Document of
The World Bank

Report No: ICR2594

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA)

ON

GRANTS

IN THE AMOUNTS OF

SDR 12.8 MILLION (US$19.0 MILLION EQUIVALENT) AND

SDR 3.4 MILLION (US$5.0 MILLION EQUIVALENT)

TO THE

REPUBLIC OF CONGO

FOR A HIV/AIDS AND HEALTH PROJECT (MAP2 PROGRAM)

DECEMBER 30, 2012

Human Development Sector
Health, Nutrition and Population (AFTHE)
Country Department 1 AFCC2
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective)

Currency Unit = Franc CFA (FCFA)
May 2004: US$1.00 = FCFA 1978
July 2009: US$1.00 = FCFA 3445.0

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Anti Retroviral
BCC	Behavioral change communication
KAP	Knowledge/Attitudes/Practices
CENAMES	National Agency for the Supply of Essential Drugs and Supplies
CFAF	Central African Franc
CNLS	National AIDS Committee
CNSEE	National Center for Statistics and Economic Studies
CNTS	National Center for Blood Transfusion
COMEG	Congolese Agency for Importing Essential Generic Drugs
CPS	Country Partnership Strategy
CSN	National Strategic Framework
CSO	Civil Society Organization
CTA	Treatment Center for Ambulatory Patients
DGA	Development Grant Agreement
DHS	Demographic and Health Survey
DO	Development Objective
EA	Environmental Assessment
ESIS-C	Behavioral and Sero Prevalence Survey
ESMF	Environmental and Social Management Framework
EU	European Union
FED	European Development Fund
FM	Financial Management
FMA	Fiduciary Management Agency
FMR	Financial Management Report
GAMET	Global AIDS Monitoring and Evaluation Team
GDP	Gross Domestic Product
GFATM/GF	Global Fund to Fight AIDS, TB and Malaria
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICRR	Implementation Completion and Results Report
IDA	International Development Association
IEC	Information, Education, and Communication
IEG	Independent Evaluation Group

IOI	Intermediate Outcome Indicator
IP	Implementation Progress
IPPF	Indigenous People's Planning Framework
ISR	Implementation Status Report
KPI	Key Performance Indicators
LNSP	National Public Health Laboratory
MAP	Multi-Sectoral HIV/AIDS Program
MDG	Millennium Development Objectives
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MAS	Ministry of Social Affairs
MSM	Men who have sex with men
MCTP	Mother to Child Transmission Prevention
MTR	Mid-Term Review
MWMP	Medical Waste Management Plan
NAC	National AIDS Committee
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
OI	Opportunistic Infection
OI	Outcome Indicator
PAD	Project Appraisal Document
PADEPP	Project to Decentralize and Expand Prevention and Treatment of PLWHA
PCD	Project Concept Document
PDO	Project Development Objective
PDSS	Health Sector Development Project
PES	Permanent Executive Secretariat
PHRD	Policy and Human Resources Development Fund
PLWHA	People Living with HIV and AIDS
PNLS	National AIDS Program of the Ministry of Health
POM	Project Operations Manual
PPF	Project Preparation Facility
PRAEBASE	Project to Support Primary Education
PRESIEC	Project to Prevent HIV/AIDS in Congo's Schools
PRSP	Poverty Reduction Strategy Paper
PURICV	Emergency Support Project
QAG	Quality Assurance Group
QEA	Quality at Entry Assessment
QALP	Quality Assessment of the Loan Portfolio
RGA	Revenue generating activities
SEP	Permanent Executive Secretariat (of the National AIDS Committee)
SIL	Specific Investment Loan
SOE	Statement of Expenditure
STI	Sexually transmitted infection
TB	Tuberculosis
TF	Trust Fund
TSS	Transitional Support Strategy

TT/TTL	Task Team/Task Team Leader
UDLS	Regional AIDS Committee
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	UN Development Program
UNESCO	UN Organization for Education, Science and Culture
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special
UNICEF	United Nations Children's Fund
UNICONGO	Association of Employers in Congo
USD/US$	US Dollar
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WHO	World Health Organization
XDR	Standard Drawing Rights

Vice President	: Makhtar Diop
Country Director	: Eustache Ouayoro
Sector Manager	: Trina Haque
Project Team Leader	: Mahamat Louani
ICR Team Leader	: Noel Chisaka

CONGO
HIV/AIDS AND HEALTH PROJECT

Table of Contents

A. Basic Information

Country:	Congo, Republic of	Project Name:	HIV/AIDS and Health (MAP program)
Project ID:	P077513	L/C/TF Number(s):	IDA-H0820,IDA-H4940,TF-90324
ICR Date:	12/24/2012	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	REPUBLIC OF CONGO
Original Total Commitment:	XDR 12.80M	Disbursed Amount:	XDR 14.56M
Revised Amount:	XDR 14.90M		
Environmental Category: B			
Implementing Agencies: Permanent Executive Secretariat / National AIDS Committee			
Cofinanciers and Other External Partners:			

B. Key Dates

Process	Date	Process	Original Date	Revised / Actual Date(s)
Concept Review:	09/17/2002	Effectiveness:	10/28/2004	10/28/2004
Appraisal:	01/26/2004	Restructuring(s):		06/23/2009
Approval:	04/20/2004	Mid-term Review:	05/04/2007	05/04/2007
		Closing:	06/30/2009	06/30/2012

C. Ratings Summary

C.1 Performance Rating by ICR

Outcomes:	Moderately Satisfactory
Risk to Development Outcome:	Moderate
Bank Performance:	Moderately Satisfactory
Borrower Performance:	Moderately Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)

Bank	Ratings	Borrower	Ratings
Quality at Entry:	Satisfactory	Government:	Moderately Satisfactory
Quality of Supervision:	Moderately Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	Moderately Satisfactory	**Overall Borrower Performance:**	Moderately Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	Yes	Quality at Entry (QEA):	Moderately Satisfactory
Problem Project at any time (Yes/No):	No	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Moderately Satisfactory		

D. Sector and Theme Codes		
	Original	**Actual**
Sector Code (as % of total Bank financing)		
Central government administration	20	35
Health	24	14
Other social services	46	10
Public administration- Health		21
Sub-national government administration	10	20
Theme Code (as % of total Bank financing)		
Gender	17	38
HIV/AIDS	33	17
Participation and civic engagement	17	34
Social risk mitigation	33	11

E. Bank Staff		
Positions	**At ICR**	**At Approval**
Vice President:	Makhtar Diop	Callisto E. Madavo
Country Director:	Eustache Ouayoro	Emmanuel Mbi
Sector Manager:	Trina S. Haque	Laura Frigenti
Project Team Leader:	Mahamat Goadi Louani	Michele L. Lioy
ICR Team Leader:	Noel Chisaka	
ICR Primary Author:	Peter Backrach	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document**)**
The Project's specific development objectives are to support actions by the Government of the Congo to:
Slow the spread of HIV-AIDS and

Strengthen support and care for people infected or affected by HIV-AIDS.

To reach these objectives, the Project follows the proven approach of supporting action across several sectors and not just in the health system. (12 sector ministries are involved). More precisely, the Project supports actions to:

(i) Support civil society and community initiatives for HIV-AIDS prevention and care;
(ii) Expand access to treatment of opportunistic infections;
(iii) Care and support for people living with HIV-AIDS (PLWHA);
(iv) Care for orphans & other highly vulnerable children; and
(v) Reduce transmission among high risk groups.

Note 1: The PDOs are taken from the Development Grant Agreement (DGA)
Note 2: The dates of indicators correspond to the following surveys:

2003: Knowledge Attitudes and Practice (KAP) Survey
2005: Demographic and Health Survey (DHS)
2009: AIDS Indicator Survey (AIS)
2011/12: Demographic and Health Survey (DHS)

Other sources are specified as Program Documents (SEP/CNLS).

Revised Project Development Objectives (as approved by original approving authority)

The revised project development objective is to contribute to the Recipient's efforts to: (i) limit the spread of HIV/AIDS and STIs in the Recipient's population; (ii) mitigate the health and socioeconomic impact of HIV/AIDS and STIs on persons infected with or affected by HIV/AIDS and STIs; and (iii) build strong and sustainable national capacity to respond to the HIV/AIDS epidemic.

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	(DGA 2004 & DGA 2009): Percentage of adults aged 15 to 49 who used a condom during their last (last twelve months DHS 2005) sexual contact with a casual partner			
Value quantitative or Qualitative)	Females: 20.0% DHS 2005) Males: 37.5% (DHS 2005)	Adults: 60.0%	Males: 60.0% Females: 40.0%	Adults: 34.3% Males: 33.3% Females: 38.7% (DHS 2011)
Date achieved	12/31/2005	12/31/2005	12/31/2009	12/31/2011
Comments (incl. % achievement)	Partially Achieved. The KAP baseline is regarded as inaccurate while the DHS asked about condom use in the last twelve months. The revised target for females was achieved (97%) and the change was significant; The DHS shows a negative trend for men			
Indicator 2 :	(DGA 2004 & DGA 2009): % of adults aged 15 to 49 reporting knowledge that HIV can be transmitted from mother to child during pregnancy.			
Value quantitative or	17.2% (Female-DHS 2005 13.4% (Male -DHS 2005)	90.0%	90.0%	Males: 72.1% (DHS - 2011)

Qualitative)				Females: 71.2% (DHS-2011)
Date achieved	12/31/2003	12/31/2005	12/31/2009	12/31/2011
Comments (incl. % achievement)	Achieved. Based on the DHS results for males and females, the overall targets were mostly achieved (80% and 79% respectively). The magnitude of change is clearly very large			
Indicator 3 :	(DGA 2004 & 2009): % of people aged 15-49 identifying condoms as a preventive measure.			
Value quantitative or Qualitative)	Females: 84.0 Males: 82.8 (DHS 2005)	90.0	Males: 95.0% Females: 75.0%	Adults: 80.8% Males: 86.9% Females: 78.2% (DHS 2011)
Date achieved	12/31/2005	12/31/2004	12/31/2009	12/31/2011
Comments (incl. % achievement)	Partially Achieved. The revised target for females was achieved (104%) but there was a decline from 2005; the original target for males was mostly achieved (96%) and there was an increase from 2005			
Indicator 4 :	(DGA 2004 & 2009): % of pregnant women attending prenatal consultations accepting voluntary testing for HIV.			
Value quantitative or Qualitative)	16.0 (DHS 2005)	70.0	90.0	76.8
Date achieved	12/31/2005	12/31/2005	12/31/2009	12/31/2011
Comments (incl. % achievement)	Achieved. The original target was achieved (128%), but the formally revised target was only partially achieved (89%). There was clearly a very significant change in this indicator.			
Indicator 5 :	(DGA 2004): HIV prevalence among 15-24 year old pregnant women.			
Value quantitative or Qualitative)	2.6 (2003 KAP)	2.0		2.0 (2009 AIS)
Date achieved	12/31/2003	12/31/2005		12/31/2011
Comments (incl. % achievement)	Achieved. The target was eliminated in the 2007 umbrella restructuring but data continued to be collected; the target was achieved in 2009.			
Indicator 6 :	(DGA 2004): HIV prevalence among 14-19 year old men			
Value quantitative or Qualitative)	1.9 (KAP 2003)	1.5		0.8 (2009 AIS)
Date achieved	12/31/2003	12/31/2005		12/31/2009
Comments (incl. % achievement)	Achieved. The target was eliminated in the 2007 umbrella restructuring; data from the AIS show that the target was achieved in 2009.			
Indicator 7 :	(DGA 2004): Prevalence of STI among pregnant women.			
Value quantitative or Qualitative)	3.0	2.0		8.2
Date achieved	12/31/2003	12/31/2005		12/31/2009
Comments (incl. % achievement)	Not achieved. The target was eliminated in the 2007 umbrella restructuring; data from the ESISC show that the target was not achieved.			

Indicator 8 :	(DGA 2004): HIV prevalence among 15-19 year old women.			
Value quantitative or Qualitative)	1.4		1.4	2.1 (2009 AIS)
Date achieved	12/31/2005		12/31/2009	12/31/2009
Comments (incl. % achievement)	Not achieved. The target was not achieved.			
Indicator 9 :	(DGA 2009): % of pregnant women living with HIV receiving anti retrovirals to reduce the risk of mother to child transmission.			
Value quantitative or Qualitative)	40.7 Program documents		80.0	60.6 Program documents
Date achieved	12/31/2008		12/31/2009	12/01/2012
Comments (incl. % achievement)	Partially achieved. The target was partially achieved (71%) and there was a 20 percentage point improvement.			
Indicator 10 :	(DGA 2009): No. of PLWHA benefiting from ARV treatment and monitoring at the frequency in the National Guidelines.			
Value quantitative or Qualitative)	11577		15000	21940
Date achieved	12/31/2008		12/31/2009	12/01/2012
Comments (incl. % achievement)	Achieved. The target was achieved (146%).			
Indicator 11 :	(DGA 2009): No. of orphans and vulnerable children (OVC) receiving a package of services.			
Value quantitative or Qualitative)	10317		25000	11764
Date achieved	12/31/2008		12/31/2009	12/31/2011
Comments (incl. % achievement)	Not achieved. The target was achieved 47% of the target.			
Indicator 12 :	(DGA 2009): No. of regional HIV/AIDS committees (UDLS) reporting annually on at least 75% of M&E indicators			
Value quantitative or Qualitative)	11		12	12
Date achieved	12/31/2008		12/31/2009	12/01/2012
Comments (incl. % achievement)	Achieved. The target was achieved (100%).			

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	(DGA 2004): No. of functional HIV and STI sentinel sites.			
Value (quantitative or Qualitative)	0	13		19
Date achieved	12/31/2003	12/31/2005		12/31/2009
Comments (incl. % achievement)	Achieved. The target was achieved (146%).			
Indicator 2 :	(DGA 2004): No. of health facilities providing quality treatment of STI in five regions covered under the Project.			
Value (quantitative or Qualitative)	0	23	23	2009:42 2011:46
Date achieved	12/31/2003	12/31/2005	12/31/2009	12/31/2011
Comments (incl. % achievement)	Achieved. The target was achieved (183%). On average, 45 health facilities have provided treatment since 2007.			
Indicator 3 :	(DGA 2004): % of pregnant women testing positive who benefit from the global care, support and treatment strategy			
Value (quantitative or Qualitative)	undetermined	80		2009: 37.8 2011: 68.7
Date achieved	12/31/2003	12/31/2005		12/31/2011
Comments (incl. % achievement)	Achieved. The target was mostly achieved (80%) and there was a very significant change during the additional financing.			
Indicator 4 :	(DGA 2004): % of sale points experiencing a shortage of condoms in the last month.			
Value (quantitative or Qualitative)	undetermined	80		0
Date achieved	12/31/2003	12/31/2005		12/31/2009
Comments (incl. % achievement)	Achieved. The target was achieved.			
Indicator 5 :	(DGA 2009): % of blood units used for transfusion screened for: HIV, HBV, HCV, and syphilis.			
Value (quantitative or Qualitative)	HIV: 100% HBV: 100% HCV: 81% Syphilis: 41%		HIV: 100% HBV: 100% HCV: 100% Syphilis: 98%	HIV: 100% HBV: 100% HCV:100% Syphilis: 100%
Date achieved	12/31/2008		12/31/2009	12/31/2011
Comments (incl. %	Achieved. The target was achieved.			

achievement)				
Indicator 6 :	(DGA 2009): No. of health facilities providing quality HIV counseling and testing.			
Value (quantitative or Qualitative)	59		99	144
Date achieved	12/31/2008		12/31/2009	12/31/2011
Comments (incl. % achievement)	Achieved. The target was achieved (145%).			
Indicator 7 :	(DGA 2009): No. of health facilities providing quality HIV/AIDS care and treatment.			
Value (quantitative or Qualitative)	32		40	65
Date achieved	12/31/2007		12/31/2009	12/31/2011
Comments (incl. % achievement)	Achieved. The target was achieved in 2008 (113%). Since 2009, an average of 61 facilities has provided quality HIV/AIDS care and treatment; in 2012, the target was achieved (163%).			
Indicator 8 :	(DGA 2009): No. of infants born HIV positive and treated according to national protocols			
Value (quantitative or Qualitative)	632		1485	1320
Date achieved	12/31/2005		12/31/2009	12/31/2011
Comments (incl. % achievement)	Partially achieved. The target was partially achieved (86%).			
Indicator 9 :	(DGA 2009): No. of TB centers that integrate testing and care of HIV.			
Value (quantitative or Qualitative)	16		24	24
Date achieved	12/31/2005		12/31/2009	12/01/2012
Comments (incl. % achievement)	Achieved. The target was achieved (100%).			
Indicator 10 :	(DGA 2009): No. of health centers offering care/prophylaxis for victims of sexual violence.			
Value (quantitative or Qualitative)	2		18	2
Date achieved	12/31/2005		12/31/2009	12/01/2012
Comments (incl. % achievement)	Not achieved. The target was not achieved (11%).			
Indicator 11 :	(DGA 2004): All of the selected sector ministries are implementing more than 80% of the agreed Action Plan.			
Value (quantitative or Qualitative)	0	12		15
Date achieved	12/31/2005	12/31/2005		12/31/2009
Comments	Partially achieved. The target for the selected sector ministries was achieved (125%);The			

