCT. Baselines did not exist for most HIV/AIDS indicators and many targets were not quantified before effectiveness. Research, studies and other data collection activities were expected to refine and complete baseline data and targets.[27] There was no monitoring and evaluation plan other than the expectation that indicators would be reviewed as required by the second medium-term plan review process (not defined). Standard Bank reporting requirements on implementation included: (a) semi-annual progress reports to IDA; (b) annual joint (IDA/Government) reviews; and (c) a mid-term review.

25. Regional Commissions for Population and Human Resources, created in 1994; and Prefectoral Health Councils, created in the late 1980s.

26. During negotiations the Government gave assurances that it would maintain in the budget of the ministries involved in AIDS control a separate budgetary item for AIDS activities to meet their counterpart obligations.

27. While it provided critical information on both population and HIV/AIDS, the 1996 DHS did not provide needed data on many of the project targets and indicators.

3. Implementation and Costs

Implementation Experience

3.1 After an initial three-month delay in effectiveness,[28] the project was implemented over six years and three months (including a six-month extension[29]) and closed on December 31, 2001, with the credit fully disbursed.

3.2 **Counterpart Financing.** At the start of the project Government made its counterpart funds available, although frequently later than the agreed schedule. However, Government's failure to budget the 20 percent counterpart funding for key sectoral ministries in 1998 caused their activities to come to a halt.[30] Chronic unavailability of counterpart financing during the second half of the project life caused the working relationship and trust between the project and its suppliers to deteriorate seriously, because the latter were being paid only 80 percent of their invoices (the Bank's share). Support staff were only receiving 80 percent of their salaries and telephone and electricity were cut. The Bank was persistent in raising this issue with Ministers of Finance and of Plan, Development and Cooperation, but this issue was not resolved prior to the project's closing.[31]

3.3 **Population.** The two major studies started with some delays but were eventually completed. The Demographic and Health Survey was delayed by elections and the initial unavailability of logistics to support field work. The Migration and Urbanization Survey was delayed because UNFPA was unable to provide all of the funds it had initially committed and *CERPOD* restructuring caused a disruption in its technical support. IDA agreed to finance the gap and cost overruns given the importance of this study.

3.4 Lack of government commitment and heavy bureaucratic processes caused major delays in key project activities. The Government decree creating three key population entities -- the *HCPRH, CNPRH and CPPRH*[32] -- was signed on November 23, 1995, and the legal texts defining the composition and operations of these entities were signed on April 10, 1996. The preparation and approval of the Program for Priority Actions and

---

28. Project effectiveness slipped from July to September 1995 because of extra time taken for the Conseil Superieur de la Transition to ratify the credit.

29. The project was extended to bridge a financing gap pending the delayed start of the follow-on project.

30. The 1999 approved budget did provide for this counterpart funding, thus permitting implementation of sectoral activities that year.

31. The Bank's internal supervision reporting downgraded its rating of counterpart funding from "unsatisfactory" to "highly unsatisfactory" during the latter years of implementation.

32. HCPRH (Haut Conseil de la Population et des Ressources Humaines) is the High Council on Population and Human Resources, chaired by the Head of State, with membership comprised of Ministers, responsible for setting and enforcing population policy. CNPRH (Commission Nationale de la Population et des Ressources Humaines) is the National Commission on Population and Human Resources), chaired by the MoPC with membership comprised of representatives of public sector and civil society, responsible for coordination and oversight of policy implementation. CRPRH (Commission Régionale de la Population et des Ressources Humaines) is the Regional Commission on Population and Human Resources, chaired by the Governor, with membership comprised of regional representatives of the public sector and civil society, responsible for regional-level policy implementation.

Investments *(Programme d'Action et d'Investissements Prioritaire, PAIP),* which was the framework for population policy implementation, was delayed as a consequence. It was transmitted to the *HCPRH* for its review and approval on January 23, 1998, nearly three years later than planned. Furthermore, the *HCPRH* met for the first and only time on November 17, 2000 to approve the *PAIP* almost three years after it was received. A draft decree was prepared in 1998 proposing that the *HCPRH* be chaired by the Prime Minister, rather than the Head of State, to make it more operational, but the decree was never signed. In a meeting of September 7, 2001, the *CNPRH* insisted that the President continue to chair the *HCPRH.*

3.5 Six seminars for journalists, NGOs, opinion leaders, and leaders of women's organizations were carried out as planned. Some 140 union leaders (against 100 planned) were trained in population information workshops and the majority of prefects and subprefects were trained in population, as planned. The messages of these seminars and training sessions were tailored to the specific target groups, but by and large included dissemination of the Declaration of Population Policy and the social and economic consequences of rapid population growth and high fertility for the country at large, the local level, the family, as well as individuals. Themes discussed included: poverty, allocation of scarce resources, the status and role of women in development, and maternal and child health and the benefits of child spacing.

3.6 While the Population Unit was given a higher profile in MoPC – promoted first to the level of a division and subsequently to the level of a full directorate – the number of population professionals was diminishing due to death and attrition.[33] Some of them were replaced with contractual staff and others not at all. Capacity-building efforts were also undermined by the reorganization of CERPOD in 2000, with whom the Division of Population had signed a contract for technical assistance and capacity building. With many staff leaving CERPOD after the reorganization, the quality and quantity of support fell short of levels provided in the initial years of the project.

3.7 **HIV/AIDS.** Implementation of this component was constrained by weak capacity within the *PNLS* in the MoPH throughout the life of the project. Attempts to strengthen *PNLS* were made in the early years of the project with the appointment of a new coordinator and a few other qualified staff. However, inadequacies in numbers and skills of staff have persisted. Difficulties in eliminating shortages of qualified personnel were due both to paucity of available qualified staff and to the reluctance of decision-makers to dismiss weak, non-performing staff.

3.8 There were tensions between the *PNLS* coordinator and the long-term technical assistant, hired to build PNLS capacity in epidemiology and program management. One source of tension was the extent to which the technical assistant was perceived to have substituted for *PNLS* skills gaps instead of developing the capacity of *PNLS*. Interviews revealed many strong and divergent opinions, some expressing that the technical assistant

33. Five demographers have died since the start of the project, including one who was trained overseas under the project. A number of other staff trained under the project were hired by multilateral agencies (e.g., UNDP and UNICEF).

encroached on the responsibilities of the *PNLS* coordinator, while others noting that management and technical skills were so scarce and demands so great on *PNLS* that there was no other alternative and that support at the technical level was appreciated. Additionally, the terms of reference of this technical assistant included significant, additional responsibilities that extended beyond the support to *PNLS*: technical assistance and guidance to the PCT in project management and in the set-up, launch and oversight of the social fund. These responsibilities,[34] combined with the fact that his office was located with the PCT, reduced his availability to the *PNLS.* A final evaluation of this technical assistance was not undertaken by the Borrower.

3.9 Despite these constraints, most planned activities were implemented. Progressively, AIDS plans were developed and implemented at the prefecture level by prefectoral health councils. By project close, prevention activities were being undertaken in all 14 prefectures, as planned. Two hundred eighty three health personnel (against 300 planned) were given HIV/STD-related training. The project provided technical and financial support to five existing sentinel surveillance sites already existing at the project's outset and established four additional sentinel sites (versus two planned) bringing the total of fully functional sites to nine (versus seven planned).[35] Five HIV sero-prevalence studies focusing on specific groups were carried out as planned;[36] and two population-based HIV sero-prevalence studies were carried out in 1997[37] (versus none planned). In addition, three KAP studies were carried out (versus two planned); and a planned study on the socio-economic impact of HIV/AIDS was also carried out. However, of the five planned operational studies to improve health services quality, only one was carried out.[38]

3.10 **Social Marketing.** At the project design stage KfW cofinancing was slated to cover the costs of the first three years of implementation of this component (including the cost of condoms), and IDA the remaining two. However, during implementation KfW decided to extend its support, including the social marketing technical assistance, through 2001 (the end of the project).[39]

3.11 Despite initial delays in start-up activities, implementation of this component was highly successful. Earlier activities focused on the setting up of MASACOT (the project social marketing unit), promotional activities, professional training, and networking.

---

34. It is interesting to note that this project was designed during a time when the Bank sought to reduce long-term technical assistance financed under projects, given client countries' expressed resistance to the high cost of such assistance as well as to the idea of borrowing for this purpose. Project files do provide evidence of the need to strongly justify the inclusion of technical assistance. Some interviewed indicated that, in retrospect, the TOR for this assistance were too broad and ambitious for one person to fulfill.

35. A 10th site in Faya-Largeau was established with project support, but its operations were limited to notification of AIDS cases and not HIV surveillance at the end of the project.

36. Sero-prevalence studies focused on: prostitutes and military in Ndjamena (1995), military in N'djamena (1997), military in Moundou (1997), prostitutes in Sarh (1997), migrants in Logone Occidental (1997).

37. In the prefectures of Abéché and Amtiman.

38. Study completed was on the management of STDs and AIDS patients. Planned studies not carried out focused on: referral protocols for AIDS patients and families; evaluation of the clinical definition of AIDS; relationship of HIV and TB; and accessibility and utilization of health centers and district hospitals.

39. KfW's technical and financial continues today in the context of the follow-on project.

Condom sales soon exceeded project targets and increased during the first years of the project until the year 2000. In that year it was decided to replace the technical assistant for this component, who was not considered by the Bank, KfW, or the borrower to be fulfilling capacity building responsibilities specified in the terms of reference. The time and disruption of replacing this expert had a negative effect on condom sales. Also, at the end of 1999 the Government and its partners decided to transform MASACOT, which had a temporary (or project) legal status, into a permanent NGO, the Association for Social Marketing of Chad *(l'Association pour le Marketing Social au Tchad, AMASOT).* Time and effort were thus spent on the preparation and discussion of draft legal texts. The first General Assembly for this new entity met on October 17, 2001. AMASOT was formally recognized by the Ministry of Interior and Security in January 2002 and the following month regional branches of AMASOT were established in Abéché, Mongo, Moundou, N'Djamena, Pala, and Sarh. The dip in the sale of condoms was only temporary and continued to climb thereafter.

3.12 Around the time of the MTR it was decided to diversify social marketing efforts to include oral rehydration salts for home treatment of diarrhea and dehydration. The rationale for this decision was to contribute to reductions in child mortality, which is recognized to be a strong determinant of fertility. The financing of this initiative under the project was made possible after KfW financing of socially marketed condoms was extended to the end of the project, thus liberating IDA funds for this new commodity. The first packets were ordered and marketed in 2000 with great success and increasing sales over time.

3.13 **Social Fund.** This component was slow to start because of: (a) the weakness of civil society organizations; (b) Government mistrust of civil society organizations in the wake of civil conflicts; and (c) a general lack of information and discomfort about population issues and HIV/AIDS across civil society. The preparation and approval of a social fund procedures manual having been a condition of effectiveness, the first two years of activity were devoted primarily to information and outreach with potential partners (NGOs, associations, key sector ministries) to inform them of the availability of funds and the project preparation and approval cycle.

3.14 Early efforts also focused, as planned, on the recruitment of experienced NGOs to carry out capacity building and outreach with civil society groups to guide them in subproject preparation and implementation, incite the development of new subprojects and contribute to the strengthening of public-private partnerships at decentralized levels. The social fund financed six NGOs to carry out these technical support capacity-building initiatives, two more than planned.

3.15 In response to a call during the MTR for microfinance for women as a means of fighting HIV/AIDS and addressing determinants of reproductive behavior and family well-being, the Development Credit Agreement was amended and funds reallocated to support this initiative. During the second half of the project this new subcomponent

provided US$800,000 to 12 field-based agencies,[40] which provided microcredit to women's groups throughout the country.

3.16 Despite successes in exceeding implementation targets, lack of FOSAP capacity in microfinance caused a differentiation in the quality and appropriateness of approaches and results across the 12 field-based agencies. Implementation of the population and HIV/AIDS subprojects was constrained both by slow disbursements (caused in part by failure to replenish the Special Account due to delays in statements of expenses submission) and by the fact that some NGOs responsible for capacity building and outreach had a growing clientele that was exceeding their budgets and staff capacity.

3.17 FOSAP carried out independent evaluations and audits of all subprojects. Many of the local associations interviewed during field visits noted that FOSAP and PCT staff and senior NGOs (under the capacity building projects) provided critical technical guidance and support.

3.18 Originally FOSAP was conceived as an organ of the project with no life anticipated after the project's closing. However, it was later acknowledged that an important dynamic had been initiated that should continue beyond the project's closing. In 1998, the legal status of FOSAP was revised to give it a permanent legal status. As such, its management was detached from the project and given full autonomy. Two management committees, each made up of public sector and civil society representatives, oversee, respectively, the subproject grant and microfinance components. Since FOSAP achieved this autonomy, co-signature of projects by PCT was no longer necessary; and FOSAP acquired its own Special Account, which greatly facilitated disbursements.

Planned Versus Actual Costs and Financing

3.19 The total project cost was US$26.1 million equivalent, or 96 percent of the cost estimated at appraisal (US$27.2 million, see Annex D). While the IDA credit of 13.9 million SDR was fully disbursed, its dollar value decreased over the life of the project from US$20.4 million to US$18.7 million at closing (see Annex D). KfW financing was greater than initially planned because of its decision to extend its support of the social marketing component. Government counterpart financing fell short of its commitments and the actual contribution by civil society (under the social fund) was in line with appraisal estimates.

3.20 Annex D presents planned versus actual disbursements. While grants under the social fund were initially estimated at 2.70 million SDR or 19 percent of the total credit amount, actual disbursements under the social fund amounted to 3.55 million SDR or 25 percent of the total credit. An additional 5 percent of the credit (0.8 million SDR) was disbursed to support microcredit for women.

40. Many of these agencies were NGOs that did not necessarily have microfinance experience, as this was very rare on the ground. They were chosen for their overall experience in working with communities and for their management and organizational skills. The operational manual was a means of guiding these agencies in carrying out microfinance activities and in developing microfinance capacity in the country.

4. Outputs and Outcomes by Objective

4.1 Annex E provides an overview of key targets and indicators for population and HIV/AIDS supported under the project. It shows that for most of these indicators baseline data were not established, targets were not quantified, data as of the end of the project were not compiled. This being said, progress against a few of these indicators has been measured. In addition, the project supported the generation of useful demographic, social, epidemiological and behavioral data that provide additional indication of the outcomes of this investment. This chapter highlights the major achievements of the project and the outcome for each population and HIV/AIDS.

Population

4.2 ***The capacity of the Division of Population was strengthened with overseas training, study tours, and on-the-job technical assistance, but this Department remains understaffed relative to the scope of its mandate.*** Technical training was provided in demography, the use of demographic data in development planning and the implementation, management, and monitoring and evaluation of the population policy and program. However, the amount of demographic training (both in numbers of people trained and length of training) was inadequate for the needs (Wakam 2001). The effectiveness of training delivered was not evaluated. Participation at the 1994 Cairo Conference on Population and study tours to Burkina Faso, Mali, Senegal, and Tunisia increased the exposure of staff to international good practices. Training was also provided to over 60 public sector officials in the use of demographic data in development planning by all ministries, but utilization of demographic data has remained weak (Wakam 2001).

4.3 ***The project was generally successful in raising community awareness and disseminating the population policy, but attitudes are slow to change.*** At the MTR and again at the close of the project it was acknowledged that it takes considerable time to change attitudes. Nevertheless, during its field visits the mission was told about and also observed evolution in knowledge and attitudes across a wide range of groups.[41] For example, religious leaders (Muslim and Christian) are involved members of local-level population commissions and are highly committed to population policy objectives that aim to improve mother and child health and wellbeing and girls'schooling. National and international informants noted that some (initially resistant) imams are now sufficiently convinced about the benefits of birth spacing that they are promoting this practice in rural populations. This being said, there is still ambivalence and even resistance to the idea of limiting family size, whereas other components of the population policy (child spacing to promote of maternal and child health, improvement of women's status, and expansion of women's economic opportunities) are more widely supported. While the coverage targets of population IEC were essentially met, the efficiency of efforts was compromised by the

41. Opinion and religious leaders, women, NGOs, journalists, youth, union workers and local leaders.

delay in the creation of a technical coordination committee for IEC[42] and the failure of this committee to meet regularly.

4.4 ***The project was successful in generating relevant socio-demographic data and information in Chad, but it is not fully exploited.*** The three main research outputs of the project were: (a) the first Demographic and Health Survey (1996/97); (b) a study on migration and urbanization; and (c) the preparation of 15 monographs that provide for each prefecture regional-level data drawn from the 1993 census, five in-depth analyses of census data, and seven regional-level analyses of DHS data. The extent to which this data is used in development planning and evaluation has been reviewed and judged to be very weak (Wakam 2001). In addition, delays in the publication of completed studies undermine efforts to disseminate and use them. A case in point was the migration and urbanization study, which was published three years after its completion.

4.5 ***The project strengthened MCH/family well-being services at all levels of the public health system, most notably through the supply of contraceptives for these services throughout the life of the project.*** As a complement to the ongoing Health and Safe Motherhood Project, which sought to strengthen basic health services, the project averted a major gap in contraceptive supplies when USAID withdrew support to Chad in 1995. USAID had been the main supplier of contraceptives in Chad; in the absence of project support, there would likely have been a severe shortage of contraceptives in the country. Close coordination between these two projects, including joint supervision, ensured a coherence in the provision of inputs for MCH and family well-being. Other supports to MCH and family well-being included: (a) subprojects supported by the social fund to improve MCH and family well-being; (b) the production of critical baseline data on MCH and family well-being (DHS 1996/97); and (c) the improved availability and affordability of oral rehydration therapy throughout the country.

