Report Number : ICRR0020635

1. Project Data

Project ID	Project Name
P107375	LS-HIV & AIDS TAL (FY10)
Country	**Practice Area(Lead)**
Lesotho	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-H5020	31-Jan-2015	5,000,000.00
Bank Approval Date	**Closing Date (Actual)**	
27-Aug-2009	30-Jun-2016	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	5,000,000.00	0.00
Revised Commitment	4,456,980.91	0.00
Actual	4,383,763.27	0.00

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2. Project Objectives and Components

a. Objectives

According to the Financing Agreement (p. 5), the project's objective was "to assist the Recipient in building capacity of government agencies and civil society organizations at both the national and local level to address the identified key gaps in implementing the National HIV and AIDS Strategic Plan in an effort to contain and reverse the endemic." The Project Appraisal Document (PAD, p. 6) has the same wording, except that it correctly refers to the "epidemic" rather than "endemic." This error was formally corrected in a December 2011 restructuring. Although some key outcome indicators were dropped and some added at the December 2011 restructuring and again at a November 2014 restructuring, the scope of the project did not meaningfully change; the indicators were revised to provide a better measure of project achievement, and

there was no revision of targets for any single indicator. A split rating will therefore not be performed.

According to the PAD (p. 6), the "identified key gaps" were: (i) weak coordinating capacity for multi-sector response; (ii) limited research capacity to organize and use scientific evidence to guide implementation; (iii) fragmented national HIV monitoring and evaluation systems; (iv) weak implementation capacity to scale up those effective interventions that address the key drivers of the epidemic; and (v) uncoordinated local response with low capacity to monitor the implementation of HIV services and limited use of monitoring information to improve program planning and service delivery.

b. Were the project objectives/key associated outcome targets revised during implementation?

No

c. Will a split evaluation be undertaken?

No

d. Components

The project contained three components (PAD, pp. 7-8):

1. Improving institutional capacity to implement the multi-sectoral response (appraisal: US$ 1.8 million, revised to US$ 1.5 million at a December 2011 restructuring; actual: US$ 1.5 million). This component was intended to support capacity building of national-level institutions, both public and private, including the National AIDS Commission (NAC), selected line ministries (Labor and Employment, Education and Training, Youth, Gender, Sports and Recreation, and Works and Transport), the Global Fund Coordination Unit (GFCU) in the Ministry of Finance and Development Planning (MOFDP), umbrella civil society organizations, business and labor coalitions, and the Lesotho Council of NGOs. Specific activities were designed to: strengthen the NAC's capacity to coordinate the national multi-sectoral response; strengthen the country's HIV/AIDS research capacity to generate timely and accurate evidence to guide a more effective national response; contribute to the implementation of a national HIV monitoring and evaluation (M&E) system; and strengthen the NAC"s capacity to monitor resources for a better-functioning HIV national strategic plan. Financial and technical support was also to be provided for mainstreaming HIV/AIDS activities in selected key ministries and relevant institutions in the private and civil society sectors. At the December 2001 restructuring, this component was narrowed to focus only on the Lesotho Council of NGOs (LCN; focus was therefore no longer on the NAC, which was dissolved at the end of 2011).

2. Improving capacity to scale up the health sector response (appraisal: US$ 1.9 million, revised to US$ 2.3 million at the December 2011 restructuring; actual: US$ 2.49 million). This component was to support mainly Ministry of Health and Social Welfare (MOHSW) units to build capacity for delivering essential and effective HIV services and to mitigate the impact of the epidemic. It was to fill gaps in existing programs to support: integration of HIV effective HIV services with other health services such as tuberculosis (TB) and sexual/reproductive health; mitigate the impact of the epidemic on orphans and vulnerable children (OVCs); and strengthen institutional capacity for evidence-based planning and M&E. Specific capacity

building was designed to improve the ability to: facilitate implementation of HIV prevention interventions, including behavior change communication and male circumcision; strengthen integration of the TB and Sexual and Reproductive Health services; manage pediatric HIV cases, including prevention of mother-to-child transmission (PMTCT); expand and manage the OVC program; manage and analyze health information at the district level for program improvement purposes; facilitate evidence-based planning through operational research into best practices for HIV service delivery and integration; provide a more adequate legal framework for the health sector; and manage procurement of essential HIV commodities. At the December 2011 restructuring, this component was revised to focus only on key prevention and mitigation measures, rather than the full range of interventions (many of the originally planned activities had been picked up by other development partners, and the government had agreed to cover the salaries of procurement and financial management staff once their Bank contracts expired in November 2012). Activities were consolidated specifically to strengthening key aspects of the supply chain for HIV and related health commodities, and providing training and capacity building to key personnel, including social workers supporting OVCs.

