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PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 167.9 MILLION

(US$250 MILLION EQUIVALENT)

TO THE

REPUBLIC OF INDIA

FOR A

THIRD NATIONAL HIV/AIDS CONTROL PROJECT

March 22, 2007

Human Development Unit
South Asia Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective January 31, 2007)

Currency Unit	=	Rupees (Rs)
Rs44.20	=	US$1.00
US$1.00	=	SDR .6716

FISCAL YEAR

April 1 – March 31

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante-natal Care
ART	Anti-Retroviral Treatment
AWP	Annual Work Plan
BCC	Behavior Change Communication
BMGF	Bill & Melinda Gates Foundation
BSS	Behavioral Surveillance Survey
C&AG	Comptroller and Auditor General
CAS	Country Assistance Strategy
CF	William Jefferson Clinton Foundation
CBO	Community-Based Organization
CMIS	Computerized Management Information System
CPMS	Computerized Program Management System
CSW	Commercial Sex Worker
DAPCU	District AIDS Program Control Unit
DFID	Department for International Development
DIR	Detailed Implementation Review
DP	Development Partner(s)
EPW	Empowered Procurement Wing
FSW	Female Sex Workers
GAAP	Governance and Accountability Action Plan
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOI	Government of India
HIV	Human Immuno-Deficiency Virus
HRG	High Risk Groups
IBRD	International Bank for Reconstruction and Development
IBBS	Integrated Bio-Behavioral Surveillance
ICB	International Competitive Bidding
ICTC	Integrated Counseling and Testing Centers
IC-WM Plan	Infection Control and Waste Management Plan
IDA	International Development Association
IDU	Injecting Drug User(s)
IEC	Information, Education and Communication
IFR	Interim Financial Report
ITDA	Integrated Tribal Development Authorities

ABBREVIATIONS AND ACRONYMS (continued)

LOU	Letter of Undertaking
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal(s)
MOHFW	Ministry of Health and Family Welfare
MSM	Men Having Sex With Men
MSW	Male Sex Worker
NACB	National AIDS Control Board
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NCA	National Council on AIDS
NGO	Non-Governmental Organization
NNCC	NACP NRHM Coordination Committee
NRHM	National Rural Health Mission
OI	Opportunistic Infections
PEP	Post-exposure Prophylaxis
PIC	Public Information Center
PID	Project Information Document
PIP	Program Implementation Plan
PLHIV	People Living with HIV
PPTCT	Prevention of Parent to Child Transmission
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SBD	Standard Bidding Documents
SIMU	Strategic Information Management Unit
SIS	State Implementing Society
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TI	Targeted Intervention
TSU	Technical Support Unit
UC	Utilization Certificate
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
VCTC	Voluntary Counseling and Testing Center
WHO	World Health Organization

Vice President:	Praful C. Patel
Country Director:	Isabel M. Guerrero
Sector Manager:	Anabela Abreu
Co-Task Team Leaders:	Kees Kostermans & Suneeta Singh

INDIA

THIRD NATIONAL HIV/AIDS CONTROL PROJECT

PROJECT APPRAISAL DOCUMENT

SOUTH ASIA

Human Development Unit

Date: March 21, 2007	Co-Team Leaders: Kees Kostermans and Suneeta Singh
Country Director: Isabel M. Guerrero	Sectors: Health (100%)
Sector Manager/Director: Anabela Abreu/Julian Schweitzer	Themes: Health system performance (P); HIV/AIDS (P); Population and reproductive health (P); Other communicable diseases (S); Child health (S)
Project ID: P078538	Environmental screening category: Partial Assessment
Lending Instrument: Specific Investment Loan	

Project Financing Data

[ ] Loan [X] Credit [ ] Grant [ ] Guarantee [ ] Other:

For Loans/Credits/Others:
Total Bank financing (US$ million.): 250.00
Proposed terms:

Financing Plan (US$m)

Source	Local	Foreign	Total
BORROWER/RECIPIENT	61.20	21.80	83.00
International Development Association (IDA)	184.10	65.90	250.00
UK: British Department for International Development (DFID)	131.70	47.30	179.00
Financing Gap	0.00	0.00	0.00
Total:	512.00	135.00	512.00

The overall cost of NACP3 program is $2,575 million. The program has a financing gap for the latter years of $390 million. Government may approach the Bank for extra support at mid-term under conditions as explained in Annex 5.

Borrower
Government of India
Department of Economic Affairs
Ministry of Finance
New Delhi, India
110001
Tel: 91-11-23092500

Responsible Agency
National AIDS Control Organization
9th Floor Chandralok Building 36
Janpath
New Delhi, India
Tel: 91.11.2335.1700 Fax: 91.11.2332.5331
nacoasdg@gmail.com

Estimated disbursements (Bank FY/US$m)									
FY	07	08	09	10	11	12	13	0	0
Annual	58.00	71.00	91.00	30.00	0.00	0.00	0.00	0.00	0.00
Cumulative	58.00	129.00	220.00	250.00	250.00	250.00	250.00	250.00	250.00

Project implementation period: Start April 1, 2007 End: March 31, 2012
Expected effectiveness date: August 15, 2007
Expected closing date: September 30, 2012

Does the project depart from the CAS in content or other significant respects?	[ ]Yes [X] No
Does the project require any exceptions from Bank policies?	[ ]Yes [X] No
Have these been approved by Bank management?	[ ]Yes [ ] No
Is approval for any policy exception sought from the Board?	[ ]Yes [X] No
Does the project include any critical risks rated "substantial" or "high"?	[X]Yes [ ] No
Does the project meet the Regional criteria for readiness for implementation?	[X]Yes [ ] No

Project development objective:
The objective of World Bank support is 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:

1) achieving behavior change by scaling up prevention of new infections in high risk groups and general population; and
2) increased care, support and treatment of PLHIV.

Project description:
Component 1: Scaling up prevention efforts.
Component 2: Strengthening care, support and treatment.
Component 3: Augmenting capacity at district, state and national level.
Component 4: Strengthening strategic information management.

Which safeguard policies are triggered, if any?
1). Environmental Assessment (OP/BP/GP 4.01)-Category B project.
2). Indigenous Peoples (OD 4.20, being revised as OP 4.10)

Significant, non-standard conditions, if any, for:
Board presentation:
There is no policy exception required for the program support.
Loan/credit effectiveness:
N/A.

Covenants applicable to project implementation:

- ③ The GOI shall cause the MOHFW to ensure that each project state and State Implementing Agency carry out their respective activities under the project in accordance with a Letter of Undertaking (LOU) satisfactory to IDA to be signed by each project state and its respective State Implementing Agency (SIA), i.e., expenditures from a given state would not be eligible for reimbursement unless the corresponding LOU has been signed.
- ③ The GOI shall cause the MOHFW to ensure adequate management capacity in NACO, to review the number and composition of staff and requirements for technical assistance annually; to revise the staffing norms and composition if found necessary during the mid term review; to strengthen and maintain a financial management unit and a procurement

supply and logistics unit within NACO and maintain these units throughout project implementation; to maintain a unified strategic information monitoring unit which reports on activities and outcomes of all partners of NACP III and ensure timely reports in an agreed format satisfactory to IDA for the six monthly review missions.

- ③ The GOI, through MOHFW, shall cause NACO to implement the financial management reform.
- ③ NACO shall carry out a management audit as per TOR satisfactory to the Association within three months of effectiveness of the project.
- ③ NACO will upgrade its computerized program management system and maintain and support the system during implementation of the project.
- ③ The GOI shall cause audits of various project executing agencies to be conducted in a timely manner in accordance with the terms of reference set out in the Financial Management Manual and in the Procurement Manual for NACP III.
- ③ The GOI shall cause MOHFW to ensure that all NGOs/CBOs with whom NACO shall enter into a contractual arrangement for provision of targeted interventions, testing and counseling services, STI and OI diagnosis and treatment and ART provision are regularly supervised and outputs monitored and that this information is used to form the basis of their continuation of contract.
- ③ The GOI shall cause the MOHFW and the project states to implement, in a manner satisfactory to IDA, the Tribal Action Plan and the interventions targeted towards other socially deprived groups set forth therein, as well as the agreed Infection Control and Waste Management Plan, and ensure that relevant manuals and guidelines are at all times consistently and satisfactorily applied.
- ③ The GOI, throughout the duration of the program, shall cause the executing agencies to implement the GAAP, refrain from taking any action which shall prevent or interfere with the implementation of their Plan, not waive, amend or abrogate the Plan and, provide a written report on progress achieved in the implementation of the Plan semi-annually.

INDIA
Third National HIV/AIDS Control Project

CONTENTS

A. STRATEGIC CONTEXT AND RATIONALE

1. Country and Sector Issues

1. **The Problem:** Acquired Immuno-Deficiency Syndrome (AIDS) poses a serious threat to India's health gains as well as its economic growth. Given the evidence from other countries of the potentially devastating impact of a Human Immuno-Deficiency Virus (HIV) epidemic, efforts must continue to respond to the epidemic in a significant and appropriate manner in order to prevent it from spreading further to the general population, and to provide treatment, care and support to People Living with HIV (PLHIV).

2. Worldwide, a quarter of a century into the epidemic, the number of people infected with the Human Immunodeficiency Virus (HIV) which leads to AIDS is 38.6 million. Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that 4.1 million became newly infected with HIV and an estimated 2.8 million lost their lives to AIDS in 2005. In India, 20 years after the first case was identified in 1986, HIV infection has grown to 5.2 million cases by 2005 or a prevalence of about 0.9% in the adult population (15- 49 years), according to estimates based on data of the national surveillance system.

3. **The HIV Epidemic in India:** While the Indian epidemic continues to be concentrated, to a large extent, in populations engaging in high risk behaviors such as unprotected sexual intercourse with multiple partners, unprotected anal sex, and injecting drug use with shared needles, both rural prevalence and HIV prevalence among women is increasing leading to generalizing epidemics in some states. The low rate of concurrent sexual relationships with multiple partners seems to have, so far, protected the other 99% of the adult Indian population. Changing economic structures and accompanying demographic shifts may affect the sexual behavior of the society at large and thus the potential of the virus to spread further among the general population. An environment where power dynamics, gender imbalance, poverty, harmful traditions and discriminatory legal frameworks and practices reinforce vulnerability further enhances the chances for the virus to spread and hampers opportunities to fight the epidemic effectively.

4. Six states, representing 30% of India's population already have what is considered to be a high prevalence of HIV according to UNAIDS criteria (>1% in ante-natal care (ANC) attendees and >5% in High Risk Groups High Risk Groups-HRG). Three additional states have been characterized as moderate prevalence states (HIV prevalence is >5% in the HRG, 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 and the presence of structural factors of risk and vulnerability.

5. **People Living with HIV:** As the infection in successively larger cohorts of HIV infected persons expresses its natural history, India is also discovering the visible face of the epidemic with a significant number of PLHIV. This group has special issues to be dealt with including reported stigma and discrimination in the workplace, medical settings and from society at large.

A comprehensive response to the epidemic must also provide appropriate care, treatment and support to these populations.

6. **Government Response:** Over the last two decades, the GOI has developed and gradually enhanced its response to the epidemic. The National AIDS Control Program (NACP) established in 1986, received support from the World Bank in 1992 with an IDA credit of US$84 million, and a second IDA credit of US$191 million in 1999. 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 delivered through a quasi-autonomous NACO supported by a strengthened state level implementation structure. In addition, NACP began providing free anti-retroviral therapy in high prevalence states in April 2004 and now have over 47,000 persons on treatment.

7. In 2005, GOI launched the National Rural Health Mission (NRHM) with a strong commitment to reduce maternal and infant mortality, provide universal access to public health services, prevent and control communicable and non-communicable diseases, ensure population stabilization, maintain gender balance and revitalize local health traditions. NACP III will link closely with the broad operational framework provided for the Health sector by NRHM.

8. **Challenge of Coordination:** The past few years have seen a greater involvement of other Development Partners (DPs). Those who provide significant financing to the program include the Global Fund to Fight AIDS, TB and Malaria (GFATM), the Department for International Development (DFID) and the United States Agency for International Development (USAID). The Bill & Melinda Gates Foundation (BMGF) and the William Jefferson Clinton Foundation (CF) also fund HIV interventions in the country. While this has increased the overall funding envelope, it has also resulted in a fragmentation of the response, a competition among partners, sometimes a deviation from national priorities, and an insufficient focus on vulnerable and low prevalence states. GOI has responded to the challenge of coordination by preparing its plans for the Third National AIDS Control Project (NACP III) in an exemplary consultative and inclusive process at the national and state level, and is looking to the development community for funding and technical support to accomplish the goals which it has defined for this period. With IDA support, GOI proposes to implement the "Three Ones" approach espoused by the Joint United Nations Program on AIDS (UNAIDS)[1] and the international community at large.

2. Rationale for Bank Involvement

9. GOI has requested continued IDA support to help ensure adequate, flexible and continuous financing for a comprehensive program of HIV control to be funded by GOI and the large number of DPs now active in India. While there has been a significant increase in the financial resources available for HIV/AIDS as other development partners and donors have supported the program over the past 3-5 years (such as GFATM and BMGF), financial requirements for different activities are also increasing as the epidemic evolves. Preventive

[1] The "Three Ones" approach promoted by UNAIDS 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".

services need a higher coverage than has thus far been achieved. There is an urgent need to strategically scale up prevention, care and treatment interventions nationwide.

10. In addition, IDA also brings added value to the program, through: (i) its convening power, which would assist the NACO/GOI in implementing the "Three Ones" approach; (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 multi-sector response; (iv) the possibility of supporting GOI's 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 (RCH) and Tuberculosis Control Programs; and (v) its experience gained under NACP I and II.

3. Higher Level Objectives to which the Project Contributes

11. The proposed operation is in line with the strategic principles of the CAS, which include a "focus on outcomes" by directly supporting the 6th Millennium Development Goal (MDG) to combat infectious diseases, including HIV/AIDS, and "applying selectivity" through targeted activities that are high impact and that will bring greater synergy with the financing of other DPs. As recommended by the CAS, co-financing with other partners under common arrangements for national programs is being considered through a programmatic approach. The project is also in line with the World Bank South Asia Regional Strategy for which HIV is a thematic priority. Finally, the project focuses mainly on prevention amongst HRG, which is in line with the South Asia HIV strategy.

12. The importance of this project was underscored in the address by the Prime Minister of India on the 2005 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."[2]

B. PROJECT DESCRIPTION

1. Lending Instrument

13. IDA proposes to provide a Sector Investment and Maintenance Loan which it would pool with DFID, to fund a programmatic approach in order to flexibly support the government's program. As a financier of last resort, IDA will channel its support to areas of the agreed program not receiving adequate support from other financiers. This approach would be the most appropriate and relevant since it would facilitate: (a) joint support by DP and GOI for an overall program ensuring close coordination of inputs; (b) assistance for a program of work developed annually in support of a five year results oriented program rather than for specific investments; (c) performance-based support; (d) adherence to the **"**Three Ones" framework; and, (e) building in-house capacity to plan, execute and monitor the program.

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

2. Program Objective and Phases

14. As the name NACP III indicates, this constitutes the third phase of a program to which the Bank has provided support since 1992. NACP III has the ambitious goal of halting and reversing India's HIV/AIDS epidemic by 2011, ahead of the 2015 target of the 6th MDG. The program is seen as part of a longer term plan to realize the MDG and complete the long term reform agenda. The Bank is likely to be requested to provide support to a later phase of the program, however, the format of this future support will depend on evolving government policies in the health sector and the Bank's policy towards more integrated state-wise support.

3. Project Development Objective and Key Indicators

15. The objective of World Bank support is 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:

- achieving behavior change by scaling up prevention of new infections in HRG and the general population; and
- increased care, support and treatment of PLHIV.

16. The key indicators which will be used to track the project development objectives of World Bank support to NACP III are:

- percentage of female sex workers who report using a condom with their most recent client;
- percentage of male sex workers who report using a condom with their most recent client;
- percentage of injecting drug users who have adopted behaviors that reduce transmission of HIV, that is who avoid both sharing injecting equipment during the last month AND who report using a condom with their most recent sexual partner; and
- number of people with advanced HIV infection receiving anti-retroviral combination therapy.

4. Project Components

17. IDA will provide flexible funding for the implementation of NACP III based on an analysis of support from other DPs and specific government needs. The project has the following four components:

Component 1: Scaling up Prevention Efforts. With 99% of the population uninfected, prevention remains the top priority of the project, which aims to reduce new infections through saturation of coverage (>80%) of HRG over a five year period. This would be implemented through 2100 Targeted Interventions (TI) targeting one million Female Sex Workers (FSW) and their partners; 1.15 million Men Having Sex With Men (MSM) including but not limited to Male Sexual Workers (MSW), and 190,000 injecting drug users and their partners. In addition, this

component would support scaling up of interventions in highly vulnerable sub-sections of society identified as long distance truckers (3 million) and short duration migrant workers (8.9 million). Finally this component would also put in place strategies to address the most vulnerable among the general population, namely youth between the ages of 15-29 years, women in the age group of 15-49 years, children (age 0-18 years), and socio-economically disadvantaged people, including tribal people.

19. These groups would be addressed through a variety of means including through targeted plans for condom promotion and provisioning through Non-Governmental Organizations (NGO) and where possible or necessary, Community-Based Organizations (CBO); promotion of counseling and testing for HIV; better availability, testing and assurance of blood and blood products; deployment of a cadre of Link Workers and establishment of Red Ribbon Clubs to spread awareness and provide counseling for HIV; fostering an enabling environment to change the legal, policy and structural barriers; and campaigns through both mass media as well as more local and direct forms of Behavior Change Communication (BCC) to raise awareness and facilitate public dialogue. The component also focuses on mainstreaming of HIV activities in key sectors beyond the health sector, such as education, defence, justice, tribal affairs, transport and labor.

Component 2: Strengthening Care, Support and Treatment. GOI plans to expand care, support and treatment opportunities for people affected by HIV through a comprehensive strategy to strengthen family and community care, provide psycho-social support for PLHIV (especially marginalized women and children), and ensure accessible, affordable and sustainable treatment services. It is estimated that during the project period, care and support services will be provided to 380,000 PLHIV with AIDS; ART to 340,000 of which 40,000 children (in the public sector); OI treatment to 330,000 persons; and TB treatment to 2.8 million persons.

21. This component will support the strengthening of PLHIV networks, linking them to service centers and risk reduction programs; developing and implementing standard OI management guidelines; establishing community care and support centers which would act as a hub for HIV services in the community; and advocacy and social mobilization to integrate PLHIV into society.

Component 3: Augmenting Capacity at District, State and National Level. The planned decentralization and scaling-up of activities will require new and additional capacity at various levels. It is recognized under the program that systems to manage the relationships that NACO must develop with the State AIDS Control Society (SACS), and also with private sector providers of essential service support both for HRG and the general population, is going to be critical to the success of this phase of the program. Likewise, it is clear that capacities within NACO need to upgraded and improved accountability frameworks established that respond to the revised role of NACO as a catalyst and steward of HIV control activities in the country.

23. This component will support the collaborative development of standard operating procedures for crucial HIV services; setting up of internal and external quality assurance systems; establishment of improved and performance-based contracting arrangements with private providers; upgrading capacity to extend the program to socio-economically vulnerable

people, including tribal people (in the North-East, other Tribal Sub-Plan areas and mixed populations); and strengthening of both training and technical support capacities linked to core HIV control structures within government and NGO/CBO community.

Component 4: Strengthening Strategic Information Management. The NACP III proposes a significant change in the purpose and effectiveness of data collection and analysis. A Strategic Information Management Unit (SIMU) will be supported in order to maximize the effectiveness of available information and implement evidence-based planning. This will be set up at the national and state levels to address strategic planning, monitoring and evaluation, surveillance, and research. In addition, all program officers will be trained on evidence-based strategic planning methodologies, information use, and program management.

25. This component will include strengthening of the monitoring framework to provide more accessible and ready-to-use information across program content and management functions; enhanced surveillance systems to provide HIV related epidemiological, clinical and behavioral data, especially for specific high-risk behaviors, at a state and sub-state level, including for vulnerable populations where relevant; and independent evaluation and research to inform and support program implementation. The models used to generate national and state estimates on the basis of surveillance data will be reviewed.

5. Lessons Learned and Reflected in the Project Design

26. NACP III takes into account key lessons from international, national, and other IDA project experiences.

27. Key lessons from international experience include: (a) targeted interventions for marginalized groups at high risk of infection, within a broader population-wide campaign, are the most effective ways to reduce transmission of HIV; (b) working through NGOs/CBOs, 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 related issues such as STI, TB and reproductive health is beneficial for the effectiveness of all programs.

28. Key lessons from national experience of the first two phases of NACP include: (a) at the state level a combination of strong political commitment, focus on high impact interventions, good management with continuity of trained staff, strong surveillance and technical assistance, and adequate financial resources, can increase coverage among high-risk groups and lead to improvement in HIV prevalence rates; (b) successful planning of TIs include micro-site mapping that is repeated periodically, since high-risk groups are mobile and dynamically changing populations, helps in identifying coverage gaps; (c) participatory mapping involving CBOs is an example of good practice; (d) surveillance is the back bone of a successful program; (e) decentralized management is an efficient strategy so staff capacity of the SACS should be further strengthened; (f) strong partnerships with donors and with NGOs/CBOs are successful means to respond to the epidemic and will be further developed. However, NGO selection mechanisms need to be strengthened and streamlined, in order to improve accountabilities and decrease unfair competition for NGO services amongst donor agencies; (g) multi-sector involvement can address some of the underlying determinants of the epidemic, create an enabling environment, reduce

stigma and discrimination, increase awareness, and increase access and use of prevention and treatment services; and (g) enhancing awareness in the general population can contribute to a reduction in stigma and discrimination and an increase in coverage.

29. Key lessons from other IDA project experiences in India include: (a) the need to focus on links between the disease specific programs, such as TB, RCH, Vector-borne Diseases for better integration and effectiveness; (b) an important lesson from the RCH program is that for successful project implementation, management capacities of the MOHFW should be strengthened; (c) there is a need to focus on creating a robust procurement system; and (d) the Bank and other DPs should ensure the availability of more resources for effective supervision.

30. In response to these lessons, the project design provides that NACO will work closely together with the National Program Coordination Committee for RCH chaired by an Additional Secretary which has been established for providing oversight to the program. The Additional Secretary is assisted by financial management and program management groups responsible for financial management and technical guidance respectively. An Empowered Procurement Wing has been established to effectively implement some of the agreed actions under the government's GAAP (see Annex 9), while remaining actions shall be implemented by NACO. The Bank and GOI would ensure an adequate budget for implementing this plan.

6. Alternatives Considered and Reasons for Rejection

31. Three project design alternatives were considered and rejected.

(a) Continuing present level of interventions with HRG and adding ART. Present coverage of HRG with prevention efforts is insufficient to keep the epidemic under control. Therefore, the number of new infections would continue to rise.
(b) Creating an explicit multisector set-up for NACP III. Under the previous phases of NACP, the government had established NACO and SACS, under the MOHFW. Given the successful performance of the Borrower, according to the ICR and the Bank's Independent Evaluations Group, this arrangement is apparently working well. In its present design the program is capable to work with other Ministries. During NACP II a high level multi-sectoral National Council on AIDS (NCA) chaired by the Prime Minister was also established.
(c) Providing support for a general health program. Given the specificities of HIV and the support to it from the development community, it was decided to keep NACP III as a separate program which will provide the focus needed for an enhanced response and is in line with GOI organizational structure. The government intends to bring greater convergence between the NACP and disease specific programs such as the TB control program and broad programs like RCH through the NRHM. This allows for a convergence of relevant activities as opposed to the support of a general program.

32. Because of the above choices, a Sector Investment and Maintenance Loan seems to be the better fitting lending instrument, as it keeps the middle between a narrowly defined traditional investment project and the budget support of a DPL.

C. IMPLEMENTATION

1. Partnership Arrangements

33. Support to NACP III will be provided in accordance with the "Three Ones" approach. This approach applies the Monterrey Consensus and Rome Declaration on the Harmonization of Development Assistance to a specific area of development - HIV. NACO will establish a clear joint working relationship with DPs at both the national and state levels through the establishment of a coordination framework enjoining each to the spirit of "Three Ones". NACO would form with a select group of DPs (including the UN, DFID, USAID, and the World Bank) a Steering Committee for Donor Coordination to: (a) prevent duplication of DP efforts; (b) share information on action plans; and (c) review program performance during quarterly reviews. Besides this, all DPs providing support to NACP III are meeting regularly as a Thematic Group to coordinate their support.