4.6 ***The social fund was successful in mobilizing and financing a response from civil society organizations in addressing population issues and in inciting and supporting an integrated public sector response at decentralized levels of the administration.*** Forty-five population subprojects (against 20 planned) were carried out. Of these, 30 were executed by local associations supporting a variety of activities (maternal and child health and family well-being, promotion of women and youth, and studies), and 15 integrated projects (addressing direct and indirect determinants of population and reproductive health) were implemented by the 15 *CRPRH.*

4.7 Evaluations of subprojects commissioned by the social fund focused more on implementation rates than on results. However, field discussions highlighted results reported by implementers and beneficiaries, including an increase in the use of prenatal services, improved economic opportunities for youth, increased enrollment of girls in school, increases in exclusive breastfeeding, and a reduction in severe cases of malnutrition among children.

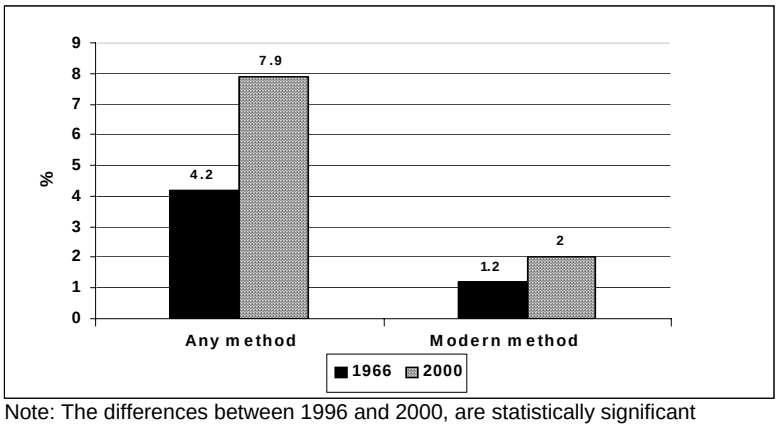
42. Created in September 1997, almost two years after the initial target date.

4.8 ***The provision of microfinance for poor women achieved positive changes in important, inter-related determinants of fertility: (a) increased income generation and economic opportunities for women; (b) increased investments in the health, nutrition and education of their children; (c) improved social and economic status of women; and (d) improved information on reproductive health and family health.*** These achievements, relative to the counterfactual of no support, are documented both in the final evaluation of the microfinance component (Miller 2001) and in discussions with about 50 beneficiaries of this support the cities of Mao, Bongor, Moundou and Mongo. Informed questions posed by these women about the relative safety and risks of different methods of contraception provided an indication of their basic knowledge and internalization of messages about reproductive health and family planning choices. However, as is documented later in this chapter, these achievements have not yet translated into increases in the CPR.

4.9 ***The introduction of oral rehydration packets into the social marketing portfolio of AMASOT to fight diarrhea in children under five addressed yet another critical determinant of fertility – that of high child mortality.*** Sales thus far have exceeded initial expectations due to a very high demand for this product. The potential impact of this activity on child mortality is significant, but it has not yet been evaluated.

4.10 **Project assistance did not succeed in increasing the modern contraceptive prevalence rate (CPR) from an estimated 1 percent in 1990 to the target of 10 percent by 2000.**[43] As illustrated in Figure 2, Chad achieved a modern CPR prevalence rate of 2.0 percent in 2000 (UNICEF 2001), a statistically significant increase over the 1996 level of 1.2 percent (DHS 1996/97), but, nevertheless, considerably lower than the target. The figure also shows that the CPR for modern and traditional contraception combined increased from 4.2 percent to 7.9 percent over the same period. Table 3 in Annex D shows a breakdown in contraceptive use by level of education and place of residence in 2000. The modern CPR is significantly higher among women with secondary school education (12.3 percent) as opposed to those with primary education

Figure 2. Use of contraception among married women and those in consensual union, 1996 and 2000



Note: The differences between 1996 and 2000, are statistically significant at $p \leq .05$.
Source: DHS 1996/97 and UNICEF Multiple Indicator Survey 2001; Reproduced from Country Status Report (World Bank 2004).

43. While it was acknowledged at the MTR that the program's (and project's) original objectives and targets were, in retrospect, unrealistic and would not be met, there was no formal revision of objectives. UNFPA was working on revising the objectives, but their consultants are reported to have worked very slowly and realistic data were available only for the 2nd project.

(2.8 percent) or some education (1.4 percent); and modern CPR is also higher among women living in urban areas (6.6 percent), especially in N'Djamena (9.0 percent), as opposed to their rural counterparts (0.8 percent).

4.11 Available data indicate that the total fertility rate (TFR) in Chad has remained constant over the life of the project. The DHS revealed a TFR of 6.6 children in 1996/97; recent analytic work suggests this same rate for 2000 (CSR 2004).

4.12 The population strategy also aimed, through an anticipated increase in the CPR, to reduce the annual rate of population growth from 2.4 percent in 1990 to 2 percent by 1999. According to the most recent Government estimates, the actual rate of population growth is about 3.1 percent.[44]

4.13 It is important to note that at the time of the MTR (1997), when the results of the first-ever DHS in Chad became available, it was acknowledged by the Bank and the borrower that the objectives of increasing the use of modern contraceptives and decreasing fertility and the population growth rate were, in retrospect, not realistic and would not be achieved. They expressed the intention of setting new targets on the basis of the DHS data. UNFPA hired consultants to this end, but the work of these consultants progressed slowly; and the Development Credit Agreement was not formally amended to set more realistic objectives against which the project would be measured.

HIV/AIDS

4.14 ***Epidemiological and behavioral surveillance was improved under the project and documented the seriousness and scope of the epidemic.*** The project supported the strengthening and functioning of the epidemiological surveillance system for HIV, comprised of nine fully functional sentinel sites[45] by the end of the project (versus seven planned), two of which were set up with project assistance (see list in Annex D). This system collects and reports annual data on HIV prevalence among pregnant women using prenatal services, blood donors, STD patients, and TB patients.[46] Sentinel sites also monitor and report on prevalence of syphilis among women using prenatal services. Technical supervision and support of sentinel sites was somewhat constrained by staff turnover,[47] but compensated in part by the support of the long-term technical assistant.[48]

---

44. Source: Directorate of Coordination of Population-Related Activities, Ministry of Planning, Development and Cooperation (MPDC), 2004 data.

45. At the time of the project's closing, a tenth site (Faya) is only reporting AIDS cases (and not HIV prevalence) for the moment.

46. At the time of the mission's visit, four annual statistical reports had been produced, providing a series of data for the years 1999, 2000, 2001, and 2002. While the project financed training and other support to the functioning of the surveillance sites, the quality and completeness of the data are still in need of improvement.

47. PNLS staff person responsible for epidemiological surveillance at the project's outset received training in epidemiology, but was transferred to another post upon his return to Chad. He was replaced by a non-specialist who received no technical training in epidemiology.

48. The long-term international technical assistant, who is an epidemiologist, did not provide full-time support to this effort, because his terms of reference were very broad. In addition to epidemiological

4.15 HIV prevalence and behavioral studies have supported the documentation of trends, issues, and consequences of the epidemic and the development of strategies on how best to fight it. HIV seroprevalence studies in different geographical regions, some focusing on the general population others focusing on specific high-risk groups, have permitted in some cases an assessment of trends in the epidemic (see Annex D). Sentinel sites and studies data were often cited by regional authorities and actors and may well be motivating local commitment and, to a lesser extent, the design and targeting of activities. Also contributing to improved knowledge and insight were: knowledge, attitude and practice (KAP) surveys and sociological studies on high-risk groups (such as prostitutes) and a study to assess the economic and social impact of the epidemic.

4.16 The IEC Unit within *PNLS* produced materials and carried out campaigns to inform the general population and target groups and enhance their ability to protect themselves. These efforts were complemented by the numerous and widespread IEC efforts carried out by other national partners (such as the Ministry of Communication, the IEC division of MoPH, and public and non-public actors at the local level) targeting many groups across the country. Many actors encountered during field visits acknowledged the good quality and utility of IEC material produced by the IEC unit in *PNLS*. Many also called for more locally appropriate material in local languages, better coordination of IEC, and more research for adjusting interventions and target groups. There was consensus among the majority of informants that evolution has occurred in the knowledge and attitudes of a range of actors and stakeholders. HIV/AIDS is no longer taboo, but rather recognized for what it is: a threat to the development of Chad and the well-being of its population that requires urgent and persistent action. While IEC efforts do seem to have had some impact, their coordination and efficiency are in need of improvement.

4.17 ***The project supported the strengthening of the public health system's capacity in: the diagnosis of HIV infection (including equipment of laboratories), the psycho-medico-social care of HIV/AIDS patients, the diagnosis and treatment of opportunistic infections, and STD syndromic treatment.***[49] The project provided technical training and consumables for laboratories and established a national laboratory referral center for HIV/AIDS diagnosis. It also financed a CD4 count instrument and the establishment of Enzyme-Linked Immuno Sorbent Assay (ELISA) chains in five hospitals. Support for improved STD services included the training of over 2000 service providers and the preparation of STD treatment guidelines. Some training on the use of anti-retroviral drugs (ARV) and triple therapy was also provided.[50] No evaluation has been carried out

---

technical support, his terms of reference also included the provision of technical/managerial support to the PCT/MoPC in coordinating HIV/AIDS activities and to the social fund entity, FOSAP.

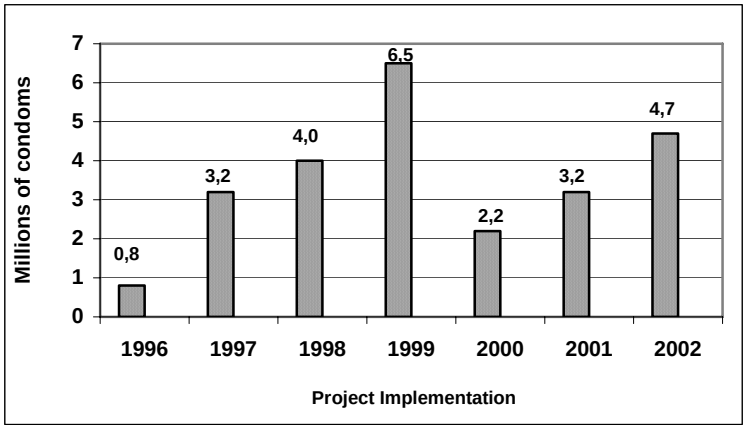
49. The syndromic approach to STD patient management bases diagnosis and treatment on the presence of symptoms, generally without resort to confirmatory laboratory tests. This approach is recommended by WHO in developing country settings as it allows treatment with a single visit and away from a laboratory setting.

50. The project did not finance the purchase of ARVs. In 1994 when the project was designed ARVs were very expensive and not widely available; and Chad's second medium-term plan for HIV/AIDS placed highest priority on prevention activities.

to assess the extent to which these investments culminated in more and higher-quality services. A number of those interviewed noted that HIV/AIDS and STD patients are still not well managed and that there are still considerable gaps between facility-based and community-based care. Data were not available to check progress against the project target of 12,000 AIDS patients being treated by the health system. The project also invested in the strengthening and expansion of counseling and testing services; at the end of the project some 13 centers were functioning (target not specified in project documentation), with more slated to be established.

4.18 ***The social marketing program has significantly increased the availability of condoms in Chad at an affordable price.*** A total of 19.9 million condoms were sold during the life of the project (1996-2001) through a network of over 1,200 points of sale throughout the country, against the initial target of 14 million. The annual sales target set for the last year of the project (4.8 million condoms) was exceeded in the third full year of the project (6.5 million in 1999). For reasons explained in Chapter 3, annual sales declined temporarily in 2000, then steadily increased over the following two years, achieving 4.0 million in 2002. Figure 3 shows trends in annual sales over the life of the project and during the first year after the close of the project (2002). Annex D shows a further breakdown of these sales by month and average monthly sales for each year (just under 300,000 condoms).

Figure 3. Condom Sales, 1996-2002



Source: AMASOT statistics, 2004

4.19 The very low price of less than US$0.02 per unit (50 CFA francs for a packet of four) has made condoms widely accessible to the general population. It has also prompted the sale of these condoms in neighboring countries of Cameroon and Central African Republic, where the price of condoms is higher. A study of social marketing programs in the three countries estimated that up to 20 percent of *AMASOT* condoms (about 4 million units) may have been resold in these countries (Lehmann et al. 2003). Net of estimated sales in neighboring countries, the total number of condoms sold in Chad over the life of the project (15.9 million) still exceeded the project target of 14 million. In October 2003, *AMASOT* increased the price of condoms to 100 CFA francs.[51]

51. In October 2003, AMASOT doubled the price of condoms (from 50 to 100 CFA francs for a packet of 4) to discourage their cross-border sales, still keeping the price affordable for most Chadians. Sales data in late 2003 and early 2004 reveal a decline in overall sales, attributable by AMASOT both to a reduction in cross-border sales and to a temporary decline in in-country sales because of the price increase.

4.20 While condoms were taboo at the start of the project, they are now sold openly in shops, market stands, inns, and hotels across the country. The Bank evaluation mission was told by the majority of those interviewed that condoms are used more frequently during casual sexual encounters.[52] There are now some 25 billboards with HIV/AIDS messages prominently displayed in major cities. Messages abound as well in newspapers and on posters placed in many public venues: workplace, stadium, restaurants, hotels, and public transport. Religious institutions and leaders who were vehemently against condom promotion at the project's outset have tempered their opinions and have a laissez-faire demeanor, with some tacitly promoting their use as a means of preserving family health and well-being. As a consequence, there seems to be considerably less stigma associated with the purchase of condoms.

4.21 ***The social fund has been complementary to AIDS interventions carried out by Government.*** A total of 97 HIV/AIDS subprojects were prepared and implemented throughout the country (against 40 planned), of which 68 by local associations (prevention targeted at youth, prostitutes, and psycho-social-medical care), three by regional Islamic associations (in three prefectures), 15 integrated projects under the coordination of Prefecture Health Councils, and 11 by eight sector ministries.[53] The impact of these efforts has not been evaluated, but the social fund has achieved an expansion of national capacity to respond to HIV/AIDS and has broadened the range of actors and scope of activities.

4.22 ***The social fund has nurtured and supported a response from civil society organizations in addressing HIV/AIDS:*** Civil society projects covered a range of advocacy, IEC, behavior change interventions, and community-based efforts to provide care and social support to people living with HIV/AIDS (PLWHA). Field discussions with implementers and beneficiaries pointed to improved awareness and knowledge, better quality of life for PLWHA and their families, and greater civil society pressure on public sector leaders to be accountable for addressing HIV/AIDS.

4.23 ***The social fund has also strengthened the capacity of civil society to conceive and implement activities in support of HIV/AIDS.*** Six experienced NGOs carried out capacity development activities, based in, and covering, different geographical zones across the territory of Chad. Assistance included subproject design, proposal writing, implementation, and monitoring and evaluation. This approach put needed technical assistance and support within immediate access of a relatively inexperienced and weak civil society. A significant majority of the numerous local associations interviewed during the evaluation mission considered this assistance to be pivotal in their ability to access funds and implement subprojects successfully. Another outcome of the efforts of the capacity building efforts is the development of new local associations, in particular associations of prostitutes and associations of PLWHA. This is an important accomplishment, given taboos prevalent at the project's outset and given the great potential of these two groups to contribute to HIV/AIDS prevention efforts. A number of

52. Unfortunately available data is inadequate to document this trend.

53. Social Action and Family; National Education; Defense; Finance; Justice; Communiation; Health; and Interior.

experienced NGOs raised concern about the limits of their ability to provide effective support to the increasing number of local associations with limits in financial and human resources defined in their contracts.

4.24 ***Improved capacity of poor women to earn income under the microfinance component, combined with the provision of practical information on HIV/AIDS decreased the vulnerability of women to HIV infection.*** An evaluation of this subcomponent was undertaken (Miller 2001)[54] and corroborates the findings of the mission, derived through interviews with microfinance agencies and about 50 women beneficiaries in four prefectures. The large majority of women's groups succeeded in using microfinance resources to start or expand economic activities that resulted in increased income used for investments in family well-being. Together, the extra income and the information on HIV/AIDS were reported to have given women an equal partnership with their husbands, higher self esteem and dignity, and the knowledge to protect themselves from HIV infection. Women benefiting from this assistance reported that it protected them informal prostitution for income and equipped them to reduce vulnerabilities of their daughters and other women. In short, they expressed a strong sense of economic, social and personal empowerment.

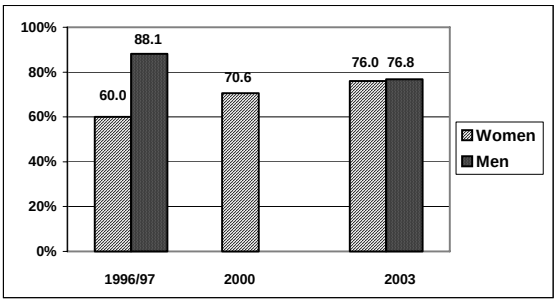
4.25 ***The social fund mobilized and financed the involvement of key sector ministries in HIV/AIDS efforts.*** The social fund has supported HIV/AIDS activities of eight key ministries, who have designated a focal person and, in some cases HIV/AIDS units, to address HIV/AIDS issues, targeted at staff and clients. Among activities supported are: HIV/AIDS training and IEC in schools (Ministry of Education), social support of PLWHA and their families (Ministry of Social Action and Family), medical and social support of HIV/AIDS patients (Ministry of Public Health), training of journalists, and radio and television media campaigns (Ministry of Communications), sensitization of military and prevention of contamination in health facilities (Ministry of Defense), protection of prisoners (Ministry of Justice), information and mobilization of local officials and traditional leaders (Ministry of Interior). However, the effectiveness of these activities has not been evaluated.

