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The World Bank

Report No: ICR2189

IMPLEMENTATION COMPLETION AND RESULTS REPORT

(IDA-42900)

ON A

CREDIT

IN THE AMOUNT OF SDR 23.5 MILLION

US$35 MILLION EQUIVALENT

TO THE

REPUBLIC OF BENIN

FOR A

SECOND MULTISECTORAL HIV/AIDS CONTROL PROJECT

June 6, 2013

Human Development Sector
Health, Nutrition and Population (AFTHW)
Africa Region Office

CURRENCY EQUIVALENTS

(Exchange Rate Effective 06/26/2013)

Currency Unit = FCFA

US$1 = 504 FCFA

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

fDB	African Development Bank
AGeFIB	*Agence de Gestion Fiduciaire du Bénin* (Benin Fiduciary Management Agency)
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral (drugs)
CBO	Community-Based Organization
CCDV	*Centre de Conseil et de Dépistage Volontaire* (Voluntary Counselling and Testing Center)
CCLS	*Comité Communal de Lutte Contre le SIDA* (Local Center for Fight against AIDS)
CDLS	*Comité Départemental de Lutte Contre le SIDA* (Provincial Center for Fight against AIDS)
CFMS	Country Financial Management System
CIPEC	*Centre d'Information, de Prospective et de Conseil* (Center for Information, Prospective and Consulting)
CNLS	*Comité National de Lutte contre le SIDA* (National Committee for the Fight Against AIDS)
CSLS	*Cellule Sectorielle de Lutte contre le SIDA* (Sectoral Unit in charge of the Fight Against HIV/AIDS)
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DNCMP	*Direction Nationale du Contrôle des Marchés Publics* (National Directorate for Procurement Control)
EDS	*Enquête Démographique et de Santé* (Demographic and Health Survey)
ESDG	*Enquête de Surveillance de Deuxième Génération des IST/VIH/SIDA* (Second Generation Survey for STI and HIV/AIDS)
FA	Financial Agreement
FBO	Faith-Based Organization
FM	Financial Management
FMA	Financial Management Agency

GDP	Gross domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOB	Government of Benin
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IDA	International Development Association
ICR	Implementation Completion and Results Report
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
INRSP	*Institut National de Recherches en Santé Publique* (National Public Health Research Institute)
ISR	Implementation Status and Results Report
MAP	Multi-Country HIV/AIDS Program for Africa
MWMP	Medical Waste Management Program
MOH	Ministry of Health
MMR	Maternal Mortality Ratio
MTCT	Mother-To-Child Transmission of HIV
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organization
OED	Operations Evaluation Department
OVC	Orphans and other Vulnerable Children
PAD	Project Appraisal Document
PCR	Polymerase Chain Reaction
PDO	Project Development Objective
PIU	Project Implementation Unit

PLWHA	People Living With HIV/AIDS
PMLS II	*Deuxième Projet Multisectoriel de Lutte Contre le SIDA* (Second Multisectoral Project against HIV/AIDS)
PMTCT	Preventing Mother-To-Child Transmission of HIV
PNLS	*Programme National de Lutte Contre le SIDA* (National Program against HIV/AIDS)
PPLS	*Projet Plurisectoriel de Lutte Contre le SIDA* (Multisectoral Project against HIV/AIDS)
PPF	Project Preparation Facility
PSI	Population Services International
SAI	Supreme Audit Institution
SGASS	Second Generation STI/AIDS Surveillance Survey
SIDAG	National Service for Free Voluntary and Anonymous Testing
SPEP	Standard Public Expenditures Procedures
SP/CNLS	Permanent Secretariat/National Committee for the Fight Against AIDS
STD	Sexually Transmitted Diseases
TTL	Task Team Leader
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNDP/HDI	United Nations Development Program Human Development Index
UNGASS	United Nations Second Generation STI/AIDS Surveillance Survey
USD	United States Dollar
VCT	Voluntary Counseling and Testing for HIV
WB	World Bank
WHO	World Health Organization
XDR	Special Drawing Rights
XOF	West Africa Unit Currency, usually known as CFA Franc

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Country Director: Madani Tall
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ICR Team Leader: Aly Boury Sy

REPUBLIC OF BENIN

SECOND MULTI-SECTORAL HIV/AIDS CONTROL PROJECT

CONTENTS

A. Basic Information			
Country:	Benin	Project Name:	Second Multisectoral HIV/AIDS Control Project
Project ID:	P096056	L/C/TF Number(s):	IDA-42900
ICR Date:	06/28/2013	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	GOVERNMENT OF BENIN
Original Total Commitment:	XDR 23.50M	Disbursed Amount:	XDR 22.51M
Revised Amount:	XDR 22.51M		
Environmental Category: B			
Implementing Agencies: Projet Multisectoriel de Lutte contre le VIH/SIDA			
Cofinanciers and Other External Partners:			

B. Key Dates				
Process	**Date**	**Process**	**Original Date**	**Revised / Actual Date(s)**
Concept Review:	04/11/2006	Effectiveness:	01/09/2008	01/09/2008
Appraisal:	11/27/2006	Restructuring(s):		12/21/2010 06/10/2011
Approval:	04/05/2007	Mid-term Review:	01/18/2010	01/18/2010
		Closing:	12/31/2011	06/30/2012

C. Ratings Summary

C.1 Performance Rating by ICR

Outcomes:	Satisfactory
Risk to Development Outcome:	Moderate
Bank Performance:	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 Unsatisfactory
Quality of Supervision:	Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	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):	None
Problem Project at any time (Yes/No):	Yes	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Satisfactory		

D. Sector and Theme Codes		
	Original	Actual
Sector Code (as % of total Bank financing)		
Central government administration	21	21
Health	32	32
Other social services	34	34
Solid waste management	4	4
Sub-national government administration	9	9

Theme Code (as % of total Bank financing)		
HIV/AIDS	33	33
Nutrition and food security	17	17
Other social development	33	33
Population and reproductive health	17	17

E. Bank Staff		
Positions	At ICR	At Approval
Vice President:	Makhtar Diop	Hartwig Schafer
Country Director:	Madani M. Tall	James P. Bond
Sector Manager:	Trina S. Haque	Francois G. Le Gall
Project Team Leader:	Christophe Lemiere	Nicolas Ahouissoussi
ICR Team Leader:	Christophe Lemiere	
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F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)

The development objectives of the proposed project are derived from the country's strategic plan for fighting HIV/AIDS and its effects, and for preventing the further spread of HIV/AIDS by means of a multisectoral program approach. They are essentially similar to those under the predecessor project. Thus, complementing the activities financed by other sources, the purpose is to help Benin Government implement its new 2006-2010 National Strategic Framework for boosting its national response to HIV/AIDS by contributing to increase and improve the coverage and utilization of prevention services, treatment and care for specific high-risk and vulnerable groups. More specifically, the project will contribute to: (a) strengthening access to and increasing utilization of prevention services for vulnerable groups (women, youth, etc.) and the high-risk groups such as the commercial sex workers and staffs of some key ministries; (b) improve access and utilization of treatment and care services for HIV/AIDS infected and affected persons, notably those living with HIV/AIDS (PLWHA), and orphans and vulnerable children (OVC); and (c) consolidate the coordination, management, and the monitoring and evaluation of the national response to HIV/AIDS for its sustainability.

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

There were no changes to the original PDOs. However the baseline and target values of several PDO-level indicators were adjusted to take into account newly available data and the results framework was updated accordingly.

(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 :	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission in the last 12 months.			
Value quantitative or Qualitative)	Initial (2006): 36.82% (overall); 34.1% for boys and 39.6% for girls Revised (2008): 21.5%.	75%	45%	67.6%.

Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met. The achievement rate was 150.2% of the revised target but only 90% of the original target.			
Indicator 2 :	Percentage of young women and men aged 15-24 reporting the use of a condom during the last sexual intercourse with a non-regular or non-cohabitating partner (of those reporting sexual intercourse with a non-regular partner in the last 12 months)			
Value quantitative or Qualitative)	Initial (2006): 59.9% (overall); 70% for boys and 51.8% for girls. Revised (2008): 49.5%	85%	65%	68.1%.
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met (as reported by the 2012 ESDG), with a 104.77% achievement rate.			
Indicator 3 :	Percentage of sex workers who report using a condom with their most recent client.			
Value quantitative or Qualitative)	Initial (2006): 69.2 Revised (2008): 79.7%	90%	90%	84.9%
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target not met, although by very little with an achievement rate of 94.33%.			
Indicator 4 :	Percentage and number of people with advanced HIV infection receiving anti-retroviral combination therapy			
Value quantitative or	Initial (2006): No baseline value	3,300 adults and 900 children	19,000 adults; 2,000 children.	22,522.

Qualitative)				
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	This indicator (reported by the PNLS 2011 Statistical Book) has surpassed its target by 7.24%.			
Indicator 5 :	Percentage and number of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT			
Value quantitative or Qualitative)	Initial (2006): 52% Revised (2008): 52.8%	80%	70% (2689 women).	(58%) 1,560 women
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target not met. Although it was initially announced to have reached 6,654 women, the 2011 PNLS Statistical book and the X-monitoring database used by the project both confirmed that only 1,560 women (58%) did actually receive ARV.			
Indicator 6 :	Number and percentage of persons aged 15 and older who undergo HIV voluntary counseling and testing in the last 12 months and know the results			
Value quantitative or Qualitative)	Initial (2006): 0 revised (2008): 175,086	375,000	375,000	1,035,740
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met, with an achievement rate of 276.2%. It should be mentioned that the target value is assumed, both in aide-memoire and project reports, to be expressed as a cumulated value instead of an annual value.			
Indicator 7 :	Annual joint reviews and work planning exercise by all donors (under the coordination of SP/CNLS)			
Value quantitative or Qualitative)	0	4	4	4

Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target fully met (100% achievement rate).			

(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 :	Number of subprojects financed			
Value (quantitative or Qualitative)	0	800	700	985
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met. The achievement rate is respectively 140.71% and 123.12% relative to the revised and original targets.			
Indicator 2 :	Number of persons reached with community outreach/IEC/BCC programs			
Value (quantitative or Qualitative)	0	1,500,000	1,500,000	5,563,754
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met with an achievement rate of 370.92%.			

Indicator 3 :	Number of male and female condoms distributed			
Value (quantitative or Qualitative)	0	11,000,000	3,500,000	7,612,321
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met. The achievement rate is 217.49%.			
Indicator 4 :	Number of public sector organizations supported and implementing interventions			
Value (quantitative or Qualitative)	Initial (2006): No baseline value	---	15	16
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met. The achievement rate is 106.67%.			
Indicator 5 :	Number of PLWHA receiving psychological support			
Value (quantitative or Qualitative)	0	10,000	8,000	14,273
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met with an achievement rate of 178.41% relative to the revised target. When compared to the original target, the achievement rate for this indicator falls to 147.73%, still above the target.			
Indicator 6 :	Number of PLWHA receiving nutritional support			
Value	0	5,000	5,000	7,791

(quantitative or Qualitative)				
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met with an achievement rate of 155.82%. These 7,791 PLWHA are the ones who benefited from the project support, but in all 12,156 received nutritional support funded by the country and development partners.			
Indicator 7 :	Number of orphans and other vulnerable children whose households have received care and support			
Value (quantitative or Qualitative)	0	2,500	2,500	12,197
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target met with an achievement rate of 487.88%.			
Indicator 8 :	Number and percentage of CDLS operational			
Value (quantitative or Qualitative)	0	100%	6 (100%)	6 (100%)
Date achieved	06/06/2005	12/31/2011	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target fully met with an achievement rate of 100%.			
Indicator 9 :	Number and percentage of municipal committees (CCLS) operational			
Value (quantitative or Qualitative)		N/A	48 (60%)	53 (68.83%)

Date achieved		04/14/2007	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target fully met.			
Indicator 10 :	Number of persons trained in HIV Service Delivery			
Value (quantitative or Qualitative)	40,000	50,000	65,000	71,539
Date achieved	06/06/2005	04/14/2007	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target fully met. The achievement rate is 110.06%. When compared to the original value, the target is still met and the achievement rate jumps to 143.08%.			
Indicator 11 :	Percentage and number of implementing agencies (public sector and civil society) submitting timely monitoring and financial reports to SP/CNLS in the last 12 months			
Value (quantitative or Qualitative)	Initial (2006) No baseline value	N/A	48 (100%)	48 (100%)
Date achieved	06/06/2005	04/14/2007	12/31/2011	06/01/2012
Comments (incl. % achievement)	Target fully met with an achievement rate of 100%.			

G. Ratings of Project Performance in ISRs

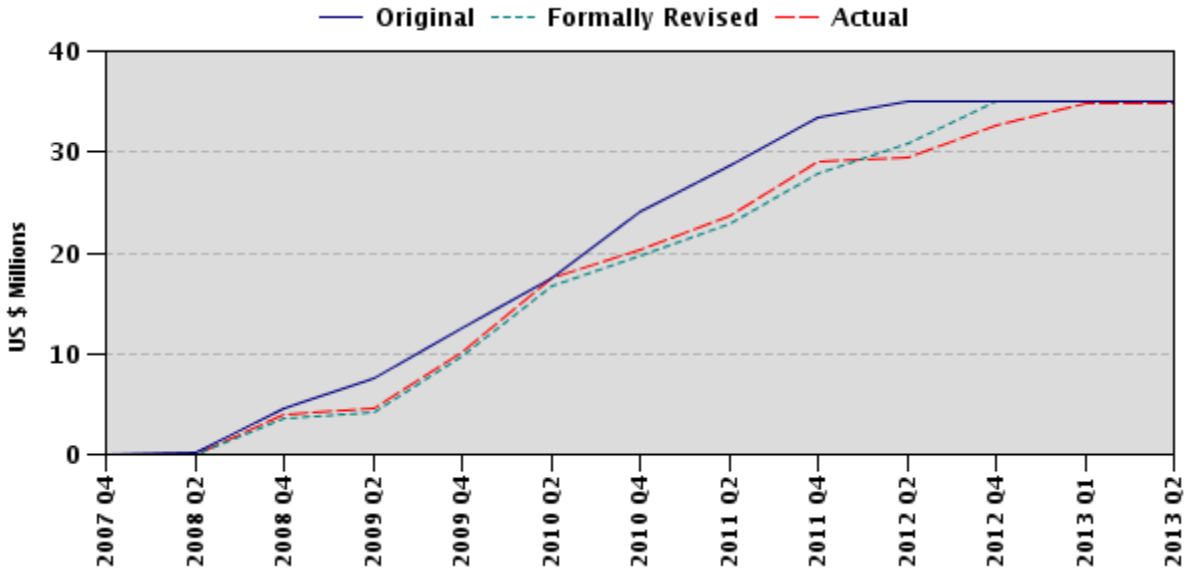
No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	11/15/2007	Satisfactory	Moderately Unsatisfactory	0.00
2	02/15/2008	Satisfactory	Moderately Satisfactory	0.00
3	06/17/2008	Satisfactory	Moderately Satisfactory	3.26
4	12/08/2008	Satisfactory	Moderately Satisfactory	4.55
5	06/10/2009	Moderately Satisfactory	Moderately Satisfactory	10.09
6	12/17/2009	Moderately Satisfactory	Moderately Satisfactory	17.55
7	02/12/2010	Satisfactory	Satisfactory	17.55
8	11/03/2010	Satisfactory	Satisfactory	20.40
9	04/19/2011	Satisfactory	Satisfactory	23.77
10	12/19/2011	Moderately Satisfactory	Satisfactory	29.43
11	06/26/2012	Satisfactory	Satisfactory	32.65

H. Restructuring (if any)

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions	Reason for Restructuring & Key Changes Made
		DO	IP		
12/21/2010	N	S	S	23.77	Increase Efficiency and allow project to operate more smoothly. Two changes were made: the first was to adjust project baseline indicators and their target values to take into

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions	Reason for Restructuring & Key Changes Made
		DO	IP		
					account newly available data; and the second was to reallocate funds to take into account changes that had occurred in the volume of expenditures in the different disbursements categories due to incorrect estimations and to changes in the exchange rates.
06/10/2011		S	S	29.07	To respond to the new government strategy of better targeting high-risk groups, and focusing on quality rather than quantity of preventive activities. It was also done in response to the project current needs and to help boost the only indicator that was still lagging, the percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission. The changes involved a reallocation of funds between categories of expenditures. The second change made was a 6 months project extension to give the project enough time to complete critical activities and reach its end targets.

