

# THE EXPANDED AND COMPREHENSIVE RESPONSE:

## A FRAMEWORK FOR ACTION

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SNAPSHOTS FROM THE FIELD



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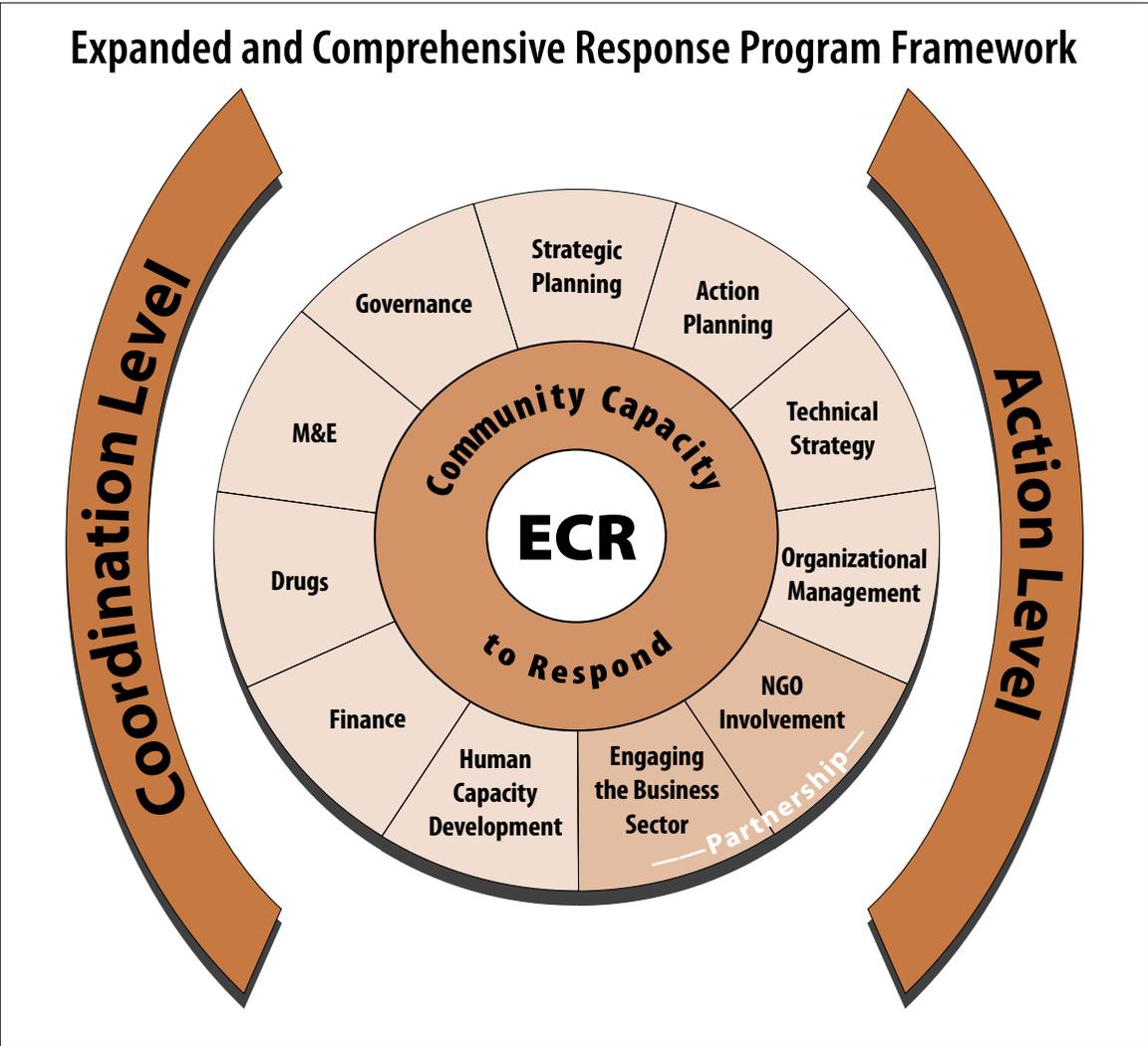
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Cover photo: Having lost both parents to AIDS, Caroline cares for her two younger sisters and her own son in Nakuru, Kenya. Caroline earns money selling samosas and receives assistance from the Society for Women and AIDS in Africa/Kenya (SWAAK), a longtime FHI partner. The expanded and comprehensive response process is poised to help Kenya strengthen its HIV response, which would benefit individuals like Caroline. Photo: Steve Taravella/FHI