4.26 ***The social fund launched and supported the decentralization of HIV/AIDS activities in all 14 prefectures.*** Carried out under the auspices of inter-sectoral Prefecture Health Councils, the effectiveness of the subprojects, focusing on a range of prevention, care, and mitigation activities, has not been evaluated. Over and above the financing of these activities at the regional and subregional level, project support provided a dynamic for local-level, inter-sectoral deliberation and action on HIV/AIDS.

54. This evaluation focused more on the process and efficiency of the microfinance scheme than on the impact of this investment. Nevertheless, the methodology did include interviews with beneficiaries in five prefectures to assess the impact of this investment on their lives and on the lives of their families. While the report provides useful insights on impact, the authors note that their evaluation of impact was not sufficiently systematic or rigorous, and recommend that an in-depth evaluation be undertaken.

4.27 ***Awareness and knowledge of HIV/AIDS, among men and women, both urban and rural, have increased during the life of the project.***[55] The most significant improvements found among women, rural residents and the poorest income quintiles (see text Figures 4, 5, 6, and 7; and Annex D). Improvements have thus reduced important disparities in knowledge and awareness between men and women, urban and rural residents, and the poorest and richest segments of the population. Trends in knowledge of high risk groups are not known.[56]

Figure 4. Percent of men and women surveyed declaring they have heard of AIDS



Source: DHS 1996/97; UNICEF 2001; KAP 2003

Figure 5. Percent of men and women who know condoms are a means of protection

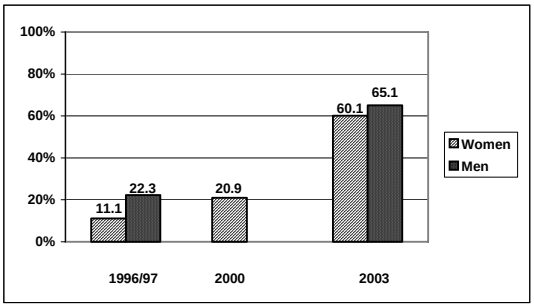
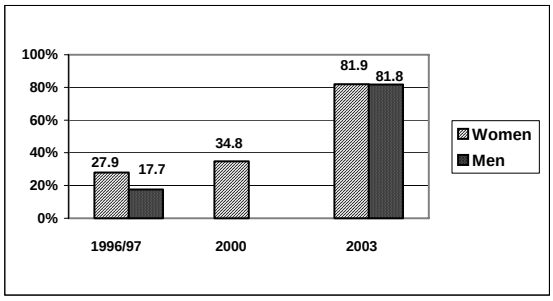


Figure 6. Percent of men and women who know that fidelity is a means of protection

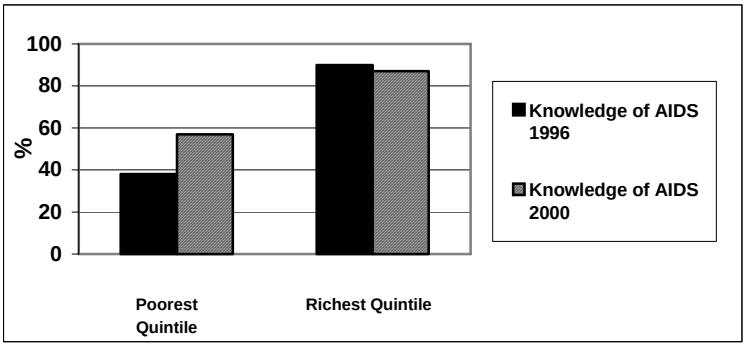


Source: DHS 1996/97; UNICEF 2001; KAP 2003.

55. Trends on awareness and knowledge presented in this report are derived from three national studies: (a) the 1996/97 Demographic and Health Survey; (b) the 2001 UNICEF Multiple Indicator Survey; and (c) a 2003 KAP survey commissioned by Government. All three surveys are national in coverage and based on the zones defined during the 1993 population census. All three cover women in the same (15-49 year) age group; and the first and third surveys also include men in the same (15-59 year) age group. DHS questions related to knowledge and awareness were open-ended, whereas the UNICEF and KAP survey questions were prompted. All three surveys covered both urban and rural populations and properly weighted the data to reflect the urban/rural population distribution. Sample size for the DHS included 7,454 women and 2,320 men. UNICEF's sample size covered 5,865 women; and the KAP sample was comprised of 1,148 women and 1,332 men. Different questions were posed across the three surveys with regard to condom utilization, thus limiting the possibility of deriving trends on behavior.

56. A nationwide study of prostitutes in Chad found that 96 percent of prostitutes living in urban areas and 74 percent in rural areas were aware of HIV/AIDS and possessed the knowledge of sexual transmission and how to protect themselves (Ngoniri 2001). No baseline data on knowledge of prostitutes was established, against which these levels can be compared. Prostitutes were a priority target group for HIV awareness and prevention of the first medium-term HIV/AIDS plan (1990-1993).

Figure 7. Evolution in Levels of Knowledge of Women by Socioeconomic Group, 1996–2000

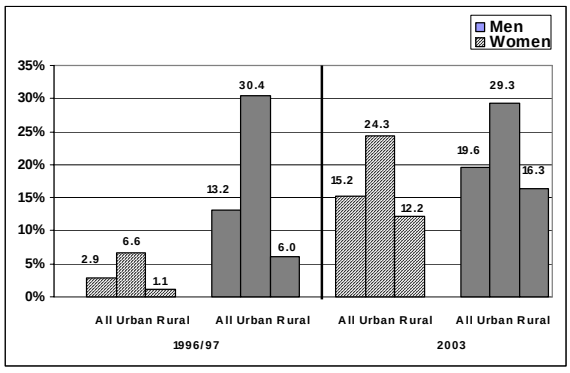


Source: DHS 1996–97 and Unicef Multiple Indicator Survey. Reproduced from Country Status Report (World Bank 2004).

4.28 The proportion of adults reporting that they have ever used a condoms has risen over the period 1996-2003, with the most significant increase among women (Figure 8). While urban-rural and gender differentials are still evident in 2003, they have been reduced since 1996/97.

4.29 In 2003, 6.6 percent of women surveyed reported using condoms regularly and another 6.5 percent of women reported using them occasionally. higher than in 1996/97, when 0.7 percent of women having knowledge of AIDS and having sexual relations within the last 12 months reported using a condom in their most recent sexual encounter (DHS 1997). Men also reported higher levels of condom use than women in 2003 than in 1996/97: 8.7 percent reported regular use and 9.1 percent reported occasional use in 2003, up from 2.2 `percent of men knowing about AIDS and having sexual relations within the past 12 months reported using a condom in their most recent sexual encounter (DHS 1997). Trends in condom use by high-risk groups have not been systematically tracked, but a recent study reveals high rates of condom use by prostitutes.[57]

Figure 8. Ever-Use of Condoms (percent), 1996 and 2003



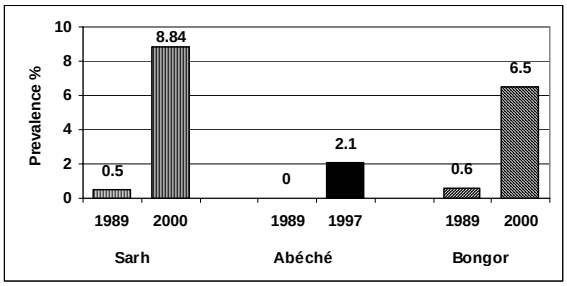
Source: DHS 1996/97; KAP 2003

57. The Ngoniri study (2001) reveals that use of condoms by prostitutes is highest in urban areas, where 82 percent of professional prostitutes and 52 percent of those engaged in clandestine prostitution report that they regularly use them. In rural areas an estimated 55 percent of professional prostitutes report regular use of condoms, while regular use among clandestine prostitutes is much lower at 20 percent. While there is no baseline against which to compare these findings, discussions with a wide range of actors and stakeholders, and consultation of project design documentation, reveal that condoms were both unavailable and taboo in the early 1990s.

4.30 ***In the absence of incidence data, it is difficult to evaluate the extent to which the project has slowed the spread of HIV infection.***[58] At the time of project design 2,865 AIDS cases had been reported over the 9-year period 1986-1994. During the following eight-year period (1995-2002) an additional 14,108 cases were reported, a fivefold increase. However, even the most recently reported cases were most likely the result of infections which occurred before the start of the project and AIDS cases are underreported.

4.31 A series of population-based surveys of general and specific populations reveal HIV prevalence rates for different geographical regions, different population groups, and different periods (Annex D). These data for the most part show snapshots of rates of certain groups and/or regions at a certain time. The only trends that these datashow are (a) an increase in the prevalence rates in the cities of Sarh, Abéché and Bongor (see Figure 9), and (b) a slight decline in the prevalence among military personnel in N'Djamena (from 10.2 percent in 1995 to 8.40 percent in 1997).[59]

Figure 9. Trends in Adult Prevalence in Three Cities



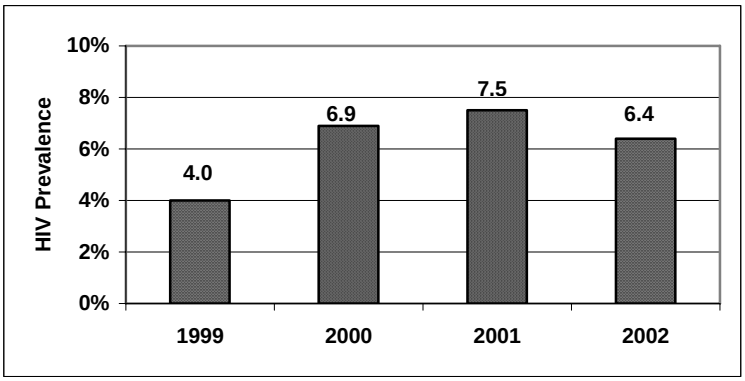
Source: Population based study covering 6 cities (N'Djamena, Moundou, Sarh, Bongor and Abéché. (Organization for the Coordination of Epidemics of Central Africa, OCEAC, 1989); and population based surveys on Abéché, Bongor, and Sarh (PNLS) 1997 and 2000

58. The objective of the project was to slow the spread of HIV, which means reducing the number of new infections. Prevalence is affected by the number of new infections, the number of past infections and the AIDS mortality rate and therefore masks the rate of new infections (incidence). Because of the delay in the onset of AIDS of 10 years or more, HIV prevalence can rise quickly early in an epidemic, before AIDS mortality affects HIV prevalence. Subsequent declines in prevalence will be attributable in part to AIDS mortality and may not necessarily reflect declines in new infections.

59. The sample size of these studies is not known.

4.32 Figure 10 shows that prevalence among women using prenatal services in four urban sites[60] has increased from 4.0 percent in 1999 to 7.5 percent in 2001 and then decreased to 6.4 percent in 2002.[61] While available data reveal that HIV prevalence has risen over the past decade in the general population and that it may have stabilized among pregnant women using prenatal services in urban areas, these data do not reveal the extent to which changes in prevalence are due, on the one hand, to rising mortality due to AIDS, and, on the other hand, to reductions in new infections.

Figure 10. HIV Prevalence Among Women Using Prenatal Services in Four Urban Sites, 1999-2002



Source: MOPH 1999-2002 sentinel site data from: Bol, N'Djamena, Bongor, and Sarh.

5. Ratings

5.1 **Outcome.** The outcome of the Population and AIDS Control Project is rated **moderately satisfactory** overall, based on an *unsatisfactory* outcome of the population objective and a *satisfactory* outcome of the HIV/AIDS objective (see Table 1). The final rating was derived from a heavier weighting of the outcome of the HIV/AIDS objective, commensurate with its high relevance and its share of the total project cost (about two-thirds).

Table 1. Summary OED Ratings* by Objective

	Relevance	Efficacy	Efficiency	Outcome
To advance the onset of fertility decline by increasing the use of modern methods of contraception	Modest	Negligible	Modest	Unsatisfactory
To slow the spread of HIV infection by promoting behavioral change	High	Substantial	Substantial	Satisfactory

* See inside cover of this report for definitions of relevance, efficacy, efficiency and outcome.

60. The only four sentinel sites for which data is available every year during the period 1999-2002 are the urban sites of Bol, N'djaména, Bongor and Sarh. Two other urban sites (Abéché and Moundou) did not have complete data sets over this time period and so were eliminated from this trend analysis.

61. Data from all 11 sentinel sites reporting in 2002 (of which seven classified as urban and four classified as rural) indicate an overall prevalence rate among pregnant women using prenatal services of 5.82 percent (see Annex D for details). Given that seven of the 11 sites are urban, national prevalence among this group is likely to be lower when weighted for the urban/rural population distribution. These data should be interpreted with caution as capacities for the collection and analysis of epidemiological data are still considered to be weak; and rural data are too recent to reveal trends. Furthermore the representativity of these data is not sure as less than half of all women utilize prenatal services (Annex D).

Population Outcome

5.2 ***Based on assessments of its relevance, efficacy and efficiency, the overall rating of the outcome of the population objective is unsatisfactory.*** The fundamental objectives of reducing fertility and reducing population growth are not articulated in the Government's PRSP (October 2003), nor does it mention family planning for birth spacing and family well-being. The document's treatment of population is to note that demographic factors (including population growth) call for strong economic growth to ensure sufficient jobs and access to services for a growing population, and a redistribution of the fruits of economic growth to those most in need. Neither are the control of population growth or the reduction of fertility specified among the Bank's CAS objectives (November 2003). Under the umbrella of the MDGs, however, a number of determinants of fertility are highlighted in the CAS, including: reduction in the poverty and vulnerability of women, increased girls' enrollment in school, and reductions in maternal and child mortality. **Relevance** of the population objective is thus rated as **modest**.

5.3 **Efficacy** in achieving the objective of raising the modern contraceptive prevalence rate to 10 percent by the year 2000 is **negligible**. Population-related behavior change is progressing slowly, at best, with only very modest increases in contraceptive prevalence rates documented between 1996 and 2000. **Efficiency** of efforts to reach the population objectives is **modest.** Because of staffing shortages, a shortfall in UNFPA financing, and upheaval caused by a reorganization of *CERPOD*,[62] the Department of Population was late in producing major research and studies, although the quality of these studies is high. Absence of effective coordination of the multiplicity of IEC initiatives and IEC units across have caused efforts to be fragmented and uncoordinated. The institutional framework for population policy approval and oversight was highly inefficient. At the decentralized level initial efficiency of the newly established *CRPRH* was low, but improved over time.

HIV/AIDS Outcome

5.4 ***The overall outcome of the HIV/AIDS objective is satisfactory, based on the following ratings of its relevance, efficacy and efficiency.*** The **relevance** of the HIV/AIDS objective is **high.** Both the PRSP and CAS are articulated around the MDGs, which specify the goal of controlling the spread of HIV and a three-year outcome indicator of reductions in high-risk behavior for HIV/AIDS prevention. The project's **efficacy** in achieving the HIV/AIDS objective is **substantial**. Overall, good progress has been made in increasing levels of, and decreasing inequities in, awareness and knowledge of the population about HIV/AIDS. The social marketing program has significantly increased the availability of condoms throughout Chad at an affordable price. Taboos associated with the purchase and use of condoms have decreased considerably. Available data indicate modest, but positive, changes in behavior, a trend which is likely to continue, and which contributes directly to reductions in infection. There is inadequate

62. With whom a major contract was signed to provide technical assistance and capacity building.

evidence available on trends in the number of new infections (incidence) in the general population and among high-risk groups.

5.5 The **efficiency** in achieving HIV/AIDS objectives is judged to be **substantial** overall**.** More than half the project resources were ultimately channeled through the nongovernmental sector to two autonomous agencies, which proved to be efficient in their operations. First, *FOSAP* (responsible for the social fund) disbursed 133 percent of funds initially allocated for civil society and decentralized subprojects. The microfinance subcomponent achieved a reimbursement rate that exceeded 90 percent, in spite of the fact that it relied on the few microfinance organizations that existed in Chad, whose capacity was weak. Challenges remain to improve the coordination of subprojects so as to minimize duplication or gaps in essential interventions. Second, *AMASOT*, in charge of the social marketing component, was efficient in its organization and its operations, especially after the initial technical assistance was replaced at the mid-term by new technical assistance that was more geared to the transfer of skills.

5.6 The *PNLS* has not been fully efficient in leading and coordinating MoPH's response to the HIV/AIDS epidemic. By design, the PCT in the MoPC carried out the role of inter-sectoral coordination of HIV/AIDS actors and activities. The PCT was highly efficient in managing and overseeing project implementation and was proactive in communicating with the multiplicity of actors and beneficiaries, both through frequent field visits[63] and through regular (monthly) meetings with key actors on each of the four components.

5.7 **Institutional Development.** The project's support to the development of institutions for population and HIV/AIDS is **substantial.** The establishment of a social fund has (a) significantly strengthened incentives of a range of public and nongovernmental stakeholders to become involved in population and AIDS; (b) supported the decentralization of population and HIV/AIDS activities; (c) incited a new dynamic of inter-sectoral and public-private partnerships in the planning and implementation of activities, especially at the local level; and (d) fostered the strengthening and expansion of civil society organizations. FOSAP is a well-established agency, with substantial reach throughout the country made possible by its contractual arrangements with field-based, intermediary NGOs. It evolved from a temporary agency set up under the auspices of the PCT into a fully autonomous agency with a permanent legal status. Likewise, the social marketing entity set up under the project evolved from a temporary project entity (MASACOT) into a fully autonomous agency (AMASOT) with a permanent legal status. AMASOT's performance is strong, with growing sales in condoms and oral rehydration packets and an expanding portfolio[64] and it is staffed with capable staff both in the areas of social research and marketing/sales. The creation and successful operation of these two legally autonomous entities has reformed the way population and HIV/AIDS activities are carried out. A significant portion of the

63. Most field visits undertaken were carried out jointly with the management/team of the ongoing health operation.

64. Other commodities are being added to its portfolio under the follow-on operation, including impregnated mosquito nets, female condoms and hormonal contraceptives for women.

population and HIV/AIDS agenda is in essence subcontracted out to the nongovernmental sector.