34. DFID intends to pool its support to NACP III with IDA and GOI.

2. Institutional and Implementation Arrangements

31. While health is a state subject under the Indian Constitution, issues of national public health concern fall within the purview of the Centre. Therefore from its inception in 1992, the NACP has been a centrally sponsored scheme receiving 100% financing from GOI.

32. The NACP is managed by NACO which is an integral unit of the MOHFW. Under NACP III, NACO would consolidate the decentralized model of implementation established under the prior two phases and provide direction and stewardship to the national program, while institutionalizing coordination with partners within and outside government. NACO intends to constitute Technical Advisory Groups comprising of leading experts to provide guidance and review of the program's thematic areas. Coordination of the program with the NRHM will be facilitated by the NACP NRHM Coordination Committee (NNCC) headed by the Secretary, MOHFW.

33. NACO reports to the National AIDS Control Board (NACB) chaired by the Secretary, MOHFW, which also has oversight of activities carried out by partners whose programs do not pass through the national budget. In June 2005, the NCA was constituted under the chairmanship of the Prime Minister and with membership of 31 central ministers, six state chief ministers and civil society. This body will provide the highest political oversight and support to the implementation of the national HIV control framework especially to mainstream HIV control into the work of all organs of government, private sector and civil society and lead a multi-sector response to HIV/AIDS in the country. The states will establish State Councils on AIDS along the pattern of the NCA to be chaired by the Chief Minister and having the Minister of Health as Vice Chair.

34. Civil society partnership fora will be established at national, state and district level with membership of active civil society partners representing the various constituencies that are stakeholders in HIV control. Their inputs will be sought for planning purposes and during annual

program reviews. A wide range of stakeholders - public sector managers and service providers; private sector partners in the program, especially NGOs; other civil society groups, some businesses; researchers; international development partners - have been involved in project preparation in a variety of ways including 14 topic-based working groups, consultations with civil society and HIV-positive people, e-consultations, national and state-level meetings, and a social assessment. Many will continue to be involved in implementation, monitoring and evaluation. For example, NGOs and private sector agencies are widely involved in prevention and care, and support activities; public sector providers will be sensitized and trained to increase the reach of Integrated Counseling and Testing Centers (ICTC) and treatment facilities; and social marketing firms are integral to condom distribution under the program. Periodic consultations will be held with civil society organizations including women's groups, organizations of the socio-economically vulnerable, and organizations of HRG and PLHIV. The NACP is among the few governmental programs in India that are substantially implemented by non-governmental organizations, and in which 'public voice' is central. The social impacts of the project will be monitored within its overall monitoring framework and through special studies contracted from time to time.

35. Responsibilities and core functions at the national and state levels: In accordance with its stewardship role, NACO is responsible for: (a) setting the program framework and establishing accountability systems; (b) carrying out broad advocacy and social mobilization in support of normative behavior change; (c) establishing technical support capacities; (d) facilitating the mainstreaming of HIV control into the work of other ministries, the private sector and civil society; (e) instituting partnerships with significant stakeholders who are vested with capabilities for HIV control; (f) requiring and using regular monitoring, surveillance, and evaluations of NACP III at every level; (h) setting standards and putting in place a system to assure the quality of laboratory and treatment facilities; and (i) establishing robust, transparent and efficient systems for procurement of pharmaceuticals, medical supplies and equipment, goods, works and services. NACO is headed by an officer of the Indian Administrative Service at the level of Additional Secretary to the GOI. These functions will be distributed among four strengthened core units each led by a Joint Director/Director. In addition, NACO will establish a sub-office within the NRHM's North Eastern unit.

36. Implementation of HIV control activities vests primarily with the states. SACS, established under NACP II, are expected to assume a leadership role and coordinate the work of all partners in each state. In states where Municipal AIDS Control Societies or other societies have been established, their work plans would be subsumed under the overall workplan for the state. In a few states, SACS have been merged into an overarching State Health Society and in some, this may happen during the life of the project, however, characteristics of SACS will continue to be maintained. The SACS or State Health Society would be responsible for: (a) planning and implementing interventions with high risk, bridge and general populations; (b) undertaking state level advocacy, Information, Education and Communication (IEC), social mobilization and youth campaigns; (c) providing technical support to partners within and outside the health department in respect of program components; (d) supporting intersectoral collaboration with significant stakeholders; and (e) undertaking essential procurement as per the agreed procurement arrangement. SACS staffing decisions will be based on the size of the state

and disease burden. Similarly Technical Support Units (TSUs), established in response to problem size, will assist in the management of the TI programs with HRG.

37. A key feature of the effective implementation of HIV interventions with some of the most marginalised groups in society is the use of NGOs and CBOs. Guidelines on their involvement have been reviewed in detail during the formulation of NACP III and will be finalized after consultation with NGO partners presently providing services under the program.

38. With regards to the flow of funds at the GOI level, the project's funding requirements are budgeted within the budget of the MOHFW and the NACP III program will have a separate budget head operated by NACO. The annual budget of the project would be allocated as per national Program Implementation Plan (PIP) and take into account the actual pace of implementation. At the state level, the budget would be allocated to each state based on the approved state Annual Work Plan (AWP). The annual budget allocated to each state would be released only in two installments during the 1st and 3rd quarters of each fiscal year. Funds required to implement the Project will be released by NACO to the SACS. The SACS in turn would release necessary funds to various implementing units (NGOs, ICTCs, blood banks, district units, etc.) based either on contractual obligations (NGOs) or sanctioned amount for the specific activity. A shift to electronic transfer of funds (to begin with from GOI to states) will be instituted during program implementation by building on the experience in RCH II (see Annex 7 for further details).

3. Monitoring and Evaluation of Outcomes/Results

31. India has many of the elements of an effective monitoring and evaluation system. These elements need to be integrated into a cohesive and coherent national monitoring and evaluation system to assist with progress measurement, accountability, learning and planning.

32. During NACP III, India will strengthen: (a) the overall system; (b) program monitoring, which will be based on several sources: (i) health services will be tracked using data from the Health Management Information Systems and episodic health facility surveys; (ii) intervention coverage, particularly of HRG, will be assessed using coverage modules in behavioral surveys; and (iii) reporting forms and systems will be developed to track services provided outside the health sector; (c) surveillance, which will be strengthened in the following ways: (i) existing surveillance data from numerous sources, including ANC sentinel sites, Prevention of Parent to Child Transmission (PPTCT), blood donors, population-based surveys and targeted surveys, will be rigorously analyzed and synthesized; (ii) National Family Health Survey will undertake a national household bio-behavioral survey; (iii) ANC surveillance will be strengthened; and (iv) national integrated bio-behavioral surveillance (IBBS) of HRG will be undertaken at yearly intervals; (d) data analysis and use to improve policies and programs will receive major emphasis. Data from each of the above sources will be analyzed in an integrated manner, to produce a holistic understanding of India's HIV epidemic and responses. Important findings will be shared widely through numerous dissemination fora and used to strengthen national and state planning and programming; (e) financial tracking, financial monitoring and expenditure tracking will be used to monitor resource use and needs; and (f) procurement tracking for the physical and financial progress of the contracts issued; and (g) essential research. In addition to surveillance,

essential research will be commissioned to better understand HIV incidence, risk factors, HIV transmission dynamics and intervention effectiveness.

33. The intention of the proposed framework is to move from a traditional "monitoring and evaluation" system to a strategic information management approach. The system will produce a clearly defined set of products on a quarterly, annual or periodic basis to allow information to be used strategically.

34. It is expected that progress could be tracked using an approach that recognizes the implementation plans of the program both in terms of their ability to cover sufficiently large sections of the HRG, as well as their ability to influence outcome indicators over time. Thus it is proposed that IDA would apply a "ladder approach" to incrementally measure program progress, outputs and outcomes over the period of support. The achievement of these measures could also provide confidence in assessing the ability of the program to absorb funds. See Annex 3 for further details on the "ladder".

35. **Supervision:** The infrastructure and systems put in place by GOI will be used to measure the actual performance of states and NACO and the program's achievements. The tools produced by the system - monthly program reports, quarterly dashboard (see Annex 3), annual state of the epidemic report, external program evaluations, and periodic published reports - have been developed to measure improvements in the performance of SACS and NACO. The Bank will use a subset of data from this system to track progress of the program (see Annex 3). NACO and pooling DPs will carry out joint annual performance reviews of the program. A Steering Committee for Donor Coordination will be formed by NACO at the national level and this group will meet quarterly for program review. A similar forum will be formed in the states and will be convened by the SACS. The Bank and DFID will carry out semi-annual review missions to monitor and support program implementation.

36. The project will require extra supervision in the initial year especially for ensuring successful implementation of the state level financial management and fund flow arrangements. A mid-term review would be conducted after two and a half years of the project to comprehensively review the overall performance of the project in achieving its targets and maintaining strong fiduciary mechanisms, and the requirement for additional financing (see Annex 5).

4. Sustainability

37. Political sustainability: GOI has demonstrated significant commitment to containing the HIV epidemic through the establishment of NACP in 1986 and its continued actions, funded through its own budget and international funds. The program has formed an integral part of successive five year plans, including the ongoing 10^{th} five year plan. In June 2005, GOI established the NCA under the chairmanship of the Prime Minister (see paragraph 2 on "Institutional and Implementation Arrangements" for further details). With a few states in India now showing stabilization of HIV prevalence rates, India is set to scale-up its control efforts throughout the country by leveraging the important experiences it has gained.

38. Institutional sustainability: While NACP II focused on targeted interventions for high risk marginalized groups, the third phase of the program seeks to maintain this focus while also mainstreaming and scaling up a number of HIV control activities in the health department's routine activities (see paragraph 2 on "Institutional and Implementation Arrangements" for further details). Further, NACP III also proposes to partner with private sector players in important areas such as testing and counseling services, Sexually Transmitted disease (STD) services and continued provision of TI, and establishing systems that support quality services made available through them. The repositioning of the SACS as the nodal agency for all HIV/AIDS activities in the state and the operationalization of the "Three Ones" principle will ensure greater institutional stability in the program.

39. Financial sustainability. See Section D.1 "Economic and Financial Analyses"

5. Critical Risks and Possible Controversial Aspects

Risk	Risk Mitigation Measure	Risk Rating
To project's development objective		
Decline in political commitment	▯ Agreed National Strategic Framework and Program Implementation Plan ▯ Prime Minister chairing NCA ▯ Involvement of NGOs, PLHIV networks and civil society in the NCA	L
Pressure to shift focus toward treatment services at the cost of prevention	▯ National Strategic Framework and Program Implementation Plan agreed between GOI, state governments and partners ▯ Use of common Monitoring and Evaluation (M&E) systems to determine project focus and results ▯ Project would finance broad social mobilization and informed advocacy with significant pressure groups to keep focus on prevention agenda	M
Scaled up targeted interventions not effective in modifying behavior sufficiently to halt and reverse the epidemic	▯ Performance based monitoring of non-government sector delivered behavior change strategy will be put in place ▯ Supervision of TI programs will be decentralized to dedicated support units at state level with appropriate oversight by peer based organizations ▯ Operational research for best practice models	M
To project's outputs		
Managerial capacity and/or staffing not expanded and upgraded to deliver project outputs	▯ Significant capacity building is proposed to strengthen the system to deliver and supervise activities ▯ Institutional framework of HIV control program being revised and upgraded to reflect the new roles necessary for intended outputs	M

Risk	Risk Mitigation Measure	Risk Rating
Linkages to ongoing GOI programs e.g., NRHM, Revised National TB Control Program not fully established	▯ Program implementation plan sufficiently recognizes the need to integrate medical services with ongoing public sector service delivery as well as interventions with the private sector as necessary ▯ Implementation plan to take this into account in order to ensure accountability for these program components so that it is adequately integrated into the M&E systems ▯ Convergence of various disease-specific health programs and RCH under the NRHM	M
Mainstreaming and partnerships not fully developed	▯ Agreed National Strategic Framework is taken as the basis for the work by the NCA ▯ Special institutional arrangements established within NACO to engage with, support and monitor mainstreaming and partnership development activities during program period ▯ Maintaining strong DP coordination mechanisms	L
Monitoring and evaluation not used as a basis of programming decisions	▯ Quarterly dashboard will be used to track data on key indicators in a regular manner; annual indicator to measure whether states are submitting their dashboards to NACO in a timely manner ▯ Behavioral Surveillance Survey (BSS) at the state level on an annual basis ▯ Special research studies and external evaluations will be commissioned during the project to generate new research for programming decisions. Results will be widely disseminated to the appropriate audiences	M
Procurement and financial management show weakness	▯ Capacity building of program staff at central and state levels to manage these functions effectively ▯ Supervision of these functions to be integral to the M&E system which would be used for evidence based programming ▯ Strengthened contracting arrangements for contracts with private sector, including NGOs and CBOs. ▯ Agreement on a GAAP which would be supervised closely as part of program supervision during Joint Review Missions ▯ Procurement and financial management carried out in accordance with strict fiduciary arrangements (see Annexes 7 and 8)	S
Overall risks		M

Risk Rating: L (Low or Negligible); S (Substantial); M (Modest)

6. Credit Conditions and Covenants

- GOI shall cause the MOHFW to ensure that each project state and State Implementing Agency carry out their respective activities under the project in accordance with a LOU satisfactory to IDA to be signed by each project state and its respective State Implementing Agency (SIA), i.e., expenditures from a given state would not be eligible for reimbursement unless the corresponding LOU has been signed.
- The GOI shall cause the MOHFW to ensure adequate management capacity in NACO, to review the number and composition of staff and requirements for technical assistance annually; to revise the staffing norms and composition if found necessary during the mid-term review; to strengthen and maintain a financial management unit and a procurement supply and logistics unit within NACO and maintain these units throughout project implementation; to maintain a unified strategic information monitoring unit which reports on activities and outcomes of all partners of NACP III and ensure timely reports in an agreed format satisfactory to IDA for the six monthly review missions.
- The GOI, through MOHFW, shall cause NACO to implement the financial management reform.
- NACO shall establish a system of management audit as per TOR satisfactory to the Association within three months of effectiveness of the project.
- NACO will upgrade its computerized program management system and maintain and support the system during implementation of the project.
- The GOI shall cause audits of various project executing agencies to be conducted in a timely manner in accordance with the terms of reference set out in the Financial Management Manual and in the Procurement Manual for NACP III.
- The GOI shall cause MOHFW to ensure that all NGOs/CBOs with whom NACO shall enter into a contractual arrangement for provision of targeted interventions, testing and counseling services, STI and OI diagnosis and treatment and ART provision are regularly supervised and outputs monitored and that this information is used to form the basis of their continuation of contract.
- The GOI shall cause the MOHFW and the project states to implement, in a manner satisfactory to IDA, the Tribal Action Plan and the interventions targeted towards other socially deprived groups set forth therein, as well as the agreed Infection Control and Waste Management Plan, and ensure that relevant manuals and guidelines are at all times consistently and satisfactorily applied.
- The GOI, throughout the duration of the program, shall cause the executing agencies to implement the GAAP, refrain from taking any action which shall prevent or interfere with the implementation of the Plan, not waive, amend or abrogate the Plan and, provide a written report on progress achieved in the implementation of the Plan semi-annually.

D. APPRAISAL SUMMARY

1. Economic and Financial Analyses

40. The AIDS epidemic generates significant externalities, and therefore necessitates public intervention regarding policy and allocation of resources. The focus of NACP III on targeted interventions for the high-risk groups and "bridge" populations will mitigate these externalities

to a large extent. AIDS also causes significant loss of income. This ranges from 10 percent of household income where PLHIV is still working, to 66 percent in the case of incapacitation due to HIV/AIDS.[3] Public expenditure on mitigating the costs of care and treatment is justified especially for disadvantaged or discriminated-against high-risk groups, and given the unusually large burden that HIV/AIDS poses on households. NACP III therefore incorporates both externality and equity considerations in the design of the program, in line with the recommendations of the World Bank OED Report on improving the effectiveness of HIV/AIDS assistance.[4]

41. Increasing the efficiency and coverage of targeted interventions will help prevent new infections that will reduce the long-run cost to the health system and mitigate income loss for the general population. Achieving NACP III prevention objective would reduce the number of PLHIV by 0.94 million at the end of the project period as compared to continuing with NACP II strategy.[5] As per the proposed NACP III budget, the cost per infection prevented is around US$500. In comparison, the average cost of ART is $250 per PLHIV per year for medication alone, or US$1250 over the five years of the program. The focus on preventing new infections through TIs is a cost-effective strategy especially considering the proposed scale-up of ART, both in the medium and long term.[6]

42. Given the threat of the epidemic to India, the proposed scale-up of NACP III is justified in order to reduce long-run costs to the economy and the country's development. Assuming that GOI's share covers 30 percent of total program cost of about US$2.5 billion, there is a need to mobilize considerable resources from external sources – institutional, private foundations, international NGOs etc. Therefore, bridging any resource gap by domestic (both government and private sector contribution) and external donor agencies would be critical for the success of the program. Financing plans shared with IDA indicate that such a gap exists at the present time, and GOI proposes to seek additional DP support. However, if such support is not received and the achievement of program objectives becomes critically dependent on additional financing, GOI may approach the Bank for such funding. The Bank would consider supplemental financing (in the region of US$250 million) only when satisfied that implementation of the project, including disbursement and substantial compliance with loan covenants, is satisfactory. Performance would be measured in terms of program and financial/disbursement indicators. Further details of project financing can be found in Annex 5.

2. Technical

43. The HIV/AIDS epidemic in India remains highly concentrated in key populations at higher risk of infection. Therefore, priority given to prevention efforts and increase of coverage

[3] Socio-economic Impact of HIV/AIDS in India. NACO-NCAER-UNDP Study, 2006.
[4] Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance. Operations Evaluation Department, World Bank, 2005.
[5] Rao, Kurien and Sudhakar, Modelling HIV Epidemic in India, Background Paper for NACP III. July 19, 2006 version.
[6] Mead Over et.al., Integrating HIV prevention and anti-retroviral therapy in India: Costs and Consequences of Policy Options. 2004

of these groups with high quality targeted interventions in NACP III is appropriate.[7] Since the virus penetrates only slowly from these groups into the general population, the rising prevalence in both rural and female populations is worrying. The epidemic is also clustered in certain geographical areas.

44. It is appreciated that NACP III is broadening the scope of the fight by including issues such as the rights of the affected groups; that it looks at the enabling environment of the planned interventions; and that it focuses on mainstreaming of efforts through multiple ministries, including the MOHFW, and partnerships with civil society including PLHIV, and the private sector. Individuals' vulnerability to HIV and the extent to which they are affected will depend on a variety of social, cultural and economic constructs. The ability for anyone to protect him or herself from infection is influenced by the ability to negotiate safer sexual practice and access appropriate information, services and commodities. The expected outcomes of NACP III will not be reached if individuals are to live in an environment where power dynamics, gender imbalance, poverty, harmful traditions and discriminatory legal frameworks and practices reinforce vulnerability. Therefore, this National Strategic Framework for Action assumes that the underlying constructs of vulnerability will be challenged and changed through the implementation of the strategies laid out in the document, moving from criminalization to regulation of Commercial Sex Workers (CSW) and MSM. Providing more attention for care and treatment is also appropriate and several treatment options are now well within the means of the Government.

3. Fiduciary

45. Financial Management: The project has a financial management system that is adequate to account for and report on project expenditures in a timely manner as well as satisfying the fiduciary requirements of IDA.This is a follow on project from NACP II, under which a Computerized Program Management System (CPMS) was developed and successfully implemented. In addition, uniform accounting policies and financial reporting (internal and external) by project components were achieved during implementation. However the financial management arrangements (staffing, accounting internal control processes etc) did not keep pace with the increased resource allocation and increasing number of sources of funding, leading to parallel systems and procedures for various development partners.

46. Accordingly an independent assessment of the effectiveness of the financial management arrangements under NACP II and the modifications required in response to: (i) the growth of the program; (ii) changes envisaged in the institutional arrangements such as creation of District AIDS Program Control Units (DAPCU); and (iii) change in the nature of interventions, was carried out by NACO as part of the preparation of NACP III.

47. Based on the study's recommendations NACO has taken the following actions: (i) initiated action to award a contract for upgrading the CPMS and aligning the chart of accounts and financial reports in line with the new interventions; (ii) updated the financial management manual incorporating the annual work plan requirements/ timelines, good practices identified in

[7] Successful prevention efforts amongst high risk groups will cause a decrease in HIV incidence, while infections and AIDS cases amongst the general population will increase *as a proportion* of all infections and AIDS cases.

the assessment and the process of selection of external audit firms by the SACS and incorporating financial management aspects in the manual for NGO/CBO selection and monitoring; (iii) contracted additional finance consultants in NACO and proposal to strengthen the finance function in identified large states and TSU responsible for NGO/CBOs; and (iv) instituted a system of management audit with specific TOR. In addition, NACO developed a financial management improvement plan with timelines which focuses on further enhancing the systems and processes such as regular training of finance staff, electronic transfer of funds etc

48. The external audit will be carried out by the Comptroller and Auditor General (C&AG) for expenditures at NACO and by independent firms of chartered accounts at the SACS level. This will be based on TOR approved by the Bank and consented to by the C&AG.

49. Public Disclosure & Transparency: With greater functional autonomy and delegation to the SACS it is important to build mechanisms whereby the financial (audited financial statements) and physical performances and shortfalls, if any, are reported and made available in the public domain. The annual program report will be prepared at the individual SACS level and also at the overall program level and made available on the websites of NACO and the SACS. This is also in line with the Output Budgeting and Right to Information Act of the Govt of India.

50. The disbursement arrangements and the detailed financial management arrangements are given in Annex 7.

51. Procurement: NACP III would involve the procurement of minor civil works, pharmaceuticals, goods, equipment, services and other miscellaneous items to be procured by NACO and SIS levels. A review (funded by DFID) of existing procurement policies and procedures was carried out through a consulting firm in respect of NACO and a sample of SIS to identify areas for strengthening, to allow their use for procurement under the program. Based on the findings of the national and state level procurement assessments, and the irregularities observed in RCH I, the procurement risk is considered to be *High*.

52. The issues relating to improving Good Manufacturing Practice (GMP) certification process, increasing competition and mitigating collusion, strengthening procurement implementation including supply chain management and contract monitoring, handling procurement complaints, and disclosing information have been discussed with NACO and MOHFW at a senior level, which along with the agreements reached on proposed actions, are summarized in the GAAP. The GAAP shall be further strengthened based on the risks identified and the recommendations of the ongoing DIR, the procurement review by international consultants supporting Empowered Procurement Wing (EPW) of the MOHFW, and the report on the assessment of quality and quantity of pharmaceuticals and medical goods/supplies under Bank supported health sector projects.

53. Until such time that the capacities of the EPW, NACO and SIS are strengthened satisfactorily to pooling partners, all ICB/LIB procurement, the NCB contracts estimated to cost more than US$100,000 for goods and works, Consultancy services contracts for firms estimated to cost more than US$150,000, and individual consultants costing more than US$50,000 will be carried out by a qualified procurement agent or through a UN agency hired to do so. In this

regard, the MOHFW is in advanced stage of negotiations with UNOPS to act as procurement agent for central health sector projects including NACP III. NACO/SIS may also procure pharmaceuticals and medical supplies directly from UN agencies with the Bank's prior approval. The procurement agent (commercial or UN agency acting as procurement agent) will follow the World Bank Guidelines dated May 2004 and other procurement arrangements agreed for the project. For the interim period (until the procurement agent is appointed and becomes operational), EPW will be allowed to handle the urgent procurement under an oversight arrangement satisfactory to the pooling partners.

54. NACO has traditionally been procuring services without involving PSAs, and has developed in-house capacity for handling service procurement. These services include IEC, specialized studies and training activities, operational and epidemiological research and other services. NACO has also provided assurances that a dedicated procurement staff/consultant will be recruited by March 31, 2007 to handle procurement of services. Based on these factors, NACO has been permitted to handle the procurement of services on its own, without the involvement of either EPW or the procurement agent. However this arrangement will be reviewed once the results of DIR are available.

