1. Project Data

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Sector(s)
Other social services(100%)

Theme(s)
HIV/AIDS(67%):Regional integration(33%)

Prepared by Judyth L. Twigg
Reviewed by Soniya Carvalho
ICR Review Coordinator Joy Behrens
Group IEGHC (Unit 2)

2. Project Objectives and Components

a. Objectives

According to the Grant Agreement (p. 5), the objectives were to: "(i) increase preventative action in relation to and reduce misconceptions of refugees, Internally Displaced Persons (IDPs), returnees, surrounding host communities, and cross-border and mobile populations (CBMPs) concerning HIV/AIDS prevention, treatment, and mitigation in selected sites in the territory of the Member States; and (ii) establish a common and sustainable regional approach to supporting these populations in the territory of the Member States."
b. Were the project objectives/key associated outcome targets revised during implementation?

No

c. Components

The project contained three components:
1. Support to Refugees, IDPs, Returnees, Surrounding Host Communities and Cross-Border and Mobile Populations (appraisal, US$ 10.0 million; estimate with Additional Financing (AF), US$ 13.5 million; actual US$ 12.0 million). This component was to scale up HIV interventions, in terms of size and geographic area, for refugees, IDPs, returnees, and surrounding host communities, as well as for vulnerable CBMPs. The United Nations High Commissioner for Refugees (UNHCR) was to provide services for refugees, IDPs, and returnees, including prevention, care, support, treatment, and mitigation, with precise services to depend on the country and refugee/IDP site situation. For CBMPs, selected hot spots were to be identified jointly by IGAD and member states as points for delivery of services to be provided by selected non-governmental organizations (NGOs). IGAD is the Inter-Governmental Authority on Development launched in 1996, consisting of Djibouti, Ethiopia, Kenya, Somalia, Sudan (eventually split into Sudan and South Sudan), and Uganda.
2. Cross Border Collaboration on the Health Sector Response to HIV/AIDS (appraisal, US$ 2.0 million; estimate with AF, US$ 1.1 million; actual US$ 0.9 million). This component was to address the health sector response to HIV/AIDS with regard to migrant populations across the borders of IGAD member states. It was to provide a forum for information exchange, sharing of country experiences, and dissemination of best practices and lessons learned; develop mechanisms for cross-border continuity of services; and develop and adopt a regional strategy for improved HIV and sexually transmitted infection (STI) prevention, treatment, and care services for CBMPs. A rapid survey of health facilities located in border areas was to be conducted, with findings used to develop a capacity strengthening plan.
3. Project Management, Coordination, Capacity Building and Monitoring and Evaluation (M&E) (appraisal, US$ 2.6 million; estimate with AF, US$ 7.4 million; actual, US$ 9.1 million). This component was to establish a Program Facilitation Office (PFO) and capacity support for IGAD as a facilitating organization; train key stakeholders and implementers; and support the development of a project M&E system that was to serve as a precursor to a regional M&E framework.

The appraised costs also included a project preparation facility of US$ 0.4 million.

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

Project Cost: Estimated original total project costs were US$ 15 million, increasing to US$ 22.622 million with an AF in 2013. Actual total costs were US$ 22.28 million. According to the Operations Portal, US$ 0.4 million was cancelled.

Financing: The project was initially to be financed by an Africa Catalytic Growth Fund (ACGF) Grant of US$ 15 million. Additional Financing of US$ 7.622 million from the Canadian International Development Agency (CIDA) was approved in May 2013. The AF was intended to ensure project continuity after the original grant had completely disbursed and a modest scale-up of scope (though no outcome targets were revised).

Borrower Contribution: There was no planned Recipient contribution.

Dates: The project underwent seven restructurings to extend the closing date, from December 2011 to June 2012, October 2012, December 2012, March 2013, May 2013, December 2014, and June 2015. The restructuring that extended the closing date to December 2014, approved in May 2013, also approved the CIDA Additional Financing.

