1. Project Data:

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<tr>
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<td>Total War Against Hiv And Aids (towa) Project</td>
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<td>HIV/AIDS (33%); Other public sector governance (17%); Participation and civic engagement (17%); Health system performance (17%); Social Inclusion (16%)</td>
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</tbody>
</table>

Prepared by: Judyth L. Twigg
Reviewed by: Denise A. Vaillancourt, Lourdes N. Pagaran
ICR Review Coordinator: IEGPS2
Group: IEGPS2

2. Project Objectives and Components:

a. Objectives:

According to the Financing Agreement (p. 6), the project’s objectives were to “assist the Recipient to expand the coverage of targeted HIV and AIDS prevention and mitigation interventions through sustaining the improved institutional performance of the Project Implementing Entity and supporting the implementation of the Kenya National HIV and AIDS Strategic Plan (“KNASP”).”

The Project Appraisal Document (p. 26) has a similar formulation of the objectives: “to assist Kenya to expand the coverage of targeted HIV and AIDS prevention and mitigation interventions.”

At a restructuring on November 18, 2010, the project’s objectives and one key outcome target were revised. The revised objectives were to: (a) expand the coverage of targeted HIV and AIDS prevention and mitigation measures; and (b) expand access to bed nets among targeted people living with HIV and AIDS and other households in malaria risk areas.” Because the objectives were revised, this Review will undertake a split evaluation.

b. Were the project objectives/key associated outcome targets revised during implementation?
Yes
If yes, did the Board approve the revised objectives/key associated outcome targets?
Yes
Date of Board Approval: 11/18/2010

c. Components:

The project contained two components. Final contribution of the government by component is not available, and therefore only final Bank costs by component are reported here.
1. Strengthening Governance and Coordination Capacity (appraisal: IDA US$ 19.7 million, DfID US$ 8.1 million, Government US$ 2.0 million; additional IDA financing US$ 16.6 million; actual IDA contribution, US$ 38.4 million). This component was to provide support for the strategic leadership function of the National AIDS Control Council (NACC), focusing on its institutional strengthening and on activities by its decentralized structures to coordinate the national program and project activities. This component was also intended to strengthen implementation of the national monitoring and evaluation (M&E) framework and to build capacity of implementing partners, specifically community-level grantees.

2. Support for Program Implementation (appraisal: IDA US$ 57.3 million, DfID US$ 23.7 million; additional IDA financing US$ 38.4 million; actual IDA contribution, US$ 96.6 million). This component was to make financial resources available to civil society, the public and private sectors, and research institutions, focusing on initiatives in line with the KNASP, responding to priorities identified by the annual Joint HIV and AIDS Program Review (JAPR). It was also to support the procurement of essential commodities.

   - Proposals from the private sector, civil society organization (CSOs), research institutions, and universities were to be solicited through a call-for-proposals (CfP) mechanism. Target populations and interventions specified in the PAD (p. 30) included interventions with the largest impact in preventing further spread of HIV, and target populations most susceptible to infection or most affected already, including (but not necessarily limited to): commercial sex workers (CSWs); orphans and vulnerable children (OVCs); highly mobile populations (truck drivers, migrant workers); women (including widows); youth (including young girls); workers in small and medium-sized enterprises, micro-enterprises, and the informal sector; people with disabilities; people exposed to sexual violence; men having sex with men (MSM); and persons who inject drugs.
   - Funds for the public sector under this component were to amplify interventions planned by targeted ministries in their own annual plans, and not to fund separate projects or work plans. Initially targeted sectors/ministries were transport, agriculture, health, education, governance, and personnel management.
   - Procurement of commodities was to focus on key items for which there was a funding gap, specifically first-line drugs for the treatment of tuberculosis (TB), condoms, and insecticide-treated bed nets (ITNs) for free distribution among people living with HIV and AIDS (PLWHA) who lived in malaria zones. Anti-retroviral medications were already being purchased by other sources. It was recognized that adjustments could be made in commodities procurement during the project’s lifetime, depending on available funding from other sources.

