PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE

Report No.: AB1559

Project Name	HIV/AIDS III
Region	SOUTH ASIA
Sector	Health (100%)
Project ID	P078538
Borrower(s)	GOVERNMENT OF INDIA
Implementing Agency	Government of India Department of Economic Affairs Ministry of Finance India 110001 Tel: 91-11-23092500
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Environment Category	[ ] A [X] B [ ] C [ ] FI [ ] TBD (to be determined)
Date PID Prepared	April 19, 2005
Estimated Date of Appraisal Authorization	October 11, 2005
Estimated Date of Board Approval	February 28, 2006

1. Key development issues and rationale for Bank involvement:

Background: State of the HIV Epidemic in India: The prevalence of HIV among women attending antenatal care (ANC) considered a proxy for prevalence among adults aged 15-49, is currently estimated at 0.8 percent in India. Given the sheer size of India's population of over 1 billion people, this ratio translates to very large numbers. It is estimated that between 5 and 5.5 million individuals are currently infected with HIV. Within the country, the epidemic is heterogeneous with important regional variations. Six states, containing 30% of India's population already have what is considered to be high prevalence of HIV according to UNAIDS standards (>1% in ANC attendees and >5% in high risk groups). Three additional states have been characterized as moderate prevalence states (HIV prevalence is >5% in the high risk groups, but <1% in the ANC population) but contain several districts with high prevalence and the remaining states are characterized as low prevalence. This paradigm has since shifted based upon existing migration patterns, gender inequality, cultural beliefs and practices, poverty, access to health and education, levels of knowledge about HIV, and health infrastructure. Further, HIV has spread from high risk to low risk populations, is spreading rapidly amongst women, is already higher in some rural areas than urban ones, and is now present in all states of the Union. Thus, states previously classified as low prevalence, have been reclassified as 'highly vulnerable' or 'vulnerable' to guard against complacency and reflect the increasing threat of the epidemic.

GOI's Response to the Epidemic and Current Challenges: The Government of India (GOI) has mounted a comprehensive response to the epidemic over the last two decades. The National HIV/AIDS Control Program (NACP) was established in 1986, and was significantly expanded in 1992 with an IDA credit of US$84 million including through the establishment of a quasi-autonomous National AIDS Control Organization (NACO). A second IDA credit for US$191 million approved in 1999 further strengthened the program, decentralizing some functions to the states and strengthening capacity of implementing entities at the state level. Other Development Partners (DPs) providing financing for the program since the early 1990s include USAID, CIDA and DFID. Until last year, however, IDA remained the main source of funds.

Much has been accomplished by the NACP over the years. State AIDS Control Societies were set up in all states to coordinate the response at the state level. NGO-implemented high impact prevention interventions targeting populations engaging in high-risk behavior increased significantly, and the beginning of a multi-sectoral response has taken shape. Health sector based services have also expanded, including an effective blood safety program, increased number of Sexually Transmitted Disease clinics, Voluntary Counseling and Testing Centers, and an expansion of Prevention of Parent to Child Transmission services. In addition, NACP began providing anti-retroviral therapy in high prevalence states in April 2004. However, important challenges remain in improving the effectiveness of GOI's response both nationally and at the state level. Coverage of NGO executed prevention interventions is limited in view of the size of the problem, and the quality and targeting of the interventions often needs to be improved. Broader public and private involvement is required to truly mainstream HIV/AIDS activities and the quality and coverage of health sector based interventions needs urgent improvement.

NACO is working at full capacity and given its existing institutional framework, staffing, and distribution of responsibilities, making marked improvements in service delivery and significantly scaling up its response remains a challenge. NACO needs to take on a stronger and more effective stewardship role, the program needs further decentralization, capacity needs to be strengthened at the state level, and management at all levels needs to focus more on results. Although political commitment at the national level is high, GOI own financing for the program remains modest and staffing is sub-optimal. With the exception of some high prevalence states where political commitment is clearly visible, many states still lack the necessary political support. A more proactive and inclusive approach needs to be adopted, ensuring convergence with other health programs and full participation of all key public and private partners both centrally and at the state level.

Other important deterrents to program expansion and improved effectiveness include the stigma associated with HIV/AIDS and with some of the behaviors that spread it. Stigma affects people's access to services, the quality of those services, limits political commitment, people's rights, and spreads misinformation.

Finally, the overall coordination of the response faces important challenges given the increased number of financers, each with its own thematic and geographic priorities, some of which finance implementers directly. While this has increased the overall funding envelope, it has led to some fragmentation of the response, competition amongst NGOs, deviation from national

priorities, and an insufficient focus on vulnerable and low prevalence states.