55. NACO, in consultation with the pooling partners, has prepared a procurement manual for guidance of the procuring agencies at all levels under the project. Goods and works contracts above US$100,000 and consulting services above US$50,000 will follow the World Bank's procurement/consultant guidelines respectively. All other methods will follow the procedures as per the NACO Procurement Manual for NACP III.

56. Condoms for NACP III will continue to be procured by MOHFW under existing arrangements and will be financed by Government of India outside the pool. NACO will however set-up an arrangement satisfactory to the pooling partners regarding timely delivery and quality assurance of condom supplies. The entire procurement for Care, Support and Treatment is likely to be funded by GFATM outside the pooling arrangement.

57. The pooling partners will support procurement of pharmaceuticals and medical supplies through NCB, shopping and direct contracting only after concerns regarding revised Schedule M have been addressed in a way that is satisfactory to the Bank and the recommendations of the detailed implementation review (DIR) of the health sector projects are incorporated in to the GAAP. The exception to this will be the small procurement of pharmaceuticals and medical supplies by NGO/CBO under the Targeted Interventions and Care, Support, Treatment (TI and CST) service contracts issued to them by SIS, with a maximum value of USD 75,000 per year, subject to an aggregate of USD 150,000. Under such contracts procurement of pharmaceuticals and medical supplies manufactured by WHO GMP-certified manufacturers (as per the list available on MOHFW website) shall be allowed up to 5% of the value of the TI and CST service contract or USD 3500 per annum, whichever is higher**.** However this arrangement will be reviewed once the results of DIR are available.

58. All contracts below prior review threshold procured will be subject to periodic post review on sample basis. A multi-stage stratified random sampling is proposed for the periodic post reviews. For states, this sampling takes in to consideration the potential risk as well as

volume of procurement. Monitoring the implementation of the GAAP would be an integral part of the project review and supervision plan. In addition to regular monitoring and prior reviews, the designated procurement specialist will be participating in the six monthly review missions.

59. NACO will ensure that the key procurement related posts as identified in proposed organograms for NACO are filled up by October 31, 2007 in addition to the dedicated procurement staff/consultant for handling the service contracts who will be in place by March 31, 2007. SIS will be required to fill up the key procurement related posts by October 31, 2007.

60. Detailed procurement arrangements for the project are described in Annex 8.

4. Social

61. In the socio-cultural and political contexts of India, the project presents a number of important opportunities, constraints, potential impacts and risks. The key opportunity is to address current inequities in access to information and condoms to prevent HIV infection, and in treatment, care and support of those infected. The inequities are related to geographical location and socio-economic status, including income levels, literacy and gender. As the NACP has been largely urban based to date, residents of rural and tribal areas have had less access to services (except in a few areas of the country). However, during this third phase of the program it will expand into these areas, thus increasing the likelihood of benefits to rural and tribal people. However, the ability to address these inequities is constrained *inter alia* by the lack of infrastructure (e.g., health centers, roads, NGOs) in under-developed areas, and by social barriers to providing information and influencing attitudes and behaviors related to sex and use of health care.

62. The project proposes to address these constraints directly by expanding communications and services in difficult areas and to people who come into contact with the high risk and bridge groups. It will achieve this through a better communications strategy, increasing the number of non-governmental partners, sensitizing public service providers and planners, social marketing, and other means. These activities would also address the important social issues of stigma and discrimination. The main risks are that: (a) all these means together may not be adequate to safeguard a population the size of India's from continued transmission of infection; and (b) social barriers may prove intractable as overcoming them involves changing the power dynamics related to sex (and drug use), i.e., that between males and females, rich and poor, informed-unaware, provider-client, young-old, and so on.

5. Environment

63. The proposed project has been classified as category B for environmental screening purposes, given the risks associated with the handling and disposal of infectious wastes resulting from AIDS related preventative and treatment activities. Such wastes are sharps (infected needles and syringes, surgical equipment, IV sets) infected blood, HIV test kits used in VCT

centers, blood banks and laboratories and pharmaceutical wastes. Proper management of such wastes is integral to prevention of further infection and control of the epidemic.

64. An Infection Control and Waste Management (IC-WM) Plan has been developed by NACO which focuses on the establishment of a sound management system for the treatment and disposal of the waste related to the treatment and prevention of HIV/AIDS and STI and includes generic guidance and protocols and alternative technologies for treatment, transportation and disposal in accordance with the size of healthcare facilities. The IC-WM Plan includes an Addendum which details national building rules and regulations related to construction, site selection, facility design and waste management. The IC-WM Plan was discussed at a stakeholder consultation workshop and after finalization was disclosed in-country and through the Bank's InfoShop.

65. NACO plans only minor civil works under NACP III, such as rehabilitation and remodeling of existing buildings. The Infection Control and Waste Management Plan includes guidelines and instructions to mitigate adverse environmental impacts from the proposed minor construction activities. The Plan also mentions the steps NACO will need to take if major construction is planned in the future.

6. Safeguard Policies

66. This project has triggered OP 4.01 Environmental Assessment due to the potential negative environmental impacts of healthcare waste as discussed in the previous section. The safeguard screening category is S2. An environmental assessment was undertaken in a sample selection of 33 facilities in three states, which included field visits and consultations. The key findings were that SACS run facilities had high levels of awareness regarding infection control and universal precautions practices but were dependent on conditions in their host facilities. The IC-WM Plan addresses these issues and also provides guidance on mainstreaming integration of environmental and infection control activities in various health programs. NACO and the SACS may not have the necessary institutional capacity to implement the IC-WM Plan and would need to obtain appropriate support for components such as training, IEC and monitoring. An external independent evaluation is recommended before the mid term review of the program to ensure all activities are on track.

67. The project triggers the Indigenous Peoples' safeguard as there is the 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 STIs among tribal people; (b) high vulnerability in areas where they come into frequent contact with non-tribal populations, especially among migrant groups; and (c) low access to health facilities and high recourse to faith healers and unqualified health practitioners. These and other findings have been addressed through a Tribal Action Plan for the program (see Annex 11) which includes actions to improve: (i) participation of tribal people in program design, implementation and monitoring; (ii) program planning (especially at the district level) to ensure 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 to further increase understanding of needs, constraints and opportunities relevant to HIV/AIDS.

68. NACO and the SACS currently have limited capacity to implement the tribal action plan. Capacity will be built 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.

69. The social assessment involved consultations at the field level in a sample of districts and states across the country. Tribal people, NGOs 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 program'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. The final version, revised in keeping with comments received through the website, consultation and reviewers, was sent to the World Bank InfoShop in November 2006 and reposted on the website.

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

7. Policy Exceptions and Readiness

70. There is no policy exception required for the program support. Safeguard clearances have been obtained. The program is ready for implementation as evidenced by the following: (a) the NACP III Program Implementation Plan has been prepared and found to be of sound quality; (b) the procurement plans for ICB contracts have been developed and shared with IDA; (c) the IC-WM Plan have been finalized, cleared with IDA and disclosed to the public by the Borrower; (d) adequate allocations for the program have been included in GOI's budget for 2006/07; and (e) indicators for results monitoring have been specified and will be collected routinely.

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

Annex 1: Country and Sector or Program Background
Third National HIV/AIDS Control Project

With a population of over 1100 million people, India is a country of great diversity and sub-cultures which have an important bearing on the AIDS epidemic that it presently faces. The first case of HIV infection in India was detected in 1986 in Chennai, Tamil Nadu. India is today home to the largest number of HIV infected persons (approximately 5.7 million) and the second largest number of adults (approximately 5.2 million) living with HIV infection in the world.

India is experiencing a significant, complex and heterogeneous HIV/AIDS epidemic. Within the country, the epidemic has important regional variations. Six states, representing 30% of India's population have a high prevalence of HIV according to UNAIDS standards (>1% in ANC attendees and >5% in HRG). Three additional states have been characterized as moderate prevalence states (HIV prevalence is >5% in the HRG, but <1% in the ANC population) but have high prevalence in several districts. 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.

However in all these states, HIV infection remains largely concentrated in population groups routinely practicing high risk behavior, i.e., IDUs, MSM and CSW - male, transgender and female. In some North Eastern states, sharing needles among seems to be the main risk factor, while in the Southern states sexual transmission is the main factor. Further, certain population groups likely to have frequent interaction with these groups have likewise been identified, and hence act as a "bridge" between these and the population-at-large. These are the truckers and transport community, and the migrant workers' community. Further it is recognized that youth, more generally, are also at risk. If HIV continues to spread widely among those with high risk behaviors and their immediate sexual partners, several million new infections will result.

The country has displayed commitment at the highest level and the national leadership has repeatedly emphasized the need to respond to the threat posed to public health by the HIV/AIDS epidemic. Following the identification of the first few cases, a National AIDS Committee was set up to carry out national surveillance to track the course of the epidemic. In 1990 a Medium Term Plan was launched focus on the drivers of the evolving epidemic. Subsequently, the GOI, in association with IDA and the World Health Organization (WHO) began the National AIDS Control Project in 1992 focusing on blood safety issues and the establishment of an autonomous NACO among other areas. NACP II, which began in 1997, broadened the response and was successful in the creation of SACS, which allowed for more decentralized planning and implementation including through the establishment of a Central Management Information System (CMIS) and a fully functional CPMS. Another major achievement was the setting up of an HIV Sentinel Surveillance with 670 sites and behavioral sentinel surveillance system, but which is probably the best in the developing world and has the largest coverage in the world. The NACP II has led to developing national and state level capacity in government, private sector, NGOs, communities and PLHIV. Targeted Interventions involving over 1,000 NGOs, national coverage of the Blood Safety Program, establishment of 848 Voluntary Counseling and Testing Centers (VCTC), a successful PPTCT program through 312 centers, upgrading of 845 STD

clinics, a successful condom promotion program including social marketing, establishment of 135 Community Care Centers and drop-in centers, and ART made available through 75 centers are other significant achievements. While the current stage of the epidemic raises formidable challenges, India has the commitment and capacity to mount an effective response.

The response to the epidemic varies across India. In many parts, prevention efforts to reduce HIV prevalence among groups with high risk behavior seem not yet fully effective and coverage, especially for MSM, is low. As a result an increasing number of monogamous women, including in rural areas, have become HIV positive. In other areas, such as Tamil Nadu, prevention efforts have borne fruit and HIV prevalence rates in the general population and in several of the HRG are on the decline.

NACP III aims to shift from project to program mode, using principles of the sector-wide approach. NACO will change its role from implementation agency to a program catalyst/steward of the program, while implementation responsibilities will be consolidated at the SACS. This will require an organizational restructuring (NACO & SACS) and capacity building at all levels for a strengthened state and district level response, including planning exercises which reflect programs and resources of all international and local development partners. Local planning will be evidence based and the monitoring of implementation will focus on results. Prevention efforts through TI of HRG will continue to have the highest priority. HIV interventions will be mainstreamed into sectoral programs and partnerships including the private sector, and will be further expanded. NACP III will have an increased focus on vulnerable and North Eastern states, and there will be more attention for adolescents, youth and women. Prevention efforts will also be better integrated with care, support and treatment.

NACO has undertaken the preparation of NACP III through an intensive participatory process which involved wide-ranging consultations with other government departments and various sections of society. To do this, NACO put together a planning team to orchestrate a process for preparation of the Strategic Framework which included: meetings of 14 Working groups; an e-consultation; a civil society consultation; consultation with positive people; two state level and one national level “Three Ones” consultations; and state level meetings. Fourteen working groups met to discuss key evidence and strategies for 14 thematic areas; representatives of government, and national and international development partners participated actively in the groups. Specific studies and critical assessments were commissioned and results used in developing the PIP along with the reports of five assessments related to procurement, financial management, social aspects, and the environment (see Annex 16 for a full listing). An e-consultation was organized with the assistance of UN Solutions Exchange to which over 800 people subscribed and hundreds of reactions/comments were received. The site is, until today, a very lively forum for discussion. In addition to these initiatives, a consultation with civil society was undertaken which led to further cooptation of civil society in the development and implementation of NACP III. Reports are available summarizing these consultations.

By seeking the participation of the people-at-large in the design of the program, the government is setting an example and a new standard for other sectors. We expect that this greater involvement will be carried throughout implementation and evaluation of the program.

There are also clear signs that at the highest level of government, political support for the fight against HIV/AIDS is increasing. The Prime Minister in his Independence Day address urged the people to initiate a mass movement to check and arrest the spread of HIV on a war footing. The Common Minimum Programme established by the present government makes special mention of their leadership in the response to HIV/AIDS. An NCA has been formed, presided over by the Prime Minister, and the Council will mainstream HIV control into the work of all organs of government, private sector and civil society and lead a multisector response to HIV/AIDS in the country.

Annex 2: Major Related Projects Financed by IDA and/or other Agencies
Third National HIV/AIDS Control Project

Sector: Health, Nutrition and Population	Project	Cr. No.	PSR/OED Ratings (IDA-financed projects only) As of April 1, 2006		
			Implementation Progress (IP)	Development Objective	OED Rating
IDA-financed *Ongoing*	Uttar Pradesh Health Systems	3338	MU	MU	
	Uttaranchal Health Systems	3338	S	S	
	Food and Drugs Capacity Building	3777	S	S	
	Rajasthan Health Systems	3867	MU	MS	
	Integrated Disease Surveillance	3952	MS	MS	
	Tamil Nadu Health	4018	MS	S	
	Reproductive & Child Health Project II	4227	S	S	
	Second National Tuberculosis Control	4228	S	S	
	Karnataka Health System Development and Reform	4229	S	S	
IDA-financed *Closed*	Immunization Strengthening	3340	MS	MS	
	Second National Leprosy Elimination	3482	S	S	
	2nd HIV/AIDS	3242	S	S	
	Maharashtra Health Systems	3149	MS	MS	
	Orissa Health Systems	N017	MS	MS	
	Tuberculosis Control	2936	S	S	
	Malaria Control	2964	S	S	
	Woman and Child Development	N042	MS	MS	
	State Health Systems II	2833	S	S	
	Population VIII	2394			S
	Population IX	2630			S
	National AIDS Control	2350			S
	AP First Referral	2663			S
	Cataract Blindness	2611			S
	ICDS II	9977			HS
	Reproductive and Child Health I	N-018			S
	APERP (Andhra Pradesh Economic Restructuring Program)				
	-Primary Health Component	3103	S	S	
	-Nutrition Component	3103	S	S	
GFATM	Grant support in selected states				
USAID, AUSAID, DFID and other donor supported projects	Grant support in selected states as well as national				

Annex 3: Results Framework and Monitoring
Third National HIV/AIDS Control Project

Results Framework

Project Development Objective	Project Outcome Indicators	Use of Project Outcome Information
Safer sexual and injecting practices in order to contribute to the national goal of reduced HIV transmission	Percentage of FSW who report using a condom with their most recent client Percentage of MSW who report using a condom with their most recent client Percentage of IDUs who have adopted behaviors that reduce the transmission of HIV (defined as: who avoid both sharing injecting equipment during the last month AND who report using a condom with their most recent sexual partner)	Assess risk reduction Review and strengthen IEC and TI in order to achieve safer sexual and injecting practices
Increased care, support and treatment for PLHIV	Number of people with advanced HIV infection receiving anti-retroviral combination therapy	Assess and improve progress of treatment program
Intermediate Outcomes	**Intermediate Outcome Indicators**	**Use of Intermediate Outcome Monitoring**
New infections in HRG and vulnerable populations prevented	Percentage of FSW reached through TI in the last 12 months Percentage of IDUs reached through TI in the last 12 months Percentage of MSW reached through TI in the last 12 months Number of TI implemented by target group	Assess coverage Review and strengthen program reach Assess scale-up of TI
The infrastructure, systems and human resources in prevention and treatment programs at the district, state and national levels strengthened	Percentage of SACS who achieve at least 80% of planned expenditure targets	Assess and improve program expenditure

Intermediate Outcomes	Intermediate Outcome Indicators	Use of Intermediate Outcome Monitoring
Strategic Information Monitoring and Evaluation Systems enhanced	Percentage of districts which have done high risk mapping Percentage of SACS that submit their most recent dashboards to NACO on time Percentage of relevant[8] districts which have mapped HRGs in tribal areas and developed Tribal Action Plans.	Assess decentralization of key element of strategic information for intervention planning

[8] i.e. in designated tribal districts with ITDAs.

Arrangements for Results Monitoring

	Data Collection and Reporting					
Project Outcome Indicators	**Baseline Yr 0**	**Mid-term Yr 3**	**End Yr 5**	**Frequency and Reports**	**Data Collection Instruments**	**Responsibility for Data Collection**
Project Development Objective						
Percentage of FSW who report using a condom with their most recent client	50%	70%	80%	Tri-annual analysis of BSS reports, annual CMIS reports and special evaluation studies	National and local BSS and special studies	NACO
Percentage of MSW who report using a condom with their most recent client	20%	40%	60%	Tri-annual analysis of BSS reports, annual CMIS reports and special evaluation studies	National and local BSS and special studies	NACO
Percentage of IDUs who have adopted behaviours that reduce transmission of HIV, that is who avoid both sharing injecting equipment during the last month AND who report using a condom with their most recent sexual partner	30%	50%	70%	Tri-annual analysis of BSS reports, annual CMIS reports and special evaluation studies	National and local BSS and special studies	NACO
Number of people with advanced HIV infection receiving antiretroviral combination therapy	42,000	230,000	340,000	Annual analysis of antiretroviral program records	CMIS ART patient tracking records	NACO
Intermediate Outcome Indicators						
Percentage of FSW reached through TI in the last 12 months	20%	30%	60%	Tri-annual analysis of BSS reports, annual CMIS reports and special evaluation studies	National and local BSS and special studies	NACO
Number of TI implemented by target group	1,000	2,000	2,100	Annual analysis of CMIS reports	CMIS	NACO
Percentage of SACS who achieve at least 80% of planned expenditure targets	__	50%	80%	Annual analysis of CMIS reports	CMIS	NACO
Percentage of districts which have done high risk mapping	__	50%	80%	Annual analysis of CMIS reports	CMIS	NACO
Percentage of SACS that submit their most recent dashboards to NACO on time	__	50%	80%	Annual analysis of CMIS reports	CMIS	NACO
Percentage of relevant districts which have mapped HRGs in tribal areas and developed Tribal Action Plans.		85%	100%	Annual analysis of CMIS reports	CMIS	NACO

The GOI proposes a significant strengthening and rationalization of the M&E systems that service the project in order to make them more user friendly on the one hand, and more product oriented on the other. The SIMU which will have units at the national and state levels, will maximize the effectiveness of available information and implement evidence based planning. In addition, all program officers will be trained on evidence based strategic planning methodologies, information use, and program management.

Thus the program would have a strengthened monitoring framework to provide more accessible and ready-to-use information across program content and management functions; enhanced surveillance systems to provide HIV related epidemiological, clinical and behavioral data at a state and sub-state level; and independent evaluation and research to inform and support program implementation. A number of reports will be produced by the system which support the various functions of the program and can be summarized as follows:

Strategic Information Management Tools to be Utilized in NACP III

Product/Tool	Levels	Purpose/Audience	Sources of information
Program Reports (Monthly/Quarterly)	National State District	Program management of specific areas e.g., ART, blood safety for program managers at the national, state and district levels	CMIS
Dashboard (Quarterly)	National State	Used by NACB to monitor NACO & NACO to monitor SACS Management tool for NACO and partners	CMIS State dashboards
State of the Epidemic and Response (Annual)	National State	Strategic management and accountability tool for NCA, NACB, NACO, SACS, partners, GOI, public and DPs ▯ Planning ▯ Monitoring ▯ Accountability ▯ Quality ▯ Dissemination	CMIS Surveillance Special surveys Research CPMS
External Program Evaluation Reports (Mid-term; End of Program)	National State and District	Measurement of progress against objectives for NCA, NACB, NACO, SACS and DPs	Annual reports, special surveys, evaluation process
Published Research/ Other Reports (Periodic)	Any	NACO, SACS, partners, wider audience	Research studies Surveys

During NACP III, monthly and quarterly program routine reporting will be captured by the CMIS which will comprise a set of input and output information. While this will provide useful inputs for program managers at the facility and district level, it may be somewhat too detailed for

management review on a quarterly basis. Hence a "dashboard" of crucial information will be distilled from these reports to provide a set of largely process and hence operational indicators. These indicators will act as reference points to inform managers whether the program is on course and will provide early warnings of weaknesses or failing processes. NACO will use the "dashboard" as its key tool for program management at the national and state levels. The NACB which is tasked with meeting quarterly to oversee program management of NACO will use national level "dashboard" as its tool, and NACO will use state "dashboards" to track and monitor performance of SACS.

Dashboard for NACP III for SACS Performance Monitoring

Indicator	Target
Number of TIs (by category)	
Percentage of TIs reporting condom stock out in last quarter	
Number of ICTC clients tested and receiving result	
Number of HIV+ pregnant women (mother and baby) receiving a complete course of ART prophylaxis	
Percentage of blood units provided by voluntary donors	
Number of ART service centers	
Number of eligible people with advanced HIV infection receiving ART (disaggregated by sex and age)	
Percentage of SACS with HRG representatives included in SACS decision-making bodies	
Percentage of districts with at least one functioning PLHIV network	
Percentage of funds utilized relative to targets	
Percentage of SACS with approved financial and administrative delegation	
Percentage of states where partnership forum met in the last quarter	
Percentage of SACS' NGO Adviser positions filled	
Percentage of SACS with director's in sole charge for more than one year	
Percentage of states with at least 80% CMIS reporting	
Percentage of states which submit their dashboards to NACO regularly	
Percentage of due procurement contracts awarded during the original bid validity period	
Percentage of ICTC centers with test kit stock-outs during quarter	
Percentage of ART centers with ART stock-outs during quarter	
Percentage of SACS where governing body met at least once during reporting quarter	
Number of district units established, staffed and reporting, relative to targets	

This will be complemented with a set of Annual Core Indicators which will form the basis of the "State of the Epidemic and Response" report which will be produced on an annual basis to describe the HIV situation in the country. These indicators are as follows:

Annual Core Indicators for NACP III

Outcomes/Outputs	Indicator	Source	Target
Goal To halt and reverse the epidemic over the next five years			
New infections in HRG and vulnerable populations prevented	**Behavior Change** 1.1 Percentage of FSW reporting consistent use of condoms with clients in the last 12 months increased from X to 80% 1.2 Percentage of IDUs who have adopted behaviors that reduce transmission of HIV in the last 30 days from X to 80% 1.3 Percentage of men reporting use of condom the last time they had anal sex with a male partner from X to 80% 1.4 Percentage of population aged 15-49 reporting condom use in last sex with non-regular partners (disaggregated by sex and age sub-group) 1.5 Percentage of men reporting they are clients of sex workers 1.6 Percentage of population aged 15-49 with accurate knowledge on HIV/AIDS (recall three modes of transmission, two modes of prevention and who reject major misconceptions about HIV transmission) increased from X to 100% disaggregated by gender and age	1.1 – 1.6 IBBS/BSS Baseline from 2006 National BSS HRG survey. Mid-line BSS in 2009. End-line BSS in 2011.	
	Intervention Coverage 1.7 Percentage of sex workers report being reached by TIs increases from 44% to 80% 1.8 Percentage of IDUs reporting being reached by TIs increased from 20% to 80% 1.9 Percentage of MSM (high as defined by NACO) reporting being reached by TIs increased from X to 80%	1.7– 1.9 CMIS, reports and special studies	80% 80%

Outcomes/Outputs	Indicator	Source	Target
	Intervention Planning 1.10 Percentage of districts which have done high risk mapping increased from 10% to 100%	1.10 CMIS, Consultant reports	
Proportion of persons living with HIV/AIDS receiving care, support and treatment increased.	**Services/Coverage** 2.1 Number of ICTC (PPTCT/VCT) facilities increased from 3919 to 4995 by 2011 2.2 Number of ICTC clients tested and receiving result increased from 3,000,000 to 22,000,000 by 2011 (disaggregated by sex and age) 2.3 Percentage of districts with at least one functioning PLHA networks increased from 10% to 40% **Treatment and Care** 2.4 Number of HIV positive pregnant women (mother and baby) receiving a complete course of ART prophylaxis increased from 8,000 to 76,500 by 2011. 2.5 Number of eligible people including children with advanced HIV infection receiving ART (disaggregated by sex and age) increased from 60,000 to 340,000 by 2011 2.6 Number of affected and vulnerable children receiving care and support through programs annually is 170,000	2.1 CMIS 2.2 CMIS 2.3 CMIS, special studies 2.4 CMIS and PPTCT records 2.5 CMIS 2.6 CMIS	4995 22,000,000 40% 76,500 340,000
Infrastructure, systems and human resources in prevention and treatment programs at the district, state and national levels strengthened	3.1 Annual increases in resources (financial and other) for HIV/AIDS in other ministries/departments according to plan 3.2 Percentage of SACS which achieved at least 80% of planned expenditure targets 3.3 Percentage of audit reports completed and forwarded within time limits to NACO 3.4 Percentage of TIs run by CBOs from 5% to 50%	3.1 SACS records, interviews with key staff	100% 100% 50%

Outcomes/Outputs	Indicator	Source	Target
Strategic information monitoring and evaluation systems enhanced.	4.1 Percentage of states with at least 80% CMIS reporting 4.2 Percentage of states which prepare dashboards, submit them to NACO and use them in their own review meetings 4.3 Percentage of states whose annual plans demonstrate effective use of M&E data and other strategic information.	4.1– 4.2 CMIS 4.3 State PIPs, State BSS, household survey data, program reports, interviews with key stakeholders.	95% 90% 95%

IDA will monitor the performance of the program on the basis of a subset of these indicators which will act as proxies for the overall achievement of objectives of the program. This will take into account the phasing in of various activities and the likely time lag before outcome can be expected to be measurable. Thus IDA would apply the following "ladder approach" to measuring outputs and outcomes over the period of support. The achievement of these measures could also provide confidence in assessing the ability of the program to absorb funds.