3. Capacity support to the decentralized local response (appraisal: US$ 1.3 million, revised to US$ 1.2 million at the December 2011 restructuring; actual: US$ 0.93 million). This component was to build capacity through provision of technical assistance to government and civil society implementers at district and community levels to plan, coordinate, implement, and monitor a range of defined essential HIV and TB services for an effective, expanded, and universal HIV response. It was to improve the capacity to implement activities that fell within a defined package of essential services known as the Essential HIV and AIDS Services Package (ESP), covering five areas: changes in sexual behavior, PMTCT, access to HIV services, OVCs, and support for people living with HIV and AIDS (PLWHA). Specifically, it was to support Community Councils to coordinate the implementation and monitoring of provision of the ESP; develop and strengthen the operational and management capacities of existing District AIDS Committees and proposed Community AIDS Committees to harmonize HIV and TB activities at the community level; and strengthen the skills and operational capacity of community-based organizations to provide, monitor, evaluate, and report on HIV and TB services at the community level. This component was not significantly changed at the December 2011 restructuring.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Project cost: The project's estimate total cost was US$ 5 million. Actual costs were US$ 4.92 million, with more spent than expected on the second component and less on the third.

Financing: The project was financed by a US$ 5 million International Development Association Technical Assistance Grant. US$ 4.92 million was disbursed.

Borrower contribution: No government contribution was anticipated or made.

Dates:

- December 16, 2011: A Level 2 restructuring revised implementation arrangements, streamlined

components, revised the results framework, and reallocated funding between components.
• November 17, 2014: A Level 2 restructuring revised the results framework and extended the closing date by twelve months, from January 31, 2015 to January 31, 2016, to allow for completion of activities.
• January 25, 2016: A Level 2 restructuring extended the closing date by a further five months, to June 30, 2016, to allow for completion of activities.

3. Relevance of Objectives & Design

a. Relevance of Objectives

At appraisal, Lesotho had the third highest adult HIV prevalence in the world, at 23.2%. In response, the government had adopted several major policies, including an overall National HIV and AIDS Policy and Strategic Plan as well as approaches to OVCs, HIV testing and counseling, blood transfusion, and labor. Financing from development partners (particularly the Global Fund to Fight AIDS, TB, and Malaria, and the United States President's Emergency Program for AIDS Relief) accounted for 57% of HIV/AIDS spending in 2007, and the overall level of support was increasing. But no significant resources were being invested to strengthen implementing systems, producing a situation where coverage of key interventions was falling behind despite rising external backing. There was no clear administrative and service delivery framework governing the country's ten districts and 128 community councils. For this reason, both the National Strategic Plan (2006-2011) and the Bank's Country Assistance Strategy at appraisal (2006-2009) called for greater attention to system strengthening and capacity building, goals to which the project's objectives were highly responsive. In essence, this project was intended to build on the previous HIV and AIDS Capacity Building and Technical Assistance Project (HCTA, US$ 5 million, 2004-2008), which had similar objectives to strengthen the implementing system and help with disbursement of large Global Fund grants, and whose outcome IEG rated Moderately Satisfactory (with Substantial achievement of the capacity-building objective). The project's objectives remain highly relevant to the Bank's current Country Partnership Framework (CPF, 2016-2019) and the government's National Strategic Development Plan (2012-2017), both of which contain a strategic objective to improve health outcomes (with specific reference to HIV/AIDS) in a context of effective, efficient service delivery. The current CPF requires all new investment projects to explore, during preparation, opportunities to prevent and/or treat HIV/AIDS.

Rating
High

b. Relevance of Design

The project's planned activities were appropriately constructed to achieve the project's implicit objective to improve government and civil society capacity to expedite the use of Global Fund and other resources. The project's design harnessed the Bank's comparative advantage in system and fiduciary strengthening in an effort to complement financing from other partners. This approach was particularly warranted given that the

Global Fund is a grant-providing agency that provides limited implementation support. The ICR (pp. 20-21) also points out that the inclusion of four different implementing agencies was appropriate, given the project's focus on capacity development at the national and local levels, as well as the fact that three of the four agencies had a track record of working together. However, the project's objective (covering five distinct but broad capacity gaps) and its proposed slate of activities were long and complex, with little sense of prioritization and/or sequencing; the required coordination mechanisms and management/technical capacity were not in place to accommodate this level of ambition and complexity, especially with the expectation that the implementing agencies would work outside their usual silos. In particular, the ability of the NAC to coordinate line ministries (MOHSW and Ministry of Local Governance and Chieftanship, MOLGC) and the LCN was overestimated. Furthermore, although a Steering Committee was envisioned to facilitate linkages and coordination across components, the planned mechanisms and scope of integration were not sufficient. The Project Concept Note review highlighted these design shortcomings, but they were not addressed (ICR, p. 11). In addition, the level of the project's funding and scope of its planned activities were far too limited to address the second part of the stated objective, "in an effort to contain and reverse the spread of the epidemic"; the PAD's discussion makes it clear that containing and reversing the spread of the epidemic is a longer-term outcome that would not have been achieved solely through this relatively small investment, and its inclusion in the formal statement of objectives may not have been appropriate.

Rating
Modest

4. Achievement of Objectives (Efficacy)

Objective 1

Objective
Address the identified key gaps in implementing the National HIV and AIDS Strategic Plan

Rationale
Outputs:

LCN (with 118 members at project appraisal, and a Principal Recipient for Global Fund Round 8), with project support including staffing, training, office space, and technical assistance, conducted a capacity-building program targeting 100 civil society organizations in six of the country's ten districts: Maseru, Mohale's Hoek, Leribe, Berea, Mafeteng, and Thaba Tseka. This training focused on capacity gaps identified in a 2012 mapping and assessment exercise: HIV/AIDS competency, HIV/AIDS programming, livelihood and income-generating activities, organizational development and management, and project development and management.