### THE CONCEPT, THE CONTEXT

Policymakers and health officials in countries threatened by the HIV pandemic increasingly use strategic planning to guide national prevention, care and treatment programs. Many of these broad-scale AIDS strategies include projects to scale-up targeted prevention, VCT, home-based care, clinical treatment and other key interventions.

Yet too often national strategies have limited impact at the local level—the real front line of the epidemic—where authority is decentralized and where conditions, resources and community capacity influence how and whether programs are implemented. The absence of adequate local action frameworks and networking systems may further fragment the response. The problem is exacerbated when community leaders, program partners and other stakeholders don't communicate effectively with each other. And with the dramatic increases in AIDS funding that have occurred in the past few years, local authorities are struggling to absorb new resources efficiently and distribute them equitably. Few countries, provinces or districts have implemented mechanisms to build a rational, organized and locally coordinated response.



The Expanded and Comprehensive Response (ECR) is an action framework that mobilizes resources and organizational capacity to effectively and rapidly deliver an expanded and comprehensive response to the HIV epidemic. ECR supports a shift from project-based programming to systems-based programming, from experimental pilots to evidence-based interventions, from limited access to an expanded response, and from prevention-centered programs to a comprehensive continuum of care.

ECR supports the “Three Ones” principles that UNAIDS asks each country to adopt: one national AIDS coordinating authority, one country-level monitoring and evaluation system, and one action framework that provides the basis for coordinating the work of all partners at all levels. ECR helps translate national strategic vision into coordinated, district-level actions.

But explaining ECR can be difficult. Preventing mother-to-child transmission (PMTCT) averts new cases of disease, ART extends lives, and psychosocial support helps people adjust to difficult circumstances. But ECR is not an intervention *per se*. Rather, it is a structured process for coordinating interventions. It is a framework that helps districts identify and prioritize a range of needs—such as staff training, improved quality, additional facilities, better access—and then create joint action plans to address them. Because ECR responds to local needs, the results are different each time. David Dobrowolski, FHI’s director of capacity development, refers to ECR as “a structured, yet flexible, process where solutions are locally generated.”

The framework that FHI published about ECR is called *Strategies for an Expanded and Comprehensive Response to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*. This 128-page book explains the aim of ECR is “to ensure quality, improve accountability systems, and increase the range of interventions and programs that are delivered to populations not currently served.” The book features nine modules: Strategic Planning, Technical Strategies, Administration and Resource Management, NGO Involvement, Human Capacity Development, Costing and Use of Resources, Managing the Supply of Drugs and Commodities, Measuring for Impact, and Engaging the Business Sector. The book was developed with several FHI partners and national programs, including those in Kenya



*In China, partners work together to develop a vision and action plans.*

Photo: David Dobrowolski/FHI

and Nigeria. Each module provides government officials with a set of key issues to address when planning an HIV/AIDS response, as well as resources for doing so.

While the book began as a tool largely for national strategic planning, ECR's main application has been in district-level action planning and provincial oversight and support to this process. ECR has evolved to have a larger impact on a smaller geographic area. While this geographic area is referred to as a "district" in some countries, ECR may be more appropriate at a county, state, province or other regional level, depending on size and other factors. Maureen Murphy Richardson, a senior program officer in FHI's China office, pictures feet walking across a map: "The idea of ECR is to leave deep, noticeable footprints with each step forward. Step by step, district by district, the map will be filled with small footprints. This will begin to stamp out the epidemic."



*Ruth Odhiambo, an FHI field manager in Kenya, facilitates a lively a group discussion about ECR.*

Photo: David Dobrowolski/FHI

district must have access to resources. While some ECR actions require simple reallocation or coordination, many require new spending.