Ladder of Achievement for NACP III

Year 1	Year 2	Year 3	Years 4 and 5
Program	Coverage + Program	Behavioral outcomes + Coverage + Program	HIV impact ***(national level)*** + Behavioral outcomes ***(PDO level)*** + Coverage + Program

Indicators

			HIV impact Stabilized HIV prevalence among sex workers, IDU, MSM and antenatal clients	*HIV impact* Stabilized HIV prevalence among sex workers, IDU, MSM and antenatal clients
		Behavioral outcomes Increased safe sexual and injecting practices	*Behavioral outcomes* Increased safe sexual and injecting practices	*Behavioral outcomes* Increased safe sexual and injecting practices
	Coverage Percentage of sex workers, IDU, MSM and clients reached by TI	*Coverage* Percentage of sex workers, IDU, MSM and clients reached by TI	*Coverage* Percentage of sex workers, IDU, MSM and clients reached by TI	*Coverage* Percentage of sex workers, IDU, MSM and clients reached by TI
Program Percent resources spent Number TI supported	*Program* Percent resources spent Number TI supported	*Program* Percent resources spent. Number TI supported	*Program* Percent resources spent Number TI supported	*Program* Percent resources spent. Number TI supported

Annex 4: Detailed Project Description
Third National HIV/AIDS Control Project

The overall goal of the NACP III program is to halt and reverse the epidemic in India over the next five years by instituting good quality, scale interventions with HRG and integrate programs for prevention, and care, support and treatment for the wider population. This is proposed to be achieved through four strategic objectives namely:

The objective of World Bank support will be 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:

- achieving behavior change by scaling up prevention of new infections in HRG and the general population; and
- increased care, support and treatment of PLHIV.

The goal, objectives and strategies will be informed by a set of tenets that include the "Three Ones" principle; equity and universal access in both prevention and impact mitigation; respect for legal, ethical and human rights of PLHIV; creation of an enabling environment; and civil society participation in planning and implementation of NACP III.

The program will place the highest priority on preventive efforts amongst those at the highest risk of acquiring or transmitting the infection. Thus sex workers, MSM and IDUs would receive priority attention, while long distance truck drivers, prisoners, migrants and street children would also be an important focus of prevention programs. All persons, including children, who require testing and treatment will be assured access and treatment for OI and first line ART. NACO will collaborate with agencies providing specialized services such as nutritional support child care etc. and will support community care centres to provide outreach, support and palliative care. Mainstreaming and partnerships will be a key approach to facilitate a multi-sector response engaging a wide range of stakeholders including the private sector, civil society, PLHIV networks and government departments. The program intends to leverage the financial and technical resources of the development partners to achieve the objectives of the program.

The objective of World Bank support will be to contribute to the NACP III goal by attaining the following project development objectives in accordance with the first two national strategic objectives:

- promotion of behavior change by scaling up prevention of new infections in HRG and THE general population; and
- increased care, support and treatment of PLHIV including through support to infrastructure and systems strengthening which form the last two strategic objectives of the NACP III.

Project Components

Project activities are grouped into four components. All components reflect activities at the national, state, and municipal levels.

Component 1: Scaling Up Prevention Efforts
Program cost US$1,652 million

(i) ***Saturating coverage in HRG:*** The project aims to reduce infections by reaching a high coverage of HRG over a five year period. This is to be implemented through 2100 TI targeting one million FSW and their partners, 1.15 million MSM including but not limited to those practicing sex work, and 190,000 IDU and their partners. It is expected that NACP III would focus significantly on groups that were not well covered during the last phase of the program viz. IDUs and MSM. The activities listed below are expected to be delivered through NGOs and if possible, about half of these would be delivered through CBOs by year five of the program.

This component will include:

- an effective BCC intervention with high-risk target groups to increase demand for products and services- this will include a variety of interventions such as education of individuals in negotiation skills, and training on use of condoms for personal protection;
- provision of STI services including counseling at service provision centers to increase compliance of patients to treatment regiments, risk reduction training, and a focus on partner referral;
- both promotion and provisioning of condoms to HRG to promote their use, and use by clients, of condoms in every sexual encounter;
- creation of an enabling environment to facilitate dialogue with relevant stakeholders such as the police, community leaders, local public functionaries and introduce changes in the social, structural, and policy environment to motivate the community to practice safer behaviors;
- community organizing and ownership building to empower HRG to create CBOs to implement the program in their communities - this is an important new area of attention during NACP III to promote sustainability of the program; and
- linking HIV related care, support and treatment with other services so that HRG can access them without stigma or discrimination.

(ii) ***Scaling up of interventions in highly vulnerable populations:*** These groups have been identified as being long distance truckers and mainly temporary migrants. There are an estimated three million long distance truckers of which about 20% are thought to be HIV positive. There are another 8.9 million temporary short duration migrants who are thought to be particularly vulnerable to infection. In both cases, further information, mapping of peer networks that can be used to approach and influence their choices and improving their access to preventative services, is of importance.

This component would include:

- BCC through peer led interventions of either individuals or groups to create awareness of their vulnerability and increase demand for products and services;

- the promotion and provisioning of condoms through both free supplies and social marketing;
- development of linkages with local institutions, both public and NGO owned, for testing, counseling and STI treatment services - this will be an important area of public-private partnerships within the program; and
- in the case of migrants, creation of "peer support groups" and "safe spaces" for migrants at destination.

(iii) ***Interventions in the general population:*** Strategies for the general population will take into account the specific risk factors and vulnerabilities of population groups such as youth (age 15-29 years); women (age 15-49 years) and children (age 0-18 years).

This component will include:

- the deployment of a cadre of link workers to reach young people including women, in villages with BCC, condom provision – both free and through social marketing - and linkages to health services;
- enhancing access to testing facilities for HIV infection which have links to associated programs, and to counseling and treatment services by the establishment of ICTC;
- establishing Red Ribbon Clubs where 'youth friendly information services' will be provided;
- improving access to testing and treatment for PPTCT;
- improving availability, testing and assurance of blood and blood products;
- providing STI treatment in public and private health facilities for easy access to the community; and
- undertaking effective communication programs to encourage normative changes aimed at stigma and discrimination reduction in society at large.

(iv) ***Multi sector mainstreaming***: This component envisages that work will be carried out with relevant ministries, government departments and private players to establish programs to minimize infections and mitigate effects on vulnerable populations; key sectors make HIV and AIDS their core business; and incorporate HIV and AIDS as an integral part of their policies, products and processes. They will be encouraged to identify their added value, roles and responsibilities; develop plans and allocate budgets to contribute to the development objectives of the national program; and coordinate their activities within one common national framework

Component 2: Strengthening Services for Care, Support and Treatment
Program costs: US$414 million

This component aims to adopt a comprehensive strategy to strengthen family and community care, provide psycho-social support for PLHIV (especially marginalized women and children), and ensure accessible, affordable and sustainable treatment services. It is estimated that during the project period, care and support services will be provided to 380,000 PLHIV; ART to 340,000 of which 40,000 children (in the public sector); OI treatment to 330,000 persons; and TB treatment to 2.8 million persons. Socio-economically disadvantaged people would be reimbursed the cost of transportation and other costs related to access of ICTC and ART

facilities (for both the affected person and an attendant); and costs of CD4 testing and treatment with ART would be waived for tribal people. Especially for this component, networks of health professionals must be involved in the planning and implementation.

This component will include:

- strengthening PLHIV and other networks of vulnerable populations with enhanced linkages with service centres and risk reduction strategies;
- developing standard HIV and OI management guidelines including improved referral to the Revised National Tuberculosis Control Program for TB treatment begun under the NACP II;
- establishing community care centres which will provide outreach, referral, counseling and treatment, and patient management services - this will be an important innovation under NACP III which will be taken to scale during the program; and
- undertaking advocacy, social mobilization and BCC to integrate HIV positive persons into the society at large while reducing stigma and discrimination.

Component 3: Augmenting Capacity at District, State and National Level
Program costs: US$254 million

The component aims to undertake strengthening and skills development within NACO and the SACS to better carry out the task of instituting good quality, greatly scaled up interventions in MOHFW and other ministries; while at the same time, recruiting private sector systems to public health goals. It is proposed that this would be carried out through a streamlining of NACO and SACS' form, function and accountability framework on the one hand, and systems to manage the relationship with private sector entities recruited to provide HIV related services on the other.

This component will include:

- collaborating with partners on developing standard operating procedures in respect of crucial HIV services, as well as the establishment of internal and external quality control systems;
- adopting standard, performance based contractual arrangements linked to delivery of HIV-related services;
- providing high quality, operational training in areas critical to the scaling up needs of the program such as support to establishment of CBOs, ART training etc. within and outside the government sector;
- establishing such technical support instruments as necessary, linked to HIV control structures within the government. These could range from TSGs at the level of NACO or TSUs at the level of the SACS; and
- engaging the services of a procurement agent for carrying out procurement of pharmaceuticals, medical supplies, and other goods and works required under the project

Component 4: Strengthening Strategic Information Management
Program costs: US$76 million

The NACP III proposes a significant change in the purpose and effectiveness of data collection and analysis. A SIMU will be established in order to maximize the effectiveness of available information and implement evidence-based planning. This will be set up at the national and state levels to address strategic planning, monitoring and evaluation, surveillance, and research. In addition, all program officers will be trained on evidence based strategic planning methodologies, information use, and program management.

This component will include:

- a review of the appropriateness of the information gathered, in order to generate specific information on high risk behavior, and project related impact on behavior change;
- strengthening of the monitoring framework to provide more accessible and ready-to-use information across program content and management functions through review and revision of existing NACP II frameworks;
- enhancing the surveillance systems to provide HIV related epidemiological, clinical and behavioral data at a state and sub-state level;
- a review of the models used for the generation of various state and national estimates on the basis of surveillance data; and
- undertaking independent evaluation and research to inform and support program implementation.

Annex 5: Project Costs
Third National HIV/AIDS Control Project

GOI estimates that the total country program costs of NACP III will be approximately US$2.5 billion. Taking into account the financing of condoms and direct funding of NACO's program, the domestic budget of GOI contributes a quarter of these estimated costs. The program is also supported by a variety of players including the BMGF and Clinton Foundation (international NGOs), GFATM and local private sector, US government, UN family, and other development partners.

Table 1 presents: (a) country program cost by components; (b) the funding from sources outside the government, i.e. the private sector; (c) others, which includes mainly the UN agencies, BMGF etc.; (d) funds tied up from Non-Pooling DPs (GFATM and US government); (e) condom procurement; (f) STD pharmaceuticals from NRHM sources; (g) contribution to GFATM and (h) the residue which needs to be funded by GOI and part financed by the pooling partners, i.e., the World Bank and DFID. DFID and WB would finance part of GOI's investment in the program by contributing to a Pool of resources referred to in column (g) of Table 1. GOI funding represents 16% of the Pooled Financing available for the Project, while its overall contribution to the Program is 42% of committed funding. See Table 2. The data provided are obtained from NACO. The Bank team's appraisal of the PIP supports the approach proposed and the estimates of total program costs provided by the GOI. Project performance (through M&E arrangements and indicators used) will measure progress of the entire country program including interventions by all players.[9]

Based on currently committed resources and projected annual expenditure, a financing gap of US$ 390 million is possible in years 4 and 5 of the plan. GOI plans to seek additional financing for these years of the program from its development partners. Such additional financing would among others depend upon budget cycles of donors, availability of donor resources, as also their readiness to provide additional resources as the program scales up its effective implementation. This gap has specifically been discussed with development partners at joint review missions during program preparation.

Additional funding from the Bank could be required if other funding for the program doesn't materialize or is delayed. Program performance would be closely monitored through a detailed Mid-Term Review including likelihood of achievement of program objectives through performance indicators, utilization of resources and review of further commitments to the program by various partners. Additional financing in the region of US$250 million would be considered only if performance indicators and disbursements under the Project are satisfactory and that it is clear that achievement of development objectives is critically dependent on such additional financing. Should the financing not be forthcoming or if the program does not scale up as envisaged, project objectives and targets would be reviewed to reflect the expectations from the program at that time.

[9] Fiduciary oversight by the WB will be limited to the Pooled funding column (g) in Table 1, while M & E will cover the entire country plan.

Table 1: Resource Envelope for NACP III (in US$ million)

Components	Country Plan	Parallel Financing		Funding from GOI Budget				
		Private sector	Others	Non-Pool	Condom procurement	Other programs	Non-Pool NACO activities	Pool funds ("Project")
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)=a-b-c-d-e-f-g
Prevention	1821	15	365	151	451	92		747
Care, Support & Treatment	457	80	20	296			10	51
Program Management, Capacity Building	213	5	165	0		0		43
Strategic Information Management	84	0	26	0		0		58
Total	**2574**	**100**	**576**	**447**	**451**	**92**	**10**	**898**

WB	**246**[10]	48%
DFID	**179**	35%
GOI	**83**	16%
Total	**508**	100%
Financing gap	**390**	
Total including Financing gap	**898**	

Footnotes to the Table:
Column (a): total program costs.
Column (b): contribution, mainly in kind, by the private sector through delivery of services.
Column (c): contribution from UN Agencies, BMGF, CF, DFID and USAID outside of the budget.
Column (d): contribution from GFATM and USAID through the budget.
Column (e): GOI budget for condom procurement.
Column (f): procurement of STD pharmaceuticals under other program of the MOHFW
Column (g): balance pooled financing by GOI, partially through DFID and WB.

[10] The Bank will in addition provide US$ 4 million towards consultancy charges of the procurement agent.

Table 2: Financing from GOI Budget (including Pool and Non Pool (in US$ million)

Development Partner	USD million	%
World Bank	246	16
DFID	179	12
Non Pooling Partners	447	30
GOI – Pool	83	42
GOI – Non Pool	543	
Total	1498	100
Financing Gap	390	
Total including Financing Gap	1888	

Table 3: Proportion of Local and Foreign Costs of the Project

Project Cost By Component and/or Activity	Local US $million	Foreign US $million	Total US$ million
Prevention of New Infections	612	135	747
Care, Support and Treatment	51	0	51
Strengthening Capacity at District, State and National Level	43	0	43
Strategic Information Management	57	0	57
Total Baseline Cost			898
Physical Contingencies[11]			
Price Contingencies			
Total Project Costs			898

[11] Contingencies, both physical and price have been built into program costs by GOI at the rate of 5%.

Table 4: NACP III Disbursement Profile and Partners' Share by Year (in US$ million)

Based Program Estimate in the PIP i.e Pool size US$ 898 million									
									USD Million
NACO Budget/ Exp Projections	**Overall %**	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-2011**	**2011-12**	**Total**
		Actuals	**Revised Est**	**Budget Est**	**Projections**				**2007-08 to 2011-12**
Non Pool DPs and certain costs at NACO outside the Pool			61	100	103	100	100	44	**447**
Pooling DP (Bank, DFID & NACO-- within the Pool)			96	102	128	164	202	301	**898**
Total Projected Budget of NACO		**119**	**157**	**202**	**231**	**264**	**302**	**345**	**1345**
Actual/Projected Increase in NACO Budget (in Nominal terms)			32%	29%	14%	14%	14%	14%	
Pool DP incl GOI				102	128	164	202	301	**898**
Total				**102**	**128**	**164**	**202**	**301**	**898**
Disbursement (Annually - in USD Million)									
Bank	48%			57	70	90	29		**246**
DFID *	35%			28	38	47	38	28	**179**
GOI **	16%			17	21	27	19		**83**
Total				**102**	**128**	**164**	**102**	**11**	**508**
Financing Gap							**117**	**272**	**390**
Partners share in % terms									
Bank				56%	54%	55%	14%	0%	48%
DFID *				28%	29%	29%	19%	9%	35%
GOI **				16%	16%	16%	9%	0%	16%
Disbursement (Cumulative)									
Bank				57	127	217	246	246	
DFID				28	66	113	151	179	
GOI				17	38	64	83	83	
Total				**102**	**230**	**395**	**497**	**508**	

* DFID has a fixed annual disbursement for each financial year – 2007-2008: 15 million; 2008-2009: 20 million; 2009-2010: 25 million; 2010-2011: 20 million; 2011-12: 15 million (all figures in Pound Sterling). The annual disbursement profile and consequently the proportion of Bank financing in each financial year has been adjusted to reflect this.

** In addition to contribution to the Pool, GOI would be responsible for supply of condoms (through own funds) &STD pharmaceuticals at PHC/CHC under the NRHM budget

Based on the disbursement profile & the project performance the GOI may seek additional financing from IDA

Annex 6: Implementation Arrangements
Third National HIV/AIDS Control Project

Under the Constitution of India, responsibility for health care provision is a state subject. However, issues of national public health concern fall within the purview of the central government. Therefore, in view of the importance assigned to the epidemic of HIV, the NACP has been a centrally sponsored scheme receiving 100% financing from the GOI from its inception in 1992.

The NACP is managed by NACO established within the MOHFW. The present location and structure of NACO is an outcome of the history of the HIV response in India. In the years since the first case was discovered in 1986, India has responded to the perceived risks posed by transmission of the virus in the community and the opportunities inherent in the health architecture of the country, by establishing a decentralized public health program which combines interventions delivered through the public health system as well as NGOs.

Under NACP III, NACO intends to consolidate the decentralized model of implementation established under NACP I & II and provide direction and stewardship to the national program. Recent changes in the health architecture afforded by the initiation of the NRHM will strengthen the delivery of health system interventions such as ICTC, STD care, PPTCT and OI and ART provision. The program intends to institute a policy of recruiting the private sector to the delivery of public ends of HIV control. The program will continue to provide prevention services to HRG through NGOs, while building long term sustainability through facilitation of both CBO development as well as PLHIV networks. The program also plans to greatly expand its reach to the population-at-large through the involvement of crucial government departments and the corporate sector. NACO will constitute Technical Advisory Groups comprising of leading experts in the country to provide guidance and review of the program's thematic areas. In the same vein, NACO would establish a Technical Advisory Group on Tribal Issues to advise on necessary and possible actions to strengthen the program for tribal populations and to provide inputs for implementation.

A key feature of the implementation of effective interventions with some of the most marginalised groups in society has been the use of NGOs and CBOs. The transfer of public funds to these groups has always been a matter of some unease. Guidelines for NGO involvement were revised during the life of NACP II in response to widespread concerns that funds were not being transferred with sufficient transparency, efficiency and attention to performance. Accordingly, this has formed an important aspect of deliberations during NACP III formulation, with attention to this on the part of the thematic working group on NGO participation, a consultancy by an international consulting firm, and discussions within NACO and the MOHFW. In view of the scaling up of NGO/CBO provided services in NACP III, NACO has put together an approach paper on contracting with the private not-for-profit sector, and has revised its guidelines for NGO/CBO contracting.

Responsibilities and core functions at national level: The functions of NACO would be distributed among four strengthened core units each led by a Joint Director/Director. NACO would continue to be headed by an officer of the Indian Administrative Service at the level of

Additional Secretary to the GOI. The proposed organogram is attached as Figure 2 in this Annex. While NACO will maintain staff to execute all core functions, several functions that are better outsourced, will be contracted to private entities using performance-based contracts.

The technical and institutional needs of the five North Eastern states are unlike those of India, due to the geographic location of the region and differing capacity of the states. Thus there is a need for sustained technical support for all the states to address the specific needs of the eight states and the regional strategy. NACO will establish a sub-office – the Regional AIDS Control Unit - within the NRHM North Eastern Regional Resource Unit which would provide implementation support to the states of this region. There will be a NNCC chaired by the Secretary, MOHFW, which would ensure the full cooperation between programs such as the RCH and TB programs on the one hand, and the NACP on the other.

In accordance with its stewardship role, NACO would be responsible for: (a) setting the program framework and establishing accountability systems; (b) carrying out broad advocacy and social mobilization in support of normative behavior change; (c) establishing technical support capacities; (d) facilitating the mainstreaming of HIV control into the work of other ministries, private sector and civil society; (e) instituting partnerships with significant stakeholders who are vested with capabilities for HIV control; (f) requiring and using regular monitoring, surveillance, and evaluations of the HIV control program at every level; (h) setting standards and putting in place a system to assure the quality of laboratory and treatment facilities; and (i) establishing robust, transparent and efficient systems for procurement of pharmaceuticals and equipment, goods, works and services.

Responsibilities and core functions at state and sub-state level: At the commencement of NACP phase II, autonomous decentralized societies called SACS were set up giving states more functional autonomy than available to the State AIDS Cells set up under phase I. Implementation of HIV control activities would vest primarily with the states. SACS established under NACP II are expected to assume a leadership role and coordinate the work of all partners in each state. In states where Municipal AIDS Control Societies or other societies have been established, their workplans would be subsumed under the overall workplan for the state. In a few states, SACS have been merged into an overarching State Health Society and in some, this may happen during the life of the project, however, characteristics of SACS will continue to be maintained.

SACS staffing decisions will be based on size of state and disease burden. Similarly TSUs, established in response to problem size, will assist in the management of the TI programs with HRG. The government proposes to gradually set up dedicated implementation units at the district level called DAPCU, strengthening the ability to implement various components of the program. NACP III provides for capacity development of the SACS and DAPCU as an important output of the program which would support the major scaling up of program interventions. However, where states fail to take adequate ownership of the program, NACO intends to institute special measures to ensure implementation of the program.

The SACS or State Health Society would be responsible for: (a) planning and implementing interventions with high risk, bridge and general populations; (b) undertaking state level advocacy, IEC, social mobilization and youth campaigns; (c) providing technical support to

partners within and outside the health department in respect of program components; (d) supporting intersectoral collaboration with significant stakeholders; and (e) undertaking essential procurement per the agreed procurement arrangements.

The DAPCUs will gradually be established and when fully functional, will have their own action plans and budget with a separate account. These will be closely linked to the institutional arrangements for the NRHM at the district level. All medical functions at the district level will be supervised by the Chief District Medical Officer under the aegis of the District Health Society. The Hospital Safety Units of district hospitals will be in charge of managing hospital waste and ensuring hospital safety under the district health society. All non-medical functions, i.e., preventive services, IEC, social mobilization, outreach services and facilitation of TI will be discharged by the DAPCU.

For proper planning and management of activities both by NACO and SACS, a "dashboard" has been developed by which both NACO and the SACS can monitor progress of the program per state and compare states in performance (see Annex 3).

Oversight arrangements: NACO would report to the NACB chaired by the Secretary, MOHFW, which would also have oversight of work carried out by partners whose programs do not pass through the national budget. The NACB will consist of the Secretary of Health, Secretary of Family Welfare, Director General of Health Services, Director General of the Indian Council of Medical Research, Joint Secretary & Finance Advisor, a representative from the Ministry of Finance (Department of Expenditure), Project Director and Additional Secretary, NACO and representatives of civil society including NGOs, national trade unions, private sector, and AIDS experts.