3. Relevance of Objectives & Design

a. Relevance of Objectives

At the time of project appraisal, mobility and migration of populations across the IGAD countries was common. In cross-border areas, transport workers, community sex workers (CSWs), and other CBMPs interacted at “hot spots,” while refugees and IDPs resided along the borders and hot spots, including in refugee camps. HIV prevalence in the region was high (above 1% in 2006 for all countries in the region among persons aged 15-49). The movement of vulnerable populations was seen as a catalyst to the HIV/AIDS crisis, and reaching those populations as a particular challenge. A 2004/2005 Bank-sponsored regional mapping assessment of cross-border HIV/AIDS interventions had identified an absence of counseling and testing services at sampled border locations across the Horn of Africa. The project was
responsive to the national HIV/AIDS strategies of the IGAD member states (both at appraisal and at closing). It was also responsive to the Bank's commitment to Millennium Development Goal 6 (to halt and reverse the spread of HIV/AIDS), and to the individual Country Partnership Strategies for the IGAD member states, which continue to stress the provision of prevention, treatment, care, and mitigation services for vulnerable groups as well as the needs of migrant and refugee populations. However, the project objectives are not clearly formulated, indicating an objective to “increase preventative action” in relation not only to HIV/AIDS prevention but also to treatment and mitigation, which are generally understood separately from prevention, and also not drawing a clear distinction between prevention the spread of HIV and reducing misconceptions about HIV/AIDS.

Rating
Substantial

b. Relevance of Design

Contracting with UNHCR and with NGOs and local health facilities was likely to increase the availability and use of HIV/AIDS prevention and treatment services, and the project incorporated provisions for locating and targeting high-risk and vulnerable groups. The development of communication channels, information sharing networks, mechanisms for continuity of services across borders, and joint strategies was likely to lead to the establishment of regional approaches to HIV/AIDS prevention and care for mobile populations and host communities in participating states. However, the set of activities was large and complex, with insufficient consideration of the challenges of providing consistent services to target groups that are, by definition, moving from place to place.

Rating
Modest

4. Achievement of Objectives (Efficacy)

Objective 1

Objective
Increase preventative action in relation to and reduce misconceptions of refugees, Internally Displaced Persons (IDPs), returnees, surrounding host communities, and cross-border and mobile populations concerning HIV/AIDS prevention, treatment, and mitigation in selected sites in the territory of the Member States.

Rationale
The formulation of the objectives in the project documents is unclear. As provision of accurate information and education on HIV (reducing misconceptions among target populations) is a central component of HIV prevention, the objective to increase preventative action and reduce misconceptions among the target populations is treated here as a single objective (in contrast to the ICR, which rates separately the increase in preventive action and the reduction of misconceptions).

The Bank was not the only contributor toward achievement of project objectives. Governments, implementing partners, and United Nations agencies also contributed funding toward services that were supported under the project, and project funding went primarily to pre-existing structures, agencies, and organizations whose mandate covered HIV/AIDS services. The project's major specific contribution was therefore to strengthen and tighten those agencies' focus on CBMPs.

Outputs:
The project supported implementing partners and health centers to deliver services to target populations at 48 sites, across Djibouti, Ethiopia, Sudan, South Sudan, Uganda, and Kenya. The ICR (p. 40) reports that many public sector sites were remote from border areas and therefore were difficult to access for the target populations; the project responded by financing the construction of some voluntary counseling and testing centers near points such as truck parking areas. Gender was mainstreamed into the HIV/AIDS programs at all 48 sites. Health facilities were equipped to provide voluntary counseling and testing in 93 facilities (exceeding the target of 80). A network of local support groups, associations, and educators was supported for service delivery, including 56 associations of persons living with HIV and AIDS.
participating countries. As a result, achievement of this objective is rated Modest.

The percentage of those ages 15-49 in project hot spots who underwent HIV voluntary counseling and testing and knew their results in the preceding 12 months increased over the project's lifetime among males and females in Uganda, North Sudan, South Sudan, and Kenya, but did not reach targets.

The percentage of those ages 15-49 in project hot spots who could correctly identify three ways of preventing sexual transmission of HIV and who rejected major misconceptions about HIV transmission increased over the project's lifetime and reached targets among Ugandan females and Kenyan males. There was no improvement on this indicator among North Sudanese males or South Sudanese females. Among Ugandan males, North Sudanese females, South Sudanese males, and Kenyan females, there was improvement, but not sufficient improvement to reach targets.

The percentage of those ages 15-49 in project hot spots who used a condom at last sex with a non-regular partner improved over the project's lifetime among all respondents in Uganda, North and South Sudan, and Kenya, and reached targets for all groups except Ugandan and North Sudanese males.

The percentage of those ages 15-49 in project hot spots who used a condom at last sex with a transactional partner improved over the project's lifetime among all respondents in Uganda, North and South Sudan, and Kenya, and reached targets for all groups except North Sudanese males.