Community Council Support Persons (CCSPs) were hired with project support to implement an HIV Essential Service Package (ESP) that included interventions on changing sexual behavior, PMTCT,

accessing HIV testing services, supporting OVCs, and supporting PLWHA. These CCSP contracts ran for 18 months and were discontinued as of October 2011, as the program was judged not to be cost-effective. According to a 2013 ESP Assessment Report that was produced with project support, by the time these contracts ended, service providers had been identified and linked to community councils across a full range of HIV/AIDS issues. However, the ICR (p. 36) also states that CCSPs were never integrated into decentralized government structures, and so their continuing impact is unclear.

From the beginning of 2015, the project supported community engagement to support HIV/TB coinfection interventions led by LCN and MOHSW, strategic planning and capacity support to local governments on mainstreaming HIV, and training of village health care workers on 2016 HIV treatment guidelines in support of the government's "Test and Treat" campaign (to start antiretroviral therapy immediately after an HIV-positive diagnosis).

Training and operational support were provided to the Global Fund Country Coordinating Mechanism (CCM).

The project supported the development of a curriculum on the identification, referral, and follow-up of OVCs that was integrated into the standard Auxiliary Social Workers (ASW) training program housed within the National Health Training College (NHTC). All ASWs are now trained in the identification, referral, and follow-up of OVCs. The project also supported staffing of NHTC instructors for scale-up of the ASW cadre.

A training manual for a new HIV/AIDS monitoring system, the Lesotho Output Monitoring System for HIV and AIDS (LOMSHA), was developed. On the basis of this manual, training was conducted for M&E officers of the NAC, but this training was not rolled out to district staff or to civil society implementing partners. Although LOMSHA was intended to be used for routine monitoring of all HIV services provided to communities, it was never fully implemented and was subsequently abandoned when the NAC closed in December 2011.

Beginning in 2013, technical assistance and training for MOHSW was supported by the project on HIV strategic planning, forecasting, quantification, and procurement, including a visit by key staff to Zambia to learn about health commodity logistics management and distribution. As a result, a condom forecast and procurement plan was developed. Beginning in 2015, capacity building support was also provided to a new MOHSW Supply Chain Coordinating Unit.

The MOHSW and NAC were provided with technical support in the creation of health laws, policies, and regulations necessitated by the impact of the HIV epidemic in the country, and in the development of documents for the governance of health research (including for conducting ethical research). Terms of reference were developed for the MOHSW Research Unit, Ethics Committee, and Proposal Review Committee, these committees were established, and a Health Research Agenda was developed to identify priority areas for research.

After a December 2015 drought, the project supported a nutrition and HIV rapid assessment of its impact on vulnerable groups. Drought relief agricultural inputs were procured and distributed to 100 LCN-affiliated civil society organizations.

Outcomes:

Address capacity gap 1 - Weak coordinating capacity for multi-sector response (Modest):

- The national health law has been updated, and two pieces of legislation were drafted (a Public Health Bill, updating a Public Health Order of 1970, and a new Health Professions Bill) but still await approval by the Ministry of Law and Constitution. Policy guidelines on the foster care and adoption of orphans were developed in 2012 and approved by the Cabinet in 2014.
- Through the early years of the project period, the NAC led the development of the National HIV/AIDS Strategic Plan for 2011-2016 through a participatory process involving a wide range of stakeholders at the national district, and community levels; established district and community AIDS Committees in all ten districts to handle HIV/AIDS issues at those levels; and coordinated monitoring of the HIV response. However, the ICR (p. 12) also points out that the NAC unevenly coordinated the project's implementing agencies and activities over the project's first two years, leading to delays in finalizing work plans and obtaining data. The NAC was closed in 2011, and "a vacuum was created in the coordination of the national HIV response" (ICR, p. 22).
- LCN was suspended in February 2012 as a Principal Recipient of the Global Fund Round 8 grant due to programmatic and financial compliance issues. However, the project team later added that LCN remained a sub-recipient, continued to be a major player in the civil society response, and was seen as a capacity "gap filler" in support to civil society organizations. The Global Fund later specifically requested that LCN support other sub-recipients under Phase 2 of Round 8.
- A planned HIV SWAp was not implemented.
- The percent of clients expressing satisfaction with HIV coordinators at the NAC and LCN was 87.7% and 85.7% respectively in 2011, exceeding the target of 60%. The PAD offered an estimated baseline of 45% for this indicator, but there are no data to support this estimation, leaving this indicator without a meaningful baseline.
- The ICR (p. xi) reports that the percentage of programmatic and financial reports submitted by the LCN, MOLGC, and MOHSW to the Bank and the Global Fund within five working days of their due dates increased from 25% in December 2011 to 100% in March 2012, but this indicator was dropped at the November 2014 restructuring. The ICR (p. xii) also reports 100% attendance at project committee meetings by LCN, MOLGC, and MOHSW through 2014, though this indicator was also dropped in November 2014.
- Overall, the ICR (p. 35) reports that the lack of a national coordinating body with decision-making authority "created a vacuum in the HIV response in Lesotho that is felt by program implementers at all levels as well as development partners," that "frequent turnover in senior management led to delayed staffing and budgetary decisions which in turn had a negative impact on the planned capacity building within implementing agencies," that there was "delayed strategic decision making in programming and prioritizing the implementation of project activities," and that there was "limited multi-sectoral cooperation and collaboration across the project components."