**d. Comments on Project Cost, Financing, Borrower Contribution, and Dates:**

**Project Cost:** Final project costs were US$ 137 million. The difference between and estimated and actual costs was an additional US$ 20 million for the procurement of bed nets for the malaria program. Planned financing included an unallocated US$ 4.2 million.

**Financing:** The project was to be financed by an International Development Association (IDA) credit of US$ 80.0 million (70% of total project costs), with US$ 33.0 million in co-financing by the UK Department for International Development (DfID).

According to the ICR (p. 6), the planned funding from DfID did not materialize. In August of 2008, the IDA contribution was increased to cover the planned DfID contribution over the first two years of the project, with the expectation that the IDA share would be decreased when DfID funding became available in year three. When DfID support was still not forthcoming, the project was amended in August of 2009 so that IDA financing would cover all project costs through 2010. Finally, in November of 2010, it was concluded that DfID would not be co-financing the project at all, and the project was amended to remove DfID as a co-financier and to increase IDA financing. The ICR does not explain why planned DfID financing did not materialize; the project team later explained that this was due to post-election violence in Kenya following the 2008 elections, followed by the change in UK government and subsequent review of its bilateral programs. The total Additional Financing in November 2010 was US$ 55 million: US$ 33 million to replace the DfID contribution, US$ 10 million to purchase additional ITNs, and the remainder for support for other activities across both components.

**Borrower Contribution:** The planned Recipient contribution of US$ 2.0 million was made in full. The ICR does not explain what this contribution covered. The project team later explained that it covered activities with the NACC.

**Dates:**

August 2008: The project was amended to allow IDA to cover planned DfID contributions for two years (2008-2009).
August 2009: The project was amended to allow IDA to cover planned DfID contributions for another year, through 2010.

August 2010: The project was amended to allow IDA to continue to cover planned DfID contributions, and to enable the purchase of additional ITNs for the malaria program.

November 2010: The project was restructured to revise the development objectives, and to allow IDA to cover project costs in full through an Additional Financing of US$ 55 million. The closing date was extended from December 31, 2011 to June 30, 2013 to allow for completion of activities. At the time of this restructuring US$ 52.85 million of the Bank Credit, or 39.1% of total Bank financing, had been disbursed.

March 2013: The project was restructured again to extend the closing date from June 30, 2013 to December 31, 2013 to allow for an impact evaluation and completion of activities.

December 2013: The project restructured again to extend the closing date from December 31, 2013 to June 30, 2014 to enable full use of the remaining Credit.

3. Relevance of Objectives & Design:

a. Relevance of Objectives:

Relevance of the original objectives is rated Substantial.

At the time of appraisal, HIV prevalence in Kenya was estimated at 7.1% among those ages 15-64, with particular impact among a range of high-risk groups as specified in the PAD. Women, youth, and young women in particular were at greatest risk. The Kenyan government had formulated a national HIV and AIDS strategic plan (2005-2010) that aimed to reduce the spread of HIV, improve the quality of life for those infected and affected, and mitigate the socio-economic impact of the epidemic. The current Kenya AIDS Strategic Framework (2014-2019) similarly contains strategic pillars on reducing new infections, improving health outcomes and wellness of people living with HIV and AIDS, and facilitating access to services. At closing, the Bank’s current Country Partnership Strategy (CPS, 2014-2018) calls HIV “still a pressing issue for certain segments of the population” (p. 4), and includes HIV and AIDS under the umbrella of its continued “strong engagement in social protection” (p. 29). Given the country context, government strategy, and Bank strategy, it was appropriate that the objectives dealt with prevention of HIV and mitigation of its impact, and that interventions were expected to be appropriately targeted.

