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Report Number : ICRR14199

IEG **ICR Review**
Independent Evaluation Group

1. Project Data:		Date Posted : 10/03/2013		
Country :	India			
Project ID :	P078538		Appraisal	Actual
Project Name :	India: Third National Hiv/aids Control Project	Project Costs (US$M):	512	512
L/C Number :	C4299	Loan/Credit (US$M):	250	241
Sector Board :	Health, Nutrition and Population	Cofinancing (US$M):	179	172
Cofinanciers :		Board Approval Date :		04/26/2007
		Closing Date :	09/30/2012	09/30/2012
Sector(s):	Health (40%); Other social services (25%); Sub-national government administration (20%); Central government administration (15%)			
Theme(s):	HIV/AIDS (29% - P); Health system performance (29% - P); Other social development (14% - S); Population and reproductive health (14% - S); Other social protection and risk management (14% - S)			

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2. Project Objectives and Components:

a. Objectives:

According to the Financing Agreement (p. 5), the project's objective was "to support the third phase of the Recipient's National AIDS Control Programme (NACP, 2007-2012) through: (i) promotion of behavior change by scaling up prevention efforts in the High Risk Groups and the general population; and (ii) increased care, support, and treatment of people living with HIV/AIDS (PLHIV)."

The Project Appraisal Document (PAD, p. 4) states the objective as "to contribute to the NACP III goal of halting and reversing the AIDS epidemic by attaining the following project development objectives in accordance with two of the national program's strategic objectives: (i) achieving behavior change by scaling up prevention of new infections in High Risk Groups and the general population; and (ii) increase care, support, and treatment of PLHIV."

Both statements of the objective focus on the third phase of the NACP, whose outcome -oriented objective was to halt and reverse the AIDS epidemic, through outputs related to promotion /achievement of behavior change through scaled-up prevention efforts and increased care, support, and treatment .

NACP III was the third phase of sustained Bank support, following credits of US$ 84 million in 1992 and US$ 191 million in 1999 that had helped the Government develop an effective blood safety program, increase the number of clinics for sexually transmitted infections and counseling and testing, expand prevention of mother -to-child transmission services, strengthen State -level implementation structures, and undertake widespread information and education efforts.

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

No

c. Components:

The project contained four components. The costs shown by component are project rather than total program costs. The PAD does not provide project costs by component, and so the ICR (p. 30) assumes that planned project financing was allocated across components proportionately to the component share of total program costs; those figures are reported here as the appraisal estimates by component. The project team confirmed that these figures are the correct estimated costs by component.

1. Scale Up Prevention Efforts (appraisal; US$ 424 million; actual, US$ 403 million). Prevention among high-risk groups was explicitly stated as the project's top priority. Specific activities were to include 2,100 targeted interventions to reach one million female sex workers and their partners, 1.15 million men having sex with men, and 190,000 injection drug users and their sexual partners; scaling up of interventions targeting long-distance truckers (three million) and short-duration migrant workers (8.9 million); and devising of strategies to address the most vulnerable among the general population, particularly youth and women.

2. Strengthen Care, Support, and Treatment (appraisal: US$ 28 million; actual, US$ 47 million). Activities under this component were embedded within a comprehensive strategy to strengthen family and community care, provide psychosocial support, and ensure accessible, affordable, and sustainable treatment services. Specific activities were to include care and support services for 380,000 PLHIV, provision of antiretroviral therapy to 340,000 people (including 40,000 children), and treatment of opportunistic infections for 330,000 persons and of tuberculosis for 2.8 million persons.

3. Augment Capacity at District, State, and National Levels (appraisal: US$ 27 million; actual, US$ 30 million). The main activities under this component were to include development of standard operating procedures for crucial HIV services and setting up internal and external quality assurance systems; establishment of improved and performance-based contracting arrangements with private providers; and strengthening of training and technical support capacities within Government, non-governmental organizations, and community-based organizations.

4. Strengthen Strategic Information Management (appraisal, US$ 33 million; actual, US$ 31 million). The main activities under this component were to include strengthening of the monitoring framework to provide more accessible and ready-to-use information across program content and management functions; enhancing of HIV surveillance systems to provide epidemiological, clinical, and behavioral data, especially for high-risk behaviors, at the State and sub-State levels; and conducting of independent evaluation and research to inform and support program implementation.