In June 2005, the NCA was constituted under the chairmanship of the Prime Minister and with membership of 31 central ministers, six state chief ministers and civil society. This body will provide the highest political oversight and support to the implementation of the national HIV control framework especially in order to mainstream HIV control into the work of all organs of government, private sector and civil society and lead a multi-sector response to HIV/AIDS in the country. States will establish State Councils on AIDS along the pattern of the National Council on AIDS to be chaired by the Chief Minister and having the Minister of Health as Vice Chair.

Partnership with the civil society at national, state and district levels: Civil society organisations have been active partners of the national response to HIV/AIDS.

Civil society partnership forums will be established at national, state and gradually at district levels with membership of active civil society partners and representing the various constituencies that are stakeholders in HIV control. District forums of civil society whose membership would include any civil society organisation e.g., NGOs, CBOs, PLHIV networks, tribal people/organizations (in predominantly tribal districts), private sector organisations and academic institutions working in the area of HIV are proposed. The district forum will pay special attention to the needs of socio-economically vulnerable (including tribal people), develop collaborative district implementation plans, and review progress. These will be federated to the

state level forum through elected representatives of the district level, not exceeding two per district. The national forum will have representatives from the state level forums.

Partnership arrangements with development partners: Support to NACP III will be provided in accordance with the "Three Ones" approach. This approach applies the Monterrey Consensus and Rome Declaration on the Harmonization of Development Assistance to a specific area of development - HIV. NACO will establish a clear joint working relationship with DPs at both national and state levels through the establishment of a coordination framework enjoining each to the spirit of "Three Ones." NACO would form with a selected group of DPs (including the UN, DFID, USAID, BMGF, CF and WB), a Steering Committee to: (a) prevent duplication of DP efforts; (b) share information on action plans; and (c) review program performance. Joint annual program reviews will be carried out. IDA will work closely together with DFID, which intends to pool resources with IDA.

The program will require intensive supervision, especially in the first year of operation.

Figure 1: National Organogram

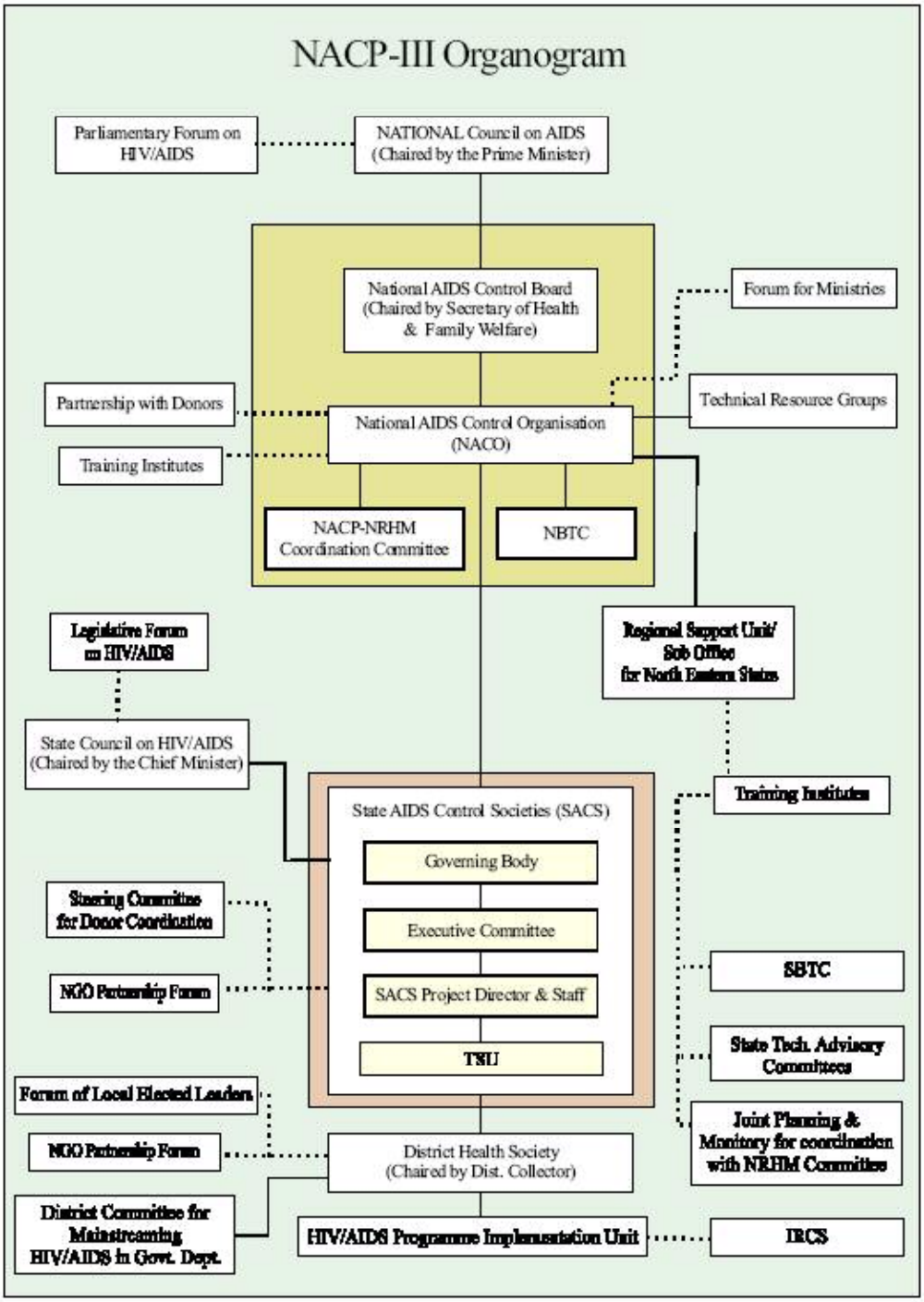
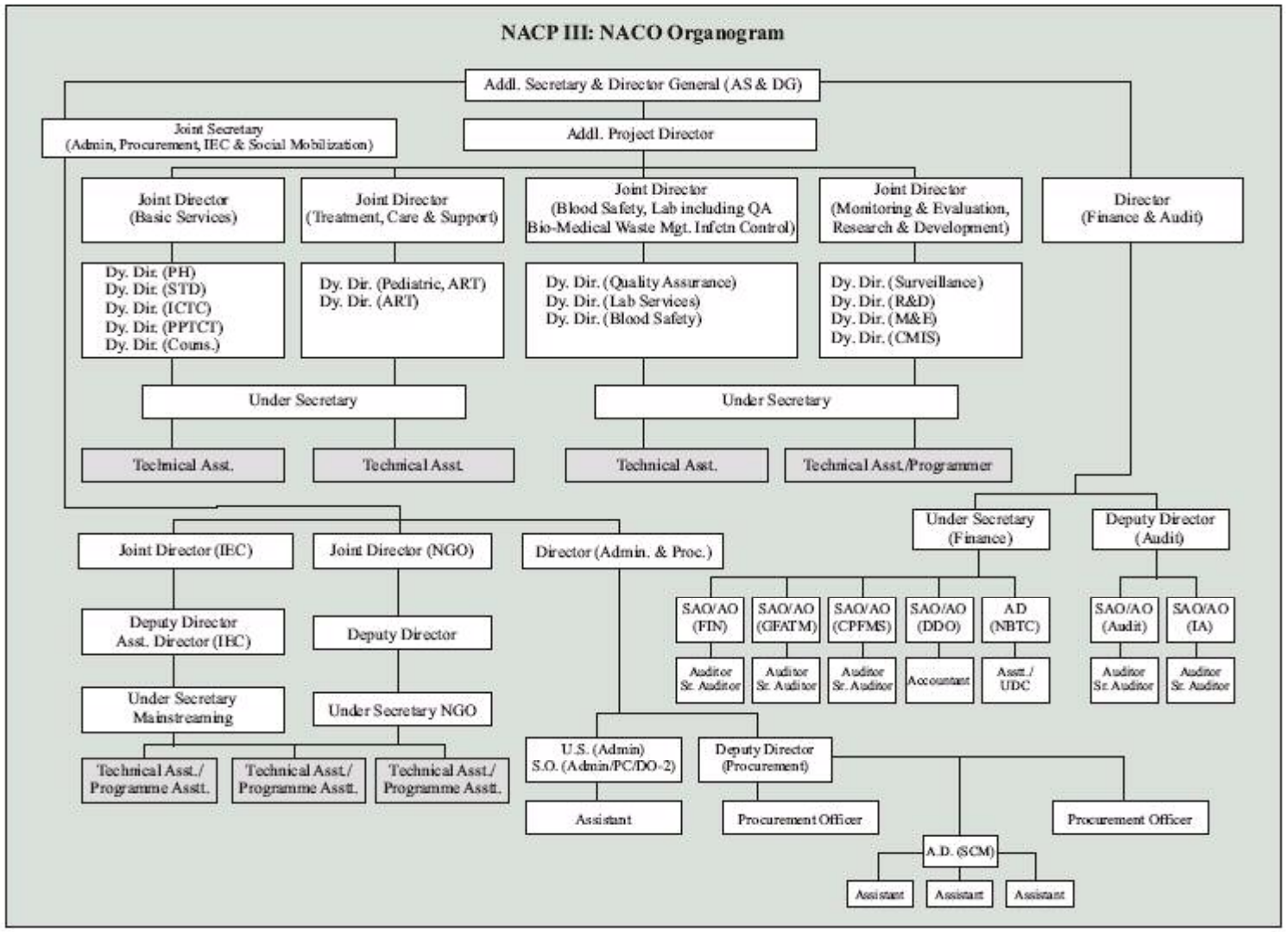


Figure 2: NACO Organogram



Annex 7: Financial Management and Disbursement Arrangements
Third National HIV/AIDS Control Project

Background

The project has a financial management system that is adequate to account for and report on project expenditures in a timely manner, as well as satisfying the fiduciary requirements of IDA.

The NACP III program of the GOI builds on the lessons learnt under the NACP II project which closed on March 31, 2006. A programmatic approach is proposed to be followed under NACP III with all development partners expected to support and align their activities and finances behind GOI's program framework for the next five years. The total program size (level of investment from all sources form within and outside GOI budget) has been determined at US$ 2.5 billion. This is expected to be financed by: (i) the private sector, independent agencies such as BMGF, various UN agencies (all these funds will be outside GOI NACP III budget for the program); (ii) budget provisions in other line ministries/ programs; and (iii) budget provision within MOHFW/NACO for the NACP III program. The Bank (along with DFID as pooling partner) will finance part of NACO's expenditure on the program, which are not financed by other non-pooling development partners such as GFATM, USAID, etc.

Financial Management Capacity Assessment

This is a follow on project from the NACP I and NACP II projects. In NACP II the implementation arrangements and consequently the financial management arrangements changed with the creation of SACS. Under NACP II a CPMS was developed and successfully implemented. In addition uniform accounting policies and financial reporting (internal and external) by project components was achieved during implementation. However the financial management arrangements (staffing, accounting systems, internal controls etc.) did not keep pace with the increased resource allocation and the increasing number of sources of funding leading to parallel systems and procedures for various development partners. A study of the financial management arrangements was carried out. The assessment covered six SACS and NACO. In addition NACO circulated and obtained completed financial management checklist for other states which also fed into the assessment.

The key issues emerging from the study are the need for:

- Improvement (timeliness and quality of review) of the AWP preparation and reduce the budget cycle time which in turn impacts the fund release from NACO.
- Regular assessment of the project financial management arrangements and compliance with internal control procedures through a system of management audit.

- Updating the financial management manual and develop consistent accounting policies applicable for all donors. The study confirmed that under NACP II, the accounting policies were uniformly & consistently followed only in case of the World Bank funded project.
- Updating the CPMS to ensure that it is able to account for all funds instead of only World Bank financed project.
- Extending the TSU for monitoring NGOs (which were in existence in seven states) to all the SACS.
- Regular and periodic training for financial management staff.

The study also identified various "good practices" adopted in many states, which are capable of being replicated across the states. The above issues including the identified good practices have been built into the updated Financial Management Manual.

Country Issues

Generic country level issues and specific resolutions under the project are discussed further.

- GOI's existing accounting system concentrates mainly on book keeping and transactional control over expenditures and there is little in the way of a concept of financial management information being used for decision making. Also GOI considers all releases as expenditure: a separate CPMS has been developed and is in use by the project under NACP II which enables the generation of reliable financial reports. This is being updated to facilitate accounting and reporting for all donor funds which flow through the budget of MOHFW (NACO).

- Quality and timeliness of audit reports: the audit of NACO will be conducted by C&AG, India:

  - the project financial statements (sources and uses of funds) generated by the CPMS for the expenditure incurred at NACO would be audited in accordance with ToR approved by the Bank and consented to by the C & AG's office – consent to be obtained.

  - The audit of the financial statements of the SACS would be carried out by independent chartered accountants firms empanelled with the CAG. (as per TOR approved by the Bank)

- The following country issue with respect to non-availability of the project financial statements does not apply:

  - The SACS are required to prepare financial statements which will be audited by an independent chartered accountants firm. NACO will also maintain books of accounts based on which a statement of sources and applications of funds will be prepared for the expenses incurred at the central level.

- The issue of availability of funds on a timely basis to the project implementing entity does not apply to this project as the funds to meet the expenditure at the states will be remitted directly to the SACS.

Risk Analysis

Risk	Rating	Risk Mitigation Measure
While the number of accounting centers are limited to approx 45, funds are advanced to a large number of peripheral units such as NGOs, blood banks, VCTCs, schools, hospitals, district agencies (with many being one time activities),settlement of advances is time consuming resulting in delays in booking of expenditure and mismatch is physical and financial targets.	S	Many states have adopted innovative practices to address the issue of unsettled advances which have been identified in the FM study. There have been built into the updated FM manual for replication across the program. In addition a DAPCU is being created in approx. 200 high incidence districts. The DAPCU will have one to two finance staff, which would be responsible for district level planning and financial monitoring including collection of financial reports and utilization certificates from various institutions to whom funds flow in the district. Monthly cut-off procedures and financial management indicators are being built as part of CPMS upgrading which will help track build up of advances
The project proposes to implement a significant part of the project through NGOs/CBOs and scale up the number of NGO contracts to approx 2100. The capacity of the NGOs to use and report on the project funds is limited. In addition there is the risk of various donors chasing a limited number of NGOs and possibility of same financial reports being submitted to various donors.	S	A separate study on NGO contracting and capacity has been completed. A guideline on NGO/CBO selection, contracting and FM arrangements has been developed. A separate TSU is proposed in all states for dealing with NGOs/CBOs which will have a full time finance staff. In addition accounting handbook to help build capacity of NGOs developed by some states will also be rolled out across the program A system of putting information in the public domain and sharing of information amongst donors will be instituted.
Overall risk rating	**S**	

Strengths and Weaknesses

Strengths

The project has the following strengths in the area of financial management:

- The financial management unit is in place in NACO headed by Director Finance and supported by five finance staff/consultants who are well

versed with the GOI financial regulations as well as World Bank requirements. This will be further strengthened with finance staff/ qualified finance consultants in line with the PIP.

- The CPMS is operational in the SACS[12]. A contract for upgrading the CFMS and continuous system support has been awarded by NACO. The upgrade is expected to be completed by October 31, 2007.

Weaknesses

Significant weaknesses	Mitigation
In centrally sponsored projects the flow of funds from the center to the states and the district is not normally linked to meeting financial reporting targets (i.e., timely submission of SOE, FMR's and audit reports).	It has been agreed and included in the Finance Manual that flow of funds will be linked to adherence to financial reporting conditions. The new General Finance Rule of GOI (July 2005) now require that the second installment can be released only on receipt of audited financial statements.
Inadequate use of financial information for planning & decision making.	A set of financial management indicators has been developed and included in the financial management manual which will help finance and program managers in NACO/SACS to monitor the financial progress and controls.

Implementing Entities

The project will be implemented by the NACO at the central level and by the SACS at the state level. NACO is responsible for overall management of the project, its financial management, central level procurement, review and approval of AWPs, management and technical support to the states and for annual progress review of the program. The DG of NACO would have overall responsibility for the proposed project. The DG is supported by various technical specialists including a Joint Secretary in charge of Administration, Procurement, IEC and Social Mobilization; and a finance unit headed by a Director Finance, a senior Indian Administrative Service (IAS) officer, responsible for financial management.

At the state and district levels SACS have been in existence under the NACP II project and have been implementing the program. The project director of the SACS supported by a financial controller is responsible for financial management of the project within the state, state level procurement, annual work plans management and technical support to the districts and annual progress review of the program in the state. Under NACP III it is proposed to create district level units –DAPCU which will be responsible for district level planning and monitoring. No funds are expected to flow to these units except to meet its operational costs.

[12] Some SACS have reverted to manual systems in 2006-07 due to lack of continued IT support from the consultants following the close of the NACP II project.

Budgeting & Annual Work Plans

At GOI level the project's funding requirements are provided within the budget of the MOHFW and NACP III program will have a separate budget head (minor head). At the national level, the budget would be operated by NACO. Annual budget of the project would be allocated as per national PIP and the actual pace of implementation. At the state level the budget would be allocated to each state based on the approved state AWP. As this is 100% centrally sponsored scheme, funds would be made available to the states, on a full grant basis. The existing scheme guidelines/ FM manual have been reviewed and updated to incorporate the revised cost norms, the timelines for preparation of AWP by SACS and review and approval by NACO. Timelines have been incorporated to ensure that all AWPs are reviewed and approved by NACO before the start of the financial year. In addition NACO will carry out a mid-year review of the SACS AWP and implementation performance.

Fund Flow Arrangement

The annual budget allocated to each state would be released in two installments during the 1st and 3rd quarters of each fiscal year. Funds required to implement the Project will be released by NACO to the SACS. The SACS in turn would release necessary funds to various implementing units (NGOs, VCTCs, blood banks, district units, etc.) based either on contractual obligations (NGOs) or sanctioned amount for the specific activity. The release of the first installment by NACO to the SACS would be determined on the basis of the approved AWP and will be subject to receipt of provisional Utilization Certificates (UC) from the states. A shift to electronic transfer of funds (to begin with from NACO to states) will be instituted during program implementation by building on the experience in RCH II.

Release of second installment funds from NACO to the SACS would be incumbent on the receipt of the audit certificates and UC for the previous year. Under NACP II there were instances of delayed funds flow to NGOs. This aspect has been addressed by de-linking the financial reporting from the funds flow to ensure that there is a float (working capital of approx 2/3 months) available with the NGOs.

Books of Accounts and Accounting Policies

The project costs incurred at NACO (program management, IEC, etc.) and costs incurred on central procurement of pharmaceuticals and test kits etc would be recorded in the books of NACO at MOHFW in accordance with procedures and policies prescribed in the General Financial Rules (GFR). As the GOI follows a cash accounting system, all funds either transferred to the states and to central level implementing units are recorded as expenditure in the books of the GOI. For the purpose of the project however the accounting policies as documented below will be followed.

Level	Activity	Mainstream GOI	For Project
At the central ministry level (NACO)	Centralized procurement including ICB, training, monitoring, evaluation and IEC.	Will be carried out by independent procurement agent, empowered procurement wing in MOHFW and Media Agencies (for IEC contracts) who receive advances from NACO. The books of account for this are maintained by the Chief Controller of Accounts. Advances to the procurement agencies are recorded as expenses (Non plan) and transferred to Plan expenditure once the procurement process is completed, i.e. proof of delivery is provided by the agents. The advances for IEC are recorded as expenditure when funds are released and UC are required to be provided by such agencies.	The NACO (Finance Cell) will monitor advances/ settlement to the procurement agents and other consultants. For the purpose of financial reporting to the Bank only the actual expenditure as reported by the various agents and institutes will be recognized as expenditure and the balance will be recognized as advance.
State Society (SACS)	All activities funded as per AWP	Fund releases to State Societies are also recorded as expenditure in GOI's books with a requirement the UC are submitted within 9 months from the end of the financial year.	The actual expenditure incurred & reported by the State & District Society (based on accounting policies prescribed in the Financial Management Manual) will be the basis both for reporting and for the financial statements

A CPMS for the project has been in use by the project at the SACS level to account for the expenditures under the World Bank assisted project (see section on information systems below for improvement in the CPMS). Expenses would be recorded on a cash basis and would follow broadly the project activities for ease in reporting to various stakeholders. Standard books of accounts on a double entry basis (cash and bank books, journals, fixed assets register, advance registers are available in the CPMS and will continue to be maintained under the project by NACO/SACS.

Internal Control

Under NACP II project internal controls (financial & operational) controls were found to be weak in a few states with issues such as delays in settlement of advances by peripheral units/NGOs, lack of timely bank reconciliations and inadequate arrangements for financial review of NGO activities. These have been addressed by updating the NGO/CBO guidelines (which includes financial management aspects) and the FM Manual which provides the overall internal control framework for the project. The finance manual laying down the financial policies and procedures, periodic & annual reporting formats including financial statements, flow of information and methodology of compilation, budgeting & flow of funds, format of books of accounts, chart of accounts, information systems, disbursement arrangements, internal control mechanisms, internal and external audit for the project has been updated to incorporate various guidelines, circulars and amendments issued during the implementation and to also reflect 'better practices' adopted by certain states. In order to improve the internal controls a set of checklists, year end cut off procedures and financial management indicators have been developed for monitoring purposes. NACO has also developed a time bound financial management reform plan which has process improvement measures such as electronic transfer, web-enabling of the CFMS and its interface with the Computerized Management Information System and regular training plans for finance staff etc. The training manual developed for NGOs in Tamil Nadu will be extended to all states. The timely implementation of this reform plan is a legal covenant and will be monitored during project supervision.

Finance Staffing and Training

The Finance Unit in NACO is headed by a Director – Finance and supported by 5 finance staff/ consultants. In view of the increased scale of operations the finance unit will be further strengthened by deputation/contracting additional qualified consultants by October 31, 2007. The finance cell is responsible for establishment of the agreed financial management arrangements, providing timely financial reports to the stakeholders including the Bank, ensuring smooth and timely flow of funds and providing overall guidance in respect of the financial management issues for the project.

At the state level depending on the size of the program the finance unit is headed by a Finance Controller/Finance Officer. The FM assessment study has suggested strengthening the finance units in larger states and a focus on regular and periodic training. The additional finance staff has been built into the national PIP, the states will hire additional staff as required to strengthen the finance units by October 31, 2007. Some of the constraints relating to finance staffing and training under the NACP II project was the lack of regular training to finance staff and vacancy in the position of Director (Finance) for one year and qualified finance consultant – for two years in NACO which led to a lack of adequate oversight/ monitoring of the financial management arrangements in the SACS. This is being addressed by building in regular & periodic training as part of the FM reform plan and the need for continuity in the position of Director (Finance) as a legal covenant.

Information Systems

The project implemented a CPMS system under NACP II which is functional in the SACS. This system however only accounted for World Bank project and while the funds from other donors where accounted for in parallel systems. A contract to upgrade the CPMS has been awarded and is expected to be completed by October 31, 2007. The upgrade inter alia includes (a) facilitate accounting and reporting multiple donor funding; (b) amending the chart of accounts to facilitate reporting in line with the proposed activities; (c) web enabling of the CPMS; (d), development of a budget module with interface with the accounting module; and (e) ageing of advances and financial indicators calculation etc. The first set of upgrade (chart of accounts, monthly cut off procedures etc) is expected to be completed by April 30, 2007 and the balance by October 31, 2007. A group of Trainers who are familiar with the CPMS from well performing SACS will also be developed.

External Audit

Since the project is implemented throughout the country 42 audit reports were required to be submitted by the various states and union territories under NACP II every year. The audit reports from the SACS under NACP II were received with some delays and the Bank had to resort to suspension of disbursement for 5 to 6 SACS in the years 2001 and 2005. The lessons learnt under NACP II are the need to improve the quality of firms auditing the project, the timeliness of the audit reports and for NACO to take responsibility for review of the reports and take appropriate actions to address issues arising from the reports. These are addressed under NACP III by:

- The process of selection of the auditors is being strengthened with a view to obtain better and timely audit assurance, with the initial shortlist being based on the list of Chartered Accountants empanelled with the C& AG The TOR for audit by CA firms and process of selection of auditors has been documented in the FM Manual and the process of appointment is also being advanced by six months to address the issue of delay in appointment of auditors.
- NACO will review and provide to the pooling DP's (Bank and DFID) a Consolidated Report on the Audit of the Project. This report will consolidate the all Project Expenditure incurred by the states. The report will also consolidate the key observations arising from the audit reports of each state and the actions being taken/ proposed to be taken by NACO to addresses the weaknesses where necessary.

