1. Project Data:

<table>
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<tr>
<td>Project Name</td>
<td>Hiv/aids Prevention &amp; Control Project</td>
</tr>
<tr>
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<td>Guyana</td>
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<tr>
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<td>Population and reproductive health (25% - S)</td>
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<td></td>
<td>Tuberculosis (25% - S)</td>
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2. Project Objectives and Components:

a. Objectives:

The project was part of the third phase of the Bank’s Caribbean Multi-Country HIV/AIDS Prevention and Control Adaptable Program Loan (APL) approved in June 2001. Guyana was the seventh country to obtain support under the APL. According to the Development Grant Agreement (DGA, p. 18), the project’s objective was:

“to assist the Recipient in reducing the incidence of HIV/AIDS related deaths in the Recipient’s territory by: (a) preventing and controlling the transmission of HIV and STIs; (b) prolonging and improving the quality of life of people living with AIDS; and (c) mitigating the negative impact of HIV/AIDS on persons infected with and affected by the disease.”

The Project Appraisal Document (PAD, p. 3) states the initial part of the objective differently:

“to slow the increase of or reverse this trend,” with “this trend” referring to years of potential life lost due to HIV/AIDS. The remainder of the objectives, elements (a), (b), and (c), are stated identically in the DGA and the PAD.

This review assesses the achievement of the objectives as stated in the DGA.

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

No

c. Components (or Key Conditions in the case of DPLs, as appropriate):
I. Institutional Capacity Strengthening, Monitoring, Evaluation, and Research (appraisal US$ 2.68 million; actual US$ 2.31 million). This component supported institutional capacity building for scaling up the response through financing of technical advisory services, training, staffing, equipment, goods, and general operating costs. Specifically, the project was expected to provide support to the newly established Presidential Commission Against HIV/AIDS (PCHA) and the Project Management Unit (PMU), including training on financial management and procurement procedures. This component also provided support to ongoing data collection efforts such as the Behavioral and Risk Surveys, and for enhancing information technology capabilities through hardware and software to strengthen monitoring and evaluation (M&E) capacity, case management and surveillance, and a health management information system.

II. Scaling Up HIV/AIDS Response by Line Ministries, Civil Society Organizations, and the Private Sector (appraisal US$ 3.13 million; actual US$ 5.15 million). This component supported a coordinated, multi-sectoral response by strengthening the involvement of non-health line ministries to expand initiative in accordance with National Strategic Plan (NSP) priorities, based on annual work plans, and in their role of reaching their own staff with workplace interventions and the populations they serve through their official mandates. This component also engaged civil society organizations (CSOs) who could provide access to people living with HIV and AIDS (PLWHA), commercial sex workers (CSWs), men who have sex with men (MSM), prisoners, truck drivers, youth, orphans, and others. The project provided support for training, information education communication (IEC/BCC), condom distribution, treatment and care for the infected and affected, and workplace policy formulation, including reduction of stigma and discrimination and HIV/AIDS impact assessments.

III. Expanding Health Sector Prevention, Treatment, and Care Services for HIV/AIDS (appraisal, US$ 5.19 million; actual, US$ 3.22 million). This component provided support to strengthening, upgrading, and expanding health care systems for delivering services for prevention, treatment, care, and mitigation of HIV/AIDS:

- Support for health care systems included: (a) upgrading laboratory facilities; (b) training health care workers and counselors; and (c) the provision of key inputs such as equipment, drugs, supplies, testing kits, condoms, and development of treatment protocols.

- Support to prevention interventions included: (a) developing a comprehensive IEC/BCC strategy; (b) ensuring a high level of blood safety through the provision of reagents and strengthening logistical systems at the central and regional level; (c) scaling up voluntary counseling and testing (VCT) by adding and refurbishing VCT facilities and supplying them with test kits and reagents; (d) strengthening the syndromic management of sexually transmitted infections (STIs) by improving laboratory capacity through equipment, training and condom promotion; (e) integrating the prevention of mother-to-child transmission (PMTCT) program with the wider Ministry of Health (MOH) maternal and child health services; and (f) training health care workers on proper handling of infectious waste.