However, it was a shortcoming that the objectives were insufficiently ambitious. They were framed in terms of coverage and expansion of interventions rather than the results of those interventions; although the project’s objectives, and hence its primary indicators, focused on numbers of individuals (including members of high-risk groups) reached with behavior change education, condoms, counseling/testing, etc., the objectives do not explicitly anticipate that the project’s interventions will actually have made a demonstrable difference in actual behavior change, reducing the spread of HIV and AIDS, and/or on mitigating the impact of the epidemic.

Relevance of the revised objectives is also rated Substantial.

As of 2008, malaria was responsible for 30% of outpatient consultations, 19% of hospital admissions, and 3-5% of inpatient deaths in Kenya. 70% of Kenya’s population lives in malarious areas. Malaria is highlighted as part of the Bank’s current CPS under its commitment to social protection. Kenya’s National Malaria Strategy (2009-2017, p. 17) stresses the importance of vector control using insecticide-treated nets, as well as the distance the country had yet to travel from its 2009 rate of household ownership of ITNs (0.8 nets/household) to a level considered to be full coverage (2 nets/household). However, the framing of the added malaria objective had the same shortcoming as the HIV and AIDS objective: it was expressed in terms of an output, distribution of and access to bed nets, rather than actual usage of those nets and/or impact of the nets on malaria control.

b. Relevance of Design:

Relevance of design under both the original and revised objectives is rated Substantial.

The project’s planned activities were logically and plausibly connected to achievement of anticipated outcomes. Importantly, the grant activities contained a mechanism (annual priority setting through the JAPR) to guide targeting/coverage toward population groups where current data indicated that most new infections were occurring. Capacity building was explicitly planned for entities most in need: the NACC and its decentralized
agencies, institutions responsible for M&E, and community-level grantees. Planned procurement of commodities explicitly took into account funding shortfalls over the range of purchases by other donors. However, it is a shortcoming that, although data on most-at-risk populations (MARPs) were not available at the time of both project preparation and restructuring, amounting to "a major bottleneck to effective targeting and programming for MARPs" (ICR, p. 11), project design did not include explicit activities for increasing knowledge of population size/location and baseline data for these groups.

4. Achievement of Objectives (Efficacy):

**ORIGINAL AND REVISED OBJECTIVES:**

Expand the coverage of targeted HIV and AIDS prevention interventions is rated **Substantial**.

**Outputs:**

10,712 grants were awarded to CSOs and private sector entities (98% of the 10,912 proposals approved), surpassing the target of 8,400. The number of funded grants increased every year of the project’s lifetime. The project accounted for about one-third of the 29,157 CSO/private sector projects supported under the KNASP between 2009 and 2014 (with the remainder supported by the government and other donors).

16% of the CSO/private sector grants targeted most-at-risk populations (MARPs), accounting for 13% of total grant expenditures.

Eight facilitating agents contracted by the project trained 8,394 sub-implementers. In 2014, 89.9% of grantees received "very good" or "excellent" scores for project achievement in annual performance audits. The proportion of CSOs reporting through the Community Based Program Activity Reporting Tool (COBPAR), which was developed through the project, at the time of the JAPR increased from 65.8% in 2008 to 100% in 2014, exceeding the target of 90%.

Capacity building was implemented for staff at the NACC and its decentralized structures. M&E was supported through the development of a grants management system, the engagement and support of independent fiduciary agents, and strengthening of the Management Information System (MIS). 87% of NACC clients reported being satisfied in a Customer Satisfaction Survey in 2013, surpassing the original target of 78% and the revised target of 75%. Although NACC received qualified annual audit reports, all issues raised annually were addressed in a satisfactory manner by the end of March of the following year, meeting the target. 96% of KNASP M&E indicators were included in the NACC’s annual M&E report and were disseminated in time for the JAPR in 2014, an improvement over 2008 (when 55% of indicators were included/available), meeting the original target of 95% and exceeding the revised target of 85%.

**Outcomes:**

323 million condoms were procured and distributed, exceeding the original target of 168 million and the revised target of 150 million. According to the ICR (p. 45), the project was Kenya’s main source of male condoms during the implementation period.