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

1. In 2007, Benin was a very poor and highly indebted country (ranked 163rd out of 177 countries in the UNDP Human Development Index) relying mainly on cotton exports (55.9% of total exports in 2007) and services sectors (mainly transit trade with Nigeria). The Gross National Income (GNI) per capita was US$510. Fighting poverty was the Government's main objective, given that prevalence of poverty had risen from 26.5 percent in 1996 to 33.8 percent in 2002.

2. In the health sector, infectious diseases were the leading causes of deaths and accounted for close to 60% of consultations in health facilities. The maternal mortality ratio was about 400 deaths per 100,000 live births while the child mortality rate reached 120 per 1000 live births. In other words, Benin was off track for reaching the MDGs 4 (child mortality) and 5 (maternal mortality). Among communicable diseases, prevalence of HIV/AIDS was low in the general population (i.e. 2%), but still high within some groups, such as sex workers (25.5% in 2005). For this reason, the epidemic was considered as "concentrated".[1]

3. The Government was committed to fighting HIV/AIDS and had just put out, through a participatory process involving the donor group and other stakeholders, its second Strategic Plan for Fighting HIV/AIDS covering the period 2006-2010.[2] This strategy focused on six strategic axes: (i) coordination, partnership and resource mobilization; (ii) preventing and promoting tests; (iii) access to care and treatment; (iv) support to people infected or affected by HIV/AIDS and respect of human rights; (v) strategic information: epidemiological and behavioral surveillance and research promotion and; (vi) monitoring and evaluation.

4. At the time of appraisal, the World Bank had just closed its SDR 17.8 million (i.e. about US$23 million) Multisectoral Assistance Project for the control of HIV/AIDS (MAP) and the Government of Benin was striving to close the financing gap to fight the epidemic. The HIV/AIDS prevalence rate in the general population had fallen down to 2.0% in 2006 according to a Sero-surveillance Report published by the National Program Against HIV/AIDS (PNLS). But HIV-/AIDS prevalence could be much higher in high-risk groups. For instance, among female sex workers, this rate was as high as 25.5%.[3] Funding the fight against HIV/AIDS

[1] According to David Wilson (2006), "an HIV epidemic is **concentrated** if HIV transmission is primarily attributable to HIV-vulnerable groups and if protecting HIV-vulnerable groups would protect the wider population. In contrast, an HIV epidemic is **generalized** if the converse is true – HIV transmission is not primarily attributable to HIV-vulnerable groups and protecting HIV-vulnerable groups would not in itself protect the wider population." (Wilson, David, "HIV epidemiology: a review of recent trends and lessons", Sept 2006).

[2] This second strategic plan for HIV-AIDS had roughly the same objectives as the first one. In particular, it maintained the principle of addressing prevention and treatment at once. However, as for implementation, the second strategic plan took into account the lessons learnt from the previous plan and especially the fact that prevention can best be delivered through NGOs and social mobilization.

[3] This shows a decline from its 2004 level of 27.9% (the EDSB-III put this rate at 1.2 for the same year). Background studies done for the Abidjan-Lagos Corridor Project in 2005 show even higher rates for sex workers (30.1%) while for the police and military personnel prevalence was 8%.

remained a serious problem because, although funds had been pledged by development partners,[4] a sizeable gap (close to US$160 million) had been identified.

5. Beyond the need to close this funding gap, there were two main reasons for the World Bank to be involved in the fight against HIV/AIDS in Benin. The first reason was the previous experience gained by the Bank when it funded the first MAP in Benin (i.e. the PPLS) which had been set up to support the implementation of the First HIV/AIDS Strategic Plan. This Project had shown that the WB had strong comparative advantages in designing and supporting multisectoral approaches and in mainstreaming and unifying coordination arrangements for the fight against HIV/AIDS. The PPLS was seen as a success[5] (i.e. its ICR shows that ISR ratings for DO and IP were consistently rated as satisfactory) and the WB presence and involvement was perceived as "*instrumental in ensuring the effectiveness of the "Three Ones" principles*".[6] The second reason was that the WB involvement was expected to facilitate leveraging additional funding for HIV/AIDS from other development partners.

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

6. As stated in the PAD, *the Project was to contribute to three outcomes:*

a. strengthening access to and increasing utilization of prevention services for vulnerable groups (women, youth, etc.) and the high-risk groups such as the commercial sex workers and staff of some key ministries;

b. improve access and utilization of treatment and care services for HIV/AIDS infected and affected persons, notably people living with HIV/AIDS (PLWHA), and orphans and vulnerable children (OVC); and

c. consolidate the coordination, management, and the monitoring and evaluation of the national response to HIV/AIDS.

7. To reach these outcome objectives, a set of seven key indicators were defined. These are shown in the results framework table below.

PDOs	PDO-level indicators
(a) strengthening access to and increasing utilization of prevention services for vulnerable groups (women, youth, etc.) and the high-risk groups such as the commercial	- Percentage of young women and men aged 15 -24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission in the last 12 months (UNGASS, IDA 14). - Percentage of young women and men aged 15-24 reporting the use of a condom during last sexual intercourse with a non-regular or non-cohabiting partner (of those reporting sexual intercourse with a non-

[4] In addition to the US$ 68 million pledged by the Global Fund (until 2010), the African Development Bank (AfDB) had committed US$ 4 million per year (until 2008), USAID US$ 7 million (until 2010), Denmark US$ 8.8 million (until 2010) and part of the US$ 45.6 million set up by the Global Fund for the Abidjan-Lagos Corridor involving 5 countries.

[5] By achieving all its stated development objectives, this project (the PPLS) had a positive impact on the fight against HIV/AIDS in that it built capacity in both the private and public sectors, and accelerated these sectors' response to the HIV/AIDS epidemic in Benin.

[6] The "Three Ones" principles were a set of principles for fostering aid harmonization and alignment and agreed by major HIV-AIDS donors in 2004. The "Three Ones" principles are: (i) one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; (ii) one national AIDS coordinating authority, with a broad based multi-sector mandate; and (iii) one agreed country-level monitoring and evaluation system.

sex workers and staff of some key ministries;.	regular partner in the last 12 months) (UNGASS). - Percentage of sex workers who report using a condom with their most recent client (UNGASS).
(b) Improve access and utilization of treatment and care services for HIV/AIDS infected and affected persons, notably the persons living with HIV/AIDS (PLWHA), and Orphans and Vulnerable Children (OVC).	- Percentage and number of people with advanced HIV infection receiving antiretroviral combination therapy. (UNGASS). - Percentage and number of pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT (UNGASS). - Number and Percentage of persons aged 15 and older who undergo HIV voluntary counseling and testing in the last 12 months and know the results.
(c) Consolidate the coordination, management, and the monitoring & evaluation of the national response to HIV/AIDS for its sustainability.	- Annual joint program reviews and work planning exercise by all donors

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

8. There were no changes to the original PDO. During the first restructuring of the Project (December 21, 2010), the baseline and target values of four PDO-level indicators (numbers 1, 2, 4 and 5) were adjusted to take into account newly available data and the results framework was updated accordingly The main reason for this adjustment was that most of the original baseline values referred to data collected in 2005 and released in 2006. As the Project became effective only in 2008, these baseline (and consequently target) values were mostly outdated, giving a picture that did not reflect the situation at the actual start of the Project. Moreover, for indicators number 1 and 2, the original baseline values were inconsistent, as they were higher than current values at restructuring. When new figures were provided by the Second Generation STD/AIDS Surveillance Survey (ESDG) in 2008, the Benin counterparts and the World Bank Team agreed during the Mid Term Review to use those figures as they were the main data source for several of the Project's core indicators.

PDO level indicators revised at first restructuring				
Revised indicator	**Original Baseline**	**Revised Baseline**	**Original Target**	**Revised Target**
Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission in the last 12 months	36.82% (overall); 34.1% for boys and 39.6% for girls	21.5%	75% overall	45% overall
Percentage of young women and men aged 15-24 reporting the use of a condom during the last sexual intercourse with a non-regular or non-cohabitating partner (of	59.9% (overall); 70% for boys and 51.8% for	49.5% overall	85% overall	65% overall

those reporting sexual intercourse with a non-regular partner in the last 12 months)	girls			
Percentage and number of people with advanced HIV infection receiving anti-retroviral combination therapy	N/A	52.7% for adults (11,308); 57.8% for children (770)	3,300 adults; 900 children	19,000 adults; 2,000 children
Percentage and number of HIV infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	52%	52.8% (1,447)	80%	70% (2,689)

1.4 Main Beneficiaries

9. The individuals and organizations expected to be the primary target groups of the Project were (i) those at high risk of contracting HIV/AIDS; and (ii) those already infected or affected by the HIV/AIDS epidemic. More precisely, the Project was targeting (i) vulnerable groups (women and youth), high risk groups (including commercial sex workers and staff of some key line ministries), and (ii) people living with HIV/AIDS (PLWHA), and other infected or affected people and orphans and other vulnerable children (OVC). Other beneficiaries were partner organizations (local NGOs, Ministries…), which received funding or assistance from the Project.

1.5 Original Components *(as approved)*

10. The Project had three main components. The first component focused on prevention, while the second component concentrated on testing and treatment services. The third component supported Project coordination, management and M&E.

11. **Component 1: Social Mobilization and HIV Prevention Services (US$11.90 million[7]):** This component was to provide funds for further scaling up of HIV/AIDS prevention efforts in Benin. Activities under this component were to be carried out mostly as subprojects by local communities, civil society and community based organizations and the private sector to support persons living with HIV/AIDS and vulnerable groups such as youth, commercial sex workers and orphans and vulnerable children. Activities under this component also included psychological and economic support to infected and affected persons. These activities were grouped under two sub-components, namely (i) support for community and NGO prevention activities to encourage behavior change, and (ii) support for impact mitigation activities for OVCs and PLWHAs.

[7] There seems to be a little confusion in the costing related to these components as they are shown in the PAD annexes. There are discrepancies in the document as, comparing annex 4 and 5, shows that US$ 35 million is only the baseline costs and does not include contingencies. If, as annex 5 shows, contingencies are included, the project cost increases to reach a total of US$ 37.45 million. In the annex 4 however, the total cost is US$ 36.75. The footnote to annex 5 of the PAD (page 45) does not clarify this.

12. **Component 2: Access to Treatment, Care, and Impact Mitigation Services (US$15.40 million):** This component, which was to be implemented by the PNLS, was to provide support to targeted activities in order for the country to achieve the goals of care and treatment for all people infected with HIV/AIDS, as spelled out in the 2006-2010 National HIV/AIDS Strategic Framework. Three main areas were to be covered under these activities: prevention, treatment and care.

13. **Component 3: Coordination, Management and Monitoring and Evaluation (US$7.70 million):** Under this component, the Project was to: (i) provide support for a unified national and decentralized coordination system and leadership; (ii) provide support for a uniform national monitoring and evaluation system; and (iii) provide financing for the coordination and management of the Project implementation unit.

1.6 Revised Components

14. During the two restructurings, neither the Project components, nor the activities included in each of them were revised, but allocation of funds to these different components was modified following the changes in the allocation of proceeds, as described in the next section.

1.7 Other significant changes

15. Implementation Arrangements. As implementation was somewhat slow during the first years of the Project, changes were introduced in the institutional arrangements to clarify roles between the SP/CNLS and the Project Implementing Unit (PIU). Practically, after an institutional assessment and the Mid-Term Review, the Project Implementation Manual was revised and expanded so as to define clearly the respective roles of the SP/CNLS and the PIU, especially regarding procurement processes.

16. Allocation of Proceeds. The allocation of proceeds was modified twice as is shown in table 1 below.

Table 1: Changes in the Allocation of Proceeds during the Project

Category of expenditures	Allocation expressed in XDR		
	Initial	First Revision	Second Revision
1.Works	670,000	758,000	758,000
2 (a) Vehicles, motorcycles and Equipment	740,000	1,029,000	1,049,000
2 (b) Medical equipment, Drugs, Tests and Reagents	7,200,000	7,536,000	8,950,000
3.Consultants, Services, Audits and Training	3,700,000	4,413,000	4,150,000
4 (a) Grants to CBOs	2,350,000	1,540,000	1,279,000
4 (b) Grants to CSOs	4,200,000	4,897,000	4,320,000
4 (c) Grants to Line Ministries	1,000,000	451,000	370,000
5.Operating Costs	2,100,000	2,785,749	2,533,749
6.PPF	330,000	90,251	90,251
7.Unallocated	1,210,000	0	0
TOTAL	23,500,000	23,500,000	23,500,000

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

Soundness of background analysis

17. The background analysis done for this Project was thorough. First, the Project team benefited from various analytical reports, including the 2005 OED evaluation of the Bank multisectoral HIV/AIDS Projects (MAP) in Africa. This report was highlighting the need to strengthen and harmonize M&E arrangements. In addition, the Project team could draw on data collected and analyzed during the previous MAP. It therefore built on the achievements and lessons learned from the previous Project, the PPLS.[8] More specifically, as a continuation Project, it drew on the PPLS' experience in scaling up the fight against HIV/AIDS and in setting up priorities among the national HIV/AIDS strategies and emphasized a need for cost effectiveness and results. It also took note of the weak coordination of activities management and M&E that were at the root of inefficiencies during the previous Project. Indeed, while the PPLS was being executed, the PNLS and various NGOs and bilateral agencies were implementing their own programs without coordinating with the SP/CNLS. That explains the heavy reliance put by this new Project on the "three ones" approach. Other important lessons learned were: (i) that community engagement for the promotion of HIV/AIDS testing was widely accepted and generated overwhelming demand at health centers; (ii) that participatory approach worked well by improving understanding and support and producing better action plans for operations; (iii) that stigma reduction was possible if appropriate messages were used and disseminated, and; (iv) that PLWHA could be reached successfully through community mobilization and use of multiple channels.