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

Project Cost/Financing: According to the PAD (data sheet), the project was to be financed through a US$ 250 million IDA credit (Sector Investment and Maintenance Loan), US$ 179 million from the UK Department for International Development, and US$ 83 million from the Recipient, for a total project cost of US$ 512 million. Bank funds were to be pooled with DfID funds for "a programmatic approach in order to flexibly support the government's program" (PAD, p. 3).

Beyond project funds, non-pooled partners were to contribute US$ 447 million to NACP III, and the government was to contribute US$ 543 million outside the pooling framework of the project, for a total planned financing for NACP III of US$ 1498 million. At the time of appraisal, the total costs for NACP III were estimated to be US$ 1888 million, leading to a financing gap at appraisal for NACP III of US$ 390 million.

The ICR does not provide actual costs for the entire NACP III. The ICR also does not explain why the actual costs for the second component were significantly higher than estimated costs, but this was likely to due to the project putting more people than estimated on treatment as well as a 2009 change in the medical threshold for treatment that resulted in a large number of new people becoming eligible.

Borrower Contribution: The Borrower made US$ 99 million of a planned US$ 83 million contribution to the project.

Dates: A Level 2 restructuring was approved in June 2010 to change financing shares (by "depooling" part of the Government's financial contribution, with a corresponding increase in the percentage of some eligible expenditures financed by the Bank and DfID, to speed up lagging disbursements and enable the Government to pay for a large single-source information, education, and communication contract); amend duplicative audit requirements; adjust procurement thresholds in line with inflation; and allow additional consultant procurement methods. The project closed as planned on September 30, 2012.

3. Relevance of Objectives & Design:

a. Relevance of Objectives:

Relevance of Objectives is rated Substantial. At the time of appraisal (2007), 5.7 million HIV infections had been identified in India, with an adult HIV prevalence rate of 0.9%. Stigma and discrimination deterred people from being tested for HIV. The epidemic was geographically concentrated and also concentrated among high-risk groups, though changing economic structures and demographic shifts were providing opportunities for transmission patterns to shift. The Government had gradually enhanced its response after creating a National AIDS Control Program (NACP) in 1986, and had set ambitious goals for halting and reversing the epidemic by 2011, ahead of the 2015 Millennium Development Goal (MDG) 6 target. The Bank's current Country Partnership Strategy for India (CPS, 2013-2017), while not stressing specifically the fight against HIV/AIDS, focuses on equity in access to high-quality health care (p. 16), the critical importance of a healthy population for sustained economic growth, and service delivery effectiveness. The project's objectives are substantially relevant to country conditions at the time of appraisal, the Government's current strategy, the Bank's CPS, and the Bank's institutional commitment to the MDGs. HIV/AIDS is one of only a small number of national-level government initiatives in health, and the only one with a dedicated agency led by a special secretary and coordinating body chaired by the prime minister. Although recent estimates have adjusted downward the national figures for HIV prevalence, the adjusted estimates do not change the need for effective prevention among groups where most new infections are occurring (ICR, p. 2).

b. Relevance of Design:

Relevance of Design is rated Substantial. The activities specified in the project's components were plausibly and explicitly linked to achievement of the development objectives. Project design recognized the need to enhance capacity within the National AIDS Control Organization (NACO). Appropriate focus was also placed on prevention interventions among high-risk groups engaging in behaviors most likely to transmit infection. The PAD (p. 1) specifically lists populations engaging in high-risk behaviors (such as unprotected sexual intercourse with multiple partners, unprotected anal sex, and injecting drug use with shared needles) as the groups in which the Indian HIV epidemic was concentrated, with the low rate of concurrent sexual relationships with multiple partners apparently protecting most of the adult population. The PAD (p. 22) also cites injection drug users, men having sex with men, and commercial sex workers (male, female, and transgender) as specific risk groups, as well as some groups that were identified as a "bridge" between those groups and the population-at-large: truckers and the transport community and migrant workers. The project's priority focus on prevention efforts among these groups was therefore appropriate. The project's integration of HIV testing, counseling, and treatment with other health services exemplified good practice in HIV programs. Geographically, the project appropriately divided the country into high-, moderate-, and low-prevalence states, with the low-prevalence states further classified as "highly vulnerable" or "vulnerable" to guard against complacency. Within states, districts (as the units of service delivery) were similarly classified (PAD, p. 95).