(incl. % achievement)	target for Action Plan implementation was not achieved (12%); the proportion varied from 6% (in 2009) to 42%			
Indicator 12 :	(DGA 2004 & 2009): % of population reached through HIV/AIDS IEC/BCC radio/TV programs			
Value (quantitative or Qualitative)	53.9	90	90	94
Date achieved	12/31/2003	12/31/2005	12/31/2009	12/31/2011
Comments (incl. % achievement)	Achieved. The target was achieved (104%).			
Indicator 13 :	(DGA 2009): % of schools teaching HIV/AIDS modules in national curricula.			
Value (quantitative or Qualitative)	Primary: 0% Secondary: 100% Technical: 0%		Primary: 60% Secondary: 100% Technical: 60%	Primary:33.4% Secondary: 35.2% Technical: 50.0%
Date achieved	12/31/2003		12/31/2009	12/01/2012
Comments (incl. % achievement)	Partially achieved. The targets for primary, secondary, and technical schools were partially achieved (56%, 37%, and 83% respectively).			
Indicator 14 :	(DGA 2009): No. of schools having active out-of-school HIV/AIDS programs.			
Value (quantitative or Qualitative)	106		526	291
Date achieved	12/31/2008		12/31/2009	12/31/2011
Comments (incl. % achievement)	Partially achieved. The target was partially achieved (55%).			
Indicator 15 :	(DGA 2009): Adoption and dissemination of law protecting PLWHA and protecting women against sexual violence			
Value (quantitative or Qualitative)	0		1	1
Date achieved	12/31/2009		12/31/2009	12/31/2011
Comments (incl. % achievement)	Achieved. The target was achieved; the law was adopted and signed in 2011			
Indicator 16 :	(DGA 2009): No. of uniformed persons reached by national HIV/AIDS programs (cumulative)			
Value (quantitative or Qualitative)	5012		5300	6267
Date achieved	12/31/2009		12/31/2009	12/01/2012
Comments (incl. % achievement)	Achieved. The target was achieved (118%).			
Indicator 17 :	(DGA 2009): No. of prisons with active HIV/AIDS programs			
Value (quantitative	2		6	2

or Qualitative)				
Date achieved	12/31/2009		12/31/2009	12/01/2012
Comments (incl. % achievement)	Partially achieved. The target was partially achieved (50%).			
Indicator 18 :	(DGA 2004): Disbursement for community, civil society and private sector initiatives reaches at least 70% of planned level			
Value (quantitative or Qualitative)	undetermined	70		32.5
Date achieved	12/31/2005	12/31/2005		12/31/2009
Comments (incl. % achievement)	Partially achieved. Actual cumulative expenditures for the civil society response (excluding OVC) were 32.5% of planned expenditures; the target was partially achieved (46%).			
Indicator 19 :	(DGA 2009): No. of community-based HIV/AIDS projects approved, completed successfully and accounted for.			
Value (quantitative or Qualitative)	95		190	264
Date achieved	12/31/2005		12/31/2009	12/01/2012
Comments (incl. % achievement)	Achieved. The target was achieved (164%).			
Indicator 20 :	(DGA 2009): No. of private enterprises that offer HIV/AIDS services to workers			
Value (quantitative or Qualitative)	31	40		50
Date achieved	12/31/2008	12/31/2008		12/01/2012
Comments (incl. % achievement)	Achieved. The target was achieved (125%).			
Indicator 21 :	(DGA 2009): No. of condoms distributed/sold with label "AMI3" each year			
Value (quantitative or Qualitative)	7977953		9000000	5818237
Date achieved	12/31/2008		12/31/2009	12/01/2012
Comments (incl. % achievement)	Partially achieved. On average, 5,818,237 condoms were distributed/sold each year from January 2009 to June 2012. The target was partially met (65%)			
Indicator 22 :	(DGA 2009): No. of active support organizations for orphans and other vulnerable children (OVC)			
Value (quantitative or Qualitative)	17		17	17
Date achieved	12/31/2008		12/31/2009	12/31/2011
Comments (incl. % achievement)	Achieved. The target was achieved (100%).			
Indicator 23 :	DGA 2004): By June 2005, data for the monitoring of outcome and impact indicators are			

	collected regularly			
Value (quantitative or Qualitative)	undetermined	undetermined	undetermined	undetermined
Date achieved	12/31/2005	12/31/2005	12/31/2009	12/31/2011
Comments (incl. % achievement)	Achieved. By June 2005, this was not the case; by 2006, monitoring and evaluation was much improved; and by 2007, monitoring and evaluation was regular and comprehensive. The target is considered achieved.			
Indicator 24 :	(DGA 2009): No. of coordination meetings held each year			
Value (quantitative or Qualitative)	CNLS: 0 Steering Com.: 2		CNLS: 0 Steering Com.: 2	CNLS: 0 Steering Com.: 2
Date achieved	12/31/2008		12/31/2009	12/31/2011
Comments (incl. % achievement)	Not achieved. Over the four-year period 2008-2011, the National AIDS Council met once in three years; over the same period, the Steering Committee met twice in only one year (and once in two others). The target was not achieved (50%).			

G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	06/15/2004	Satisfactory	Satisfactory	0.00
2	09/07/2004	Satisfactory	Satisfactory	0.00
3	12/15/2004	Satisfactory	Satisfactory	0.00
4	03/21/2005	Moderately Satisfactory	Moderately Satisfactory	3.50
5	08/30/2005	Moderately Satisfactory	Moderately Satisfactory	5.27
6	03/22/2006	Moderately Satisfactory	Moderately Satisfactory	7.66
7	12/23/2006	Moderately Satisfactory	Moderately Satisfactory	9.84
8	06/29/2007	Satisfactory	Moderately Satisfactory	12.28
9	07/19/2007	Satisfactory	Moderately Satisfactory	12.43
10	01/16/2008	Satisfactory	Satisfactory	14.22
11	06/28/2008	Satisfactory	Satisfactory	15.39
12	12/28/2008	Satisfactory	Satisfactory	18.25
13	06/29/2009	Satisfactory	Satisfactory	18.92
14	12/05/2009	Satisfactory	Satisfactory	19.27
15	06/24/2010	Satisfactory	Satisfactory	19.76
16	03/28/2011	Satisfactory	Satisfactory	20.33
17	11/05/2011	Satisfactory	Satisfactory	21.28
18	03/11/2012	Moderately Satisfactory	Moderately Satisfactory	21.75
19	06/20/2012	Moderately Satisfactory	Moderately Satisfactory	22.16

H. Restructuring (if any)

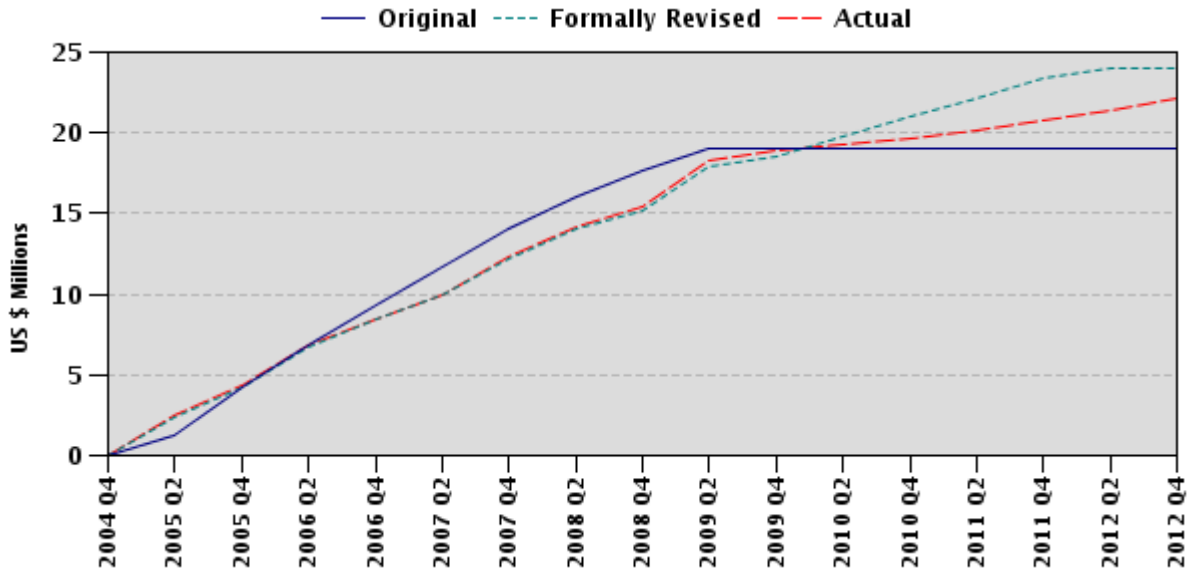
Restructuring Date(s)	Board Approved PDO	ISR Ratings at Restructuring	Amount Disbursed at	Reason for Restructuring & Key Changes Made

	Change	DO	IP	Restructuring in USD millions	
06/23/2009	Y	S	S	18.75	(i) support priority interventions responding to evidence on the drivers of the epidemic; (ii) scale up activities targeting higher-risk and vulnerable population groups; (iii) build capacity for sustainability and incorporate lessons of experience; and (iv) leverage additional government and donor funding and apply the Bank's global knowledge and experience.

If PDO and/or Key Outcome Targets were formally revised (approved by the original approving body) enter ratings below:

	Outcome Ratings
Against Original PDO/Targets	Moderately Satisfactory
Against Formally Revised PDO/Targets	Moderately Satisfactory
Overall (weighted) rating	Moderately Satisfactory

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

1. **Country context.** Despite advantages stemming from its natural resources (especially oil and forest products) and a relatively small and urbanized population (roughly 60% of the population live in the major cities), Congo's development has been hampered by political, economic and social problems. Decades of single party rule, poor economic management, and falling petroleum prices during the 80's contributed to unrest, which led to the National Conference (1990) and the reestablishment of a multi-party system. Poverty and competition for national resources continued, however, and contributed to social stresses and three periods of violent conflict: in 1993-94, 1997, and 1998-99. At the height of the crisis in late 1999, an estimated 810,000 people, or about one-third of the Congolese population, were displaced. Though a cease-fire accord was signed December 1999, agreement with the last rebel group was only reached in March 2003.

2. The recurrent conflicts severely damaged physical infrastructure in the country: (i) about half the national road network was not passable; (ii) schools, particularly in the south, suffered considerable damage; and (iii) agriculture was devastated (with an estimated 50% of agricultural tools destroyed and 75% of livestock lost). Damage to public well-being was perhaps even greater: (i) life expectancy dropped from about 52 years in the early 1990s to 48.6 years in 2002; and (ii) the proportion of Congolese living below the poverty line increased from about 30% at the beginning of the conflicts to 70% at the end. Several groups were considered particularly vulnerable: some 11% of children under 15 were orphans, about 60,000 women and girls were victims of rape, and 5,000 children fought during the war.

3. The health sector was not spared. First, more than half of all health facilities were ransacked, and buildings, equipment, and access to clean water deteriorated for lack of preventive maintenance or repair. Second, the number of health staff declined (from 7,400 in 1995 to 4,500 in 2002), and the distribution of personnel (always skewed toward urban areas) became even more concentrated with over 75% of staff in Brazzaville and Pointe Noire. In addition, pay cuts, lack of promotional opportunities, and insecurity had reduced the motivation of these personnel. Third, the public agency responsible for procuring essential drugs and supplies (CENAMES, created in 1995) had never been able to overcome the handicaps of civil disorder, despite assistance from the European Community.

4. Beginning in 2003, the country initiated reconstruction (financed by oil revenues and assistance from the IMF, World Bank and European Union) and political reform (focused on decentralization to improve service delivery and empower communities). Though GDP recovered rapidly, social indicators continued to trail significantly behind, and progress was further complicated by the advent of the HIV/AIDS pandemic.

5. **HIV/AIDS situation and the national response.** HIV/AIDS was first diagnosed in Congo in 1983 and by the end of 1996 had become a major cause of death among adults aged 15 to 45 (35% of all deaths in this age group, with a total of 10,777 AIDS cases reported). The successive conflicts reduced the sentinel surveillance system, but a limited survey conducted by the Ministry of Health (MOH) in 2000 showed that 14.6% of pregnant women were infected with HIV in Pointe-Noire and 5.4% in Brazzaville. In 2001, UNAIDS estimated that 110,000 people were living with HIV and that the national sero-prevalence rate was 7.2%. A national HIV sero-prevalence survey carried out in November 2003 (but limited essentially to urban areas) established the national sero

prevalence rate for the adult population at 4.2% with women 20-35 years old suffering from higher infection rates[1], and at a younger age, than men.

6. In response to the growing problem, the National AIDS Program (PNLS) was established in 1987 within the Ministry of Health; the National AIDS Committee was established in 1988 to make policy. Thereafter, the PNLS launched a series of plans: an emergency plan, followed successively by a short-term plan (1988), a first medium-term plan (1989-1991) and a second medium-term plan (1996-1998). The 1997 war prevented any implementation of the second plan and prevented the collection of regular data on the evolution of the epidemic. There was a consensus, however, that insecure social and political conditions had increased poverty, weakened health services, and undoubtedly contributed to increased prevalence.

7. At the end of 2000, the Government launched a series of important initiatives: (i) on AIDS Day 2000, the President announced the Government's decision to re-launch the AIDS program; (ii) in April 2001, he signed a decree creating the HIV Mother-to-Child Transmission Prevention Project (MCTP); and (iii) in November 2001, he announced the approval of an annual expenditure of CFAF 1 billion as the Government's contribution to the care and treatment of PLWHA. Congo also: (i) prepared a three-year plan for 2002-04; (ii) was included in the UN's "Accelerated Access to HIV/AIDS Care" Initiative (ACCESS) enabling it to benefit from lower prices for anti-retro-viral (ARV) drugs from the major pharmaceutical companies; and (iii) participated in the Congo-Oubangui-Chari Rivers initiative to fight HIV/AIDS. Concurrently, the Ministry of Education's launched a project to prevent AIDS in Congo's schools (PRESIEC) with the assistance of UN agencies (UNDP, UNESCO, and UNICEF) and others. Finally, UNDP began working with the private sector to make it aware of the socio-economic implications of the pandemic.

8. **Country Assistance Strategy and Rationale for Bank Involvement.** A Transitional Support Strategy (TSS) [2] for 2001-02 was approved by the Board in January 2001 to support the Government in facing the challenges of: (i) advancing the democratization of political life; (ii) physically reconstructing the country; and (iii) improving economic management, comprising a five-pronged approach: (i) strengthening economic reforms, stability and equitable growth; (ii) reestablishing basic economic and social services; (iii) building capacity of government and civil society; (iv) fighting the growing threat of HIV/AIDS[3]; and (v) providing assistance to war-affected and vulnerable groups.

9. Overall, the project intended to contribute directly to the fourth strategy and indirectly to the second and third strategies, by fighting HIV/AIDS, particularly among war-affected and vulnerable groups (e.g., displaced persons, rape victims, orphans, and PLWA. In addition, the project was expected to contribute to other areas including: reestablishing social services in parts of the health system; building the capacity of Government by investing in the development of the National Aids Council (CNLS), the National Technical HIV/AIDS Commission and its secretariat, funding HIV/AIDS programs in ministries, and developing the capacity of civil society to initiate actions in

[1] Particularly in the war-damaged Niari Valley towns of Dolisie and Sibiti, where sero-prevalence rates among women 20-35 years old were about 10%. The survey also confirmed the HIV sero-prevalence rate of 7.9 % found in sentinel sites based on pregnant women.

[2] In the case of post conflict countries, such as the Republic of Congo, a Transitional Support Strategy covering two years is prepared; it addresses the issues of stabilization, reconstruction and the return to development. A TSS with similar objectives was completed in August 2003 for FY04 and FY05.

[3] The Emergency Infrastructure Rehabilitation and Living Conditions Improvement Project which became effective in 2002 included an HIV awareness component and construction/equipping of two HIV test centers in Brazzaville.

the area of HIV/AIDS.

10. Bank support was justified by several important factors: (i) the lingering effects of civil unrest which had contributed to persistent social problems (risky sexual behavior, inadequate management of STIs, etc.) and the lack of partners and potential financing for addressing serious health sector issues (infrastructure, human resources, drugs, etc.); and (ii) the lack of proven strategies to address prevention at the grassroots level and the Government's limited partnership with and inadequate resources for improving the institutional and managerial capacities of an emerging and untested civil society network to scale up and intensify prevention efforts.

1.2 Original Project Development Objectives (PDO) and Key Indicators (as approved)

11. The PAD's specific development objectives were to support the Government's actions to: (i) slow the spread of HIV/AIDS; and (ii) strengthen support and care for people infected or affected by HIV/AIDS. The DGA rephrased these objectives as assisting the Recipient to: (i) limit the spread of HIV/AIDS and STIs in the Recipient's population; (ii) mitigate the health and socioeconomic impact of HIV/AIDS and STIs on persons infected with or affected by HIV/AIDS and STIs within the Recipient's territory; and (iii) build strong and sustainable national capacity to respond to the HIV/AIDS epidemic.

12. Project impact was to be measured among key vulnerable groups, as defined in the outcome indicators, comprising the following:

Limit the spread of HIV/AIDS and STIs

- By project end, 60% of adults 15-49 use a condom during their last sexual contact with a casual partner;
- By project end, 90% of people aged 15-49 report knowledge of vertical transmission (mother to child) and 90% mention condoms as a prevention measure;
- By project end, 70% of women attending prenatal consultations will accept voluntary testing for HIV;
- By project end, HIV prevalence among 15-24-year-old pregnant women is <2% and among 14- 19 year old men 1.5%;
- By project end, the prevalence of sexually transmitted infections (STI) among pregnant women decreases to 2%

As shown, only the first PDO was addressed by the indicators under the original grant, and only pregnant women were singled out to as a vulnerable group.

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification

13. The original PDOs were formally revised in May 2009, when additional project financing was approved to: (i) support priority interventions responding to evidence on the drivers of the epidemic; (ii) scale up activities targeting higher-risk and vulnerable population groups (orphans and other vulnerable children, commercial sex workers, widows, youth, indigenous people, sexual minorities, the uniformed services, and prisoners); (iii) build capacity for sustainability and incorporate lessons of experience; and (iv) leverage additional government and donor funding and apply the Bank's global knowledge and experience.