Assessment of Project design

18. The Project design at appraisal is deemed as appropriate. Although the design was slightly more complex that for the PPLS, it was using only institutions that were already existing and that had been used successfully during the PPLS. The Project departed from the PPLS only, by helping to set up a strong SP/CNLS (and agreeing to be integrated in this structure) and a strengthened and single M&E framework and operational plan. Conversely, it followed on that Project's footstep by using community mobilization and multiple channels to reach those infected or affected by HIV/AIDS, given the success of this strategy in the previous Project.

Adequacy of Government's commitment

19. With strong support from the Office of the President, the Government was highly committed to the fight against HIV/AIDS, as is shown by its increased budget allocations for the fight against this epidemic from US$ 1.0 million in 2002 to US$ 3.6 million in 2005. By 2006 it had established a Monitoring and Evaluation Plan ready to be tested by the new PMLS2. It also

[8] In the ICR prepared at the end of the PPLS, this previous project was considered to have attained its development objectives and reached its outcome and output objectives. The PPLS succeeded in training 652 civil organizations, establishing 3,137 community-based groups, establishing and supporting 33 national and local associations for PPLWHA, engaging nearly all government administrative infrastructure in the fight against HIV/AIDS, facilitating testing for 202,000 people (of whom 1,233 turned out to be seropositive), providing capacity building, equipment and ARV drugs (toward the end of the project), and providing sensitization and other services to HIV/AIDS infected or affected staff in 40 non-health public ministries and agencies.

showed its commitment by fulfilling all the conditions needed to be included in the Bank's MAP program.

Assessment of risks

20. The risks identified at appraisal were real and very relevant. The risk associated with a weak M&E system was adequately assessed and addressed with relevant mitigation measures (i.e. intense capacity building on M&E). The other main risk, relating to the staffing and leadership capacity of the SP/CNLS, was also rightly identified at appraisal. However, during implementation, the mitigation measures (also consisting in capacity building for the SP/CNLS) proved to be insufficient as section 4 below shows.

2.2 Implementation

21. Despite strong Government's commitment and the PPLS experience, it took eight months for the Project to become effective and implementation remained slow after effectiveness because of major bottlenecks. The main reason for the 8 months gap between credit signature and effectiveness has to do with delays in getting the Parliament authorization to ratify the credit agreement. This delay was due to the strained relations between the Government and the Parliament (in which the President did not hold a majority). As for implementation, although the Project disbursed 97% of its budget and achieved most of its indicators, it was challenged by a few issues: (i) the 2007 Presidential Decree on allowances ("per-diems") to be paid to Civil Servants attending training sessions and seminars; (ii) some conflicts originating from the existing institutional arrangements; and (iii) procurement delays.

22. The 2007 Presidential Decree set maximum amounts that could be paid to civil servants as per-diems for their missions and training. Many civil servants viewed the maximum amounts as too low. But while the Bank complied with this decree, several donors continued their past practices of offering higher per-diems to civil servants attending their training. Thus this decree had two unintended consequences. It reduced the motivation of health workers to attend needed training sessions and seminars (especially those funded by the Government, which includes the PMLS2), which slowed down Project implementation. And it was one of the root causes of numerous strikes by health workers.

23. Another challenge was related to the institutional arrangements between the SP/CNLS and the Project Implementing Unit (PIU), two units that were supposed to work very closely together. As described later in the ICR, a sort of "mission creep" occurred with the SP/CNLS, as it increasingly tried to take more responsibilities in implementation (for instance in procurement processes) although its role was merely one of coordination. These jurisdiction problems between the two institutions were eventually solved by clarifying roles after a Bank-commissioned institutional assessment prepared for the MTR.

24. Some procurement delays were generated by the *Direction Nationale de Contrôle des Marchés Publics* (National Agency for Public Procurement Control). It is important to note that this bottleneck is not a sectoral one, but rather a national one. All Bank Projects in all sectors have faced procurement delays because of this national agency. Also, these delays did not prevent the Project to disburse almost all its budget.

25. The Mid-Term Review took place in January 2010. Despite some implementation issues (which were discussed with the Government), the MTR concluded that the Project was making satisfactory progress both on PDOs and implementation. Indeed, at MTR stage, the Project had a disbursement rate close to 50%. No restructuring was therefore proposed at this stage, but the Bank asked the Government to prepare a document spelling out clearly the respective responsibilities of the SP/CNLS and the PIU.

26. The Project was restructured twice during its implementation phase. The first restructuring, made after the mid-term review, was triggered by the recent availability of the findings from the 2008 Second Generation STD/AIDS Surveillance Survey (ESDG). The restructuring was signed on December 21, 2010 and involved adjusting the PDO indicator values to factor in the newly available data from the 2008 ESDG. It also included a reallocation of the proceeds of the Credit to take into account, among other things, the fact that expenses under some categories had been overdrawn to face higher levels of spending (for rehabilitation works, equipment and other types of expenditures) and a depreciation of the dollar. This reallocation also took into account the fact that only about a third of the funds set aside for the Project preparation (PPF) were actually spent.

27. A second restructuring occurred on June 10 2011 and involved another reallocation of the proceeds and an extension of the closing date of the Project (from December 2011 to June 2012). At this time, the Project had disbursed 80% of its credit. The restructuring was merely a reshuffle of funds between the different disbursement categories in favor of medical equipment, drugs and reagents with the aim of giving the Government the means to scale up the implementation of Prevention of Mother-To-Child Transmission (PMTCT). To compensate for this increase, and to take into account the government's new strategy of better targeting of high risk groups and putting the focus on quality rather than quantity, cuts were made on the grants to civil society organizations and community-based organizations categories. The Project extension by six months was to give the Project enough time to complete activities that were critical to reach the end targets, especially those related to the only indicator that was lagging behind, the prevention of the mother-to-child transmission of HIV/AIDS.

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

28. Tremendous efforts were made to ensure that Monitoring and Evaluation was one of the strongest assets of this Project. These efforts have been mostly successful, although some weaknesses are still present.

M&E Design

29. The Project fully supported the recently validated national M&E framework. As mentioned earlier, for the sake of harmonization and alignment, the Bank agreed at appraisal to use the national M&E framework, notwithstanding that some capacity building was still necessary (and was included in the Project). A performance indicator tracking table was designed for the Project to show the expected evolution of indicators over the course of the Project, the data collection instruments, the frequency of the reports and the institution responsible for the

data collection. These national M&E indicators were to be reviewed annually. M&E specialists were to be deployed at the national and decentralized levels and an array of approaches was defined to collect routine data and to support epidemiological surveillance and operations research focusing on at-risk populations. The SP/CNLS (at the national level) and the CDLS and CCLS (at the decentralized level) were to be responsible for implementing and coordinating this system. At appraisal, the capacities of these entities were assessed as weak, which explains why the Component 3 included capacity building for the M&E system. As stated in the PAD, the M&E of progress toward Project objectives was to rely on "*a combination of routine health services data collected at the national and decentralized levels, monitoring data on HIV/AIDS program activities, periodical behavioral and surveillance surveys and periodic surveys on the coverage and quality of services*".

M&E Implementation

30. During implementation, M&E was the only field that has been constantly rated as Satisfactory in the ISRs (except during the Mid-term Review when it was downgraded to Moderately Satisfactory because some indicators had to be clarified and better tied to activities, therefore generating a new results framework). Afterwards, M&E was consistently rated as Satisfactory.

M&E Utilization

31. Information collected by the M&E system was very useful to Project managers and to the Bank team as it provided real time data, thus allowing some change in Project proceeds after the mid-term review. Produced data induced a focus on more efficient interventions like those targeting high-risk groups. As mentioned previously, routine data provided by the M&E system showed the need to review and clarify indicators and better tie them to proceeds.

32. One challenge faced with the M&E system was regarding the collection of data from households[9] and from specific population groups. As such, the first three PDO indicators pertaining to specific groups were best monitored through data collected by an independent survey (i.e. the Second Generation STD/HIV-AIDS Survey or ESDG). It is worth noting that, in this ICR, when data was available for these indicators from both the ESDG and the DHS, the ICR team retained the DHS numbers. Although ESDGs are usually reliable because of their focus on data collection among high risk groups, the 2012 ESDG encountered difficulties related to organizational issues with data collection and problems in the analysis and interpretation of collected data that made the reliability of its results questionable to all the sectors' stakeholders.

33. The decision to use the DHS data explains why the ICR is produced 12 months after the closing date of the Project since the ICR team had to wait for the final results of the 2012 DHS

2.4 Safeguard and Fiduciary Compliance

Safeguard Compliance

[9] Data for households is best obtained with very large surveys, such as DHS. DHS findings are always the most reliable ones, due to their very large sample size (about 17,000 households for a DHS versus 4,000 for an ESDG).

34. Based on the Bank policy on safeguards, the Project triggered BP/OP 4.01 on environmental assessment. The existing medical waste management plan (MWMP) was updated and used for this Project. While activities to be funded by the Project were not expected to cause any harm to the environment, in order to make sure that any potential risk was mitigated, the borrower assigned an environmental health specialist with responsibility for following up on the recommendations made by the MWMP. Also, to mitigate the risks inherent to biomedical waste, the Project (i) provided 24 Montfort type incinerators and 2 large electric incinerators for health facilities generating large quantities of biomedical waste; (ii) trained 253 health auxiliaries in the management of biomedical waste; and (iii) printed and distributed training documents pertaining to the management of such waste. Furthermore, the Project organized - in conjunction with the Abidjan-Lagos Corridor Organization - a regional dissemination workshop for the simplified waste management manual in the 5 countries involved in the Abidjan-Lagos Corridor. Overall, no environmental issue occurred during the Project's implementation.

Fiduciary Compliance

a. Financial Management Issues

35. The initial intent was to use the Country Financial Management System (CFMS) and Standard Public Expenditures Procedures (SPEP) for this Project and to have it audited externally by the Supreme Audit Institution (SAI). However, as the PAD stated "*it is uncertain how the Country FM will be implemented*". Due to the risk presented by the slowness of implementation of the CFMS and the fact that the SAI was not yet accustomed to the Bank audit procedures, mitigating measures had to be taken before these two issues were fully resolved.

36. The main mitigating measure was to ensure the PMLS2 would, like other HIV/AIDS Projects/programs, have its own FM system in line with other IDA financed Projects. For audit purpose, an independent accredited auditing firm was contracted for the first two years.

37. During Project implementation, financial management complied with Bank policies and procedures and was always rated satisfactory, except in two instances. At the end of 2008, some weaknesses in the organization of accounting tasks and in the follow up of advanced funds to certain institutions[10] were observed and quickly addressed by the PMLS2. In addition, some expenditures were deemed to be ineligible by an audit conducted in 2009 (for the 2008 fiscal year). The US$ 28,000 that had been unduly spent on gasoline was subsequently refunded by the Government.

b. Procurement Issues

38. Procurement Plans have been regularly prepared by the PIU and the hiring of a Procurement Specialist at the beginning of the Project helped to successfully implement these plans. Procurement was closely monitored as each Bank supervision mission included a procurement specialist. Post reviews carried out by the Bank team generally concluded that Bank

[10] For instance, delays ranging from 2 weeks to 3 months, instead of the 72 hours mentioned in the Manual of Procedures.

policies and procedures were properly followed. However, the Project experienced some delays in its procurement processes.

39. While the Project disbursed 97% of its funds, it encountered procurement delays, due to tensions between the SP/CNLS and the PIU on one hand; and long delays in approval by the *Direction Nationale de Contrôle des Marchés Publics* (National Agency for Public Procurement Control). Jurisdiction problems between the SP/CNLS and the PIU were eventually solved by clarifying roles after a Bank-commissioned institutional assessment. Regarding the second factor, lengthy procurement delays, a common problem in Benin, slowed down the delivery of drugs, equipment and medical supplies on occasions, thus affecting progress under component 2 of the Project. It has also at times delayed the hiring of critically needed staff (for instance M&E specialists, database and procurement officers) or the delivery of equipment like mobile laboratories. Near the end of the Project however, these delays were drastically cut as the approval process by the *Direction Nationale de Contrôle des Marchés Publics* dropped to 2 weeks instead of up 4 to 12 weeks as previously experienced.

2.5 Post-completion Operation/Next Phase

40. While the Bank has no plan for a next phase, the Global Fund has ramped up its financial support to the national HIV-AIDS strategy so that there is no funding gap (see section 4 for financial details). Furthermore, institutional arrangements which the Bank-financed Project helped to set up are still in place and will profoundly help in controlling the spread of HIV-AIDS in the future.

41. For instance, the “Three Ones” system is now fully operational and partners have all subscribed to it, therefore intervening within one strategy framework coordinated by one institution (the SPCNLS) and using one single M&E system. The Bank-financed Project has also strengthened institutions that are key in the fight against HIV/AIDS and will be essential in furthering the progress already made. At the government level, it has helped strengthen the capacity of the SP/CNLS (both at the central and regional levels); the Project has helped Ministries elaborate action plans that can be used in the future; it has also strengthened the capacity of health facilities to provide services needed to fight the propagation of HIV/AIDS, by providing technical equipment , rehabilitating physical facilities, training staff; it has increased the overall testing capacity by decentralizing laboratory activities, through the provision of mobile laboratories and by rehabilitating the national reference laboratory; it has strengthened the SIDAG and transformed it into a national reference and training center to be used by other Voluntary Counseling Centers in the country; finally, it has strengthened the biomedical waste management capacity through the provision of incinerators and septic tanks to health facilities. For community social mobilization, the Bank-financed Project has also strengthened the institutional and technical capacities in community organizations, CSOs and various HIV/AIDS related associations. Even if the Bank does not continue its presence in the fight against HIV/AIDS in Benin, by contributing to these arrangements and by strengthening these public and non-public institutions, it has left a long-lasting mark in the fight against this epidemic in Benin, and has left institutions and a setting that will be used in the future to more effectively control the spread of HIV/AIDS.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

Rating: Substantial

Relevance of Objectives

42. **Relevance of objectives** is rated as **highly satisfactory**. The PDOs are fully in line with the existing national HIV/AIDS strategy as well as the national health strategy plan and the Bank Country Assistance Strategy. They are also consistent with the current evidence-based recommendations at global level. In particular, these global recommendations insist on (i) supporting both prevention and treatment; and (ii) focusing on vulnerable and high-risk groups in countries of low-intensity epidemic like Benin. For the latter, the available evidence in Benin confirms that HIV prevalence levels have been 10 to 20 times higher among female sex workers than among women in the general population. Prevalence is also several-fold higher among male clients of female sex workers than among men in the general population. Therefore, targeting of female sex workers is essential for preventing the spread of HIV in the general population.

Relevance of Design and Implementation

43. **Relevance of design and implementation** is deemed as **satisfactory**. The Project benefited from lessons drawn from the previous Project (the PPLS) and therefore was built around a unique coordinating body (the SP/CNLS), developed a strong M&E system and heavily used community mobilization and multiple channels to reach beneficiaries. As this approach was recommended when faced with a HIV/AIDS concentrated epidemic[11], the Project was well suited in choosing HIV prevention policies focused on changing sexual behavior patterns in high-risk groups and in the general population, particularly focusing on reducing multiple and concurrent partnerships, as well as other prevention technologies. The only point in the design where flaws could be traced is in the institutional arrangements that were initially set up, and specifically, the definition of roles between the SP/CNLS and the PIU. This reduced the synergies that could have been brought by these 2 entities working closely together.