Among specific risk groups ages 15-49 -- female sex workers, truckers, and male and female youth -- surveyed in project hot spots in the four countries noted above, there were few groups with improvements over baseline in the percentage who underwent voluntary counseling and testing and knew their results in the preceding 12 months. Only female Ugandan youth both showed improvement over the project's lifetime and reached targets.

Among those specific risk groups -- female sex workers, truckers, and youth -- surveyed in project hot spots in the four countries noted above, about half improved over baseline on the indicator to correctly identify three ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission. However, none of these groups reached targets.

Among those specific risk groups -- female sex workers, truckers, and youth -- surveyed in project hot spots in the four countries noted above, only South Sudanese truckers and Kenyan female sex workers showed improvement on the indicator for reported condom use at last sex with a non-regular partner, and none of the groups reached targets.

Among those specific risk groups -- female sex workers, truckers, and youth -- surveyed in project hot spots in the four countries noted above, about half showed improvement on the indicator for reported condom use at last sex with a transactional partner, but none (except South Sudanese truckers) reached targets.

In terms of treatment outcomes, the number of people with access to a basic package of health, nutrition, or reproductive health services at project sites increased from 7.5 million to 10.4 million over the project's lifetime, essentially meeting the target of 10.5 million. 112,287 clients received STI services over the project's lifetime, surpassing the target of 65,021 clients. The number of pregnant women tested for HIV/AIDS at project-supported sites increased from zero at baseline to 10,147 in 2009 and reached a peak of 67,432 in 2013/2014. The percentage of these women who were found to be positive for HIV at project-supported sites decreased from a high of 2.6% in 2010/2011 to 1.3% at project closure in 2015. All women who tested positive, throughout the project's lifetime, were referred for ART services. Although the project did not systematically track adherence to ART, and the ICR (p. 19) acknowledges that VCT sites supported by the project were often far away from sites offering ART and that drug supply was a challenge, data collected at one ART site (Nimule, in South Sudan) found an increase in adherence from 84% in 2009-2011 to 94% in 2011-2012.

HIV prevention education did not produce improvements in knowledge and behavior change to a level that reached targets. The Borrower's ICR (p. 62) suggests that this result stems from the challenges in providing regular intervention programs to target groups that are, by definition, moving from place to place. In addition, data are of questionable quality and are not provided for UNHCR sites or for three of the participating countries. As a result, achievement of this objective is rated Modest.
Objective 2

Objective
Establish a common and sustainable regional approach to supporting these populations in the territory of the Member States.

Rationale

Outputs:
The project supported a large number of cross-border consultations, meetings, and workshops. It provided a platform for regional collaboration specifically among the member states’ National AIDS Councils and Ministries of Health. Several analytical papers were supported to broaden regional knowledge of CBMPs, though the ICR (p. 24) reports that the quality of these studies was variable.

Outcomes:
A regional strategy for improved HIV/AIDS/STI prevention, treatment, and care services specifically for CBMPs, refugees, and IDPs was finalized in October of 2012. According to the ICR (p. 24), that strategy continues to guide member countries through identifying regional-level priorities that require collaborative approaches, identifying harmonized service provision imperatives for mobile populations, acting as a tool to leverage national-level resources for CBMPs, and strengthening mechanisms for effective regional planning.

Seven harmonized protocols were developed and adopted by all member states by 2010, covering voluntary counseling and testing, prevention of mother-to-child transmission, tuberculosis, STIs, ART, opportunistic infections, and pre-exposure prophylaxis. These protocols were distributed to all health facilities in project hot spots, and personnel in these facilities were trained on the protocols.
Harmonized cross-border referral strategies to benefit CBMPs were developed, though the efficacy of these strategies has not yet been monitored. In principle, this referral mechanism allows any person who tests positive for HIV and agrees to commence ART to follow up with ART in any other IGAD member country.

Rating
Substantial

5. Efficiency

No formal economic analysis was conducted for the PAD. As the project's monitoring and evaluation (M&E) system experienced shortcomings capturing disaggregated cost and output/outcome data, the ICR also encountered challenges conducting quantitative analysis. The ICR speculates that the private benefits of annual income accrued by males who did not become HIV-infected because of the project's interventions, as well as the reduced cost to families when children are not born with HIV, likely well exceed the present value of the project's cost. Similarly, the public benefits due to the reduction of public health costs for HIV/AIDS care are also likely to exceed the project's cost many times over. However, as the ICR points out, these cost-benefit relationships would have to be verified by a sound M&E system.

