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APPRAISAL STAGE

Report No.: AB2461

Project Name	National AIDS Control Project III
Region	South Asia
Sector	Health (100%)
Project ID	P078538
Borrower(s)	Government of India
Implementing Agency	
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1. Country and Sector Background

The epidemic of infection with Human Immunodeficiency Virus (HIV) leading in time to the Acquired Immuno-Deficiency Syndrome (AIDS) among those infected has grown rapidly from one case in 1986 to an estimated 5.2 million cases in 2005. HIV/AIDS has the potential in the long term, to severely impact India's health gains as well as its economic growth.

The Indian epidemic continues to be concentrated in populations showing high risk behavior characterized by unprotected sexual intercourse with multiple partners, anal sex, and injecting drug use with shared needles. The mode of transmission of HIV leads to clustering of the epidemic in certain populations groups of size. The low rate of multiple partner concurrent sexual relationships among the wider Indian community seems so far, to have protected the larger body of people with 99% of the adult Indian population continuing to be HIV negative. This situation must be protected, as experience in other parts of the world has shown the potentially devastating impact of an HIV/AIDS epidemic on individuals and countries alike.

Six states, representing 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). A few 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. The remaining states, which were 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.

Many more districts are now 'high prevalence' with over 1% of their general adult population infected with HIV, and rates among rural populations and women are climbing. Changing economic structures and accompanying demographic shifts may have effects on the sexual behaviors in society at large and hence on the potential of the virus to spread within society.

Further India is discovering the visible "face" of the epidemic after 20 years of an epidemic of a chronic condition: that of a significant number of people living with HIV (PLHIV). As with the infection, these are also clustered and may be more visible in some areas than in others, as some workers in this field report.

GOI's Response to the Epidemic and Current Challenges: Over the last two decades, the Government of India (GOI) has maintained a sustained response to the epidemic. 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) and State AIDS Control Societies. 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) who provide significant financing to the program include the Global Fund against AIDS, TB and Malaria, USAID, CIDA and DfID. The Gates Foundation also funds HIV interventions in the country. This sustained commitment has yielded benefits, 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.

The nature of the epidemic suggests that immediate and full scale efforts need to be made to address the communities in which HIV incidence is highest. India must rigorously and dramatically scale up interventions regarding which it has now developed valuable experience. Since these high risk groups are among the most marginalized in society, there is need to organize the interventions so that efforts made to contain the epidemic are effective. It suggests that there be a massive all-out effort to equip everyone to protect themselves from infection through appropriate knowledge and easy availability of condoms and sterile needles, as appropriate. And it suggests that those affected by the virus receive all possible treatment and support both to alleviate their own and their relatives' suffering, as well as to motivate other people to seek testing and reduce transmission.

All possible avenues must be used to address the people at large including through mainstreaming HIV prevention into all aspects of government and economic activity. Broader public and private involvement for advocacy and awareness is required. The multisectoral approaches need to be scaled-up strategically, and the quality and coverage of health sector based interventions needs urgent improvement. Although NACO (National AIDS Control Organization) is working at full capacity it is unable, within the existing institutional framework, staffing, and distribution of responsibilities, to make marked improvements in service delivery or indeed to significantly scale up its response to more adequately address HIV/AIDS. The Government of India's (GOI) financing for the program is low and the program remains seriously understaffed.

Coordinating the increased number of partners and donors, each with different thematic and geographic priorities, presents an additional challenge. While this has increased the overall funding envelope it has also resulted in fragmentation of the response; competition; deviation from national priorities; and an insufficient focus on vulnerable and low prevalence states. GOI has responded to this through its commitment to a more programmatic approach, clarifying its plans over the coming five years. The NACO leadership is placing a lot of emphasis on repositioning NACO from implementation to 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.

2. Objectives

The project aims to support the GOI in achieving its goal of halting and reversing the HIV/AIDS epidemic by 2011 through integration of prevention and care, support and treatment programs. This will be achieved through four main strategies of the program:

- Preventing new infections in high risk groups and vulnerable populations;
- Increasing the proportion of persons living withHIV/AIDS receiving care, support and treatment;
- Strengthening the infrastructure, systems and human resources in prevention and treatment programs at district, state and national levels;
- Establishing a nation-wide strategic planning, program management, monitoring and evaluation system;

The proposed operation is fully consistent with the Country Assistance Strategy (CAS) of September 2004 and with the HIV/AIDS Strategy for the World Bank Group that was prepared and discussed with GOI as part of CAS preparation. It is in line with the Strategic Principles of the CAS, which include a "focus on outcomes" by directly supporting the achievement of the 6th Millennium Development Goal, which is to combat infectious diseases, including HIV/AIDS; and "applying selectivity" by targeting activities that are high-impact and that will bring greater synergy with financing of other Development Partners. As recommended by the CAS, co-financing with other partners under common arrangements for national programs is being sought through a program-based approach. The project is clearly in line with the South Asia Regional Strategy which has HIV as one of its thematic priorities.