Overall Relevance

44. Considering both the high relevance of objectives and the adequate relevance of design and implementation, the overall relevance is rated as **satisfactory**.

3.2 Achievement of Project Development Objectives

Rating: Satisfactory

[11] See in Mishra S, Sgaier SK, Thompson LH, Moses S, Ramesh BM, et al. (2012) HIV Epidemic Appraisals for Assisting in the Design of Effective Prevention Programmes: Shifting the Paradigm Back to Basics. PLoS ONE 7(3): e32324. doi:10.1371/journal.pone.0032324.

45. As the HIV/AIDS Control Strategy framework was a national endeavor involving many partners and stakeholders, the achievement of development objectives cannot be attributed solely to the World Bank Project, but it nevertheless provided a sizeable portion of the funds used to implement the strategy. With US$ 35 million, the World Bank was the second financier behind the Global Fund (in addition to the US$ 68 million pledged until 2010, this institution also provided US$ 45.6 million to be shared between 5 countries, including Benin, in the Abidjan-Lagos Corridor Project). Other financiers included the USAID with US$ 7 million until 2010, the AfDB with a commitment of US$ 4 million per year until 2008 and Denmark with US$ 8.8 million until 2010. More importantly, while the Global Fund has been mostly funding treatment costs, the Bank was the main financier for prevention costs. Therefore, most of the results achieved in prevention (i.e. Component 1) can be reasonably attributed to the Bank Project.

46. Out of the seven PDO indicators, five have surpassed their target values and two have not (but have come very close, as one reached a 94% achievement rate while the other reached 83%). The overall rating given to the "Achievement of Project Development Objectives" was not only based on the success in reaching the revised PDO indicator targets of the Project. As these indicators were modified during the 2010 restructuring, the ICR guidelines recommendation to do a split evaluation was followed as is shown further below.

47. The weighted rating (based on the respective disbursement levels) of the achievement of PDO indicators at the time of restructuring and at the end of the Project is presented in table 3. At the time of the 2010 restructuring, available data show that three out of four PDO indicators had achieved their targets, and only one had not. For the other 3 PDO indicators (PDO indicators 1, 2 and 3), data was not available for measurement, before the 2012 ESDG, which was to be done at the end of 2011. If the focus is put on the intermediate indicators, the picture becomes even brighter (see below).

PDO-LEVEL INDICATORS

PDO 1: Strengthen access and utilization of <u>prevention</u> services for vulnerable groups (women, youth, etc…) and the high-risk groups (such as the commercial sex workers and the staff of key line ministries).

48. PDO 1 achievement is rated **Highly Satisfactory**, given that two indicators met their targets and one only partially met its target. The component 1 was addressing this first PDO: To that end, the component 1 was mostly supporting more than two thousand subprojects managed by communities and local NGOs. Most of these subprojects consisted in (i) carrying out behavioral change activities for young people and women, and (ii) distributing about 5 million condoms. Prevention plans from 12 Ministries were also funded. Radio stations were also supported for disseminating messages on HIV/AIDS prevention.
Three indicators were proposed for assessing progress regarding this PDO:

- Percentage of young women and men aged 15 -24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission in the last 12 months (UNGASS, IDA 14).

- Percentage of young women and men aged 15-24 reporting the use of a condom during last sexual intercourse with a non-regular or noncohabiting partner (of those reporting sexual intercourse with a nonregular partner in the last 12 months) (UNGASS).
- Percentage of sex workers who report using a condom with their most recent client (UNGASS).

49. *PDO indicator one: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission in the last 12 months.* The ICR Team considers that **this indicator met its target**. Although there are two sources of data for this indicator (ESDG-2012 and DHS), the ICR team retained the one produced by the DHS, because of its higher accuracy and because of the many problems linked to this specific ESDG. The preliminary results from the DHS (the 2011-2012 EDS-MICS-B IV) provide an estimate of 67.6%, much higher than the target value (45%).[12] Note also that this indicator reflects the impact of the Project on access to prevention services, while indicators 2-3 (use of condoms) and 6 (testing) correspond to utilization of these services. This achievement of this PDO-level target can be linked to the outputs of Component 1, whose activities (i.e. outreach and IEC programs) have reached more than 5.5 million individuals (which is almost the entire targeted population in Benin).

50. *PDO indicator two: Percentage of young women and men aged 15-24 reporting the use of a condom during the last sexual intercourse with a non-regular or non-cohabitating partner (of those reporting sexual intercourse with a non-regular partner in the last 12 months).* With a percentage level of 68.1% reported by the 2012 ESDG, **this indicator met its target**. This achievement can be explained by the Project activities, which has distributed about 7.6 million condoms, as well as funded massive communication campaigns (as seen earlier).

51. *PDO indicator three: Percentage of sex workers who report using a condom with their most recent client.* **This indicator,** computed at 84.9% at the end of the Project, **did not meet its target** of 90% according to Project figures and the 2012 ESDG results. One can nevertheless see that the Project misses this target by a very thin margin. Indeed, although using a slightly modified indicator, a PSI report[13] shows this number to be consistently above 90% (91.7% for 2007, 92.3% for 2009, and 94.6% for 2011). These PSI numbers would tend to show that the target has been reached.

The Project (with its Component 1) was indeed focusing on this high-risk group. This group benefited not only from massive distribution of condoms (see supra), but also from about 50 subprojects targeting female sex workers on better awareness regarding HIV-AIDS.

[12] The indicator measured by the DHS is a close proxy of the PDO indicator given that it measures the percentage of women and men aged 15-24 who know that using a condom and reducing the number of sexual contacts to those with one non-infected partner can reduce the risk of contracting HIV. Note that the other source of data (2012 ESDG) gave an actual percentage of 14.7. However, during the workshop held in November 2012, the accuracy of the numbers produced by the 2012 ESDG were widely criticized by stakeholders and members of the PIU.

[13] See pages 5 and 7 of the TRaC Summary Report on the PSI Dashboard called "Benin (2011): Evaluation de l'utilisation du condom chez les Travailleuses du Sexe de 15-29 ans des zones d'intervention du projet IMPACT" (3eme passage).

PDO 2: Improve access and utilization of treatment and care services for HIV/AIDS infected and affected persons, notably the persons living with HIV/AIDS (PLWHA), and Orphans and Vulnerable Children (OVC).

52. PDO 2 achievement is rated **Satisfactory,** given that two indicators met their targets and one did not. The component 2 was focusing on the second PDO and funded a wide array of activities for strengthening delivery of HIV/AIDS treatment and care, including (i) the support of dozens of health facilities for improving PLWHA care, (ii) purchase and distribution of ARVs, and (iii) training for health workers.
Three indicators were used for monitoring progress on that PDO:
- Percentage and number of people with advanced HIV infection receiving antiretroviral combination therapy. (UNGASS).
- Percentage and number of pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT (UNGASS).
- Number and Percentage of persons aged 15 and older who undergo HIV voluntary counseling and testing in the last 12 months and know the results.

53. *PDO indicator four: Percentage and number of people with advanced HIV infection receiving anti-retroviral combination therapy*. **This indicator surpassed its target** by 7%, under the assumption that only the aggregated value of the indicator is to be taken into account. It should also be mentioned here that the revised target was 475% higher than the initial one, and still the target was reached.[14] This result can be safely attributed to the Project, given that the recipients of ARV drugs were tracked by the PMLS2. Indeed, the Project records mention that 25,522 patients with advanced HIV infection had received ARV drugs through the PMLS2.

54. *PDO indicator five: Percentage and number of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT*. **This indicator did not reach its target value.** Conflicting numbers were produced for this indicator, as the latest ISR mentions an actual value of 6,654 drawn from the December 2011 Project Report while the PNLS-generated "*Annuaire Statistique Provisoire 2011*" shows it to be 1,560 (58%). This latter figure, which also appears in the Beneficiary ICR, was confirmed by the PIU during the ICR mission to Benin. There is no actual percentage available at the end of the Project for comparison purpose. Note that this indicator is the only one that has been lagging throughout the Project implementation.

55. *PDO indicator six: Number and percentage of persons aged 15 and older who undergo HIV voluntary counseling and testing in the last 12 months and know the results.* **This indicator surpassed its target** by about 176% (1,035, 740 for a target of 375,000). In comparison to the other PDO-level indicators, this last result is more difficult to attribute to the Project itself. One can only conclude that this result may be partially explained by the communications efforts

[14] This conclusion has to be qualified however by the fact that both the baseline and target values for this indicator had two groups to monitor, adults and children. Only one aggregated number (including both adults and children) was given at the end of the project. In September 2011, 19,279 adults were already receiving ARV therapy, it is not too far-fetched to assume that this number did not increase by more than 1,500 in one quarter (October to December 2011), thus leaving children to be the remaining 2,000 people receiving ARV therapy.

financed by the PMLS2, efforts that have reached about 5.5 million people in the country and that may have lured them to ask for counseling and testing.

PDO 3: Consolidate the coordination, management, and the monitoring & evaluation of the national response to HIV/AIDS for its sustainability.

56. PDO 3 achievement is rated as **Highly Satisfactory**, as its indicator fully met its target. The component 3 was set up to contribute to the third PDO and supported various activities for (i) strengthening the SP/CNLS (rehabilitation, office equipment, vehicles), (ii) supporting the national M&E system (IT consultants, training, equipment), and (iii) covering the operating costs of the Project.
One indicator was used for assessing the progress made towards this PDO.

57. *PDO indicator seven: Annual joint reviews and work planning exercise by all donors (under the coordination of SP/CNLS).* **This indicator fully met its target.** As noted earlier, the PMLS2 has been instrumental in fostering the implementation of the "Three Ones" approach and can therefore be credited for this achievement.

Original PAD Indicators	Baseline Value	Original target Value at end of Project (from the PAD)	Target Value at time of Restructuring (extrapolated from the PAD)	Actual Value achieved at time of Restructuring (from Annex 1 of the October 12-25 2011 Aide-Memoire)
1. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission in the last 12 months	36.8%	75%	57.5%	N/A
2. Percentage of young women and men aged 15-24 reporting the use of a condom during the last sexual intercourse with a non-regular or non-cohabitating partner (of those reporting sexual intercourse with a non-regular partner in the last 12 months)	59.9%	85%	75%	N/A
3. Percentage of sex workers who report using a condom with their most recent client	69.2%	90%	82.5%	N/A
4. Percentage and number of people with advanced HIV infection receiving anti-retroviral combination therapy		3,300 Adults and 900 Children	2,300 Adults and 600 Children	17,756 Adults and 1,400 Children
5. Percentage and number of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	52%	80%	75%	51% (1,650)
6. Number and percentage of persons aged 15 and older who undergo HIV voluntary counseling and testing in the last 12 months and know the results		375,000	225,000	480,384
7. Annual joint reviews and work planning exercise by all donors (under the coordination of SP/CNLS)		4	3	3

INTERMEDIATE OUTCOME INDICATORS

58. All intermediate outcome indicators have reached their revised targets. For Component 1 (Social mobilization and HIV prevention services), all four indicators reached their revised targets; at restructuring however, one of the indicators (the number of female and male condoms distributed) did not meet its target.[15] A possible explanation was that the target was unrealistic.

[15] To determine the target values at the time of restructuring, expected annual values shown in the PAD were used to estimate what these values should be.

This explains why this target value was lowered by two third at restructuring. For Components 2 (Access to treatment, care and impact mitigation services) and 3 (Coordination, management and M&E), all indicators met their target (both compared to original and revised ones). [16]

59. Thus, as is shown in the table below, by factoring in results from both the PDO and Intermediate indicators, the ICR team concludes by rating the achievement of objectives as **Satisfactory.**

Table 3: Summary of Project Development Indicators

	At Restructuring	**At end of Project**	**Total**
Key PDO Indicators			
Achieved	3	5	
Partially Achieved	0	1 (i.e. 94.3% achievement rate)	
Not Achieved	1	1 (i.e. 83% achievement rate)	
Not Measured	3	0	
Total	***7***	***7***	
Ratings	Moderately Satisfactory	Highly Satisfactory	
Point-Equivalent	4	6	
Actual disbursements (in millions of SDR)	20.40	13.52	33.92
Weight: Share of Total Disbursements	60.14%	39.86%	100%
Weighted Rating	**2.41**	**2.39**	**4.80**
Intermediate Indicators			
Achieved	10	11	
Partially Achieved	0	0	
Not Achieved	1	0	
Not Measured	0	0	
Total	11	11	
Overall Rating	Substantial		

[16] A possible question is whether the revised targets for this Project were not set too low. Without being able to confirm with certainty that it was not the case, the ICR team believes that the fact that all Intermediate Outcomes indicators have been reached (whether the original or the revised targets are used) suggests that the revision of targets was done in a realistic and honest way.

3.3 Efficiency

Rating: Satisfactory

60. The interventions funded by the Project are among the most cost-effective ones for fighting HIV-AIDS. Most of these interventions are indeed part of the Copenhagen Consensus (which rigorously estimates the most cost-effective interventions in development aid).[17] Also, there is a very strong body of evidence confirming that interventions focusing on sex workers. (and more generally on high-risk groups) are the most cost-effective ones against HIV-AIDS. For instance, Hogan and others (2005[18]) found that these interventions (i.e. focusing on sex workers) have an average cost US$3-US$4 for one averted DALY[19], while other interventions (such as school based education) require at least US$400-US$500 for one averted DALY.

61. As for the efficiency of the interventions as implemented by the Project, HIV/AIDS interventions have been implemented by the Project in a very efficient way, thanks to the following factors: (i) the Project did not create any new entity but rather built on existing ones. For instance, advocacy on HIV/AIDS was done through contracting with communities and existing NGOs; (ii) partnerships with local councils have been fostered, not only for efficiency but also for sustainability; (iii) the Project has implemented some "task-shifting"[20] to increase the capacities of existing health workers (i.e. nurses) for providing high-quality HIV/AIDS treatment. A much less efficient way would have been the recruitment of new health workers, such as doctors; and (iv) grants have been managed more efficiently than during the previous HIV/AIDS Project, as evidenced by the evaluation of AGeFIB's performance in 2010, which concluded that the grants were adequately managed.

62. A study, commissioned by the Bank in 2011, explored the cost-effectiveness of the services provided by the Project to sex workers. The study found that the average cost per reached sex worker (including testing and preventive treatment) was about US$107 and was therefore in line with the costs observed in other similar Projects.[21] Similarly, the study found that the average cost per sex worker visit (supported by the Project) in a health care facility was about US$28 and that this average cost was similar to the costs faced by other donors in Benin and was even lower than for similar Projects elsewhere (for instance, lower than the US$36 for a Project in India). Also, Project's operating costs accounted for less than 14% of the total Project costs, which is a reasonable ratio (and better than the previous HIV/AIDS Project, where the percentage was 19%).