**Get government leaders invested.** ECR has generally begun with a meeting between an FHI officer and government leadership to introduce the ECR concept, discuss the government's role, and explain the types of outcomes to expect. The goal is to help government officials commit to the

## **A STRUCTURED, FLEXIBLE PROCESS**

Four countries where FHI works have developed ECR initiatives: China, Ethiopia, India and Kenya. Guinea, Guyana and Nigeria are beginning ECR processes, as well. These countries have followed a flexible sequence of steps that can guide other country efforts:

**Determine whether ECR is appropriate.** Not all regional areas are well-suited for ECR. Planners must address a series of readiness criteria before committing to the process. First, ECR is premised on a dedication to tackling the epidemic. Stakeholders must be committed to fighting the epidemic and willing to work together. Second, since ECR is a tool for designing comprehensive, linked programming, the region where it will be applied should already have some basic programs in place, such as VCT, behavior change communication (BCC) activities, and home- and community-based care (HCBC). And finally, the

idea, as they will ultimately steer the effort. The government leads the effort; FHI plays a support role and adapts the ECR programming framework to the government's requirements.

Selecting which officials to approach is important. ECR usually operates at a district level, but some country offices have opted to approach national officials for their support before broaching the topic with district-level leaders. (Although ECR action planning is tailored to the district, it has also been applied in larger and smaller geographic areas.) In selecting the level, the aim is to find the smallest area that acts as a functioning programming unit capable of coordinating the response. It is also important to decide which agency to approach. ECR can be based in an AIDS commission, a health ministry or even a planning ministry. Many agencies will be involved later, but the first agency selected must be capable of leading the effort, creating an enabling environment and supporting follow-through. Once the government has taken interest, FHI and other NGOs can provide technical support and direction.

**Perform a needs assessment.** Districts should inventory stakeholder and governmental needs and capacity to help identify priority areas. Assessing both the drivers of the epidemic and the existing response is important. Assessments can be conducted by stakeholders, facilitators or third-party researchers. This preliminary step contributes to productive, evidence-based discussions when stakeholders gather for workshops. Gaps and strengths are identified and channeled into the subsequent steps.

**Conduct a stakeholder workshop.** FHI's 2003 *ECR Facilitator's Guide* walks facilitators through a five-day workshop for district-level stakeholders from government agencies, NGOs, the private sector, and marginalized groups, including people living with HIV/AIDS (PLHA). The workshop revolves around activities that first create a vision and then support action-planning. These steps include:

1. Conducting an "appreciative-inquiry" exercise to identify agencies' and organizations' successes and strengths;
2. Creating a group vision that promotes unity among the stakeholders;
3. Performing a "gap analysis" to identify areas needing improvement;
4. Developing actions to address these gaps;
5. Prioritizing which actions to undertake based on importance and feasibility; and
6. Determining who is responsible for each action and when it must be completed.

This process fosters connections between organizations and creates a system of accountability.

**Conduct trainings and provide resources using technically guided facilitation.** A central feature of ECR is joint action planning, where multiple stakeholders come together to develop solutions to programming gaps. For these joint meetings to function smoothly, facilitators create a comfortable environment where people can speak honestly about problems and creatively about solutions. The district must train facilitators and program planners in both facilitation skills and ECR concepts. Deryk Omuodo, who is an ECR specialist in with FHI's Kenya office, says

“facilitation is the key that unlocks the potential.” After the plans are developed, FHI and other agencies provide financial and other resources to mobilize capacity for implementation.

**Set up implementation and monitoring structures.** The government agency leading the ECR initiative is responsible for supporting implementation. A multisectoral commission often oversees implementation and ensures follow-through. Technical personnel must also be involved to support capacity-building needs. In Nakuru, Kenya, the District Development Committee is the primary district-level planner. A 15-member ECR Technical Committee, comprised of government officials, NGOs, CBOs and FBOs, assists with technical direction. And Constituency AIDS Control Committees mobilize resources and monitor implementation at the constituency level, one level beneath the district.

## FEATURES OF THE FRAMEWORK

While ECR requires adaptation to each country context, several characteristics are common among all ECR applications. ECR is both top-down and bottom-up simultaneously. It is also multisectoral, evidence-based, transparent and flexible.