14. The revised project development objective was to contribute to the Recipient's efforts to: (i) limit the spread of HIV/AIDS and STIs in the Recipient's population; (ii) mitigate the health and socioeconomic impact of HIV/AIDS and STIs on persons infected with or affected by HIV/AIDS

and STIs; and (iii) build strong and sustainable national capacity to respond to the HIV/AIDS epidemic. One KPI for the first PDO was changed (and two others modified), and KPI were added for the other two PDO:

Limit the spread of HIV/AIDS and STIs

- By project end, 60% of adults 15-49 use a condom during their last sexual contact with a casual partner;
- By project end, 90% of people aged 15-49 report knowledge of vertical transmission (mother to child) and 90% mention condoms as a prevention measure;
- By project end, 90% of women attending prenatal consultations will accept voluntary testing for HIV;
- By project end, HIV prevalence among 15-19 year old women remains at 1.4%;
- By project end, 80% of pregnant women living with HIV receive anti retrovirals to reduce the risk of mother to child transmission;

Mitigate the health and socioeconomic impact of HIV/AIDS and STIs on persons infected with or affected by HIV/AIDS and STIs

- By project end, 15,000 PLWHA benefit from ARV treatment and monitoring at the frequency in the National Guidelines;
- By project end, 25,200 of orphans and vulnerable children (OVC) have received a package of services;

Build strong and sustainable national capacity to respond to the HIV/AIDS epidemic

- By project end, all regional HIV/AIDS committees (UDLS) report annually on at least 75% of the indicators specified in the Project Implementation Manual.

1.4 Main Beneficiaries and Benefits

15. Five of the eleven regions were included in the project, but the entire population was expected to benefit from the prevention efforts, particularly: (i) those in the productive age brackets; (ii) those most vulnerable to HIV/AIDS, such as pregnant women, commercial sex-workers, persons in uniform, long-distance traders, forestry workers and the young in general; (iii) PLWHA and their immediate families (estimated at more than half a million people); and (iv) orphans and families headed by children. The PAD identified four kinds of benefits: (i) economic (resulting from prevention of the spread of the disease among the most productive elements of the population); (ii) social (resulting from the improved capacity to provide support to groups infected or affected by HIV/AIDS); (iii) institutional (resulting from the strengthened capacity of key stakeholders and community groups); and (iv) health (resulting from contributions to the country's prevention, diagnosis and treatment efforts[4].

1.5 Original Components

16. **Component 1: Public sector response (US$ 4.70 million).** In accordance with the National HIV/AIDS Strategic Plan, the project was expected to provide support to the Ministry of Health and 12 non-health ministries were responsible for coordinating the public sector response.

17. Sub-component A: Health sector response (US$ 2.6 million). The Ministry of Health was expected to strengthen priority actions for: (i) a range of preventive actions; and (ii) an overall

[4] See also Annex 3.

approach to care, support and treatment to reduce the impact of HIV/AIDS. The preventive actions aimed to support:

- establishment of a system to purchase, promote, and distribute condoms, using social marketing;
- programs for diagnosis, treatment and prophylaxis of sexually transmitted infections;
- development and implementation of a national policy on voluntary testing, including counseling units with personnel specially trained in psycho-social and cultural aspects of HIV/AIDS; and
- bio-security measures to improve: (i) blood transfusion services, including the protection of health personnel and the provision of emergency therapy in case of accidental exposure; (ii) hygiene and prevention in clinical settings by rationalizing the use of injections, systematically disposing of needles, etc.; and supporting the proper elimination of medical waste.

18. The overall approach to care, support and treatment to reduce the impact of HIV/AIDS had as objectives to support: (i) a full range of medical interventions comprising laboratory monitoring, prevention and treatment of opportunistic diseases (including tuberculosis), prescription and delivery of drugs (for STIs, OIs, and ARVs), and non-medical support to patients; (ii) prevention of mother to child transmission; and (iii) care for victims of sexual violence. The sub-component would rehabilitate health units providing counseling, voluntary testing/diagnosis, and treatment services, support the preparation of guides (on STIs, counseling and treatment of PLWHA, etc.), and train health personnel.

19. Sub-component B: Non-health sector response (US$ 2.1 million). The non-health ministries were expected to: (i) establish five-member teams (including a focal point and an accountant)[5]; and (ii) plan and implement action plans to benefit the vulnerable groups under their jurisdiction both at both central and regional levels. These plans comprised both "essential" actions and "supporting actions" (such as training, transport, etc.) necessary to carry out the essential activities. The ministerial interventions were expected to be phased with: (i) an initial period devoted to support (specifically six national guides prepared under the PHRD) and training for the teams; and (ii) a subsequent period focused mostly on social communication and advocacy[6]; activities aimed at the vulnerable groups under their jurisdiction.

20. **Component 2: Civil society sector response (US$ 3.50 million).** The project intended to provide support for the civil society response by financing community-based interventions and the private sector.

21. Sub-component A: Community-based interventions. The sub-component was expected to: (i) channel financing for qualifying micro-projects proposed by civil society (comprising national NGOs, unions, private sector and community-based organizations such as churches, parent-teacher associations, traditional leaders, clubs, etc.); and (ii) provide technical support to these CSO through national or international NGOs which would conduct rapid participative assessments; help the CSO to identify their priorities and formulate their micro-projects; assure institutional strengthening (including setting up associations, training personnel, etc.); and assess the quality of the CSO

[5] These teams were not envisioned in the first decree (2002) but were later included in the revised decree (2004).
[6] There were exceptions such as the Ministry of Justice, the Ministry of Social Affairs and the Ministry of Communication which focused on other matters as well.

activities.

22. Sub-component B: Private sector response. Based on initiatives promoted by UNDP and follow-up contacts by the SEP/CNLS, the employer association (UNICONGO) and other private sector associations, the Project would provide limited support (including training, especially for peer education, and provision of educational materials) to enterprises that request assistance the private sector would receive assistance for training and provision of educational materials to address the effects of the HIV pandemic on their personnel and their enterprises.

23. **Component 3: Orphans and other extremely vulnerable children (US$ 3.50 million).** With the intention of gaining practical knowledge in assisting OVC and to preparing a larger-scale component, the project initiated (with assistance from Médécins d'Afrique as well as UNICEF, the World Food Program (WFP), and the Ministry of Social Welfare) a pilot project to assist about 500 orphans in the poor Brazzaville neighborhood of Moungali. The pilot involved: (i) conduct of household surveys to identify the most vulnerable children using objective indicators of their vulnerability (e.g., health, education and economic conditions); (ii) definition and delivery of a basic package of services, comprising: medical insurance (for visits to health centers and for pharmaceuticals); fees for enrollment in primary school and early secondary school (along with school uniforms and textbooks) or skills training; and psychological support groups.

24. **Component 4: Management and coordination, capacity building, and monitoring and evaluation (US$ 6.3 million).** The project intended to provide support for policy development and management, capacity-building, and data collection, monitoring and evaluation.

25. Sub-component A: Policy development and management. This subcomponent was intended to support the structures responsible for management of the program (essentially the CNLS and the Permanent Executive Secretariat), provide training at the different levels, update the requisite implementation documents (the National Strategic Plan, the annual action plans, etc.), and finance the contracting out of essential fiduciary functions (financial management, procurement, and data collection for monitoring & evaluation) to a reputable international firm reporting to the Permanent Executive Secretariat to the CNLS.

26. Sub-component B: Capacity building. This sub-component was intended to support capacity strengthening and training (as well as supply of related equipment and materials) for the CNLS, the Permanent Executive Secretariat, Government ministries, and civil society organizations. In addition, the sub-component was expected to finance the recruitment of both long and short-term experts for specialized tasks (e.g., communications strategies, training in counseling, prescription of ARVs, support for OVC, etc.).

27. Sub-components C&D: Data collection, monitoring and evaluation. Following on the paucity of data available due to the long period of instability and civil conflict, these sub-components were intended to support: (i) the conduct of a demographic and health survey by the national statistical authority of the Ministry of Plan (CNSEE) in collaboration with the MOH, the SEP/CNLS, and the relevant UN agencies (WHO, UNICEF and UNFPA); and (ii) implementation of an M&E system based on the model established by UNAIDS but simplified and including only easy-to-measure indicators guaranteed to provide useful information for all levels (and not just for the central level). Both the DHS survey and the M&E system were initiated under the Project Preparation Facility.

1.6 Revised Components

28. The additional financing of the project did not alter the four original project components.

1.7 Other significant changes

29. The original Development Grant Agreement (DGA) was amended in 2006 to reallocate the project proceeds by increasing the amounts for: (i) works to cover underestimates at appraisal and rising cost of works in the country; (ii) pharmaceuticals to meet the rapid increases in persons seeking treatment for HIV/AIDS and STIs and the effect of inflation over the previous year; and (iii) service contracts for the civil society activities to compensate for the "gross underestimation" of the task of building NGO capacities[7].

30. The project benefitted from two sources of additional financing: (i) in 2007, the project received a PHRD implementation grant; and (ii) in 2009, the project received Additional Financing and the project closing date was extended to June 30, 2012. Following a request from Government in June 2012, US$2 million equivalent was canceled from the project and recommitted to the Water, Electricity and Urban Development Project to deal with effects of a catastrophic explosion in Brazzaville.

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

31. **Project preparation.** Despite the country's significant post-conflict constraints, the identification mission (April 2002) proposed an ambitious project and a rapid preparation plan (envisioning effectiveness by June 2003). The Project Concept Document (PCD) review (September 2002) raised concerns about: (i) potential project complexity if both HIV/AIDS and health components were included[8]; (ii) essential capacity building actions; and (iii) the proposed preparation schedule, resource requirements[9], and project risk rating.

32. By November 2002, progress was slow, and there were concerns about both the Government's commitment and its technical and financial capacity to fight HIV-AIDS[10]. In response, it was agreed to use a Project Preparation Facility (PPF)[11] to recruit technical assistance[12] to prepare the health and orphan components, conduct the institutional analysis of the Ministry of Health and the NGOs, and prepare the project implementation manual and the M&E plan. Concurrently, a Bank-managed PHRD grant[13] would finance: (i) studies (on sero-prevalence, condom distribution, socio-cultural and behavioral elements, and socio-economic impacts of the epidemic); (ii) three national reference guides (for peer education, counseling and psycho-social support); and (iii) a strategy for social communication (to be finalized before project effectiveness).

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[7] This was a major contributing factor to the amount spent on Component 4; see Annex 1.

[8] Project cost was also an issue, but the review meeting maintained the proposed amount of US$14 million. The meeting further agreed that project financing of ARVs would not be considered until UNAIDS criteria were met.

[9] In view of the amount of preparatory work required, the review recommended that both a PHRD and a PPF be requested.

[10] In addition, an audit of the EU's essential drugs procurement agency and evaluations of other EU projects indicated widespread corruption, particularly in the health sector with allegations of trafficking in medications, notably ARVs.

[11] A first PPF, in the amount of US$600,000, was approved in January 2003; a second PPF in the amount of US$400,000 was approved in November 2003.

[12] The mission proposed (and the Government agreed) to recruit the firm on a sole source basis because of the time constraints. It was also proposed that this firm (or another) could assist the project implementation team during the first year of the project.

[13] The PHRD grant, in the amount of US$628,575, became effective in February 2003.

33. Subsequently, the pace of project preparation accelerated. In December 2002, the National AIDS Council (CNLS) was created under the Presidency of the Republic; members were appointed in September 2003 (including representatives of government agencies and civil society organizations) and a National Executive Secretariat was staffed. Regional and Local Committees were set up in line with the ongoing decentralization process. A comprehensive, participatory HIV/AIDS strategic plan was developed in 2003 for the period 2003-07 and included objectives and strategies to: (i) contain or reduce the level of the epidemic by 2007; (ii) mitigate the health and socioeconomic impact of HIV/AIDS at individual, household and community levels; and (iii) increase access to prevention services as well as care, treatment and support of those infected and affected by HIV/AIDS, in particular by developing local responses to the epidemic.

34. In February 2003, the Government met the remaining MAP eligibility criteria[14] and agreed with the mission on: (i) the project preparation structures; (ii) the essential technical elements and geographical scope of the different project components; and (iii) the revised plan and methodology (including a pilot program for the orphan assistance component[15]) for preparing the operational plans for funding. In addition, preliminary arrangements were initiated to ensure the conduct of a Demographic and Health Survey by the end of 2003.

35. The Decision Meeting (January 2004) recommended maintaining the scope of the project and requested further assessment of the institutional capabilities of the implementing agencies but did not raise an important issue common to the MAPs, namely the tensions between the National Executive Secretariat (with newly named staff and supported by consultants, good quality sectoral plans, and sound arrangements for community-based activities and care for orphans and other vulnerable children) and the Ministry of Health (with its reduced coordination role, minor responsibility for procurement of ARVs[16], weak sectoral plan, and limited participation in substantive discussions with the Bank). During appraisal, the Bank felt obliged to assist MOH in revising and completing their action plan and budget, while recognizing the implications for component ownership.[17]

36. Negotiations were conducted in March 2004, and the project was approved on April 20, 2004.

37. Soundness of the background analysis. The background analysis comprised: (i) existing documentation concerning health sector conditions and risk/vulnerability factors; (ii) studies financed by the PHRD and PPF; and (iii) current experience with other MAP projects[18]. The PHRD and PPF funds (constituting more than 10% of the total project proceeds) financed several highly relevant studies between October 2003 and June 2004. Carried out under very difficult circumstances (which limited some results only to urban areas), these studies enabled the country to re-establish an HIV/AIDS database[19]. Only the preliminary sero-prevalence results were available

[14] The criteria are set out in the Second Multi-Country HIV/AIDS Program (MAP-2 Report No. P7497AFR of December 20, 2001).
[15] The NGO Médecins d'Afrique was selected to implement the pilot program for orphan assistance, based on its experience in the country through UNICEF financing.
[16] Corruption related to the procurement and distribution of ARVs was a major recurring theme, particularly in discussions with the European Union and in the Back-to-Office Reports to management.
[17] The mission was also concerned by the institutional fragmentation of the Ministry but proposed to wait for the European Union project to address the issue of ministerial reorganization.
[18] See the MAP-2Memorandum and Recommendation of the President (Report No. P7497AFR of December 20, 2001).
[19] As the studies listed in Annex 9 show, the project contributed to the country's data base throughout implementation. This was also a major contributing factor to the amount spent on Component 4; see Annex 1.

to be included in the PAD[20].

38. MAP 1 lessons learned were discussed, including the need for political leadership and commitment, a multi-sectoral approach, community participation, and effective monitoring and evaluation. Though the Bank had no Congo-relevant experience for preparing the project, its discussions with other partners (particularly the Global Fund and the European Commission) proved useful in identifying complementary as well as problematic areas for project financing. In particular, during Negotiations, the Bank conditioned any future support for CENAMES (to procure drugs and other consumables) on progress achieved with EU funding.

39. Government commitment. Though somewhat critical of Government commitment during preparation, the PAD notes that: (i) support for an HIV/AIDS response had been demonstrated at the highest levels; (ii) the appropriate coordinating and implementing structures had been established; and (iii) the necessary measures taken to ensure wide participation in the adoption of the national strategy and the planned interventions. In addition, Government agreed during negotiations to finance (beginning in Year 3) some of the additional operational costs of the project, so as to ensure future financing.

40. Assessment of the project design. Several design options were considered and rejected before adopting the MAP approach[21]. Though there were concerns that the proposed multisectoral and decentralized design was complex, several measures were introduced to enhance feasibility. A five-year[22] project was proposed given the limited government and NGO capacity; and the design also adopted the recommended MAP practices of sequencing and prioritizing project interventions to: (i) phase in simpler interventions initially while the country was still in a post-conflict mode) and address more challenging interventions later; (ii) use contracting out and international project facilitation to provide implementation assistance while building national capacity; and (iii) except for blood transfusion, limit project activities to five regions (Brazzaville, Kouilou, Niari, Lekoumou, and Sangha[23]), comprising about 82% of the population and 91% of HIV infected persons (according to the 2003 HIV sero-prevalence survey). A comprehensive project manual was prepared to counter the tendency for MAP projects to lose momentum after Board approval by strengthening program coordination and implementation mechanisms and commencing pilot operations prior to effectiveness.

41. Risk Assessment and mitigation. The QEA noted that the PAD did not adequately discuss the political risks associated with the country's post conflict situation or the project's financial viability, but these criticisms seem somewhat unfair given the country's TSS. The risk ratings seem, in retrospect, to have been accurate. On the other hand, the QEA correctly concluded that the proposed mitigation measures were inadequate to address weak Health Ministry capacity, but its proposal to

[20] Responding to this issue from the QEA panel, the team stated that it chose not to include extensive results which "would have made the PAD longer without providing an advantage to the users of the results of the studies".

[21] First, the Emergency Rehabilitation and Reconstruction Project and the Transparency and Governance Capacity Building Project included funds for HIV/AIDS (US$1.5 million for information and sensitization and US$0.4 million for strategy preparation and operations, respectively), but the team was reluctant to add a multisectoral HIV/AIDS component to either of these post-conflict projects. Second, given the urgency and magnitude of the HIV/AIDS problem, a project under the MAP-2 umbrella but with a significant health component (rather than the reverse) seemed more appropriate to bring the health sector to the standard necessary for the fight against HIV/AIDS.

[22] The PCD meeting proposed implementing the project over more than five years, but other MAP assessments recommended implementing in less than five years.

[23] The preparation team assumed that Congo' s re-submission to the GFATM would be approved and that GFATM funds would allow for the extension of HIV/AIDS interventions to the remaining regions.

recruit an independent agency to implement the component was, as noted by the task team, not politically or practically feasible.

42. **Quality at Entry.** A Quality at Entry Assessment was conducted in June 2005 and rated the overall quality of the preparation as Moderately Satisfactory[24]. Also rated Moderately Satisfactory were: Policy and Institutional Aspects, Environmental Aspects, Implementation Arrangements and Risk Assessment; Strategic Relevance and Approach, Technical, Financial and Economic Aspects, Fiduciary Aspects, Poverty, Gender and Social Development as well as Bank Inputs and Processes were rated Satisfactory.

2.2 Implementation

43. Conditions of effectiveness included: (i) adoption of an implementation manual; (ii) recruitment off the Financial Management Agency and establishment of an accounting and financial management system[25]; and (iii) modification of the CNLS decree. Recruitment of an external auditor was included as a dated covenant so as not to delay implementation of an urgently needed project. Because the effectiveness conditions had not been met by August 5, 2004, effectiveness was extended until November 5, 2004; the project became effective on October 28, 2004.

