1. Project Data:

<table>
<thead>
<tr>
<th>Country:</th>
<th>St Vincent &amp; Grenadines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project ID:</td>
<td>P076799</td>
</tr>
<tr>
<td>Project Name:</td>
<td>St. Vincent and The Grenadines HIV/AIDS Prevention And Control</td>
</tr>
<tr>
<td>Project Costs (US$M):</td>
<td>Appraisal: 8.75, Actual: 8.66</td>
</tr>
<tr>
<td>L/C Number:</td>
<td>C3946; CH111; L7251</td>
</tr>
<tr>
<td>Loan/Credit (US$M):</td>
<td>Board Approval Date: 07/06/2004, Closing Date: 06/30/2009</td>
</tr>
<tr>
<td>Sector Board:</td>
<td>Health, Nutrition and Population</td>
</tr>
<tr>
<td>Cofinancing (US$M):</td>
<td>Board Approval Date: 07/06/2004, Closing Date: 04/30/2011</td>
</tr>
<tr>
<td>Sector(s):</td>
<td>Central government administration (61%); Health (28%); Other social services (11%)</td>
</tr>
<tr>
<td>Theme(s):</td>
<td>HIV/AIDS (33% - P); Tuberculosis (17% - S); Population and reproductive health (17% - S); Participation and civic engagement (17% - S); Nutrition and food security (16% - S)</td>
</tr>
</tbody>
</table>

Prepared by: Judyth L. Twigg; Reviewed by: George T. K. Pitman; Soniya Carvalho; Group: IEGPS1

2. Project Objectives and Components:

a. Objectives:

According to the Loan Agreement (LA, p. 20) and the Project Appraisal Document (PAD, p. 4), the project’s objective was "to assist the Borrower in controlling the spread of the HIV/AIDS epidemic through: (a) the scaling up of programs for the prevention of HIV/AIDS, targeting in particular both HIV/AIDS high-risk groups and the general population; (b) the scaling up of programs for the treatment and care of people living with HIV/AIDS; (c) the reduction of the degree of stigma and discrimination associated with HIV/AIDS; and (d) the strengthening of the institutional capacity of the Ministry of Health and Environment (MOHE), other related government agencies, and civil society organizations to ensure the effectiveness and sustainability of the project."

The project team stated that during implementation, the project was understood to have four objectives, those listed as (a) through (d) above. However, (a) through (d) above are clearly outputs, intended to achieve the project's sole outcome/objective, "to assist the Borrower in controlling the spread of the HIV/AIDS epidemic." This review will therefore treat (a) through (d) as outputs, or the means to achieve the objective of controlling the spread of infection.

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

No

c. Components:

The project contained four components:

1. Scaling up the HIV/AIDS response by civil society organizations (CSOs) (appraisal: US$ 0.98 million; actual: US$ 0.33 million, or 34% of planned). Civil society groups such as non-governmental organizations (NGOs), community-based organizations, faith-based organizations, and the private sector were to be funded to reach various groups, including those at high risk for contracting and spreading HIV (commercial sex workers (CSWs), men having...
The closing date was extended twice. The first extension, on June 17, 2009, moved the closing date to December 31, 2010, to provide additional time to complete planned activities. It also aligned the legal agreements with the PAD to include provisions for civil works, refurbishment of 18 VCT rooms, and construction of a new orphanage in Georgetown. On December 23, 2010, the closing date was extended to April 30, 2011. This extension was to allow for completion of activities after unforeseen delays due to national elections and Hurricane Tomas and to review and approve the contract for health management information system hardware equipment.

2. Scaling up the response by line ministries (appraisal: US$ 1.60 million; actual: US$ 0.51 million, or 32% of planned). Support to line ministries, in accordance with the country’s 2004-2009 National Strategic Plan for AIDS, was to include cross-cutting activities focusing on prevention of HIV/AIDS and sexually transmitted infections (STIs) through training, information/education/communication (IEC)/BCC, condom distribution, treatment and care for infected and affected families, workplace policy formulation (including reduction of stigma and discrimination), and HIV/AIDS impact assessments. Also planned were HIV/AIDS-related interventions specific to each ministry’s external clients, for example, students, teachers, and parents for the Ministry of Education. Interventions were to be tailored by each of the ministries to their respective clients.

3. Expanding health sector prevention, treatment, and care services for HIV/AIDS (appraisal: US$ 3.48 million; actual: US$ 5.43 million, or 156% of planned). Support for strengthening, upgrading, and expanding prevention, treatment, and care services through the health care system was to include: upgrading of laboratories to enable in-country HIV testing; establishment of voluntary counseling and testing (VCT) rooms; training of health care workers and counselors; provision of equipment, drugs, supplies, testing kits, and condoms; provision of technical assistance (TA) for IEC/BCC, VCT, condom distribution, blood supply safety, treatment of STIs and opportunistic infections, treatment with anti-retroviral medications (ARVs), development of a program for prevention of mother-to-child transmission (PMTCT), laboratory services, biomedical waste management, development and implementation of standardized protocols and guidelines for HIV/AIDS care, and strengthening of the existing HIV/AIDS legal framework to prevent discrimination.