5.6 million individuals received HIV counseling and testing services through the project, far exceeding the target of 172,045. Counseling and testing activities accounted for 42% of project funds (ICR, p. 103). 983,166 couples were counseled and tested, far exceeding the target of 6,305. The ICR reports that high annual achievements were maintained throughout the lifetime of the project. The project contributed about 15% of all counseling and testing in the country during its lifetime, helping to increase the percentage of adults and adolescents ever tested for HIV from 34.3% in 2007 to 71.3% in 2012. Knowledge of HIV status among HIV-infected persons increase from 16% in 2007 to 47% in 2012.

4.88 million youth were reached with HIV prevention messages, far exceeding the target of 348,232. The ICR reports that high annual achievements were maintained throughout the lifetime of the project.

The project supported community mobilization, information, counseling, and testing in traditionally non-male-circumcising communities, providing circumcision or referrals for 10,067 men, surpassing the target of 6,899. According to the ICR (p. 44), as a result of project interventions, the percentage of circumcised men in targeted regions increased by over 30%. Overall, the percentage of men circumcised in the country increased from 85% in 2007 to 91% in 2012, and in Nyanza district (which has the lowest circumcision rate in the country) from 48% to 66% (ICR, p. 25).
More than 7.5 million members of MARPs were reached with behavior change communication, including through 193 drop-in centers specifically targeted at these populations across the country. The ICR’s Table 2c (pp. 51-61) provides extensive data on activities involving various groups, particularly long-distance truck drivers and drug users, but it is difficult to discern aggregate activity or coverage among these groups based on the information provided, and some of the data in this table differ from that in the Borrower’s ICR. In addition, no information is provided on CSWs, MSM, or other risk groups.

12,172 pregnant women/couples were provided with prevention of mother-to-child transmission (PMTCT) services, exceeding the target of 7,725 (ICR, p. 56). PMTCT coverage increased from 73% in 2009 to 90% in 2012.

Nationwide, HIV prevalence among men and women aged 15-49 declined from 7.1% in 2007 to 5.6% in 2012 (despite an increase in prevalence that might be expected from increased availability of antiretroviral medications). From 2007- to 2012, HIV prevalence among those aged 15-19 decreased from 3.5% to 1.1%, and among those aged 20-24 from 7.5% to 4.6%, suggesting a decline in the number of new infections (incidence) over that time period. The ICR (p. 28) reports that HIV incidence was stable between 2007 and 2012 at 2.5 new infections/100 persons/year, and that among men and women aged 15-24 incidence declined from 1.1% in 2007 to 0.9% in 2012. It is unclear how much of this decline can be attributed to the project’s interventions. In terms of behavioral outcomes, there was no change from 2007 to 2012 in the percentage of people aged 15-24 reporting sexual debut before the age of 15 (21%). However, reported condom use at first sex among women aged 15-24 increased from 26% in 2007 to 67% in 2012, and among men aged 15-24 from 29% to 58% over the same time period.

Expand the coverage of targeted HIV and AIDS mitigation interventions is rated Substantial.

Outputs:
PLWHA were provided with training and services on HIV prevention, condom use/disposal, human rights, and public speaking.

Outcomes:
10,574 clients with HIV were provided with palliative care in the reporting year 2013-2014, exceeding the target of 3,483. The ICR does not indicate what level of coverage this represents.

43,481 OVCs were supported through provision of nutrition, clothing, education, medical assistance, and other services. However, only 0.9% of all OVCs received at least one type of OVC support.

Over 100,000 patients benefited from the project’s purchase of anti-TB drugs. All TB patients were screened for HIV, and all HIV positive people were screened for TB, and those found positive were put on treatment (ICR, p. 27). The effectiveness of use of the TB drugs is not reported (treatment adherence, cure rates).