44. The ISRs (Data Sheet, Section G) rated performance on Development Objectives (DO) and Implementation Progress (IP) as Satisfactory or Moderately Satisfactory throughout implementation. The final two ISRs rated the DO and IP as Moderately Satisfactory, in line with the 2010 QALP assessment.

45. **Disbursement overview.** The project was financed by: (i) the initial grant (H0820) in the amount of US$19.0 million equivalent, which was signed on May 5, 2004 and expected to close on June 30, 2009; (ii) a Japanese implementation grant (TF-90324) in the amount of US$967,050; and (iii) additional financing (H4940) in the amount of US$5.0 million equivalent, which became effective on January 15, 2010 and closed on June 30, 2012). The borrower was expected to finance an additional US$2.0 million for the initial grant[26] and an additional US$10.0 million for the additional grant. On June 22, 2012, the Government cancelled approximately US$2.0 million of the AF.

46. The context for HIV/AIDS financing changed in three significant ways during project implementation. First, from 2004-06, the MAP was the single largest source but from 2007 on, the Global Fund replaced IDA as the single largest source. Overall, IDA's share of total partner financing declined from 100% (2004-06) to 27% (2007-09) to approximately 15% (2010 to closing). Second, strict counterpart financing arrangements under the Additional Financing (requiring US$2 of Government financing for each US$1 of IDA financing) and delays in Government contributions reduced IDA's annual disbursements from about US$2.9 million annually (under the original grant) to US$0.7 million annually under the Additional Financing. Third, the complementarity of Global Fund financing as well as the Bank-financed Health Sector Services Development Project compensated in large measure for the decreased MAP

[24] The QEA's principal comments (e.g., capacity development through "twinning", targeting and geographic focus, donor coordination, etc.) and especially its suggestions seemed somewhat irrelevant as the preparation team correctly pointed out in its response that they had been addressed in the PAD and during the various review meetings.
[25] While the firm was being recruited, the Project Unit of the PURICV (an urban rehabilitation project financed by IDA and including a HIV/AIDS component) had responsibility for managing PPF funds and overseeing procurement.
[26] UN agencies were expected to contribute an additional US$0.4 million to the original grant.

disbursement[27].

47. **Implementation overview.** Despite the continuing constraints of the post-conflict situation, reviews in 2005-06 noted progress on all of the components (except the health sub-component), with delays due primarily to mobilizing and disbursing project funds[28]. Difficulties with the health sub-component were attributed to a "dysfunctional" PNLS with institutional and technical shortcomings[29]; proposed measures to improve performance were essentially ignored by the Ministry until February 2006, when financial management issues resulted in the transfer of financial management responsibilities from MOH to the Fiduciary Management Agency (FMA).

48. Over the period from March 2006 to April 2007[30], several fundamental changes occurred as the Government: (i) embraced the "three-ones" approach to improve national strategy, program coordination, and M&E for HIV/AIDS; (ii) organized the national response as a program (comprising many technical and financial partners, including the newly received Global Fund financing) rather than a project; and (iii) promoted decentralized planning and implementation of the 2007 work plans at the regional level[31]. The Mid-Term Review consolidated these orientations for: (i) coordination to reduce persistent conflicts between the Permanent Secretariat and the MOH/PNLS; (ii) decentralization to accelerate the response to the epidemic in all eleven regions; (iii) greater involvement of PLWHA to strengthen all aspects of prevention, care (with a focus on nutrition), and treatment; and (iv) M&E to link resource utilization to results.

49. During 2007-09, the pace of implementation accelerated. First, with World Bank support, MOH performance improved with the expansion and improved integration of prevention, testing, care and treatment services (for ISTs, HIV, and TB/HIV co-infection) at the health facility level. Second, the project complemented the traditional community-level sub-projects with more innovative sub-projects using new communication channels to reach targeted, vulnerable groups[32]. A Japanese Trust Fund (awarded in 2007 in the amount of US$0.97 million) contributed to four key elements of the project: (i) expansion of Voluntary Counseling and Testing (VCT) and HIV/AIDS care and treatment; (ii) community initiatives, and particularly OVC; (iii) better integration of gender issues in the project; and (iv) strengthening of M&E.

50. Additional Financing was approved (May 2009) and expected to: (i) promote the complementarity of support from various donors, such as IDA (PDSS, PRAEBASE), GFATM

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[27] The Permanent Secretariat was also expected to implement the Avian Flu Project (with the Ministry of Agriculture) (P105743), but the summary sheet shows no commitments before the project was closed on December 31, 2009.

[28] Delays in effectiveness contributed to a temporary suspension of the orphan pilot project serving 500 OVC, but the project was restarted without adverse effects on the OVC but with a postponement of the final report (by Médecins d'Afrique) intended to provide guidance for expanding the program.

[29] These shortcomings were characterized respectively as inadequate delineation of the respective responsibilities of PNLS, LNSP, CNTS, and CENAMES and insufficient development of a comprehensive strategy comprising care and psychological support for PLWHA not medically eligible for ARV. The proposed measures included changes in the legal texts and the establishment of technical commissions within MOH to adopt standard services for HIV prevention and care and develop a plan for expanding coverage and deploying trained personnel.

[30] This period comprised the mid-term review of the national strategy (March 2006), the initial joint program review (October 2006), and the project mid-term review (April 2007).

[31] The April 2007 supervision mission noted that all of the conditions necessary for decentralization were not there due to shortcomings in the training of the regional permanent secretariats.

[32] These included: (i) prevention efforts for sex workers aimed at managing risk; (ii) micro-credit projects for very young mothers; (iii) dedicated telephone lines (provided by MTN-Congo) to provide information to (generally young) callers; (iv) mobile testing services; (v) summer vacation activities around the theme of HIV prevention (kersivac); and (vi) support for the Traditional Mediators, responsible for both marrying couples and resolving familial issues.

(PADEPP and Round 9), EU, etc. for the implementation of the 2009-13 strategic plan; and (ii) permit the Government to rationalize the use of its own increasing resources allocated for HIV/AIDS without abruptly ending IDA funding. Delays in the effectiveness[33] and (especially) the financing modalities of the Additional Financing reduced available project financing and affected project planning and implementation throughout the remaining project period. Despite these difficulties, program outputs steadily progressed over the additional financing period (see Annex 2) as the project capably managed the various sources of funding.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

51. **M&E design.** M&E was based on: (i) physical and financial monitoring (contracted out to a FMA); (ii) project monitoring (using the M&E plan, based on the UNAIDS model and financed by the PPF); and (iii) surveys and studies (including demographic and health surveys/DHS); establishment of sentinel sites; surveys on knowledge, attitudes, beliefs and practices; etc.).

52. The proposed M&E guide was reviewed by GAMET during pre-appraisal and modifications adopted[34]. The M&E arrangements were summarized in the PAD and detailed in the Project Operations Manual. The CNLS would establish a committee of experts (including representatives of the WHO and UNICEF), assisted by the Secretariat's M&E expert, to oversee development of the M&E system.

53. The QEA mentioned three concerns which turned out to be pertinent during project implementation: (i) that the weak capacity of the Ministry of Health would hinder the data collection effort; (ii) that greater clarity was needed on the mechanisms for participatory monitoring at the community level; and (iii) that the use of M&E results for decision-making and program management were not sufficiently detailed[35].

54. **Implementation.** Physical and financial monitoring was organized by the FMA, whose systems worked well from the start and provided timely and accurate information. The single weakness pointed out by the supervision missions was the inability of the FMA to link expenditures to outputs, which handicapped any discussion of potential efficiencies from region to region. In addition to the FMA, the project established an internal audit service which produced a number of reports on a variety of topics, such as following up Bank supervision missions, evaluating the performance of the FMA, and examining the use of MAP funds in specific structures (e.g., the sectoral ministries, the National Laboratory, beneficiary NGOs, etc.). A technical audit was organized in 2007 to review project implementation but was not subsequently repeated.

55. Though many of the elements of the project monitoring system were in place soon after project effectiveness, there were some initial delays in training and organizing the DHS. More significantly, the resignation of the Secretariat's M&E specialist and weaknesses in MOH's Health Management Information System (HMIS) contributed to a shortage of information, particularly in 2004. Progress accelerated after the 2006 joint annual review: (i) of additional staff were recruited at central and regional levels; and (ii) the indicators (as well as the sources and methods for data collection) were better defined. Problems remained however as there was: (i) a frequent turnover of staff of central-level staff and weak capacity of regional-level staff; (ii) a resulting gap in the organization and

[33] Effectiveness was delayed until January 15, 2010 as a result of delays in: (i) ratifying and promulgating the grant agreement and the legal opinion; and (ii) depositing the initial advance of US$1.0 million in the project account.
[34] Modifications included: (i) different indicators based on the M&E guide for the national program; (ii) a more efficient process focused on providing specific information for use at each level; and (iii) simplified data collection tools.
[35] The QEA also noted insufficient discussion about monitoring implementation of environmental aspects of the project.

quality control of the data collected; and (iii) difficulties in using the selected computer tool (CSPro) for collating and analyzing data[36].

56. For the Additional Financing, the results framework was organized to: (i) take account of improved sources of data which were not available for the preparation of the original Project, as well as areas where data availability remains limited; (ii) make the results framework more gender sensitive by disaggregating indicators to show results for males and females; (iii) clarify certain indicators for better measurement of the intended outcome, especially for targeted high risks and vulnerable groups; and (iv) reflect the additional three years of Project implementation.

57. Presentations for the annual joint reviews and final annual reports were available from 2006 on and provided comprehensive and consistent information on the outcome and intermediate outcome indicators. The Mid-Term Review was carried out as scheduled (2007), and detailed summaries of project achievements were prepared at the end of the original grant (2009) and at project closing (2012).

58. Surveillance and research. In addition to the PHRD studies (2003-04), periodic sentinel surveillance was carried out (2005, 2007, and 2011). National household surveys including the DHS (the first ever DHS in the country was financed by the Project) were carried out in 2005 and 2011and an AIDS Indicator Survey (the ESISC) was carried out in 2009. The project also carried out an ambitious program of research aimed at collecting information on the higher risk populations. These studies examined: (i) the vulnerability of girls and women (2005); (ii) knowledge and attitudes of prisoners (2006); (iii) knowledge and attitudes among students (2008); (iv) behavior and HIV prevalence of military (2009), (v) and extensive integrated behavioral sero-surveillance survey (IBSS) was conducted among sex workers, MSM, and prisoners (2012), and (vi) behavior and HIV prevalence of indigenous groups (2012). Extensive research was also conducted on the education sector, examining its response to the epidemic (2009) and the impact on students and staff as well as the sector as a whole (2012). Periodic UNGASS reports were prepared, and an evaluation of the status of the national strategic framework was carried out (2007).

59. **Utilization.** The PAD proposed arrangements to produce and use M&E information at regional and national levels (through the HIV/AIDS councils, the project operations committee, and the thematic groups). While the formal HIV/AIDS councils and the operations committee did not meet as frequently as proposed in the decree, other measures for sharing and discussing M&E data were implemented as planned: (i) joint annual reviews were held; (ii) information from the various surveys and studies was systematically disseminated; and (iii) annual reports and plans were circulated (though frequently with significant delays). The final project evaluation noted, however, that no formal feedback of information received from the regions was transmitted to the regions.

60. M&E is rated **Substantial**. From a situation of the near absence of credible information on HIV, the project contributed significantly to a better understanding of the epidemic. Appropriate measures were taken to ensure the regular availability of adequate information to assess the financial, implementation, and epidemiological results of the project. The timeliness and quality of reporting (FMR, annual reports) were satisfactory; and a number of important surveys and studies were conducted on key aspects of the national response to the epidemic[37]. The regional and national

[36] The participation of MOH/PNLS was problematic in that the Global Fund project offered financial incentives for providing the required data while the MAP did not; as a result, MOH was reluctant to provide regular data to the regional secretariats. Arrangements were made in June 2010 to harmonize the MAP and GF projects.

[37] Several supervision missions noted that the project might have: (i) better analyzed the effectiveness and efficiency of expenditures to implement the national response; and (ii) monitored the environmental aspects of the project.

structures intended to use the information were not entirely satisfactory, but joint annual reviews were consistently carried out and Bank supervision missions systematically charted project responses to past recommendations with indications of how information was used to improve project performance.

2.4 Safeguard and Fiduciary Compliance

61. **Environment**. The environment category of the project at the time of appraisal was B. The Medical Waste Management Plan (MWMP) (December 2003) focused on: (i) installation of appropriate incinerators in facilities supported by the Project; (ii) training of health staff in handling sensitive materials; and (iii) sensitization of the population about HIV/AIDS waste issues. The MWMP figured prominently in Schedule 4 of the DGA. This MWMP was considered "overly ambitious" (by the QEA) and scaled-down to cover only project facilities. Supervision missions noted institutional issues within MOH over implementation responsibilities. Over the period 2005-09, ISR ratings of MWMP implementation improved gradually (from MU to MS to S), but an evaluation the first phase of the project in 2009 concluded that progress had been limited to a few incinerators, some training, and guidelines (which were never validated) and attributed the lack of progress to insufficient funds.

62. For the Additional Financing (also Category B), the 2003 MWMP was updated (with similar activities but more emphasis on monitoring). The last supervision mission confirmed that very little was achieved during the second phase of the project, though the ISRs were only downgraded from S to MS. In addition, the Additional Financing's proposed support for HIV/AIDS prevention efforts among the Pygmies triggered the safeguard policy on Indigenous Peoples and the Indigenous People's Planning Framework (IPPF) was prepared in May 2009. A program tailored to the needs of this population group was formulated and implemented, and an evaluation of the vulnerability of this group was conducted in 2012.

63. **Procurement, Disbursement, and Financial Management.** Though the FMA had initial difficulties adapting to accepted Bank procurement procedures, its performance on procurement and financial management was never rated less than MS from December 2004 on.

64. Procurement. Within a difficult overall country context, early missions noted the weaknesses including: (i) tardy preparation of the procurement plan; (ii) poor organization of the different tenders; and (iii) insufficient knowledge of Bank procurement procedures. Performance subsequently improved: (i) though the procurement plan was often received late, it was judged to be complete; and (ii) the evaluation of offers was judged (with the occasional exception) to be well done. Other problems included: (i) insufficient attention to the publication of tender announcements and subsequent awards; (ii) inadequate contract management; and (iii) poor archiving of documents related to the various tenders. Bank reviews also indicated the absence of measures to fight fraud. Though many of these problems were observed throughout project implementation, the supervision missions generally noted efforts to implement the recommendations and progress in each of these areas.

65. Financial management. Efforts were made to ensure the adequacy of the FMA's systems, establish an internal and technical audit capacity, and strengthen the accounting capabilities for the sectoral ministries and the NGOs providing managerial support. However, the February 2006 mission identified four important FM issues: (i) the complexity of the procedures described in the project operations manual; (ii) insufficiently transparent project budgeting; (iii) accounting problems related particularly to outstanding advances, incomplete documentation, and poor organization of justifications for expenditures; and (iv) shortcomings in the installation of

TOMPRO[38].

66. At the mid-term review (May 2007), it was agreed that the basic FM elements were in place but insufficient capacity at central, regional and beneficiary levels remained a major constraint. In addition, the MTR noted the relatively low absorption of project funds and linked this result to delays in providing justifications for expenditures (particularly by UNDP and PNLS). While the Bank concluded that the FMA's performance was "acceptable", the MTR criticized it for insufficient personnel, inadequate supervision of the implementing agencies, and rigidity in controlling NGO expenditures.

67. For the Additional Financing, fiduciary arrangements were modified to move FM under the direct management of the Permanent Executive Secretariat[39]. Minor problems persisted (related to delays in project budgeting, insufficient justifications for expenditures, and modifications to TOMPRO) and contributed to a substantial risk rating, but FM was considered satisfactory throughout the entire period of Additional Financing. During this phase, the financial monitoring reports (FMR) were received on time and were of satisfactory quality; and annual audits were received on time and were unqualified. Global FM risk was considered substantial throughout additional financing.

2.5 Post-completion Operation/Next Phase

68. Government ownership of the strategic and programmatic directions of the national response, evidenced by the National Strategic Framework (2003-07), became effective in 2007 with the adoption of the "three ones". Subsequent revisions of the National Strategic Frameworks for 2009-13 and 2013-17 as well as the annual performance reviews have strengthened national ownership, despite some institutional constraints resulting from infrequent CNLS meetings and continuing problems between the Permanent Secretariat and the Ministry of Health. The linkage of the Permanent Secretariat to the Office of the President and the Prime Minister should facilitate the sustainable transfer of full responsibility for financing and supervising the project activities to the Government of Congo; and the promulgation of the law protecting the rights of PLWHV should provide the necessary legal framework for future action.

69. Implementation capacity has improved throughout project implementation and particularly since 2009 as a result of the additional staff and increased experience of the Permanent Secretariat. In addition, the Permanent Secretariat has benefited from: (i) the availability of data to improve targeting by both the public and private sectors; (ii) the focus on key ministries, proven NGOs, and the principal association of Congolese businesses; and (iii) the introduction of innovative approaches and learning by doing approaches.

70. Financing of the national response remains the key constraint, especially given the paucity of partners contributing to the National Strategic Framework. Government has made progressive strides to finance treatment[40] and demonstrated its commitment by agreeing to finance almost 75% of the estimated costs of the National Strategic Framework for 2009-13 (US$80 million of $126 million). It has also budgeted annually almost 300 million FCFA for the HIV/AIDS activities of the key sectoral ministries (see Annex 2). The Additional Financing paper anticipated funding from

[38] The accounting software adopted by the project.
[39] In fact, the same staff employed by the FMA was simply retained by the Permanent Executive Secretariat.
[40] Between 2003-05, ARVs were dispensed based on a graduated payment (roughly US$10-80) based on the patient's income; in 2006, the Government decided to dispense ARVs without charge (though biological testing was still charged); and in 2008 biological testing was made free of charge.