**Top-down:** Getting government officials on board from the beginning and enabling them to drive the process is important. They play a critical coordination role and help create an environment that enables action. Their leadership is key to making ECR sustainable.

**Bottom-up:** While government officials coordinate the workshops, it is the stakeholders and service providers who must design the plans. This participatory, bottom-up approach seeks to harvest wisdom from each stakeholder. It recognizes that PLHA and front-line practitioners have important insights into decision-making. And it promotes greater responsiveness to client needs and provider capacity. It cultivates a sense of ownership.

**Multisectoral:** ECR benefits from the participation of many public sector agencies, private sector actors, NGOs, CBOs, FBOs, PLHA and other marginalized groups. ECR operates on the belief that the group, as a whole, is greater than the sum of its parts. It also recognizes that AIDS is not simply a health problem, but rather a development issue that cuts across many areas of expertise.



*Peter Mwarogo, deputy director of FHI/Kenya, explains the basic ECR concepts at an action planning workshop.*

Photo: David Dobrowolski/FHI

ECR provides the space for organizations to eliminate duplication, pool resources, and create stronger referral networks. It supports mainstreaming of HIV responses into other line agencies of the government.

**Evidence-based:** The needs assessment informs the stakeholder workshop, ensuring that that action plans are responsive to local needs. Similarly, when there is an information gap, stakeholders can elect to conduct additional assessments as a first action step, to make sure future actions are data-driven. M&E teams frequently support the process.

**Transparent:** Because many stakeholders understand program expectations from the beginning, a system of public accountability is built into the process.

**Flexible:** ECR can be adapted to smaller and larger countries, centralized and decentralized planning settings, and concentrated and generalized epidemics. In Ethiopia, ECR takes place at a regional state level, rather than a district level. In India, rather than holding an action-planning workshop, researchers and consultants meet with each sector individually, and then design an action plan. The Chinese have expanded the ECR concept (and have even added a fourth letter to the acronym). And Kenyans have sub-divided their district action planning workshops into smaller local groups.

## COUNTRY SETTINGS

Kenya, India, China and Ethiopia have the most developed ECR processes to date. This section examines how these countries have conceived and implemented the framework in different ways.

### KENYA: PILOTS WITH POTENTIAL

Kenya has eight provinces, each divided into districts, which are further divided into constituencies. ECR in Kenya has been coordinated at the district level with action planning taking place at both the district and constituency levels. The three ECR pilot districts (Bungoma, Malindi and Nakuru) are progressing toward action plan implementation. While it is too early to tell what the long-term impact will be, many positive milestones have been identified during the process.

To begin the ECR process, FHI consultants held meetings with the National AIDS Control Council and district-level leaders to ensure they recognized the importance of ECR. FHI planners believed getting national officials on board first would help engage district-level officials. Once leaders at both levels were on board, a multi-sector team was trained in each district to facilitate the ECR process. The teams first conducted and then disseminated a community capacity assessment identifying current trends in management, coordination, human resource capacity, monitoring and evaluation, and advocacy. Different weaknesses surfaced in each district. The Nakuru assessment revealed a limited reach of activities and poor coordination between organizations and agencies. Bungoma had weak service structures and systems in need of strengthening and improvement. Malindi services were concentrated in one constituency and were limited in scope.

In addition, Malindi lacked financial resources and was struggling to develop political will to confront AIDS.

With those three pieces in place—supportive government officials, a trained facilitation team, and an informed picture of the local situation—stakeholders in each district met to create a group vision, prioritize local needs and prepare joint work-plans. In Nakuru, the most developed ECR site, stakeholders developed the following vision:

*Our endeavor and commitment is to have a comprehensive and coordinated program that interlinks various partners to offer effective prevention, care and support for STIs and HIV/AIDS through services for those infected and affected individuals with community participation. It will be an unmatched model with referral systems that offer the community access to unlimited services.*

With a district vision in place, the larger group broke into constituency units for action planning. They decided to divide their action plans into three categories: human capacity, scale, and community capacity-building. Within human capacity, action steps covered the spectrum from preliminary activities (conducting needs assessments, for instance) and implementation (training of trainers) to follow-through (developing supervision tools). The scale component seeks to identify coverage gaps and develop joint funding proposals. The community capacity section centers around NGO, CBO, and FBO assessment, PLHA mobilization, and resource mobilization. A different party is responsible for each action and has a target deadline, as well as a finished measurable product, such as a training report or a supervisory tool.