4. Achievement of Objectives (Efficacy):

Attribution: This Bank-financed project provided programmatic support, and therefore is evaluated against outcomes attributed to the overall program. The Bank financed about 10% of total program costs, and nearly half of total project funding, with DfID providing about 35% and the Government about 15% of project costs. About half of total Bank support supported prevention interventions targeted at key high-risk groups, delivered primarily through non-governmental and community-based organizations. According to the ICR (p. 14), the Bank's technical contributions helped NACO to ground decisions firmly in evidence and global best practice, and supported studies and analysis that kept the program focused on cost-effective approaches. It is quite likely that Bank-financed activities contributed significantly to observed outcomes.

Contribute to the goal of halting and reversing the AIDS epidemic is rated Substantial .

Outputs:

The number of targeted interventions funded by NACO increased from 1,000 at baseline to 1,821 in September 2012, not reaching the target of 2,100. The percentage of female sex workers reached through targeted interventions in the previous 12 months increased from 20% at baseline to 88% in September 2012 (678,000 of an estimated total 868,000 female sex workers in the country), exceeding the target of 60%. The percentage of injection drug users reached through targeted interventions in the previous 12 months increased from 20% at baseline to 81% in

September 2012 (142,000 of an estimated total 177,000), meeting the target of 80%. The percentage of men having sex with men reached through targeted interventions in the previous 12 months was not known at baseline, but in September 2012 it was 67% (274,000 of an estimated total of 427,000), not reaching the target of 80%.

2.8 million migrants and 2 million truckers were reached with prevention services including behavior change communication, condoms, and referral services.

According to the UNAIDS/WHO Annual State of the Epidemic Report 2011, India is one of only three low- and middle-income countries world-wide that meets the recommended target of providing at least 200 clean needles/syringes annually to injection drug users. An average of 228 per drug user were provided in 2010. 3 million condom outlets were established across the country.

The number of HIV-positive pregnant women and their babies receiving a complete course of anti-retroviral therapy increased from 9,268 in 2007 (covering 18.04% of need) to 12,269 in 2011 (covering 32.10% of need). This achievement did not reach the target of covering 76,500 women, although revised estimates of the total number of HIV-positive pregnant women in India in 2007 revealed that the number of HIV-positive pregnant women had been significantly overestimated, dramatically decreasing the estimated need to 51,375 in 2007 and 38,202 in 2011, voiding the original target. However, the original target implied 75% coverage, which was not achieved by the end of the project period. The project's assignment of priority to prevention interventions among high-risk groups, with a lower priority assigned to interventions among pregnant women (which requires testing very large numbers of women), was a cost-effective approach to halting and reversing the epidemic (see Section 5).

A reporting system was established in 35 State AIDS Control Societies (SACS), 3 Municipal AIDS Control Societies, 9,459 integrated counseling and testing centers, 1,758 targeted intervention facilities, 12,00 blood banks, 255 community care centers, and 1,112 sexually transmitted infection clinics. 1,359 surveillance sites were established across the country. 97% of SACS submitted their most recent dashboards to NACO on time in the July-September 2012 time period, exceeding the target of 80%. Mapping of high-risk groups was completed in 21 of 28 states (75%), not reaching the target of 80%. Mapping was done in rural areas in 127 districts of 18 states. All 192 districts with minority tribal populations developed a Tribal Action Plan. A large number of studies were completed, based on data acquired through the surveillance and reporting system, for making program decisions.

249,112 health personnel received training under the project, exceeding the target of 200,000. A link workers scheme was established, covering 209 districts across 20 states, to provide prevention services in rural areas.