ADDITIONAL REVISED OBJECTIVE:
Expand access to bed nets among targeted people living with HIV and AIDS and other households in malaria risk areas is rated Substantial.

Outputs:
The project purchased and/or distributed 2,875 million ITNs in eight high malaria burden counties, meeting the target of 2.8 million.

Outcomes:
5.25 million individuals were reached with an ITN by the project, exceeding the target of 5.1 million (no baseline is provided). Of these, 500,000 were PLWHA, and the remaining 4.75 million were reached through mass distribution.

81.2% of households in malaria endemic regions in the districts supported by the project had at least one insecticide-treated bed net in 2012, an increase from 27.6% in 2008. A post-distribution survey (ICR, p. 27, timing of survey not specified) indicated that 91.7% of households in the endemic areas own at least one bed net, and over 75% own two. This met the target of 80%. It is not clear what percentage of these households included
PLWHA, and there are no data provided on use of the bed nets.

5. Efficiency:

Neither the PAD nor the ICR conducted a formal economic analysis. The PAD (p. 50) briefly outlines the economic impact of HIV and AIDS, both generally and in Kenya. The ICR (pp. 29-31) expands slightly on this analysis, offering no explicit cost-benefit or rate-of-return calculation. However, the ICR’s analysis demonstrates that some of the project’s interventions have been generally found to be cost effective in the fight against HIV and AIDS, and applies those calculations to project interventions: the cost per HIV infection averted through voluntary counseling and testing, for example, is US$ 249, such that the project’s estimated 610,000 averted infections translates into savings of US$ 151 million. Male circumcision is also a cost-effective intervention, with a unit cost of US$ 150-900 per HIV infection averted over ten years, compared with estimated discounted lifetime treatment costs exceeding US$ 7,000 in Kenya. The ICR also indicates that investments in capacity-building among project sub-implementers were cost-effective, producing improvements in target achievement from 69% in the first three sub-grant rounds to 89% in the final two rounds (ICR, p. 31).

Mapping analyses conducted in 2008 and 2012 indicated that MARPs accounted for approximately one-third of new infections among adults, and yet only 13% of CSO/private sector grant funding under the project was targeted at these groups. While the ICR (p. 24) refers to the project's prioritization of MARPs, it is not clear that the emphasis placed on these groups was sufficiently robust. Even in an environment such as Kenya’s, where a large number of new infections was within stable sexual relationships among the general population, it has been demonstrated that targeted prevention interventions among high-risk groups are a key and cost-effective means of slowing the spread of HIV.

Implementation efficiency was mixed. Minimal stocks of condoms or ITNs were lost in the supply chain, with the number procured matching the number delivered and distributed. Use of existing national distribution arrangements to deliver bed nets enhanced efficiency. Unit costs of services delivered through project-funded sub-grants were low, as many grant implementers were volunteers or local workers on modest stipends, with an average grant amount of US$ 5,000 (ICR, p. 31). Local consultants were trained in sub-grant auditing, enabling the project to move away from the use of international consultants for this purpose and contributing not only to cost savings but also to local capacity building. However, there were inefficiencies. Procurement was slow under the NACC and then the United Nations (see Section 11b). Mainstreaming activity of public sector agencies was also ineffective, with slow disbursement resulting in eventual reallocation of funds to other purposes.

Efficiency is rated Modest.

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

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<th>Rate Available?</th>
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* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome:

Relevance of both the original and revised objectives is rated Substantial, as the objectives reflected country conditions and both Bank and government strategy. Relevance of design under both the original and revised objectives is rated Substantial, with a results chain that plausibly and logically connected planned activities to achievement of the stated objectives. Achievement of both of the original HIV and AIDS objectives, as well as the added malaria objective, is rated Substantial, with targets met or exceeded for expansion of HIV and AIDS prevention and mitigation interventions and of access to bed nets. Efficiency is rated Modest, as the project did not invest adequately in prevention interventions among high-risk groups, and delays were experienced in procurement and in mainstreaming activities among public sector agencies. Taken together, these ratings are indicative of moderate shortcomings in the project’s preparation and implementation under both the original and revised objectives, and therefore an Outcome rating of Moderately Satisfactory.