4. Institutional capacity strengthening, monitoring, evaluation, and research (appraisal: US$ 2.55 million; actual, US$ 2.38 million, or 93% of planned). Support included institutional capacity building for scaling up the response through financing of technical advisory services, training, staffing, equipment, goods, and general operating costs, aimed at improving coordination and management of the Government’s National HIV/AIDS Program through the National AIDS Council and its operating arm, the National AIDS Secretariat. M&E was also to be strengthened, through support for monitoring program implementation, epidemiological surveillance, and establishing the HIV/AIDS/STI clinical management information system and required information technology platforms for the country’s main public hospital and for 18 selected VCT health centers.

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

Project Cost: The project spent significantly more than expected on Component 3, and less than expected on Components 1 and 2. Funds allocated to purchase antiretroviral drugs remained unspent, as the country received these drugs through the Organization of Eastern Caribbean States Global Fund project and donations from the Government of Brazil. Also, uptake of funds from CSOs and line ministries was much lower than anticipated. The project team added that increased costs for Component 3 were due to expenditures on civil works that were not originally planned (including conversion of the Stubbs Health Center into a polyclinic), and higher-than-anticipated costs for planned civil works. In addition, in June 2009 funds were reallocated among disbursement categories of eligible expenditures to address increased project costs, including expenses already incurred in upgrading health clinics and the National AIDS Secretariat building, and future project needs, such as civil works related to the Bread of Life orphanage construction (ICR, p. 5).

Financing: The US$ 7 million provided by the Bank was blended as follows: 50% IBRD Loan, 25% IDA Credit, and 25% IDA Grant. The IDA Credit for US$1.75 million increased to US$ 1.95 million by closing as a result of the appreciation of the US$ against Special Drawing Rights. Similarly, the IDA HIV/AIDS Grant increased from US$1.75 million to US$1.87 million. In compensation, the more expensive IBRD Loan of US$ 3.50 million was reduced to US$2.68 million by cancellation of US$0.82 million. Overall, of the planned Bank financing of US$ 7.00 million, US$6.51 was disbursed.

Borrower Contribution: The Borrower financed US$ 1.87 million, more than the planned US$ 1.75 million contribution.

Dates: The closing date was extended twice. The first extension, on June 17, 2009, moved the closing date to December 31, 2010, to provide additional time to complete planned activities. It also aligned the legal agreements with the PAD to include provisions for civil works, refurbishment of 18 VCT rooms, and construction of a new orphanage in Georgetown. On December 23, 2010, the closing date was extended to April 30, 2011. This extension was to allow for completion of activities after unforeseen delays due to national elections and Hurricane Tomas and to review and approve the contract for health management information system hardware equipment.
3. Relevance of Objectives & Design:

a. Relevance of Objectives:

**Substantial.** At appraisal in 2004, a total of 796 HIV cases had been reported (of an estimated total country population in 2004 of 103,330, and a prevalence rate of 0.77%), with 54% of those having developed AIDS-related diseases and a case fatality rate of 51%. The objectives are substantially and currently relevant to the Bank’s Regional Partnership Strategy for the Organization of Eastern Caribbean States for 2010-2014, which emphasizes the importance of continued effort to improve health services and systems, including those that involve HIV/AIDS. The objectives are also substantially relevant to the St. Vincent and Grenadines National Strategic Plan for HIV/AIDS for 2010-2014, which continues to implement the multi-sector strategy that was begun in 2005; this strategy’s three main goals are reducing the transmission of new HIV infections, mitigating the impact of HIV/AIDS on the population, and achieving a sustained, effective, multi-sectoral infrastructure to support the national response.

b. Relevance of Design:

**Modest.** The project’s components were not well aligned with the objective of controlling the spread of HIV/AIDS. Activities oriented toward prevention were not well organized to ensure that behaviors at highest risk of transmitting HIV were addressed, which is key to achievement of the prevention objective. There was ambiguity in project design regarding which agencies would address prevention among which populations. It was not made clear in the project’s design how line ministry and demand-driven CSO activities would be brought to bear on the most effective and efficient ways of controlling the spread of HIV. Although treatment of infected persons can reduce the probability of HIV transmission, it is not an efficient way to do so; the main benefits of treatment are to increase life expectancy and improve quality of life for those infected, which were not objectives of this operation. If the project anticipated achievement of these benefits, then it should have been restructured to include them as part of the development objectives.