- Support to treatment and care included: (a) the management of opportunistic infections by developing standardized protocols and guidelines for HIV/AIDS care at all levels, including drug provision and training; (b) strengthening the national tuberculosis (TB) program through increase screening and Directly Observed Therapy Short-Course (DOTS) coverage; and (c) the provision of antiretroviral therapy (ART) and training at all levels on its delivery.


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

Project Cost:
- On 5/27/2009, the project was restructured for three reasons: (a) adding the construction of a medical warehouse in the DGA (Component III); (b) reallocating Grant proceedings among disbursement categories (from Category 3, ARVs, to Category 1, Works, to allow for the construction of the warehouse; and (c) extending the closing date for one year, from 6/30/2009 to 6/30/2010, to allow for completion of warehouse construction.
- The Bank provided US$ 0.5 million toward the US$ 1.3 million costs of the warehouse, with the balance provided by parallel funding from the Inter-American Development Bank (IADB) and the Global Fund to Fight AIDS, TB, and Malaria (Global Fund). The Bank funds had been freed because of the Global Fund’s financing of ARVs.
- The development objectives were not changed as a result of this reallocation.

Financing:
- The grant was fully disbursed by 1/15/2010, prior to the 6/15/2010 closing date.

Borrower Contribution:
- The Recipient contributed its full planned contribution of US$ 1.00 million.

Dates:
- At mid-term (May 2007), the key performance indicators (KPIs) were changed to improve alignment with the national HIV/AIDS M&E framework. Management advised at that time that a restructuring with Board approval was not required, since the development objectives were not being changed. The ICR does not present a clear, complete comparison of the original versus the revised KPIs, other than to note (p. 3) that the new indicators were better aligned with the 2007-2011 NSP.
- The project closed one year later than planned, on 6/30/2010, to allow for warehouse construction.
3. Relevance of Objectives & Design:

Objectives: Substantial. At the time of appraisal, Guyana had the second highest HIV prevalence in the Latin America and the Caribbean region. The opening up of Guyana’s hinterland for development, the proposed Guyana/Brazil road, and the resulting further increase in the mobility of the population raised concerns about a potentially rapid increase in HIV infection. The project was substantially relevant to Guyana’s 2002-2006 National Strategic Plan (NSP) for HIV/AIDS, which called for reducing the risk and vulnerability to infection through prevention and control of transmission of STIs, promotion of sexual health, and saving, prolonging, and improving the quality of life of people living with STIs and HIV/AIDS. The NSP envisioned a coordinated, multi-sectoral approach that would involve not only government but also PLWHA and CSOs to reach high-risk groups. The project’s objectives remain substantially relevant to the government’s current 2007-2011 NSP, which retains the previous plan’s strategic goals. The Government’s ICR states that “the project constituted an integral component of the overall Government’s response” (ICR, p. 45). The objectives are no longer of strategic relevance to the Bank’s Country Assistance Strategy (CAS) for Guyana (2009-2012), because HIV/AIDS activities are now covered well by other donors. The Bank’s current strategic focus in Guyana rests on two pillars: strengthening environmental resilience and sustainability, and improving education quality and social safety nets. The CAS (p. 16) explicitly states that this HIV/AIDS project is not part of the Bank’s forward-looking engagements with Guyana, and is not part of the CAS pillars.

Design: Substantial. The PAD (pp. 23-39) contained a results framework in which the project’s three elements, preventing infection, treating infection, and caring for those who are infected/affected, were aligned with a set of project outcome and output indicators. A clear results chain established the expected linkages between inputs, outputs, and outcomes. The project's components were comprehensive and would plausibly have been expected to achieve the project's desired outcomes, particularly due to their strong intended focus on prevention interventions involving high-risk groups, including PLWHA, CSWs, MSM, prisoners, and truck drivers.

4. Achievement of Objectives (Efficacy):

Eighty CSO proposals received project funds to implement a variety of HIV-related activities that cut across objectives, against a target of 74. 49 different organizations implemented these subprojects, spending a total of US$ 1.8 million. The ICR (pp. 16, 30) reports that the CSOs placed special focus on MSM, CSW, miners, truckers, loggers, indigenous populations, OVCs, PLWHA, and poverty-affected populations, but exact data on these activities are not provided (other than the creation of a website/forum for MSM and support activities for OVCs).