Constituency AIDS Control Committees (CACCs) have been established to oversee follow-through at the constituency level. They are responsible for mobilizing resources and monitoring implementation. In addition, the district has a 15-member ECR Technical Committee, comprised of government officials, NGOs, CBOs, FBOs and the private sector, which provide technical direction to the constituencies. Collaborating with District Development Committees, the primary district-level planners, these committees coordinate and monitor ECR-related activities.

ECR has succeeded at bringing new groups into the process. Peter Mwarogo, FHI’s Deputy Country Director, explains that one of ECR’s key strengths in Kenya has been its ability to engage new groups. “We are making connections with all the other groups that are providing

**KENYA**

**Geographic coverage:** Three districts

**Population covered:** 369,900

**Quote:** A USAID consultant, Deryk Omuodo explains that in Kenya, “facilitation is the key that unlocks the potential for action.”

**Highlights:**

- Kenya linked ECR to its national AIDS strategic plan as the main method for scaling up the HIV/AIDS response at the district, constituency and community levels.
- With the help of FHI/IMPACT, 40 Community Based Organizations (CBOs) developed ECR-centered funding proposals to the Global Fund for AIDS, Tuberculosis and Malaria, all of which were funded.

services and to other sectors that are linked with HIV/AIDS, so that people can see the linkages. There are other groups that are providing nutritional services, for example, but they don't see themselves as doing anything in HIV/AIDS. We know that there is a role for nutritional services, as part of care for people living with HIV, so we bring all these groups together, and say, 'These are our means. You are providing this; we are providing this. How can we link with each other so that we have a more comprehensive program?'"

Collaboration between the three sites advances ECR in Kenya. To improve facilitation capacity in their districts, the Bungoma and Malindi facilitation teams attended the Nakuru workshop before facilitating workshops in their own districts. This cross-fertilization is important for capacity development. Although the framework is geared toward local-level action, scale-up of ECR in Kenya or elsewhere can benefit from this same approach.

Though still in its early stages, ECR has taken a toehold in Kenya with great potential for scale-up; national bodies have taken notice and adopted the ECR. The Kenya AIDS NGO Consortium (KANCO), Kenya's umbrella organization for NGO capacity building, embraced the framework. With the help of FHI/IMPACT, 40 CBOs in KANCO prepared ECR-centered funding proposals for the Global Fund for AIDS, Tuberculosis and Malaria—and all were funded. Similarly, the national Government of Kenya, through the National AIDS Control Council (NACC), adopted ECR as its main capacity-building and comprehensive-response framework. Kenya opted to link it to the national AIDS strategic plan as the main method for scaling up the HIV response at the district, constituency and community levels. This is a strong gauge of ECR's promise in Kenya.

## **INDIA: DISTRICT-LEVEL SUPPORT**

India has 5.1 million HIV-positive people, second only to South Africa in absolute numbers. Of India's 28 states and seven union territories, the National AIDS Control Organization (NACO) had designated six as high prevalence: Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Manipur and Nagaland. Of India's more than 600 districts, NACO has designated 49 as high prevalence, 45 of which are in the country's six most affected states.

While transmission in India still occurs mainly within such at-risk populations as sex workers and their clients, truckers, men who have sex with men (MSM), migrants and injection drug users (IDUs), several regions now face generalized epidemics. In the southern state of Tamil Nadu, for example, antenatal prevalence is more than 1 percent in several districts.

Using the ECR process, USAID/FHI is providing technical assistance to government planning efforts in four high-prevalence districts in Tamil Nadu: Namakkal, Madurai, Theni and Tirunelveli. The goal is to help the Tamil Nadu State AIDS Control Society (TANSACS) and the District Collector (the Government District Administrator) develop and implement HIV/AIDS District Action Plans (DAPs). The plans are not stand-alone efforts but rather are integrated into the existing government district planning process to address HIV with multisectoral approaches.