4. Achievement of Objectives (Efficacy):

The ICR (p. 12) states that, although the Bank was only one of several development partners working on HIV/AIDS in the country, its involvement “largely solidified” the National Response Program and allowed many complementary prevention and treatment activities from other organizations to materialize and realize synergies. The ICR does not report the activities that other donors were financing or their levels of spending, but the project team clarified that the project accounted for 85% of funding for HIV/AIDS during the project period, making it reasonable to attributed observed outcomes to project-financed interventions.

The ICR does not present meaningful data on behavior change, particularly among high-risk groups, and project-financed activities appear not to have substantially reached high-risk groups.

**Control the spread of the HIV/AIDS epidemic:** Modest.

**Outputs:**

*Scaling up of prevention programs:*

The number of line ministries that have implemented work plans according to the National HIV/AIDS Strategic Plan increased from 2 in 2005 to 10 in 2010, exceeding the target of 9. Line ministries were supported in the introduction of workplace policies, education and sensitization activities, training, and workshops.

Information/education/communication and behavior change communication (IEC/BCC) activities were implemented, including recruitment of an IEC/BCC specialist, development of a draft BCC strategy, development and dissemination of materials, installation of billboards, convening of public school speaking competitions on HIV/AIDS themes, producing and airing of media programs (television, radio, and newspapers), placement of HIV/AIDS messages on promotional items, participation in Health and Wellness Weeks and World AIDS Days, and launching of several awareness campaigns to reduce stigma and discrimination.

Training programs were conducted in a large number of areas, including VCT, HIV rapid testing, provider-initiated testing and counseling, and basic HIV/AIDS education. The number of public facilities staffed by trained counselors providing specialized HIV counseling and testing increased from 18 in 2004 to 39 in 2010, meeting the target. Of these 39 public facilities, 19 provide rapid testing. 8,927 individuals were tested for HIV over the lifetime of the project, exceeding the target of 2,000. The number of infected and affected individuals who received supportive counseling in the previous 12 months increased from 267 in 2006 to 3,781 persons in 2009. However, only 1,863
were counseled in 2010, falling short of the target of 4,000. The reasons for the decline in 2010 are not given in the ICR.

2,017,335 condoms were distributed, exceeding the target of two million. Mass education campaigns (content and coverage unspecified) were conducted. 19 condom-dispensing machines were installed island-wide, at bars frequented by at-risk population groups. Information sessions on HIV prevention were provided to taxi driver associations and tourism industry workers.

The national laboratory continued to test 100% of all donated blood according to World Health Organization guidelines.

CSOs conducted sensitization, education, and awareness activities, primarily targeting youth. CSOs also developed training manuals and other materials for pre-school centers, aired HIV/AIDS-related radio dramas and jingles, targeted youth with camps and workshops, held activities such as rallies to address stigma and discrimination, and held workshops and training programs targeting churches.

The percentage of primary, secondary, and tertiary level students receiving upgraded life skills and HIV/STI prevention instruction at least twice monthly increased from 22% in 2005 to 100% in 2010 for primary and secondary level private schools, meeting the target. The project team confirmed that no data are available for private and tertiary level schools.

No data were available on two of the project’s key performance indicators related to prevention: the percentage of taxi drivers’ associations implementing workplace prevention programs; and the percentage of businesses in the tourism industry with workplace programs for HIV/AIDS education among staff.

Treatment and care programs:

In 2004, the Government adopted Clinical Guidelines for the Care and Treatment of HIV-Infected Persons in the Caribbean.

23 health facilities were rehabilitated using project funds, exceeding the target of 21.

An HIV/AIDS/STI clinical management information system was developed as part of the health management information system for the main public hospital and for health centers.

The number of CSOs contracted to provide care for PLWHA and their families increased from 3 in 2004 to 14 in 2010, against a target of 15.

Support was provided for treatment of opportunistic infections, provision of second-line anti-retroviral drugs, nutritional interventions for PLWHA, procurement/storage/distribution of pharmaceuticals/equipment/supplies required for effective management of HIV/AIDS, strengthening of laboratory capacity, and training of health care workers on HIV treatment protocols. However, the number of health care facilities that have the capacity to deliver palliative care, treatment, and referral for HIV-infected patients according to national guidelines, and that provide ARVs, remained at one (the Main Hospital), not reaching the target of 3. Budget constraints resulting from the global financial crisis prevented the Government from fully implementing its plan for all three centers.

The number of PLWHA receiving ARV treatment increased from 36 in 2004 to 204 in 2010, exceeding the target of 180. The cumulative number of persons on treatment increased from 115 in 2004 to 474 in 2010, exceeding the target of 275. The ICR does not specify whether it was the project or another donor who provided the ARV drugs.