[17] The 2004 Copenhagen Consensus rated "control of HIV-AIDS" as the most cost-effective intervention, compared to other interventions in health and other economic sectors.
http://www.copenhagenconsensus.com/sites/default/files/copenhagen_consensus_result_FINAL.pdf

[18] Hogan Daniel et alii, "Cost-effectiveness analysis of strategies to combat HIV_AIDS in developing countries", British Medical Journal, November 10, 2005.

[19] DALY: Disability Adjusted Life Year

[20] Task-shifting means that, instead of training new highly skilled (and expensive) health workers (such as doctors), existing (and lower skilled) health workers are trained to be able to perform selected procedures. This approach has been extensively used in the field of HIV-AIDS.

[21] See *Analyse Des Programmes De Santé Et De Lutte Contre Les Ist/Vih Ciblant Les Travailleuses Du Sexe Et Leurs Partenaires Sexuels* Au Bénin (Analysis of health and HIV-AIDS programs targeting sex workers and their users in Benin), 2012.

63. As for the overall economic analysis (see annex 3), it could not be updated, because of a lack of data. However, the ICR team has been able to verify that the assumptions made by this analysis at Appraisal turned out to be correct. That further supports the conclusion that the interventions funded by the Project were highly cost-effective.

64. For all these reasons, efficiency is rated as **Satisfactory**.

3.4 Justification of Overall Outcome rating

Rating: Satisfactory

65. Considering the substantial rating for relevance, achievement of objectives and efficiency shown by this Project, the overall outcome is rated **Satisfactory** by the ICR team.

Table 4: Overall Outcome Rating	
ITEM	**RATING**
Relevance	Satisfactory
Achievement of Objectives	Satisfactory
Efficiency	Satisfactory
Overall Outcome Rating	Satisfactory

3.5 Overarching Themes, Other Outcomes and Impacts

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

66. The Project, by reducing the spread of HIV/AIDS and by providing treatment to those infected by HIV/AIDS, has likely helped reduce catastrophic health expenditures and thus reduce poverty. Furthermore, by funding income-generating activities, it has given those infected or affected by HIV/AIDS the mean to provide for themselves, therefore reducing poverty. Indeed, the Project has funded 88 subprojects for helping PLWHA to start or continue income generating activities.

67. High focus was put on high-risk groups like female sex workers and schoolgirls. Indeed, as the most at-risk group and the group with the highest prevalence in the population, female sex workers received special attention from the Project.

68. Finally, the PMLS2 has provided significant support to Orphan and Vulnerable Children (OVCs). For instance, it has funded 8 training facilities for OVCs so that they could still benefit from schooling.

(b) Institutional Change/Strengthening

69. The Project was instrumental in implementing the “Three Ones” approach and therefore has helped in improving aid harmonization and alignment in Benin. In particular, the Project supported the strengthening of the SP/CNLS and its decentralized units (such as the communal

and departmental committees for the fight against HIV/AIDS) with equipment (computers, vehicles, etc.), training, studies and offices (only for the S/CNLS). It also posted M&E specialists in the departmental committees and focal points in all 77 communal committees. Thanks to this support, the SP/CNLS is now fully considered as the coordinating body for the fight against HIV/AIDS. Similarly, the national M&E is recognized by all donors, who are much less often setting up their own M&E arrangements.

(c) Other Unintended Outcomes and Impacts (positive or negative): N/A

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

70. In the 2012 Beneficiary Survey, carried out by the Project, institutional partners (like the UFLS, the PNLS, the AGeFIB, personnel in health facilities, CD/CNLS, CC/CNLS and managers of deconcentrated technical services) appreciated and recognized the PMLS II as a Project that came to bridge the gap in the fight against HIV/AIDS. They felt that their collaboration with the Project had been very good and that the Project intervention approach had been very efficient. Regarding direct beneficiaries, 68% of those interviewed were positively satisfied with the quality of services provided to fight HIV/AIDS with the main reasons given being the regularity of IEC actions (for 83% of them), the free provision of condoms (72%) and the efficiency of STI treatments. Furthermore, 76%, 74% and 67% of those interviewed were satisfied respectively with (i) PMTCT; (ii) screening/IEC and promotion of condoms; and (iii) access, care and socioeconomic support received.

71. During the stakeholders' workshop, the message relayed by beneficiaries to the team was that the WB was funding services, such as prevention, that other partners did not care to cover and that, without these services, gains that have been made in the fight against HIV/AIDS would quickly be lost.

4. Assessment of Risks to Development Outcome

Risk to Development Outcome is rated as Moderate

72. The main risk to the sustainability of development outcome is related to the funding of the national HIV-AIDS strategy. Some stakeholders have indeed expressed concerns that the absence of a follow-up to the Bank Project would jeopardize the sustainability of the Project's achievements. For the period 2012-2016, the Government has estimated its essential funding needs at about US$120 million. The Government has received two installments from the Global Fund: a US$60 million grant, complemented by an additional US$80 million grant. Consequently, there is no funding gap for the HIV-AIDS strategy in Benin.

73. Furthermore, as is shown on the Grant Agreements it signed with three institutions in Benin (the PNLS, Plan Benin and the Industrial and Building Electricity Company [SEIB], the Global Fund financing greatly reduces the "programmatic" risk. This is the risk, mentioned by beneficiaries, that programs that were covered mostly or solely by the Bank funding would cease to exist once the Project was over. The Global Fund financing not only continues covering

activities it was previously funding, but also takes over most prevention activities previously funded by the Bank. For instance, one of the goals of the Grant Agreement with the SEIB is to "*reduce the risks of HIV transmission in the general population, among women and key high risk populations by intensifying the prevention interventions*" while another is to "*strengthen the HIV prevention interventions at the workplace, including apprentice programme workplaces*". In the Grant Agreement signed with the Ministry of Health (i.e. through the PNLS), one objective is "*strengthening the access and quality of the services of counseling and testing, prevention of HIV Mother-to-Child Transmission and blood transfusion safety*". In the Grant Agreement with Plan Benin one of the objectives is "*to reinforce social mobilization and communication interventions for the fight against HIV/AIDS among women, adolescents and young people and key populations with a high risk of HIV infection*". The key high-risk groups will therefore be covered by the Global Fund financing.

74. Another risk to development outcome is the institutional risk. The experience with the SP/CNLS has left stakeholders wondering if that institution's perceived weaknesses would not have a negative impact on the achievements made by the Project. By doing an institutional assessment, the Project has been able to define better how responsibilities were to be split between the different stakeholders. The Project has also strengthened institutions, including the SP/CNLS (both at the central and departmental levels). In so doing, it has considerably lowered the institutional risk that the achievements made by the Project would not be sustained. In light of all this, the risk to development outcome is rated as **Moderate**.

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in ensuring Quality at Entry

Rating: Satisfactory

75. The Bank Performance in Ensuring Quality at Entry is rated as **Satisfactory**. As mentioned previously, the background analysis done by the Bank for this Project was thorough and the Project was strategically highly relevant to the situation of Benin at the time. The results framework was complete, although time showed later that the values of some of the baseline indicators were not properly assessed. Technical aspects were well covered and took into account lessons learned from the predecessor Project (the PPLS). As this was a follow-up to the PPLS (a Project which has been rated satisfactory in its ICR), the Bank made sure not only to keep the same Project format but also to fine tune it by taking into account all the lessons drawn from the PPLS. Specifically, it made sure that community mobilization would be used as the preferred means to reach people affected or infected by HIV/AIDS. Safeguards were properly assessed and mitigation measures well defined. Institutional aspects were properly assessed and potential issues identified, specially the one relating to the leadership role of the SP/CNLS. Among those institutional aspects, using a private Financial Management Agency (which had been used in the PPLS), the AGeFIB, to manage the downstream flow of funds, thus relieving the PIU of a cumbersome task, was a very good idea. As for the M&E design, the Bank invested heavily

(both in time and resources) in the design of a single and efficient system that was to be used by all stakeholders in the spirit of the WHO-backed "Three Ones" approach. This focus on a single and national strengthened Monitoring and Evaluation (M&E) system draws its origin from the PPLS experience. Risk assessment was well done and provided proper mitigation measures, although in the end these proved insufficient. The Bank input and processes was of high quality as it brought in a strong multidisciplinary team and worked closely with all stakeholders to make sure that this Project would achieve its planned development objectives.

(b) Quality of Supervision

Rating: Satisfactory

76. The Quality of Supervision is rated as **Satisfactory**. The Bank made sure that each of its supervision missions would involve at least one specialist in each of the fiduciary topics (Financial Management and Procurement). Regular fiduciary reviews were held during the course of the Project and training was suggested for stakeholders involved in the Project when insufficiencies were detected. When the Project progress warranted it, it also brought other specialists to focus on removing the bottlenecks. For instance it brought an environmental specialist when the institution in charge of the management of biomedical waste showed its limitations. It was also very quick to identify the lack of clarity in the way responsibilities were shared between the SP/CNLS and the PIU in the Project implementation (it did mention it as early as in its June 2008 mission aide-memoire, less than 6 months after Project effectiveness). It repeatedly brought the issue to the authorities and facilitated its resolution by bringing in an external consultant to do an institutional review in order to solve the problems that were slowing down the Project. The Bank used the Mid-term review to bring corrective measures to various issues, such as the lack of precision in some indicators or the lack of balance in the initial allocation of funds to Project categories. The Bank was also quick to track, highlight and suggest corrective measures when needed. For instance, near the end of the Project, it suggested changing the focus to at-risk groups like sex workers and the youth and re-allocating funds accordingly. On another instance, when there was slow progress on the implementation of the safeguard issue, it took the initiative to suggest corrective measures (such as outsourcing key activities to the civil society and the private sector) that, once applied, brought the situation back to normal.

(c) Justification of Rating for Overall Bank Performance

Rating: Satisfactory

77. In view of the ratings for the Quality at Entry and the Quality of Supervision, the Overall Bank Performance is rated as **Satisfactory.**

5.2 Borrower Performance

(a) Government Performance

Rating: Moderately Unsatisfactory

78. Government Performance is rated as **Moderately Unsatisfactory**. On one hand, the Government was able, during the design stage, to create the conditions for a strong and unified M&E system and to support the preparation of one Strategic Plan to which all stakeholders aligned themselves. In doing so, it created the basis needed for the Project to succeed and for activities to be scaled up in the future if and when funding becomes available. On the other hand, the Government was unable to remove key bottlenecks encountered during Project implementation. The Project took 8 months to become effective due to strained relations between the Government and the Parliament. Once the Project became effective, the Government chose to change the Permanent Secretary of the CNLS twice instead of tackling more upfront the institutional problem. It did not fully support the strengthening of the capacity of the CNLS.

79. Other Government's responsibilities that had a bearing on the Project. While it deposited the counterpart fund in an account to be used for the payment of civil servants involved in the Project at the SP/CNLS, the initial funds could not be used as the "*Arrêtés*" needed to use them took time to be signed by the Government. Around that same vein, was the 2007 Presidential Decree on allowances given to civil servants attending seminars and other training sessions. This Decree, which among other things caused strikes from Ministry of Health staff, also had the undesired effect of keeping staff away from training needed to implement Project activities.

(b) Implementing Agency or Agencies Performance

Rating: Moderately Satisfactory

80. Performance of the main Implementing Agency, the PIU, is rated as **Moderately Satisfactory**. Under adverse circumstances due to not clearly defined share of roles and responsibilities with the SP/CNLS, the PIU was able to steer the Project and remove many bottlenecks. Project management was rated less than satisfactory after the first year of implementation due to the tensions with the SP/CNLS on acquiring equipment, medical supplies and hiring needed staff and problems caused by other Government institutions (that delayed the purchase of goods, medical equipment, drugs and reagents). The Project management rating was upgraded after changes were implemented following the mid-term review and the institutional assessment.

81. Performance of the AGeFIB is rated as **Satisfactory**. This Financial Management Agency which piloted the implementation of Component 1 did very well in managing the funding provided for sub-Projects to civil society organizations, community-based organizations NGOs and private sector companies that were supporting people living with HIV/AIDS, at-risk groups like orphans, youth, women, sex workers, and in providing support to infected and affected people. Most of the achievements under this component can be linked to the AGeFIB.

(c) Justification of Rating for Overall Borrower Performance

Rating: Moderately Satisfactory

82. In view of the Moderately Unsatisfactory performance of the Government and the Moderately Satisfactory Performance of Implementing Agencies, Overall Borrower Performance is rated as **Moderately Satisfactory**. The justification is that the implementing agencies (PIU and AGeFIB) have played a much more important role in the implementation of the Project that the Government had. A higher weight is therefore given to their rating.

6 Lessons Learned

Wide general application

83. Monitoring indicators based on household data is always challenging and innovative solutions should be used. Even a very strong (routine) M&E system will have difficulties in collecting reliable data at household level. Such data is best collected through very large surveys, like DHS. But DHS are typically done only every 5 years. A long-term solution is to institutionalize annual "mini-DHS". Senegal is currently implementing this approach. Another solution is to use survey techniques such as LQAS (Lot Quality Assurance Sampling). Such surveys should have been planned, financed and carried out under the Project.

84. It is crucial to express effectiveness conditions in precise terms in order to avoid loopholes that can jeopardize Project implementation. This was the case for the counterpart funds that were to be made available to cover top-ups for civil servants involved in the Project. Although the effectiveness condition was met, as the funds were set aside by the GoB as required, the laws that were to make them readily available to health staff took a very long time to be signed by the Government. These laws should have been included in the effectiveness condition.

85. Having a thorough understanding of HIV/AIDS epidemic dynamics by population group and geographic areas is a mandatory pre-requirement to design programs and invest resources where they can achieve the highest impact.

86. The selection of indicators in the results framework needs to be aligned with the likely major contribution made by the Bank resources, following the results chain. In this Project, while most of the prevention activities target sex workers, their clients and partners, outcome indicators measure behavior change in young population. As this behavior change is the result of a combination of programs and interventions, it is impossible to attribute it to one specific program, although this program may have been the main contributor.

Project specific

87. Using a fiduciary agency to manage the subproject component can be the key to successful implementation as it leaves the PIU free to concentrate on coordination instead of getting involved in a field for which it does not have a comparative advantage.

88. Using a fiduciary agency, like AGeFIB, to run the financial management of simultaneous funding of community-based organizations increases operation efficiency where community-level action is required.

89. While setting up a sector-wide coordinating mechanism (i.e. the SP/CNLS) is a highly relevant objective, the potential risks are not only with the inadequacy of capacity building, but also with a "mission creep" issue. This latter risk is highly likely with institutions that are brand new and with a vague ("coordinating") mandate. Allocation of roles and responsibilities should be defined precisely upfront.

90. Using local councils to work with NGOs and to be responsible for implementing and coordinating the M&E system at the decentralized level can be a key to success by producing needed data in a timely and efficient manner.