The number of people testing annually for HIV increased from 3 million in 2007 to 19.47 million by 2011-2012, short of the end-of-project target of 22 million. More importantly, however, the number of members of high-risk groups tested annually increased from 0.7 million in 2009-2010 to 1.5 million in 2011-2012. The ICR does not report other outputs, beyond testing, for the general population.

1,122 designated clinics for sexually transmitted infections (STIs) were established in government health facilities, with 28,000 STI clinics under the National Rural Health Mission. 4,018 preferred private providers for STIs were established for high-risk groups. Standard treatment protocols were developed for STI management, with drugs customized into color-coded kits.

The number of people with advanced HIV infection receiving antiretroviral combination therapy free of charge through the project increased from 42,000 at baseline to 512,412 in June 2012, exceeding the target of 340,000. The percentage of people needing treatment and receiving it increased from 16% in 2007 to 50% in 2011; this increase was achieved despite a change in eligibility criteria (raised CD4 threshold) that caused a large increase in the number of people needing treatment in 2009. 355 functioning treatment centers were established, far exceeding the target of 250, as well as 739 Link ART centers (that decentralize treatment access and decongest the main centers), and 10,515 Integrated Counseling and Testing Centers (more than double the target of 4,994). 263 CD4 machines were procured and installed. According to the ICR (p. 20), the project adequately expanded the availability of quality testing and free treatment with a reliable supply of drugs, and provided sufficient support to patients to ensure high treatment compliance.

Outcomes:

The percentage of female sex workers who reported using a condom with their most recent client increased from 50% at baseline to 91% (range 83-97%) in 2009, exceeding the target of 80%. The percentage of male sex workers who reported using a condom with their most recent client increased from 20% at baseline to 86% (range 43-100%) in 2009, exceeding the target of 60%. The 2009 data are mean and range estimated from behavioral survey data in six states, consistent with data from an Integrated Bio-Behavioral Assessment conducted in 2006 and 2009 in southern high-prevalence states.

The percentage of injection drug users who reported both avoiding sharing injecting equipment during the last month and using a condom with their most recent sexual partner increased from 30% at baseline to 62% (43-91%) in 2009 for equipment sharing, and 88% (77-95%) for condom use. The 2009 data are also from the six-state behavioral survey and Integrated Bio-Behavioral Assessment.

For the above-listed outcomes on sex workers and drug users, endline data are from 2009. End-of-project data are not provided, and with the project effective in 2007, plausible attribution of these outcomes to project-sponsored interventions is tentative at best. However, given the targeted, well-designed monitoring and interventions for these groups, positive trends are likely to have been sustained.

A November 2012 estimate from NACO and the India National Institute of Medical Statistics indicated that, from 2007-2011, both HIV prevalence and incidence nationally were "stable to declining," with estimated annual incidence dropping from 143,000 in 2007 to 130,000 in 2010 (ICR, p. 17). These national trends, based on the 2011 population census and sentinel surveillance sites, were "primarily attributable to the roll-back of the epidemic in high-prevalence categorized states" in which the project focused its interventions (ICR, p. 17). The ICR also cautions, however, that there is a marked slowing in the decreasing trend in new infections during the 2007-2011 time period.

Only prevalence (rather than estimated incidence) data are available for high-risk groups, and these data therefore reflect the net effect of deaths and new infections. Among female sex workers, HIV prevalence declined from 5.06% in 2007 to 2.67% in 2011, and according to the ICR (p. 18), similar declines were recorded in most states, although exact data at the state level are not provided. HIV prevalence also declined nationally among men who have sex with men, from 7.41% in 2007 to 4.43% in 2011, although there were several states where prevalence has not declined. Given the large expansion in access to anti-retroviral therapy during this time period and resulting decrease in AIDS-related deaths, combined with trends in safer behaviors, it is plausible that these declining prevalence trends are also indicative of declines in the rate of new infections.

Among injection drug users, HIV prevalence was essentially stable during the project period, at 7.23% in 2007 and 7.14% in 2011. According to the ICR (p. 18), declines were observed in the North Eastern states where interventions for IDUs were focused, but newer pockets of high prevalence have emerged in other locations.
The survival rate for all persons who started anti-retroviral treatment under the project is 79%, indicating good compliance and quality of treatment services. The goal of no drug stock-outs reported by any treatment center was reached in 2012. The annual number of AIDS-related deaths fell 29% from 2007-2011 (ICR, p. 20). According to the ICR (p. 21), treatment provided in the private sector comprised less than 10% of total treatment, indicating that the project's contribution to these outcomes was significant.