The number of orphans and vulnerable children receiving psychosocial support increased from 33 in 2004 to 127 in 2010, exceeding the target of 100.

Reduction of stigma and discrimination:

A law, ethics, and human rights national assessment was undertaken, with reports prepared on laws and policies pertaining to HIV/AIDS human rights issues and model policies and legislation. A consultant is currently developing a workplace policy on HIV/AIDS, partially achieving the indicator of creating and implementing legal and policy measures to guard the human rights of all PLWHA and their significant others.

The percentage of people expressing an accepting attitude toward PLWHA was 4% among ages 15-24 and 6% among ages 25-49 in 2006. There are no end-of-project data directly comparable to the baseline, but a 2008 Knowledge, Attitudes, and Practices (KAP) survey showed that 63% of those ages 14-17 had an accepting attitude.
toward PLWHA, saying that infected students and teachers should not be barred from school. The project team stated that this survey question was comparable to the survey question asked at baseline, and that these results are therefore indicative of progress in youth attitudes toward PLWHA.

**Strengthening of institutional capacity:**

According to the ICR (p. 26), the national policy development process "has started and is ongoing." According to the project team, the 2010-2014 National HIV/AIDS Strategic Plan, developed with Bank support, has set an effective framework for continued policy development and institutional capacity development.

**Outcomes:**

The ICR reports that the number of new HIV cases decreased from 108 in 2004 to 64 in 2010, exceeding the target of < 100/year. If these data capture the number of people who were tested and received a positive test result each year, they are not indicative of prevention success. There is no way to know how recently those infections occurred or what percentage of all people with HIV infection were accessing testing services.

The total number of AIDS cases decreased from 75 in 2004 to 33 in 2010, exceeding the target of a 15% decrease. The number of new AIDS cases decreased from 40 in 2004 to 25 in 2010. The HIV/AIDS case fatality rate decreased from 63% in 2003 to 13% in 2010, exceeding the target of 40%. The ICR does not specify over what time period this indicator was measured (time from diagnosis to fatality). It is not clear how many new cases of HIV were prevented as a result of treatment interventions.

The percentage of women counseled and tested as part of antenatal care increased from 58% of pregnancies in 1999/2000 to 99% in 2010. The percentage of pregnant women who are HIV+ provided with treatment and care fell from 95% in 2004 to 82.4% in 2010, but these percentages reflect very small denominators; in 2010 there were 17 HIV+ pregnant women and three missing cases: one premature delivery who never received ARVs, and two women who never attended antenatal care clinics. In 2007, 100% of pregnant women received treatment, and 95% of pregnant women received treatment in 2008. The number of HIV+ pregnant women was not reported for years other than 2010. All babies born to HIV+ mothers during the life of the project were provided with testing and treatment, with a mother-to-child transmission rate of 0%. The ICR does not report the number of babies who were born to HIV+ mothers during the life of the project.

The ICR presents data that are not comparable across two points in time (2006, and 2007/2008) for age of first sexual contact, condom use, and number of sex partners. Because the data are not comparable, and because the ICR does not provide end-of-project data, the information cannot be used to assess prevention outcomes.

The ICR provides percentage reduction figures for gonorrhea (53% reduction), syphilis (24% reduction), and Chlamydia (84% reduction) over the life of the project, but it does not provide actual baseline and endline data, and it does not specify the population from which these data are drawn.

The ICR presents data that are not comparable across two points in time (2006, and 2007/2008) for age of first sexual contact, condom use, and number of sex partners. Because the data are not comparable, and because the ICR does not provide end-of-project data, the information cannot be used to assess prevention outcomes.

The ICR does not report data on prevention outcomes such as coverage or access of high-risk groups to prevention services, knowledge about and use of condoms among high-risk groups, or the number of partners among high-risk groups.

**5. Efficiency:**

Efficiency is rated Modest. The ICR (pp. 34-38) carried out a cost-benefit analysis comparing scenarios with and without the project. The analysis estimated HIV infections averted, resulting in quantifiable benefits of averted productivity losses and savings on inpatient care and on treatment of opportunistic infections. The stream of costs and benefits from the project yielded an internal rate of return (IRR) of 41.3% and a net present value (NPV) of US$9.48 million (based on a 10% discount rate). The calculation yielded $15,725 for each HIV infection averted and $476 for each year of life saved. The analysis is based on a number of assumptions: that without the project, HIV cases would continue to rise as they had from 1984-2004; and that the project was largely responsible for observed reductions in the number of new HIV cases after 2007, and that those trends would continue. However, attribution of trends to project-financed interventions is difficult, since the project did not effectively reach high-risk groups and has not provided meaningful evidence of behavior change.