The project efficiently targeted groups at highest risk for HIV infection: female sex workers, truckers, youth, refugees, and IDPs. Existing institutions were used to deliver services, minimizing service delivery costs.
However, several aspects of implementation efficiency were not cost-effective. The geographically dispersed nature of the numerous implementing partners made it difficult to achieve efficiency gains from the regional-level approach. Also, because of coordination challenges between the participating member states, implementation of many activities was slow, resulting in multiple project extensions due to lack of disbursements. The ICR (pp. 27-28) demonstrates that project expenditures skewed disproportionately toward project management, and there were significant fiduciary challenges. As a result, project efficiency is rated Modest.
Independent Evaluation Group (IEG)  
Horn of Africa HIV/AIDS ACGF(P104523)

**Implementation Completion Report (ICR) Review**

**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:

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

6. **Outcome**

The relevance of the project's objectives is rated Substantial, as they were awkwardly worded but responsive to regional context, Bank strategy, and the strategies of the participating member states. Relevance of project design is rated Modest, as it did not take into account the challenges of providing consistent services to groups that were, by definition, mobile. Achievement of the objective to increase preventative action and reduce misconceptions related to HIV/AIDS among target groups is rated Modest, due to lack of outcome data for many project sites, and failure to meet targets for improved knowledge and reported behavior change among target groups at project “hot spots.” Achievement of the objective to establish a common and sustainable regional approach to HIV/AIDS for target groups is rated Substantial, as a regional HIV/AIDS strategy, numerous harmonized protocols, and a regional referral strategy were developed and implemented. Project efficiency is rated Modest due to significant implementation challenges and delays. Taken together, these ratings are indicative of moderate shortcomings in the project's preparation and implementation, and therefore an Outcome rating of Moderately Satisfactory.

a. **Outcome Rating**

   Moderately Satisfactory

7. **Rationale for Risk to Development Outcome Rating**

According to the ICR (p. 46), anecdotal evidence indicates that many project sites remain functional after project closure. Project investments in infrastructure and human resources appear likely to be sustained. However, while a common regional approach to CBMPs was developed under the project, it is unclear that collaboration, cross-border activities, and harmonization efforts will continue following project closure in the absence of a coordinating institution to support the agenda. The Global Fund is exploring ways to continue supporting IGAD, but the Bank's emphasis appears to be moving in a different direction (ICR, p. 15). Monitoring and evaluation challenges also must be addressed in order for outcomes to be sustained. Political commitment from member governments is key for maintaining funding, and it is not clear that this is forthcoming. Relationships between IGAD member states are tenuous, and there is the possibility of escalating conflict in some of these countries.

a. **Risk to Development Outcome Rating**

   Substantial

8. **Assessment of Bank Performance**
Independent Evaluation Group (IEG)
Horn of Africa HIV/AIDS ACGF(P104523)

Implementation Completion Report (ICR) Review

a. Quality-at-Entry
The project appraisal team facilitated negotiations among the IGAD member states, and the PAD (p. 12) cites lessons noted from previous projects (including the need for relatively simple project design in a complex operating environment, and the importance of institutionally strong implementing agencies). Despite this explicit recognition in the PAD, however, risks related to the complexity of project design, the existence of a large number of implementers and their capacity constraints, and efficiency implications of these complex arrangements were not appropriately flagged and mitigated. The project's objectives were not clearly formulated. The results framework was weak, with key indicators not well chosen and baselines not established (see Section 10a). A Quality at Entry Review and Regional Operations Committee review were conducted with positive results, but according to the ICR (p. 31), doubts were expressed (but not addressed) about the quality of the results framework. Finally, it was not adequately recognized that formal agreements between member states, IGAD, UNHCR, and the Bank would be required before implementation could begin; completing these agreements took over a year, significantly delaying project effectiveness.

Quality-at-Entry Rating
Moderately Unsatisfactory

b. Quality of supervision
Supervision missions were often carried out jointly with regional and country counterparts. However, according to the ICR (p. 31), almost no supervision budget was spent in fiscal years 2010-2013, calling into question the adequacy of supervision of a project with significant needs and a large number of countries involved; it is not clear why this was the case. Although early issues and challenges were recognized at the mid-term review in 2010, this was rather late to address M&E, disbursement, financial management, and implementation capacity challenges. Supervision improved in 2012 as the Task Team became based in Uganda, and capacity of the implementers, M&E, and financial management improved from that point forward. Nonetheless, significant M&E shortcomings persisted, including the lack of endline behavioral surveillance surveys for the UNHCR sites and for Ethiopia and Djibouti. Compliance with environmental safeguards was not fully monitored, though the project team confirmed that this was due to the security situation in South Sudan and Somalia.