The ICR does not report outcomes related to truckers/transport workers and migrants.

5. Efficiency:

Efficiency is rated Substantial.

The PAD's economic analysis (pp. 14-15, 80-83) focused on relatively low cost and high impact of prevention of new infections versus treatment of existing infections, justifying the project's core approach of disrupting the core transmission mechanisms of HIV/AIDS among high-risk groups. Its financial analysis addressed the justifications for and risks of scaling up India's existing HIV/AIDS program, as well as sustainability issues. The ICR does not repeat this analysis, but it provides a convincing justification of the project's decisions in terms of both allocative and technical efficiency.

NACO set an ambitious target that 50% of all targeted interventions would be led by community-based organizations by 2012, but there were simply too few resources for NGOs to build community capacity to reach this target, and too few NGOs with relevant experience or ability to work with MSMs and IDUs. These shortcomings constituted "major barriers to scaling up at the speed and to the level needed" (ICR, p. 10). Despite these capacity challenges, however, the project's consistent and strategic focus on targeted interventions among groups most likely to spread infection is a highly efficient approach to achievement of the objective to halt and reverse the epidemic. In particular, the project's priority focus on prevention interventions among high-risk groups, with secondary priority to prevention of mother-to-child transmission (PMTCT), was a cost-effective approach to halting and reversing the epidemic. Although (of course) extremely beneficial for HIV-positive mothers, their infants, and their families, effective PMTCT requires testing very large numbers of women. Given political pressures to dilute the priority focus on high-risk groups and expend resources on less efficient testing of large numbers of pregnant women (despite very low prevalence among pregnant women), India's achievement is important and impressive. Also, the project efficiently, and in a manner reflecting global best practice, continually mapped and re-mapped high-risk groups to guide allocation and reallocation of resources.

The project also continually evaluated the effectiveness of targeted interventions, discontinuing those that were relatively ineffective. The average number of beneficiaries per intervention increased during the project period from 474 to 595, enabling the same number of beneficiaries to be reached with 20% fewer interventions. The average cost per HIV infection averted under the targeted interventions was approximately US$ 105, which is highly cost-effective compared with the cost of treatment (ICR, p. 35, citing study published in the journal *STI*).

Costs were cut by integrating HIV services into existing service delivery channels. Stand-alone counseling and testing centers were transitioned into fully integrated centers, with the proportion of the latter increasing from 20% in 2009 to 57% in 2012. Cost savings were also achieved through improvements in procurement and supply management of condoms, drugs, and other supplies. Savings of 500 million Rupees were achieved by streamlining free condom distribution and setting up systems to estimate condom demand for each targeted intervention and track supply and usage.

Donors relied on a single program monitoring system, shared information, and prepared Joint Implementation Reviews throughout the project. These measures avoided duplicative reporting, saved time for NACO, and enabled the donor group to conduct field visits to a larger number of states each year than would have otherwise been possible. Put another way, a relatively small investment in monitoring and evaluation (US$ 16 million) produced significant efficiency gains across the entire program.

a. If available, enter the Economic Rate of Return (ERR)/Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation :

	Rate Available?	Point Value	Coverage/Scope*
Appraisal	No		
ICR estimate	No		

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

6. Outcome:

The project's objectives were substantially relevant to country conditions at the time of appraisal, and to Bank strategy and Government strategy at closing. Despite recent downward revisions in estimated HIV prevalence in India, the need for effective prevention interventions among high-risk groups remains acute. The project's design was also substantially relevant, with planned activities explicitly and plausibly linked to the achievement of desired outcomes. The project's objectives of halting and reversing the spread of the epidemic were substantially achieved. There is strong evidence of a causal chain linking project outputs to outcomes indicating significant behavior change among key high-risk groups, and a resulting decline in the number of new HIV infections during the project period. The project's focus on targeted interventions among key high-risk groups demonstrates substantial efficiency.