The ICR (p. 14) states that "it remains unclear what impact the project had on high-risk groups such as men having sex with men; prevention interventions among groups most likely to spread infection are the most efficient way to curb the spread of the epidemic. As the ICR states (pp. 15-16), "a more focused approach, wherein only line ministries that reach the key high-risk groups could be involved, for example, might have been more efficient."

As
Implemented, the project may have allocated resources to a larger number of line ministries than was optimally efficient, and it spent a large share of resources (more than planned) on treatment, which is a very costly way of preventing the spread of the epidemic. Any prevention benefits achieved by the project do not appear to have been achieved at least cost.

<table>
<thead>
<tr>
<th>Rate Available?</th>
<th>Point Value</th>
<th>Coverage/Scope*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appraisal</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>ICR estimate</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

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

6. Outcome:
Based on substantial relevance of objectives, modest relevance of design, modest achievement of the objective of controlling the spread of HIV/AIDS, and modest efficiency, the project’s Outcome is rated Moderately Unsatisfactory. The project financed interventions in the health sector and across a range of line ministries and CSOs, resulting in the development of new policies. It could have more effectively targeted resources and strengthened CSO capacity toward interventions reaching high-risk groups. As a result, there is limited evidence of behavior change among the high-risk groups that are key to preventing the spread of the epidemic. Project resources were focused on interventions aimed at the general population and at treatment of those already infected, which are not cost-effective ways of achieving the primary development objective.

6a. Outcome Rating: Moderately Unsatisfactory

7. Rationale for Risk to Development Outcome Rating:
There is continued risk to achievement of the primary objective of preventing the spread of HIV, as the groups practicing the riskiest behavior were not reached, and it was demonstrated mid-project that infection rates were higher than previously believed among these groups. It is not clear that the Government, or other donors, are currently reaching these populations.

The Government has approved and is currently implementing its National Strategic Plan for 2010-2014. This plan outlines a resource mobilization strategy involving fund-raising activities with development partners, Government, and the private sector. The country continues to benefit from technical and financial assistance from the United States President’s Emergency Plan for AIDS Relief to support laboratory and health systems strengthening and prevention programs, as well as from the Global Fund to support care and treatment. Bank support such as training opportunities for fiduciary and technical staff enhanced the country’s institutional capacity, and National AIDS Secretariat staff have moved to permanent Ministry of Health and Environment structures, which should promote continuity of key program interventions. Clinics have been staffed with trained counselors, enhancing the probability that patients with HIV will be diagnosed early and improving the quality of treatment. Guidelines on standards of care, treatment, and referrals are in place. The health management information system is installed or being installed in 39 health clinics in districts across the country, and it is currently being expanded to include programs housed in other ministries. However, there is general consensus (ICR, p. 9) that more work needs to be done to minimize stigma and discrimination, that line ministries whose external clients provide access to high-risk groups should be better engaged, and that links with CSOs should be further strengthened so that their activities can be sustained beyond the project’s financial and technical support.

7a. Risk to Development Outcome Rating: Moderate

8. Assessment of Bank Performance:

8a. Quality at entry:
The PAD cited lessons learned from other HIV/AIDS projects in the Caribbean and the Africa Region (PAD, pp. 7-8), including the need for: (i) high-level political commitment and leadership; (ii) a comprehensive approach to prevention, treatment, care, and support; (iii) awareness of rapidly changing prices and technology of AIDS-related items; (iv) M&E to provide timely information for scaling up the national response; (v) attentiveness to slow start-up within projects; (vi) recognition of all stakeholders; and (vii) building a strong fiduciary architecture. In addition, the project took into account the challenge of working in a small country with limited
human resources, as highlighted in the Country Assistance Strategy (CAS) for the Eastern Caribbean Sub-Region in 2001; for example, the need for training and intensive implementation support was identified. Project components were structured around implementing agencies, creating a clear division of labor that made specific agencies responsible for particular activities, with corresponding financial resources; this eliminated confusion that has sometimes characterized other projects related to who was responsible for achieving what results.

However, lessons about the need to reach high-risk groups appear not to have been adequately incorporated into project design. The project's inclusive multi-sector approach may have spread resources unnecessarily thin, working through a large number of line ministries in a very small country; according to the ICR (pp. 15-16), “the experience from project implementation now indicates that a more focused approach, wherein only line ministries that reach key high-risk groups were involved, for example, might have been more efficient.” Also, according to the ICR (p. 16), other existing multisector HIV/AIDS programs in the Caribbean could have better informed project design. The Bank should have anticipated that coordinating multiple stakeholders would be transactions-intensive. Risks were adequately identified (PAD, p. 12), including the risks that project implementing agencies would not have sufficient authority, leadership, and capacity to meet project objectives; that stigma and discrimination would slow the expansion and use of resources; and that CSO, line ministry, and National AIDS Secretariat/Project Coordination Unit (PCU) capacity would be inadequate. However, appropriate and sufficient mitigation strategies were not uniformly identified and implemented. For example, CSOs were not adequately objectively identified during project design; there was no assessment of their capacity and identification/addressing of weaknesses before implementation (ICR, p. 22), and it was not recognized that CSOs are often reluctant to focus on risk groups and tend to prefer working on care and mitigation issues. Finally, the project could have benefited from a stronger and more streamlined M&E design typical of other Bank lending projects, rather than incorporating a long list of 22 project development indicators (several of which had no baseline or target). The M&E plan was not sufficient to generate end-of-project evidence on outcomes, or to evaluate elements of the project during the course of implementation.