Reduce the incidence of HIV/AIDS related deaths: Substantial.

Outputs:

- The percentage of HIV-infected pregnant women who received a complete course of antiretroviral therapy (ART) increased from 63% in 2006 to 84.4% in 2009, against a target of 85%. 95.5% of those treated were reached by counseling and testing.
- The percentage of men, women, and children with HIV infection who are eligible according to national guidelines who are receiving ART was 83.5% in 2009, against a target of 85%. The number of regions with at least one service outlet providing ART services following national standards increased from 2 in 2004 to 10 (all) in 2009, meeting the target.
- The number of service outlets offering PMTCT services increased from 94 in 2006 to 157 in 2009, against a target of 130. 17 health centers were refurbished to include VCT services, five tester/counselors were hired, and furniture and other equipment was procured for all VCT sites.
- Laboratory support was provided to the National Public Health Reference Laboratory through the provision of equipment, reagents, and test kits for the diagnosis of opportunistic infections and monitoring of patients on care and on ART.
- The percentage of HIV-positive registered TB patients who were given ART during TB treatment increased from 26.3% in 2004 to 93% in 2009, against a target of 43%. The project procured second-line TB medications, refurbished and equipped physical facilities of the National TB Control Program, and provided a laboratory coordinator and a pharmacist. The CD4 threshold for referring TB patients to be treated with ARVs was increased from 200 to 350.
- The percentage of service outlets with record-keeping systems to monitor HIV and AIDS care and treatment increased from 15% in 2006 to 100% in 2009, against a target of 50%. The project supported initial development of a Health Management Information System (HMIS), allowing monitoring of ART services.

Outcomes:

- The percentage of all deaths attributable to AIDS decreased from 9.5% in 2002, to 7.1% in 2004, to 6.86% in 2005, to 4.7% at the end of 2008.

Prevent and control the transmission of HIV and STIs: Substantial.
Outcomes:

- A National Strategic Plan and policy information packages on HIV/AIDS were developed and disseminated to senior government staff. Ten line ministries and 6 national agencies had HIV work plans and budgets, meeting the target. 11 line ministries submitted program monitoring forms to the PCHA in the last year of the project.
- The National AIDS Program Secretariat distributed over 2.3 million condoms (male and female), and it is estimated that the ten regional health services together with the private sector distributed additional condoms sufficient for the total to reach the target of 3.3 million. Distribution was mainly through CSOs and the public health delivery system.
- The percentage of the general population aged 15-49 receiving HIV test results in the previous 12 months increased from 11.3% of females and 10.3% of males in 2005, to 24.8% in 2009, against a target of 13.8%.
- The percentage of men and women with STIs at health care facilities who are appropriately diagnosed, counseled, and treated increased from zero in 2005 to 100% in 2009, against a target of 90%.
- 23,552 BCC materials were distributed by CSOs. CSOs reached 16,760 people with messages promoting behavior change beyond abstinence and faithfulness; 9,047 people with messages promoting abstinence; 1,502 people with messages promoting faithfulness; and 8,590 people with messages promoting both abstinence and faithfulness. IEC/BCC initiatives included drama programs, music/dance competitions, radio serials, posters, handbooks, summer camp programs, athletic events, stickers for vehicles, and other interventions. 200 calendars, stories, and other HIV prevention messages were produced in Makushi and disseminated in Amerindian communities. An unspecified number of CSWs was reached with messages that promoted behavior change beyond abstinence and faithfulness (partner reduction, condom usage, etc.), BCC materials, and trainings on skills and capacity building. An unspecified number of miners, truckers, and loggers were also reached with prevention activities that promoted behavior change beyond abstinence and faithfulness (partner reduction, condom usage, etc.) and BCC materials.
- Reagents and consumables for safe blood were procured, and refurbishment of the building housing the National Blood Transfusion Services was completed.