Address capacity gap 2 - Limited research capacity to organize and use scientific evidence to guide

implementation (Substantial):

- A MOHSW Institutional Research Ethics Committee/Institutional Review Board (IRB) was registered with the United States Department of Health and Human Services. This IRB is currently functional and can review U.S.-funded research involving human subjects. The ICR (p. 25) reports that all studies and surveys are now reviewed by the Ethics Committee and Proposal Review Committee and that all studies are now aligned to the established MOHSW research agenda, but it does not provide further detail to support this statement. For example, the ICR states that a biannual research forum is now held to present research findings and recommendations, but it does not state how many times this forum has been held and how the supported/presented research is aligned with the research agenda, nor does it provide information on the substance or priorities of that agenda. The ICR also does not make it clear how or to what extent research findings were used to guide implementation of the country's HIV response. The project team later added that seven research forums have been conducted since 2013, prioritized around the main elements of the MOHSW research agenda: HIV/AIDS, tuberculosis, maternal health, nutrition, and immunization. According to the project team, several international organizations (Elisabeth Glaser Pediatric AIDS Foundation, United States Centers for Disease Control and Prevention, Partners in Health, and others) collaborated with MOHSW on these studies, whose findings have informed key stakeholders and partners through dissemination meetings and through the research forums. In addition, the project team clarified that about 120 research proposals annually go through the IRB.

Address capacity gap 3 - Fragmented national HIV monitoring and evaluation systems (Modest):

- The percent of district management teams reporting routine health system data on time increased from 10% in 2009 to 19% in 2011, not achieving the original target of 30%; this indicator was dropped at the December 2011 restructuring. The ICR (p. xiii) reports that, according to the 2013-2014 MOHSW Annual Joint Review, the timeliness of disease surveillance data in the country has fluctuated below the internationally set target of 80% between 2010 and 2013 (6% in 2010; 19% in 2011; 41% in 2012; and 20% in 2013). After the closing of the NAC in 2011, the project did not focus on building M&E capacity (ICR, p. 26).

Address capacity gap 4 - Weak implementation capacity to scale up those effective interventions that address the key drivers of the epidemic (Substantial):

- Of the 100 civil society organizations that received training from the LCN, the percent with increased knowledge and skills in at least two of the five priority areas (listed under "Outputs") reached 100% by 2016, surpassing the target of 80%. A 2016 beneficiary survey found that, as a result of project support, these organizations were meeting more regularly and self-reported improved internal governance (ICR, pp. 45-54). 24 of these organizations developed legally registered constitutions that permitted them to seek external support. Overall, 60 organizations initiated voluntary savings and loan schemes and self-contributions (to manage their own resources) or developed proposals to local and international funding

agencies. As of August 2016, seven had received funding, with nine others awaiting decisions on pending proposals. 18 of the 100 organizations built capacity to identify the symptoms of TB and provide counseling on where and how to seek treatment, and they served as peers in conducting community dialogues on HIV/TB coinfection culminating in a June 2016 two-day National TB Dialogue. Overall, according to the ICR (p. 25), the organizations acquired "enhanced skills on organizational development and management" enabling them better to "manage their daily business to the extent of monitoring, evaluating and reporting on HIV and TB issues at district and community levels." The beneficiary survey (ICR, pp. 32-33) shows that "generally there has been improvement in knowledge and skills of the organizations that benefitted from the project," but "weak implementation capacity remains a challenge for some" due to limited resources available to finance their workplans. Although the ICR demonstrates institutional capacity development among some of these organizations, it does not address the extent to which their activities address the key drivers of the epidemic (nor does it systematically identify these key drivers). The project team later added that "HIV/AIDS competency" was a key area of capacity development, based on a capacity needs assessment of the organizations with a focus on women and girls (who are more disproportionately affected by HIV/AIDS in Lesotho): promotion of healthy lifestyles (safe sex), treatment adherence and counseling, prevention of mother to child transmission, psychosocial support, behavior change communication, and stigma/discrimination. These topics represented many of the main drivers of the epidemic.