5.8 Public sector institution building for population has been modest. The numbers and qualifications of staff in the Directorate of Population fall short of those needed to fulfill its mandate, particularly in the disciplines of demography and sociology. Regional-level capacity in the planning and implementation of population activities was strengthened through the technical and financial support of the inter-sectoral *CRPRH,* which conceived and oversaw local-level population activities.

5.9 Some HIV/AIDS institutional development has also been achieved in the public sector, although considerably more is needed. By design *PNLS* was relieved of inter-sectoral coordination responsibilities under the project[65] to enable it to focus its limited capacity on mobilizing and guiding MoPH in fulfilling its critical mandate in the fight against HIV/AIDS. Progress was made in strengthening capacity for epidemiological surveillance and in the provision of critical inputs for key HIV/AIDS and STD services delivered through the public health system. In addition, regional level capacity for the planning and implementation of HIV/AIDS activities was developed through the provision of technical and financial assistance channeled through inter-sectoral Regional Health Councils in support of local level HIV/AIDS initiatives. These Councils existed prior to the project, but informants have reported that they were not functional until they benefited from project support.

5.10 **Sustainability.** The sustainability of project efforts is **likely**. Both FOSAP and AMASOT have permanent legal status that provide them with autonomy in their functioning, an independent and competitively recruited staff of professionals and viable mechanisms for public-private oversight and control. Furthermore, their strong and improving performances are attracting the financing of other partners in development wishing to contribute to the fight against HIV/AIDS. Revenues from the sale of commodities are used to finance the operational costs of AMASOT. The strong demand for the services of both entities underpin sustainability from a social perspective. There is also evidence that the strengthening and involvement of civil society has achieved momentum at the local level that will last beyond any one investment. Empowerment and self-reliance was observed in the input and demeanor of local associations, some of which were formed and functioning without direct (continued) project support. Civil society is also carrying out an advocacy role from the local level (e.g., prostitutes, PLWHA) to the national level (e.g., national-level NGOs of women, ministers, parliamentarians, retired civil servants).

5.11 The sustainability of efforts to establish, disseminate and effectively use demographic and socio-economic data will depend heavily on Government's success in the recruitment of an adequate number of professional staff, continued efforts to generate demand for these products, and the relevance of the population messages.

---

65. The MoPC was chosen as implementing agency given the multi-sectoral nature of population and HIV/AIDS activities. The PCT was responsible for the management, supervision and financing of HIV/AIDS activities.

5.12 **Bank Performance.** The performance of the Bank is judged to be **satisfactory** overall: ***satisfactory*** during project preparation and ***highly satisfactory*** during project implementation.

5.13 During preparation, the Bank helped accelerate the development and official adoption of the population policy as well as the second medium-term plan for AIDS control. A participatory approach to project preparation helped to engender understanding and commitment among a broad range of stakeholders. The Bank also deserves credit for a project design that emphasizes public goods that have often been neglected in other projects. However, for the majority of project indicators baseline data were not established, some project targets (notably the population objective) were not realistic, and others were never quantified.

5.14 During implementation the Bank was persistent, candid, and vigilant in carrying out advocacy at all levels of government about the risks and consequences of the HIV/AIDS epidemic and incited government officials to visit the field to observe the realities of the HIV/AIDS epidemic and population issues. The Bank is credited with contributing to breaking the taboo of HIV/AIDS with frank and open discussions about highly sensitive issues (e.g., condoms, prostitution). The Bank's advocacy about population, especially the promotion of family planning for maternal and child health and family well-being, was met with great discomfort and even resistance on the part of Chadian leaders and authorities; and so a tactical decision was made to focus Bank advocacy where there was more receptivity and opportunity for achieving goals. The frequency, staffing and duration of Bank missions and the continuity of the task team management[66] have enhanced Bank effectiveness during implementation. The Bank was considered by many interviewed to be very client-oriented, with good listening and response skills. A case in point is the task team's success in introducing the microfinance for women subcomponent following the MTR, which was initially resisted by some Bank experts.

5.15 **Borrower Performance** was **satisfactory** overall. Its most notable accomplishments *during preparation* were the preparation and approval of the national population policy and the second medium-term plan for the fight against HIV/AIDS. Failure to deposit the initial counterpart funds as originally agreed led to delays in project effectiveness.

5.16 *During implementation* the Government's failure to provide counterpart funds in adequate amounts and on time impeded the efficiency and timeliness of project implementation. Furthermore, the failure of the high-level population commission to meet and approve the plan of action and priority investments for population *(PAIP)* was an important cause of delay in the population component and an indicator of lack of Government commitment. Health-related activities and epidemiological surveillance were implemented, albeit with some difficulty, attributable to very weak capacity of *PNLS.* Despite difficult country circumstances, and weak Government capacity overall,

66. The task manager remained the same from effectiveness through the to the close of the project (and continues with the implementation of the follow-on operation).

the other two components were well implemented with very good performances by the implementing agencies, AMASOT and FOSAP. The performance of the PCT was highly satisfactory with regard to management, coordination, and oversight of project implementation, good quality and regular communications with the key actors and implementers of each component, and fulfillment of all fiduciary and reporting requirements of the Bank. Synergies established with the project management of the ongoing health operation permitted good coordination and complementarity of the two operations.

6. Findings and Lessons

6.1 ***The Bank can be instrumental in stimulating government commitment with regard to population and HIV/AIDS through policy dialogue, advocacy, technical support and lending, but such support is insufficient to consolidate and sustain that commitment.*** Through policy dialogue and technical assistance provided in the context of project preparation, the Bank supported the development and approval by Government of policy and strategic documents for addressing population issues and for fighting HIV/AIDS. Government's agreement to borrow for HIV/AIDS was in considerable part attributable to the Bank's persistence in highlighting the risks and consequences of not addressing HIV/AIDS during the preparation of the health operation in 1994. The Bank's persistence and candor helped open a national discussion on HIV/AIDS.

6.2 ***Other factors that are critical to raising and sustaining Government commitment are (i) the relevance of the objective, determined in part by the availability of local evidence and data; and (ii) the degree of mobilization of civil society.*** The support of HIV/AIDS research, data collection and analysis, studies and the strengthening of a sentinel surveillance system have provided concrete, country-specific (and region-specific) information to sensitize officials on the progression of the epidemic, and its socioeconomic consequences. Over and above these data, the fight against HIV/AIDS became more relevant (especially in the south) as the epidemic progressed and more people observed first-hand and were affected by the disease and its consequences.[67] The objectives of the second medium-term plan (to prevent further infection, to care for those infected and to mitigate the social and economic impact of the disease), thus have immediate and growing relevance. As civil society mobilized itself to undertake its own action, as new local associations of vulnerable and affected groups were formed, and as public-private partnerships were formalized, civil society advocacy has raised pressure for public sector engagement and accountability (associations of PLWHA at the local level, and national NGOs of women ministers and parliamentarians are two cases in point).

6.3 Data was also generated on population size, growth and dynamics in Chad and projections were available as early as 1994, assessing the consequences of rapid population growth on the socio-economic development prospects of the country. While

67. Informants at the local level frequently referred to the infection or death of a family member or close friend.

there was general consensus in Chad about the desirability of implementing the population policy components aimed at improving the rights, opportunities, services and well-being of mothers and children, the notion of limiting family size was met with some reticence. High infant and child mortality and poverty have propelled couples to have more children for social security in their old age and for supplemental household income and labor. As opposed to HIV/AIDS, the relevance and immediacy of objectives to reduce the rate of population growth were not nearly as apparent. Even the use of modern contraception for child spacing – which can lower child mortality and improve maternal and child health -- has not been fully embraced. As a consequence, civil society advocacy around the objective of increasing the modern contraception rate has not happened.

6.4 ***Successful achievement of population and HIV/AIDS objectives requires the conviction and commitment of public sector and nongovernmental leaders and decision-makers in all layers of Chadian administration and society. The stimulation and nurturing of national commitment requires continuous and multiple efforts, given population mobility and turnover in leadership and public sector positions.***

6.5 ***Capacity building of public sector institutions will not be successful if efforts are not aligned with the official mandates of these institutions.*** The institutional framework for the fight against HIV/AIDS had already been established at the project's outset. By government arrête[68] the *PNLS* was given the responsibility for the coordination and management of HIV/AIDS/STD activities in the country, including the provision of technical oversight and support to national partners in their fight against HIV/AIDS/STDs, and for epidemiological surveillance and other relevant data collection and analysis. However, because the *PNLS* in effect was so weak, and because the other components of the institutional framework for HIV/AIDS were not considered to be sufficiently functional,[69] the project was set up to give the PCT/MoPC the *de facto* responsibility for inter-sectoral coordination.

6.6 Because *PNLS*'s mandate was never changed, there was confusion and frustration about its role. Tracking and coordination of financial and technical assistance to the fight against HIV/AIDS, as well as strategic program coordination and oversight, have not been effectively carried out to date.[70] An institutional audit has recently been carried out that has launched a reflection within Government and between Government and its partners about a realignment of responsibilities in line with comparative advantages, on which basis adequate staffing and capacity building can be envisioned.

---

68. Arrêté No. 577/MSP/DG/98 of April 28, 1998, modifying arrêté No. 59/MSPAS/SE/DG/PNLS/91 of May 13, 1991, modifying Arrête No. 31/MSP/SE/DG/013/DAFM/DILA/88.

69. The National Committee for the fight against HIV/AIDS (CNLS), created in 1988 by government decree No. 035/PR/PSP/88 of March 19, 1988, and the Technical Commission for the Fight Against HIV/AIDS (CTLS), created by government arrêté No. 012/PMT/95 of February 12, 1995.

70. As a consequence, this evaluation was unable to provide an overview of the nature, levels and impacts of other partners' contributions to HIV/AIDS control efforts during the life of this project.

6.7 By the same token, an institutional framework for the coordination and implementation of population policy had been established before the project, but an institutional assessment was not undertaken to inform the design of the project's capacity building efforts. Efforts to amend this framework during implementation were unsuccessful.

6.8 ***The channeling of funds to inter-sectoral committees responsible for population and HIV/AIDS at the regional level stimulated decentralized, multi-sectoral action. However, the absence of full-time staff at the regional level to undertake HIV/AIDS program management and coordination has undermined the effectiveness and efficiency of regional level operations.***

6.9 ***Financing and technical support alone will not optimize the individual and collective efforts of the various sectors.*** The project stimulated and supported the preparation and implementation of HIV/AIDS proposals from seven sector Ministries, and elicited Government co-financing of 20 percent of the costs of these activities. The stimulus was the availability of supplemental funds (both those provided by the project and those provided through budget supplements). A number of ministries did not (fully) include in their proposals key activities for which they have the comparative advantage. For example, the Ministry of Justice supported targeted activities for prisoners, but has an important role to play in defining and defending a legal framework for the fight against HIV/AIDS, including the protection of rights of people living with HIV/AIDS. Another example cited is the potential role of Ministry of Social Affairs and Family to expand its role beyond the care of orphans to encompass ways and means of reducing vulnerabilities. A definition of roles, comparative advantages and target groups might have elicited the most critical responses from respective sector ministries for higher impact results, more fully responsive to national objectives. Currently there is little rigor in the specification and monitoring of accountabilities for results. For the most part HIV/AIDS activities are designed and implemented by HIV/AIDS focal persons or designated units, with little involvement of the rest of the Ministry; and inter-sectoral coordination has not fully exploited potential synergies across sectoral responses.

6.10 ***Absence of a strategy on communications for behavior change and the lack of clarity of roles and responsibilities across the multiple institutions that carry out IEC, have undermined the quality and effectiveness of public sector and nongovernmental action.*** Virtually all sector ministries and non-public partners design their own prevention messages and campaigns. There is no one entity responsible for coordination and oversight. Ministry of Communication has a full-time person responsible for HIV/AIDS activities (training of journalists and radio and television media campaigns), the IEC unit within PNLS has developed some IEC material and carries out an ongoing HIV/AIDS campaign carried out by and for youth, but does not have the capacity for oversight and coordination of all communications efforts for prevention. Some sector ministries have an IEC unit. The Population IEC unit, responsible for coordinating and overseeing all population-related IEC has remarked that they have great difficulty in mobilizing various IEC experts from different ministries for discussion and coordination because they are not sufficiently elevated in the public sector hierarchy or have sufficient authority to

oversee IEC activities in other ministries. The project missed an opportunity to clarify roles and responsibilities and strengthen coordination capacity in this regard.

6.11 ***Even in the context of a multi-sectoral approach to the achievement of HIV/AIDS and population objectives, the role of the health sector is pivotal.*** The health sector's ability to carry out its potential role effectively was undermined. First, its mandate is not fully or clearly defined in the health policy document, nor are accountabilities of relevant departments and divisions of MoPH specified;[71] Second, the health sector response is limited by very weak health sector capacpity overall.[72] Project support has made headway in strengthening epidemiological surveillance, but this capacity must be mainstreamed into the MoH, beyond the *PNLS*. However, the health sector is very behind in taking on other core activities that are public goods. Technical experts interviewed have estimated that the blood supply is still unsafe. Training, guidelines and protocols and the provision of drugs have started to build capacity of health services to diagnose and treat STIs and opportunistic infections, but the quality and coverage and reliability of these services are lacking. Testing capacity is far below what is needed, especially now that the Government is subsidizing ARVs, which will stimulate increased demand for tests. Prevention of transmission within health facilities is inadequate. It was mentioned numerous times during field visits and exchanges with actors at the national level that health sector personnel are among the least mobilized of all civil servants working on HIV/AIDS and that more effort is needed to inform and involve them in the fight and to relieve them of the fear and stigma with which they tend to be associated.

6.12 ***The absence of baseline data for many of the key indicators and of a monitoring and evaluation plan has undermined opportunities to track the performance and impact of national population and HIV/AIDS efforts and to refine approaches and increase effectiveness in light of experience.*** Information on trends is limited thus far to HIV among pregnant women, which is not particularly useful for gauging trends in new infections. Some trends on knowledge, awareness and behavior can be derived from the DHS (1996/97), the UNICEF multiple indicator survey (2000) and the 2003 KAP, but questions and indicators vary across surveys making them non-comparable. Furthermore, data collection activities were not designed to measure many of the indicators identified at project appraisal. Informants have pointed out the absence of denominators of key target groups such as number of orphans, schools, etc. and of current coverage of these groups (numerators) that make it impossible to set viable targets for coverage of services. Implementation of the civil society projects has been evaluated and audited by the Social Fund, but program effectiveness would benefit from results-focused evaluations. The functional relationship between the M&E unit of *PPLS* and the *PNLS*/MoH is weak.

---

71. The 2000 health policy makes reference to the PNLS as the responsible department for HIV/AIDS activities, making no reference to any responsibilities of other departments. It also highlights the importance of multisectoral collaboration without clearly distinguishing MoPH's role and comparative advantages.

72. Overall weaknesses in health system capacity, include: human and financial resources constraints, low service quality and utilization rates (see Annex D), sporadic availability of drugs and supplies, and many competing priorities.

6.13 ***The Bank can be effective in influencing the Borrower to support public goods and high-impact interventions.*** Within the overall context of population policy and the second medium-term plan for HIV/AIDS, the Bank supported the production of public goods, in terms of collection and maintenance of basic epidemiological, behavioral and population data, that most likely would not have enjoyed such high priority in the absence of Bank assistance.

6.14 The inclusion of a well-designed component on social marketing of condoms channeled resources to a potentially high-impact intervention. The social fund supplemented the borrower's implementation capacity with that of civil society and established partnerships with civil society and across development sectors. Within those partnerships the Bank encouraged the targeting of high-risk groups, and (as experience was gained) the definition of mandates of public and civil society actors in line with in line with their comparative advantages. The Bank's support of intermediary NGOs for capacity building of local associations was also a good strategic choice. As ARVs became more affordable and Parliament passed a bill to subsidize their costs, the Bank continued strong advocacy for maintaining a priority on prevention. The Bank was less successful in encouraging targeted behavior change interventions, as opposed to IEC.

6.15 The strategy of intensive IEC in the early years of the project to inform civil society about the social fund, followed by the recruitment of intermediary NGOs to build capacity in subproject proposal writing and implementation and to stimulate the formation of additional relevant local associations, proved to be very effective in gradually engaging civil society in population and HIV/AIDS while providing them with needed support and guidance. This experience also points to the need for improved coordination and monitoring and evaluation of NGO activity.

6.16 Government financing of NGOs supported not only a complement to public-sector activities, but also strengthened advocacy role of civil society. The creation of associations of PLWHA and prostitutes give legitimacy to these groups and contribute for human rights and equity advocacy. The support of associations of Parliamentarians, high-level civil servants, the business sector and retired technicians has created an important force in demanding the involvement and accountability of public officials in addressing HIV/AIDS.