**Quality-at-Entry Rating:** Moderately Unsatisfactory

**b. Quality of supervision:**

The Bank team was candid in highlighting potential obstacles and offering potential solutions; the team was proactive throughout the life of the project to ensure the progress of implementation, including follow-up on the recommendation of the June 2007 Mid-Term Review (MTR). The Bank team also followed up with Government on the recommendations of the 2005 Caribbean Multi-Country HIV/AIDS Program (MAP) Review. Appropriate efforts were made to coordinate with other donors. Although the project’s Task Team Leader changed three times, there was no indication that the transitions were anything but smooth. According to the project team, the Bank team was proactive in offering training as part of supervision missions, in response to client requests to learn from other Caribbean country counterparts’ experiences in managing a national HIV/AIDS response. The project team stressed its contributions to capacity-building among CSOs (including exchange opportunities with other Caribbean countries, twinning arrangements between CSOs with shared visions, and mentoring arrangements between experienced and new CSOs), and to health systems strengthening.

However, the original set of 22 key development indicators proved to be unwieldy, resulting in a decision during implementation to focus on a smaller set of six indicators, and also to add two indicators to monitor HIV prevention knowledge and efficacy of treatment. According to the ICR (p. 3), a formal restructuring should have been undertaken to revise the key development indicators. Even more fundamentally, focus could have been placed more heavily on prevention activities targeted at high-risk groups, particularly after mid-project sero-surveys indicated that at-risk groups in the country exhibited a much higher rate of infection than the general population. Alternatively, the team could have restructured the project to include treatment and care in the development objectives, which would have aligned the objectives with what was being implemented and would have better matched the Government’s HIV/AIDS strategy. M&E implementation was not sufficient to provide data against which to measure achievement of the objective.

**Quality of Supervision Rating:** Moderately Unsatisfactory

**Overall Bank Performance Rating:** Moderately Unsatisfactory

9. Assessment of Borrower Performance:
a. Government Performance:

The Government demonstrated continued commitment throughout the life of the project to the reduction of HIV/AIDS and mitigation of its impact on the population. In general, there were no issues with counterpart funding, although budget challenges posed by Hurricane Tomas in 2010 and the global financial crisis resulted in delayed payments to contractors for the construction of an orphanage and polyclinic. According to the ICR (p. 11), the Government faced some challenges in managing non-health sector participation in the project, as coordinating multiple stakeholders proved to be more transactions-intensive than anticipated. Also, participation of the National AIDS Council was uneven over the course of implementation (ICR, p. 18); in particular, its failure to meet regularly resulted in delays in response to some CSO proposals. According to the ICR (p. 18), had the Government provided appropriate up-front orientation to the project, the working relationship between the National AIDS Secretariat and PCU could have been improved. Also, shortcomings in the project’s Operational Manual (ICR, p. 18) produced implementation delays due to lack of understanding of some procedures, roles, and responsibilities. These coordination and implementation issues were progressively resolved after the mid-term review.

b. Implementing Agency Performance:

The Ministry of Health and Education Permanent Secretary was strong and consistent in advancing project activities throughout the project. Engaging non-health ministries was a challenge throughout, mainly due to the small size of ministries and limited number of civil servants, and a widespread belief that HIV/AIDS is a health problem and should be handled through the Ministry of Health and Environment. Notable exceptions were the ministries of education, labor, and tourism/youth/sports. Despite these problems, participation improved over the course of implementation; by closing, nine non-health ministries were actively engaged in project implementation. During the life of the project, the Project Coordination Unit (PCU) experienced a number of challenges related to financial management (see Section 11). The mid-term review found that PCU capacity was insufficient, and that CSO and line ministry engagement was weak and inconsistent. The number of CSOs is small, and many are faith-based, with religious orientations preventing productive work with some high-risk groups (CSWs, men having sex with men). However, with increased support from the National AIDS Secretariat and the PCU throughout the project, CSO procurement and financial management capacity improved. The ICR does not provide details on improvements in PCU capacity following the mid-term review; the project team later added that additional support staff were hired after the mid-term review to support the PCU, and that the Bank proactively organized technical training and workshops specific to PCU staff and also made Bank procurement and financial specialists available.