a. Outcome Rating : Satisfactory

7. Rationale for Risk to Development Outcome Rating:

A follow-on National AIDS Control Support Project (US$ 510 million) was approved in May 2013, with objectives and components very similar to the project evaluated here. It is scheduled to close on December 31, 2017. Many activities funded by the Bank under the project evaluated here are now fully supported by the Government under the domestic budget, enabling the follow-on project to focus more narrowly on remaining specific challenges. The systems established under the project remain in use and are embedded in the design of the new project. NACO's staffing and capacity has been strengthened through effective use of technical assistance, and the same is true of most State AIDS Control Societies (ICR, p. 24), indicating that implementation performance will continue to be strong. Surveillance systems remain in place and functioning, which should enable continued reallocation of resources to areas of new infections in order to match changes in the epidemic. According to the ICR (p. 24), the notion that India might phase out the vertical or specialized part of its HIV/AIDS program is "not an idea with any currency."

a. Risk to Development Outcome Rating : Negligible to Low

8. Assessment of Bank Performance:

a. Quality at entry:

The preparation team included recognized world experts in HIV prevention and treatment, and there was close collaboration and coordination with key development partners. Lessons were learned from international, national, and other Bank project experiences, including: targeted prevention interventions among high-risk groups, within a broader population-wide campaign, are the most effective and efficient way to reduce HIV transmission; working through non-governmental and community-based organizations is an effective prevention strategy; merging HIV programs with related health programs such as those dealing with sexually transmitted infections is highly effective; periodic mapping of interventions is important to maintain coverage of key groups; and strong partnerships among donors and NGOs are essential. A wide range of stakeholders, including the public, was extensively involved in project preparation (PAD, p. 9). Key risks were identified and appropriate mitigation measures planned, including risks related to pressure to shift resources to treatment services, ineffectiveness of targeted prevention interventions, and inadequate managerial, implementation, M&E, and procurement /financial management capacity (PAD, pp. 12-13). Preparation was based on extensive and rigorous background analysis of the epidemic and response to date, including a social assessment of HIV among tribal populations (ICR, p. 6). Where appropriate, HIV testing, counseling, and treatment services were increasingly integrated with the National Rural Health Mission that had been established in 2005. The ICR (p. 7) suggests that two sets of risks were underestimated: the ability to identify, reach, and effectively change the behaviors of MSM and IDUs; and the willingness of NACO to process reimbursement claims based on Interim Unaudited Financial Reports (which had been intended to avoid disbursement delays). The ICR (p. 25) also suggests that project design might have been more innovative in the fiduciary arrangements for non-governmental and community-based implementers, and that the Tribal Action Plans did not adequately tackle the complex social issues related to HIV prevention among tribal groups. However, given that these risks did not materialize in a way that significantly adversely impacted project outcomes, these shortcomings are judged to be minor.

Quality-at-Entry Rating: Satisfactory

b. Quality of supervision:

There was continuity of staffing, with one task team leader for most of the project. Management of relationships between the central and state levels of implementation, which are complicated in India even in the best of circumstances, was effective, requiring frequent supportive supervision, intensive technical support and training, and best-practice manuals, guidelines, and financial management systems. The Bank team provided strong support to the procurement agents as they became familiar with Bank requirements and procedures. There was strong trust and a productive personal relationship between the project team and NACO, despite an earlier Detailed Implementation Review (DIR) by the Bank's Integrity Vice Presidency on five health projects in India, including the precursor AIDS project; that Review, however, led to risk aversion within the Bank that slowed some procurement decisions and disallowed some expenditures. As a result, there was a disincentive to draw on Bank funds, particularly in the presence of adequate non-pooled government and other donor funding to use instead, leading to Bank disbursements running behind schedule for most of the project period. Frequent and regular follow-up with NACO, with meetings sometimes as often as weekly, rectified this situation in the final year of the project. The project team was diligent in monitoring safeguards and in ensuring fiduciary compliance throughout the project period. Preparation of a follow-on project to continue support of the national program started well before closing, reflecting an ongoing commitment to sustainability.