Quality of Supervision Rating
Moderately Unsatisfactory

Overall Bank Performance Rating
Moderately Unsatisfactory

9. Assessment of Borrower Performance

a. Government Performance
Despite early delays in project endorsement, government commitment to the project among all member states was strong. A project steering committee of National AIDS Council (NAC) focal points resulted in clear and decisive support. However, many of the NAC focal points did not have broad authority over the health sector (impacting ART provision) and/or did not have the authority to make financial commitments on behalf of their governments. In effect, supervision of actual implementation frequently fell to District Health Authorities who were not directly supported under the project. Despite a lack of incentives, funding, or training, these district authorities in most cases were engaged and implemented activities effectively (ICR, p. 33).

Government Performance Rating
Moderately Satisfactory

b. Implementing Agency Performance
IGAD was the regional agency formally charged with coordinating project implementation, while day-to-day project management was the responsibility of the Project Facilitation Office (PFO) located in Kampala. This split location produced coordination challenges, and the IGAD secretariat was also burdened with many other responsibilities outside the project. Both entities experienced improved commitment and performance over the project's lifetime, and especially in the latter half of the project period, from which point the PFO in particular became more effective and proactive in addressing implementation challenges. It carried out a review of local implementing
partners and linked their further participation in the project to performance; it bypassed administrative layers in some countries to avoid bottlenecks; it began hiring implementing partners directly in order to speed disbursement and implementation; and it provided direct support to all three territories of Somalia, one of the only regional institutions to do so. Nevertheless, there were significant shortcomings. M&E issues and project reporting remained problematic even after 2012 (see Section 10b and ICR, p. 32), and prior to mid-term the PFO experienced high staff/management turnover and financial management issues (see Section 11b).

Implementing Agency Performance Rating
Moderately Unsatisfactory

Overall Borrower Performance Rating
Moderately Satisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design

According to the PAD (p. 33), the project was to contribute to the development of a regional M&E system, which did not exist at appraisal, to provide systematic and regular updates on cross-border and mobile populations. IGAD and UNHCR had responsibility for finalizing baseline data and targets. However, project design included a large number of indicators that were poorly defined and lacked accurate baselines. In particular, baselines for indicators related to HIV prevention were included in implementation status reports (ISRs) only two years into the project, and they erroneously covered populations at UNHCR project sites only (omitting populations served at "hot spots"). Furthermore, obtaining data for HIV prevention indicators relied on complex and expensive behavioral surveillance surveys. Responsibility for data collection and analysis was not clearly specified in the PAD.

b. M&E Implementation

Changes to indicators were made in implementation status reports through the first several years of the project without authority or formal restructuring, until a final set of indicators was formalized at the additional financing in May 2013. Although this formally revised set of indicators was simplified and tightened, those related to project management and M&E were dropped. As a result, the task team was not alerted to continued weaknesses in M&E. In particular, delays in carrying out behavioral surveillance surveys meant that baseline data were available for UNHCR sites only in 2009, and for "hot spots" only in 2011/2012 (meaning that no baseline data were available for the start of the project in 2007), and the 2009 UNHCR site baselines were never updated to include "hot spot" sites. The "actual values" for most HIV prevention indicators reported in ISRs from 2010 onwards were derived from routine administrative data, which were not comparable with baselines and in any event of questionable quality. Endline behavioral surveillance survey data were never collected at the UNHCR sites. Furthermore, endline data were never collected for Ethiopia, and neither baseline nor endline data were collected for Djibouti or Somalia. According to the ICR (p. 11), it is not clear why these omissions occurred, but most likely they were due to political difficulties and capacity/funding constraints. UNHCR did not find it feasible to track indicators related to a relatively small portion of their overall portfolio. Finally, questions were raised about the quality of behavioral surveillance data due to small and not always representative sampling.

c. M&E Utilization

The ICR (p. 13) points out that, given strong global interest in CBMPs, dissemination of data and analysis from the project beyond the participating countries and region was limited. Several regional studies (on HIV/AIDS among pastoralists, along main transport corridors, and among women) were "notable," but they were not distributed widely. Although the project participated in several regional conferences, there were few efforts to reach broader audiences.