6.17 ***A second Population and AIDS project[73] continues Bank support to Chad's population policy and HIV/AIDS strategic plan.*** Its development objective is to contribute to the behavior change of different populations in an effort to reduce the risks of HIV infection, closely spaced births, and unwanted pregnancies.[74]

---

73. Credit No. 3548 was approved on July 12, 2001, and became effective on April 11, 2002.

74. To this end it supports: (i) scaling up multi-sectoral and decentralized activities carried out by public and private sector agencies and civil society; (ii) targeted behavior change interventions; (iii) an increase in voluntary testing and counseling; (iv) reduction in vulnerability factors through income génération, women's education, and care of those infected and affected by the epidemic; and (v) an increase in the availability of condoms and contraceptives to enable adoption of healthy behaviors. Support is channeled through four components: (a) strengthening of the capacities of the key ministries; (b) strengthening of grants and micro-

6.18 In addition, the Health Sector Support Project (HSSP)[75] supports the strengthening of basic health services, including reproductive health, and includes an HIV/AIDS component to support epidemiological surveillance and health care practices for limiting the risks of HIV transmission (enhanced blood safety, improved STI treatment and control, and reduction of risks of clinical infection).

6.19 The Government is currently financing ARV treatment for about 80 AIDS patients and the Global Fund will support expansion of this program. Additional patients are accessing ARV through a Government subsidy program.[76] While HSSP does not finance the purchase of ARV drugs, it has positioned itself to support needed strengthening of treatment and referral services. The second Population and AIDS Project is financing a consultant to help MoPH develop a global care and treatment framework, a management system for ARVs, and a national reference guide.

6.20 Current Bank support to population and HIV/AIDS remains strong and reflects many lessons learned during the implementation of the first operation, corroborated by other relevant OED reports, [77] notably: (a) continued emphasis on prevention; (b) the development of a communications strategy for behavior change and definition of roles and responsibilities for its coordination, management and implementation; (c) continued efforts to address vulnerabilities, building on the experience and outcome of microfinance for women and expanding to other vulnerable groups (such as prisoners); (d) review and revision of the institutional frameworks for population and HIV/AIDS for greater efficiency; (e) intensified support to MoPH capacity; and (f) improvements to program monitoring and evaluation.

6.21 The importance of sound and rigorous monitoring and evaluation cannot be overemphasized. With the ongoing Bank support a project monitoring and evaluation plan was developed and agreed that defines 24 indicators and specifies data collection methodologies and responsibilities. Impact indicators focus on behaviors, HIV prevalence, and measures of STDs among key populations. A second DHS is planned, along with the first national HIV sero-prevalence survey and a beneficiary assessment. A full-time M&E expert has been recruited into the PCT. However, there is scope for intensifying efforts on a number of fronts, notably: establishment of baseline data for all program indicators; greater consistency in the type and frequency of data collection to enable the tracking of trends over time; and inclusion of measures of incidence to track rates of new infections among the general populations and among high-risk groups.

---

credits under the social fund; (c) support to the social marketing program; and (d) population policy implementation.

75. Credit No. 3342 was approved on April 27, 2000, and became effective on February 28, 2001.

76. The monthly cost of ARV is 20,000 CFA francs, or about US$40 (price at which the Central Procurement Agency buys the drugs); under the Government's ARV subsidy program, Parliament voted a budget which finances 15,000 CFA francs of the monthly costs of ARV and the patient co-pays the balance of 5,000 CFA francs.

77. "Nongovernmental Organizations in World Bank-Supported Projects," 1999; "Social Funds: Assessing Effectiveness," 2002; and "OED Review of Bank Lending for Lines of Credit," 2004.

References

Ahmat, Bongo. 2001. «Evaluation du programme de crédit de l'association d'appui aux initiatives a la base (APIBASE).» Novembre 2001.

Assemblee Nationale, Réseau des Parlementaires Tchadiens, Population et le Developpement, Coordination, Secretariat Executif. «Proposition de Loi portant lutte contre le VIH/SIDA/IST en Republique du Tchad.» Fevrier 2001.

Banque Mondiale, Region Afrique, Departement du Developpement Humain. «Le secteur de la Santé au Tchad: Analyse et Perspectives dans le cadre de la strategie de reduction de la pauvreté: Raport analytique Santé et Pauvreté. Serie Documents de Travail No. 48. March 2004.

"Big Oil and Health: Lessons from the Chad-Cameroon Pipeline Project." Princeton University, Woodrow Wilson School of Public Health and International Affairs. May 2004.

Bilan de l'exercise 2001, PPLS (internal project report). 2001.

Epi Sida Tchad : Bulletin semestriel d'information epidemiologique du PNLS/IST

Gbenyon, Dr Kuakuvi. 2001. "Analyse des organs et mechanisms de mise en oeuvre de la declaration de la politique de population du Tchad et assistance technique : Rapport d'evaluation 2eme partie, N'Djamena, 24 avril 2001.

Greindl, Dr. Isaline. 1997. « Evaluation externe du volet lutte contre le SIDA du projet population et lutte contre le SIDA au Tchad, » 17 septembre – 10 octobre 1997.

Guengant, Jean-Pierre. 2001. « Rapport de Mission 'Plan de suivi et evaluation'. » 12 juillet 2001.

«Le FOSAP dans la perspective du PPLS 2.» Decembre 2000.

Lehmann, L. and A. Lemel. 2003. « Ventes transfrontalières de préservatifs des programmes de marketing social en Afrique Central. » KfW. Mars 2003.

Kayaye, Adam Abakar. "Projet de Promotion de la Jeunesse Descolarisee par la couture et la menuiserie; Mao/Kanem, 1999-2001: Rapport Final des Activités." 2001.

Miller, Hillary A. et John Jespen. 2001. «Evaluation du Fond de Soutien aux activités en matière de population (FOSAP): le Rapport Final.» Mars/Avril 2001.

Ministère de la Promotion Économique et du Developpement, Direction de la Statistique, des études économiques et demographiques, bureau central du recensement. «Enquête par grappes a indicateurs multiples: Rapport complet.» janvier 2001.

Ministère de la Promotion Économique et du Developpement. 2000. «Le FOSAP: Cinq Années d'Appui a la Lutte Contre le SIDA et a la Politique de Population au Tchad.» Decembre 2000.

Ministère de la Santé Publique, Direction General, Programme National de Lutte Contre le SIDA, Division du Système d'Information Sanitaire, «Système de Surveillance Epidemiologique du VIH/SIDA/MST: Reformulation.» Decembre 1995.

Ministère de la Santé Publique, Direction Générale, Programme Nationale de Lutte Contre le SIDA. «Rapport annuel d'activités 1997.» Janvier 1998

Ministère de la Santé Publique, Secretariat d'État, Direction Générale, Programme Nationale de Lutte Contre le SIDA. «Plan Stratégique National de Lutte Contre le SIDA 2001-2003.» Juillet 2001.

Ministère de la Santé Publique, Secretariat d'État, Direction Générale, Programme National de Lutte Contre le SIDA, «Politique Nationale de Lutte Contre le SIDA.» Mars 1990.

Ministère de la Santé Publique, Secretariat d'État, Direction Générale, Programme Nationale de Lutte Contre le SIDA/MST et Organisation Mondiale de la Santé, Bureau Regional pour l'Afrique. 2002. «Protocole pour la surveillance de second génération de l'infection par le VIH.» Mars 2002.

Ministère de la Santé Publique, Secretariat General, Direction Générale des Ressources et de la Planification, Direction de la Planification, Division du Système d'Information Sanitaire. «Fiche Relative a l'Appui du Projet Population et Lutte Contre le SIDA a la DSIS: de 1997 à 2001.» 2001.

Ministère de la Santé Publique. «Politique Nationale de Santé.» 1999.

Ministère de la Santé et des Affaires Sociales, Direction de la Planification, de la Coopération et des Statistiques, et Région Afrique, Banque Mondiale, « Le Secteur de la Santé su Tchad : Analyse et perspectives dans le cadre de la stratégie de réduction de la pauvreté, » Région Afrique, Département du Développement Humain, Série documents du travail, No. 48, Mars 2004.

Ministère du Plan, du Developpement et de la Cooperation, Secretariat General, Direction General, Programme Nationale de Lutte Contre le SIDA/IST. «Bilan Analyse et evaluation des activités de la caravane des jeunes anti-SIDA du PNLS?IST (1999-2001).» Decembre 2001.

Moto, Dr. Daugla Doumagoum, Dr. Yemadji N'Diekhor, Dr. Deoudje Noe, Nathan Naibei. 2000. «Étude transversale de seroprevalence du VIH/SIDA/MST dans la ville de Bongor. » Janvier 2001.

Moto, Dr. Daugla Doumagoum, Dr. Yemadji N'Diekhor, Dr. Deoudje Noe, Nathan Naibei. 2000. «Étude transversale de seroprevalence du VIH/SIDA/MST dans la ville de Lere. » Septembre 2001.

Moto, Dr. Daugla Doumagoum, Dr. Yemadji N'Diekhor, Dr. Deoudje Noe, Nathan Naibei. 2000. « Étude transversale de seroprevalence du VIH/SIDA/MST dans la ville de Moussoro. » Novembre 2000.

Moto, Dr. Daugla Doumagoum, Dr. Yemadji N'Diekhor, Dr. Deoudje Noe, Nathan Naibei. 2000. « Étude transversale de seroprevalence du VIH/SIDA/MST dans la ville de Sarh. » Mai 2000.

Ngaidoro, Djimdingar Zaboul. 2001. «Evaluation Finale du Projet appui aux activités de l'association des femmes et enfants d'abord, execute par ASFEA. » Aout 2001.

Ngaidoro, Djimdingar Zaboul. 2001. "Evaluation Finale du Projet d'education et de prevention des jeunes de la ville de N'Djamena sur le SIDA, execute par OFAD." Ministere de la Promotion Économique et du Developpement, Comite Interministeriel de Coordination des Activités des ONG, Secretariat Permanent des ONG (SPONG), Aout 2001.

Ngaidoro, Djimdingar Zaboul. 2001. "Evaluation Finale du Projet de prevention a la transmission sexuelle et bien-etre familial, execute par ADELIT." Ministere de la Promotion Économique et du Developpement, Comite Interministeriel de Coordination des Activités des ONG, Secretariat Permanent des ONG (SPONG), Aout 2001.

Ngarmig-Nig, Djibrine. 2002. « Rapport Final du Projet Population et Lutte contre le SIDA : Credit 2692-CD ». Ministere de la Promotion Économique et du developpement,

Secretariat d'État, Direciton Générale, Projet Population et Lutte Contre le SIDA (PPLS). Fevrier 2002.

Ngoniri, Gos M'Bairo. 2003. "Rapport d'Evaluation du programme de micro credit du APIBASE. » Aout 2003.

Ngoniri, Gos M'Bairo, 2002. "Rapport d'Evaluation du programme de micro credit du CEPRIC." Novembre 2002.

Oumar, Caman Bedaou. « Enquête CACP/IPP (Comportement, Attitude, Croyance, Pratiques/Indicateurs Prioritaires de Prevention. » Ministere du Plan, du Developpement et de la Cooperation, Projet Population et Lutte Contre le SIDA. Octobre 2003.

Oumar, Caman Bedaou et Jean-Pierre Guengant. « Second Rapport : Indicateurs de Suivi et Evaluation, Janvier a Juin 2003. » Ministere du Plan, du Developpement et de la Cooperation, Secretariat General, Equipe de Coordination du Projet Population et Lutte contre le SIDA 2. Decembre 2003.

Piche, Victor. 1997. "Evaluation du volet population du projet population et lutte contre le SIDA (Credit IDA 2692-CD): Rapport d'Evaluation," Departement de demographie, Universite de Montreal/N'Djamena, 2 septembre 1997.

Projet Population et Lutte Contre les IST/SIDA. 2001. "Analyse de la situation dans le contexte de la prostitution au Tchad: Étude qualititative."

«40 ans de delestage.», N'Djamena Hebdo No. 436 du 07 septembre 2000, p. 9

«Rapport de Cinq Annees (1997-1998-1999-2000-2001-2002) d'Activités de PPLS I dans le Kanem/Bahr – El-Gazal.» Commission Regionale de la Politique de Population du Kanem, Bureau du Secretriat General de la Commission. 2002.

«Rapport de Synthese Activités, Projet Education Nutritionnelle et Sanitaire dans le Cadre de PPLS 1, Aout 1999 au octobre 2000.» Association de Lutte contre la malnutrition dans le Kanem (ALCMK). 2000.

Republique du Tchad, Region du Guera, Departement du Guera, Comisión Prefectorale de la Population et des Ressources humaines du Guera. « Rapport des Activités de 1999 a 2002.» Juin 2003.

Wakam, Jean. 2001. « Niveau d'application de la Declaration de la Politique de Population et contribution du PPLS `a sa mise en œuvre : Rapport d'evaluation du volet population : Premiere Partie », avril 2001.

Wyss, Kaspar, Guy Hutton, N'Diekhor Yemadji, Laoubaou Abdias Nodjiadjim, Tinro Mbaiogoum, Nathan Naibei. 2001. « Impacts socio-économiques du VIH/SIDA au Tchad : Rapport Final d'Étude, Tome B. » Swiss Tropical Institute, Centre de Support en Santé Internationale au Tchad. Juin 2001.

World Bank. Development Credit Agreement (Population and AIDS Control Project) between Republic of Chad and International Development Association. Credit Number 2602 CD. April 14, 1995.

World Bank. 2000. Project Appraisal Document: Health Sector Support Project. Report No. 20189-CD.

World Bank. 2001. Project Appraisal Document: Second Population and AIDS Project. Report No. 22003-CD

World Bank. 1995. Staff Appraisal Report: Population and AIDS Control Project. Report No. 13869-CD. March 3, 1995.

World Bank: Internal Documents.

Annex A. Basic Data Sheet

POPULATION AND AIDS CONTROL PROJECT (CREDIT 2692)

Key Project Data

	Appraisal Estimate		Actual or current estimate		Actual SDR cost as % of appraisal estimate in SDR
	US$	(SDR equiv.)	US$	(SDR equiv.)	(SDR equiv.)
Total project cost	27.2	(18.5)	26.1	(19.4)	105%
Loan amount	20.4	(13.9)	18.7	(13.9)	100%
Government	1.3	(0.9)	0.7	(0.5)	55%
Communities	1.0	(0.7)	0.9	(0.7)	100%
Cofinancing	4.5	(3.1)	5.8	(4.3)	139%
Cancellation	---	---	0.05	(0.04)	---

Project Dates

	Original	Actual
Board approval		03/23/95
Signing		04/14/95
Effectiveness	7/14/95	09/08/95
Closing date	06/30/2001	12/31/2001

Staff Inputs (staff weeks)

	Actual/Latest Estimate	
	N° Staff weeks	USUS('000)
Identification/Preparation[a]	23.3	63.7
Appraisal/Negotiations	16.6	66.6
Supervision	101.8	418.5
ICR	7.2	33.1
Total	148.9	581.9

a. The low number of staff weeks for project preparation and appraisal is related to the fact that most of the project was prepared as part of a "Health and Population" operation. However, during the appraisal mission of the Health and Population project (November 1993), it was decided to divide the project into two separate projects and to add AIDS mitigation activities to the Population activities. The Health and Safe Motherhood Project included all the health aspects of the prepared project and was to be implemented by the MOPH. The Population and AIDS Project was to be implemented by the then Ministry of Planning (now the MEPD). In fact there was only one project preparation mission in May 1994 when the AIDS component was prepared. The project appraisal was carried out in November 1994, at the same time as the first supervision mission for the Health and Safe Motherhood Project. With regard to supervision, the number of staff weeks is also low in comparison with similar projects because the supervision always took place at the same time as the supervision of the Health and Safe Motherhood project.

Mission Data

	No. of persons	Specializations represented	Performance rating	Rating trend
Identification/Preparation[a]	6	1 Division Chief/Economist, 1 Population Spec., 1 Community-Development Spec., 1 Public Health Spec., 1 IEC/Pop. Spec., 1 Consultant		
FY1994				
FY1995	4	1 Population Spec., 1 Community-Development Spec., 1 Public Health Spec., 1 IEC/Pop. Spec.		
Appraisal/Negotiation	7	1 Sr. Pop. Spec., 1 Architect, 1 Pharmacist, 1 STD Spec. 1 Implementation Spec., 1 Community Dev., Spec., 1 Public Health Spec.		
FY1995				
Supervision				
FY1995	4	1 Sr. Pop. Spec., 1 Public Health/AIDS Control Spec., 1 Division Chief, 1 Sr. Staff Assist.	S	S
FY1996	3	1 IEC/Pop. Spec., 1 Implementation Spec., 1 Proc. Spec.	S	S
FY1997	4	1 AIDS Control Spec., 1 IEC/Pop. Spec., 1 Sr. Procurement Spec., 1 consultant	S	S
FY1998	10	1 IEC/Pop. Spec., 1 Sr. Procurement Spec., 1 Architect, 1 Sr. Implementation Spec., 1 Public Health/STD Spec., 1 AIDS control Spec., 1 Pop. Spec., 1 Economist/Social Fund Spec., 1 Senior AIDS Adviser, 1 Consultant.	S	S
FY1999	11	1 IEC/Pop. Spec., 2 Sr. Procurement Spec., 1 Sr. Implementation Spec., 1 Population Spec., 1 Sr. Public Health Spec., 1 AIDS Control Spec., 1 Social Protection Spec., Sr. AIDS Control Adviser, 1 Economist/Social Fund Spec., 1 Financial analyst, 1 Spec. in Community Participation.	S	S
FY2000	5	1 IEC Spec., 1 Implementation Spec., 1 Public Health Spec., 1 Demographer & Economist, 1 Financial Management Specialist.	S	S
FY2001	5	1 IEC Spec., 1 Implementation Spec., 1 Public Health Spec., 1 Demographer & Economist, 1 Financial Management Specialist.	S	S
FY2002	5	1 IEC Spec., 1 Implementation Spec., 1 Public Health Spec., 1 Demographer & Economist, 1 Financial Management Specialist	S	S
ICR				
FY2002	3	1 Sr. Population Spec., 1 Public Health Spec., 1 Implementation Spec.		

a. Most of the preparation was done as part of a "Health and Population Project" which was split in two.