## INDIA

**Geographic coverage:** Six districts

**Population covered:** 1,495,661 in Namakkal plus five other districts

**Quote:** Dr. Bitra George, associate director of program and technical, explains, “If ECR had not existed, there would have been no structured HIV/AIDS planning exercise and projects would have been funded and supported in an ad-hoc fashion, without conducting needs assessments and a proper gap analysis in the district.”

### Highlights:

- ECR housed in the District Collector’s office, rather than the department of health
- Third-party consultants and researchers have been actively involved in the needs assessment process

In 2003, USAID/FHI gave support to TANSACS and the District Collector to develop a planning process with NGOs, including the USAID-funded AIDS Prevention and Control Project (APAC); community-based organizations (CBOs); all government departments and the private sector.

In Namakkal, development of the DAP was unique because it extended beyond the usual collection of data through interviews, focus groups and assessments that can be used later to design the plan. The plan preparation process itself catalyzed stakeholders to initiate responses before finalizing the overall plan. Thus while the DAP was being developed, several projects were concurrently implemented: USAID/FHI initiated support to a district-level network of people living with HIV/AIDS (PLHA) for comprehensive prevention-to-care projects, APAC made plans to fund mapping studies, and NGOs expanded their work among high-risk behavior groups.

The ECR planning process also created an environment in which previously uninvolved parties could become committed to addressing HIV. FHI consultants had conducted a multisectoral situational assessment of the district, interviewing public, private and NGO stakeholders in a range of sectors such as health, education and trans-

port, as well as women and children. The assessment was disseminated in a district-wide stakeholder workshop. The entire process helped government and private actors become aware of linkages that are critical for effective interventions. Private and public associations in the handloom and power loom industry, as well as trucking and rig owner groups, became sensitized and began to plan interventions. District administrators also openly discussed HIV in a public forum. A unique achievement of the multisectoral Namakkal District Action Plan (DAP), therefore, was improvement of the ECR planning process itself.

The Namakkal DAP supports collaboration across sectors with a range of partners—NGO, private and public—for a comprehensive response. The plan is an evolving document that includes ongoing and planned activities, donor involvement and strategic gaps in ten sectors critical to addressing HIV. Six ECR strategies form the basis for activities under the Namakkal DAP: increase quality and access to prevention; increase quality and access to care and support; link prevention, care and support through referral mechanisms; raise capacity for HIV/AIDS prevention and care and mainstream HIV; create an enabling environment for greater involvement of people living with HIV/AIDS (GIPA) and reduction of stigma and discrimination; and improve management and coordination of governance, including monitoring and evaluation.

The Namakkal DAP provides a way to coordinate activities in the health sector, including condom promotion and STI treatment, with such education sector efforts as the School AIDS Program and peer education for youth. For example, by mapping transport sector HIV prevention programs with truckers in the overall situational assessment, the DAP allows for an overarching view of ongoing activities and gaps. Planned activities include development of workplace policies in the transport and handloom industries and creation of linkages between ongoing children's support services and HIV programs through the Social Welfare Department. Existing activities, such as forming savings groups for PLHA and sex workers, are being linked to other income-generation and self-help group schemes.

In three other districts in Tamil Nadu, situational assessments looking at demographic data, HIV vulnerability and existing responses by sector have been completed. District planning will soon be under way using a participatory process with local district administrators, private industry and NGO partners. Concurrently, FHI is building a strong team in Tamil Nadu to help the state AIDS control societies and District Collectors use the ECR process to develop and implement district plans and to respond to requests to support even more districts in the planning process.

### CHINA: AN INTEGRATED GOVERNMENTAL APPROACH

Chinese villagers often use large wooden buckets to carry water. If the wood is not properly paneled together, or if planks are missing, water will leak out. "This is also true of our AIDS approach. I see these buckets as a system that will hold the resources. Each piece of planning is like a plank. If you dip from the well of resources and you haven't built your bucket well, resources will be wasted," observes Ms. Richardson of FHI/China. "ECIR helps us build a better bucket."