GFATM Round 9, which was received and has contributed to financial sustainability in the medium term. Sustainability for the medium to the long term remains positive especially as the HIV/AIDS effort link to the Health System Strengthening Project and increased GFATM support and Country commitment.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

71. The overall relevance of the project is rated **Substantial** for both the initial credit and the additional financing. For each phase, the objectives were (and remain) highly relevant to the existing political orientations and technical considerations.

72. Relevance of the project objectives. The relevance of the project's development objectives, components, and specific activities is rated **High** for both the original and the Additional Financing based on consideration of the project's: (i) adherence to the basic objectives of the PRSP, the CPS and the principles of the MAP approach; (ii) support for Congo's international and regional obligations (through the MDGs and the Chari River Basin initiative); and (iii) the evidentiary support for its national policies and directives (including the "three ones", indigenous populations, etc.).

73. The project was consistent with Bank strategies throughout preparation and implementation: from the initial TSS for the post conflict phase (2000-02), through the various interim strategy notes ending with the FY07-FY09 ISN, and including Country Partnership Strategy (CPS) for FY10-FY12 aiming inter alia at strengthening access to service delivery for the poor. Congo's Poverty Reduction Strategy Paper (PRSP), adopted in April 2008, includes as one of its five pillars combating HIV/AIDS.

74. The Government of Congo has also approved a series of National Strategic Frameworks to Combat HIV/AIDS (CSN), beginning with the period 2001-2003, and continuing with the Frameworks for 2003-2007, 2009-2013, and 2013-17. These frameworks have aimed to reduce the incidence of infection in the Congolese population and improve the quality of life of people infected and affected by HIV/AIDS. They have been accompanied by joint annual reviews since 2006, and mid-term reviews as well as surveys and studies to confirm the status of the targeted populations and determine the effectiveness of the interventions.

75. Relevance of the project design. The relevance of the project design is rated **Substantial** for both the original grant and the additional financing. The rating for the original grant is based on consideration of the project's: (i) use of the PHRD and PPF financing to constitute an evidentiary basis, prepare a strategic framework, and establish the requisite institutional arrangements; (ii) focus on five of the priority regions while anticipating additional resources (from the Global Fund and the Bank for a health project) to finance the national response; and (iii) subcontracting of fiduciary tasks to a firm and technical elements to NGOs (for treatment, sexual violence, and orphans) while building capacity to transfer responsibilities to national institutions during the second phase.

76. The QEA noted that the original grant could have had "a more focused strategy to better concentrate on the prevention of transmission among groups most at risk", and the Additional Financing addressed this issue, with increased emphasis on sex workers, MSM, prisoners, uniformed services, etc. The QEA also noted that in view of "the lack of commitment and weak capacity of the Ministry of Health, alternative implementation arrangements (might have been) identified", and this issue was addressed through the separate Health Sector Services Development Project (PDSS). Similarly, the project design addressed the issue of drug supply and distribution only through other projects (EU and PDSS).

77. The QALP (2010) for the Additional Financing assessed the likelihood of achieving the DOs as moderately likely and rated all three sub-dimensions of design (Strategic Relevance and Approach, Realism of Project Design, and Risks and Fiduciary, Safeguards and GAC Aspects) as moderately satisfactory ("3"). The QALP also noted that the original results framework was revised to include better baseline data, clearer outcome indicators, and more realistic targets. The decision to substantially increase the Government's counterpart financing requirement was meant to establish the basis for future sustainability.

3.2 Achievement of Project Development Objectives

78. Project efficacy is rated **Substantial** for the original grant and **Substantial** for the additional financing. The rating is justified by: (i) the project's results as summarized in in Section F of the Data Sheet; (ii) the quantitative outputs (as presented in Annex 2); and (iii) the project's weighted results as a proportion of actual disbursements at the time of the additional financing and at closing.

79. The following table summarizes the results of the data sheet and shows 75% of the PDO indicators and 91% of the intermediate outcome targets were either achieved or partially achieved.

Table 2: Summary of the Achievement of Project Objectives

Achievement	**Indicators**				
	Outcomes (PDOs)	**No. (%)**	**Intermediate (IOs)**	**No. (%)**	Total (%)
Achieved	2, 4,5, 6, 10, 12	6 (50%)	1,2,3,4,5,6,7,9,12,15, 16,19,20,22,23	15 (62.5%)	58.3%
Partially Achieved	1,3,9	3 (25%)	8,11,13,14,17,18,21	7 (29.2%)	27.8%
Not Achieved	7,8,11	3 (25%)	10, 24	2 (8.3%)	13.9%
Total		12 (100%)		24 (100%)	100

80. There are three PDO indicators which are important and reasonably easy to measure. (Prevalence rates were excluded because they were removed from the results framework in 2009). PDO #1 (condom use) was partially achieved; PDO#4, (HIV testing among pregnant women) was achieved; and PDO#10 (PLWHA on ARV treatment) was achieved. Prevalence rates, including among high risk groups, are discussed separately below.

An overview of the level of achievement of the KPI by PDO is presented in the following paragraphs. Details on annual results (in absolute numbers and percentages) may be found by OI and IOI in Annex 2.

81. **Project Development Objective 1: Limit the spread of HIV/AIDS and STIs.** Of the targets set for the eight outcome indicators, three were achieved:

- OI 3: 86.9% of males (91% of the target), 78.2% of females (104% of the target), and 80.8% of all adults (90% of the target) were able to identify condom use as a preventive measure;
- OI 4: 76.8% of pregnant women accepted voluntary testing, which was 128% of the original target and 89% of the revised target;
- OI 5: Though eliminated for the additional financing, the spread of HIV was limited as prevalence was estimated at 0.8% among young men in 2009 (as against 1.9% in 2003) and at 1.6% among pregnant women in 2012 (as against 2.4% in 2003).

82. Two targets were partially achieved

- OI 2: 72.1% of males (80% of the target) and 71.2% of females (79% of the target reported knowledge that HIV can be transmitted from mother to child during pregnancy;
- OI 8: 60.6% of pregnant women living with HIV (71% of the target) received ARVs to reduce the risk of mother to child transmission. .

83. Three targets were not achieved: OI 1: 33.3% of males (56% of the target), 38.7% of females (99% of the target), and 34.3% of all adults (57% of the target) used a condom during their last sexual contact with a casual partner, OI 6/STI prevalence among pregnant women (which increased from 3.0% to 8.2%) and OI 7/HIV prevalence among young women (which increased from 1.4% to 2.1%) and

84. For OI 1-3, results are available from the DHS (2005 and 2011) and from the ESISC (2009) which used the same methodology as the DHS. The results for these indicators are presented in the following table and show both the ambitiousness of the targets and slow progress in achieving them:

Table 2: Selected outcome results from the periodic surveys

Outcome indicators	Target	2005 DHS	2009 ESISC-I	2012 DHS
60% of adults aged 15 to 49 used a condom during their last sexual contact with a casual partner (OI 1)	60.0%	30.1%	28.1%	34.3%
Male	60.0%	42.8%	27.9%	33.3%
Female	40.0%	21.0%	29.0%	38.7%
90% of adults aged 15 to 49 report knowledge of vertical transmission (mother to child) (OI 2)	90.0%	45.5%	55.6%	71.2%
90% of adults aged 15 to 49 mention condom use as a preventive measure (OI 3)	90.0%	75.6%	75.3%	80.8%
Male	95.0%	84.0%	84.3%	86.9%
Female	75.0%	72.1%	67.3%	78.2%

85. Though eliminated as a PDO indicator in 2007, the project continued to collect prevalence data. For pregnant women, it appears that there has been a substantial decline in prevalence rates over the past 5+ years:

Table 3: Prevalence of HIV among pregnant women

	2007	2008	2009	2010	2011	2012/Q1
Prevalence rate	5.2%	3.9%	3.4%	3.1%	2.7%	2.7%

86. Among the general population HIV prevalence appears to have a positive down ward trend. Proxy indicators for both pregnant women and males show a remarkable reduction from baseline except for women aged 14-19 were there is an apparent increase. On note in the almost 50 fold reduction in HIV prevalence in pregnant women attending antenatal care between 2007 and 2012. Overall population prevalence has shown a reduction from 4.2 to 3.3 a reduction of about 23.9%.

Table 4: Prevalence of HIV in different population groups and the general population

Indicator	Baseline	2005	2009	2012
HIV prevalence among 15-24 year old pregnant women	2.4 (prevalence Study)		2.0 (AIS 2009)	
HIV prevalence 14-19 year old females	1.4 (Prevalence study)		2.1 (AIS 2009)	

HIV prevalence 14-19 year old males	1.9 (Prevalence study)		0.8 (AIS 2009)	
HIV prevalence pregnant women attending antenatal care	5.2 (2007)		3.4 (AIS 2009)	2.7 (DHS 2012)
Prevalence of HIV in the General population	4.2 (Prevalence study)			3.2 UNGASS

Source: HIV prevalence study/KAP 2003, AIS 2009, DHS 2012. Note: The data presented the available information at the time given the prevailing situation in the Congo. (See context at project design)

87. **Low CSW Prevalence:** It appears that Congo has an exceptionally low HIV prevalence rate among commercial sex workers compared to other countries in Central Africa who have similar levels of overall HIV prevalence. Table 5 indicates that the 2012 HIV prevalence results among sex workers in ROC are one third or less of those in other countries (although Burundi has made progress too in the last few years). This low prevalence rate is not likely due to early mortality among CSWs as there has been a large increase in the number of people who are on ARVs. While no baseline data is available for ROC, the 2012 results are very encouraging.

Table 5: Comparaison of Prévalence of HIV in commercial sex workers and general population in Countries of Central Arica in relation to Republic of Congo

Country	**Prevalence of HIV in commercial sex workers**	**Prevalence of HIV in population 15-49 years**
Cameroun	35.5%	5.3%
Burundi (2006)	38.4%	3.1%
Gabon	23.6%	3.4%
Chad	20.0%	5.2%
Republic of Congo (ROC)	**7.5%**	**3.2%**

Source UNAIDS 2010 and ROC 2012: Study of HIV in High Risk groups

88. All five of the intermediate outcome indicators (related to the availability of services) were achieved as the project: (i) established 19 functional sentinel surveillance sites (target: 13) for HIV and STI (IOI 1); (ii) extended the coverage of quality treatment of STIs to 46 facilities (target: 23) in the five regions (IOI 2); (iii) ensured that no sale points experienced a shortage of condoms in the last month (IOI 4); (iv) screened 100% of blood units used for transfusion for HIV, HBV, HCV, and syphilis (IOI 5); and (v) increased the number of facilities providing quality HIV counseling and testing from 6 to 144 (target: 99) (IOI 6). According to the project's final report, the number of persons knowing their HIV status increased from 2,191 in 2004 to 326,089 in March 2012.

89. Finally, several indicators were linked to efforts to limit the spread of the disease among vulnerable populations. The target was achieved for uniformed persons (IOI 16) as 6267 uniformed persons (118% of the target) were reached by national HIV/AIDS programs. The establishment of programs for school and prison populations were less successful:

- IOI 14: 291 schools (55% of the target) introduced active out-of-school HIV/AIDS programs;
- IOI 17: 3 prisons (50% of the target) introduced with active HIV/AIDS programs.

As Annex 2 shows, information on prisoners reached has been available since 2006 and on the other groups since 2011. In 2011-12, a prevalence and behavioral study of professional sex workers, MSM, and prisoners[41] was carried out:

- 96.3% of professional sex workers had heard of HIV/AIDS, but only 24.5% correctly answered all six questions about the transmission of the virus. 81% of sex workers had used a condom with their last client (though only 21% with a non-paying partner). HIV prevalence among sex workers was estimated at 7.5%.
- 98.7% of MSM had heard of HIV/AIDS, but only 21.9% correctly answered all six questions about the transmission of the virus. 64% of MSM had used a condom with their last client (though only 40.6% with a non-paying partner). HIV prevalence among MSM was estimated at 26.1%.
- 95.8% of prisoners had heard of HIV/AIDS, but only 32.6% correctly answered all six questions about the transmission of the virus. None of the 6 prisoners 6.3% of prisoners had used a condom during their last sexual encounter. HIV prevalence among prisoners was estimated at 8.3%.

90. Overall, the project's performance on this development objective was substantial for the original grant and S**ubstantial** for the additional financing.

91. **Project Development Objective 2: Mitigate the health and socio-economic impact of HIV/AIDS on persons infected with or affected by HIV/AIDS and STIs.** For those persons infected by HIV/AIDS, the number of PLWHA benefiting from monitoring and treatment according to the national guidelines (OI 9) increased from about 5,000 in 2006 to about 22,000 in 2011 (target: 15,000). Of the four intermediate outcome indicators, targets for two were achieved as the number facilities providing quality HIV/AIDS care and treatment increased from 32 (2007) to 65 (in 2012) (target: 40) (IOI 7); and the number of TB centers integrating testing and care of HIV increased from 16 to 24 (target: 24) (IOI 9). Targets for two additional indicators were partially achieved as the proportion of pregnant women testing positive and benefiting from global care, support and treatment (IOI 3) rose from 37.8% in 2009 (47% of the target) to 68.7% in 2012 (80% of the target); and the number infants born positive and treated according to national protocols (IOI 8) increased from 632 in 2008 to 1,320 in 2011 (86% of the target).

92. For those persons affected by HIV/AIDS, the target was not achieved as the number of OVC benefiting from the defined package of services (OI 10) increased annually only from about 3,000 in 2006 to 11,500 in 2011[42] (47% of the target). Of the two intermediate outcome indicators: one was achieved as 17 support organizations for OVC were established (target: 17) (IOI 22); and one was not achieved as the number of health centers offering care and prophylaxis for victims of sexual violence remained at 2 during the second phase (target: 18) (IOI 10).

93. Even though only one indicator (partially achieved) was included in the original credit, progress towards mitigating the health and socio-economic impact of HIV/AIDS on persons infected with or affected by HIV/AIDS and STIs performance continued. However, performance was **Modest** during the first phase and **Substantial** for the additional financing.

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[41] CNLS, Enquête comportementale couplée à la sérologie VIH chez les professionnelles du sexe, hommes ayant des rapports sexuels avec les hommes et détenus en République du Congo (juin 2012).

[42] The project's own final evaluation notes that 29,576 OVC received support from the project, but the ICR team was unable either to independently verify this number or to determine whether this number benefited from some or all of the services offered in the package.

94. **Project Development Objective 3: Build strong and sustainable national capacity to respond to the HIV/AIDS epidemic.** The only outcome indicator (introduced for the additional financing) was achieved as 12 of 12 regional HIV/AIDS units (UDLS) reported annually on at least 75% of M&E indicators (OI 11). Of the thirteen intermediate outcome indicators, five were achieved:

- IOI 12: 94% of the population (104% of the target) was reached about HIV/AIDS through IEC/BCC programs on radio and television;
- IOI 15: A law protecting PLWHA against discrimination and protecting women against sexual violence was adopted and signed in 2011;
- IOI 19: 264 community-based HIV/AIDS projects (164% of the target) were approved, completed successfully, and accounted for; and
- IOI 20: 50 private enterprises (125% of the target) began offering HIV/AIDS services to their workers.

95. Targets for seven of the intermediate objective indicators were partially achieved:

- IOI 11: 15 selected sector ministries (125% of the target) and 21 ministries overall implemented action plans in 2012; the overall implementation rate for the action plans was 12% (target: >80%).
- IOI 13: 33.4% of primary schools (target: 60%), 35.2% of secondary schools (target: 100%), and 50% of technical schools (target 60%) introduced the national HIV/AIDS modules;
- IOI 18: Actual cumulative expenditures for the civil society response (excluding OVC) were 32.5% of planned expenditures (46% of the target);
- IOI 21: On average, 5,818,237 condoms were distributed/sold each year from January 2009 to June 2012 (65% of the target); and
- IOI 24: Over the four-year period 2008-2011, the National AIDS Council met once in three years; over the same period, the Steering Committee met twice in only one year (and once in two others) (50% of the target)

96. The regular collection of monitoring data (IOI 23) was not established by June 2005, but was in place (as noted previously) by 2006.

97. Overall, the project's performance on this development objective was **modest** for the original grant and **substantial** for the additional financing.

98. **Overall achievement result**. Based on the project's initial and revised indicators and the ICR guidelines, the following table assesses the project's overall efficacy as **Substantial**.

Table 4: Combined overall project achievement ratings / Efficacy

	Considerations	Against Original PDOs	Against Restructured PDOs	Overall
1	Rating value	2.94	3.06	
2	Amount disbursed	18.60	3.91	22.51
3	Weight (% disbursed before/after PDO change)	83%	17%	100%
4	Weighted value (1 x 3)	2.43	0.53	2.96
5	Final rating (rounded)			**Substantial**

Source: OPCS, ICRR Guidelines (rev. June 2007), Appendix B, pp. 42ff.

3.3 Efficiency

99. The PAD relied on the economic justifications contained in the Multi-Country HIV/AIDS Program for the Africa Region (Report No. 20727 AFR) but did not present an analysis of the potential impact of the project on the economy. The ICR team concluded that the project made a concerted effort to ensure that costs were reasonable with respect to both recognized norms ("value for money") and benefits; three aspects are important.

100. First, based on available MAP experience, the project included several management measures to enhance early project implementation capacity, including: (i) a five-year time frame and a limited geographic scope; (ii) an emphasis on capacity building in each component; and (iii) use of contracting out for specific financial and technical components of the project. Later, the national strategic frameworks and the coordination skills of the national and regional secretariats improved project performance. In addition, the adoption of the "three ones" strengthened coordination, increased participation in planning and budgeting, and enhanced the use of M&E results through the annual reviews.