a. Outcome Rating: Moderately Satisfactory
7. Rationale for Risk to Development Outcome Rating:

International contributions have funded 80-84% of the current national HIV/AIDS strategic plan, but most donor funding agreements have ended or will do so soon. An HIV Trust/Investment Fund has been established to cope with the phasing out of external funding, and an HIV investment unit was set up in the NACC for fiscal year 2015/2016 to make plans for sourcing and leveraging of funding (ICR, p. 17). Political risk is also a major contextual factor, given the increasingly challenging security environment in the country. However, the project built significant capacity among government agencies (particularly the NACC) and CSOs, reducing institutional risk, and government commitment to the fight against HIV and AIDS remains strong.

a. Risk to Development Outcome Rating: Significant

8. Assessment of Bank Performance:

a. Quality at entry:

Project preparation relied on extensive data and analysis regarding the trajectory of the HIV and AIDS epidemic in sub-Saharan Africa and in Kenya, the role of other donors, and the institutional capacity of AIDS institutions in the country. Appropriate lessons were learned and applied from earlier projects in Kenya (including lessons related to anti-corruption efforts) and from the Bank’s global experience fighting the epidemic (PAD, pp. 33-36). Risk assessment and mitigation was thorough, with particular attention to the risk of inadequate targeting of vulnerable groups with adequate interventions (PAD, p. 47); this risk was effectively addressed through the planned use of the JAPR process to identify annual priorities. Preparation of M&E included intensive capacity-building efforts, and appropriate indicators and targets were established. However, project design did not include explicit activities aimed at increasing knowledge of population size/location and baseline data for high-risk groups.

Quality-at-Entry Rating: Moderately Satisfactory

b. Quality of supervision:

Bank missions contained an appropriate mix of expertise and followed up thoroughly on issues raised by prior missions. Appropriate attention was paid to institutional capacity building needs of the NACC, especially related to fiduciary and technical/managerial issues, and the Bank team provided important guidance and support to the NACC Secretariat. Emerging implementation challenges were proactively managed in tandem with government entities and implementing agencies. Communication and collaboration with development partners was strong. Project restructuring and the addition of a malaria objective was appropriately undertaken, given the funds being allocated to the purchase of bed nets.

Quality of Supervision Rating: Satisfactory

Overall Bank Performance Rating: Moderately Satisfactory

9. Assessment of Borrower Performance:

a. Government Performance:

The government was and remains strongly committed to the fight against HIV, AIDS, and malaria, and to improving the effectiveness of government institutions involved in that fight. It made its full planned financial contribution to the project. Government strategy and policy relevant to HIV and AIDS is in place and is updated appropriately in response to the dynamics of the epidemic. However, there were delays in hiring fiduciary agents in several government agencies during the project’s lifetime (ICR, p. 37), and decentralization policies and activities toward the end of the project period disrupted financial flows and interrupted project activities. Slow clearance by the Kenya Bureau of Standards delayed procurement of essential commodities
Early in the project period, the mainstreaming activity of public sector agencies was ineffective, with slow disbursements resulting in eventual reallocation of funds to other purposes.

**Government Performance Rating**: Moderately Satisfactory

**b. Implementing Agency Performance:**

The National AIDS Control Council (NACC) was the project’s implementing agency. The NACC provides effective strategic leadership, oversight, and political mobilization for the national HIV and AIDS response. The project provided significant support for NACC capacity building during the project’s lifetime. NACC staff “showed high levels of professionalism and dedication to achievement of the objectives of the project” (ICR, p. 37). NACC supervision of grantee activity was strong, with effective monitoring of programs, consistent results orientation, and productive feedback to the sub-implementers. However, there were many delays and challenges with NACC-led procurement in the early years of the project due to weak capacity at the central and local levels; eventually, procurements for the project were carried out through the United Nations and then the Kenya Medical Supplies Authority (under the Ministry of Health) (ICR, p. 17).