In China, ECR has taken on a fourth letter, "I," making the acronym ECIR. FHI's country director in China, Cheng Feng, who expanded the acronym, explains that the "E" (for *expanded*), refers to coverage; the "C" (for *comprehensive*), to a full spectrum of technical approaches; and the "I" (for *integrated*) to organizational relationships. It is not enough for the bucket to be large (expanded) with all planks intact (comprehensive); those planks must fit tightly together (integrated) in a seamless continuum of care.

The China-UK Project, with funding from the U.K.'s Department for International Development and technical support from FHI, has completed the ECR action planning process in Sichuan and Yunnan provinces, with a total of 19 ECR sites in 43 counties, covering a population of 160 million. FHI/IMPACT will now introduce Guangxi to the ECIR model. The strength and centrality of the Chinese government, as well as the huge geographic area, have provided unique challenges for applying the ECR framework.

The sheer size of the country makes integration a challenge. It is not easy for a VCT facility to appear connected to a care and treatment center when, in fact, the two are ten miles apart and serve different populations. The goal is to make a continuum of interventions and services avail-

able to each target population within a given geographic area. For example, Richardson says, “injecting drug use interventions not only include health education, but also comprise needle exchanges, voluntary counseling and testing, and/or peer education. As for HIV-positive injecting drug users (IDUs), in addition to the above interventions, the priority is to reduce social discrimination and to provide HIV/AIDS care and social support.” A comprehensive array of interventions is effective only when the interventions are integrated.

Despite ECR’s multisectoral approach, China has little more than a public sector. The few NGOs that exist in China tend to be quasi-governmental. As a result, ECR has taken place predominantly within the public sector, but a plurality of government agencies can help make up for the limited NGO presence. They bring a diversity of perspectives to the table. For example, while the Public Security Bureau may conceptualize homeless IDUs as a public safety problem, a health ministry might see them as a population to serve. When people come together for action planning, these different perspectives tend to complement each other, rather than compete, as might happen if they planned in isolation.

The Chinese government’s tendency toward centralization has shaped ECR planning here. The Chinese government is skilled at taking an intervention that works in one area and applying it to another, creating great potential for ECR scale-up in China. After being virtually ignored for many years, HIV has become a government priority. In the MOH’s new China CARES Program, the basic components of the 51 comprehensive treatment pilots reflect the ECR model. China is rapidly scaling up services to HIV-infected people and creating a political atmosphere that demands action at all levels. Cheng Feng finds the framework helpful and believes “it will become the mainstream of HIV/AIDS control in resource-limited settings, particularly in China.”

**ETHIOPIA: CULTIVATING COHESION AMONG STAKEHOLDERS**

In Ethiopia, ECR has been used as an umbrella term for programming, not strictly as a framework for local action planning. It has been applied in four high-prevalence regional states: Addis Ababa; Oromia; Amhara; and Southern Nations, Nationalities and Peoples Region (SNNPR). These regions are home to 85 percent of the country’s population and are USAID priorities. In addition, ECR has recently commenced in Tigray, Harar, Dire Dawa and Benishangul-Gumuz regional states.

**CHINA**

**Geographic coverage:** 19 sites in 43 counties

**Population covered:** 160 million

**Quote:** “In the past, if one location had VCT, care and treatment went to another. In the big picture it looked like there was coverage, while there was actually fragmentation,” explains Maureen Murphy Richardson.

**Highlights:**

- ECR has evolved into “ECIR.” The “I” stands for “integrated” and refers to the need for strong organizational relationships
- Despite ECR’s multisectoral approach, China in general and the ECR framework in particular—has limited NGO participation

## ETHIOPIA

**Geographic coverage:** Initially four provinces, then expanded coverage to three more

**Population covered:** 57,674,000

**Quote:** “We profile ourselves, FHI, as background. We want in-country partners to be able to continue on their own, without us playing a central role,” says Country Director, Francesca Stuer.