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

a. M&E Design:

An M&E Plan was drafted in accordance with the National Strategic Plan, with technical assistance provided by the Bank’s Global Monitoring and Evaluation Team (GAMET). An M&E Reference Group was formed to provide a forum for stakeholder discussion of project implementation based on indicators. The project’s monitoring framework included 22 indicators, more than are usually included in a Bank lending project. Baseline data, where available, were from the country’s routine surveillance reporting from a Behavioral Surveillance Survey conducted in 2005. The PAD notes that additional baseline data from a Knowledge, Attitudes, and Practices survey of youth, workplace discrimination surveys, and key informant interviews would be used; the project team confirmed that a United Nations Children’s Fund survey among youth, a serosurveillance survey among men having sex with men, and a Population Services International survey of sexually active young males, all completed during implementation, provided additional baseline data for some specific indicators. Baseline data were not included for all indicators, and progress in achieving the project’s objectives could have been measured using fewer indicators. Overall, the M&E plan was not sufficient to generate end-of-project evidence on outcomes, or to evaluate elements of the project during the course of implementation.

b. M&E Implementation:

During the life of the project, the HIV/AIDS M&E functions were carried out by an advisor, who collected and aggregated data, generated reports, provided feedback to stakeholders, and contributed to further development of
M&E capacity among stakeholders. According to the project team, a Monitoring and Evaluation Reference Group provided a forum for stakeholder discussion of implementation based on indicators. According to the ICR (p. 8), the development and use of an M&E Manual resulted in considerable improvements in data collection and reporting over the life of the project. The M&E function was transferred from the National AIDS Secretariat to the Ministry of Health and Environment in June 2009. During implementation, the project and Government teams agreed on a simplified, shortened list of six indicators to be monitored. This agreement also added two new indicators to monitor HIV prevention knowledge and efficacy of treatment. An electronic patient monitoring system was launched in 2007 at the Care and Treatment Center in the country’s main hospital; this system provided data crucial to tracking patient progress and managing ongoing patient care. In addition, the health management information system (developed by the Ministry of Health and Environment with project support) was rolled out in 36 of 39 health clinics across the country. According to the ICR (p. 8), the country was thorough in its data collection, due largely to dedicated and dynamic staff. However, the ICR (p. 8) notes that there remains room for improvement, as evidenced by the discovery of significant errors in the documentation and calculation of such key indicators as AIDS case fatality rate for 2010. A major weakness was the failure to conduct a planned follow-up behavioral surveillance, resulting in an inability to monitor key behavioral changes and to measure progress via directly comparable baseline and endline indicators; six behavioral indicators with baseline data from the 2004 baseline could not be directly assessed because of the absence of a follow-on survey. Since June 2009, the epidemiologist performing disease surveillance for the Ministry of Health and Environment Epidemiology Unit has also been serving as the M&E advisor, which is an unsustainable double workload and a set of tasks requiring two different skill sets.

c. M&E Utilization:
Epidemiological data (including data from private laboratories) are compiled on a monthly basis into a central unit, and then analyzed and shared with the Ministry of Health and Environment and National AIDS Secretariat. This process helped the Government to respond to various reporting requirements, including the United Nations General Assembly Special Session and the Bank, as well as to produce and disseminate semi-annual and annual national reports. The health management information system generates information for decision making at the point of service through online electronic medical records, pharmaceutical supply chain management, and other modules. The ICR does not contain information on the use of M&E data for policy-making; the project team stated that M&E data were used for development of the National Strategic Plan 2010-2014, and for the preparation and review of work plans (particularly by the Ministry of Health and Environment). However, it remains unclear how project results could have been used for strategic planning related to the overall development objective of controlling the spread of the epidemic, since the project did not produce data that could measure trends in prevention outcomes or any prevention outcomes related to high-risk groups.

M&E Quality Rating: Modest

11. Other Issues

a. Safeguards:
The only safeguard policy triggered by the project was the Environmental Assessment (OP/BP 4.01). The project received a Category B environmental rating at the appraisal phase and was not expected to generate adverse environmental effects. A biomedical waste management assessment and plan for implementation were prepared in 2001, and its provisions were implemented by the Ministry of Health and Environment throughout the life of the project. The project received a Satisfactory rating in the ICR for safeguard compliance.

b. Fiduciary Compliance:
During the life of the project, the PCU experienced challenges: delayed in receiving bank statements and other documents required to prepare Financial Management Reports and Financial Statements; poor oversight and accountability in preparing monthly bank account reconciliations and in making direct payments; lack of staff to cover workload; and poor file management. An external audit in 2007 found the project’s risk level to be Substantial. Similar findings were observed in Bank supervision missions. The Bank made itself available for technical support and training as needed, and as a result financial management gradually improved, although the Bank’s financial management review in December 2010 found inconsistencies and indicated that there was still need for improvement. The ICR does not state whether audits were on time and unqualified. The project team added the audits were usually provided with a few months’ delay; however, the project team always informed the Bank team about these delays. In addition, according to the project team, financial audits were mostly unqualified, though auditors noted some weaknesses related to internal controls structure. The number of such weaknesses diminished toward the end of project implementation.