**Implementing Agency Performance Rating**: Moderately Satisfactory

**Overall Borrower Performance Rating**: Moderately Satisfactory

10. M&E Design, Implementation, & Utilization:

**a. M&E Design:**

Project design gave significant attention to M&E, resulting in a clear framework governing both the KNASP and the project. A community-based monitoring system contained a comprehensive database of CSOs, a program activity reporting system (COBPAR), and a financial reporting system. Clear reporting procedures and systems were also designed for key public sector entities. Project indicators focused primarily on outputs, which was in line with the project’s objectives, though two behavior change indicators were also included that intended to measure behavioral outcomes (proportion of sexually active youth aged 15-24 who report having had sex with a non-regular partner in the past 12 months, and proportion of sexually active youth aged 15-24 who report having used a condom during their last sexual encounter with a non-regular partner), even though these outcomes were not embedded in the objectives. An impact evaluation was planned on behavior change communication among youth in two provinces. More than half of the project's indicators lacked baseline values or targets, including indicators for most key populations (MSMs, sex workers, and drug users). According to the ICR (p. 15), the framework in some instances used outdated (2003 or 2007) baseline values that could have been updated by the time the M&E plan was implemented.

**b. M&E Implementation:**

The NACC implemented almost all M&E activities in the project’s original first-year work plan on schedule using alternative funding sources to compensate for delays in project effectiveness (these delays stemmed from post-election violence in early 2008 and time needed to recruit fiduciary consultants). An M&E Coordination Specialist, database administrator, and analyst/programmer were recruited and trained. A new NACC local area network/wide area network hosted the COBPAR system. Monitoring and Coordination Groups (MCGs) were set up for each priority area of the project, and formal linkages were established with entities responsible for other sources of data. An M&E Technical Working Group actively coordinated M&E activities, standards, and essential funding. The project funded the HIV testing modules of the Kenya Demographic and Health Survey (KDHS) in 2007, and part of the costs of the Kenya AIDS Indicator Survey (KAIS) in 2012.

However, the two behavior change indicators included in the results framework were not reported on during implementation. Although overall reporting levels were strong among the health sector and CSOs, the reporting rate for public sector entities was below 50% (ICR, p. 16). "Concerns were raised about data quality with respect to completeness, accuracy, and double reporting" (ICR, p. 16). Furthermore, the planned impact evaluation was not conducted due to delays in contracting with survey firms.
c. M&E Utilization:

Current data on the HIV and AIDS epidemic were presented at each Joint Annual Program Review (JAPR) and were used to identify gaps and set priorities. The MCGs, which were responsible for monitoring progress against the project’s results framework, provided a forum for overcoming implementation delays and bottlenecks, as well as making specific recommendations for policy action. Data from the KDHS 2007 and KAIS 2012 guided the priorities and direction of the national HIV and AIDS strategic planning process.

M&E Quality Rating: Modest

11. Other Issues

a. Safeguards:

The project was Category B and triggered OP/BP 4.01, Environmental Assessment. It made use of existing arrangements under a previous HIV and AIDS project in Kenya, and a national Medical Waste Management Action Plan was developed and disclosed by the government. The medical waste action plan was implemented under a separate Health Sector Support Project (ICR, p. 16). Enhanced concerns about indigenous people triggered OP 4.10, Indigenous Peoples, during the preparation for the Additional Financing. An Indigenous People Planning Framework (IPPF) was prepared, disclosed, and successfully implemented through targeted assistance to local sub-projects (ICR, p. 16).

b. Fiduciary Compliance:

Financial Management: A Financial Management Agency (FMA) provided oversight on all aspects of grant management, from management of the award process through payments to grant recipients and collection/verification of financial and program monitoring data. Funding flows to grant recipients were linked to quarterly targets for grant-specific indicators. FMA field officers monitored grantee performance in financial management and built capacity where necessary. Accounting staff of the NACC managed FM and disbursement. The ICR does not provide information on project audits. The project team later confirmed that all audits were on time and unqualified.