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

(a) Borrower/Implementing Agencies

91. The borrower prepared a draft ICR which has been summarized and included as annex 7 to this report.

(b) Cofinanciers

N/A

(c) Other Partners and Stakeholders
(i.e. NGOs/Private sector/Civil society)

Annex 1. Project Costs and Financing

(a) Project Cost by Component (in USD Million equivalent)

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Social Mobilization and HIV Prevention	11.90	11.87	99.7%
Access to Treatment, Care, and Impact Mitigation	15.40	13.43	87.2%
Coordination, Management, and Monitoring and Evaluation	7.00	7.29	104.1%
PPF	0.70	0.70	100%
Total Baseline Cost	35.00	33.29	95.11%
Total Project Costs	35.00	33.92	96.91

(b) Financing

Source of Funds	Type of Cofinancing	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Borrower		2.00	0.00	0%
International Development Association (IDA)		35.00	33.92	96.91%

Annex 2. Outputs by Component

Component 1: Social Mobilization and Prevention Services

Under this component the Project provided funds for interventions to continue to scale up HIV/AIDS prevention efforts, particularly for activities relating to information, education, and communication (IEC) leading to behavioral change; for care and support of infected and affected persons; to support promotion of health services not under MOH, and for the distribution and social marketing of condoms.

Subcomponent 1 (a): Support for community and NGO prevention activities to encourage behavior change

The subcomponent funded 985 subprojects and 1,178 community action plans dealing with HIV/AIDS prevention and behavior change activities and providing support to vulnerable groups such as orphans, women, youth, TB patients, and commercial sex workers. The component aimed to increase and scale up prevention efforts undertaken during MAP I, but with a specific focus on reaching the vulnerable groups with interventions designed to encourage behavior change in a participatory fashion. The subcomponent helped consolidate and increase the number of "*caisses de solidarité*" and train their committee members ("*porte paroles*") in evaluating sub-Projects and identifying good practices to be replicated.

(i) Promoting access to HIV/AIDS prevention information and services for all. The subcomponent provided financial assistance to CSOs and NGOs that carry out prevention activities in communities. Priority was given to CSOs that deal with PLWHA, commercial and clandestine sex workers, youth and adolescents, women, and traditional healers and midwives. NGOs that direct their activities to vulnerable groups such as fishermen, drug users, transport workers, refugees, and amulet vendors were also assisted. The activities financed included: (i) prevention activities relating to HIV/AIDS and reductions in STI (training will be provided to NGOs and CSOs leaders on the norms and procedures for fighting STIs and behavior change interventions developed under MAP I); (ii) advice and promotion of voluntary HIV/AIDS testing; (iii) promotion of the use of condoms (both of male and female condoms); (iv) strengthening prevention messages and utilization of prevention mechanisms among youth and women; (v) intensification of communication that encourages changes in sexual behavior and patterns; (vi) promotion of communication between various associations, including those of traditional healers; and (vii) support to local radio stations for their HIV/AIDS-related programs. These activities have been identified as being particularly relevant to ensuring behavior change in the vulnerable groups since it was already identified under MAP I that the use of public service messages delivered by radio and TV and the use of community activities to encourage testing were highly effective. Public service messages of this type were so successful that they generated an overwhelming demand for testing at the health centers, which were not equipped to

handle the demand. The activities of national and "departmental" NGOs with proven experience and expertise in reaching high-risk groups such as professional and clandestine sexual workers, men having sex with men, or doing social marketing activities among the vulnerable groups, were also financed to implement larger scale activities.

(ii) Priority Line Ministries. The subcomponent supported action plans prepared by line ministries in the public sector. The component financed annual action plans prepared by Focal Point Units in the key ministries and approved by SP/CNLS, targeting the client groups of the key ministries. The key ministry action plans included: (i) prevention activities for raising awareness; providing communication that encourages changes in sexual behavior and practices; (ii) advice and promotion of voluntary HIV/AIDS testing; (iii) advocacy, communication, and availability of information and guidance on HIV/AIDS matters in the ministries; and (iv) offering psychosocial counseling of infected persons. The Ministries of Education, Youth, Family, Women and Children, and Agriculture were identified as those that could be most effective in reaching the greatest coverage and target vulnerable groups for prevention and care. The Ministry of Defense had also been identified as a key ministry and was used to support activities for personnel that are located within other ministries but represent the vulnerable group of uniformed personnel, such as policemen, park rangers, and border patrol officers, and who often utilize the Ministry of Defense health facilities. The Ministry of Family, Women and Children was supported to ensure their role in coordinating and supervising the quality of NGO interventions funded under subcomponent 1(b) for the care and support of OVCs. This Ministry was also critical in encouraging changes in cultural and male behavior patterns that contribute to increased HIV vulnerability in the society.

(iii) Capacity building. Besides financing subprojects, effective implementation of the subcomponent also required capacity building at several levels. Capacity building activities included (generally as part of subprojects), standardization of the participatory approach at the local level, and strengthening of institutional and technical capacities in community organizations, CSOs, and various HIV/AIDS related associations. NGOs were recruited, when needed, to provide technical capacity building to the local communities on how to prepare better action plans with identified results and targets contributing to the overall results framework, implement them effectively, and carry out "self-evaluation" (evaluation of subprojects and their implementation by beneficiaries). The activities benefited committee members in communities, "*agents d'accompagnement*," radio producers and speakers, and staff of CSOs and HIV/AIDS-related associations.

(iv) Intensification of the fight against HIV/AIDS in the workplace. The subcomponent financed activities that (a) improve the advocacy, communication, and availability of advice in the workplace concerning HIV/AIDS; (b) increase prevention and understanding of HIV/AIDS and the effects of HIV/AIDS on infected persons; and (c) reduce the stigma of the HIV infection. The activities included training, development of communication programs, development of workplace strategies and policy regulations on HIV/AIDS, and mitigation of the impact on

PLWHA. Some key non-formal sector groups were targeted, such as the motorbike taxi operators who by virtue of their business may be vulnerable to HIV infection, or groups such as the young female vendors along the roads who sometimes also engage in clandestine commercial sex work. Health personnel of the public, private, and religious organizations are particularly vulnerable because they are constantly exposed to HIV in their workplace, and often unaware of their own risk and how to protect themselves. The Ministry of Health had already initiated activities within the public sector to train health personnel on reducing their exposure to HIV in the workplace and was supported to extend this training to all health personnel in Benin, even outside the public sector, in conjunction with the Global Fund support. The subcomponent also improved policy knowledge, training in biomedical waste management and helped protect health personnel against infection from such waste. Training was provided on improving medical waste management in health facilities and appropriate use of waste management equipment provided under Component 2 and under the Benin PRSC.

Subcomponent 1 (b): Support for impact mitigation activities for OVCs and PLWHAs

This subcomponent allowed for support to be provided directly and indirectly to mitigate the impact on people living with HIV and orphans and vulnerable children infected and affected by the epidemic (including psychosocial and economic support).

During MAP I, faith-based and charitable organizations proved to be effective in caring for HIV/AIDS-infected and affected people. Under this subcomponent financing was made available for subprojects for looking after infected and affected people and operated by faith-based and other organizations. These may be private, religious organizations or other association-run health centers that have been accredited by the Ministry of Health PNLS unit to provide (i) ARV treatment and management of opportunistic infections and that take care of AIDS patients; (ii) care for infected children; (iii) provide nutritional support to families affected by AIDS; or (iv) provide psychosocial care and counseling to individual patients or families. There are several such institutions that are already providing ARV care, are recognized as providing high quality services and often present the closest option for ARV services to PLWHAs, but are now limited in their ability to scale up services to more patients because of the question of payment. Project assistance subsidized existing or new activities for these purposes**.** This support was provided directly to these facilities on the basis of the identified number of patients treated at the facility over a given period of time.

In order to ensure that the Project reaches the intended beneficiaries and has an impact directly on the people living with HIV, this sub-component also supported the activities of the PLWHA associations at departmental and national level and their networks, to ensure that they have a voice in policymaking and in activities that are intended to benefit them.

In addition, this subcomponent allowed for PLWHA to benefit from income-generating activities (IGAs) that will be funded through the PLWHA associations for the benefit of indigent members

or all the members of an association. This IGA support was provided at no interest in a limited amount (generally about US$4,000 for each association) and the associations were required to reimburse the funding to the financial management agency engaged by the Project after a specified period of time to demonstrate the sustainability and performance of the IGA.

The component also provided funding for care and support of orphans and vulnerable children (OVCs), as identified by communities or health centers as being infected or affected by HIV/AIDS. The Ministry of Family, Women and Children had the responsibility and lead authority to work with OVCs and had put in place a national minimum package of support for orphans that the Project also supported. The component support OVCs in ensuring that they had access to this minimum package of support that has been agreed upon by the Ministry and other partners. The orphans were supported to ensure that they were able to re-enter the education system and provide support to purchase their books, uniforms and other necessary school equipment since Benin has a free primary education policy in place. In addition, where there were orphans who were either the heads of household for child-headed household or where their re-entry into school would not be possible, the component supported them through assistance for apprenticeship fees and equipment to learn a trade. Nutritional support was also provided to those households that are caring for orphans and need additional support.

More precisely, the outputs for this component were the following:

Support to CBOs	Hired 25 CBOs
	Funded 1,178 Community Action Plans for the fight against HIV/AIDS
Support to CSOs	Funded 985 sub-projects to support NGOs and Communities. Through this funding, the following was provided: IEC sessions provided by 26 NGOs to 383,854 young people aged 15-24 for behavior change; 197,000 women were sensitized; 122,300 people sensitized for behavior change through activities done during PACLS implementation; More than 4,932,304 condoms distributed during social mobilization activities
Support to Ministries[22]	Funded Action Plans for 6 Priority Ministries
	Funded Action Plans for 6 Non-Priority Ministries
Support to CDLS	Funded Action Plans for 6 CDLS
Support to Health NGOs and Confessional Organizations	Funded 11 sub-projects through 13 NGOs and Organizations. These sub-Projects provided: Drugs for Opportunistic Infections; Food; Laboratory equipment and material; Etc. …
Support to PLWHA and OVCs	Funded 25 sub-projects covering medical, psychosocial and nutritional care for PLWHA, affected people and their families, care for OVCs and their families, and tuition, school supplies and school-feeding costs
	Funded 88 Income Generating Activities (IGA) for PLWHA Associations
	Funded 44 Institutional Action Plans for PLWHA Associations and Networks
Support Social Mobilization activities through Radio Stations	Signed contracts and funded 25 community radio stations that were able to reach 50,00 young people
Implement a Communication Plan for the MAP II	
Support Studies, Training and Audits	

Under this component, the following results were achieved

[22] The 6 priority ministries are: 1. Higher Education; 2. Youth, Recreation and Sports; 3. Family; 4. Nursery and Primary Education; 5. Secondary, Technical and Vocational Training, and; 6. Agriculture, Livestock and Fisheries. The non-priority ministries are: 1. Responsible for relations with institutions; 2. Micro-finance; 3. Health; 4. Land transport, air transport and public works; 5. Public service and labor, and; 6. Energy and Water.

Indicator	Initial Target	Revised Target	Results/Achievements
Number of public sector organizations supported and implementing HIV interventions		15	16
Number of persons reached with community outreach and support and IEC/BCC programs	1,500,000	1,500,000	5,563,754
Numbers of condoms sold/distributed	11,000,000	3,500,000	7,612,321
Number of subprojects financed targeting vulnerable populations, high risk groups and geographic hot spots	Total of 800 (650 for vulnerable groups/hot spots, 100 for PLWHA/OVC, and 50 for selected high-risk groups)	700	985

Component 2: Access to Treatment, Care, and Impact Mitigation services

The objectives of this component were to enable Benin, by year 2010, to: (i) increase by 10 percent each year the number of people tested to reach a target of 600,000; (ii) provide, each year, ARV treatment to 3,000 HIV positive pregnant women; (iii) provide medical checkups to at least 6,000 CSW at least twice in each year; (iv) provide ARV treatment to 3,300 PLWHA including 900 children; (v) provide biological follow-up services for 6,500 PLWHA under ARV treatment; (vi) provide psychosocial support to 10,000 PLWHA (with the Ministry of Family Affairs being the implementing agency of this assistance); (vii) provide nutritional support to 3,300 PLWHA under ARV treatment; and (viii) strengthen the system of epidemiological surveillance and monitoring evaluation of the PNLS/MOH.

Under this component, the Project supplemented the financing provided by the Global Fund and others, in order to help the country achieve the ultimate goals of care and treatment of HIV/AIDS infected people as spelled out in the national HIV/AIDS Strategic Framework 2006-2010.

To achieve these objectives, the PNLS/MOH relied on the following strategies:

• Moving forward with the decentralization of the minimum care package through increasing the number of VCT, PMTCT, care and treatment sites throughout the country in order to reach as many patients as possible.

• Effective integration of HIV/AIDS related activities with basic care services provided in all health facilities (TB-HIV/AIDS, Malaria/HIV/AIDS).

• Strengthening of health facilities through the rehabilitation of main buildings, improvements in the technical equipment and standards of laboratories, the provision of reagents and other medical drugs, and capacity building of health personnel.

• Strengthening the referral laboratory by rehabilitating its physical facilities and improving its technical capabilities.

• Decentralization of laboratory activities with the provision of two mobile laboratories equipped to provide VCT services.

• Strengthening of SIDAG (the national service for free voluntary and anonymous testing) to transform it into a national reference and training center for other VCT centers.

• Integration of HIV teaching in the curriculum of medical schools and technical training centers.

• Strengthening of activities initiated under other Projects (such as SIDA 3 financed by ACDI) targeting high risks groups such as CSWs and mobile populations.

• Promotion and dissemination of sound practices in the management of medical waste in line with the policies adopted in the Medical Waste management Plan (MWMP).

This component complemented funding by the Global Fund and other financiers and provides support to the following activities:

- *Testing of HIV*. The Project financed the establishment, at reasonable cost, of 6 new VCT centers, materials and reagents needed in testing and by providing equipment to the testing laboratories, as well as by training their staff.
- *Increased access for PMTCT*. The Project helped the health sector extend efforts to prevent mother-to-child-transmission to all zones where the Project is active. The assistance included (i) strengthening of the health-sector staff capacity in PMTCT management; procurement of reagents, medicines, and other requirements such as computers; (ii) monitoring of and medical, social, and psychosocial support to children born as seropositive; (iii) social mobilization and sensitization of the population to accept the seropositive children; and (iv) nutritional care of infected and affected children.
- *Treatment of AIDS patients.* The Project continued to provide medicines for patients who need ARV drugs, an activity started by the predecessor Project PPLS. In addition, the

Project financed procurement of reagents and consumable materials needed in medical care and treatment of these patients, and improved the quality of the treatment facilities.

- *Prevention and treatment of STIs* and *OIs:* The Project accelerated promotion of the methods of diagnosing and treating of STIs among high risk groups and procure medication, reagents, other materials, and condoms for prevention and treatment of STIs and opportunistic infections.
- *Support for the safety of blood transfusion*. The Project provided reagents and other materials to secure the quality of blood used for transfusion, improve the technical capacity of the transfusion personnel, and encourage the sexual fidelity of blood donors; improvement of blood security by strengthening blood banks with laboratory equipment and two mobile laboratories will be acquired to support the implementation of health advanced strategies.
- *Capacity building for health staff* at all levels of the health pyramid for diagnosis, care and treatment of STIs, HIV/AIDS and OIs, as needed.
- *Restructuring of selective health facilities* in order to facilitate the integration of HIV/AIDS related activities (VCT, care and treatment to other basic health services such as ANC, TB and Malaria).
- *Management of medical waste* by financing activities underscored in the MWMP.
- *Nutritional support to PLWHA*, including training in sound nutrition practices.
- *Strengthening of epidemiological surveillance*, operational research, monitoring and evaluation.
- *Support to traditional medicine* by financing operational research on ethics used, strengthening collaboration between traditional and modern medicine, and promoting research on plants used for traditional medicines and their potential usefulness in treatment of STIs, OIs, and AIDS.