Prolong and improve the quality of life of people living with AIDS: Substantial

Outcomes:

- The percentage of people aged 15-24 who could correctly identify ways of preventing sexual transmission of HIV and who rejected major misconceptions about HIV transmission increased from 36% in 2005 to 45.5% in 2009, against a target of 63%.
- HIV prevalence among 15-19 year olds, a proxy for rate of new infection, is reported by the ICR to have increased (p. 12), but exact data are not provided. Reported HIV cases fluctuated: 951 in 2005, 1430 in 2006, 983 in 2008, and 1219 in 2009.
- HIV prevalence among the general population decreased from 2.5% in 2007 to 1.9% in 2009. HIV prevalence among pregnant women dropped from 5.6% in 2000, to 1.3% in 2007, to 1.1% in 2009; among MSM from 21.25% in 2004 to 19.4% in 2009; among STI patients from 17.3% in 2005 to 13.3% in 2009 for males, and 16.9% in 2005 to 10.9% in 2009 for females; and among female CSW from 26.6% in 2004 to 16.6% in 2009. For pregnant women, data are not provided for the specific years of the project, making attribution of those observed results to project-financed interventions difficult. Also, HIV prevalence is a flawed indicator, as it conflates incidence with mortality and migration; however, in this case, in a context of decreased mortality, it is reasonable to assume that declining prevalence is an acceptable proxy for declining number of new cases.

Outputs:

- Training was conducted on depression, home-based case, syndromic management for HIV/AIDS, and post-exposure prophylaxis. Health care workers were trained on the management of opportunistic infections. Treatment sites were refurbished to ensure that sites were positioned to implement a multidisciplinary, holistic approach to treatment and care.
- Ten people were trained at the American University of Peace Studies in areas related to home-based care. Several hundred care providers were sensitized on issues of stigma and discrimination.
- Training was provided to an unspecified number of PLWHA in various vocations skills, to empower income-generating activities.
- The project provided technical assistance on legislation and policy to address HIV/AIDS stigma and discrimination. CSOs reached 4,229 people with messages promoting reduction of stigma and discrimination.

Outcomes:

- Home-based care and support services were provided to more than 90 PLWHA, including nutrition support (food hampers, vitamins, hot meals, counseling); education sessions on nutrition, adherence, STI management, and re-infection; psychosocial counseling and support; vocational skills training and access to small loans; home-based health care; and hospital day visits. The number of persons receiving home palliative care following national standards increased from 280 in 2005 to 826 in 2009, against a target of 1,150. However, the project was able to identify only 826 persons in need of home palliative care, and 100% of those persons were provided with the needed care, thus the target was over-estimated. CSOs provided this care to 672 of these 826 people.
Mitigate the negative impact of HIV/AIDS on persons infected with and affected by the disease: Modest.

**Outputs:**
- The ICR was unable to determine the percentage of orphans and vulnerable children (OVCs) whose households received free, external basic support in caring for the child. This indicator, for which a target of 60% was set, was not monitored because UNGASS recommends that it be monitored by countries with national HIV prevalence greater than 5%. CSOs reached 2,141 OVCs with nutritional support; 459 with shelter and care; 543 with psychosocial support; 791 with school assistance packages; and 627 with educational/vocational training.

**Outcomes:**
- The ratio of current school attendance among orphans to that among non-orphans aged 10-14 years increased from zero in 2005 to 1:1 in 2007, against a target of 1:1 for 2009. The 1:1 ratio indicates that 100% of orphans are attending school. No data are provided for 2009.

5. **Efficiency (not applicable to DPLs):**

Efficiency is rated Substantial.

An economic analysis was conducted (ICR, pp. 34-37), using a comparative analysis of with-project and without-project scenarios to determine the net benefit associated with the project. Under the assumptions used in the analysis, the HIV prevalence rate among the general population would have reached 3.11% in the absence of project-financed interventions, versus the current actual 1.9% prevalence rate. The stream of cost and benefit yielded an internal rate of return (IRR) of 43.8%, and a net present value of US$ 15.31 million, assuming a 10% discount rate. The measure of cost-effectiveness in this analysis is the ratio of project costs to a health-related outcome that can be attributed to the project: HIV infections averted, and years of life saved. The calculation yields $6,162 for each HIV infection averted.

The ICR (pp. 4, 16) states that CSOs worked largely with high-risk groups, but it does not provide precise data on these interventions, nor does it indicate whether these interventions were focused on prevention activities; prevention interventions targeted at groups most likely to spread HIV are known to be the most efficient means of curbing the epidemic in a low-prevalence environment.