Annex B. Persons and Organizations Consulted

CHAD

N'Djamena

Ministry of Plan, Development and Cooperation

Mahamat Ali Hassan, Minister of Plan, Development and Cooperation
Saradimadji Mingabaye, Secretary General
Djourbé Taiki Zeune, Director of Population Activities Coordination,
Ninoam Ngakoutu, National Expert, Population and Development
Nodjimbantem Ngoniri Joel, Statistical Demographer/Consultant, Population and Development
Mahamat Saleh Idriss, Coordinator, Population and AIDS Control Project (PPLS)
Caman Bedaou Oumar, M&E Officer, PPLS

Ministry of Public Health

Madame Aziza Baroud, Minister of Public Health
Dr. Mahamat Saleh Younouss, Secretary General of Health
Dr. Hamid Djabar, Coordinator of the National AIDS and STD Control Program (PNLS/IST)
Abdoulwahab Sani, Youth Leader, PNLS
Ahmat Idriss Rozi, Administrator/Manager, PNLS
Dr. Donato Koyalta, Assistant Coordinator, PNLS/STDs
Dr. Noué Déoudjé, Epidemiological Surveillance Service, PNLS
Moussa Issaye, Administrator of Planning Department, Health Information Systems
Youssouf A. Kadjangaba, Chief, Information, Education and Communications Unit, PNLS
Mme Nalga Katir, Information, Education and Communications Unit
Rangar Ndjenadjim, Responsible for Oversight of NGOs, PNLS
Dr. Noel Djemadji, Chief of Sexually Transmitted Diseases Division

Other Public Sector Agencies/Actors Implementing HIV/AIDS Activities

Mahamat Galli Mallah, Secretary General, MSPI
Dr. and Colonel Adrinkaye Allao Dounia, Director of Health and HIV/AIDS Coordinator, Ministry of Defense
Kouladingar Kaha Dakor, Coordinator of AIDS and Population Unit, Ministry of Communication

Mbaindingatoloum Rawei Elise, Coordinator of AIDS Unit, Ministry of Social Action and Family Affairs
Moulkogue Boulo Félix, Coordinator of AIDS Unit, Ministry of National Education

Non-Governmental Sector/Civil Society

A. NGO Subprojects:

NGO in charge of civil society capacity building :

- Mr. Piquet, SONGES
- Nateguingar Franco-Joseph, Researcher and NGO Support Officer,Health and Environment Support Office (BASE)

NGO Implementors[78]:

- Mme Carmel Ngarmbatinan, President, Network of Women Parlementarians and Ministers and President of the Board of AMASOT
- Pastor Djibé, Network of Evangelist Missions and Churches in Chad
- Mme Djikoloum Kesias Garba, CCEVF
- Mbaiguedem Djai Daniel, CCEVF
- Pastor Mbaiadoum Obed, JACT
- Nassaradoumadji Mathieu, JACT
- Mahamat Béchir, ITS
- Mahamat Amine Abdel-Mazid, C.S.A.I.
- Corinne Bali, Coordinator, Support for Eastern European and African NGOs (SONGES)
- Arsene Mayangar, SONGES
- Loum Hinansou Laina, CONALUS
- Mme Zenaba Borgoto ASFEA
- Dr. Mbeurnodji Lucien, UCCT
- Nodjitoloum Justin, UCCT

B. Microfinance:

FOSAP (Fonds de soutien aux activités en matière de Population et de Lutte contre le SIDA) ;

- Nodjikwambaye Enock, Deputy Administrator-Manager
- Ache Djidda, Accountant
- Ngarbaroum Modobe, Microcredit Officer

78. These NGOs represented a range of constituencies, themes and missions, including: health of nomads, Islam, Christian religions, community development and empowerment, youth movements, coalition of public sector leaders, women and children's health and well-being, among others.

C. Social Marketing:

Social Marketing Association of Chad (Association our le Marketing Social au Tchad – AMASOT):

- Dokblama Kadah, Director of Service Center
- Rino Guy Meyers, Technical Adviser

Bilateral and International Partners

Marie-Paule Fargier, Pharmacist, European Union
Dr. Abdelmajid, Health Program Officer, Swiss Cooperation
Dr. Faria Ibrahim, Technical Adviser, HIV/AIDS Project, UNDP
Dr. Kekoura Kourouma, Country Program Coordinator, UNAIDS
Keumaye Ignegongba, Assistant to the Resident Representative, Poverty Alleviation Unit, UNDP
Mouenon Denis, Technical Adviser, French Cooperation
Dr. Granga Daouya, UNICEF

World Bank Office, N'Djamena

Gregor Binkert, Country Manager
Mahamat Goadi Louani, Senior Human Development Specialist
Joel Tokindang, Economist, World Bank
Fridolin Ondobo, Financial Management Specialist

Moundou/Department of Lac Wey/Region of Logone Occidental

Mahamat Béchir Cherif, Governor, Region of Logone Occidental

Regional Commission on Population and Human Resources and Health Advisory Committee Members

Mbaikeboum Kagao, Prefect, D. Lac Weg
Malangso Souleymane, Secretary General of Commission, Ministry of Plan, Development and Cooperation
Passeh David, Assistant Secretary General/CRP, Civil Society
Dingamtoudji Ngana Esaie, First Vice President, Chadian Association of Family Wellbeing (ASTBEF)
Miambaye Rando, Treasurer, DRCJS
Mme Ndingambaye Romian, TGA, DRASL
Ndingambaye Pascal, Logistics Officer
Weigue Laoundodji, Regional Delegate for National Education, Ministry of Education
Vissia Bouranga, Regional Delegate for Economic Affairs for the 2 Logones and Tandjile Districts
Mbairareou Yanlingar, Logistics, Ministry of Commerce

Dr. Mbaintissem Mbuitotouvas, Chief Medical Officer, Moundou District

Non-Governmental Sector/Civil Society

NGO in charge of civil society capacity building:

- World Vision

Microfinance Agency: CEPRIC

- Kagdom Magourna, Coordinator
- Mme Tamissengar Evelyne, Manager
- Mme Nadingar Ndjilarlem Odile, staff
- Bendodjim Benjamin, Accountant
- Koulangar Ngartoubam, Trainer
- Keimbaye Mbailemdana, Trainer

Beneficiaries:

- Representatives of Women's Groups and Women's Cooperatives (names not obtained)

Regional Branch of AMASOT

Bongor/Department of Mayo-Boneye/Region of Mayo-Kebbi Est

Governor of the Region

Regional Commission on Population and Human Resources and Regional Health Advisory Committee Members

Goundoul Vikama, Director of Plan, Secretary of the Commission
Mor Victor, Mayor of Bongor city
Nodji Wassem Gerard, SGRMKE
Mme Moussa Charlotte Ouagadijio, Regional Delegate of women's associations of Mayo-Kebbi/Tandjile

Dr. Bopan Tekemet, Regional Delegate for Public Health, Mayo-Kebbi
Bakreo Dakssala, Regional Delegate for Social Action and Family Affairs, Mayo-Kebbi/Tandjile
Dingatoloum Barack, Animator, CLAC/Bongor
Gnavourbe Tao, Regional Delegate for Public Works
Seibana Daniel, DDCJS/Mayo-Boneye
Loubata Jean, Regional Delegate of Police/Mayo-Kebbi Est
Dosso Bessoum, Adviser to the Minister of Plan

Non-Governmental Sector/Civil Society

NGO in charge of civil society capacity building:

- SONGES

Local Associations:

- ADSEC Guidawa

Microfinance Agency: APIBASE (Association d'Appui aux Initiatives de Base – Association for the Support of Community-Based Initiatives)

- Mana Malgueteng, Chief
- Andrews Yoh Pudens, Animator
- Mhary Mournor Jean, Animator
- Jurs Clement, Animator
- Tocsouma Houmaizou, Accountant

Beneficiary Women's Groups:

- Iya Gama ElHadji Oumar, Member, Tamidja
- Falmatou Sidi, Secretary, Udjekusa renove
- Yoma Rosalie, Member, Udjekusa renove
- Yawada Marie, Secretary, Minaituya
- Zeno Marcelline, Secretary, Udjekusa
- Doudou Moksia, President, Minaituya
- Samba Rigale, President, Takasna 1
- Denise Vayanga, President, Takasna 1
- Ndiguimal Rebecca, President, Komna le Denedje
- Modjimariya Nahomie, President, Takasna II
- Largoto Martine, Member, Takasna II
- Mianda Falla, Cashier, Minaituya
- Delao Marthe, Cashier, Takasna II

Mao/Region of Kanem

Governor of Kanem

Regional Commission on Population and Human Resources andRegional Health Advisory Committee Members

Issen Ben Moussaye, Regional Delegate for National Education, Ministry of National Education
Malloum Abakar Kaya, Association to Fight Malnutrition in Kanem
Heriata Moussa, Association Fernink
Doh Mallah, Coordinator, ETMS/Mao
Kedela Batran, Chief, Forestry Inspection, Kanem

Dr. Oumar Abdelhadi, Regional Delegate for Health, Ministry of Public Health
Barka Tambour, Regional Delegate for Social Action and Family Affairs
Ahmad Moustapha, P. Com. Su. Affairs, DKM
Azina Ollo Japhet, Pastor, Evangelist Church of Chad
Adoum Goulgue, Representative, Catholic Church
Representative of Islam

Non-Governmental Sector/Civil Society

NGO in charge of civil society capacity building:
- Dr. Bruma Masumbuko, Technical Advisor, GTZ
- Ahamat Mahamat Abdou, Trainer, GTZ

Local Associations :
- Malla Batran, Health Agent and President, ADESK
- Moustapha Ngartorangal, Representative, ARNUT
- Achta Bintou Moustapha, Women's Group Loelle, Social Center of GFB
- Ache Bougoudi, staff, AFAT
- Fatime Mahamat Seid, Women's Group of Matoboko
- Ahmat Moustapha Outman, ASUDEK
- Abdallah Moustapha, Secretary General, APLFT
- Hisseine Issa, Red Cross of Kanem
- Ali Abakar, President, ADEK
- Malloum Abakar, Representative, ALCMK
- Ali Larme, Secretary General, AJAC/Kanem
- Choukou El-Hadj Mahamat, Head, ADIS

Microfinance Agency : ADIS (Agence d'Encadrement pour les Credits)
- Choukou El-Hadj Rahamata, Head
- Haoua Sedik, Credit Agent
- Achta Bouguidi, Credit Agent

Mitoissi Kossadoum, Manager, FOSAP

Beneficiaries of Microcredits/Representatives of Women's Groups:
- Hadje Achta Oumar
- Bintou Batran
- Zara Laye

Mongo/Region of Guéra

Secretary General of Guéra Department

Regional Commission on Population and Human Resources and Regional Health Advisory Committee Members

Ibrahim Hassan Bargouley, Regional Delegate for Finance, Ministry of Finance
Ramat Mangue, Regional Delegate for Social Action, Ministry of Social Action and Family Affairs
Yadia Banserne Pierre, Regional Delegate for Economic Affairs, Ministry of Commerce
Nossor Doungous, Regional Delegate for National Education, Ministry of National Education
Souk Kangoutoum, Regional Delegate for Culture, Youth and Sports, Ministry of Culture, Youth and Sports
Ganda Nabia Koutou, Chief of Bureau, Customs and Taxes
Adoum Vamalia Abakar, Regional Delegate for Plan and Development, Ministry of Plan
Daniela Stirpe, Public Health Doctor, SECADEV
Hassana Anguimi, Subprefect of Mongo
Dr. Ali Soumaine Baggar, Regional Delegate for Health, Ministry of Public Health
Mme Mahazal nee Mankassia Tchere, member
Yacoub Hassan, IFC Officer

Non-Governmental Sector/Civil Society

NGO in charge of civil society capacity building: ITS/Swiss International Organization

- Mahamat Abbo, Officer, ITS/CSSI
- Abdel-Madjid Hanan, Assistant Officer, ITS/CSSI
- Akaye Albert Mustapha, Animator, ITS/CSSI
- Djimye Weletna, Animator, ITS/CSSI

Local Associations:

- Fatime Sorom, Presidente, AFGDR
- Maimouna Moussa, Treasurer, AFGDR
- Maimouna Tassigot, AFGDR
- Mariam Mahamat Saleh, AFGDR
- Amsakine Outman, Adviser, AFGDR
- Kadidja Ayoub, Adviser, AFGDR
- Younous Dris, ADECAB
- Hamdan Ibet, ADECAB
- Hassan Souleymane, Financial Secretary, ADECAB
- Allamine Moussa, Secretary General, ADESCAMO
- Ali Chachate, ADESCAMO
- Mahamat Chaltout, ADESCAMO
- Mahamat Madri, ADESCAMO
- Asan Souleymane Al-Nidal
- Abdel-Aziz Abbas, Administrative Secretary, Al-Nidal (association of combatants)

- Moussa Faya Douzet, President, Al-Nidal
- Makaye Elie, Assistant Secretary General, APLD
- Brahim Dabara, President, PROJAET
- Djimet Darap, Treasurer, PROJAET
- Hissein Dagasche, Adviser, PROJAET
- Caleb Deodere, Secretary, PROJAET
- Association of Free Women, various members

Microfinance agency : ACCORD

- Seid Gaye Alexis, Head
- Idriss A. Foudoussia, Supervisor

Kilabe Mbaitoloum Abel, Regional branch of AMASOT

WASHINGTON, D.C.

Laura Frigenti, Sector Manager, Human Development, AFTH3, World Bank
Michele Lioy, Senior Population Specialist, AFTH3, World Bank

Annex C. Population and AIDS Control Project (Credit No. 2692) -- Presentation of Project Components

The project was designed to assist the Government in implementing its long-term strategy in population and family planning and its medium-term plan 1995-99 (MPT 2) for AIDS control. Its overall objectives were to advance the onset of fertility decline by increasing the use of modern methods of contraception (from 1 percent in 1990 to 10 percent by 2000), and slow the spread of HIV infection by promoting behavioral change. Project assistance was channeled through four components:

(a) Strengthening of national capacity to implement the population policy (US$8.0 million). This component sought to strengthen capacity of the newly created Division of Population within MoPC to undertake population-related activities, particularly: (a) the dissemination and coordination of the implementation of population policy; (b) the planning, management, and evaluation of population-related activities; (c) the planning, coordination, and implementation of donor-financed projects; and (d) the integration of demographic variables into sector plans. Project support included office rehabilitation, equipment, logistical support, participation in international meetings, contractual staff, training, technical assistance, including a twinning arrangement with the Center for Research on Population and Development (CERPOD), in Bamako Mali.[79] The project also financed IEC activities and radio and TV programs in an effort to disseminate the population policy and to promote awareness of the relationship between population and development, especially among identified target groups such as opinion and religious leaders, women, NGOs, reporters, youth (12-25 years), and members of trade unions and associations.

This component also supported collection and analysis of basic demographic data to improve knowledge of socio-demographic indicators. To this end, it financed a national study on migration and urbanization and analysis of the 1993 census data and the first demographic and health survey (DHS). Project assistance also included contraceptive supplies for maternal and child health services provided through the public health system to fill the gap created by the withdrawal of USAID support in 1995. The total estimated cost of contraceptives to be provided under the project was US$3.0 million (38 percent of the component cost).

(b) Strengthening of national capacity to contain the spread of HIV/AIDS/STDs (US$6.6 million). This component sought to strengthen the capacity of the Ministry of Public Health (MoPH) to manage and coordinate the AIDS Control Program and to carry out epidemiological surveillance and operational research. Project support consisted primarily of (a) long- and short-term technical assistance in key disciplines, notably epidemiology and program management; and (b) long- and short-term training in

79. A Sahelian institution of the Inter-Country Committee on the Fight against Desertification (Comite inter-états de lutte contre la secheresse dans le Sahel, CILSS).

epidemiology, management, IEC, and health information systems. Support was directed at the *PNLS*, *CNLS*, *CTLS*, and the MoPH division in charge of health management information systems. In addition, this component financed epidemiological, operational, and socio-economic research under the supervision of the General Directorate of Planning of the MoPC. Planned activities included the development of two additional sentinel sites (for a total of seven); five studies of HIV/STD prevalence among target groups; two knowledge, attitude, practice (KAP) studies; and a study on the priority indicators of prevention to permit assessment of impact of interventions. Other studies planned to improve health services response included: the development of algorithms for the management of STDs and AIDS patients; the preparation of a referral protocol for people with HIV/AIDS and their families; the evaluation of the clinical definition of AIDS; a study on the relationship of HIV and tuberculosis (TB) to improve the treatment of TB and a study on the socioeconomic impact of AIDS at the individual, family, community, and macroeconomic levels.

(c) Establishment of a social marketing program for condoms (US$7.1 million). This component aimed to increase the availability and promote the use of condoms for AIDS prevention. The main benefit envisaged was reduced transmission of HIV and other sexually transmitted diseases (STDs), a secondary benefit being protection against unwanted pregnancies. Targets were to increase the use of condoms from an anticipated 2 million in the first year of the project to about 4.8 million in the last year of the project, reaching a cumulative total of about 14 million condoms sold during five years. Project support included: technical expertise in social marketing and auditing, contractual professional staff; training and study tours to develop capacities in social marketing and IEC; condoms; equipment and logistical support; and rehabilitation works.