The external audit arrangements will be as under:

Audit of State AIDS Control Societies: will be done by firms of private Chartered Accountants as per TOR approved by IDA.

Audit of NACO: will be carried out by the C&AG. The audit will be conducted as per the terms of reference agreed by IDA and consented by the C&AG, wherein an opinion

on the project financial statements (sources and uses of funds) will be given by the C&AG.

In addition, an audit report for special account held at GOI would also be submitted in the usual manner. Thus, the following audit reports will be monitored in Audit Reports Compliance System (ARCS):

Implementing Agency	Audit	Auditors
NACO, MOHFW (1 audit report)	Project Audit for central level activities	Comptroller & Auditor General of India
Consolidated report on audits of all state societies (with the State reports as attachments)(1 audit report)	Project Audit for state level activities	Private Chartered Accountants
DEA/GOI	Special Account	Comptroller & Auditor General of India

Internal Audit

Since there are a large number of peripheral units (blood banks, VCTCs district units, medical colleges etc) to which funds are released by SACS and there is a delay in reporting of expenditures and settlement of advances, a system of internal audit an quarterly basis in 20 large states will be implemented under this project. The audit will include the SACS and a pre-determined sample of peripheral units very quarter. The terms of reference for internal audit have been reviewed by the Bank have been documented in the FM Manual and the appointment of the auditors would be would be made by the SACS. A copy of the report will be submitted to NACO and shared with the development partners during the supervision missions

Management Audit

A system of management audit is proposed to be instituted by outsourcing to an independent agency. The terms of reference for the audit have been reviewed by the Bank. This would cover six to seven states a year selected by NACO. The scope of management audit will include the review of financial management and procurement aspects and operational issues which have a linkage to financial management, review of adequacy of / adherence to financial and administrative controls, including physical verification of assets at various peripheral units etc. The findings of the management audit will enable NACO and SACs to identify internal control weaknesses, process constraints/ bottlenecks and take appropriate remedial action. These reports will be shared with the bank during the supervision missions.

Disbursement Arrangements

The Bank and DFID (the pooling partners) will finance a share of the project expenditures incurred by NACO and the SACS, which are not financed by non pooling development partners (GFATM, USAID etc). The pooled funding will be for the period April 1, 2007 to March 31, 2012. The key features of disbursement arrangements are:

- The disbursement of pooled financing will be on an annual basis based on the Interim Financial Reports (IFRs) covering the previous financial year which will include procurement contracts under ICB. The program expenditures reported in the IFRs will be subject to confirmation/ certification by the expenditures reported in the annual audit reports of the implementing states and GOI.
- The Finance Unit within NACO will provide a consolidated IFR and a consolidated financial statements based on the individual audited financial statements from states and GOI with the audit observations/ disallowances. Any variances between the amount reported in the IFR and the consolidated audited expenditure report will be adjusted (recovered or reimbursed) from the next disbursement to the GOI as per the schedule below.
- While linking disbursement to audit reports would obviate the need for reconciliations of expenditures as per IFRs with those as per the audit report, experience with Centrally Sponsored Projects (where the funds are provided by the GOI, but implementation remains largely with the states) has indicated that linking disbursements to receipt of financial reports will act as a strong incentive both at the state level (to send such reports) and at the GOI level (to pursue and follow up such reports). This would also enable receipt of financial information for project monitoring on a timely basis, which could get delayed in cased disbursements are linked to the audit reports.

Disbursement Schedule

Expenditure Period	IFR *	Disbursement in	Audit Report	Adjustment
April 07 to March 08	May 31 08	June 08	Sept 08	July 09
April 08 to March 09	May 31 09	June 09	Sept 09	July 10
April 09 to March 10	May 31 10	June 10	Sept 10	July 11
April 10 to March 11	May 31 11	June 11	Sept 11	Oct 11
April 11 to March 12	May 31 12	June 12	Sept 12	Oct 12[13]

* The IFR for the period ending September each year will be submitted by November 30 each year but this will not be used for disbursement.

[13] Any recovery arising out of the audit report would have to be physically refunded by the GOI as there would be no future disbursement against which it could be adjusted.

Other Disbursement Features

- Disbursement would be subject to receipt of the Consolidated Report of Audits due by September each year. If this Consolidated Report is not received by January of the following year, no further disbursement would be made until the report is received. The GOI would however still be required to submit the IFRs on the due dates i.e., May and November of each year.
- If the audit reports indicate higher levels of eligible expenditure as compared to the IFRs for the same period, the excess will be added to the next report based disbursement; and when the audit report indicates lower levels of eligible expenditure against the relevant IFRs, an adjustment will be made to the next disbursement by way of a reduction.
- Any default/delay by a state in reporting in annual expenditure in time for the May IFRs will result in under reporting of project expenditure and such expenditure can be included in the Consolidated Report on Audits and claimed in the next due disbursement.
- In case of late submission of an audit report by a state, GOI would not hold back submission of the Consolidated Report on Audits to the Pooling Partners. If such state audit reports are submitted to the GOI at a later date, the same would be factored in the next disbursement (in June) provided a revised Consolidated Report on Audit is submitted to the Association by May.

Financial Reporting and Monitoring

NACO will obtain financial reports from the states on a quarterly basis to begin with and gradually move to a monthly basis during project implementation. Based on the individual state reports NACO will prepare and submit consolidated financial reports on a six monthly basis to the pooling DP's. The FM report will include a comparison of budgeted and actual expenditures and analysis of major variances. These financial reports will also form the basis/ format of the annual financial statement to be prepared by the SACS. The Financial reporting will be done on a semi annual basis by way of Interim Financial Reports (IFR) (for the period ended September and March every year) and will be submitted by May 31 and November 30 of each year to the pooling DP's. The IFR's will include state wise and activity wise expenditure for the previous half year, year to date and cumulative to date. The important change is that the reporting to the pooling partners is being aligned with the internal reporting for the project. This will make it useful and relevant for decision making and monitoring. Under the NACP II the FMRs were submitted to the Bank, with delays and it was not used for any internal review.

Public Disclosure

An annual report will be prepared for the program which will include program and financial information and will be available in the public domain. In addition, the SACS will also be required to prepare an annual report on program performance which will include the audited financial statements and will be posted on the NACO/ SACS websites. This is likely to be implemented in a phased manner.

Advance for GOI

An advance of US$35.00 million will be provided to the project which represents approximately 15 % of the Bank's contribution to the pooled financing.

Retroactive Financing: The Bank will finance a share of the eligible expenditures not exceeding US$10 million incurred from April 1, 2007 to the date of credit signing. The eligibility of the expenditures to be financed by the World Bank would be determined by two criteria: i) the expenditures must be in line with the objectives of the project (NACP III), and ii) the expenditures must have been made using procurement procedures acceptable to the World Bank i.e., the procedures agreed upon between the Government of India and the World Bank for the Project.

Project Covenants

Apart from the covenants regarding audit and submission of IFRs the following covenants will be included in the financing agreement.

- NACO will maintain throughout project implementation a finance unit headed by a Director (Finance) supported by qualified finance consultants.
- Management audit as per terms of reference satisfactory to the association will be appointed within 3 months of effectiveness of the project.
- NACO will complete the upgrade of the CPMS by October 31, 2007 and maintain and support the system during the implementation of the project.

Supervision Plan

The project would require an in-depth supervision in the initial year especially for ensuring successful implementation of the state level FM and fund flow arrangements and monitor the implementation of the FM reform plan. Mid term review would be conducted after two and a half years of the project to comprehensively review the FM performance of the project.

Annex 8: Procurement Arrangements
Third National HIV/AIDS Control Project

General

This project would be implemented by MOHFW, through NACO at the national level, and by SIS at state level and some Municipal AIDS Control Societies (the term SIS has been used hereafter for both these categories). The NACP III would follow a program approach and there will be a pool of funds with contributions from IDA, DFID) and the GOI. NACP III is proposed to be implemented in accordance with the "Three Ones" approach and would be carried out through sustained technical and training support to public/private agencies, NGO/CBO, and organizations of PLHIV.

NACO, in consultation with the pooling partners, has prepared a procurement manual called the "NACO Procurement Manual for NACP III" dated March 8, 2007 for guidance to the procuring agencies at all levels under the project. The Manual gives details of various procurement methods along with steps and thresholds to be followed under each method of procurement. These guidelines will be used by NACO and SIS for carrying out procurement under the project. Procurement thresholds for goods and works and hiring of consultant services agreed with NACO are mentioned below. Goods and works contracts above US$100,000 and consulting services above US$50,000 will follow the World Banks' procurement/consultant guidelines respectively. All other methods will follow the procedures as per the NACO Procurement Manual.

Category	Method of Procurement	Threshold (US$ Equivalent)
Works	ICB	>2,000,000
	NCB	50,000 to 2,000,000
	Shopping	Up to 50,000
	DC/Force Account	Up to 10,000
Goods (except Vehicles) (also applicable for non-intellectual services and the services contracted on the basis of performance of measurable physical outputs)	ICB	>1,000,000
	LIB (wherever agreed by Bank)	>1,000,000
	NCB	50,000 to 1,000,000
	Shopping (or Director General of Supplies & Disposals rate contract)	Up to 50,000
	DC	Up to 10,000
Goods (only Vehicles)	ICB	>1,000,000
	NCB	100,000 to 1,000,000
	Shopping (or DGS&D rate contract)	Up to 100,000
Consultants' Services (except contracts for TI/CST awarded to NGO/CBOs, Mass Media and IEC Services)	SSS/LCS/CQS	Up to 50,000

Category	Method of Procurement	Threshold (US$ Equivalent)
Consultants' Services (only for TI and CST contracts awarded to NGOs/CBOs)	SSS/CQS	Up to 150,000
Consultants' Services (only for Mass Media and IEC Services)	SSS/CQS	Up to 100,000
Consultants' Services (all cases not covered above)	QCBS (or QBS, where Bank agrees) (i) International shortlist (ii) Shortlist may comprise national consultants only	Beyond above thresholds >500,000 Up to 500,000
Consultants' Services (Individuals)	As per para 5.2 to 5.4 of the World Bank Guidelines	--
Service Delivery Contractors	As per para 3.21 of the World Bank Guidelines	--

ICB: International Competitive Bidding; NCB: National Competitive Bidding; LIB: Limited International Bidding; SSS: Single Source Selection; QCBS: Quality- and Cost-Based Selection; QBS: Quality-Based Selection; LCS: Least Cost Selection; CQS: Selection Based on Consultants' Qualifications.

Invitation for Bids (IFB) for works, goods and equipment for all ICB contracts and advertisement for calling of Letters of Expression of Interest (EOI) for short listing of consultants for services costing more than $200,000 equivalent will be published in UNDB and dgMarket.

Limited Tendering (viz. NCB without advertisement but inviting bids from limited number of suppliers), may be used in place of NCB only in exceptional circumstances with the prior approval of the Bank.

Agreed Procurement Arrangements

Goods & Works: MOHFW has established an Empowered Procurement Wing (EPW) to professionalize the procurement of health sector goods and services. An internationally selected consultancy firm (Crown Agents) with appropriate technical expertise in pharmaceuticals, biomedical equipment, quality assurance and supply logistics, is helping EPW in developing its capacity. The procurement activities of both Health and Family Welfare Departments will be overseen by this wing. Until such time the procurement and supply management capacities of the EPW, NACO and SIS are developed to the satisfaction of pooling partners, all ICB/LIB procurement and the NCB contracts estimated to cost more than US$100,000 for goods and works [14] will be carried out by a qualified procurement agent or through a UN agency hired to do so. In this regard, the

[14] Procurement of pharmaceuticals and medical supplies shall be taken up only through ICB/LIB until the concerns regarding revised Schedule M have been addressed in a way that is satisfactory to the Bank and the recommendations of the Detailed Implementation Review (DIR) of the health sector projects are incorporated in to the GAAP

MOHFW is in advanced stage of negotiations with UNOPS to act as procurement agent for central health sector projects including NACP III. The procurement agent (commercial or UN agency acting as procurement agent) will follow the World Bank Guidelines dated May 2004 and other procurement arrangements agreed for the project. For the interim period (till the procurement agent is appointed and is operational), EPW will be allowed to handle the urgent procurement under an oversight arrangement satisfactory to the Bank.

The remaining procurement of goods and works, if any, under the thresholds for procurement agent shall be handled by EPW on behalf of NACO, while SIS would initially undertake the procurement up to US$50,000 threshold only. For procurement of goods and works, NACO will take care of functions like periodically updating the procurement plan, development of specifications, monitoring of the procurement done by EPW/Procurement Agent and SIS, and supply chain management etc. NACO/SIS may also procure pharmaceuticals and medical supplies directly from UN agencies acting as suppliers with the prior approval of the Bank.

Services: Until such time the procurement and supply management capacities of the EPW, NACO and SIS are developed to the satisfaction of pooling partners, Consultancy services contracts for firms estimated to cost more than US$150,000, and individual consultants costing more than US$50,000 will be carried out by a qualified procurement agent or through a UN agency hired to do so. However pending the outcome of DIR and other reviews, NACO is permitted to handle the procurement of services on its own without involving either EPW or the procurement agent SIS would initially undertake the service procurement up to US$50,000 threshold only except for TI and CST contracts issued to NGO/CBO where the threshold will be US$ 75,000. The duration of TI and CST contracts issued to NGO/CBO contract will initially be one year only and based on the reviews of the contracting arrangements by Bank, SIS and NACO; result of DIR and other reviews and the performance of NGO/CBO during the first year of contract, contracting arrangements for further years will be decided.

NACO has proposed to restructure the current procurement organization and under the proposed NACO organogram, a joint secretary level official shall be the overall in charge of procurement assisted by the Director Administration and Procurement. The day to day operations would be looked after by the Deputy Director Procurement and six other dedicated procurement staff. Bill & Melinda Gates Foundation has extended a grant of US$ 1.5 million to NACO to strengthen the procurement capacity. Financial assistance to this end is also provided for in GFATM support to NACO. NACO will ensure that all the key procurement related posts as identified in proposed organograms for NACO are filled up by October 31, 2007 (including a dedicated procurement staff/consultant for handling the service contracts to be in place by March 31, 2007). SIS will also be required to fill up the key procurement related posts by October 31, 2007.

Details for Procurement of Civil Works

Most of the civil works involved would be small works viz. minor modifications/ alterations/renovation/upgrading of offices/stores/laboratories and establishing or extending infrastructure for blood safety at the state and municipal levels. These would be procured under shopping or direct contracting. There are no civil works expected to fall in the category of NCB/ICB. Wherever it is unavoidable, works less than US$10,000 may also be undertaken by state public works departments using their own resources (Force Account). Total estimated value of civil works is not expected to exceed US$81 million.

Details for Procurement of Goods

Apart from the procurement of pharmaceuticals and medical supplies described in the following paragraph, the project would broadly include procurement of: (i) equipment for modernization of Blood Banks; (ii) Elisa Reader, Shredder for hospital waste, Plasma Fraction units, Blood Separation units and consumables for equipment; (iii) vehicles for AIDS societies, mobile blood banks and refrigerated vans; and (iv) computers, furniture and other office equipment. Total value of goods excluding pharmaceuticals to be procured is estimated to be US$85 million approximately.

Goods/equipment under the project will be procured following ICB, NCB, LIB, Shopping, and Direct Contracting (DC). Rate contracts of the Directorate General of Supplies and Disposals shall also be an appropriate method of procurement under Shopping only. For NCB for works/goods/equipment/pharmaceuticals, NACO will adopt GOI's Task Force bidding documents as modified from time to time. These documents have been approved by the Bank and have been used for several years for all Bank financed procurement.

Details for Procurement of Pharmaceuticals and Medical Supplies

HIV test kits like Elisa test kits, Hepatitis test kits and VDRL test kits and Blood collection bags shall be supported by the pooled funding with estimated procurement of US$103 million. For procurement under this category, the standard bidding documents for health sector goods shall be used.

Condoms for NACP III will continue to be procured by MOHFW under existing arrangements and will be financed by the government outside the pool. However, NACO will set up an arrangement satisfactory to the pooling partners regarding timely delivery and quality assurance (viz. pre shipment and post-shipment/on-site inspections by accredited labs, adherence of agreed quality standards/certification and documentation/periodic reporting to the pooling partners) of the condoms supplied. Expenditures on condoms would be eligible for financing by the Association, as and when arrangements and procedures satisfactory to the Association are being used. The entire procurement for Care, Support and Treatment is likely to be funded by GFATM. In the unlikely event that pooled funding is to be used for ART procurement, acquisition of

such medicines will be guided by a WHO list of approved manufacturers. Furthermore, because of limited number of suppliers and high unit prices, the procurement of ART may require the use of less competitive procurement methods such as LIB.

MOHFW is in process of appointing a qualified consultant to be selected internationally through QCBS procedures, satisfactory to the Bank, to conduct a review of the quality and quantity of pharmaceuticals and medical goods supplied under Bank financed health sector projects. The findings of this review will be used to improve quality of pharmaceuticals and medical goods to be procured by MOHFW under Bank supported projects, including NACP III.

Drugs Controller General (India) (DCGI) is entrusted with issuing Certificate of Pharmaceutical Products (COPP) i.e., Good Manufacturing Practices (GMP) as per WHO certification scheme for ICB contracts. The GMP certificate as per WHO certification scheme (TRS 863) will be issued by a team of three experts, one each from the central government, the state and an independent expert. Pending new certification procedures, it will be ensured that 100% post certification is done for all successful bidders recommended for award of the contract on the basis of existing WHO GMP certificates. Post certification shall include site inspection of the winning bidder and regular pre and post shipment inspections of the goods/medicines.

In case of NCB, shopping and direct contracting, Indian GMP (revised Schedule M), which has been made mandatory for all Indian Pharmaceutical manufacturers, will be applicable. The pooling partners will support procurement of pharmaceuticals and medical supplies through NCB, shopping and direct contracting only after concerns regarding revised Schedule M have been addressed in a way that is satisfactory to the Bank and the recommendations of the detailed implementation review (DIR) of the health sector projects are incorporated in to the GAAP. Until this is resolved, the pooling partners will only finance procurement of pharmaceuticals and medical supplies following ICB (or LIB procedure, if applicable depending upon the market situation of the item and its value). MOHFW has prepared technical notes to strengthen the Indian GMP and shared the same with the Bank. The workshops to train the state drug inspectors in using these technical notes are planned shortly.

Details of Procurement of Services

Services to be procured include hiring of agencies as procurement agent, inspection agent, institutional strengthening, training and preparation of training guidelines and modules, workshops for inter-sectoral linkages and collaboration, IEC, advocacy, contractual services to private parties and NGOs/CBOs (including TI contracts), maintenance contracts and contractual staff. Total estimated cost of consultancy services is US$372 million approximately.

For hiring of consultant services, the method of selection would be QCBS, QBS, SSS, LCS, CQS, hiring of service delivery contractors and hiring of individuals. All consultant services contracts below US$50,000 equivalent shall be made per procedures prescribed

in the NACO Procurement Manual. Above this threshold, consultants would be procured as per the World Bank's "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated May 2004 and World Bank's standard request for proposals (RFP)[15].

Due to their reach and economy, state owned agencies like Doordarshan (state television channel), All India Radio (state radio channel), DAVP, DFP, Song & Drama Division etc. are planned to be contracted on single source basis for IEC campaigns. Based on the justifications provided, IDA has no objection for contracting these dependent agencies on sole source basis as per the details indicated in the procurement plan.

SIS would use the NGO/CBO Guidelines prepared by NACO for conducting the due diligence process to identify the NGO/CBO to be contracted through SSS (alternatively CQS may be used for engaging NGO/CBO) for TI and CST contracts. These service contracts would typically have a maximum value of USD 75,000 per year, subject to an aggregate of USD 150,000. NGO/CBO under the service contracts issued by SIS would be permitted to procure pharmaceuticals and medical supplies manufactured by WHO GMP certified manufacturers (as per the list available on MOHFW website) up to 5% of value of the contract or USD 3500 per annum, which ever is higher. However this arrangement will be reviewed once the results of DIR are available. The agreements to be issued to NGO/CBO for TI and CST contracts would include the provisions like the Bank's right to audit, Bank's remedies in case of fraud and corruption and the agreed arrangements for procurement of pharmaceuticals and medical supplies by NGO/CBO. In case of any conflicting provisions between the NGO/CBO guidelines and the agreed procurement arrangements, the provisions contained in agreed procurement arrangements would prevail.

Details of Operating Expenditure:

The expenditure on routine operation and maintenance of buildings, equipment, furniture and vehicles; office rentals/utilities bills, salaries to project staff, general office expenses, travel allowances for project staff, expenses for participation of project staff in training, expenses for hiring of vehicles etc. shall be governed by the rules and regulations of the NACO/SIS.

Assessment of the Agency's Capacity to Implement Procurement

The Constitution of India (Seventh Schedule) lists specific subjects in which the union government or the state government alone can make laws and concurrent subjects in which both the union and state government can make laws. Procurement falls in the concurrent list.

[15] In case the service providers are engaged for non-intellectual types of services and the services contracted on the basis of performance of measurable physical outputs, these will be procured in accordance with the World Bank's Guidelines: Procurement under IBRD Loans and IDA Credits dated May 2004 and the thresholds/procurement methods as indicated for goods shall be applicable in such cases.

Procurement of goods/works and services by MOHFW and the state governments (except for Tamil Nadu and Karnataka, who have passed their own procurement legislations) is regulated mainly by the General Financial Rules of the Government (GFR), 2005; Indian Contract Act 1872 as amended to date, Sales of Goods Act and, in special cases, by the Essential Commodities Act.

A Country Procurement Assessment Report (CPAR) was prepared in 2001, which provides an understanding of National Procurement System. A State Procurement Assessment Report (SPAR) was also prepared for the states of Karnataka, Tamil Nadu, Maharashtra and Uttar Pradesh in 2002 and 2003. Based on these assessments, the existing basic framework of rules and procedures in India requires open tenders; open to all qualified firms without discrimination, use of non-discriminatory tender documents, public bid opening and selection of the most advantageous contractor/supplier. However, the various assessments (CPAR/SPAR) revealed significant weaknesses and lack of compliance with the basic framework of rules and procedures, as follows; absence of a dedicated policy making department, absence of a legal framework, absence of credible complaint/challenge/grievance procedures, absence of standard bidding documents, preferential treatment in procurement, delay in tender processing and award decisions, adoption of two envelope system and negotiations.

The issues listed above are generic issues at the country level and are being discussed as part of the country dialogue with the government. Revised General Financial Rules (GFR) were already issued in 2005 albeit with some shortcomings. This dialogue is continuing with the government to improve the procurement regime in India. However, specific issues for the project are intended to be addressed through the Governance and Accountability Action Plan (GAAP) and NACO procurement manual.

All states and union territories will be participating in the NACP III project. A review (funded by DFID) of existing procurement policies and procedures was carried out through a consulting firm in respect of NACO and a sample of SIS, local units, and independent support units, to identify areas of weaknesses and suggestions for strengthening of the government procurement systems, to allow their use for procurement under the program. The study pointed out various weaknesses in areas such as weak procurement organization (both at NACO and SIS), selection of PSAs, delays in finalization of annual procurement plans and poor quality of procurement plans, ambiguous and incomplete specifications for equipment and pharmaceuticals, procurement procedure followed by NACO, delays in procurement decisions including delay in technical evaluation, piece meal procurement by SIS, absence of SBD for procurement on rate contract basis, absence of procurement manual, quality assurance and inspection of goods, supply chain management, logistics and cold storage facilities, capacity of procurement personnel, post-award reviews, complaint handling mechanism inclusive of independent appeals procedure etc. The areas for strengthening have been identified in the report, and will be addressed through the NACO and the states' own Procurement Reform Programs. The Central GAAP (and State GAAPs, if any) shall be further strengthened, based on the risks identified and the recommendations of the DIR, the procurement review by international consultants supporting the EPW, and the report

on the assessment of quality and quantity of pharmaceuticals and medical goods/supplies under the Bank supported projects.
NACO has been traditionally procuring the services without involving the PSAs and has developed some in-house capacity for handling specialized service procurement. These services include IEC, specialized studies and training activities, operational and epidemiological research and other services. Based on these factors, NACO will be permitted to handle the procurement of services on its own and without involving either EPW or the procurement agent.