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:**

The project was well designed, and its objectives and design were substantially relevant. It achieved its objectives with substantial efficacy for three of four objectives and substantial efficiency. The percentage of deaths in the country attributable to AIDS decreased markedly, and care and support were provided to people infected or affected by the virus.

a. **Outcome Rating**: Satisfactory

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

Political risk is low. The National HIV/AIDS Program enjoys support at the highest levels of government, and the 2007-2011 NSP is firmly established as a programmatic priority.

Financial risk is moderate. Guyana is currently the recipient of US$ 34 million from the Global Fund and applied in October 2010 for additional resources from the United States Agency for International Development (USAID). For this reason, there will be no follow-on Bank-financed HIV/AIDS project. The project’s PMU is continuing to implement Global Fund-financed activities. 14 staff positions in the Health Services Development Unit are being financed by the Global Fund, and the MOH is currently considering funding most or all focal points within line ministries with Global Fund resources. It is questionable whether the government would be able to sustain current levels of activity in the
Institutional risk is also moderate. Guyana’s President continues to chair the PCHA, which includes nine sector ministers and representatives from the private sector and international community. However, PCHA meetings are not as regular as they were when the institution was first established in 2004.

### a. Risk to Development Outcome Rating: Moderate

#### 8. Assessment of Bank Performance:

**Quality-at-Entry:**
- A Quality Assurance Group (QAG) review found Quality at Entry to be Moderately Satisfactory. Preparation involved a wide array of stakeholders, including extensive consultations with indigenous peoples; and Indigenous People’s Development Plan (IPDP) was developed as part of the project. Project design incorporated lessons outlined in the Caribbean Multi-Country AIDS Program (MAP), including (PAD, pp. 7-8): (a) ensuring the highest level of political commitment from the government; (b) embarking on a comprehensive approach to prevention, treatment, and care, but putting the major emphasis on prevention as the most cost-effective means of managing the epidemic; (c) recognizing behavior change as a key prevention intervention; (d) strengthening surveillance and M&E to be able to scale up the national response; (e) ensuring agreement on an operational manual for the first year of project operation; (f) earmarking funds to support line ministries and CSOs; and (g) giving priority to fiduciary mechanisms and contracting when in-house capacity was inadequate. The PAD (p. 13) also identified key risks and proposed effective mitigation measures, including three risks rated as Substantial: that stigma and discrimination would slow down the expansion and use of services; that there would be insufficient capacity among line ministries, the private sector, and CSOs; and that PMU capacity would be inadequate. Given data indicating that HIV prevalence was highest among female CSWs and STI clinic attendees, project design that focused on these groups was appropriate.
- The project’s design indicated that emphasis would be placed on prevention interventions among high-risk groups, and several of the key performance indicators (PAD, pp. 24-26) focused on these groups; however, these indicators targeted HIV prevalence, which is known to be a flawed proxy for tracking the rate of new infections. It appears that none of the revised indicators tracked behaviors or outcomes among high-risk groups.
- A fast-track approach to preparation meant that key fiduciary and M&E staff were not in place from the outset; the project would have benefited from regional or international recruitment for these positions, given the limited human resources pool in Guyana. The lack of key staff contributed to initial challenges on fiduciary matters and project monitoring; however, these problems were relatively quickly and effectively overcome during implementation.

**Supervision:**
- The project was managed by two Task Team Leaders (TTLs), and the transition between them was smooth. Supervision missions were regular and contained appropriate specialists, including technical M&E specialists from the Global AIDS Monitoring and Evaluation Team (GAMET). The team was proactive in addressing project challenges through three amendments to the DGA: (a) the team addressed disbursement challenges by increasing the authorized allocation of the Special Account, to ensure that funding was available to keep pace with project implementation; (b) the team reallocated funding from ARVs to CSOs and non-health line ministries, in response to increased availability for ARVS from the Global Fund; and (c) the team made some of the savings on ARVS available for construction of a medical warehouse. Environmental safeguards were implemented although it is unclear that they have been applied nationally; the project team added information that the project complied fully with environmental safeguards. While inclusion of indigenous peoples was planned early in the project, implementation of the Indigenous People's Development Plan was not given sufficient attention until 2006; the project team added information that these delays were due to necessary capacity-building prior to implementation.