The importance of this project was underscored in last year's address by the prime minister of India on the Independence Day celebration, when he stated that "AIDS is now becoming a major national problem and we need to tackle this on a war-footing. We need to have a mass movement to ensure that this disease is rapidly checked and its growth arrested."[1]

3. Rationale for Bank Involvement

Until 2003, the Bank had been the main provider of external financial support to India's response to the epidemic through two IDA credits, with the second credit closing on March 31, 2006. There has been a significant increase in the financial resources available for HIV/AIDS as other development partners and donors have entered in the past three years, especially the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and the Gates Foundation. However, financial requirements are increasing as the epidemic evolves and the scale of the necessary intervention increases. There is an urgent need to strategically scale up interventions nationwide, therefore continued IDA support to NACO would help ensure that there is adequate and continuous financing for a comprehensive program. In addition to extra finances being provided, IDA also brings added value to the program, through (i) its convening power, which would assist NACO/GOI in implementing the "Three Ones"[2]; (ii) its worldwide experience and technical expertise on HIV/AIDS programs; (iii) its ability to work with other sectors receiving Bank support to foster a more sustainable multisectoral response; and (iv) the possibility to support GOI's

[1] "Prime Minister Manmohan Singh's Independence Day address" The Hindu, August 15, 2005

[2] "Three Ones" endorsed by the Development community refers to: "one agreed HIV-AIDS action framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad based multi-sectoral mandate; and one agreed country level Monitoring and Evaluation System.

efforts to increase convergence with other health programs through our ongoing health operations, including health sector reform projects and centrally sponsored schemes such as the Reproductive and Child Health and TB Programs.

4. Description

Component 1: Prevention of new infections. The component has the following sub-components: (a) saturation of targeted interventions for high risk groups/high risk areas, through: (i) generating demand and access to condoms; (ii) strategic communications integrating advocacy, behavior-change, project support and mobilization of community resources; (iii) fostering an enabling environment to change the legal, policy and structural barriers; (iv) providing sexually transmitted infection services; (v) ensuring focused behavior change communication/harm-reduction interventions with intravenous drug users; (vi) promoting effective strategies for men having sex with men and transgender people, (vii) strengthening linkages between TI and care, support and treatment; and (viii) increasing ownership and pro-active participation of civil society in program design and implementation; and (b) scaling up of interventions among the general population through: (i) raising awareness and public dialogue; (ii) assuring safe blood supplies; (iii) developing a sustainable condom market; (iv) focusing prevention–based activities on women, children, adolescents and youth; (v) identifying self-risk and expanding voluntary counseling and testing services; (vi) mainstreaming workplace interventions; and (vii) instituting special efforts for migrants, refugees and cross border areas.

Component 2: Care, support and treatment. Under NACP III, Government plans to expand care, support and treatment opportunities for people affected by HIV, through: (i) systematically reducing stigma and discriminatory attitudes and practices; (ii) improving access to treatment for opportunistic infections (OI); (iii) gradually increasing the number of PLHIV with anti-retroviral treatment (ART); (iv) integrating prevention in balance with care, support and treatment; (v) expanding voluntary counseling and testing, prevention of parent to child transmission, and Post-exposure Prophylaxis; (vi) supporting community care and support programs; (vii) instituting programs for orphans and affected children; and (viii) cooperating with networks of PLHIV.

Component 3: Strengthening capacity at district, state and national level. The planned decentralization and scaling-up of activities will require new and additional capacity at various levels. The most important interventions scheduled are: (i) a review of all positions and job descriptions in order to hire staff with the appropriate skills; (ii) sustained technical and training support to public/private agencies, community based organizations, non-governmental organizations, and networks of PLHIV; (iii) capacity to facilitate mainstreaming of HIV programs into the regular programs of the Ministry of Health and Family Welfare, other Government ministries, such as education, transport, and creation of better partnerships with private sector, development partners and other stakeholders; and (iv) specific training for prevention and care, support and treatment for all involved in such programs.