The condom social marketing program was managed in an autonomous manner by a social marketing unit established with project assistance, under the general direction and guidance of ASTBEF[80] with the technical support of a social marketing firm, in close coordination with PNLS and in collaboration with public sector and civil society. Project support envisaged included specialist services, local professional staff, training, logistical support and office equipment, studies, and operating costs.

(d) Promoting the participation of the nongovernmental sector in population, family planning, and HIV/AIDS/STDs programs (US$5.5 million). This component supported the establishment of a social fund *(Fonds de Soutien aux Activités en matière de Population, FOSAP)* to provide grant financing to civil society for population and AIDS control activities in order to complement and enhance the interventions of government and the social marketing program. A minimum of 40 AIDS control subprojects would be supported encompassing (a) prevention aimed at key target groups;[81] and (b) mitigation through the provision of psychosocial support for HIV/AIDS persons and their families in

80. Chadian Association for Family Well-being (Association Tchadienne pour le Bien-Etre Familiale), an affiliate of the International Planned Parenthood Federation.

81. Target groups identified for prevention activities included youth, prostitutes and their clients, civil servants of key ministries, migrant workers, and truck drivers on major migration and transport routes to Cameroon and Nigeria.

five prefectures. The project also envisaged support to a minimum of 20 population subprojects including (a) targeted IEC;[82] (b) activities to improve women's income-earning capacities and status; and (c) studies and operational research on the acceptability of new contraceptive methods. In addition, given the weak capacity of potential beneficiaries of the grants (national NGOs, local associations and individual health service providers) FOSAP would support several "resource projects" (*projets dynamisateurs)* by well-established NGOs to build capacity among potential beneficiaries in the preparation, implementation, and evaluation of their subprojects

82. Target groups identified for population IEC included men, teenagers, workers, agricultural extension workers, community development workers, women's associations, rural development cooperatives, and private employers.

Annex D. Program and Project Data

1. HIV/AIDS/STD and Behavioral Surveillance Data

(Source: PNLS/MoPH Surveillance Data)

Table D-1. Evolution of Prevalence Rates in General and Specific Populations derived from Seroprevalence Surveys 1997 - 2000

Year	*Geographic Area*	*Prevalence Rates*		
		General Population	*Specific Populations*	*Prevalence Rate*
1989	Abéché	0%		
	Sarh	0.5%		
	Moundou	1.6%		
	Bongor	0.6%		
	N'Djamena	1.02%		
1995	N'Djamena		Prostitutes	14%
	N'Djamena		Pregnant women using prenatal services	2.1%
	N'Djamena		Military personnel	10.2%
1997	Abéché	2.1%		
	Am-Timan	6.1%		
	Sarh		Prostitutes	26.4%
	Logone Occidental/ Moundou		Migrants	7.93%
	Moundou		Military personnel	8.48%
	N'Djamena		Military personnel	8.40%
2000	Sarh	8.84%		
	Kelo	15.03%		
	Lere	11.21%		
	Lac	10.10%		
	Moussoro	2.68%		
	Bongor	6.5%		

Source: Ministry of Health, National AIDS Program, drawing from a series of seroprevalence studies during over the period 1989-2000.

Table D-2. Prevalence of HIV Among Blood Donors (percent), by Year
[number of people sampled]

	1999 (2nd half)	2000	2001	2002
N'Djamena	27.8	8.1	2.8	4.8
	[1520]	[2381]	[1930]	[1888]
Sarh			9.1	9.9
			[197]	[202]
Moundou	25.4	8.3	5.0	
	[181]	[591]	[398]	
Doba		2.43	16.7	
		[41]	[12]	
Bongor	3.0	6.9	6.6	
	[338]	[577]	[1017]	
Kelo		0	0	
		[25]	[7]	
Amtiman		0	0	
		18	2	
Kourma			0	
			[21]	
Abéché			0	
			[10]	
Ati		0		
		[18]		
Average/ Total	23.5	7.8	4.5	5.3
	[2039]	3651	3594	2090

Source: *PNLS*/MoPH

Table D-3. HIV Prevalence among Women Using Prenatal Services by Sentinel Site and by Year

[number of people sampled]

	1999 (second semester)	***2000***	***2001***	***2002***
A. Urban Sentinel Sites				
Abéché	5.2		2.6	3.4
	[172]		[77]	[353]
Bol	2.6	2.3	4.0	4.0
	[116]	[130]	[100]	[349]
Mongo				1.2
				[331]
Bongor	3.9	3.8	8.9	5.3
	[464]	[468]	[492]	[375]
Ndjaména	3.2	6.7	5.9	7.5
	[1264]	[1960]	[406]	[399]
Moundou	10.5	11.1		11.9
	[421]	[90]		[396]
Sarh	5.3	9.0	7.9	8.3
	[849]	[1128]	[901]	[400]
a. Average/subtotals	4.8	7.0	7.3	6.2
	[3286]	[3776]	[1976]	[2603]
B. Rural Sentinel Sites				
Massaguet				7.7
				[312]
Guelendeng				2.8
				[399]
Bah				3.2
				[391]
Djoli				8.3
				[326]
b. Average/subtotals				5.3
				[1428]
C. Average/total				
	4.8	7.0	7.3	5.8
	[3286]	[3776]	[1976]	[4031]

Table D-4 Prevalence of Syphilis among Pregnant Women Using Prenatal Services by Sentinel Site and by Year

[number of people sampled]

	1999 (second semester)	*2000*	*2001*	*2002*
A. Urban Sentinel Sites				
Abéché	0.6		9.1	5.7
	[172]		[77]	[353]
Bol	6.8	5.4	5.0	20.6
	[116]	[130]	[100]	[349]
Bongor	17.2	7.4	5.5	5.9
	[464]	[468]	[220]	[375]
Mongo				2.4
				[331]
N'Djamena	3.0	5.3	5.2	15.3
	1264	[1960]	[406]	[399]
Moundou	1.9	1.1	1.0	6.1
	[421]	[90]	[300]	[396]
Sarh	5.7	6.0	2.3	4.0
	[849]	[1128]	[901]	[400]
a. Average/subtotals	5.6	5.7	3.4	8.6
	[3286]	[3776]	[2004]	[2603]
B. Rural Sentinel Sites				
Massaguet				18.6
				[312]
Guelendeng				4.0
				[399]
Bah				7.2
				[391]
Djoli				3.1
				[326]
b. Average/subtotals				7.8
				[1428]
C. Total/Average				
	5.6	5.7	3.4	8.3
	[3286]	[3776]	[2004]	[4031]

Table D-5. HIV Prevalence among TB Patients by Hospital Facility
[number of people sampled]

City/Town	*1999*	*2000*
N'Djamena	26.2	20.7
	[477]	[381]
Am-Timan		15.4
		[13]
Ati		9.5
		[95]
Koumra		60.0
		[120]
Total/Average	26.2	25.5
	[477]	[636]

Table D-6. HIV Prevalence among STD Patients
[number of people sampled]

City/Town (Region)	*1999*	*2000*
Am-Timan		9.1
		[11]
Ati		0
		[21]
Biltine		0.7
		[139]
Bongor	22.7	5.2
	[44]	[115]
Bol	23.1	
	[13]	
Faya	21.3	20.1
	[141]	[194]
Mongo		0
		[6]
Sarh		42.6
		[61]
Mao		21.1
		[61]
Total/Average	21.7	14.1
	[198]	[608]

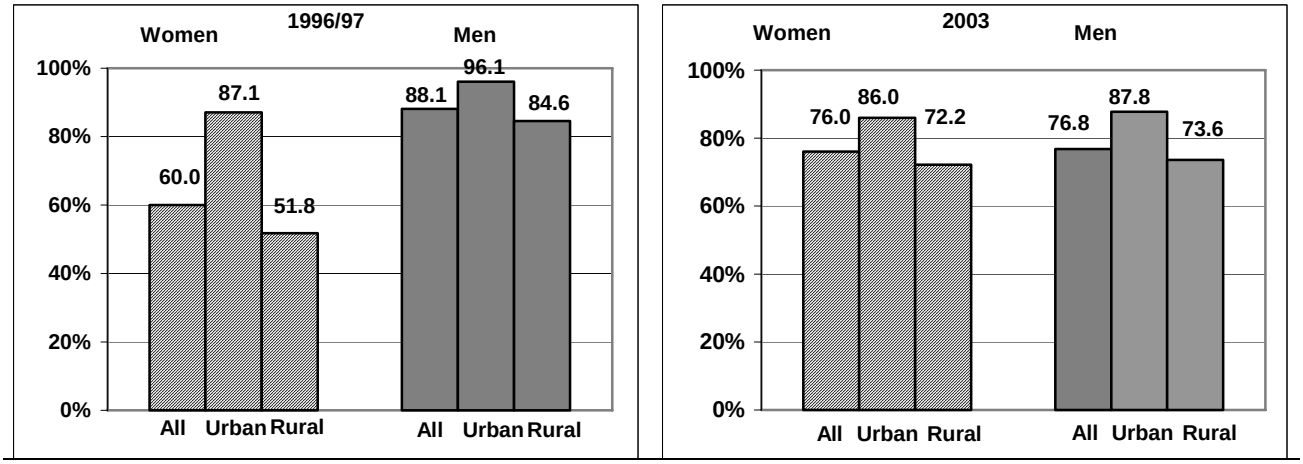
Table D-7. Sentinel Sites and Centers for Drawing Blood Samples for Each Sentinel Site

Sentinel Sites ***Town/City (Prefecture or Department)***	***Centers for Drawing Blood***
Urban Sites	
1. Abéché (Ouaddai)	Taiba Health Center Badawi Health Center
2. Mongo (Guera)	Urban Health Center of Mongo
3. Bol (Lac)	Urban Health Center of Bol Ngarangou Health Center
4. N'Djamena (Chari-Baguirmi)	Assiam Vantou Center Polyclinic No. 1 National Reference Hospital Center/Maternity Liberte Hospital
5. Bongor (Mayo Kebbi)	Urban Dispensary of Bongor Dispensary of Mairie
6. Moundou (Logone Occidental)+	Family Planning Center 15 Years Health Center
Rural Sites	
8. Bah (Bar Koh)	Bah Health Center Dowala-PESANA Health Center
9. Djoli (Logon Occidental)	Djoli Health Center Balmani Health Center
10. Guelendeng (Mayo Boneye)	Guedeng Health Center Moulkou Health Center
11. Massaguet (Hadjar Lamis)	Massaguet Health Center Gredaya Health Center

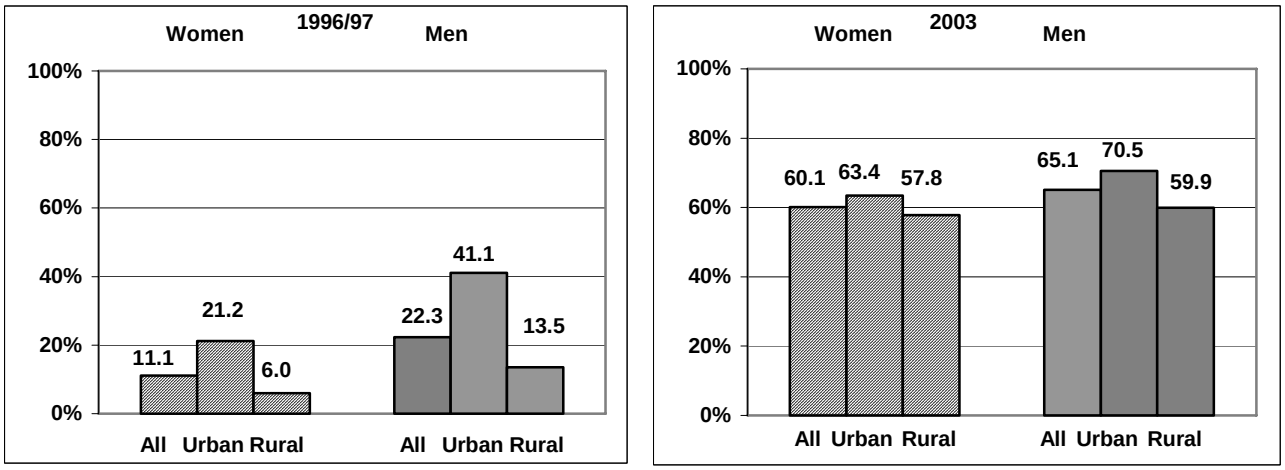
Note: Sample size is 400 blood tests for each site.
Source: MoH/National AIDS/STI Program statistics, 2003

Figure D-1. Evolution in Awareness and Behavior 1996/97, 2003

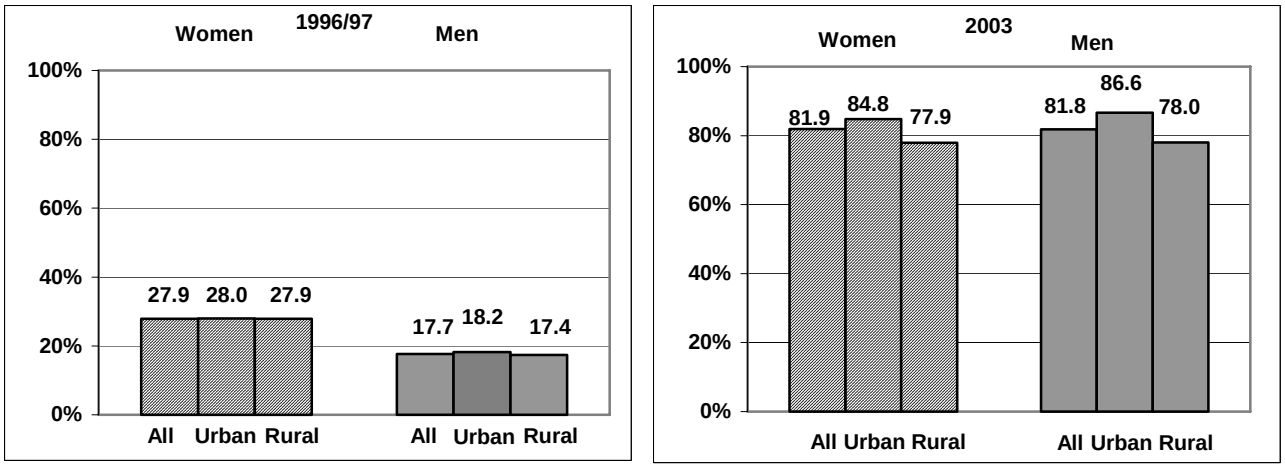
a. Percent of those surveyed declaring they have heard of AIDS



b. Percent of those who know condoms are a means of protection



c. Percent of those who know that fidelity is a means of protection



Source: DHS 1997 and Oumar 2003: KAP Study

2. Reproductive Health Services

Table D-8. Utilization of Modern Methods of Contraception by Women Who Are Married or in Consensual Unions, 2000

	Modern Methods							*Traditional Methods*					*Modern and Traditional*
	Female sterilization	*Pills*	*IUD*	*Injections*	*Condom*	*Diaphragm/gel*	*All Modern*	*Lactational amenorrhea*	*Periodic abstinence*	*Withdrawal*	*Other*	*All traditional*	
Residence													
N'Djamena	1.8	5.9	0.3	0.7	0.3	0.1	9.0	2.7	3.1	0.0	0.0	5.9	14.9
Urban	1.4	4.4	0.1	0.4	0.2	0.1	6.6	3.8	2.2	0.1	0.1	6.2	12.8
Rural	0.4	0.1	0.0	0.1	0.0	0.0	0.8	4.4	1.3	0.0	0.0	5.8	6.5
Level of instruction													
None	0.6	0.6	0.1	0.1	0.0	0.0	1.4	4.6	1.6	0.0	0.1	6.3	7.7
Primary	0.4	1.5	0.1	0.4	0.1	0.3	2.8	3.9	0.5	0.0	0.0	4.4	7.1
Secondary	1.3	8.9	0.0	1.2	0.8	0.0	12.3	2.4	3.8	0.0	0.0	6.3	18.6
Total	0.6	1.1	0.1	0.2	0.0	0.1	2.0	4.3	1.5	0.0	0.1	5.8	7.9

Table D-9. Distribution of Prenatal Services Provided to Women Giving Birth in the Past Year of Type of Expert, 2000 (Percent)

	Type of staff providing services treatment					*Prenatal Services Delivered by All*	*No Prenatal Care of Any Kind*	*Total*	*Number of Women in Sample*
	Doctor	*Nurse/assistant*	*Midwife assistant*	*Traditional midwife*	*Other/ND*				
N'Djamena	2.3	64.1	1.4	5.5	0.0	67.7	26.8	100.0	136
Other cities	2.8	58.7	5.1	4.7	1.3	66.5	27.5	100.0	161
All urban	2.5	61.2	3.4	5.0	0.7	67.1	27.2	100.0	297
Rural	1.5	26.2	6.9	8.3	2.3	34.5	54.8	100.0	1072
No schooling	1.6	27.3	5.6	8.9	1.9	34.5	54.7	100.0	1068
Primary	1.9	55.6	9.6	3.5	2.7	67.1	26.6	100.0	230
Secondary & +	4.1	78.7	3.8	0.8	0.8	86.6	11.8	100.0	45
Total	1.7	33.8	6.1	7.6	1.9	41.6	48.8	100.0	1369

Source: World Bank, Government of Chad, Joint Country Status Report 2004

Table D-10. Percentage of Women Giving Birth in the Past Year Receiving Assistance during Delivery of Expertise of Assistance

	Personnel Assisting in Delivery					*Other/No specified*	*Qualified Health Personnel*	*No assistance*	*Total*	*Sample size*
	Doctor	*Nurse/ Midwife*	*Assistant midwife*	*Traditional birth attendant*	*Relative /Friend*					
N'Djamena	2.7	46.8	2.7	14.1	25.0	2.7	52.4	6.0	100.0	136
Other cities	1.9	32.8	5.9	27.5	25.4	2.3	40.6	4.2	100.0	161
All urban	2.3	39.2	4.5	21.4	25.2	2.5	46.0	4.9	100.0	297
Rural	0.2	5.9	2.0	46.0	36.3	2.6	8.0	7.0	100.0	1072
No schooling	0.3	8.7	2.0	43.3	35.9	2.3	11.0	7.5	100.0	1068
Primary	1.2	25.4	3.9	31.3	31.1	3.6	30.5	3.5	100.0	230
Secondary & +	4.9	55.0	8.2	12.0	17.0	2.1	68.1	0.8	100.0	45
Total	0.6	13.1	2.5	40.7	33.9	2.6	16.2	6.6	100.0	1369

Source: World Bank, Government of Chad, Joint Country Status Report, 2004

3. Project Data

Table D-11. Planned Versus Actual Costs by Component (US$ million equivalent)

Component	***Planned***	***Actual***	***Actual as % of Planned***
Reinforcing the national capacity to implement the national population policy	7.0	6.1	87%
Strengthening the national capacity to contain the spread of HIV/AIDS and STDs	5.9	5.6	95%
Putting in place a social marketing program for the promotion of condom use	6.4	6.9	109%
Promoting the participation of the private sector and NGOs in population, family planning and HIV/AIDS and STD programs	5.5	5.6	102%
Project Management	-	1.9	
Total Base Costs	24.8	26.1	
Physical contingencies	1.0	-	
Price contingencies	1.4	-	
Total Project Costs	**27.2**	**26.1**	**96%**

Source: PCT/MOPC, 2004

Table D-12. Planned Versus Actual Project Financing (US$ million equivalent)

Financier	***Planned***	***Actual***
IDA	20.4	18.7
KfW	4.4	5.7
UNFPA	0.1	0.1
Government	1.3	0.7
Communities	1.0	0.9
Total	**27.2**	**26.1**

Note: Sources for actual data are as follows: IDA: World Bank Disbursement records; KfW: AMASOT (equivalent of 12 million Deutsche Marks during 1996-2001); Government (World Bank 2002); Communities (calculation of 20% counterpart based on FOSAP grants).