101. There were some costs associated with these achievements throughout project implementation. In particular, the process of reviewing the annual plans consistently postponed final approval (from January to March or April), which (combined with late counterpart financing, particularly during additional financing) decreased the time for plan implementation and delayed disbursements. The result was a decrease in the implementation rate of planned activities:

Table 5: Proportion of planned activities implemented during Phases 1 and 2

	2004-06	2007	2008	2009	2010	2011	2012	Total
Original credit								
Activities planned	463	689	517	534	533	534		3 270
Activities implemented	431	378	366	414	416	416		2 421
% implemented	93%	55%	71%	78%	78%	78%		74%
Additional financing								
Activities planned					444	581	700	1 725
Activities implemented					108	228	244	580
% implemented					24%	39%	35%	34%

102. The phasing of interventions did allow the project to manage the number of ministries, community groups, and private sector entities involved between 2005-08 and to improve the targeting of groups (particularly sex workers, MSM, prisoners, and local ethnic groups) and the approaches used (replacing broader social communication with more comprehensive "thematic" days and peer education) after 2009. The project also piloted and then scaled up effective communications channels for reaching youths (through youth fairs and the hotline), young couples (through the traditional mediators), and those without easy access to testing (through mobile units).

103. Second, as shown in Annex 2 and confirmed by the table presented in Annex 3 (assessing efficient resource use to avert potential infections[43]) the project made important contributions not only to prevention among MSM and sex workers and in the workplace[44] but also to blood safety,

[43] World Bank (2008) The World Bank's Commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007-2011, March, citing Bollinger and Stover (2007).

[44] A rough calculation of expenditures shows that 17% were spent on MSM, sex workers, condom distribution, and workplace programs.

PMTCT, and VCT. Although the supervision missions noted interruptions in the supplies of laboratory reagents and insufficient quality (including a lack of qualified staff for counseling, weak organization of services, inadequate confidentiality, etc.), significant progress was achieved over the duration of the project and particularly during the additional financing phase.

104. Third, as summarized in Annex 3, the final supervision mission estimated the economic benefits of the project for three preventive activities: (i) blood security, (ii) prevention of mother to child transmission, and (iii) behavior change among professional sex workers. The results are presented in the following table:

Table 6: Economic benefits resulting from selected project interventions

Intervention	Economic Benefit
Testing of Blood Donated for Transfusions	$ 22 158 044
PMTCT	$ 244 000
BCC for Commercial Sex Workers	$ 2 811 565
Total	$ 25 213 609

The results show that the total economic benefit for these three preventive activities exceeds the amount spent from project funds for the interventions and is slightly less than the total estimated cost of the project as shown in Annex 1b. Since these activities represent a subset of the project's preventive activities, the overall benefit of the project would almost surely exceed the project's cost.

105. Despite the measures taken to improve project start-up, the difficulties of strengthening institutional capacity, managing a variety of multi-sectoral and decentralized agencies, and carrying out unfamiliar Bank procedures contributed to **Modest** efficiency for the initial credit. The rapid expansion of services (despite reduced Bank financing) combined with the emphasis on proven interventions with demonstrated economic benefits for the country contributed to **Substantial** efficiency for the additional financing.

3.4 Justification of Overall Outcome Rating

106. Based on IEG guidance and the previous ratings of Substantial for relevance, Substantial for efficacy, and Modest/Substantial for efficiency, the overall outcome rating for the project is **Moderately Satisfactory**.

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

107. Poverty. Though the PAD viewed the post-conflict situation, the generalized poverty of the population, and the growth of the epidemic as interrelated elements (with each contributing to and resulting from the other elements), the project did not explicitly address poverty. The project did not include the financing of revenue-generating activities (RGA) for associations of PLWHA as a priority; RGA were mentioned in the original grant but not at all in the additional financing. The project did address (in conjunction with the World Food Program) the issue of nutrition for PLWHA. RGA were financed for sex workers, girls with children and OVC, but the effectiveness of these interventions was not evaluated. Beginning in 2006, however, the Government initiated the free provision of ARVs, which was followed in 2008 by free medical follow-up of those requiring ARVs.

108. Gender. The project addressed gender initially from the perspective of sexual violence, as some 60,000 women and girls had been victims of rape during the decade of social conflict. To this end, the project extended the intervention of Médecins sans Frontiers (MSF) to ensure: (i) the

transfer (in 2005) of its rape clinics to the gynecological services of two hospitals (Talangaï and Makélékélé in Brazzaville); and (ii) the care and treatment of about 360 victims of violence per year[45]. Both the 2006 joint annual review and the MTR (May 2007) raised the issue of sexual violence, but the project's focus had turned instead to a broader analysis of women's vulnerability (and the feminization of the epidemic), formulation of a legal framework to counter the effects of the epidemic on women, and better targeting of sensitization and education efforts[46]. Resources for these activities were included in the additional financing, and the results framework was made more gender sensitive by disaggregating indicators to show results for men and women.

109. Social development. The project's impact on social development can be seen at three levels. First, at a societal level, the adoption of legislation provided guidelines for: (i) preventing HIV/AIDS (among students, health workers, incarcerated persons, women and girls, and other vulnerable groups); and (ii) protecting the rights of PLWHA (by forbidding discrimination). Second, among specific populations, the recognition of socially marginalized groups (CSW, MSM, inmates, PLWHA and their families, OVC) signals their inclusion in the national dialogue about the spread of the epidemic. Third, among the public and private sectors, the development of an overarching programmatic response to the epidemic constitutes an important partnership for a common national response.

110. A particular emphasis on indigenous populations (pygmies) was formally introduced in the additional financing as part of the environmental and social management framework (ESMF).

(b) Institutional Change/Strengthening

111. The project contributed to establishing and strengthening national and regional institutions capable of formulating and coordinating the national response: (i) at central level with the National Committee, the Steering Committee, and the National Permanent Secretariat; and (ii) at regional level with the Regional Committees and the Regional Permanent Secretariats. Combined with the series of national strategic frameworks (for 2003-07, 2009-13, and 2013-17), the project has put in place the necessary instruments for implementing the national response.

112. Within this framework, the project has effectively promoted a multi-sectoral response to the epidemic by: (i) mainstreaming HIV/AIDS activities into the action plans of key sector ministries and decentralizing resources and responsibility for implementing these activities; and (ii) strengthening the management capabilities and financing of a range of private sector entities (including UNICONGO) and civil society associations (the NGO Forum, religious groups against HIV/AIDS, PLWHA) to improve results at local levels. The project was less successful in forging a harmonious working relationship with the Ministry of Health.

(c) Other Unintended Outcomes and Impacts (positive or negative)

113. Though not unintended, the introduction of diverse communications channels proved effective in reaching the target populations; in particular the youth fairs (KERSIVAC), the HIV/AIDS hotline (la ligne jaune), and the mobile testing unit (UMODEV) represented, according to a special Bank mission, "home grown foundations for behavioral change and an improved national response to the particular HIV/AIDS epidemic profile of the Republic of the Congo". The project also supported interventions by the Traditional Mediators, who preside over traditional

[45] Evaluation of the original credit (2009) noted that: (i) data were not collected after 2005; (ii) the problem was thought to have significantly diminished; and (iii) the integration of sexual violence services in the hospitals had not succeeded.
[46] These points had been raised during preparation in a proposed strategy to establish an "obsérvatoire" to reduce the vulnerability of girls and women to HIV/AIDS and sexual violence. The "obsérvatoire" was not created.

marriages and use the occasion to sensitize those in attendance.

114. In addition, the project made a significant contribution (in collaboration with UNESCO) to the development of a comprehensive response to HIV/AIDS in the education sector, combining: (i) studies examining the impact of HIV/AIDS on students, teachers, and administrative staff and on the sector as whole; and (ii) policies and strategies for an enhanced sectoral response to the epidemic.

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops

N/A

4. Assessment of Risk to Development Outcome

Rating: **Modest**

115. The risk to development outcome is assessed as modest based on: (i) Government's commitment to fighting HIV/AIDS; and (ii) the legal, institutional and strategic measures described previously. Over the past decade, the Government has systematically: (i) promoted appropriate institutional arrangements and participatory mechanisms (at central, provincial, and community levels); (ii) developed consistent and coherent national strategies, including the adoption of a programmatic approach ("the three ones"); and (iii) adopted adequate program policies and procedures (for testing, care and support, and treatment). Particularly significant progress has been made in enhancing surveillance and knowledge of the most vulnerable populations, expanding testing and counseling, acknowledging (and slowly reducing discrimination against) PLWHA, and providing MTCT prevention and ARV treatment. An adequate ESMF is in place, though progress on introducing measures for waste management has been slow.

116. Administratively, while delays in planning and budgeting, procurement, and financial management will continue, adequate measures have been established to ensure effective implementation by the responsible agencies at central, regional, and community levels.

117. Concerns about the financial future and sustainability of the national response remain. Historically, Congo has allocated (though not always disbursed)[47] significant amounts of financing from its own resources[48]; as a middle income country, it has the means to provide adequate resources for the national response to the epidemic. The country has also mobilized external sources from the Global Fund (Round 9) and various UN agencies for HIV/AIDS and other sources (including the IDA-financed PDSS) for health. However, given the experience with: (i) delays in disbursing counterpart funding; and (ii) the prospects for financing the national program after the current Round 9, the risk to development outcome is considered modest.

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry

Rating: **Satisfactory**

118. From identification (April 2002) to Board approval (April 2004), the Bank's preoccupations were clear and clearly transmitted to the Government: (i) define and strengthen

[47] Since 2008, allocations to key ministries have averaged 280 million FCFA, but actual disbursements are not known.
[48] UNAIDS data from 2009-2010 estimated the proportion of expenditures as follows: public (37%), donors (53%), NGOs (3%), and other/out of pocket (7%).

institutional relationships; (ii) strengthen capacity to ensure effective implementation; (iii) focus on specific vulnerable groups, establish priorities, and sequence interventions; and (iv) establish sound monitoring and evaluation. Substantial PHRD and PPF funding (US$1.6 million) was mobilized to prepare an evidentiary base (e.g., KAP and prevalence studies), address key implementation issues (e.g., communications strategies, condom distribution, support for OVC), draft guidelines for training and program implementation, and prepare a project operations manual. The PAD was clear and concise.

119. A QEA rated the preparation as moderately satisfactory, with: (i) strategic relevance and approach, technical, financial and economic aspects, fiduciary aspects, poverty, gender and social development as well as Bank inputs and processes rated Satisfactory; and (ii) policy and institutional aspects, environmental aspects, implementation arrangements, and risk assessment as moderately satisfactory. Certainly, the preparation team did not solve all of the problems (notably those related to MOH participation and drug distribution), but the ICR team believes that: (i) the policy and institutional aspects deserved a higher ranking; and (ii) the efforts to establish baseline data and other information under difficult, post conflict circumstances were not sufficiently appreciated by the QEA panel.

120. There was a slight delay in effectiveness, but the availability of the PPF mitigated any delay in project implementation.

(b) Quality of Supervision

Rating: **Moderately Satisfactory**

121. Three TTL (the last based in Brazzaville from 2010-12) assured continuity during project implementation. Supervision missions were conducted regularly. Informative aide-memoires were submitted in a timely manner; with detailed component results and list of observations and recommendations. The task team's contributions to the project were especially useful for: (i) the inclusion of HIV/AIDS in school curricula; and (ii) programs for OVC.

122. The QALP (2010) rated supervision as: (i) satisfactory for the supervision inputs and process and for candor and realism of ISRs; and Supervision Inputs and Processes); and (ii) moderately satisfactory for the focus on development effectiveness and fiduciary/safeguard aspects. The ICR team believes that the individual ISRs were of only average quality and candidness, and some of the ratings seem to have been too generous, notably for financial management, counterpart financing, and safeguards. In retrospect, the S ratings for the DO and IP ratings from 2008-11 seem too optimistic; the MS ratings in 2012 seem more justified. A detailed aide-mémoire was prepared for the last mission and rated the various components and the project as a whole.

123. The QALP assessed the likelihood of achieving the DO as moderately likely based on the changes incorporated into the additional financing (e.g., better phasing, more focus on prevention among groups most at risk, a more realistic results framework). The QALP also noted that: (i) earlier approval of the separate Health Sector Services Development Project (i.e., before FY08) could arguably have strengthened its contribution to the HIV-AIDS program; and (ii) the longer-term sustainability issue will ultimately need to integrate and mainstream HIV/AIDS activities into the public health system overall, which will hopefully be one outcome of the parallel Health Sector Services Development Project.

(c) Justification of Rating for Overall Bank Performance

Rating: **Moderately Satisfactory**

124. Based on a Satisfactory rating for Quality at Entry, a Moderately Satisfactory rating for supervision, the Bank's performance is rated **Moderately Satisfactory**.

5.2 Borrower Performance

(a) Government Performance

Rating: **Moderately Satisfactory**

125. The Government's performance is rated as Moderately Satisfactory. Among the Government's important contributions were: (i) its ownership and commitment to achieving the development objectives with particularly valuable support from the Prime Minister's Office; (ii) its contribution to the development of a common enabling environment (politico-legal, institutional, technical, financial, and administrative) facilitating the national response by public and private actors; (iii) its productive relationships with donors, partners, and other stakeholders; and (iv) its investment in studies and surveys to monitor the epidemic. Though not functional during the original grant, the National AIDS Council and the Steering Committee met at least annually during the additional financing phase. The regions developed and approved their annual plans throughout project implementation. Government performance was diminished by: (i) an inability to improve cooperation between the Permanent Secretariat and the Ministry of Health; and (iii) delays in disbursing counterpart financing which reduced the overall amount of project funding and diminished potential project activity.

126. Performance by the key ministries (and public sector officials) at central and regional levels varied but was generally positive as MAP support provided the means for implementing their annual programs and demonstrating their capabilities to other potential sources of financing. Though disbursement tended to be slow and justification of expenditures even slower, the authorities interviewed during the ICR mission expressed satisfaction with what they were able to achieve.

(b) Implementing Agency or Agencies Performance

Rating: **Moderately Satisfactory**

127. Initially, project implementation was shared by: (i) the National Permanent Secretariat which was responsible for policy, program coordination, and technical oversight; and (ii) the Financial Management Agency which was responsible for procurement and financial management. After the additional financing the responsibilities of the FMA were incorporated into the National Permanent Secretariat.

128. **National/Regional Permanent Secretariats.** After initial difficulties, related perhaps to its post conflict situation, the implementing agencies made significant and sustained progress in project implementation. The ISRs consistently rated implementation progress in general and project management in particular as S or MS. Project management: (i) achieved (or partially achieved) 90% of its objectives; (ii) carried out the major project milestones (the mid-term review, and the Borrower's ICR) in a timely manner; (iii) adapted to changed circumstances when inadequate counterpart financing after 2009 required constant adjustments in planning and implementation of the national response; and (iv) managed a successful monitoring and evaluation system, joint annual reviews, and a substantial program of studies and surveys. Project management was also successful in supporting a wide range of private sector and civil society actors; it was less successful in convening the national and regional coordinating structures and in working with the Ministry of Health.

129. **Financial Management Agency.** In 2007, the project's internal audit unit assessed the

FMA's performance as moderately satisfactory: (i) satisfactory on the day to day financial operations, withdrawal applications, financial monitoring reports, etc.; and (ii) moderately unsatisfactory on strengthening the accounting tools and FM capacity of staff recruited by the project. Since financial management was rated satisfactory after the integration of the FMA's responsibilities into the Permanent Secretariat, this weakness seems to have been corrected.

(c) Justification of Rating for Overall Borrower Performance

Rating: **Moderately Satisfactory**

130. Based on a Moderately Satisfactory rating for the Government's performance and a Moderately Satisfactory rating for the implementing agencies, the Borrower's performance is rated **Moderately Satisfactory**.

6. Lessons Learned

131. The project provides support for three important lessons involving the importance of: (i) establishing an enabling environment for the HIV/AIDS response; (ii) strengthening management capacity and promoting innovation; and (iii) ensuring the evidence basis for and appropriateness of indicators of project achievement.

132. **Strong political commitment is critical to establishing an enabling environment to address the HIV/AIDS challenge in post-conflict situations:** As the first major health HIV/AIDS response for Congo, the project provided an opportunity to galvanize the Government's institutional and programmatic response to the threat of the HIV/AIDS epidemic. Through its own achievements, the increasing allocation of its own resources, and its commitment to persons infected and affected by the disease (as reflected in the 2011 law to protect the rights of these groups), the Government strengthened the platform for future technical engagement and established incentives for the contributions of other funding sources (and especially the Global Fund and UN agencies) in health and HIV/AIDS. Two aspects of this enabling environment are particularly worth noting: a strong political commitment and a multisectoral approach.

133. Strong political commitment. The Government's initial willingness to address HIV/AIDS during the highly volatile post-conflict period was rewarded with progress (on strategic directions, institutional and organizational arrangements, and technical results). This commitment further enhanced programmatic results (the "three ones"), increased overall funding, and contributed to the achievement of many of the project's objectives.

134. Multi-sectoral approach in responding to HIV/AIDS. As part of the strong government commitment, the Prime Minister's Office provided leadership in the multi-sectoral response across all sectors. Within this overall context, the project has demonstrated the importance of focusing on sectors with the greatest potential impact on the epidemic and emphasizing the potential contributions of community organizations and the private sector.

135. **Strengthening management capacity and promoting innovation are essential to achieve results in low-capacity post-conflict environments.** As a result of the post-conflict situation, the overall capacity of project management capacity in the country was weak at the outset of the project. The recruitment of dedicated staff at central and regional levels, the sub-contracting of specific technical and managerial functions to more competent agencies and NGOs, and the heavy investment in capacity-building over the initial years of project implementation resulted in an increasing capability and confidence at all levels of the response to the HIV/AIDS epidemic.

136. These managerial achievements were most visible in the promotion (particularly during the second phase of the project) of innovations through: (i) strengthening local managerial capacity in both the public and private sectors; and (ii) using diverse communications channels to reach marginal but highly vulnerable populations (e.g., MSM, prisoners, etc.) and to implement potentially effective interventions (e.g., the youth fairs, the hotline, etc.). As an example of how to increase coverage, the project may serve as a useful example for other projects in similar post-conflict or capacity-constrained settings.