Component 4: Strategic information management. India is experiencing a significant, complex and heterogeneous HIV/AIDS epidemic, which requires an effective monitoring and evaluation system. India aims to stabilize HIV at 2005 levels by 2011, primarily by expanding the quality and coverage of high risk group interventions. Monitoring and evaluation will play a central role in NACP III, assisting India to track the HIV epidemic, relevant bio-behavioral factors, program activities and the overall adequacy and effectiveness of India's HIV response. Monitoring and evaluation is vital to ensure that India's HIV response is analytic, rigorous, prioritized and evidence-informed. NACP III will: (i) establish an enhanced nation-wide strategic information, monitoring and evaluation system; (ii) improve sero-surveillance, and surveillance of behavior, STI and other markers such as OI, Hepatitis B, C etc.; and (iii) support evaluation and a program of operational research to follow-up or pilot innovations in the program.

Component 5: Creating an enabling environment. Effective prevention, care and support for HIV are possible through the creation of an enabling environment that respects the human rights of those infected and affected by HIV. Therefore, the program will seek: (a) Greater Involvement of People Living with HIV/AIDS (GIPA) though: (i) supporting and strengthening the capacity of PLHIV networks in all districts/ states by 2010; (ii) developing institutional structures within NACO and State AIDS Control Society for planning, implementing and monitoring GIPA; (iii) facilitating linkages of PLHIV groups; and (iv) creating an enabling environment for GIPA; (b) combating stigma and discrimination through: (i) systematically involving PLHIV in service delivery; (ii) advocating for and promoting media support for the proposed HIV/AIDS Bill; (iii) periodic training of service providers and counselors; and (iv) advocating a rights based approach to HIV with elected representatives; and (c) addressing legal, ethical and human rights issues through: (i) creating links between AIDS and human rights organizations and strengthening legal networks; (ii) developing a Code of Ethics and ensuring ethical standards to research are adhered to; (iii) reviewing existing laws and disseminating HIV/AIDS legislation; (iv) sensitizing and training law enforcement authorities; and (v) establishing minimum standards for prevention, care, support and treatment.

5. Financing

Source:		($m.)
BORROWER/RECIPIENT		800
INTERNATIONAL DEVELOPMENT ASSOCIATION		200
	Total	1000

6. Implementation

Support to NACP III will be provided in accordance with the "Three Ones" approach. UNAIDS has developed the approach, which is in fact the application of the Monterrey Consensus and Rome Declaration to a specific area of development: HIV/AIDS, under which Development partners work according to the following principles:

- One Agreed Action framework that provides the basis for coordination the work of all partners;
- One national HIV/AIDS Coordinating Authority, with a broad-based multi-sectoral mandate; and
- One agreed national Monitoring and Evaluation system.

To make this a reality, development partners will establish a clear joint working relationship with Government under which their role vs. the Government's role is clearly defined and which clarifies how development partners coordinate amongst themselves. A "code of conduct"/"Partnership Arrangement" will be developed before project appraisal.

While health is a State subject under the Indian Constitution, issues of national public health concern fall within the purview of the Centre. From its inception in 1992 therefore, HIV control has been a centrally sponsored and financed scheme.

At a national level, NACP III would be managed by the NACO established within the Ministry of Health and Family Welfare, and which reports to the National AIDS Control Board. Oversight of the performance of NACO and overall policy directives are provided by a National AIDS Committee which is chaired by the Minister for Health and has membership of senior officers of related ministries. Further, in June 2005, a National Council on AIDS was constituted under the chairmanship of the Prime Minister and with membership of 31 Central Ministers and six State Chief Ministers and Civil Society, to mainstream HIV into the work of all departments and lead a multi-sectoral response to HIV/AIDS in the country. NACO would remain responsible for: (a) setting the program framework and establishing management systems; (b) carrying out broad national level advocacy and social mobilization; (c)

establishing training capacities; (d) providing support to mainstream the HIV control agenda into the work of other ministries; (e) partnering with significant stakeholders who are vested with capabilities for HIV control; (f) funding of relevant operational research and R&D; (g) carrying out regular surveillance and evaluation of large initiatives for HIV control; and (h) oversight of technical resource groups.