A major part of the project will be implemented through NGO/CBO, who will be issued a large number of contracts (about 4000 in number). Monitoring such large number of contracts poses additional risk as SIS are not well equipped to do so.

Based on the findings of the CPAR, SPARs, the findings of the above-mentioned study and the irregularities observed in RCH-I, the procurement risk is considered to be *high*.

Keeping in view the experience gained and lessons learned in the RCH I project, issues relating to improving GMP certification process, increasing competition and mitigating collusion, strengthening procurement implementation including supply chain management and contract monitoring, handling procurement complaints, and disclosing information have been discussed with NACO and MOHFW at a senior level, which along with the agreements reached on proposed actions, are described in the attached GAAP.

Procurement Plan

The total value of the procurement from the pooled funding is about US$640 million over the five year project period. In the event that further scaling up of the program or inclusion of new categories under the pool financing is decided at mid-term review stage, the procurement plan will change accordingly. During the first 18 months, the value of the procurement is likely to be about US$179 million.

The SIS will handle the procurement of goods, works and services up to a threshold of US$50,000 in the beginning except for NGO/CBO contracts where the initial threshold will be US$ 75,000. Periodic assessment of the SIS capacity will be carried out by NACO. On the basis of the results of these assessments and also other reviews conducted by the Bank and NACO reflecting the SIS capacity to undertake procurement consistent with the GAAP principles, additional responsibilities for procurement may be transferred to the SIS.

Procurement plans have been prepared by NACO for the full project period for contracts for goods and works to be awarded under NCB/ICB/LIB and for consultancy contracts aggregated under different activities. NACO has also indicated aggregate values under shopping/DC/Force Account under different categories of items, which have been reflected in the procurement plan with a note that these shall be procured by the SIS and value of each contract will be below the threshold for shopping/direct contracting/force account. Keeping in view the fast changing scenario in HIV/AIDS sector and also due to

new donors coming up for funding the sector, the procurement plan may require frequent changes.

The summary of the procurement plan (including both pooled and non-pool funding) is given below:

Pooled Funding (DFID, World Bank, Government of India)

S.No.	Item Category	Cost (Rs.Lakhs)	Method of Procurement	Procurement by
A	**Medical Supplies**			
1	TEST KIT ELISA	2075	ICB	NACO
2	HEPITITIS-C ELISA	1689	ICB	NACO
3	HEPITITIS-C RAPID	8208	ICB	NACO
4	HEPITITIS-B KIT ELISA	2456	ICB	NACO
5	HEPITITIS-B KIT RAPID	5219	ICB	NACO
6	VDRL KIT	1535	ICB	NACO
7	BLOOD COLLECTION BAGS	25100	ICB	NACO
	Sub-Total	***46282***		
B	**Equipments**			
8	COMPUTER	80	Shopping	SACS
9	ELISA READER	1316	ICB	NACO
10	SHREDDER FOR HOSPITAL WASTE	480	Shopping	SACS
11	MODERNIZATION OF BLOOD BANKS			
	a) District Level Blood Banks	82	NCB	NACO
	b) Model Blood Banks and Metro Blood Banks	1593	ICB	NACO
	c) Blood Separation units	2858	ICB	NACO
12	PLASMA FRACTIONATION UNIT	6500	ICB	NACO
13	Consumables for equipments	12523	DC/Shopping	SACS
	Sub-Total	***25432***		
D	**Vehicles**			
14	Diesel Utility Vehicles	675	ICB	NACO
15	Refrigerated Van	5000	ICB	NACO
16	Operating Cost for Vehicles	6562	DC/Shopping	SACS
	Sub-Total	**12237**		
E	**Office Furniture**			
17	office Furniture for SIS	145	Shopping	SACS
	Sub-Total	***145***		
	Total for Medical Supplies/ Equipment	**84095**		
F	**Civil Works**			
1	Minor Modifications, Alterations, Renovations of Mobile Blood Banks, ICTC & ART Centers	36300	DC/Shopping/ Force Account	SACS
2	Creation of 10 Centers of Excellence	200	DC/Shopping/ Force Account	SACS
	Total for Works	**36500**		
G	**Services**			
1	IEC Services from DD/AIR/DAVP/SDD/DFP	13383	CQS/SSS/QBS	NACO
2	IEC Material Development	500	CQS/QCBS/QBS	NACO

S.No.	Item Category	Cost (Rs.Lakhs)	Method of Procurement	Procurement by
3	Media Planning/Monitor	250	CQS/QCBS/QBS	NACO
4	Production of TV Serials	4000	CQS/QCBS/QBS	NACO
5	Radio Spot Production	1867	CQS/QCBS/QBS	NACO
6	Procurement Agent	2685	QCBS	NACO
7	Post Audit of Contracts	400	QCBS	NACO
8	Inspection Agency	1790	QCBS	NACO
9	Inventory Monitoring	400	QCBS	NACO
10	AMC contracts	120	QCBS	NACO
11	Other Consultancies	200	QCBS	NACO
12	M&E Research	6000	QCBS	NACO
13	One time evaluation	150	QCBS	NACO
14	PSU Contracts	2925	QCBS	NACO
15	IEC Contracts at SACS	37500	SS/CQS/QBS	SACS
16	Other Consultancies/service contracts at state	5000	SS/CQS/QBS	SACS
17	TI and CST Contracts to NGO at SACS	35745	SSS	SACS
18	TI and CST Contracts to CBO at SACS	54407	SSS	SACS
	Total for Services	**167322**		
	Total for Pooled Procurement	**287917**		

Prior Review

The method of procurement as well as thresholds for procurement review will be based on the total value of the bid, rather than the value of each individual contract/schedule/ lot/slice. Thresholds for prior review by the Bank are:

Works/Goods:	All contracts more than US$1.0 million equivalent
Services: (other than consultancy)	All contracts more than US$1.0 million equivalent
Consultancy Services:	> US$200,000 equivalent for firms; and > US$50,000 equivalent for individuals

In addition, all contracts to be issued on single-source basis to firms (including NGO/CBO) exceeding US$ 75,000 in value and to individuals exceeding US$ 50,000 in value shall be subject to prior review. In case of single source contract to individuals, the qualifications, experience, terms of reference and terms of employment shall be subject to prior review.

These thresholds shall also be indicated in the procurement plan. The procurement plan will be updated annually in agreement with the project team or as required to reflect the actual project implementation needs and institutional capacity.

Post Award Review

All contracts below the prior review threshold procured will be subject to periodic post review (in accordance with Paragraph 5 of Appendix 1 to the Bank's Procurement Guidelines) on a sample basis. This includes those contracts handled by the procurement agent (or the UN agency acting as procurement agent), NACO, EPW, SIS as well as NGO/CBO. These reviews are meant to ensure that the agreed procurement procedures are being followed. A multi-stage stratified random sampling is proposed for the periodic post reviews. For states, this sampling takes in to consideration the potential risk as well as volume of procurement. In the first stage the states are stratified in to three groups: large states, north eastern states and other small states and union territories. In the second stage the large states are further sub-classified based on Transparency International's corruption ranking of Indian states 2005. The third stage of sampling involves selection of the district from the sampled state. The sample size in each state will be adjusted according to the risk. Accordingly, there will be higher samples in states carrying out large procurement with very high risk (20%) and high risk (15%), lesser samples in moderate risk (10%) and low risk (5%) states. The procurement directly handled by EPW, NACO and NGO/CBO will use a sample size of 10% and those by the procurement agent will be 5%. All the percentage shall be decided on the basis of the number of contracts and the sample shall be representative viz. various procurement methods and sizes of the contracts shall be proportionally included in the sample to the extent possible. The sample size may be increased or decreased based on the findings of the post reviews.

The ex-post review by the Bank will be conducted either by Bank staff or by independent firms hired by the Bank. NACO will implement a document management and record-keeping system to ensure that the data and documentation pertaining to all the contracts are kept systematically by the implementing agencies and are provided to pooling partners in a timely manner. The online database for contracts being developed for RCH II and TB II will also be used for NACP III for the purpose of post-award review as well as for data mining for the purpose of running the anti-fraud and corruption software to be developed as part of GAAP. Another option is to use the data collected by CPMS.

NACO will also hire an independent agency for undertaking yearly post review of the contracts awarded by the program implementing agencies at all levels (Procurement Agent, NACO, EPW, SIS and also NGO/CBO) to cover a minimum of 10% of the contracts issued during the year. The TOR for this agency shall be shared with the Bank for no objection. The report submitted by the consultant would be part of the consolidated audit reports to be submitted to the Bank.

In addition to the above reviews, the C&AG/State Audit Departments, statutory auditors, management auditors and internal auditors for the SIS (all referred in Annex-7) may also cover review of procurement process as part of the financial audit. The agreed procurement arrangement for pharmaceuticals/medical supplies under NGO/CBO contracts would additionally be monitored through a review arrangement satisfactory to the Bank.

Misprocurement

In case goods, works and services have not been procured in accordance with the prescribed procedures outlined in: (i) the Bank's Procurement Guidelines for ICB/LIB/NCB contracts for goods and works contracts above US$100,000; (ii) the Bank's Consultancy Guidelines for above US$50,000; and (iii) NACO's Procurement Guidelines for other methods of procurement, IDA will declare misprocurement and will cancel its portion of the credit allocated to the goods and works that have been misprocured.

Procurement Supervision

Monitoring the implementation of the GAAP would be an integral part of the project review and supervision plan. The supervision of the GAAP has been agreed during the negotiations between the GOI, and the development partners including the Bank, and constitutes one of the legal covenants for the project. In addition to regular monitoring and prior reviews, the designated procurement specialist will be participating in the review missions on bi-annual basis. Further, the periodic ex-post reviews, the ongoing procurement review by the international consultant supporting EPW, report of ongoing DIR and the report of the inspection agency reviewing the quality and quantity of pharmaceuticals and medical goods will provide updates on implementation of agreed procurement processes.

Annex 9: Governance and Accountability Action Plan (GAAP)
Third National HIV/AIDS Control Project

Introduction

NACO, Ministry of Health and Family Welfare (MOHFW), GOI is fully committed to improve governance and accountability by ensuring efficient program management, sound financial management, and better competition and transparency in procurement and supply of health sector goods and services required for delivery of quality services in all its programs. Various mechanisms such as the NACB (for overseeing the program management), NACO Finance Unit (for financial management), NACO Procurement Unit (for procurement of services, monitoring of procurement by SIS and supply chain management) and EPW (for procurement of pharmaceuticals and medical supplies and other goods) are established for this purpose.

Scope and Purpose

NACO, MOHFW has developed this Governance and Accountability Action Plan (GAAP), in consultation with the Pooling Partners (the Bank and DFID), to summarize critical operational concerns relating to program management, financial management and procurement in NACP III. The key issues and actions to address these concerns are included in the matrix below.

The GAAP applies to NACP Phase III supported by the Bank and other Pooling Partners, articulating the specific roles and responsibilities of different stakeholders (public, private and civil society institutions).

The GAAP will be strengthened, as necessary, based on risks identified and the recommendations of the RCH I investigations, the DIR, the procurement review by the EPW consultant, and the report on the quality and quantity of pharmaceuticals and medical goods.

The Bank financed “Food and Drugs Capacity Building project (Credit No. 37770)” would also support some of the broader issues related to strengthening of regulatory institutions especially effective implementation of GMP in the pharmaceutical sector as envisaged under the GAAP.

Issue	Agreed actions	Implementation Status	Person/agency responsible for implementation
Improving quality assurance mechanism	**Implement the quality assurance mechanism agreed to by MOHFW (listed below).** **Making WHO GMP (TRS 863) certification mandatory for ICB.** **Pending new certification procedures (see next bullet) ensuring 100% post certification of all successful bidders recommended for award of the contract on the basis of existing WHO GMP certificates.** **Agreeing on actions for GMP certification process and implementation arrangements satisfactory for pooling partners for non-ICB procurement of pharmaceuticals and medical supplies under pooled financing.** **NGO/CBO will be allowed to procure pharmaceuticals and medical supplies under the service contracts issued to them following the provisions contained in NGO/CBO Guidelines.**	**Agreed, to begin from April 1, 2007** **Agreed, to begin from April 1, 2007** **Agreed, to begin from April 1, 2007** **Completing the agreed actions and incorporating recommendations from the DIR in the GAAP will make non-ICB procurement eligible for pooled financing.** **Agreed, to begin from April 1, 2007**	**NACO, MOHFW (to coordinate for SIS and act as nodal point)**
Increasing competition and mitigating collusion	**Finalizing future lot size, estimated prices and qualification criteria for procurement of pharmaceuticals and medical supplies based on market surveys about availability of products, prices and production capacities of manufacturers.**	**Agreed, to begin from April 1, 2007. Based on toolkit developed by the Bank, the first round of market survey of pharmaceuticals has been completed.**	**NACO & MOHFW (to coordinate for SIS and act as nodal point)**

Issue	Agreed actions	Implementation Status	Person/agency responsible for implementation
	Including a qualification requirement of a minimum share of at least 20% revenue to be derived from non-Bank financed contracts in bid documents.	**Agreed, to begin from April 1, 2007**	
	Seeking "list of references" in the form of an affidavit in case of supplies made to public sector in past contracts. In the case of supplies made to the private sector in the past, affidavit as well as supporting evidence will be sought.	**Agreed, to begin from April 1, 2007. NACO/SIS will verify the authenticity of referred documents on past performance only for the successful bidder.**	
	Including "independent experts" in the bid evaluation process.	**Agreed, to begin from April 1, 2007.**	
	Sharing record of public opening of bids for all contracts with the Pooling Partners within two working days.	**Agreed, to begin from April 1, 2007.**	
	Ensuring payment within 30 working days of receiving the bill with supporting documents from the suppliers or communicating deficiency in the bill within 15 working days.	**Agreed, to begin from April 1, 2007.**	
	Establishing clear and concise bid evaluation criteria.	**Agreed, to begin from April 1, 2007.**	
	Evolving generic and broad technical specifications	**Agreed, to begin from April 1, 2007. MOHFW has compiled a database of generic technical specifications for commonly procured equipment, which has been disclosed on their**	

Issue	Agreed actions	Implementation Status	Person/agency responsible for implementation
		website. The database is currently being refined to make it more useful.	
Strengthening procurement implementation and contract monitoring	**Strengthening procurement capacity at NACO and SIS, including engagement of external consultants, if necessary.** **Establishing a "procurement monitoring and complaints" database* to monitor adherence to the standards listed in the Procurement Manual. This database would be online with restricted access.** **Developing and deploying software for the early identification of indicators of fraudulent or corrupt practices.**	**The capacity at NACO to be strengthened for handling the procurement of services, effective monitoring of procurement and supply chain management. All the key procurement related posts are to be filled by October 31, 2007. Procurement arrangements at SIS to be reviewed by NACO and strengthened suitably. All the key procurement related posts are to be filled by October 31, 2007.** **Agreed, to begin from April 1, 2007. Manual database established in MOHFW and computerized database is expected by March, 2007. NACO/ SIS to follow the same format.** **Software at MOHFW to be developed by July 1, 2008. NACO/SIS to use the same software thereafter**	**NACO & MOHFW (to coordinate for SIS and act as nodal point)**
Handling procurement complaints	**Updating the "Procurement monitoring and complaints" database on a monthly basis.** **Listing and discussing all complaints received**	**Manual database established in MOHFW and computerized database to be operational by March, 2007. NACO/SIS to follow the same database format thereafter** **Agreed, to begin from April 1, 2007**	**NACO & MOHFW (to coordinate for SIS and act as nodal point).**

Issue	Agreed actions	Implementation Status	Person/agency responsible for implementation
	and actions taken in the bid evaluation report. **Providing details of the administrative process for the disqualification of bidders who engage in misrepresentation in the bid process or in contract execution.** **Reporting the status of investigation of complaints and measures taken in quarterly progress reports to the Secretary (Health & Family Welfare).** **Sharing complaints status with the pooling partners once every quarter.**	**Agreed, to begin from April 1, 2007** **Agreed, to begin from April 1, 2007** **Agreed, to begin from April 1, 2007**	
Disclosing Information and promoting oversight by the civil society	**Making publicly available all annual procurement schedules for ICB and NCB promptly after finalization on the NACO website.** **Posting all bidding documents and requests for proposals (RFP) for all procurements above US$100,000 on the NACO website.** **Making available to any member of the public promptly upon request all shortlist of consultants and in case of pre-qualification, list of pre-qualified contractors and suppliers.**	**Agreed, to begin from April 1, 2007** **Agreed, to begin from April 1, 2007** **Agreed, to begin from April 1, 2007** **Agreed, to begin from April 1, 2007**	**NACO & MOHFW (to coordinate for SIS and act as nodal point).**

Issue	Agreed actions	Implementation Status	Person/agency responsible for implementation
	Disclosing information on prequalification, all bids received reasons for rejections, and award of contracts on the NACO website and sharing the same with the pooling partners to disclose at their preferred websites. **Posting annual progress (program and financial information) and Mid Term Review reports of the program on the NACO website.** **Posting annual reports of the SIS on program performance, including the audited financial statements on the websites of NACO/ SIS.** **Moving to e-procurement.**	**Agreed, to begin from April 1, 2007** **Agreed and to be introduced after project effectiveness in phased manner.** **Will be developed under the Bank supported E-Bharat project.**	
Improving Program Management	**Use the Dashboards at National and SIS level to effectively monitor the performance of the program and Implementing Agencies**	**Agreed, to begin from April 1, 2007**	**NACO & MOHFW (to coordinate for SIS and act as nodal point).**
*** The database should specifically allow: (i) complete and adequate record keeping and retrieval of all documents supporting each bid including unit prices quoted and prices at which contracts are awarded; (ii) quantities and dates of supply as per the contract and actual; (iii) rejection of supplies, if any, with reasons; (iv) date bill received, value, and date of payment and (v) complaints received, responses sent and actions taken by dates.**			

Annex 10: Economic and Financial Analysis
Third National HIV/AIDS Control Project

Economic Analysis

HIV/AIDS cases have been detected in every state of India. Although NACP II has helped to reduce the rate of increase of HIV infection in HRG, HIV prevalence is 8.44 % for CSWs, 8.74% for MSMs and 10.16% for IDUs. Sentinel surveillance data from Mumbai indicates an infection rate of 44% in CSWs and nearly 10% in MSM, while the North eastern state of Manipur has detected 22% infection among IDUs in 2004.[16] The cause of transmission is overwhelmingly through sexual contact, spreading from HRG to the general population through mobile population such as truckers and migrant workers.[17] The total number of HIV-positive adult individuals in India was estimated to be 5.2 million in 2005, while the estimated number of infected individuals in HRG is around 0.5 million. The data therefore points to significant externalities in the transmission of the epidemic, affecting people who do not engage in high-risk behavior or are not part of the bridge population. Mapping of high-prevalence districts show similar levels of prevalence across state borders, for example, between Maharashtra and Karnataka. This indicates the need for a national-level response in dealing with the crisis, since HIV/AIDS also generates geographical externalities.

Recent research has shown significant loss of income of PLHIV households across occupational categories, both in urban and rural areas. The most severe implication is for those households where the primary earning member is incapacitated due to HIV/AIDS.[18] The absence of a social safety net implies that most of the HIV/AIDS related expenditure is out-of-pocket. This leads households resorting to borrowing, dis-saving and selling assets to pay for increased healthcare costs. Data on income distribution of HIV-positive households is not yet available in India. However, it is quite conceivable that, just as for many other health problems, poor households will sink deeper into poverty, which might have inter-generational impact. The growing body of evidence, therefore, points to strong economic justification for NACP III in terms of both market failure and impact on poverty.

Market Failure: Theoretically, a system based completely on market mechanisms will fail to ensure socially optimal provision if there are substantial externalities, either positive or negative. Taking specifically the case of HIV/AIDS prevention in India, substantial negative externalities exist due to the transmissibility of the infection from HRG to the general population. The spread of HIV/AIDS can be restricted by changes in sexual and high-risk behavior through targeted interventions, information campaigns, and providing integrated support services. Relying only on the market will lead to an undersupply of these services and a higher cost of access to prevention and treatment for HIV/AIDS. NACP III also addresses the need for better institutional capacity as well as a

[16] Sentinel Surveillance Data, 2004. Source: NACO
[17] Over 85 percent of cumulative AIDS cases until July, 2005. Source: NACO.
[18] Socio-economic Impact of HIV/AIDS in India. NACO-NCAER-UNDP Study, 2006

revamped surveillance and monitoring system, which until now are perceived to be weak links in program implementation. These fall in the category of public goods, and therefore need to be funded by the government. The rationale for public intervention, therefore, is in part due to the inability of the market to allocate resources in a cost-effective and efficient manner. Moreover, states acting on the basis of information within their jurisdiction would fail to account for the spillover effects across sub-national borders. This justifies a national strategic policy framework and its monitoring that takes into account the spillover of the epidemic across sub-national jurisdictions. Substantial economies of scale are possible with a publicly funded unified policy, surveillance and monitoring framework, as envisaged in the PIP.

Impact on poverty would provide a strong argument for public intervention, Public expenditure on mitigating the costs of care and treatment is justified especially for disadvantaged or discriminated-against high-risk groups, and given the unusually large burden that HIV/AIDS poses on households. NACP III therefore incorporates both externality and equity considerations in the design of the program, in line with the recommendations of the World Bank OED Report on improving the effectiveness of HIV/AIDS assistance.[19]

Cost Effectiveness: Targeted interventions aimed at preventing the spread of the epidemic are justified in terms of their cost-effectiveness and efficiency. Significant advances were made during the NACP II period in understanding the nature of the propagation of the epidemic in India. Behavioral surveys and geographical mapping provide strong evidence that interventions focusing on HRG will be better able to disrupt the routes of transmission of HIV/AIDS, and consequently its progression from a concentrated to a generalized epidemic. Since nearly 90 percent of HIV/AIDS infections in India are either through sexual contact (FSW and MSM) or through intravenous drug use, it is possible to prevent substantial number of possible future infections if resources are utilized and targeted efficiently.

Three possible program designs have been evaluated in the simulation model for the NACP III. The business-as-usual case of the NACP II level of interventions would lead to a marginal reduction in the number of people living with HIV in 2011. The second option is to scale up ART maintaining the same level of targeted interventions currently being undertaken. The mathematical model predicts that this would in fact lead to more than a million more individuals living with HIV by 2011, since there is a high probability that high-risk behavior may increase with the perceived physiological well-being due to ART. The third alternative is to strategically scale-up prevention activities for HRG, aiming at a coverage of 80 percent through targeted interventions. This would lead to a reduction in the number of HIV-positive persons by 2011 by nearly one million. Treatment, care and support would also have intensive counseling built into the program to negate the chances of ART patients resuming high-risk behavior. The combined impact of these interventions would facilitate the objective of stabilizing and reversing the epidemic, in line with the MDGs.

[19] Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance. Operations Evaluation Department, World Bank, 2005.

It is clear from the simulation model that the third strategy, the one set out in the PIP, is the most effective one in disrupting the core transmission mechanism of HIV/AIDS in India. Analysis of data on the size of the HRG, coverage rates and projected expenditure in NACP III yields a cost of US$500 per person reduction in the HIV prevalence in the terminal year of the program. In comparison, provision of ART would entail a cost of US$1000 per person covered, and has to be sustained over the foreseeable future mainly through public provision. Scaling up of targeted interventions is therefore cost effective compared to treatment, care and support. The substantially share of expenditure for prevention and public goods such as institutional capacity building, program management, surveillance and monitoring in NACP III budget reflects the priorities of effectiveness of interventions both in terms of cost as well as outcome, as outlined in the OED report.

Financial Analysis

The financial analysis is structured around three broad themes: (i) a review of NACP II expenditure and the lessons learned from the experience; (ii) justification for scaling up of the program and the risks involved in doing so; and (iii) the long-run sustainability of the program in the context of the political and fiscal situation of the country.

Review of NACP II: During NACP II, a total of nearly US$400 million was spent jointly by the World Bank, other bilateral/multilateral institutions such as DFID, USAID and the UN system, and the Government of India. However, the total resources for HIV/AIDS is estimated to be one and a half times that amount (nearly US$600 million) since the resources mobilized through private NGOs such as BMGF, CF and other smaller donors could not be tracked in the NACP II budget framework.