- 72 ASWs have been deployed in all ten districts in the country to identify and support OVCs. The government has adopted a target of assigning at least three ASWs to each of the country's 86 community councils, and negotiations are underway (at the time of the ICR) between the MOHSW, Ministry of Public Service, and Ministry of Finance to recruit and deploy these personnel.
- By 2014, nearly 900 ESP interventions were implemented by community councils (exceeding the targeted 700). 72 out of 86 (84%) community councils have ongoing HIV/AIDS activities, based on an assessment done by the MOLGC's Department of Decentralization in 2015. According to the ICR (p. x), these activities vary in intensity and quality, and "effective mainstreaming" would be indicated by the presence of ongoing HIV/AIDS activities in all 86 councils. Additionally, the ICR (pp. 25, 27) states clearly that the MOLGC did not successfully coordinate the decentralized HIV response, leaving its activities unaligned with those of the health sector and civil society and not monitored or reported to the national level. However, the project team later stressed that the ESP interventions were well aligned with the main drivers of the epidemic at the community level, supporting HIV prevention through changes in sexual behavior (condom use and addressing multiple concurrent partnerships), prevention of mother to child transmission, access to HIV testing services, and support for people living with HIV.

Address capacity gap 5 - Uncoordinated local response with low capacity to monitor the implementation of HIV services and limited use of monitoring information to improve program planning and service delivery (Substantial):

- In 2014, a Supply Chain Coordinating Unit was established within the MOHSW to coordinate centrally supply chain management for all health commodities and implement a Procurement and Supply Chain Strategic Plan for Medicines and Health Products (2013-2017). This Unit now maintains a rolling condom

forecast and procurement plan, and staff members have the requisite skills to continue to do so. 100% of districts now report on distribution of condoms, meeting the target.

Based on Substantial progress in closing three of the identified capacity gaps and Modest progress along the other two, achievement of this objective is rated Substantial.

Rating
Substantial

Objective 2

Objective
Effort to contain and reverse the epidemic

Rationale
As noted earlier, the project's results framework did not include indicators on the trajectory of the epidemic. The ICR (p. 20) cites a continued "hyper-endemic" HIV epidemic, with HIV prevalence increasing from 23.6% in 2009 to 25% in 2014; these prevalence, data, however, are not meaningful in the absence of additional data on provision of antiretroviral therapy and/or HIV/AIDS mortality. The United Nations General Assembly Special Session (UNGASS) Progress Report for 2015 shows mixed results across the project period on key knowledge and behavior indicators used as proxy measures for HIV incidence. For example, the percentage of youth ages 15-24 who both correctly identified ways to prevent sexual transmission of HIV and who reject major misconceptions about HIV transmission remained essentially unchanged: 35.6% in 2009 and 35.5% in 2014 overall, 28.7% in 2009 and 30.9% in 2014 for males, and 38.6% in 2009 and 37.6% in 2014 for females. However, the percentage of adults ages 15-49 who had more than one sexual partner in the last 12 months and reported using a condom during their last intercourse increased overall from 46.4% in 2009 to 60.9% in 2014, for males from 52.3% to 65.3%, and for females from 37.5% to 53.9%. The percentage of HIV-positive adults and children receiving antiretroviral therapy increased from 23% to 35%, and treatment adherence (the percentage of children and adults known to remain on treatment 12 months after initiating it) remained stable at 80% in 2009 and 79% in 2014. Treatment for HIV/TB coinfection increased significantly, with the percentage of HIV-positive incident TB cases receiving treatment for both HIV and TB increasing from 28% in 2009 to 70% in 2014. The project team later added data from the 2016 UNAIDS Prevention Gap Report showing that annual new infections have declined from 30,000 new infections in 2005 to 18,000 new infections in 2015, as well as data from the 2014 DHS noting improvements in coverage of testing services from 7% of young women and 3% of young men tested and receiving their results in the preceding 12 months in 2004 to 66% of young women and 32% of young men in 2014.

Overall, the evidence on containment and reversal of the epidemic is mixed but leans positive. Although the ICR does not make the case for the project's direct impact on observed trends, the project team later stressed that the project's capacity-gap filling activities were intended as a relatively small, targeted investment in an effort to make more effective use of larger contributions from other partners and therefore

impact outcomes in the longer term. This results chain is logical and plausible. As a result, achievement of this objective is rated Substantial.

Rating
Substantial

5. Efficiency

The PAD's analysis (pp. 86-101) focused on the drivers of Lesotho's HIV epidemic, recent general findings on cost-effective response to HIV, available financing for Lesotho's response, poverty impacts of HIV, and the potential contribution of the project to improved effectiveness and efficiency of HIV spending (and therefore the creation of more fiscal space for scaled-up spending). Neither the PAD nor the ICR provide a quantitative economic analysis. The ICR (p. 31) cites the project's inherent cost-effectiveness in leveraging and indirectly supporting large investments from other development partners.

The ICR (p. 30) comments on technical efficiency by citing Bank-conducted analytical work finding that lower-level cadres and lay counselors (with appropriate training) were more efficient than other HIV/AIDS care providers, after controlling for quality of care; this finding is said to validate the project's approach of capacity enhancement for civil society organizations as a means of reducing the burden on health facilities. The project's focus on addressing stockouts is also cited as a cost-effective way to close capacity gaps, but no specific analysis is provided (ICR, p. 30). The project team later added that a technical efficiency study conducted outside the project pointed to the need for resolving stockouts of HIV prevention commodities in order to eliminate major, costly bottlenecks.