Procurement: Weak NACC capacity at the national and local levels resulted in procurement delays and challenges in the project’s initial years. Procurement risk was rated High at the time of the Additional Financing in 2010 (ICR, p. 17). These challenges prompted the use of alternative mechanisms for procurement through the United Nations, although these arrangements also encountered substantial delays. Eventually, procurements for the project were carried out successfully through the Kenya Medical Supplies Authority (KEMSA), a state corporation under the Ministry of Health established in 2013.

c. Unintended Impacts (positive or negative):

None reported.

d. Other:

12. Ratings:

<table>
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<tr>
<th>ICR</th>
<th>IEG Review</th>
<th>Reason for Disagreement/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfactory</td>
<td>Moderately Satisfactory</td>
<td>Efficiency is rated Modest. While the ICR (p. 24) refers to the project’s prioritization of MARPs, it is not clear that the emphasis placed on these groups was sufficiently robust. There were also inefficiencies related to procurement and to the mainstreaming activities of public sector agencies.</td>
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<td></td>
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<td>Project design did not include explicit mechanisms for increasing knowledge of population size/location and baseline data for high-risk groups.</td>
</tr>
<tr>
<td>Borrower Performance:</td>
<td>Satisfactory</td>
<td>Moderately Satisfactory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There were delays in hiring fiduciary agents caused by several agencies during the project's lifetime, and decentralization policies and activities toward the end of the project period disrupted financial flows and interrupted project activities. Early in the project period, mainstreaming activity of public sector agencies was ineffective, with slow disbursements resulting in eventual reallocation of funds to other purposes. There were challenges with NACC-led procurement in the early years of the project due to weak capacity at the central and local levels; eventually, procurements for the project were carried out through the United Nations and the Kenya Medical Supplies Authority.</td>
</tr>
<tr>
<td>Quality of ICR:</td>
<td>Satisfactory</td>
<td></td>
</tr>
</tbody>
</table>

NOTES:
- 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. 38-39) offers several key lessons:

- Realistic independent assessment of project progress improves project management and service delivery. In this case, the use of fiduciary agents enhanced governance, accountability, and ultimately performance.

- Technical assistance to implementers facilitates success in projects involving grants to community-level entities. In this case, investments in capacity building for community-based organizations produced improvements in project design, allocation of funds, M&E, community ownership, and possibly even poverty reduction.

IEG offers the following additional lessons:

- Investments in expansion of coverage of HIV, AIDS, and malaria interventions do not automatically translate into behavior change and/or impact on the course of these epidemics. Conveyance of information and distribution of condoms, bed nets, and other commodities, no matter how well targeted, cannot be assumed to result in meaningful outcomes. For example, distribution of condoms does not guarantee effective use of condoms; distribution of bed nets similarly does not guarantee their use. The ICR itself (Annex 5, Evaluation of the 2011/12 Long-Lasting Insecticidal Treated Nets Mass Distribution Campaign, pp. 64-77) reports high achievement in bed net distribution, but continued low bed net use among children and pregnant women, who are the groups most vulnerable to malaria infection. In the case of this project, insufficiently ambitious objectives left the project without adequate information and analysis regarding its actual impact on disease control and incidence reduction.
15. Comments on Quality of ICR:

The ICR's analysis of the validity of the project's results framework and attribution of observed results to project interventions is clear, concise, and evidence-based. However, the ICR is occasionally unclear and/or contradictory in expressing whether reported achievements were annual or cumulative numbers, and in aggregating data on populations served with behavior change, sensitization, and counseling/testing services; frequently, it is difficult to discern the numbers of individuals actually served/reached.

a. Quality of ICR Rating: Satisfactory