The outputs for this component were the following:

Acquire inputs	Provided funds to buy: a) 2 mobile laboratories; b) Medical and laboratory equipment; c) Equipment for CCDV; d) PCR equipment and reagents; e) Small materials (boots, gloves, blouses, masks, etc…); f) Consumables (60.42% of the support provided by all donors), reagents (48.16% of donors' support), drugs to fight Opportunistic Infections (40% of donors' support), ARV (38% of donors' support) and condoms.
Support PMTCT activities	Trained about 100 paramedicals, thus strengthening task shifting possibilities by delegating activities formerly reserved for medical doctors
Support activities	31 NGOs have been funded to support PSW through sensitization and reference to appropriate services. Through this funding:

targeting professional sex workers	a) 11,715 PSW have been sensitized; b) 120,338 condoms have been distributed to PSW and their clients; c) 2,389 PSW have been referred to health centers for opportunistic infections; d) 8,057 PSW have been tested voluntarily, and; e) 3,451 have been referred for systematic follow up.
Fund caregiving activities to support PLWHA	84,561 people have benefitted through support provided to the PNLS, health institutions, NGOs and private clinics. The Project has contributed 93.3% of the total cost funded by donors for this type of activities and this support has included: a) Funding 15 health facilities to provide psychosocial support to PLWHA; b) Funding 12 health facilities to treat opportunistic infections in PLWHA; c) Funding 12 health facilities to provide food and nutritional support to PLWHA; d) Funding 6 health facilities to provide VCT support to PLWHA; e) Funding 6 health facilities to provide biomedical examinations to PLWHA; f) Funding 5 health facilities to provide therapeutic education to promote patient's adherence to treatment; g) Funding 7 health facilities to cover the costs of hospitalization of PLWHA; h) Provide funding to equip 5 health facilities attending to PLWHA, and; i) Funding 8 training facilities to help keep OVCs in schools. Funding has also been provided to cover functioning costs linked to these activities (salaries and premiums, office supplies, utilities, phone and maintenance) in health institutions providing the support.
Rehabilitate infrastructure	Funds were provided to rehabilitate: a) The SIDAG (Service d'Information et de Dépistage Anonyme Gratuit) building; b) The reference laboratory, and; c) 9 caregiving sites.
Support activities relating to biomedical waste management	Funds were provided to buy and install: a) 17 Montfort-type Incinerators (installed in 6 zone hospitals, 1 central hospital, 4 health care centers, 2 community health centers and 4 CIPEC); b) 5 electrical incinerators (installed in the National University Hospital, the HOMEL, the PNLS Reference laboratory, the Zou/Collines departmental hospital and the CIPEC), and; c) 11 septic tanks (installed in 8 zone hospitals, 1 central hospital, 1 dispensary and Suru Lere).
Support capacity building for health agents	a) 1,063 traditional practitioners were trained in various approaches including on how to diagnose HIV/AIDS and how to deal with opportunistic infections; b) Training was also provided (in the 12 departments of Benin) to 253

	health professionals in the management of biomedical waste; c) 150 health agents were also trained on how to deal with STIs among transients and other mobile populations.
Support research activities	The Project participated in funding numerous studies and surveys including the ESDG, the DHS, the Second Generation Survey in detention centers, a paper on plants used by traditional healers to prevent and treat STIs and opportunistic diseases linked to HIV/AIDS, technical guides for the management of biomedical waste, etc…

Under this component, the following results were achieved:

Indicator	Initial Target	Revised Target	Results/Achievements
Number of people with advanced HIV infection receiving ARV combination therapy	3,300 adults and 900 children	19,000 adults and 2,000 children	22,522 (aggregated figure)
Number of people with advanced HIV infection receiving psychosocial care	10,000	8,000	14,273
Number of PLWHA receiving nutritional support	5,000	5,000	12,156 overall including a total of 7,791 supported by the MAP II (among them 4,365 received food distributed by the PNLS)
Number of pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of mother-to-child transmission of HIV	80%	2,689	1,560
Number of orphans and other vulnerable children whose households have received care and support in the last 12 months	2,500	2,500	12,197

Component 3: Coordination, Management, and Monitoring and Evaluation

This component had three sub-components:

- Support for a unified national and decentralized coordination system and leadership of CNLS;

- Support for a uniform national monitoring and evaluation system, and
- Finance the coordination and management of the MAP II.

Subcomponent 3 (a): Support for a unified national and decentralized coordination system and leadership of CNLS.

The Project strengthened the SP/CNLS to allow it to carry out its role, especially in implementing the "Three Ones" principles. The assistance included support to capacity building in CNLS and decentralized units (regional units, communes, "*arrondissements*," and local committees), procurement of vehicles and equipment, and funds for technical assistance.

Subcomponent 3 (b): Support for a uniform national monitoring and evaluation system

UNAIDS and GAMET jointly financed development of an important element of the "Three Ones"--the nationally functioning M&E system--that was completed in early 2006. The Project helped finance the testing of this system and its implementation at all levels in the country during the Project period. The activities that were supported included (i) recruitment of additional staff at both central and decentralized level of the SP/CNLS, necessary equipment and materials, extensive training of persons involved in M&E; (ii) financing of collection, processing, and publication of data from operations of this Project and those of other HIV/AIDS Projects; (iii) special studies relating to HIV/AIDS in Benin and evaluation of Project results (under CNLS supervision); and (iv) technical assistance.

Subcomponent 3 (c): Financing the coordination and management of MAP II

Under the auspices of CNLS, the Project was managed by a small Project Administration unit (PA), with the support of a Financial Management Agency (FMA). The Project financed the costs of these units. The support included (i) training of PA and FMA staffs; (ii) administration of the Project, including financing of FMA activities; (iii) updating and strengthening of the computerized financial management system; (iv) replacement of vehicles, equipment, and materials used for Project activities; (v) operation of the Project-specific M&E system (as part of the nationwide M&E system, but potentially with additional features and indicators); and (vi) financing of external audits.

The outputs for this component were the following:

Support a unified national and decentralized coordination system under the leadership of the CNLS	The Project provided funding to strengthen the SP/CNLS. These funds were used to: a) rehabilitate their headquarters; b) buy office furniture; c) Provide computer equipment d) acquire 4 wheel drive automobiles; Automobiles were also provided to the 6 CDLS and motorcycles

	were given to the CCLS and computer equipment was provided to those CDLS and CCLS. Funding was also provided to the SP/CNLS, the CDLS and the CCLS to organize workshops and their annual meetings and to cover expenditures such as gasoline.
Support a uniform national monitoring and evaluation system	To do so, the Project: a) Hired a database expert to set up the CRIS software used for M&E, paid the salaries of 6 M&E specialists that were subsequently dispatched in the 6 CDLS to strengthen the capacity of the decentralized M&E system; b) Posted focal points in all 77 CCLS and provided them with motorcycles and computer equipment to enable them to collect and transmit data to the SP-CDLS; c) Trained SP/CNLS and Project managers on HIV/AIDS/STI research protocols.
Finance the coordination and management of the MAP II	To do so, the Project provided funding: a) To pay the salaries of the staff (including the support staff) of the PIU; b) To buy vehicles for the PIU; c) To buy computer equipment for the PIU (including 28 desktops and laptops); d) To cover the cost of quarterly field supervisions made by the PIU staff; e) To hire a financial management agency, the AGeFIB; f) Cover the cost of audits, including annual external audits; g) To buy a monitoring and evaluation software (X-monitoring) for the PIU in order for it to monitor activities and indicators; h) To provide the AGeFIB with a financial management software (Tompro), and; i) For specific studies intended to get a better knowledge of the impact of the Project on beneficiaries.

Under this component, the following results were achieved:

Indicator	**Initial Target**	**Revised Target**	**Results/Achievements**
Annual joint work plan review and work planning exercise by all donors (under the coordination of SP/CNLS)	1 per year	4 (1 per year)	4 (1 per year)
Number and Percentage of CDLS and municipal committees operational	100%	6 CDLS and 48 CCLS	6 CDLS and 53 CCLS
Number of persons trained in HIV service delivery	50,000	65,000	71534

Percentage and number of implementing agencies (public sector and civil society) submitting timely quarterly monitoring and financial reports to SP/CNLS in the last 12 months	N/A	48	48

Annex 3. Economic and Financial Analysis

(including assumptions in the analysis)

After appraisal, no follow-up analysis has been carried out to estimate the economic impact of the Project. Consequently, the ICR is reviewing here the assumptions made at appraisal.

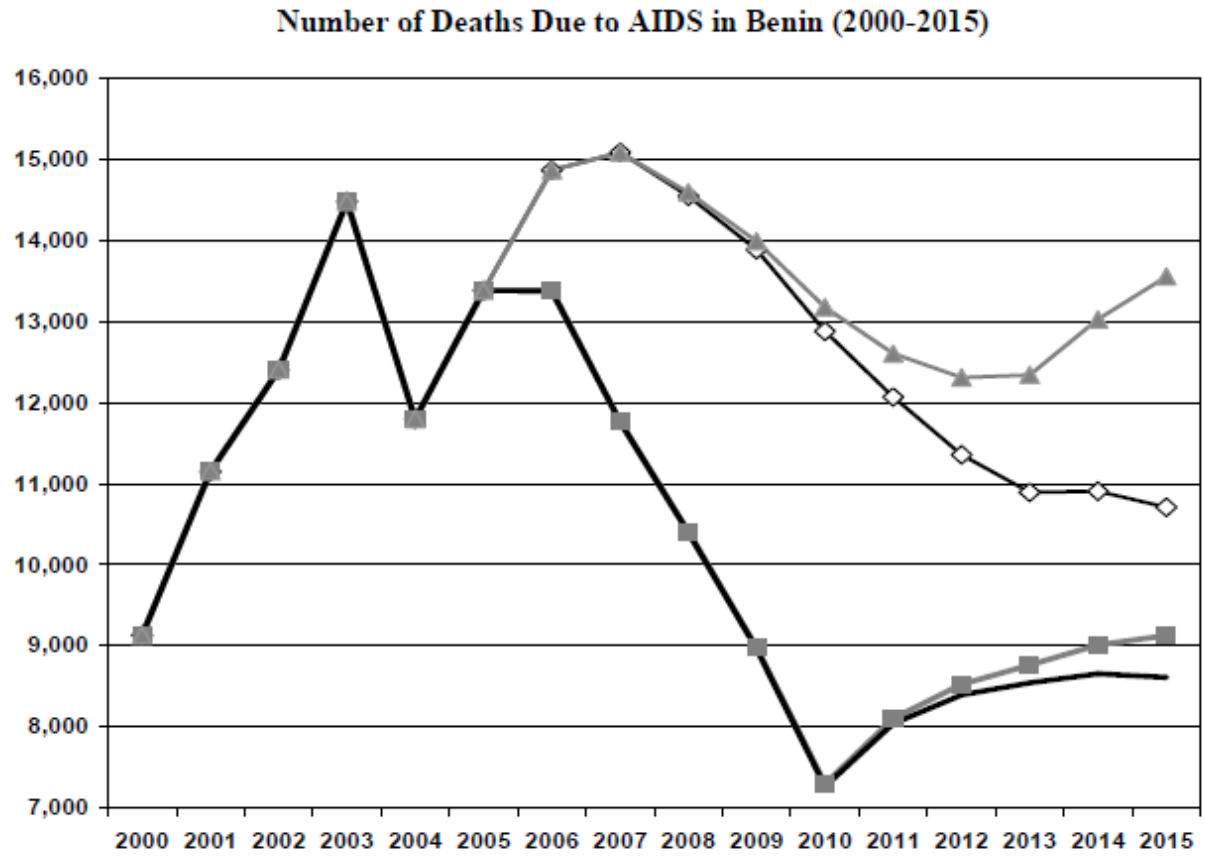
As indicated in the PAD, the benefits of the Project were estimated in terms of the number of deaths averted, as suggested by World Bank (1996). The estimation considered a number of alternative scenarios and attempted to assess whether the Project was likely to contribute towards a significant improvement in welfare for a given budget. In particular, the analysis concentrated on the cost-effectiveness ratio defined as the cost of the Project divided by the number of premature deaths prevented if the Project is implemented, when compared to the counterfactual that no action is taken. According to World Bank (ibid.), a conservative estimate of the value of a year of life saved is annual per capita income. The number of deaths averted cover the effects of the Project in terms of mortality, but one should also consider the benefits of other direct impacts such as avoided treatment costs, as well as indirect benefits, such as the reduced number of HIV/AIDS orphans and the implications in terms of human capital accumulation and need for support.

The demographic Projections used in the PAD analysis were obtained from the SPECTRUM and the AIDS impact model (AIM) software packages. The first package was used to make general demographic Projections based on data from the UN statistical division. The latter package allows to estimate future numbers of infections, AIDS cases and AIDS deaths, as well as other impacts of the epidemic, given assumptions about the future course of adult HIV prevalence. In the analysis a number of different scenarios were considered based on Benin's *Cadre Stratégique National de Lutte Contre le VIH/SIDA/IST 2006-2010* and different assumptions about future prevalence rates. The *Cadre Stratégique* sets targets in terms of coverage rates for a number of prevention and treatment services that were incorporated to the scenarios when necessary. The baseline scenario assumed that the country will continue with the current levels of coverage of prevention and treatment services and would constitute the case were the MAP II Project is not implemented, i.e., assuming that the status quo remains for the period of the Projection until 2015. The prevalence rate is also assumed to remain constant at 2 percent during the Projection period. Furthermore, in the high prevalence scenario, the levels of coverage of services remain constant at current levels, but the prevalence rate increases to 3 percent by 2015. In order to obtain estimates of the number of HIV/AIDS orphans data from the Benin DHS survey on the percentage of women aged 15-19 that never married was used. ART started in Benin in 2002 with a coverage rate of 3 percent of those in need (CNLS, 2006). For those two scenarios, coverage rates for ARV treatment for both adults and children were set at the current levels from 2005 onwards.

The MAP II scenario considered what would occur if the Project is implemented and contributes to achieving the target coverage rates set by the *Cadre National Stratégique*. Nonetheless, this scenario considers that HIV prevalence rates remain at 2 percent. One should note that increased efforts in terms of treatment and prevention may not lead to decreases in the prevalence rate in the short run, as more people infected with the virus survive for extended periods of time. Finally, the low prevalence scenario assumes that Project is implemented and the prevalence rate

declines to 1.8 percent by 2010 in line with the target set in the *Cadre Stratégique*, i.e., this is the prevalence figure used for the national strategy.