Commenting on allocative efficiency, the ICR (p. 29) states that the LCN's capacity building program for civil society organizations focused on six (of ten) districts with high HIV prevalence. However, the data provided in this discussion (ICR, map on p. 30) do not support claim that participating districts were chosen primarily on the basis of high HIV prevalence. The project team later clarified that the project deliberately excluded the lowest prevalence district (Butha-Buthe), and that the other districts had only minor differences between them; the project districts were also chosen in part due to the higher number of civil society organizations that were available as partners, as well as geographic accessibility issues.

The ICR (p. 12) notes that, over the project's first two years, a lack of strategic focus led to a proliferation of uncoordinated activities and "frequent reprogramming requests that were not strategically aligned with the [development objectives]." The Project Coordinator was not hired until over seven months after project launch. This lack of strategic direction and performance monitoring, due in part to inadequate NAC oversight, led to "major delays in finalizing the annual work plan and procurement plan, as well as delays in obtaining baseline data for the results framework" (ICR, p. 12). These challenges were sufficiently serious that the Bank team considered closing the project in late 2011. The closing of the NAC in late 2011 meant that

significant time and resources spent by the project on capacity building were lost or, at best, their impact dissipated. The ICR (p. 30) notes that, in the absence of this turmoil, coupled with delays caused by higher-level political instability, "the project would likely have been implemented in less than its six and a half years from effectiveness to closing"; this statement indicates that the project did not represent the least-cost approach to achieving outcomes.

Efficiency Rating
Modest

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐Not Applicable
ICR Estimate		0	0 ☐Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Relevance of objectives is rated High due to responsiveness to country conditions and Bank/government strategic priorities. Relevance of design is rated Modest due to a mismatch between the number/complexity of project activities and institutional capacity, as well as lack of necessary coordinating capacity. Achievement of the objective to address identified key gaps in implementing the National HIV/AIDS Strategic Plan is rated Substantial. The project contributed to improved research capacity, implementation capacity impacting key drivers of the epidemic, and program planning and service delivery, but there is limited evidence that it contributed substantially to progress along the other two capacity gaps. Achievement of the objective related to effort to contain and reverse the epidemic is also rated Substantial, with a long-term results chain plausibly demonstrating that the project's capacity gap-filling activities would have constituted an effort to reduce incidence of HIV. Efficiency is rated Modest, because of both a lack of economic analysis and indications that inadequate strategic focus and political stability/support led to inefficiencies in resource allocation. Overall, these ratings are indicative of moderate shortcomings in the project's preparation and implementation, and therefore an Outcome rating of Moderately Satisfactory is applied.

a. Outcome Rating
Moderately Satisfactory

7. Rationale for Risk to Development Outcome Rating

The Bank remains engaged in Lesotho's health sector through the Southern Africa Tuberculosis and Health Systems Support Project (US$ 122 million, 2016-2021) and Health Sector Performance Enhancement Project (US$ 20 million, 2013-2019), as well as the ongoing Health Sector Public Expenditure Review, Public Expenditure Tracking Survey, and Quantitative Service Delivery Survey. These efforts will sustain attention to health systems strengthening, financing, and performance. Most specifically, the supply chain management and social worker support interventions put in place by the project remain effective and are likely to continue to ensure adequate provision of condoms and identification, referral, and follow-up with OVCs. Nearly two-thirds of the funding for the national HIV response continues to come from international donors (primarily the Global Fund and PEPFAR), though the government has indicated its intention to increase its support in coming years. The provisional 2016 MOHSW budget includes a 57% increase for HIV/AIDS investments over 2015, and projections for 2017 and 2018 are for increases of 5% and 2% respectively. The project team later added that the MOHSW budget for the current fiscal year has been a simple continuation of the previous budget due to political turmoil that has led to shutting down the Parliament, with new elections scheduled for early June 2017.

The NAC was reformed in December 2015. Although there is cautious optimism among implementing agencies and development partners that it will fill the void left by its predecessor's closing in 2011, it faces ongoing challenges with human and financial resources. It remains a long way from playing the leadership and coordination role required for an effective national HIV response.

Staff turnover and financial challenges threaten the sustainability and institutionalization of capacity support provided to civil society organizations. Similarly, according to the ICR (p. 19), MOLGC has not made efforts to sustain capacity developed among community councils; although HIV/AIDS activities continue at the local level, their quality and intensity varies, and they are driven more by the preferences of implementers at the community level rather than by district-level strategic priorities.

a. Risk to Development Outcome Rating

Substantial

8. Assessment of Bank Performance

a. Quality-at-Entry

The project's objectives were responsive to government and Bank strategies, to prior IEG recommendations around focus on capacity building, and to the Bank's comparative advantage in systems strengthening. Joint analytic work and assessments with partners were organized to inform project design, and under a health Sector-wide Approach (SWAp), the government and partners had already established mechanisms to support collaboration and country ownership. Key lessons were taken from the predecessor HCTA project (PAD, p. 9): the need to support capacity building of existing local staff, with a focus on specific skills transfer in technical assistance contracts, to ensure sustainability; the need for clarity between user departments on the

functions to be performed by various technical assistance contracts; and the need focus on logistics management of drugs and supplies to avoid stock-outs. A multisectoral Technical Working Group worked closely with the Bank on project preparation, and there was extensive consultation with key development partners and civil society organizations.