Quality of Supervision Rating: Satisfactory

Overall Bank Performance Rating: Satisfactory

9. Assessment of Borrower Performance:

a. Government Performance:

There was consistent and strong government commitment to the national AIDS response, reflected in adequate counterpart funding, the allocation of limited Bank resources to the fight against HIV /AIDS, the assignment of highly competent and experienced officials to NACO, and the creation of permanent civil service posts for

financial managers and other positions at NACO and the State AIDS Control Societies . In 2008, the High Court of India ruled that no persons living with HIV/AIDS who met medical eligibility criteria could be denied access to treatment; this is just one example of a strongly supportive policy and legislative environment for the project .

Government Performance Rating Satisfactory

b. Implementing Agency Performance:

The NACP was managed by the National AIDS Control Organization (NACO), which is an integral unit of the MOHFW and reports to the National AIDS Control Board (chaired by the Secretary, MOHFW). The States were also to establish State Councils on AIDS, chaired by the Chief Minister of each State and vice -chaired by the State Minister of Health, and State AIDS Control Societies to assume a leadership role in coordination and implementation. NACO management was of very high caliber, able to implement several "best practice" innovations (including an initial capacity assessment and annual performance review of NGOs, and new methods for assessing the numbers of members of high-risk groups). NACO provided regular training and supportive supervisions for the State AIDS Control Societies and non-governmental and community-based organizations, as well as systematic technical assistance (TA) through specialized TA units. Interventions were customized and adjusted as epidemic patterns changed, with evidence derived from a strong computerized management information system and surveillance data triangulation. Beneficiaries were consulted and involved in a meaningful way throughout planning and implementation. Minor shortcomings included delays in recruitment of qualified procurement personnel at NACO, small delays in submission of audits, and some delays in requests for reimbursements; these delays, however, did not impact "smooth, vigorous, and timely implementation of project activities" (ICR, p. 27).

Implementing Agency Performance Rating : Satisfactory

Overall Borrower Performance Rating : Satisfactory

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

a. M&E Design:

The PAD (Annex 3) contained a clear project results framework, with a parsimonious set of indicators and complete baseline data, mid-term and endline targets, and specification of data sources, frequency of data collection, and responsibility for data collection. The PAD also listed 23 core indicators with sources and targets that were to be used for annual "state of the epidemic and response" reports, organized by project component. A Dashboard of 21 indicators was established to help NACO focus on crucial management information to monitor and support implementation performance by the states.

b. M&E Implementation:

Data sources combined the use of surveillance data, routine health system records, routine project data, and special studies. Periodic upgrades to the project's management information system improved its speed, accuracy, and usefulness. A dedicated M&E component and adequate resources promoted strong attention during implementation to data quality, on-time data collection, compilation, and use. Surveillance sites were added, especially in locations targeting sex workers, MSM, and IDUs. According to the ICR (p. 11), India pioneered the use of small-area mapping and methods to make direct estimates of the size of the highest-risk groups in urban and rural areas in 2009, enabling better targeting of interventions at the district and subdistrict level . However, there were shortcomings. Incomplete reporting from intervention sites and clinics made NACO data on prevalence of STIs inadequate as a basis for estimating the burden of disease, leading to possible overestimation of treatment targets . Also, a nationwide integrated bio-behavioral survey planned for 2011/2012 was delayed to late 2013, leaving a data gap for assessing the project's impact.

c. M&E Utilization:

Resources were redirected based on new data on changed epidemic patterns, increasing interventions and

supportive supervision in districts with high epidemic potential . The ICR (p. 11) offers several specific examples of M&E data being used to make adjustments and improvements in both prevention and treatment interventions .