Implementation of HIV control activities would vest primarily with the States. The States have established State AIDS Control Societies (SACS) under the Second National HIV/AIDS Control Program (NACP II) and these would continue to provide leadership for all HIV/AIDS Control activities in the State in the third phase of the program. In some States, it is expected that these SACS have either already been subsumed under the State Health Society, or will be during the life of the project. However, this is not expected to reduce the capacity of this agency to manage HIV/AIDS Control activities in the State, but rather to ensure that capacities strengthened under other projects supported by the development partners is available to all programs. The SACS or State Health Society would be responsible for implementing the program through: a) targeted interventions among populations exhibiting high risk behavior; b) advocacy, Information, Education and Communication, social mobilization and youth campaigns; c) intersectoral collaboration with significant stakeholders in the state; and d) coordination with all development partners. Further it would also be responsible for project activities within the health department i.e.: a) blood safety; b) voluntary testing and counseling for pregnant women, persons suspected or diagnosed to have TB and persons presenting themselves to these centers; c) STD care; d) treatment of opportunistic infections among PLHIV; and e) provision of ART.

7. Sustainability

Political sustainability. The GOI has demonstrated its significant commitment to containing the HIV epidemic through the establishment of the HIV/AIDS Control program in 1986 and its continued actions, funded through its own budget and international funds, in support of halting and reversing the epidemic in the intervening years. The HIV/AIDS control program has formed an integral part of successive five year plans, including the ongoing 10^{th} five year plan. Most recently, the government has established a National Council on AIDS in June 2005 under the chairmanship of the Prime Minister. With a few States in India now showing stabilization of HIV prevalence rates, India is set to accelerate its control efforts throughout the country by leveraging the important experiences that it has gained.

Institutional sustainability. While NACP II focused in large part on the establishment of targeted interventions for high risk marginalized groups, the third phase of the program seeks to mainstream and scale up a number of HIV control activities into the health department's routine activities. Further, this project also proposes to partner with private sector players in important areas such as testing and counseling services, STD services and continued provision of targeted interventions, and establishes systems that support quality services being made available through them. The repositioning of the SACS as the nodal agency for all HIV/AIDS activities that take place in the state and the operationalization of the 'Three Ones' principle will ensure greater institutional stability in the program.

Financial sustainability. Although the price of anti-retroviral drugs for HIV/AIDS has declined in recent years, preventive interventions still remain the most cost-effective way of dealing with the crisis. In NACP III, increasing the efficiency and coverage of interventions targeted at the high-risk population will help to prevent new infections at relatively low cost. For saturation coverage of commercial sex workers in high-prevalence states, the projected cost per new infection prevented is $24. Significant country-wide scaling-up of interventions across all high-risk groups will cost between $20 and $200 depending on the assumption of the future infection rate in the absence of such intervention. The projected increase in recurring expenditure of $37 million per year is less than one-tenth of the government's revenue expenditure on medical and public health. Given the consensus for a substantial revitalization of the

public health infrastructure and improved delivery of medical services, the recurring expenditure can be adequately met by the government's budgetary resources for the health sector as a whole. The long-run benefit in terms of reduced healthcare expenditure for treatment of HIV positive individuals outweighs the short-term increase in project costs.

8. Lessons Learned from Past Operations in the Country/Sector

NACP III takes into account key lessons from international and national experience, which clarify that: (a) targeted interventions for poor and marginalized groups at high risk of infection, within a broader population wide campaign, are the most effective way to reduce transmission of HIV because of multiplier effects of prevention to the general population; (b) working through community-based organizations, especially peer based groups, is one of the most effective HIV prevention strategies; and (c) convergence of HIV programs with programs which deal with other health issues such as STDs, Tuberculosis and Reproductive Health is beneficial for the effectiveness of all programs.

Well performing states in India show that a combination of strong political commitment, a focus on high impact interventions, and good management with continuity of trained staff, strong surveillance and technical assistance as well as adequate financial resources, can increase coverage among high-risk groups and lead to improvement in HIV prevalence rates. Successful planning of targeted intervention include micro-site mapping that is repeated periodically since high-risk groups are mobile and dynamically changing populations, and helps in identifying coverage gaps. Participatory mapping involving community-based organizations has been good practice. Strong surveillance is the back bone of a successful program. Decentralized management appears to have been an efficient strategy and will be further built-upon by strengthening staff capacity of the SACS. Strong partnerships with donors and with non-governmental/community-based organizations have played an important role in NACP II's success and will be further developed under NACP III. However, NGO selection mechanisms need to be streamlined, in order to decrease unfair competition amongst NGOs. Another lesson learned from NACP II is that the program needs increased multi sector involvement to address some of the underlying determinants, create an enabling environment – including legal framework --, reduce stigma, increase awareness, educate and increase access and use of prevention and treatment services. Enhancing awareness in the general population of HIV/AIDS can contribute to a reduction in stigma and discrimination, and increase coverage.