Government Commitment: GOI is committed to a shift to a more programmatic approach and to significantly scaling up the current program, in order to mount a more comprehensive and effective response. This is being seen as a call to action to bring together the necessary resources to move the government's HIV/AIDS agenda forward. GOI is aware that scaling up will require a new modus operandi, including adjustments to its institutional framework at the national and state level, and an expanded participation of partners. The new leadership in NACO is already taking some steps in this direction. It is placing greater stress on building national partnerships to mainstream efforts to combat the epidemic, adopting a programmatic approach in the next phase of funding to ensure coordination and synergy. It envisions repositioning NACO for a more catalytic/facilitating role, establishing strong coordination mechanisms, developing a comprehensive communication strategy to raise general awareness about HIV/AIDS to create an enabling environment (reducing stigma and increasing knowledge), strengthening monitoring and evaluation, building implementation capacity in weaker states, decentralizing the program further, and fostering greater private sector involvement and convergence with other health programs including Reproductive and Child Health and TB.

GOI has rallied the Development Partners (DPs) for support in this next phase of financing for NACP. The DP community has already committed significant funds to the program (see annex). As part of preparation for the next phase of funding from IDA, an assessment of what needs to be done to significantly scale up the response and improve program effectiveness will be carried out. On that basis NACO will develop a comprehensive work program and estimate financing requirements for the next 5 years. DPs have been requested to identify areas that they could finance within the new work program once it is finalized.

2. Proposed program development objectives.

The Program Development Objectives would be to: (a) support the Government of India in achieving its goal of containing the spread of HIV in high risk groups and in the general population through saturation with targeted interventions and scaling up of the national response, (b) generate an enabling environment to enhance program effectiveness by strengthening institutions and the capacity of the national and state Government to mount an effective response.

3. Preliminary Program Description.

The proposed operation would support a government-led program with a common framework and goals for all development partners, with IDA providing flexible support by pooling its resources with as many DP as possible. The thrust of the program would be to consolidate a durable prevention program, but also address care and treatment related issues. Support would be provided to GOI to build further capacity to roll out an effective treatment program. A strategy for engaging the private sector in expanding coverage and strengthening capacity would be developed. The Project would have two components:

Component 1: Expand Coverage and Quality of Prevention, Diagnosis, Treatment and Care. Each state, depending on its profile, would be eligible for financing of its State HIV/AIDS Plan including management, M&E, and a "package of interventions" tailored to the needs of the state based on the stage of the epidemic and its implementation capacity. It is envisaged at this time, that the states would fall into one of three general categories including, (a) Priority (high and medium prevalence) States; (b) Highly Vulnerable States (with vulnerability being defined with respect to the size of the population, the weakness of the health system, and the extent of migration); (c) Vulnerable States.

Component 2: Foster an Enabling Environment for Program Scale-up, including, (a) Augmenting NACO's stewardship role especially through strengthening management capacity, monitoring and evaluation, and research management; (b) Devolution of implementation responsibilities to the state level (some similar inputs as subcomponent 1 but with a focus on state level management, capacity building activities for state implementers); (c) Strengthening partnerships with civil society, and other sectors including the private sector; and (d) Supporting enabling policies including policy development, legal framework, which foster effective communication, advocacy and reduction of stigma.

Lending Instrument Proposed. The proposed operation would be a Sector Investment and Maintenance Loan with pooled and parallel funding to support the work program of the National AIDS Control Program. IDA and DFID have agreed to pool funds to finance aspects of the program which still need to be specified. This approach would be suitable because: (a) it would allow for joint support by DPs and GOI for an overall program ensuring close coordination of inputs; (b) support would be provided for a program of work developed annually rather than specific investments identified up front; (c) would possibly introduce performance-based support; (d) would facilitate adherence to the **"**Three Ones" framework, providing coordinated support to GOI, reduced transactions to manage DP reporting demands and a single monitoring and evaluation (M&E) system for the program as a whole; and (e) it would help build in-house capacity to plan, execute and monitor the program.

Issues to be considered: An independent assessment of the needed institutional and financial management framework for scaling up the response will be a crucial input to program design. Business as usual will not work. The carrying out of the assessment and review of needs towards a true decentralization of the program should be the cornerstone of preparation.

1. Safeguard policies that might apply

Refer to section 5 of the PCN. Which safeguard policies might apply to the project and in what ways? What actions might be needed during project preparation to assess safeguard issues and prepare to mitigate them?]

Partial Environmental Assessment (OP/BP 4.01) and Indigenous Peoples (OD 4.20).

2. Tentative financing

Source:		($m.)
BORROWER/RECIPIENT		0
INTERNATIONAL DEVELOPMENT ASSOCIATION		150
	Total	150

3. Contact point

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