M&E Quality Rating
Negligible
11. Other Issues

a. Safeguards

The project triggered OP/BP/GP 4.01, Environmental Assessment, and was classified as Category B. Medical waste management plans for each country were disclosed, but with delays in Sudan and Somalia. These two countries were still not in compliance by the time of the mid-term review in 2010, and so Health Care Waste Management Plans were prepared and financed for all individual project sites there. The ICR does not contain a straightforward statement about compliance with the Bank's safeguard policies. The project team later confirmed that project compliance was satisfactory except in Somalia and South Sudan, where security concerns prevented Bank teams from visiting project sites to ensure full compliance.

b. Fiduciary Compliance

Financial management (FM): The PFO was found to be lacking in FM capacity during the early years of the project, leading to delays in payments to the state NACs and therefore delays in payments to the implementing partners. As late as 2011, audits were finding late PFO annual work plans and weak control over payments and commercial bank reconciliations. Similarly, during the first phase of the project the NACs were not reporting on FM in a timely manner, interim financial reporting quality was weak, and regular audit reports were not being sent out. In November 2012, the original project was fully disbursed, and the Bank launched an FM assessment to determine whether there was acceptable FM in place to manage the proposed additional financing from Canada. Processing of the additional financing was made conditional on a number of reforms related to submission of auditing reports and accounting for Bank funds. Participating countries took longer than expected to meet these conditions, delaying effectiveness of the additional financing to May 2013 and disbursement to early 2014. At this point, FM improved at all levels, especially in the PFO and in collaboration between the PFO and the NACs. The audit report for calendar year 2013 expressed a clean opinion. The project team later confirmed that clean audit opinions continued into 2014 and until project closing.

Procurement: There were also early challenges with procurement. A post procurement report in 2011 noted that the PFO in Kampala was not in compliance with requirements to send to IGAD headquarters the supporting documents for procurement at the PFO level. Despite recommendations from the Bank team, the project did not at any point hire or contract a procurement specialist. After mid-term, procurement performance improved similarly to FM performance.

c. Unintended impacts (Positive or Negative)

The ICR (p. 29) notes that the project addressed economic and sexual vulnerability of CBMPs, including refugees and returnees, beyond the scope of "normal" HIV/AIDS services but using HIV programs as an entry point. The project also facilitated diplomatic relationships across IGAD member states, bringing together countries with tenuous political ties in the fight against a common public health threat.

d. Other

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12. Ratings

<table>
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<th>ICR</th>
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<td>Outcome</td>
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<td>Risk to Development Outcome</td>
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13. Lessons

The ICR (pp. 35-37) highlights a number of useful lessons, including:

Complex regional projects require a heightened level of support and scrutiny to ensure quality at entry and implementation success. The political economy of member states was not adequately considered during the design of this project, and adequate and consistent supervision and course correction were not provided prior to mid-term.

Careful reporting of baselines, definition of targets, and measurement of achievement is critical to determining progress and success. In this case, baselines were inappropriate or missing, the definition and monitoring of targets was too weak to permit identification of early implementation challenges, and reliance on behavioral surveillance data (difficult and expensive to collect) to monitor outcomes made it difficult to assess project impact.

Service delivery institutions cannot be effective if they are not located in proximity to target populations. In this case, the health centers and clinics supported under the project were often far away from border crossings, limiting access of CBMPs to services. While HIV testing centers were constructed near border crossings, they were in many cases prohibitively remote from follow-up treatment services. These shortcomings can be addressed, as the project demonstrated in some cases, through innovative solutions related to outreach, patient referral, and patient monitoring.

14. Assessment Recommended?

No

15. Comments on Quality of ICR

The ICR is clear, concise, and analytic, with an assessment of the achievements and shortcomings arising from a complex project and implementation experience. Despite shortcomings with the project's M&E, the ICR ensures that baseline, target, and endline data are comparable, always insisting on appropriate and high-quality evidence, and it pays explicit attention to attribution questions. Its efficiency analysis is multifaceted and of high quality. Its lessons are insightful and detailed, and should be useful for future projects involving regional cooperation and/or mobile populations. Environmental safeguard measures are discussed in detail, but there is a not an unambiguous statement about satisfactory compliance with safeguard policies.

- Quality of ICR Rating
  - High