137. **Ensuring the evidence basis for and the appropriateness of indicators of project achievement is key to HIV/AIDS program management.** As a post-conflict country lacking virtually any up-to-date information on the HIV/AIDS, situation, Congo required significant investment during project preparation to ensure that baseline data were collected and a data base developed for the purposes of monitoring and evaluation. There were perhaps urban biases (due to the security situation) in the information collected during preparation and a tendency for overly ambitious targets, and the project should have corrected this situation through a restructuring or at the time of the additional financing. Within this overall context, the project's efforts to establish a well-performing M&E system, to carry out annual surveillance and periodic surveys (two DHS in 2005 and 2011 and an AIDS indicator survey in 2009), and to conduct a number of important studies demonstrates that it is possible to establish an evidentiary basis in a post-conflict country.

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

138. **(a) Borrower/implementing agencies:** The task team and the Borrower reviewed and agreed on the results of the indicators reported in the Data Sheet[49]. The Borrower has prepared a comprehensive final evaluation report in French and an English summary, which is presented in Annex 7. The Borrower's final evaluation report is available from the Project Files.

(b) Co-financing: Not applicable / Japanese Grant?

(c) Other partners and stakeholders: Not applicable

[49] A technical note was prepared at the completion of the ICR mission and is available in the project file. In addition to the Executive Secretariat has prepared final project evaluation.

Annex 1: Project Costs and Financing

(a) Project Cost by Component

Components	Appraisal Estimate Original credit (USD millions)	Additional financing (USD millions)	Actual/Latest Estimate (USD millions) *	Percentage of Appraisal
1. Public sector response	4.12	1.7	4.36	74.9%
2. Civil society response	3.35	0.9	2.42	56.94%
3. Orphans and other extremely vulnerable children	3.40	0.8	1.94	46.19%
4. Management & coordination, capacity building, and M&E	5.97	1.6	11.63	153.63%
5. PPF	1.00			
Estimated Total Baseline Cost	**17.84**	**5.0**	**21.35**	**95.62%**
Physical Contingencies	0.58	**0.0**	0.58	100%
Price Contingencies	0.58	**0.0**	0.58	100%
Total Project Cost	**19.00**	**5.0**	22.51	93.79%

Sources: Annex 2 of PAD and Client Connection (November 2010).
* Increases in total project financing also reflect exchange rate fluctuation in the SDR to dollar exchange rate over the project life.

(b) Financing

Source of Funds	Type of Co-financing	Appraisal Estimate (USD millions)	Actual/Latest Estimate * (USD millions)	Percentage of Appraisal
International Development Association (IDA)		24.0	22.51	93,79%
Borrower		10.0	6.16	61.60%
Total Project Financing		**34.0**	**28.67**	**84.32%**

* Increases in total project financing also reflect exchange rate fluctuation in the SDR to dollar exchange rate over the project life.

Annex 2: Project Outputs

Indicateurs	2004-05	2006	2007	2008	2009	2010	2011	2012
ORGANIZATION OF THE INSTITUTIONAL RESPONSE								
National AIDS Committee (CNLS)								
NAC meetings **(IOI 24)**				0	1	1	1	0
Steering Committee meetings **(IOI 24)**				2	0	1	1	0
Permanent Secretariat (SE/CNLS)	1	1	1	1	1	1	1	1
Regional Coordinating Units (UDLS)								
No. of operational units	11	11	11	11	11	11	11	12
No. of regional plans	11	11	11	11	11	11	11	12
Ministerial Coordinating Units (ULS)(other than Health)								
No. of ULS implementing action plans **(IOI 11a)**	12	12	14	14	15	18	20	21
Budgeted amount for plan implementation ('000 FCFA)				260 397	288 597	288 597	288 597	288 597
Société civile								
Nbre de sous projets soumis	104					89		
Nbre de sous projets approuvés et réalisés avec succès	62	63	71	149	79	72	71	46
PLVSS **(IOI 20)**			35	112	38	29	28	22
PADEPP (Projet R9 Global Fund à partir de mai 2011)			36	37	41	43	43	24
Secteur privé								
Nbre d'entreprises engagées dans la lutte **(IOI 19)**	18	20	26	31	34	41	50	50
PREVENTION								
Sensitization								
No. of persons covered by BCC activities (by vulnerable group)								
Elèves, étudiants	13 892	40 699	60 288	50 190	46 720	44 539	123 242	
Agents en uniforme **(IOI 16)**	1 444	5 336	2 400	4 394		1 595	6 267	6 264
Détenus		566	494		641		599	
Professionnelles de sexe (PS)							1 274	1 049
Hommes ayant des rapports sexuels avec les hommes (HSH)							340	180
Populations autochtone							4 201	3 080
Public Sector								
Peer education								
No. of peer educators trained		592	100	829				
No. of vulnerable persons reached by peer educators			8 362	47 695				
PLVSS			8 112	11 287				
PADEPP			250	36 408				
Social communication								
No. of persons trained in social communication	86	37	179	165				
No. of persons reached by social communication	13 892	40 699	75 341	62 442				
PLVSS			58 671	30 248				
PADEPP			16 670	32 194				

Indicateurs	2004-05	2006	2007	2008	2009	2010	2011	2012
Thematic days								
No. of persons reach during the thematic days					46 720	44 539	123 242	626
Education sector								
No. of secondary schools						650	650	650
No. of secondary schools using the curriculum **(IOI 13)**						25	229	229
No. of secondary schools with extracurricular activities **(IOI 14)**							313	
Civil Society								
Peer education								
No. of persons reached by peer educators (annual)			22 444	70 826	20 775	41 239	27 369	1 875
PLVSS			8 494	28 439	2 429	1 180	1 912	1 875
PADEPP			13 950	42 387	18 346	40 059	25 457	0
Social communication								
No. of persons reached by social communication (annual)	13 982	40 699	15 662	61 413	15 142	54 052	130 072	26 359
PLVSS			9 549	29 317	6 395	25 497	31 960	26 359
PADEPP			6 113	32 096	8 747	25 804	98 112	
Autres						2 751		
Other sensitization activities								
Ligne jaune								
No. of calls answered (annual)				102 425	90 292	107 758	84 458	33 436
Médiateurs traditionnels								
No. of education sessions (~200 persons per session)(annual)							898	292
Kermesse Sida vacances (Kersivac)								
No. of youths participating (annual)				61 250	86 199	64 318	61 884	39 146
Distribution des condoms								
Total no. of condoms distributed	6 719 780	7 440 908	9 663 251	9 966 253	7 753 543	5 923 248	7 114 560	
PLVSS **(IOI 21)**		434 295	2 803 781	4 058 219	6 457 767	3 855 069	5 767 065	3 596 524
Blood transfusion								
No. of points for blood transfusion	15		20	25	25	25	25	25
No. of blood donations	33 508	36 699	34 675	33 811	36 178	40 409	52 950	
Total no. of blood poches	33 508	36 699	35 350	33 811	36 178	40 409	47 994	
Prop. of blood poches tested **(IOI 5)**								
VIH	100%	100%	100%	100%	100%	100%	100%	
VHB	100%	100%	100%	100%	100%	100%	100%	
VHC	34%	40%	68%	81%	100%	100%	100%	
Syphilis	13%	43%	59%	44%	98%	100%	100%	
HIV+ prevalence among blood donors	3.52%	3.22%	2.64%	3.10%	3.12%	3.60%	2.64%	
Diagnosis and treatment of STIs								
No of STI diagnostic and treatment centers	17	13	60	87	96	103	117	117
Etat							15	66
PLVSS **(IOI 2)**		7	44	47	42	47	46	46
PADEPP			16	40	54	54	51	0
Autres					0	2	5	5

Indicateurs	2004-05	2006	2007	2008	2009	2010	2011	2012
No of STI cases treated using the syndromic approach		948	14 252	37 105	41 037	36 503	27 077	11 006
Etat							966	8 550
PLVSS			7 137	10 060	7 468	4 144	4 281	2 303
PADEPP			6 045	27 045	33 569	32 057	21 668	
Autres						302	162	153
Voluntary Counseling and Testing								
No of centers offering VCT	6	14	66	98	103	118	144	144
Etat							21	21
PLVSS **(IOI 6)**			42	63	44	56	54	54
PADEPP			24	30	54	55	67	67
Autres				5	5	7	2	2
No. of persons accepting to take the test			28 965	62 063	58 764	65 864	47 995	16 517
No. of persons receiving the test results (annual)	6 413	18 242	22 399	55 892	53 633	61 156	45 557	15 808
Etat							826	11 723
PLVSS			17 054	39 183	22 911	10 118	8 182	3 838
PADEPP			5 345	16 709	28 118	48 988	36 528	0
Autres					2 604	2 050	21	247
No. of positive tests		6 355	4 078	8 213	7 228	6 926	4 823	2 118
Males			1 402	2 792			1 563	827
Females			2 676	5 421			3 260	1 291
Prop. of positive tests			14.08%	13.23%	12.30%	10.52%	10.05%	12.82%
PMTCT								
No. of centers offering minimum PMTCT services		16	42	71	87	102	124	124
Etat							21	87
PLVSS			30	30	19	33	28	28
PADEPP			12	41	68	69	66	0
Autres					0	1	9	9
No. of pregnant women attending PNC			12 758	33 759	34 513	34 843	34 036	18 900
No. of pregnant women attending PNC and receiving counseling	4 638	7 748	11 405	29 398	32 269	34 859	29 072	16 770
No. of pregnant women agreeing to be tested	4 501	6 144	8 447	23 530	28 899	30 537	21 281	12 883
Prop. of pregnant women agreeing to be tested **(OI 5)**	97.0%	79.3%	74.1%	80.0%	89.6%	87.6%	73.2%	76.8%
Etat						0	254	8 852
PLVSS					10 753	8 398	3 923	3 879
PADEPP					18 146	22 105	15 451	0
Autres						34	1 653	152
No. of HIV+ pregnanat women (annual)	373	328	438	919	986	932	569	373
Prop. of HIV+ pregnant women	8.3%	5.3%	5.2%	3.9%	3.4%	3.1%	2.7%	2.9%
HIV prevalence among pregnant women 15-24 years old **(O 6a)**					2.0%	1.6%	1.8%	1.6%
No. of centers providing PMTCT services to HIV+ pregnant women		16	17	24	30	30	35	35
No. of HIV+ pregnant women receiving ARV (new cases)				438		604	233	226
Prop. of new cases receiving ARVs **(O 9)**				48%		65%	41%	61%
No. of HIV+ pregnant women receiving >1 ARV dose (cumulative)		136	271	438	441	622	855	1 081
No. of mother/child couples benefiting from PMTCT (live births)	193	136	271	438	373	549	391	239
Prop. Covered **(IOI 3)**	51.7%	41.5%	61.9%	47.7%	37.8%	58.9%	68.7%	64.1%

Indicateurs	2004-05	2006	2007	2008	2009	2010	2011	2012
CARE AND TREATMENT								
Treatment of PLWHA								
No. of care and treatment sites (cumulative)	12	14	32	45	52	62	65	65
PLVSS **(IOI 7)**					34	33	33	33
PADEPP (Projet R9 Global Fund à partir de mai 2011 et arrêt PADEPP en nov2011)					18	22	28	8
Autres(20 site PADEPP de 2011 sont dans Etat en 2012)						7	4	24
No. of PLWHA requiring ARVs (adults, >15 yrs) **(OI 10)**		4 890	8 843	11 577	16 011	18 545	21 507	21 940
No. of PLWHA receiving ARV treatment	2 550	5 961	5 765	8 915	11 525	14 180	15 810	16 981
No. of patients receiving treatment for opportunistic infections			6 675	9 519	12 233	14 785	14 614	16 278
Pediatric care of AIDS								
No. of PLWHA requiring ARVs (children, < 15yrs) **(IOI 8)**				632	1 472	1 217	1 320	1 308
No. of patients receiving treatment for opportunistic infections				569	1 325	1 096	1 000	1 047
Treatment de TB								
No. of TB centers offering HIV testing **(IOI 9)**			1	16	16	16	24	24
No. of co-infected patients diagnosed and treated			825	2 878	2 572	2 930	2 838	945
MITIGATION								
Support for PLWHA								
No. of PLWHA associations supported							13	
Total no. of PLWHA participating in associations							118	
No of PLWHA benefiting from support							22 827	
Support for orphans and vulnerable children (OVC)								
No. of associations implementing support projects	4	4	0	25	17	17	17	17
dont PLVSS **(IOI 22)**								8
dont PADEPP (Clôture du PADEPP en Nov 2011)								9
No. of OVC benefiting from support	2 531	3 202	9 044	16 908	8 994	12 193	11 683	5 700
dont PLVSS **(O 11)**	2 531	3 202	6 750	11 330	916	3 932	3 422	5 700
dont PADEPP (Clôture du PADEPP en Nov 2011)	0	0	2 294	5 578	8 078	8 261	8 261	0

Annex 3: Economic and Financial Analysis

Like most other MAPs, the PAD for the Congo MAP referred to the economic analysis carried out in previous reports for the Africa Region[50] and summarized the main findings as follows:

- HIV/AIDS undermines the major determinants of economic growth (physical, human, and social capital) and has a negative effect on productivity levels, domestic savings and overall economic growth.
- HIV/AIDS increases health costs and runs the risks of crowding out other key public health programs, such as immunization, maternal and child health, malaria and parasitic diseases.
- Care and treatment of AIDS patients imposes high costs on families and reduces their earning capacity.
- Family coping strategies may result in children abandoning school or the family cutting other health or social expenditures to unacceptable levels.

In the absence of such analysis in the PAD, one approach is to determine whether the project focused on the most effective and efficient interventions given the prevailing epidemiological situation in the country. The table below[51] provides estimates on the potential infections averted and the cost per infection averted and suggests that Congo focused on the most appropriate interventions:

Central and West Africa (lower prevalence)			
Cost per infection averted	Impact (% of Infections Averted)		
	Low (0-10%)	Medium (10-20%)	High (> 20%)
Low (< US$ 1,000)	MSM	Sex Workers	
Medium (US$ 1,000-3,000)	Blood safety Condom distribution	PMTCT VCT Workplace programs	
High (> US$ 3,000)	Community mobilization Mass media STI treatment Education		

As shown in Annex 2, the project made important contributions not only to prevention among MSM and sex workers and in the workplace[52] but also to blood safety, PMTCT, and VCT. Although the supervision missions noted interruptions in the supplies of laboratory reagents and insufficient quality (including a lack of qualified staff for counseling, weak organization of services,

[50] See the "Economic Analysis of HIV/AIDS" in the Multi-Country HIV/AIDS Program for the Africa Region (MAP) Project Appraisal Document (Report No. 20727 AFT, Annex 5) and the Second Multi-Country HIV/AIDS Program (MAP2) (APL) for the Africa Region (Report No. P7497 AFR).

[51] World Bank (2008) The World Bank's Commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007-2011, March, citing Bollinger and Stover (2007).

[52] A rough calculation of project expenditures shows that 17% were spent on MSM, sex workers, condom distribution, and workplace programs.

inadequate confidentiality, etc.), significant progress was achieved over the duration of the project and particularly during the additional financing phase.

The PAD described the project's economic, social, institutional, and health benefits as follows:

- Economic benefits: By preventing the rapid spread of the disease among the most productive (and sexually active) elements of the population, the project would: (i) improve current productivity; (ii) reduce future costs linked to needs for treatment, care and support for patients and their families; and (iii) reduce dependency ratios over the long term.
- Social benefits: By strengthening the capacity of local communities to provide support to groups affected by HIV/AIDS, the project would promote the establishment of a social safety net, including counseling services, support groups for patients and their families, community clinics and assistance in revenue-generating activities for PLWHA. In addition, by targeting women, orphans, and persons in uniform, the project would reduce the social burden on patients and the affected families.
- Institutional benefits: By building the capacity of key stakeholders and community groups, the project would strengthen civil society by empowering them to: (i) organize and implement HIV/AIDS prevention and care activities; and (ii) to deal with the local authorities.
- Health benefits: By contributing to the country's prevention, diagnosis and treatment efforts, the project would: (i) reduce Congo's burden of disease resulting from sexually transmitted infections, tuberculosis, and other opportunistic diseases; (ii) decrease the number of HIV-infected newborns (thereby lowering the risk of increasing child mortality; and (iii) slow the progression of the disease by increasing the knowledge of HIV status (through HIV testing) and able to protect their partners.

The final supervision mission focused on three of the many preventative activities (including behavior change communication, distribution of condoms, diagnosis and treatment of STIs, etc.), and estimated the economic benefits of the project for: (i) blood security, (ii) prevention of mother to child transmission, and (iii) behavior change among professional sex workers.

The analysis was based in part on the economic cost of each new case of HIV/AIDS (i.e., the benefits of each new infection averted as measured by the cost of care for an HIV/AIDS patient over the lifetime of the patient, discounted appropriately). A detailed study in Burundi found that the cost of care per year was $590, on average (Basenya and Renaud, 2008). To be conservative, about half of this estimate ($300) was used in the present analysis for the estimated cost of care per year, for each new infection averted.

The analysis was based as well on information from: (i) the National Blood Transfusion Center for donated blood; (ii) the National Public Health Laboratory for mothers treated; and (iii) the project for the number of professional sex workers reached. The results are presented in the following table:

Table 6: Economic benefits resulting from selected project interventions

Intervention	Economic Benefit
Testing of Blood Donated for Transfusions	$ 22 158 044
PMTCT	$ 244 000
BCC for Commercial Sex Workers	$ 2 811 565
Total	$ 25 213 609

The results show that the total economic benefit for these three preventive activities exceeds the

amount spent from project funds for the interventions and is slightly less than the total estimated cost of the project as shown in Annex 1b. Since these activities represent a subset of the project's preventive activities, the overall benefit of the project would almost surely exceed the project's cost.