M&E Quality Rating : Substantial

11. Other Issues

a. Safeguards:

The project was rated Category B and triggered two safeguard policies : OP/BP/GP 4.01 Environmental Assessment, and OD 4.20/OP 4.10 Indigenous Peoples. A comprehensive Infection Control and Waste Management plan was developed, discussed with stakeholders, and finalized during appraisal . Its implementation was fully satisfactory in terms of training/capacity and awareness/compliance with best practices. A Tribal Action Plan was also developed, informed by a social assessment of issues relating to access to program benefits by tribal peoples . More than 14,000 people were trained on comprehensive Operational Guidelines for implementing this plan, with a focus on 65 districts in 13 states where 50% or more of the population is tribal. Progress in Action Plan implementation was found to be uneven across the 13 states. A 2010 study found no specific HIV vulnerability due to tribal status, except in the case of the few tribal groups with institutionalized economic reliance on sex work . The ICR (p. 12) states that there was satisfactory compliance overall with safeguard policies .

b. Fiduciary Compliance:

Overall financial management was satisfactory, with some delays in submission of audit reports . The ICR does not state whether audits were qualified; the project team later confirmed that audits were unqualified . In response to DIR concerns about large advances to NGOs and inadequate accountability for funds, the project 's financial management arrangements required NGOs to document expenditures using quarterly statements of expenditures . However, varied practices emerged across states, leading NACO to adopt a rigorous system of selecting and appraising NGOs with periodic evaluation against norms and targets, causing misalignment with the conservative fiduciary arrangements of input-based funding. This caused tension between the NGOS and NACO, as delayed funding flows to the NGOs inhibited their effectiveness. According to the ICR (p. 10), the difficult experience with the DIR contributed to NACO's reluctance to bring financial management of NGOs in line with a focus on performance instead of inputs, and was a missed opportunity for the Bank to introduce good practices in performance -based payments to NGOs.

The project contracted with a procurement agent with virtually no experience in Bank -financed procurement. As a result, the agent required extensive supervision and support from the Bank team . Eventually that agent had to be replaced, causing additional delays.

c. Unintended Impacts (positive or negative):
None reported.

d. Other:

12. Ratings:	ICR	IEG Review	Reason for Disagreement /Comments
Outcome:	Satisfactory	Satisfactory	
Risk to Development Outcome:	Negligible to Low	Negligible to Low	
Bank Performance :	Satisfactory	Satisfactory	
Borrower Performance :	Satisfactory	Satisfactory	
Quality of ICR :		Exemplary	

NOTES:

- When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1, 2006.
- The "Reason for Disagreement/Comments" column could cross-reference other sections of the ICR Review, as appropriate.

13. Lessons:

The following lessons are derived from the ICR (pp. 28-29):

Evidence-based, cost-effective prevention interventions targeted to the groups most at risk of transmitting infection are strongly effective at halting and reversing an HIV epidemic. This best-practice approach requires considerable political will, as well as continual data collection and analysis to ensure that effective interventions are targeted at groups and locations representing the "hot spots" of a dynamic epidemic.

A tailored, localized HIV response can rely on trusted community-based and non-governmental organizations as front-line implementers, as long as there are clear performance criteria, periodic evaluation, and action to terminate poor performers or help them improve. In this environment, requiring detailed records of all expenditures can be onerous and counterproductive; performance-based funding may present a viable alternative. A careful balance must be struck between good performance, which requires some flexibility and up-front financing, and appropriate and sufficient rigor in financial management and accountability.

IEG offers the following additional lesson:

Continuous localized surveillance among key high-risk groups is an essential backbone supporting effective targeted prevention interventions. In this project, such surveillance, underpinned by an effective information management system and ongoing strategic analysis, enabled constant adjustment of interventions to match the dynamic nature of the epidemic.

14. Assessment Recommended? ● Yes ○ No

Why? This project effectively located and targeted members of high-risk groups, despite a difficult and complex context. Its successes and challenges in doing so could provide lessons and guidelines of great utility.

15. Comments on Quality of ICR:

The ICR is concise, evidence-based, and complies with established guidelines. Beyond these minimum criteria for a satisfactory ICR, this ICR is rigorous in its approach to analysis of data, carefully examining the phrasing of the project's objectives and the results chain leading to achievement of those objectives. It mines all available data sources to reach its conclusions, with convincing analyses of the quality of various surveys and reports. It effectively triangulates data sources, and consistently evaluates observed outcomes against the counterfactual. The ICR not only candidly reports on the project's achievements and shortcomings during implementation, but also provides insightful explanations for important elements of the implementation experience.

a.Quality of ICR Rating: Exemplary