FHI’s ECR programming approach in Ethiopia builds leadership and coping capacity at the community level. It increases absorptive capacity at the community level, as well as among civil society and government partners, and enables other resources to be leveraged from donors.

To help fill programming gaps, FHI offers technical assistance and capacity building in several ways. It facilitates networking and experience sharing among partners and provides direct assistance to implementing agencies as needed. FHI supports efforts aimed at partnering among donor-funded projects, leveraging other donor funding, pooling existing resources to avoid duplication and providing capacity-building in key program areas.

FHI’s key role is to provide vision and assistance, while focusing on building local capacity and ownership. Francesca Stuer, FHI’s country director in Ethiopia, says, “We provide technical assistance, but this is our local partners’ program. We want them to be able to continue on their own.” So, in 2003, when the Health Bureau asked FHI to provide technical assistance to support integrating VCT into the standard package of services offered in public-sector health centers in Addis Ababa, FHI made sure to also build the capacity of the Health Bureau itself. Over time, the Health Bureau assumed more and more responsibility and now leads all training, supervision, and quality control activities for VCT in both the public and private sectors. In addition, the Health Bureau and the Addis Ababa regional HIV/AIDS Prevention and Control Office are supporting many services linked to VCT.

Demonstrating ECR’s flexibility, several process steps in Ethiopia differ from other country settings. Rather than conducting assessments followed by five-day action planning workshops, Ethiopian stakeholders first participate in three-day consensus-building workshops. The consensus-building process helps the stakeholders begin to develop referral networks, a key feature of an expanded and comprehensive response. This, in turn, allows the individuals and stakeholders to provide a continuum of care for people and households affected by HIV/AIDS.

To fill gaps in coverage, capacity and quality, FHI focuses on the regional state level, bringing together all partners active in the HIV/AIDS response. Due to the regions’ large size, a great number participate in each stakeholder workshop—usually 50-120 people, compared to 25-30 elsewhere. This critical step recognizes the key role of each stakeholder, including the government. Each implementing organization can offer the services it is best-equipped to deliver, and refer beneficiaries to other organizations when needed. This framework, in which different organizations provide services while government plays a coordinating role, allows the linkage of prevention, care and support.

Continual situational assessment is a critical part of the process. The initial three-day consensus-building workshops lead to local baseline needs assessment surveys which inform the design of interventions. At yearly update meetings, stakeholders share, analyze and document lessons learned, which then leads to refining and scaling-up implementation efforts.

## WHAT'S NEXT?

Due to different cultural contexts, epidemic profiles, funding amounts and types of programming, each ECR country has a unique balance of top-down and bottom-up structures, synergy among sectors and needs-assessment tactics. ECR's ability to adapt to these differences makes it a powerful framework. "ECR as a philosophy, as an approach to multisectoral, district-level AIDS action planning is more important than any of its processes or products," says Dobrowolski. "Because of this adaptability it is effective at improving scale, scope, quality, community-capacity and system-functioning—the key indicators of effective programming."

It is too early to rigorously evaluate ECR's outcomes, but its first applications have proven promising. It is being used in FHI's work in Guyana (funded by the President's Emergency Plan for AIDS Relief) and in Nigeria (funded by the Emergency Fund and the UK's Department for International Development). ECR holds potential for harmonizing the initiatives of multiple donors in the same geographic area.

ECR answers many international calls to action. It responds to the part of UNAIDS' "Three Ones" that calls for an action framework for coordinated planning under a single authority. It provides a mechanism to use funds more effectively. And it responds to one of UN Secretary General Kofi Annan's three priorities, laid out in his address at International AIDS Conference in Bangkok in 2004, "Leadership at every level."

"AIDS means daring to do things differently, because you understand that AIDS is a different kind of disease," Annan said. Leadership must "translate into adequate resources from national budgets. It must mobilize the entire state apparatus from ministries of education to ministries of defense and it must generate partnerships with every sector of society, business, civil society, and people living with HIV/AIDS." ECR is the bold, multisectoral framework that answers this call. It translates nationally-led strategies into locally-driven actions. It calls on governments to lead the process and the community to lead the plans. It leads many stakeholders together down a common path, district by district, step by step. Making an impact.