### a. Ensuring Quality-at-Entry: Satisfactory

### b. Quality of Supervision: Satisfactory

### c. Overall Bank Performance: Satisfactory

#### 9. Assessment of Borrower Performance:

**Government:**
- Political commitment was high throughout, although the PCHA meets less regularly than it did when established in 2004. The government remained committed to the development and implementation of the...
Within the first six months of the project, a national M&E plan was developed in consultation with civil society, including PLWHA. It includes a data collection and analysis strategy, behavioral surveillance, HIV surveillance, and routine program monitoring. It was agreed at the project launch workshop that the project indicators would continue to be monitored, but they should be revised and harmonized with the national HIV/AIDS M&E Framework 2007-2011 being developed. An M&E Technical Working Group was key to promoting ownership and coordinating activities.

At the time of project launch, the position of director of M&E in MOH was vacant, and no appropriate candidates were identified after two searches. As an interim measure, the United States Centers for Disease Control and Prevention (CDC) and the Global Fund provided M&E technical staff on several occasions, but not on a continuous basis. By the end of the project, the Director of the National AIDS Program Secretariat (NAPS) played a continuous and strong leadership and hands-on role in monitoring the epidemic and project implementation, but there were still no dedicated M&E staff to support the program.

In May 2008, a GAMET M&E specialist reviewed the objectives to ensure their alignment with the harmonized M&E framework and NSP. As a result, an M&E Operational Plan was finalized, printed, and disseminated. The M&E Technical Working Group met on a regular basis. It held trainings, including capacity building on data analysis. The first module of an M&E curriculum was developed. Biological and Behavior Surveillance Surveys (BBSS) were conducted among CSWs, MSM, in-school youth, out-of-school youth, police, and the military. A National Indicator Target Setting Workshop was conducted at the end of 2009. An M&E report on HIV, including surveillance data, was published at least annually. A Universal Access Report and Early Warning Indicators Report was completed in 2008. Data gathering for an HIV/TB Care and Treatment Client Satisfaction Survey was completed during the latter part of 2009. The country’s first-ever Demographic and Health Survey (DHS) was implemented in 2009.

An M&E system for CSOs was developed, with data collection tools and monthly reporting formats, and it was implemented in collaboration with the NAPS and HDSU. There was a harmonized list of indicators for implementers of HIV subprojects. 51 persons from 30 organizations were trained on this system. However, the ICR does not report data on the specific focus of CSO activities involving high-risk groups.

An HMIS was developed and implemented in four hospitals. A central national database with HIV-related data was set up; it is an Excel spreadsheet and is managed by the M&E Unit of the National TB Program.

M&E Utilization:
- The ICR (p. 10) reports that the project used M&E data to monitor implementation performance by line ministries.
and CSOs. Also, special programs were put in place to address issues raised by the BBSS surveys, including continued support by the Ministry of Home Affairs for prevention interventions.

**a. M&E Quality Rating**: Modest

### 11. Other Issues (Safeguards, Fiduciary, Unintended Positive and Negative Impacts):

#### Safeguards:
- The project had a Category “B” environmental rating and triggered OP/BP/GP 4.01. An assessment of Health Care Waste Management (HCWM) was prepared in January 2004 and recommended an HCWM plan (PAD, pp. 73-86). As part of the DGA amendment supporting medical warehouse construction, an Environmental Assessment was conducted, resulting in the introduction of environmental rules governing contractors, bidding documents, contracts, and work orders. A hydroclave system was procured, installed, and is fully functional at the Georgetown Hospital Corporation for the appropriate disposal of biomedical waste for Central Georgetown and its environs, with the possibility of expanding those services to other Regions. A supporting transportation system was also procured and is in place. According to Regional comments the project was in compliance with environmental safeguards.

- The DGA required that an Indigenous People’s Development Plan (IPDP) be carried out, applying OD 4.20. The plan (PAD, pp. 87-99) aimed to provide culturally appropriate HIV/AIDS prevention, treatment, care, and IEC/BEE activities to reach the Amerindian communities who live in 131 highly scattered communities, many of them sparsely populated, throughout the country. The IPDP was completed in March 2006; however, little was done to implement it until the October 2006 supervision mission. According to the project team, this delay was deliberate, to provide time for necessary capacity-building prior to implementation. As of the mid-term review in May 2007, significant progress was made in most of the relevant regions, with prevention measures undertaken by the MOH, Ministry of Amerindian Affairs, and CSOs.