However, there were significant shortcomings. The objective statement was not carefully worded, specifying ambition to "contain and reverse the epidemic" that was clearly beyond the project's intended scope. The overall risk rating (PAD, pp. 14-16) was Low, with only a few risks identified as Moderate (human resource constraints and "brain drain," political issues around decentralization, and fiduciary issues) and none as Significant or High; the ICR (p. 11) states that institutional, coordination, human resource, and procurement risks were underrated. The ICR (p. 10) also notes that the MOLGC was not optimally engaged in project preparation. Overall, the level of government commitment to the project was not appropriately assessed, such that the closure of the NAC and limited participation of the MOLGC later came as surprises. The project's overall scope was overly ambitious and design fragmented (see Section 3b), with overestimated potential for cross-sector coordination and institutionalization of decentralized structures. M&E arrangements were similarly fragmented (see Section 10a).

Quality-at-Entry Rating
Moderately Unsatisfactory

b. Quality of supervision
Local presence of Bank staff in the health sector was lacking early in the project period, hindering project start-up, monitoring, and daily coordination (ICR, p. 34). At the beginning of 2012, supervision intensified and became more focused, with regular audio and videoconferences supplementing supervision missions, recruitment of long-term technical assistance for LCN and MOHSW, and regular convening of project coordination entities. This more frequent and regular meeting schedule accelerated and focused implementation progress, including restructuring that streamlined the components and tightened the results framework. However, overall strategic coordination and M&E challenges continued to receive inadequate attention.

Quality of Supervision Rating
Moderately Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. Assessment of Borrower Performance

a. Government Performance
The government supported mechanisms that were important for the national HIV response, including Health Development Partner Meetings, Annual Joint Reviews, and a health Sector-Wide Approach (SWAp). However, political instability was a challenge at various points during the project period. In both

March and June 2014, the Parliament was suspended for several months due to no-confidence votes against the government, leading to unrest. Although a peaceful resolution was eventually reached culminating in February 2015 elections, project implementation was impacted throughout 2014 and early 2015, including: (i) suspension of Bank missions due to security concerns, and (ii) turnover producing delayed decision-making within MOHSW and MOLGC.

Most importantly, the government closed the NAC in 2011, negatively impacting the fight against HIV/AIDS in Lesotho in ways that extended beyond this project (ICR, p. 12). This decision was not formally communicated to the Bank It indicated a lack of both government commitment to addressing the epidemic and strategic direction/coordination; after the NAC was dismantled, there was no decision about which agency or ministry would assume the leadership role for the national HIV response. The majority of NAC staff, at the national, district, and community levels, were not redeployed by the government to continue working on HIV, producing a significant loss of knowledge, experience, and institutional memory. Eventually the MOHSW was assigned the lead role, but this situation produced challenges with one line ministry coordinating another (MOLGC). The NAC was resuscitated only in December 2015 under the Office of the Prime Minister, and it has not yet resumed an effective coordinating role.

Government Performance Rating
Moderately Unsatisfactory

b. Implementing Agency Performance
Implementation maximized the use of existing systems and capacity created by the predecessor HCTA project. Component 1 was implemented by the NAC, GFCU, and LCN, Component 2 by the MOHSW, and Component 3 by the MOLGC and LCN. Fiduciary aspects were handled by the Project Accounting Unit (PAU) and Procurement Unit (PU) already in place under the common fiduciary system of the health SWAp. The ICR (p. 36) reports that the MOHSW effectively coordinated the health sector response, but was less successful in fostering collaboration with the other implementing agencies; that the LCN performed effectively in its support of civil society organizations; and that the MOLGC's performance was unsatisfactory due to its inconsistent reporting, lack of support for HIV/AIDS activities in decentralized government structures, lack of integration of CCSPs into decentralized structures, suspension of ESP implementation when the NAC closed in 2011, and overall lack of focus on HIV/AIDS (there is only one HIV/AIDS focal point for the entire ministry).

To ensure coordination among these entities, a Steering Committee was established to provide overall policy and implementation guidance, and multi-sectoral Technical Working Groups (comprising technical staff of the implementing agencies) addressed specific issues within each component. The ICR (p. 11) states that the Steering Committee was an inadequate coordination mechanism, and that the NAC provided uneven coordination and management oversight (p. 12). After the NAC was abolished in 2011, the steering and technical committee were merged into a single Project Committee (PC) that began to meet regularly, with broad representation, in early 2012; however, this PC increasingly delegated responsibility to subordinates and overall provided little guidance to project implementation (ICR, p. 35).

In February 2012, LCN's appointment as Principal Recipient for the Global Fund Round 8 grant was

suspended due to lack of compliance with financial and programmatic requirements, even after the Bank had been providing technical assistance on finance, grants management, and M&E. The ICR (p. 15) indicates that this technical assistance came too late, due to contracting delays, to have the necessary impact, and may not have been appropriately targeted.