Table D-13. Planned vs. Actual Counterpart Financing (in US$)

Component	Government			Communities		
	Planned	Actual	Actual as % of Planned	Planned	Actual	Actual as % of Planned
Population	611,000	372,653	61%			
HIV/AIDS	524,600	269,633	51%			
Social Marketing	142,400	30,791	22%			
Social Fund				915,600	880,661	96%
Total	1,278,000	673,077	53%	915,600	880,661	96%

Source: Project Coordination Team/Ministry of Plan, 2004

Table D-14. Planned vs. Actual Use of IDA Credit by Disbursement Category (millions of SDR)

Disbursement Category	*Initial Allocation*	*Reallocation (by DCA amendment)*	*Actual*
(1) Goods:			
(a) Contraceptives	2.40	0.65	0.64
(b) Other Items	0.50	1.31	1.22
(2) Rehabilitation of Offices	0.01	0.08	0.07
(3) Consultants' Services	1.70	1.93	2.02
(4) Training	0.70	1.40	1.44
(5) Studies	2.70	1.90	2.04
(6) FOSAP Grants	2.70	3.23	3.55
(7) Incremental Operating Costs	1.50	1.90	1.75
(8) Refunding of PPF	0.24	0.24	0.23
(9) Unallocated	1.45	0.05	0
FOSAP microcredits	0	1.17	0.80
Reconciliation of Special Account			0.09
Total (rounded)	**13.9**	**13.9**	**13.9**

Table D-15. Evolution in condom sales, 1996-2002

	1996	*1997*	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*
January	-	214,215	238,080	240,960	12,480	270,720	458,880	799,680
February	-	295,957	213,120	397,440	66,240	229,440	447,360	114,240
March	-	288,040	311,120	695,040	251,520	267,840	352,320	249,600
April	-	286,329	544,132	616,320	121,920	328,320	485,760	386,880
May	-	324,480	339,692	735,360	114,240	229,440	432,000	409,920
June	-	206,400	351,882	908,160	208,320	323,520	230,400	531,840
July	-	279,072	346,746	356,160	374,400	390,720	514,560	257,280
August	-	413,760	275,770	519,360	203,520	119,040	633,600	167,360
September	175,599	69,120	411,040	705,600	161,280	376,320	175,680	244,800
October	196,314	176,540	340,440	563,520	235,200	280,320	582,720	292,896
November	129,877	326,400	379,920	342,720	139,200	171,840	123,840	109,728
December	277,075	338,256	261,786	384,000	262,080	258,240	266,880	63,792
Total	**778,865**	**3,218,569**	**4,013,728**	**6,464,640**	**2,150,400**	**3,245,760**	**4,704,000**	**3,628.016**

Note: Quantities over 400,000 units were eliminated from these statistics as this surplus is estimated to have been sold in neighboring countries, due to much lower pricing of condoms in Chad.Source: AMASOT 2004

Annex E. Key Targets and Indicators Supported Under Population and AIDS Project

Population Strategy:				
	Baseline	**Target (1999)**	**Actual**	**Comments**
Reduction of annual rate of population growth	2.4%	2%	3.1% (2004)[83]	
Advance the onset of fertility decline	6.6[84] (1996/97)	n.d.	6.6[85]	
Increase in modern contraceptive prevalence rate	1% (1990)	10% (2000)	2.0%[86] (2000)	At the time of the MTR this goal was acknowledged to be unattainable and it was agreed to review and revise the target through analytic work with UNFPA assistance. Consultants were hired, but the task was never completed.
Enhanced knowledge of the population of the link between population and development	n.a.	n.d..	n.a.	Not evaluated.
Increased participation of women in development activities.	n.a.	n.d.	n.a.	Not evaluated. Field visits/interviews indicate: income generation for women has enhanced family wellbeing through investments in health and education and application of information about HIV/AIDS prevention.
Validation of social status of women	n.a.	n.d.	n.a.	Not evaluated. Women beneficiaries of microfinance who were interviewed reported enhanced social status due to their success in starting/growing viable economic activities.
Strengthened and extended MCH/family well-being at all levels of the health system	n.a.	n.d.	n.a.	Not evaluated/not a goal of this project. Bank assistance to this program objective was supported primarily through the parallel Health and Safe Motherhood project. The Population and AIDS project did contribute to this objective by procuring contraceptives for FP services for the public health system.

n.a.: not available
n.d.: not defined

83. Directorate of Coordination of Population-Related Activities, Ministry of Planning, Development and Cooperation (MPDC), 2004 data.

84. DHS 1996/97.

85. Government of Chad/World Bank Country Status Report 2003.

86. UNICEF 2001.

HIV/AIDS Medium Term for 1995-1999				
	Baseline	**Target (1999)**	**Actual**	**Comments**
A. PREVENTION : TO SLOW THE SPREAD OF HIV INFECTION BY PROMOTING BEHAVIOR CHANGE				
1. Knowledge				
% population age 15-49 who can cite two acceptable ways to protect themselves from HIV infection	n.a.	100%	19.5% of women 20-49 years of age (2000)[87]	
2. Availability and acceptability of condoms				
% persons age 15-49 knowing where they can buy a condom	n.a.	n.d.	n.a.	
% persons 15-49 able to obtain or buy a condom at an affordable price		n.d.	n.a.	Condoms are widely available in the country thanks to a successful social marketing program with decentralized branches, and over 1000 points of sale. The cost of one condoms is about US$0.02.
% persons age 15-49 considered "high risk" reporting use of a condom during their last sexual encounter	1.6% of women age 15-49 and 5.3% of men age 15-59 reporting sexual relations w/ non-regular partner[88]	100% (project projected to change behavior of 415,000 sexually active persons at high risk)	In urban areas: virtually all professional prostitutes and 70 percent of clandestine prostitutes; in rural areas: 60 percent of professionals and 50 percent of clandestine prostitutes report that they use condoms regularly with their clients (2001)[89]	
3. Casual sex				
% sexually active persons age 15-49 reporting at least one incident of casual sex during the last 12 months	n.a.	n.d.	n.a.	
4. STDs				
% of total number of diagnosed STD cases that are managed according to MoH norms	n.a.	76%	n.a.	
% pregnant women age 15-24 years testing positive for syphilis of all those tested for syphilis		n.d.	5.56%[90]	
% men age 15-49 reporting an episode of urethritis during the last 12 months	n.a.	n.d.	n.a.	
5. HIV				
% of pregnant women age 15-24 years tested for HIV in prenatal clinics that are sero-positive	2.1% (N'Djamena study)	n.d.	6.87%[92]	

87 .UNICEF 2001.

88. 1996/97 DHS.

89. PPLS 2001.

90. 1999 sentinel surveillance data for: Abéché, Bol, Bongor, Moundou, N'djaména, Sarh.

HIV/AIDS Medium Term for 1995-1999				
	Baseline	**Target (1999)**	**Actual**	**Comments**
	4.8%[91]			
B. Mitigation				
Of total estimated number of people living with AIDS, % being treated by health services	36% (1993)	60% (12,000 AIDS patients projected to benefit under the project)	n.a.	
Of total estimated number of people living with AIDS, % being cared for at the community level by an NGO or CBO	n.a.	30% (21,000 families projected to benefit under the project)	More than 30,000 families benefited from community-based social-medical assistance to mitigate impact of HIV/AIDS.[93]	
% total estimated orphans benefiting from program interventions during the last 12 months	n.a.	n.d. (45,000 orphans projected to benefit under the project)	n.a.	

91. 1999 sentinel surveillance data for: Abéché, Bol, Bongor, Moundou, N'djaména, Sarh.

92. 2002 sentinel surveillance data for: Abéché, Bol, Bongor, Moundou, N'djaména, Sarh.

93. Final Evaluation Report (Ngarmig-Nig 2002).

Annex F. Borrower's Comments

This is an official translation of the original document in French

Republic of Chad
Presidency of the Republic
Office of the Prime Minister
Ministry of Planning, Development and Cooperation
General Secretariat

Document No. 1….. /MPDC/SG/05

The Minister of Planning, Development and Cooperation

N'Djamena
January 13, 2005

Mr. Alain Barbu
Manager, Sector, Thematic, and Global Group
Operations Evaluation Department
The World Bank
Washington, D.C.
Facsimile No. +1-202-522-3123

Subject: Observations on the Population and Aids Control Project (PPLS1) Performance Assessment Report

Sir,

I have the honor to transmit herewith our observations on PPLS1 for incorporation in the final version of the report.

Yours truly,

(signed)

(Minister's seal)

Mahamat Ali HASSAN

Borrower Comments

The Project Performance Assessment Report (PPAR) on the Population and Aids Control Project 1 (PPLS1) is relevant and thorough. It brings into relief the efforts made under the project and shows that it was well managed and implemented.

On a number of points regarding the effectiveness of PPLS1, the PPAR concurs with the two earlier assessments, conducted separately by IDA and the national agencies, concluding that the project was relevant and that overall the results were satisfactory, considering that the project broke new ground in two complex areas and that Chad's sociocultural environment is difficult. The fact that PPLS2 built on the achievements and lessons of PPLS1 corroborates that finding.

Two considerable achievements of PPLS1, the Social Marketing Association of Chad (AMASOT) and the Social Fund (FOSAP) have become fully-fledged institutions and play an even more active role under PPLS2. The assessment of the components of the National Program of AIDS and Sexually Transmitted Infections Control (PNLS/IST), Project Social Marketing Unit (MASACOT) and FOSAP - rated satisfactory to very satisfactory - does not warrant any particular comments.

Concerning the population component, the results of which were unsatisfactory according to the assessment, the report itself admits that, when the project was mounted, no reliable data were available in that area and consequently the goals set were unrealistic.

The assessment concerning that component should therefore be qualified, in the light of the tangible outcomes achieved by PPLS1 under three sub-projects, namely, building the capacities of the Population Division, providing support for the dissemination of the Population Policy Declaration, and carrying out surveys and research.

Furthermore, it should be mentioned that fertility and population growth can decline only as a result of a long-term process (as indicated in Annex C), for which PPLS1 has laid the groundwork. Accordingly, fertility could not be expected to start waning within five years.

Detailed Observations

Acronyms and abbreviations

CERPOD:	Center for Research on Population and Development (*Centre de Recherche sur la Population pour le Développement*)
CNPRH :	National Population and Human Resources Commission (*Commission Nationale de la Population et des Ressources Humaines*)
CRP:	Regional Population Commission, beginning in 2002. For earlier periods (and therefore at the time of PPLS1, one should refer to the Prefectural Commission on Population and Human Resources (*Commission Préfectorale de la Population et des Ressources Humaines* or CPPRH) (see footnote 29)
HCPRH:	High Councilmmittee on Population and Human Resources (*Haut Conseilmité de la Population et des Ressources Humaines*)
PAIP:	Program for Priority Actions and Investments (*Programme d'Action et d'Investissement prioritaire en matière de Population*)

Summary

P. ix, second paragraph: The law of 1920, *not* 1965.

Outputs and Outcomes by Objective

The PPLS1 project provided considerable support to the laboratory/transfusion safety unit by procuring reagents for all qualified national health-facilities to prevent contamination by blood route, particularly through blood transfusion.

4.4	"(c) the preparation of" 14 monographs … five detailed analyses and seven regional analyses of *DHS* data.
4.6	"15 integrated projects (…) were implemented by the 15 CPPRH", *not* 14 *CRPRH*.
4.12	"the actual rate of population growth is about" 3.1 percent, *not* 2.8 percent.
Footnote 41	Source: Directorate of Coordination of Population-Related Activities, Ministry of Planning, Development and Cooperation (MPDC), *not* Department of Population, MoPC, 2004.
p. 18 4.17	*PNLS*/STI component: It would also be appropriate to stress PPLS1 support to the STI unit of *PNLS*/STI for training medical staff (over 2,000) in STI treatment and drafting an STI treatment guidebook.
	Regarding HIV infection diagnosis, considerable efforts were made under PPLS1 through the national network to upgrade the technical capacities of the laboratories and provide them with AIDS detection reagents and laboratory supplies. A unit was also set up in the laboratory of the National General Referral Hospital (*HGRN*) in N'Djamena to function as a referral center for HIV/AIDS diagnosis.
	Enzyme-Linked Immuno-Sorbent Assay (ELISA) Chains were set up in the hospitals of N'Djamena, Bongor, Moundou, Sarh and Abeche. A CD4 count instrument was installed in the N'Djamena laboratory.
p. 25 4.30	Figure 9 - The caption should read "N'Djamena, Moundou", *not* "Ndjamona, Maoundou".

Background and Context
pp. 1-3

1.2	- "and half of the population living on less than 50 cents per day": Give the actual figure. - "Child mortality was estimated at 222 per thousand for" 19932003, *not* 2002. - The source of the maternal mortality figure is the 1996/1997 Demographic and Health Survey in Chad (*EDST*).
1.5	"Chad's population" was about 6.2 million, *not* 6.8 million.
1.6, box	Specify that this is a summary of the "Population Policy Objectives".
1.6	Replace "1965 law" with "1920 law".
1.7	"infant and child mortality were very high (estimated, respectively, at" 132 and 222 per thousand in 1993, [translator's note: *not* "124 and 206 per thousand in 1994".]

1.8	Moreover, a department (by "department" we mean "ministry") was responsible for demographic research and analysis. The units tasked with that activity were the Directorate of Statistics and Economic and Demographic Studies (*DSEED*) and the Population Division (*DP*), and both were accountable exclusively to the Ministry of Planning. The mission of the *HCPRH*: (1) To provide population policy orientations. (2) To adopt recommendations prepared by the National Population and Human Resources Commission (*CNPRH*).

Implementation and Costs
pp. 8-11

3.3	"The Migration and Urbanization Survey was delayed because UNFPA was unable to provide all of the funds it had initially committed": The delay was also due to the restructuring of *CEPROD*, which experienced a disruption in its technical support.
3.4, last line	However, in the meeting of September 7, 2001, the *HNPRHCNPRH* insisted that the *HCPRH* should be chaired by the Head of State.
3.6	"the Population Unit … – promoted first to the level of a division and subsequently to the level of" a full directorate, *not* "a full department".
3.6 and 4.2	Since this is an assessment of PPLS1, reference must be made to the Division of Population, *not* the Department of Population.
3.8	It should be noted that there were tensions between the last *PNLS/IST* coordinator and the assistant, whereas the supervision of the heads of the *PNLS/IST* technical units (*APMS*; Laboratory and Transfusion safety; Epidemiology; Information, Education and Communication (IEC)/Youth Caravan; etc.) by the technical assistant worked well.

Findings and Lessons
p. 30

6.3	"Limiting family size was also unrealistic in light of ethnic tensions": This affirmation is baseless, because it is not verifiable. Deleting it would be judicious.
6.21	Twenty four (24) indicators, *not* 18, were definitively adopted in the project monitoring and evaluation plan of PPLS2.

Miscellaneous

In an assessment of PPLS1, reference must be made to the Division of Population, *not* to a Department or Directorate of Population.

p. 47	Moundou/Department of Lake Wey/Region of Logone Occidental
p. 48	Bongor/Department of Mayo-Boneye/Region of Mayo-Kebbi Est
Footnote 70	" (d) population policy implementation": "population policy" is correct, "politique démographique" in the French is incorrect.