#### Fiduciary:
- Financial management initially presented challenges due to lack of human resources. Once a financial management specialist was hired, by the October 2006 supervision mission, overall financial management had improved, with a Bank financial management specialist providing support and follow-up. Counterpart funding was a challenge; “Government counterpart funding had not been included in the budget estimates at the time, which led the HDSU to prefinance the Government’s share of some project expenditures from the Special Account. The Government later reimbursed the Special Account in the amount of US$ 13,971, but this raised issues about how the Government would be able to fulfill its US$ 1.0 million counterpart funding obligation. This is what led to the second amendment of the DGA, which increased the disbursement percentages for Category 1 (Works), Category 2 (Goods), and Category 4 (Laboratory Reagents) from 80 percent to 100 percent. Moreover, this simplified payment mechanisms by eliminating the need to issue two checks for contracts in these categories” (ICR, p. 11). The ICR does not discuss audits. The project team confirmed that for 2006-2009, audits were on time and unqualified, and results for the 2010 audit are pending.

- Procurement was similarly challenged due to human resource deficits in the early phases of implementation. According to the ICR (p. 11), by mid-term, these problems were addressed, as the HDSU developed a mechanism to monitor progress; it met weekly to review procurement progress, and monthly to address project implementation issues. A monitoring system for all donor-funded contracts was developed. One critical issue raised by the Bank’s procurement specialist was the need for HDSU fiduciary staff to have regular, unlimited access to consultant contracts; these had remained in the HDSU Executive Director’s office, but they should normally be maintained by the procurement unit to ensure transparency and fiduciary oversight. At the time of the interviews conducted for preparation of the ICR, remedies recommended during supervision missions had not yet been fully implemented; the project team confirmed that the HDSU Executive Director continued not to follow the Bank’s advice on this matter.

### Ratings:

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<th>ICR</th>
<th>IEG Review</th>
<th>Reason for Disagreement /Comments</th>
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<td><strong>Outcome</strong></td>
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<tr>
<td><strong>Risk to Development Outcome</strong></td>
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</tbody>
</table>
procurement specialist was the need for HDSU fiduciary staff to have regular, unlimited access to consultant contracts; these had remained in the HDSU Executive Director’s office, but they should normally be maintained by the procurement unit to ensure transparency and fiduciary oversight. At the time of the interviews conducted for preparation of the ICR, remedies recommended during supervision missions had not yet been fully implemented; the project team confirmed that the HDSU Executive Director continued not to follow the Bank’s advice on this matter. See Section 11.

Quality of ICR: Satisfactory

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:

Attention must be paid to the “dis-economies” of small scale. Even small-scale projects require adequate skills for oversight of fiduciary matters and project implementation progress. In small countries with less human capacity, regional approaches can compensate by widening the pool of candidates and realizing economies of scale for training.

Small countries are particularly vulnerable to macroeconomic shocks, requiring careful risk analysis and contingency planning. It is important for small states to have costed National AIDS Strategic Plans that allocate funds appropriately, and that can flexibly reallocate resources if faced with unforeseen economic and financial challenges.

Disease-specific projects can and should support broader health sector support activities. In this case, the project’s support for the HIMS, M&E methodology, and managerial functions contributed to the overall strengthening of the country’s health system and made a long-lasting contribution to evidence-based policy making.

A decision to fast-track an HIV/AIDS operation should be made with consideration not only for the urgency of the need to address the epidemic, but also for the possible longer-term consequences of inadequate preparation. In the long run, limited human resources and absorptive capacity can result in a situation where the cons outweigh the pros of rapid preparation.

14. Assessment Recommended? ☐ Yes ☒ No

15. Comments on Quality of ICR:

The ICR is clear, concise, and evidence-based. Its economic analysis is thorough and explicit about the assumptions used. The lessons presented (pp. 22-23) are comprehensive and useful. The ICR does not provide a clear, complete comparison of the original versus the revised key performance indicators. It should also have discussed safeguards more fully.

Quality of ICR Rating: Satisfactory