Initial delays in procurement were resolved over time. The project team added that procurement was never a major
issue, and that additional training and staff in this area were provided during implementation. Although the PCU
provided procurement orientation to participating line ministries and CSOs, delays could have been minimized or
prevented if this training had been provided earlier.

c. Unintended Impacts (positive or negative):
The health management information system supports epidemiological surveillance, documents patient health
information, and monitors indicators in a timely fashion to support evidence-based decision-making. According to the
CR (p. 14), this system could serve as a model for other countries in the region.

d. Other:

<table>
<thead>
<tr>
<th>12. Ratings:</th>
<th>ICR</th>
<th>IEG Review</th>
<th>Reason for Disagreement /Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome:</strong></td>
<td>Moderately Satisfactory</td>
<td>Moderately Unsatisfactory</td>
<td>Project design could have more effectively targeted resources toward interventions reaching high-risk groups. As a result, there is limited evidence of behavior change among the high-risk groups that are key to preventing the spread of the epidemic. Project resources were focused on interventions aimed at the general population and at treatment of those already infected, which are not cost-effective ways of achieving the development objective.</td>
</tr>
<tr>
<td><strong>Risk to Development Outcome:</strong></td>
<td>Negligible to Low</td>
<td>Moderate</td>
<td>There is continued risk to achievement of the stated objective of preventing the spread of HIV, as the groups practicing the riskiest behavior were not reached, and it was demonstrated mid-project that infection rates were higher than previously believed among these groups. It is not clear that the Government, or other donors, are currently reaching these populations.</td>
</tr>
<tr>
<td><strong>Bank Performance:</strong></td>
<td>Moderately Satisfactory</td>
<td>Moderately Unsatisfactory</td>
<td>Lessons about the need to reach high-risk groups appear not to have been adequately incorporated into project design. The project's inclusive multi-sector approach may have spread resources unnecessarily thin, working through a large number of line ministries in a very small country. M&amp;E was not sufficient to generate evidence on outcomes. The project was not realigned or restructured to ensure that the project's activities were congruent with its development objective.</td>
</tr>
<tr>
<td><strong>Borrower Performance:</strong></td>
<td>Moderately Satisfactory</td>
<td>Moderately Satisfactory</td>
<td></td>
</tr>
<tr>
<td><strong>Quality of ICR:</strong></td>
<td>Satisfactory</td>
<td></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
13. Lessons:

These lessons are derived from the ICR, with adaptation:

Shorter lists of readily measurable indicators are preferable to complex, lengthy M&E plans, particularly in environments of limited institutional and human capacity. Abundant baseline data is not useful for measuring the project's achievements if not accompanied by comparable follow-up surveys measuring the same outcomes in the same populations. As the ICR (p. 19) notes, it may be worthwhile to establish a team of experts whose main function is the oversight of M&E.

It cannot be assumed that civil society organizations have the capacity to implement effectively HIV/AIDS interventions, or that they will necessarily be willing to address prevention among groups with the riskiest behaviors. An ex-ante assessment of their implementation capacity and their willingness to take on the role of reaching target groups is needed during the design phase of a project, for the purpose of identifying capacity-building needs and ensuring that the project includes adequate means of reaching high-risk and marginalized groups.

In a small, multiple-island country with limited human resources, there is a higher-than-average risk from complexity in project design. It is necessary to recognize that coordination of multiple stakeholders is transactions-intensive, and to prioritize appropriately in terms of institutional design and planned capacity-building.

The following is an IEG lesson:

Even in a small country where stigma and discrimination against PLWHA are high, it is still crucial to target most-at-risk populations (in addition to the general population) with prevention activities aimed at behavior change. Trickle-down of prevention activities from the general population to at-risk groups cannot be assumed; there need to be specifically-targeted activities to ensure that at-risk groups have access to prevention messages, commodities, and health services. These targeted prevention activities are necessary for an effective and efficient response.

14. Assessment Recommended?  Yes  No

Why?  To verify the ratings.

15. Comments on Quality of ICR:

The ICR is unusually clear, concise, and evidence-based. It provides a careful and thorough assessment of the achievement of all indicators specified in the PAD. It does not, however, provide information on some key issues related to fiduciary compliance, and it does not address the project's design mismatch between objective and components.

Quality of ICR Rating: Satisfactory