IEG suggests other criteria for assessing the benefits of MAPs,[53] including: (i) enhanced political commitment to controlling the epidemic; (ii) expanded and strengthened national and sub-national AIDS institutions for the long-run response; (iii) mobilization of NGOs in the national response and reinforcement of their capacity to provide access to prevention and care among the high-risk groups most likely to contract and spread the infection; and (iv) enhanced the efficiency of national AIDS programs. These were all also positive.

[53] Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance (Washington, 2005).

Annex 4: Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Specialty
Lending	
Abdessalem Mohsen Farza	Consultant
Menahem M. Prywes	Senior economist
Astania Kamau	Team assistant
Aissatou Chipkaou	Senior Program assistant
Pierre Morin	Procurement specialist
Michele L. Lioy	Health specialist
Prosper Nindorera	Procurement specialist
Anne Anglio	Senior program Asssitant
Luc Lapointe	Procurement specialist
Dana Le Roy	
David M. Blankhart	Consulant
Josyane E. Carmen Costa	Team Assistant
Nadege J. X. Marthe Bicoumou	Team Assistant
Monthe Bienvenu Biyoudi	Economist
Nestor Coffi	Financial Management Specialist
Jean Charles Amon Kra	Financial Management Specialist
Mohamed Ali Kamil	Health specialist
Michael N. Azefor	Health specialist
Jean-Jacques Frere	Health specialist
Bourama Diaite	Procurement specialist
Khama Odera Rogo	Lead Health specialist
Harry Osore	Consultant
Luc Lapointe	Procurement specialist
Bella Lelouma Diallo	Financial Management Specialist
Andy Chi Tembon	Senior Health specialist
Anne Marie Bodo	Consultant
Mahamat Goadi Louani	Senior Human development specialist
Maurice Adoni	Procurement specialist
Clement Tukeba Lessa Kimpuni	Procurement specialist
Adrien Arnoux Dozol	Health specialist
Robert Patterson	Consultant
Josiane Maloueki Louzolo	Team assistant
Enias Baganizi	Senior Health assistant
Gaspy Gedeon Muanda	Financial Management Specialist
Therese Kinkela	Consultant

Supervision/ICR			
Names	**Title**	**Unit**	**Responsibility/ Specialty**
Mahamat Louani	Senior Public Health Specialist	AFTHE	Task Team Leader
Noel Chisaka	Senior Public Health specialist	AFTHW	ICR Task Team Leader
Peter Bachrach	Consultant	AFTHE	Principal author

(b) Staff Time and Cost

Stage of Project Cycle	**Staff Time and Cost (Bank Budget Only)**	
	No. of staff weeks	**USD Thousands (including travel and consultant costs)**
Lending		
FY02	10.93	66,410.69
FY03	42.97	283,889.85
FY04	2.13	9,265.69
Total:	**56.03**	**359,566.23**

Note: Breakdown by fiscal year is not available.

Supervision/ICR		
FY03	10.93	66,410.69
FY04	42.97	283,889.85
FY05	2.13	9,265.69
FY06	38.77	204,705.60
FY07	40.48	259,791.00
FY08	48.33	226,172.77
FY09	49.20	171,124.851
FY10	32.38	136,248.45
FY11	22.53	103,917.93
FY12	19.05	78,165.81
Total:	18.78	70,110.69
	325.55	1,609,803.33

Annex 5: Beneficiary Survey Results

Not applicable

Annex 6: Stakeholder Workshop Report and Results

Not applicable

Annex 7: Summary of Borrower's ICR and/or Comments on Draft ICR

EXECUTIVE SUMMARY

In 2003, faced with a growing HIV/AIDS pandemic, the Republic of Congo, through its Permanent Executive Secretariat of the National AIDS Committee (SEP/CNLS), developed a Strategic Framework for HIV/AIDS Control for the period 2003-2007. A US$19 million grant from the World Bank enabled the country to implement the strategic framework through the HIV/AIDS Control and Health Project. This multi sectoral project comprised four components: health; non-health sectoral interventions (education, defense, etc.); community-based activities with NGOs; and coordination, monitoring and evaluation. The project was implemented in five (of eleven) departments: Brazzaville, Pointe-Noire, Niari, Lékoumou, and Sangha.

In 2009, a new strategic framework for the period 2009-2013 was developed to consolidate the experiences acquired during implementation of the 2003-2007 framework, and its execution benefited from an additional financing of US$15 million for the period 2009-2012 (of which US$5 was provided by the Bank and US$10 million by the Government. The project was carried out in the 5 departments mentioned above and made it possible not only to strengthen the national response to HIV/AIDS and STDs, but also to acquire some experience.

INSTITUTIONAL BACKING

This Project provided a significant institutional support by drafting policy documents, standards, manuals and guidebooks in various areas. The national and decentralized coordination benefited by capacity-building in terms of staff hiring and training, computing and audiovisual equipment as well as transport. The remuneration of 34% of the staff of SEP/CNLS is supported by the HIV/AIDS Control and Health Project. SEP/CNLS also benefited from significant capacity-building from the Fiduciary Management Agency (FMA) which provided procurement and financial management support. NGOs and associations have also been trained and provided with equipment.

PREVENTION-RELATED ACTIVITIES

The Project ensured the training of: (i) health care providers for the treatment of STDs and the screening of HIV; and (ii) peers, youth leaders and providers for social communication, including the organization of themed days at the community and Aids Control Units Level. Appropriate strategies making it possible to reach the targeted groups have been set up by SEP/CNLS. The various facilities have also been supplied with reagents for HIV screening and medicines for the treatment of STDs. All these interventions have consolidated the extension and decentralization of prevention services which made it possible to: (i) treat 57,128 cases of STDs (78%), (ii) screen 100% of blood pouches for the 4 markers: HIV, VHB, VHC, syphilis, (ii) screen 326,089 persons in the health centres (52,5%), and 19,760 other persons thanks to the mobile unit.

The various sites for STDs treatment and HIV screening have registered shortages of drugs, and consumables, which made it difficult to reach the targeted groups. At the level of Aids Control Units, 12,000 students, 41,844 pupils from general education, and 65,753 pupils from technical and vocational education have been screened. Classes of HIV/AIDS have been integrated in 55.66% of primary schools, 35.2% of secondary schools and 83.33% of technical and vocational schools. The

treatment of AIDS-related disorders and the management of biomedical waste remain low and are limited essentially to Brazzaville and Pointe-Noire.

TREATMENT-RELATED ACTIVITIES

The treatment of the persons living with AIDS has been strengthened and improved thanks to the HIV/AIDS Control and Health Project. The Project has thus contributed to the consolidation and decentralization of the medical treatment of the persons living with AIDS through: (i) training of providers and laboratory technicians; (ii) procurement of equipment for treatment sites and laboratories; and (iii) provision of ARVs and medicines for opportunistic infections for the treatment of adults and children. In total, 108 physicians and 94 laboratory technicians have been trained or have undergone a refresher course, and 65 or 39 sites carry out respectively adult and pediatric treatment.

Congo has 16,043 adult persons and 1,206 children living with AIDS who are presently under ARVs; those who have dropped treatment are around 21.55%. However, some difficulties related to ARV treatment include: (i) shortages of ARVs and reagents for biological follow-up in the sites; (ii) the underestimation of the numbers of PLWHA needing treatment; and (iii) an insufficient number of sites for treatment of pediatric AIDS.

Psychosocial treatment remains insufficient and constitutes the weak link of global treatment of the persons living with AIDS in Congo. In 2009, the Project provided some support which made it possible to organize the National Network of HIV+ Associations of Congo (RNAPC) which includes 8 associations throughout the country and 23 member associations. The interventions of these associations remain insufficient as regards the psycho-social needs of the PLWHA. The country has only 3 sites which carry out therapeutic education. Insufficient care and support brings about the isolation of the persons living with AIDS and might explain the high rate of patients having dropped treatment.

CIVIL SOCIETY ACTIVITIES

Before this project, Congo did not have any national mechanism for financing of community-based initiatives. To bridge this shortcoming, the project supported the capacity building of the organizations by: (i) drafting of a handbook which describes the principles and rules governing the financing of the projects of the civil society organizations; (ii) training recipients in sub-project management, supervision and follow-up assessment of activities; and (iii) networking associations to improve information exchange. The funded sub-projects have made it possible to screen a number of targeted groups: 2,421 sex workers, 540 men having sex with men, and the indigenous peoples have been screened thanks to the activities carried out by CCC and the promotion of condoms. The funding of the civil society projects remains insufficient for the implementation of interventions.

The sale and distribution of condoms has significantly increased since the project was set up. About 45,000,000 condoms have been sold or distributed by the relevant Agency (AISSC). This important growth is due to the policy of prevention and promotion of the condom. Difficulties in the promotion of condoms were also related to the shortage of stocks that occurred at the central and decentralized level.

The treatment of orphans and other vulnerable children was decentralized and implemented by Support Agencies for the treatment of Orphans and other Vulnerable Children (AESO). As of March 31st, 2012, 29,576 orphans and other vulnerable children have concurrently benefited from support by the project out of a target group of 25,000 persons (an implementation rate of 118%). These results should not however conceal the difficulties registered in the treatment of orphans and other vulnerable children for the various services and support. Insufficient financial resources and the late release of funds prevented the orphans and other vulnerable children from benefiting from all of the services planned. The lack of service indicators (schooling, medical care, insertion and psychosocial support) makes it impossible to assess the results achieved by the project.

COORDINATION, MANAGEMENT, FOLLOW-UP AND ASSESSMENT

SEP/CNLS has benefited from capacity-building in human resources and equipment to successfully implement project at central and decentralized levels. Fiduciary Management is now carried out by the SEP/CNLS management unit at the central and decentralized level which benefited from the transfer of expertise from the KPMG Consultancy. To improve supervision of the activities, a monitoring and evaluation plan, data collection and reporting tools have been implemented (DHS, sentinel surveys, behavioral studies, etc.) and made it possible to assess the results of the project.

The HIV/AIDS and STDs Control Project has made it possible to establish the basis of the national response to the fight against HIV/AIDS in Congo through its contribution to the financing of the various strategic frameworks. Many interventions in the framework of prevention, global treatment, civil society, orphans and other vulnerable children treatment coordination, management and follow-up and assessment have been carried out and have made possible a number of results and experiences. However, some difficulties related to the late release of funds (mainly the Government counterpart funds) and the insufficient financial resources for the implementation of the activities have posed major challenges for day-to-day operations and the overall quality of services and interventions.

RECOMMENDATIONS

- Involve the various stakeholders and increase the interest of the population to ensure political commitment for the fight against AIDS;
- Ensure sufficient financial resources to enable SEP/CNLS to make it possible for the stakeholders to carry out quality interventions;
- Release financial resources quickly with a view to complying with the timeframes of interventions and optimizing results;
- Provide some assistance to COMEG so that it can fully play its role as purchasing group and supply health facilities with reagents, ARVs and other medical products; and
- Strengthen the screening and treatment teams within the sites by the community providers with a view to strengthening counseling and psychosocial support.

Annex 8: Comments of Co-financing partners and Other Partners/Stakeholders

Not applicable

Annex 9: List of Supporting Documents

National documents

Laws, decrees, and regulatory texts

- Loi no. 30 du 3 juin 2011 portant lutte contre le VIH et le SIDA et protection des droits des personnes vivant avec le VIH.

Policies, strategies and regulatory measures

- Document de stratégie de réduction de la pauvreté (DRSP) (Janvier 2007)
- Politique du genre (MPFID) (2010).

Program documents

Strategic plans

- Cadre stratégique national 2003 – 2007 (2002)
- CSN 2009-2013 de lutte contre le VIH, le SIDA et les IST (2008)
- Politique sectorielle commune du secteur de l'éducation à l'épidémie du VIH et du SIDA (2012)
- Plan stratégique national de lutte contre le VIH et le SIDA du secteur de l'éducation 2013-2017 (2012)

Normes, strategies, and protocols

- Stratégie nationale de communication pour le changement de comportements en matière de lutte contre le VIH/SIDA 2004-07 (2004)
- Stratégie nationale de communication en réponse au VIH/SIDA et aux IST (2008)
- Guide thérapeutique de prise en charge du VIH/SIDA (2004, 2010 rév.)
- Algorithmes de prise en charge syndromique des infections sexuellement transmissibles au Congo (2010)
- Manuel de prise en charge pédiatrique de l'infection à VIH (2010)

Monitoring and evaluation

- Plan national de suivi et évaluation (2006)
- Plan national de suivi et évaluation du CSN 2009-2013 de lutte contre le VIH, le SIDA et les IST (2010)
- Outils primaires et secondaires de collecte des données / Manuels de remplissage des outils de collecte des données (2010, 2012)

Studies, surveys and surveillance

- Etude sur la gestion des déchets biomédicaux (2003)
- Rapport Enquête CACP (2003)
- Rapport Evaluation nationale de la séroprévalence (2003)
- Rapport Séroprévalence CACP (2003)
- Etude qualitative sur l'impact psychosocial dans la vie des personnes infectées et affectées au Congo Brazzaville (2004)
- Rapport Etude socio-anthropologique (2004)
- Rapport Indicateurs S & E (2004)
- Rapport Situation préservatifs (2004)

- Analyse situationnelle de la stigmatisation et la discrimination envers les PVVIH et les personnes victimes de violences sexuelles (2004)
- Rapport sur la vulnérabilité de la fille et la femme au VIH et au sida (2005)
- EDS (2005)
- Etude sur la situation des services socio-sanitaires et des structures d'appui de l'Université Marien Ngouabi et problématique de prise en charge des PVVIH (2006)
- Etude sur l'évaluation des connaissances, attitudes et pratiques des détenus face au VIH et au sida : Cas de la Maison d'arrêt de Brazzaville (2006)
- Etude sur les connaissances, attitudes et pratiques en santé sexuelle, reproductive, VIH et sida chez les élèves du secondaire I et II de cinq départements du République du Congo (2008)
- Rapport d'analyse de la situation de l'épidémie du VIH/SIDA en République du Congo et de la revue du cadre de stratégie national 2003-2007 (Avril 2008).
- C. Jessua et A. Nkodia, Rapport d'évaluation de la réponse du secteur éducatif au VIH et SIDA en République du Congo (Juin 2009)
- Rapport socio-comportemental et de séroprévalence VIH et syphilis chez VIH chez les agents de la Force publique dans 5 Zones Militaires de Défense (2009)
- Enquête de séroprévalence et sur les indicateurs du SIDA au Congo ESISC-I (2009)
- Rapports UNGASS (2010)
- Enquête comportementale couplée à la sérologie VIH chez les PS, HSH et détenus (2012)
- Etude d'impact du VIH et du sida sur l'éducation (2012)
- Situation du VIH parmi les élèves, étudiants et enseignants selon les données des CDAV de 2009à 2011 (volet qualitatif) (2012)
- Etude sur les déterminants de la vulnérabilité au VIH et au sida chez les peuples autochtones (2012)
- EDS (2012)
- Rapport national sur la riposte à l'infection à VIH (2012)
- REDES 2009-2010 (Etude sur les Ressources et Dépenses engagées pour la lutte contre le Sida) (2012)

Project documents

Technical and legal

- PAD
- DCA
- Aides mémoires and Implementation Status Reports

Organizational documents

- Manuel d'exécution

Implementation documents

- Component 1
  Education
  - Guide de l'Enseignant sur la prévention du VIH/sida et des IST en milieu scolaire (2004)
  - Programmes et guides pédagogique des écoles para médicosociales (EPMS) (2005)
  - Programmes et guides pédagogique des Ecoles Normales des Instituteurs (ENI) (2007)
  - Programmes et guides pédagogique du primaire (2007)
  - Programmes et guides pédagogique du secondaire 1 & 2 (2007)

- Programmes et guides pédagogique des écoles spéciales (2007)
- Programmes et guides pédagogique de l'Ecole Normale Supérieure (ENS) (2008)
- Programmes et guides pédagogique des écoles , centres d'instructions et unités de la Force Publique (2008)
- Manuels de l'élève intitulé « Apprendre sur le VIH et le sida » du Primaire, du collège et du Lycée (2010)
- Didacticiel, DVD, CD-Rom et cassettes audio sur les émissions radiophoniques d'autoformation à distance des enseignants sur le VIH et sida (2011)

Justice

- Guide des services juridiques des droits des PVVIH (2007)
- Guide d'information sur les droits des PVVIH (2007)

Travail

- Elaboration de la politique sur le lieu du travail (2010)

- Component 2
  - Guide de la prise en charge psychologique des personnes infectées et affectées par le VIH/SIDA en milieu communautaire (2004)
  - Manuel des Initiatives Communautaires (2004)
  - Bien Gérer son association / Guide à l'intention des responsables et membres des associations impliquées dans la lutte contre le VIH et le SIDA (2007)

- Component 3
  - Manuel de procédures pour la composante orphelins et autres enfants vulnérables du projet de lutte contre le VIH/SIDA et de santé (2004)
  - Rapport Stratégie Nationale Communication (2004)
  - Guide sur la Communication sociale (2004)
  - Fiche pratique du prestataire en communication sociale (2005)
  - Guide Education par les pairs (2005)
  - Guide sur les informations de base sur le VIH/SIDA (2005)
  - Guide Education par les pairs en milieu du travail (2005)
  - Fiche d'orientation pour l'animation des sessions d'éducation par les pairs destinée au pair éducateur (2006)
  - Manuel de procédures des interventions de prise en charge des orphelins et autres enfants vulnérables en République du Congo (2009)
  - Plan marketing stratégique des préservatifs 2012-2013 (2012)

- Component 4

Periodic reporting

- Rapports annuels du CNLS (2004, 2005, 2007, 2010 et 2011)
- Rapport de synthèse du PLVSS 2004-2008 (2008)
- Rapports annuels de suivi et évaluation (2006-11)
- RSF
- External audits / Rapports annuels d'audit

Monitoring and evaluation documents

- Rapport d'évaluation finale du projet de lutte contre le VIH/SIDA et de Santé (2009)
- Rapport d'évaluation du projet de lutte contre le VIH/SIDA et de Santé 2004-2012 (2012)

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