The figure below illustrates the number of deaths due to AIDS under the different scenarios. One can estimate the number of deaths averted simply by subtracting the number of deaths that would occur if the program is not implemented, i.e. Baseline and High Prevalence Scenario, from the estimated number of deaths in case the program is adopted. The figure provides a glance on the large welfare implications of HIV/AIDS interventions, even when one only considers the relatively short 5-year Project period. One should also bear in mind that if efforts to avert new infections are effective, the benefits of the Project still accrue well beyond 2010. A cursory comparison between the High and Low Prevalence Scenarios until 2015 gives us a rough quantification of the potential benefits in terms of deaths averted of reductions in the incidence rate over the Project period.



Ratio of Cost to Premature Death Prevented in Thousands of FCFA (2006-2010)

	MAP II/Baseline	MAP II/HP	LP/Baseline	LP/HP
2006	8,052	8,052	8,052	8,052
2007	10,277	10,277	10,277	10,277
2008	8,754	8,654	8,742	8,642
2009	5,244	5,138	5,237	5,131
2010	3,025	2,872	3,009	2,858
Cumulative Total	6,430	6,286	6,416	6,272

The analysis of the ratio of the cost of the program to number of premature deaths averted revealed that this cost decreases substantially over the period of the Project under all scenarios. When one considers the MAP II scenario using the Baseline as the counterfactual, one can observe that the ratio goes from FCFA 10.2 million per death averted in 2007 (around US$19,500) to FCFA 3 million per death averted in 2010 (around US$5,800). Estimates of the cost per death averted seem to be fairly robust, as significant differences do not emerge between the distinct scenarios and counterfactuals. Overall the estimates for the whole period from 2006-2010 range from an upper bound of FCFA 6.43 million (approximately US$12,200) to a lower limit of FCFA 6.27 million (approximately US$11,900). It is crucial to emphasize that one needs to contrast those costs with the possible financial and economic benefits discussed previously, such as a substantial reduction in hospitalization costs, the reduced negative fiscal impact of HIV/AIDS, as well as the reduced negative impact on the stock and accumulation of human capital among other issues.

At ICR stage, it appears that the low prevalence hypothesis was the right one, given that the overall prevalence remained below 2%. One can conclude that the assumptions made by the economic analysis were correct.

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit	Responsibility/ Specialty
Lending			
Nicolas Ahouissoussi	Senior Agriculture Economist	ECSAR	
Ayite-Fily D'Almeida	Senior Operations Officer	AFTHW	Health
Abdoul-Wahab Seyni	Senior Social Development Specialist	AFTCS	
Hugues Agossou	Sr Auditor	IADVP	Financial Management
Ahossame Ayaba A. L. Ahodehou	Program Assistant		
Itchi Gnon Ayindo	Senior Procurement Specialist	AFTPC	Procurement
Sarah G. Michael	Senior Social Development Specialist	ECSS4	
Supervision/ICR			
Hugues Agossou	Sr Auditor	IADVP	Audit
Lydie A. Ahodehou	Program Assistant	AFTPR	
Itchi Gnon Ayindo	Senior Procurement Specialist	AFTPC	Procurement
Chancelle Badiche Azo	Temporary	AFMBJ	
Ayite-Fily D'Almeida	Senior Operations Officer	AFTHE	Health
D. Petrus Dahou	Consultant	AFMBJ	
Alain Hinkati	Financial Management Specialist	AFTFM	Financial Management

Jean Hounsoulin	Consultant	AFTFM	Financial Management
Christophe Lemiere	Senior Health Specialist	AFTHW	Health
Sarah G. Michael	Senior Social Development Spec	ECSS4	Social Development
Africa Eshogba Olojoba	Senior Environmental Specialist	AFTEN	Environment
Richard M. Seifman	Consultant	AFTED	Education
Abdoul-Wahab Seyni	Senior Social Development Spec	AFTCS	Social Development
Jean Paul Tchupo	Consultant	AFTHE	Health
Sylvie Charlotte Ida do Rego	Program Assistant	AFMBJ	
Juliana C. Victor-Ahuchogu	Senior Monitoring &Evaluation Specialist	AFTDE	M&E

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD
Lending		
FY06	4.23	14,191.18
FY07	39.83	108,621.41
FY08	35.95	92,171.86
Total:	**44.06**	**122,812.59**
Supervision/ICR		
FY09	27.5	67,793.31
FY10	29.25	81,969.57

FY11	23.6	53,900.30
FY12	19.59	52,776.70
FY13	6.96	33,350.82
Total:	**135.89**	**348,611.74**

Annex 5. Beneficiary Survey Results

During Project implementation, two beneficiary surveys were contracted out, one at the end of 2009 to a local firm and, one in 2012 near the end of the Project to a foreign consulting firm.

The **first** one was a rapid survey whose purpose was to measure beneficiary participation and their satisfaction two years after the start of the Project. The study method included a desk review of Project documents and direct interviews of a sample of beneficiaries and service providers. These included the Civil Society (CSOs, Community action Plan Management Committees, etc…), public sector organizations (i.e. HIV/AIDS focal points in priority and non-priority ministries), beneficiary private sector institutions (i.e. focal points of organizations affiliated to the Coalition of Private sector firms). Also included in the survey were the SP/CNLS and its decentralized field units and the AGeFIB and its decentralized field units. Among these groups of beneficiaries, specific focus was put on Associations and networks of PLWHA, NGOs and Health facilities and local radio stations. Questions related to the following topics: (i) knowledge and appropriation of the Project by beneficiaries and service providers; (ii) participation of partner structures to the Project activities; (iii) capacity building and partnerships, including beneficiary opinion on their collaboration with other structures, and (iv) partner structure satisfaction with the impact and consequences on beneficiaries, including beneficiary satisfaction when it comes to the impact of subprojects and activities on communities and beneficiary target groups, and including beneficiary direct satisfaction when it comes to the implementation of subprojects or activities.

The study found that almost all (i.e. 99.2%) of the managers of structures and the beneficiaries interviewed during the survey knew the PMLS II, and 98.4% knew that their structures benefited directly or indirectly from its actions. The existence of AGeFIB, the partner institution of the PMLS II in this Project, was known by only 57% of the beneficiaries. When it comes to the Project objectives, 52.3% of partner structures mention the reduction of HIV/AIDS prevalence as the main objective while 32.3% saw fostering social mobilization and enhancing prevention services as the second most important objective. Regarding tools used to reach its objectives, 51.5% of partner structures identified their own implication as the main tool, followed by community implication (identified by 44.6%).

The objective of the **second** survey was to assess beneficiary needs and priorities and to measure the level of satisfaction drawn from the quality of services offered through the funding brought by the PMLS II over the years. The study method covered 6 of the 12 departments of Benin. It included a desk review of Project documents and direct interviews of a sample of beneficiaries, service providers and other stakeholders.

In general, institutional partners (like the UFLS, the PNLS, the AGeFIB, personnel in health facilities, CD/CNLS, CC/CNLS and managers of deconcentrated technical services) appreciated and recognized the PMLS II as a Project that came to bridge the gap in the fight against HIV/AIDS and felt that their collaboration with the Project had been very good and that the Project intervention approach had been very efficient.

Regarding beneficiaries, 68.01% of those interviewed were positively satisfied with the quality of services provided to fight HIV/AIDS with the main reasons given being the regularity of IEC actions (for 83% of them), the free provision of condoms (72%) and the efficiency of STI treatments. Furthermore, 76.8%, 74.8% and 67.8% of those interviewed were satisfied respectively with (i) PMTCT, (ii) screening/IEC and promotion of condoms and (iii) access, care and socioeconomic support received.

Annex 6. Stakeholder Workshop Report and Results

(if any)

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

The implementation of the Second Multisectoral HIV/AIDS Project was to strengthen the national response to the HIV/AIDS epidemic. This Project whose Financial Agreement was signed November 14, 2007 between the Government of Benin and the International Development Association (IDA), has 3 components: (i) Component A: Social Mobilization and HIV prevention services; (ii) Component B: Access to treatment, care and impact mitigation services; and (iii) Component C: Project management, coordination and monitoring and evaluation. Project objectives are the following:

- Strengthening access to and increasing the utilization of prevention services for vulnerable groups (women, youth, etc…) and high risk groups such as commercial health workers (SW) and key ministries;
- Improve access and utilization of treatment and care services for HIV/AIDS infected and affected persons, notably those living with HIV/AIDS (PLWHA) and orphans and children made vulnerable by HIV/AIDS;
- Consolidate the coordination, management and the monitoring and evaluation of the national response to HIV/AIDS.

By the end of its implementation, the Project had reached its objectives in many fields and its performance indicators, for the most part, had reached the expected levels and, sometimes, had even surpassed them.

On the other hand, it is hard to give an appreciation of its development indicators because most of these indicators come from the Enquête de Surveillance de Deuxième Génération (ESDG) whose results are still not available.

For beneficiaries however, the support provided by the PMLS II has been beneficial and has led to good results when it comes to the provision of care and treatment to PLWHA.

Indeed, those who benefited from Project interventions are mostly poor people who have found relief through activities provided by the Project. Progress can be seen not only in the provision of medical, psychological and nutritional care but also in the support provided to orphans and other vulnerable children (OVC). The Project has positively impacted the health environment. By building the capacity of health agents, buying equipment, drugs and other medical products and rehabilitating or building infrastructures, the Project had a profound impact on the health environment.

Activities targeting professional sex workers have led to a clear improvement in the attendance rate of services fit for the case detection and management of STIs through the implementation of community activities.

Communities, on the other hand, have been actively involved in the implementation of Project activities. Innovations seen in the PMLS II (compared to the PPLS) like the introduction of focal points in the town halls, widening the target group to include the OVCs, the strong involvement of religious and traditional heads have considerably reduced the sociocultural constraints that undermine the fight against this disease. Involving the CCLS, CALS and CVLS and also Civil Society Organizations, Community-Based Organizations, NGOs and other stakeholders close to communities and using different strategies to implement activities has strengthened the ownership of Project interventions by the communities.

The Project has also supported the strengthening of the CNLS and its decentralized units in order to enhance its capacity to better fulfill its role and specifically its role of coordinating, harmonizing and monitoring interventions by different partners, Projects and programs geared at the fight against HIV/AIDS.

Regarding governance, the PMLS II was, through the existing institutional channels, able to strengthen its capacity for intervention by engaging MSAS services through a partnership with the PNLS, the DHAB and the AGeFIB as a fiduciary agency. Using the services of the Organisme d'Appui aux Communautés (OAC) to technically support the communities in the elaboration and the implementation of their action plans to fight HIV/AIDS and using NGOs to support the elaboration and implementation of subprojects has strongly contributed to the achievement of the Project outcomes.

As of March 31, 2012, three months before Project closure, the global commitment rate by expenditure categories was 95.3% and the disbursement rate was 87% of this commitment rate.

Project performances would have been clearly better if the implementation had not been done in such a difficult environment characterized by constraints mostly linked to the bureaucracy surrounding procurement activities and by constraints linked to the respect of the terms of the Memorandum Of Understanding.

Annex 8. Comments of Cofinanciers and Other Partners/Stakeholders

Annex 9. List of Supporting Documents

1. Analyse des Programmes de Santé et de Lutte contre les IST/VIH ciblant les Travailleuses du Sexe et leurs Partenaires Sexuels au Bénin; Avril 2012; World Bank Internal Draft;
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MAP

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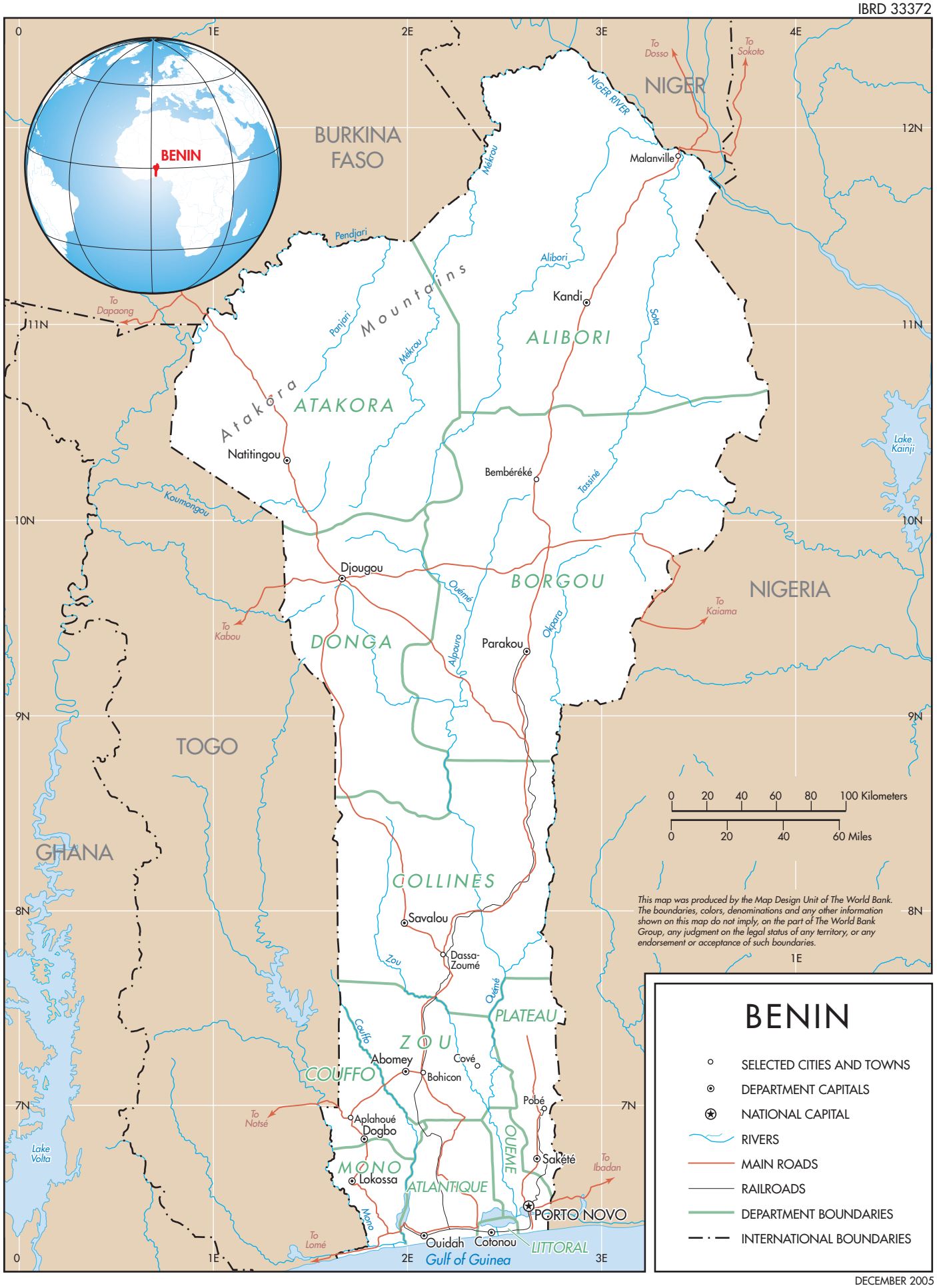

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