9. Safeguard Policies (including public consultation)

This project has triggered OP 4.01 Environmental Assessment due to the potential negative environmental impacts of medical waste as discussed in the previous section. The safeguard screening category is S2.

The project triggers the Indigenous Peoples' safeguard as there is need to ensure that India's tribal populations receive culturally appropriate benefits to prevent HIV/AIDS infections and to treat and care for those infected. A social assessment was carried out during project preparation to identify the main issues related to reaching tribal people for these purposes, and how these could be addressed. Key findings of the tribal assessment include: (a) very low awareness and knowledge of HIV/AIDS and sexually transmitted infections among tribal people; (b) high vulnerability in areas where they come into frequent contact with 'outsiders', especially among youth; and (c) low access to health facilities in tribal areas, and high recourse to faith healers and non-qualified practitioners for health care. These and other findings have been addressed through a Tribal Action Plan for the project which includes actions to improve: (i) consultation with and participation of tribal people in program design, implementation and monitoring; (ii) project processes (such as district planning) to ensure due attention to tribal areas; (iii) institutional capacity to address tribal needs, including inter-governmental coordination and private sector involvement; (iv) communication and services to tribal areas; and (v) information about tribal areas and

people, including research studies, to further increase understanding of needs, constraints and opportunities relevant to HIV/AIDS.

NACO and the SACS currently have limited capacity to implement the tribal action plan. Capacity to do so will be built during the project by (a) increasing the involvement of tribal people themselves, as well as their representatives and specialists who are knowledgeable about tribal issues in the program, at the national, state and district levels; and (b) sensitizing and training non-tribal people in relevant locations and agencies in the needs, constraints and opportunities of tribal areas, especially service providers.

The social assessment involved consultations at the field level in a sample of districts and states across the country. Tribal people, non-governmental organizations working with them and/or on HIV/AIDS, opinion leaders and health officials at local, state and national levels were consulted on the specific needs of tribal people, relevant practices, and how these could be addressed to provide appropriate services to them through the NACP III. As described above, the assessment led to the formulation of the project's Tribal Action Plan. The assessment report was made available in draft form on the UNAIDS website in early May 2006, and was the basis for a national consultation held in June 2006. The final version, revised in keeping with comments received through the website, consultation and reviewers, will be reposted on the website and sent to the World Bank's InfoShop in July 2006.

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	[x]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[x]
Pest Management (OP 4.09)	[ ]	[x]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[x]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[x]
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	[x]	[ ]
Forests (OP/BP 4.36)	[ ]	[x]
Safety of Dams (OP/BP 4.37)	[ ]	[x]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[ ]	[x]
Projects on International Waterways (OP/BP/GP 7.50)	[ ]	[x]

10. List of Factual Technical Documents

a Revised Strategic Framework NACP III, October 14, 2005.
b Reports of Working Groups for Design of NACP III, October 14, 2005.
c Draft Note for Monitoring and Evaluation Arrangements for NACP III, October 14, 2005.
d Draft Institutional Arrangements for Implementing the NACP III, October 14, 2005.
e Draft Financial Management for NACP III, October 14, 2005.
f NACP III Program Implementation Plan, A draft note on Human Resource Requirements (A Tentative Estimate), October 14, 2005.
g Enhancing the Role of Civil Society in the NACP III, National Consultation by Civil Society held in Delhi 14-15 October, 2005.
h Report from The National Consultation the "Three Ones in India" (presentation) by NACO and UNAIDS, October 10 and 11, 2005.
i Report on Stakeholder's Consultation on Environmental Assessment (Infection Control and Waste Management Plan) for NACP III, May 8, 2006 by PRIA.

* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

j Report on Procurement Capacity Assessment of NACO & Other Implementing Agencies under NACP III – Volume I & II Executive Summary with recommendations, May 7, 2006.

Government Documents:

a Revised National AIDS Control Project (NACP) Phase III, draft Project Implementation Plan, MOHFW, India

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