Implementing Agency Performance Rating
Moderately Unsatisfactory

Overall Borrower Performance Rating
Moderately Unsatisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design
The PAD (Annex 3) detailed the country's unified national HIV monitoring and evaluation system that had been in place since 2005. As that system's indicators focused on coverage of service delivery and behavior change, separate measurements of success were put in place for this project: measures of the immediate outputs of capacity development efforts; measures of the functioning of HIV response management and M&E systems themselves; and measures of the overall ability to meet HIV response targets. Data were to be collected either through the national M&E system (LOMSHA) or through two new sources of data collection included in the project's first component: a client satisfaction survey, and qualitative research to assess improvements in capacity resulting from the project. Baseline data were lacking, and there was no capacity to collect data and report on some of the key indicators. More broadly, the objectives referred specifically to a list of identified capacity gaps that the project was intended to fill, but the performance indicators were not matched across these gaps. In addition, although the PAD states that the project's results framework would not measure changes in coverage of service delivery or changes in behavior, the objectives clearly refer to "an effort to contain and reverse the epidemic." There were no indicators that measured epidemic trends.

b. M&E Implementation
When the NAC was dismantled in 2011, a significant amount of M&E capacity at all levels that had been built by the Bank and other partners (including LOMSHA) was lost. There was no longer an implementing agency with responsibility for overall monitoring of the national HIV response. Each implementing agency continued reporting on indicators for which they were responsible, but there were inconsistencies and no third-party verification. Discussions on inadequacy of the results framework produced recommendations for revision of indicators and data collection arrangements in September 2013, but it took four months to obtain the information necessary to put these revisions in place.

c. M&E Utilization
In the absence of the NAC or a successor agency fulfilling its function, there is still a major gap in

coordination and facilitation of overall performance monitoring. The NAC has been resuscitated, but according to the ICR (p. 17), it still is not playing an M&E coordinating role. Narrowly, despite this challenge, M&E data are regularly used for supply chain management, specifically for condom forecasting, procurement, and distribution.

M&E Quality Rating

Modest

11. Other Issues

a. Safeguards

The project was classified as Category B - Partial Assessment and triggered OP/BP 4.10 Environmental Assessment, as increased access to health services would generate additional medical waste. A National Health Care Waste Management Plan (disclosed in March 2009) was in place to inform the collection, transportation, treatment, and disposal of medical waste to be generated during project implementation, and the MOHSW had a health care waste management unit assigned specifically to this plan. The ICR does not state whether there was compliance with the Bank's safeguard policies. The project team later added that the environmental safeguard was rated Satisfactory throughout project implementation, and that the Heatlh Care Waste Management Plan was consolidated and upgraded during the 2012-2013 preparation of another health project.

b. Fiduciary Compliance

According to the ICR (p. 17), an adequate financial management system was in place to provide accurate and timely financial information. The project supported the Finance Manager in the MOHSW PAU for the first two years of implementation. Financial reports were submitted to the Bank on time and found acceptable. Procurement capacity, however, was weak, and the Bank provided support for an MOHSW Procurement Manager from 2010-2012; this manager also processed procurement for the Global Fund and European Union. The project team later added that the project's support for this Procurement Manager resulted in markedly improved procurement performance, and that the stability in staffing significantly leveraged other development partners' investments.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Satisfactory	---
Risk to Development Outcome	Substantial	Substantial	---
Bank Performance	Moderately Satisfactory	Moderately Satisfactory	---
Borrower Performance	Moderately Satisfactory	Moderately Unsatisfactory	Lack of government commitment, most notably the unexpected closure of the NAC that left a coordination vacuum, and unsatisfactory performance of the MOLGC.
Quality of ICR		Modest	---

Note
When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1, 2006.
The "Reason for Disagreement/Comments" column could cross-reference other sections of the ICR Review, as appropriate.

13. Lessons

The ICR (pp. 37-38) cites a number of insightful lessons:

In countries with high HIV prevalence, a national coordinating mechanism/platform to facilitate cross-sectoral collaboration is essential. In this case, when the NAC was closed, the resulting leadership vacuum negatively impacted this project and the overall national response.

Line ministries are generally not suited for leadership of multisectoral efforts. In this case, after the closure of the NAC, coordination responsibility was housed with the health ministry. This led to challenges securing coordinating with other entities, particularly the MOLGC.

When a project is significantly restructured, its intended outcomes may no longer match the original project development objectives. In this case, even the original project design was not well matched with its stated objective of an "effort to contain and reverse the epidemic."

14. Assessment Recommended?

No

15. Comments on Quality of ICR

The ICR is clear and candid, and its analysis is evidence-based. It is occasionally repetitive, but it presents effectively the implementation course of a project with multiple phases and implementing agencies. Its lessons are highly insightful and could have been elaborated even further to inform future communicable disease and health sector support projects in complex environments. However, there were some significant shortcomings. The ICR attempts no quantitative economic analysis. Its information on the project's financial management and procurement performance is thin. The ICR, in several instances (pp. 3, 53), cites change in HIV prevalence as an indication of progress against the epidemic, not acknowledging that prevalence may increase if access to antiretroviral therapy reduces mortality. Most importantly, the ICR omits key information central to assessing achievement of objectives that later had to be added by the project team.

a. Quality of ICR Rating
Modest