Although NACP is a fully central government funded program, SACS/Municipal AIDS Control Societies (MACS) were established to decentralize the planning and implementation at the sub-national level. However, several states have performed well below par in terms of resource utilization. During NACP III, further devolution of implementation is envisaged, subject to the strengthening of the institutional, infrastructural and organizational capacities both for the SACS/MACS also the public health system. The significant scaling up of programs and resources would require a higher level of efficiency in the sub-national implementing agencies.

NACP III incorporates two important lessons learned from NACP II. First, it advocates a "Three Ones" framework, where all DPs will work under one unified program of action, coordinating with one implementation agency at the central level and will use one agreed monitoring and evaluation framework. This will ensure transparency in resource mobilization and will eliminate duplication of effort at the implementation stage. Second, the PIP stresses the importance of improving program implementation and resource utilization capacity both in NACO and the SACS. Effective monitoring of program indicators are being finalized as part of the M&E system, which will help match the inputs to outputs and outcomes. NACP III intends to generate and use available data and evidence to inform implementation.

Justification for Scaling-Up: The latest population projections indicate that nearly 3.3 million people in India will die of HIV/AIDS between 2006 and 2011, and by 2026, the population will be 16 million less than in the case without HIV/AIDS, assuming current prevalence levels.[20] The primary justification for the increased resources needed for HIV/AIDS is that India needs to intervene decisively to stop the transmission of the epidemic by focusing on HRG that is likely to save up to 16 million lives in the long run. Apart from the number of lives saved, immediate scaling up of prevention measures costing US$1.6 billion over five years will reduce the long-run cost of providing universal access to ART, which will cost US$1000 per person in the period of NACP III itself. Increased expenditure on targeted interventions now will therefore significantly reduce long-run budgetary expenditure. There is however a significant risk in terms of the institutional capacity for absorbing the increase in expenditure at the sub-national level, which has to be effectively monitored.

Sustainability of the Program: During the last two years of NACP II, there was a significant increase in domestic expenditure by the GOI, averaging nearly US$55 million between 2004-05 and 2005-06. Government spending on HIV/AIDS was 32 percent of total public health expenditure, and 4.75 percent of the total GOI expenditure on health in 2005-06. However, HIV/AIDS spending was 76 percent of expenditure on all central disease control programs put together. A significant scaling-up of expenditure on HIV/AIDS may affect resources available for diseases such as tuberculosis, malaria, leprosy and other vector-borne diseases.

Projections of health expenditure indicate that while this might indeed be true in the first two years of NACP III, it is mitigated by two factors. First, there is significant front-loading of NACP III expenditures in the first half of the program in conjunction with the increase in the scale of targeted interventions. Second, there has been an average increase of 15 percent in the health budget over the last four years, and this trend is likely to continue in the future. Public health expenditure in the health budget of GOI (including other disease control programs) has increased by nearly 25 percent annually from 2003-04 onwards. This implies that in the last year of NACP III, the share of HIV/AIDS expenditure will be around 23 percent of public health, compared to 32 percent in the last year of NACP II. There is also a convergence plan between NACP and the newly-launched NRHM, which is designed to ensure continuity of HIV/AIDS interventions in the long term. The political commitment to increase public health expenditure, combined with continued high-level DP support, and a strong institutional set-up for the response, make the scale-up of interventions under NACP III a realistic. A continued strong focus of the program on prevention also will help India to deal with its HIV/AIDS epidemic in the long run.

[20] Population Projections for India and the States, 2001-2026. Office of the Registrar General and Census Commissioner, Government of India.

Annex 11: Safeguard Policy Issues
Third National HIV/AIDS Control Project

Environmental Assessment

Provision of preventative and treatment services under the HIV/AIDS project is expected to generate infectious bio-medical wastes such as sharps (infected needles and syringes, surgical equipment, IV sets) infected blood, HIV test kits used in VCT centers, blood banks and laboratories and pharmaceutical wastes. These wastes, if not managed and disposed of properly, can have direct environmental and public health implications. Systematic management of such clinical waste from source to disposal is therefore integral to prevention of infection and control of the epidemic. As per the World Bank's Safeguard policies, this project is classified as Category B, given that negative impacts can be easily managed.

NACO commissioned an Environmental Assessment study, whose main objective was to develop a comprehensive IC-WM Plan, which builds on existing documentation, to ensure the efficient and sustainable management of potentially harmful waste generated from healthcare facilities which cater to the prevention, care and treatment of HIV/AIDS. The study employed primary and secondary qualitative and quantitative data that was obtained by review of existing institutional, legal and administrative framework related to healthcare waste management in the country, field visits to four selected states and survey of sample facilities and consultations with stakeholders.

The main findings of the study included that awareness of regulatory requirements for IC-WM is high but compliance is low and generally, greater attention is paid to infection control than to waste management. Awareness of recommended practices for IC-WM and availability and use of personal protective equipment is comparatively higher in SACS-run facilities. However monitoring and evaluation of IC-WM practices is inadequate and linkages with related programs such as RCH and RNTCP are weak or non-existent despite the cross-cutting nature of this component.

The IC-WM Plan includes recommendations pertaining to: (i) the enhancement of the institutional framework for the implementation, monitoring, review and evaluation of health care waste management; (ii) capacity building, including induction and refresher training of all relevant health care workers; (iii) development of appropriate guidelines and instruction manuals; (iv) provision of equipment and protective clothing; and (v) increasing public awareness and IEC. The Plan also recommends that an external independent audit be conducted to ensure that the proposed activities are on track and are effective.

The draft IC-WM Plan was discussed with relevant stakeholders at a consultation workshop in Delhi on May 8, 2006. Participants included representatives from SACS, Medical Colleges, Vector-borne disease program, Common Treatment Facilities and NGOs. The key recommendations from the workshop included the following and these were incorporated into the draft IC-WM Plan:

- Infection Control is the responsibility of an IC-WM Task Force, which should operate at state and district levels.
- Availability and use of barrier protection and immunization is of prime importance.
- There are four key components of infection control: awareness, immunization, protection gear and management of PEP
- External agencies like the Indira Gandhi National Open University and Toxics Link should be made a part of the process especially for training and monitoring.
- There is need for standardization and dissemination of tools and methodologies and practices for training, monitoring, evaluation and reporting.

In addition to meeting Bank's requirement, the IC-WM Plan will enable the project to be in compliance in accordance with Government of India's BioMedical Rules. Once the systems, as recommended in the Plan, are put in place and efficiently implemented, the potential harmful environmental and environmental health impacts can be controlled. However, successful and sustainable implementation of the IC-WM Plan requires close ongoing collaboration and consultation between NACO and the MOHFW and their respective state-level agencies. It has to be recognized that sharps and blood safety are not limited only to the HIV/AIDS program but should be followed by all healthcare workers. The NACP III will support IC-WM activities only within the scope of its own program, but effective waste management from source to disposal can only be achieved if the existing infrastructure of the state health systems is also strengthened.

NACO plans only minor civil works under NACP III, such as rehabilitation and remodeling of existing buildings. The IC-WM Plan includes guidelines and instructions to mitigate adverse environmental impacts from the proposed minor construction activities. The Plan also mentions the steps NACO will need to take if major construction is planned in the future.

Indigenous Peoples

Social Assessment and Consultations. The project is expected to provide indigenous (tribal) people with benefits within its ambit to expand HIV/AIDS prevention, treatment, care and support to vulnerable rural and tribal areas, and is not expected to have any negative impacts on them. To develop appropriate program strategies and an implementation plan for tribal areas, a social assessment was carried out by the GOI. The assessment included primary and secondary data collection and analysis, a review of the social dimensions of other project preparation studies, and primary and secondary consultations with tribal stakeholders and other participating agencies (e.g., the Ministry of Tribal Affairs, and civil society organizations).

Important among tribal stakeholders are people who are infected or affected by HIV/AIDS, and those at risk of infection, especially sex workers, migrant workers (and families) and IDUs. The Northeast region of the country, especially the states of Manipur, Nagaland and Mizoram, has predominantly tribal populations, and high HIV prevalence,

fueled significantly by injecting drug use. Tribal areas near cities such as Mumbai, and through which truck routes pass are also highly vulnerable. The social assessment consultants interacted with these groups (and especially with women among them), and with health and non-health organizations working with them, in several states and districts in different parts of the country. Secondary consultations were held at the national level. In addition, the NACP III Planning Team and 14 Working Groups who prepared the project also interacted with tribal (and non-tribal) people across the country. The draft social assessment report and Tribal Action Plan (TAP) were disclosed in May 2006 on a widely-known and interactive UNAIDS/NACO organized "AIDS Solution Exchange" website. The final social assessment report and TAP take into account the feedback received through this mechanism, as well as through the consultative workshops and formal reviewers. They were made available on the NACO website in November 2006. The SACS and DAPCUs will disseminate summaries in the appropriate local languages within the next six months.

Key findings of the social assessment include: (i) low awareness and knowledge of HIV/AIDS and STIs among tribal people, except in the Northeast; (ii) wide variation in sexual and marital practices which have a bearing on partner infection; (iii) very low access to modern health facilities and high use of traditional healers or unqualified practitioners; (iv) and high vulnerability among youth and those who come into contact with non-tribal populations, including migrants and women who engage in sex work. The TAP aims to address these issues, involving and benefiting tribal communities, as an integral part of the NACP III.

*Tribal Action Plan***.** The implementation plan (see matrix below) is designed to improve the access of tribal people to information, prevention and comprehensive care and support under NACP III, and is tailored to three types of tribal situations. First, in the predominantly tribal northeastern region, AIDS prevention and treatment services will be strengthened and scaled up state-wide through NGOs and CBOs and government health facilities, under plans prepared and monitored by the SACS and DAPCUs. Second, in states with designated tribal sub-plan areas which have concentrated tribal populations (i.e., about 195 sub-district areas), the SACS and DAPCUs will map the vulnerable tribal groups and collaborate with officials of the Integrated Tribal Development Authorities (ITDAs) to improve prevention and treatment services. In both these sets of states, IEC materials will be translated (with the help of the local Tribal Research Institutes), and local communication channels would be used to promote safe behavior, increase access to condoms, and provide referrals to ICTC and ART services. NACO and the SACS will cooperate with the Health departments of all states to strengthen ICTC and ART services. These services will be provided free of charge to poor tribal people. Patients and attendants who travel to health centers for diagnostic or treatment services will be compensated for travel and related expenses. Districts have been categorized according to HIV prevalence and different packages of services (requiring difference resource allocations) will be made available for each category. Third, tribal people who are dispersed among non-tribal populations will be reached through mainstreaming efforts, particularly IEC, interventions for migrant workers, and other local initiatives. In all three situations, NGOs/CBOs (especially but not only those involved in tribal

development activities, such as residential schools and producer cooperatives) will collaborate in prevention and referral activities, and those with hospitals and mobile dispensaries will also support treatment and care. Within all three situations, districts in the high and moderate prevalence categories will be given priority attention.

The TAP includes activities to: (a) systematize information about HIV/AIDS in tribal areas/populations; (b) increase the access of tribal people to the range of services provided under NACP (including by improving cultural appropriateness); and (c) integrate HIV/AIDS prevention efforts in the work of other relevant government departments, local development agencies (NGOs/CBOs), and public and private health providers to expand reach to tribal people. The activities include: mapping of risk and vulnerability to HIV among tribal people; increasing awareness campaigns and condom distribution in tribal areas, with communication in tribal languages; increasing referrals of tribal people to ICTCs, STI/OI clinics, ART and other health programs; increasing ICTCs and other ART facilities in tribal areas; and training/sensitizing personnel of other departments so that they can promote HIV/AIDS prevention and care. The TAP will be translated in local languages within six months after effectiveness.

Implementation Capacity. As the NACP III is expected to expand significantly in rural and tribal areas to scale-up HIV/AIDS prevention, treatment, and care and support activities, increasing implementation capacity is a central feature. The TAP includes: establishment of a Tribal Technical Resource Group at the national level, and a regional office of NACO in the Northeast; contracting of NGOs and CBOs that are familiar with tribal culture and development work to implement action plans in the districts as well as to carry out broader activities such as training at district and state levels; and increasing the capacities of other government agencies – from state-level tribal councils to field staff - to implement and monitor HIV/AIDS activities for tribal people. In all states the SACS will ensure that tribal people receive due attention and benefits from the program as well as other marginalized groups. The TAP also aims to sensitize health staff to cultural differences and train them to reach out and provide services to tribal people, and to involve traditional health practitioners in the program.

As the social assessment found that there are few NGOs in tribal areas, the program will build on other existing initiatives for social mobilization and community involvement, notably those of the Health and Tribal Affairs departments, particularly the ITDAs. The ITDAs have Tribal Facilitators who carry out IEC activities. The NACP will collaborate with these departments as well as with private health service providers and institutions, and civil society organizations engaged in tribal development programs.

- *Monitoring and Evaluation:* Implementation of the TAP will be monitored at least annually at the district, state and national levels on the basis of reports filed by the implementing agencies. These reports will be made available to the Bank and other Development Partners during annual review missions.

Budget. The Northeast Region will get 10 percent of the total budget for program implementation, which is “earmarked” and “non lapseable”. This would cover all six

prevention components, treatment, care and support. Costing has been done with the special characteristics of the Northeast in mind. In other tribal areas, the ITDAs (which are "single-window" authorities in which all departments report to a Project Officer) have a health budget for primary health care, mobile units, referrals to city hospitals, etc. The NACP III will make an additional grant of a minimum of Rs. five lakhs to each ITDA through the SACS to raise awareness and mainstream HIV into all programs being implemented by the ITDAs. Further funds will be provided through the micro-plans prepared by the SACS and DAPCUs, and hence cannot be computed at this time.

Tribal Action Plan

Activities	Responsibility	Implementation Mechanism	Schedule (see Note 1)				
			Year I Q1 2 3 4	Year II	Year III	Year IV	Year V
For Entire Program							
Set up Tribal Technical Resource Group (TRG) at NACO	NACO (with MOTA)		x				
Hold quarterly meetings of TRGs	NACO		x x x	x	x	x	x
Prepare guidelines for mapping of risk and vulnerability among tribal groups	NACO (with MOTA)		x				
Translation of Training tools, protocols, IEC/BCC and advocacy materials	NACO through MOTA	Tribal Research Institutes (TRI)	x x x	x	x	x	x
Monitoring of tribal interventions	NACO	Consultants	x x x	x	x	x	x
Preparation of quarterly reports on activities for tribal people	DAPCUs, SACS and NACO		x x x x	x	x	x	x
Evaluation of tribal interventions	NACO	Consultants	x	x	x	x	x
Northeast States							
Scaling up of interventions among HRGs (see note 2)	SACS and DAPCUs	Contracts with NGOs and CBOs					
a. Map hotspots and vulnerable groups			x				
b. Select NGOs and CBOs for TIs			x x x	x	x	x	x
c. Continue support to on-going projects			x x x x	x	x	x	x
Advocate, facilitate, coordinate and support mainstream capacity building programs for IEC	RACU and SACS	Coordinate with state Tribal Departments, Councils, etc.	x x x x	x	x	x	x

Activities	Responsibility	Implementation Mechanism	Schedule (see Note 1)				
			Year I Q1 2 3 4	Year II	Year III	Year IV	Year V
and behavior change, and training of departmental officers to mainstream HIV in their work		Contract with NGOs or others to conduct training.					
Increase numbers of ICTC and ART facilities at government health centers	NACO and SACS	State Health departments	x x x x	x	x	x	x
Monitoring of activities	NACO	Consultants	x x x	x	x	x	x
Evaluation	NACO	Consultants	x	x	x	x	x
For Tribal Sub-Plan Areas and Concentrated Populations in other States							
Map hotspots and vulnerable groups	SACS and DAPCUs	TRIs and Consultants	x x				
Map health care facilities and providers	SACS and DAPCUs	TRIs and Consultants	x x				
Prepare specific tribal action plans within district AIDS control plans	SACS	DAPCUs (with help as needed)	x	x	x	x	x
Increase access to prevention and treatment services	SACS	DAPCUs					
a. Sensitize/train ITDA staff and partner NGOs/CBOs	SACS and DAPCUs (with ITDAs)	Consultants/NGOs	x x x x	x	x	x	x
b. Include HIV/AIDS prevention, care, support and treatment activities in the health activities of ITDA projects	SACS and DAPCUs (with ITDAs)	ITDAs	x x x x	x	x	x	x

Activities	Responsibility	Implementation Mechanism	Schedule (see Note 1)				
			Year I Q1 2 3 4	Year II	Year III	Year IV	Year V
c. Implement HIV/AIDS awareness campaigns	SACS and DAPCUs (with ITDAs)	Links with other agencies and contracts with NGOs	x x x x	x	x	x	x
d. Expand prevention, treatment, and care services through hospitals, girls' complexes and residential schools in tribal areas	SACS and DAPCUs	Contracts with NGOs and CBOs; links with ITDAs and related state departments	x x x x	x	x	x	x
e. Build capacities of health care providers including traditional healers	SACS and DAPCUs	Contracts with NGOs and CBOs	x x x x	x	x	x	x
f. Support mobile dispensaries	SACS and DAPCUs	Contracts with NGOs	x x x x	x	x	x	x
g. Health check-ups and condom promotion at weekly markets	SACS and DAPCUs	Contracts with NGOs	x x x x	x	x	x	x
h. Establish referral services for STI and OI treatment and ART	SACS and DAPCUs	Contracts with local hospitals/NGOs	x x x x	x	x	x	x
i. Ensure coverage of contiguous tribal areas	SACS	DAPCUs to coordinate with each other	x x x x	x	x	x	x
Increase ICTC and ART facilities at government health centers in these areas	NACO and SACS	State Health departments	x x x x	x	x	x	x
Reimburse cost of travel and expenses to ICTC facility for patient and attendant and waive CD4 and ART costs for tribal people	DAPCUs and SAC	State Health departments	x x x x	x	x	x	x

Activities	Responsibility	Implementation Mechanism	Schedule (see Note 1)				
			Year I Q1 2 3 4	Year II	Year III	Year IV	Year V
Translate IEC/BCC materials into local dialects; make them culture sensitive	SACS (with State Tribal Departments)	TRIs and contracts with NGOs	x x x x	x	x	x	x
Conduct training programs on HIV prevention (using trained trainers)	SACS and DAPCUs	TRIs and contracts with NGOs	x x x x	x	x	x	x
Monitoring of activities	SACS	Consultants	x x x x	x	x	x	x
Evaluation	SACS	Consultants	x	x	x	x	x
For Tribal People living among Mixed Populations							
Promotion of HIV/AIDs awareness and condom use	SACS and DAPCUs	Contracts with NGOs	x x x x	x	x	x	x
Increase referrals to ICTCs, and STI/OI treatment and ART for tribal migrant workers, slum dwellers, etc.	SACS and DAPCUs	Contracts with NGOs	x x x x	x	x	x	x
Baseline values and numerical targets for the above activities will be finalized along with those for the program at large by the end of the first quarter of project implementation (expected June 2007) and included in the overall M&E Plan for NACP III.							

Notes:

(1) In Years II to V, activities will be carried out continuously and reported and monitored every quarter.

(2) Interventions to: (a) increase access to (i) BCC (ii) condom promotion services, (iii) STI services (iv) referrals to ICTCs, (v) referrals to care, support and treatment facilities, (vi) mobile dispensaries and (vii) health check-ups and condom promotion through weekly markets; and (b) build the capacities of private practitioners (including traditional healers) in tribal areas to manage STIs, OIs, condom promotion, and referrals to ICTCs. The number and quality of these interventions would be reported and monitored separately.

Annex 12: Project Preparation and Supervision
Third National HIV/AIDS Control Project

	Planned	Actual
Project Concept Note review	06/28/2005	06/16/2005
Initial PID to PIC	07/15/2005	06/29/2005
Initial ISDS to PIC	07/15/2005	06/29/2005
Appraisal	08/30/2006	07/28/2006
Negotiations	02/26/2007	02/26/2007
Board/RVP approval	04/26/2007	04/26/2007
Planned date of effectiveness	08/15/2007	
Planned date of mid-term review	10/15/2009	
Planned closing date	09/30/2012	

Key institutions responsible for preparation of the project: NACO

Bank staff and consultants who worked on the project include:

Name	Title	Unit
Kees Kostermans	Lead Public Health Specialist/Task Team Leader	SASHD
Suneeta Singh	Senior Public Health Specialist/Task Team Leader	SASHD
Mariam Claeson	Program Coordinator (HIV/AIDS)	SASHD
Michele Gragnolati	Senior Economist	SASHD
Snehashish Rai Chowdhury	Operations Officer	SASHD
Aakanksha Pande	Junior Professional Associate	SASHD
Julie-Anne Graitge	Program Assistant	SASHD
Roselind Hari	Team Assistant	SASHD
Shivendra Kumar	Consultant (Procurement)	SASHD
Shanker Lal	Procurement Specialist	SARPS
Mam Chand	Senior Procurement Specialist	SARPS
Om Prakash	Consultant (Procurement)	SARPS
Meera Chatterjee	Senior Social Development Specialist	SASES
Ruma Tavorath	Environmental Specialist	SASES
Mohan Gopalakrishnan	Senior Financial Management Specialist	SARFM
Thao Le Nguyen	Senior Finance Officer	LOAG2
Shellka Arora	Legal Associate	SARIM
Syed Ahmed	Lead Counsel, Operations	LEGMS
Mario Bravo	Senior Communications Officer	EXTCD
David Wilson	Senior Monitoring & Evaluation Specialist	HDNGA

Bank funds expended to date on project preparation:

1. Bank resources: $564,393.89
2. Trust funds: $ 10,490.70
3. Total: $574,884.59

Estimated Approval and Supervision costs:

1. Remaining costs to approval: $ 35,000
2. Estimated annual supervision cost: $250,000

Annex 13: Classification of States and Districts
Third National HIV/AIDS Control Project

The Classification of States

States have been classified for attention and service delivery packages based upon an understanding of several evidence points: states with HIV prevalence of more than one per cent HIV among antenatal mothers presenting to general clinics (as a proxy for HIV prevalence among the general population) have been classified as having "high prevalence"; states with more than five per cent HIV positive among high risk communities as having "moderate prevalence"; and the remainder as having "low prevalence". However, on the basis of vulnerability factors such as migration, size of the population, and status of health infrastructure, "low prevalence" states/UTs are further classified as "highly vulnerable" and "vulnerable" states/UTs.

High Prevalence	Moderate Prevalence	Low Prevalence	
		Highly Vulnerable	Vulnerable
Tamil Nadu	Gujarat	Assam	Arunachal Pradesh
Andhra Pradesh	Goa	Bihar	Haryana
Maharashtra	Pondicherry	Delhi	J & K
Karnataka		Himachal Pradesh	Meghalaya
Nagaland		Kerala	Mizoram
Manipur		Madhya Pradesh	Sikkim
		Punjab	Tripura
		Rajasthan	A & N Islands
		Uttar Pradesh	Chandigarh
		West Bengal	D & N Haveli
		Chhattisgarh	Daman & Diu
		Jharkhand	Lakshadweep
		Orissa	
		Uttaranchal	

District as the Unit of Service Delivery

In NACP III the basic unit of implementation is district. The following criteria have been used for categorizing districts:

	Category of Districts		Number
1	More than 1% ANC/PPTCT prevalence in district in any time in any of the sites in the last 3 years	A	163
2	Less than 1% ANC/PPTCT prevalence in all the sites during last three years Associated with More than 5% prevalence in any HRG group (STD/CSW/MSM/IDU)	B	59

	Category of Districts		Number
3	Less than 1% in ANC prevalence in all sites during the last three years with less than 5% in all STD clinic attendees or any HRG WITH KNOWN HOT SPOTS (migrants, truckers, large aggregation of factory workers, tourists, etc.)	C	278
4	Less than 1% in ANC prevalence in all sites during the last three years with less than 5% in all STD clinic attendees or any HRG OR No or Poor HIV Data With No Known Hot Spots/Unknown	D	111
	Total Districts		611

It is postulated that demands for HIV-related services are likely to be more in the "Category A" district as against Category B, C or D. It is also reasonable to assume a graded demand from A to D types.

State wise Distribution of Districts by Category

Sl. No	States	Type A	Type B	Type C	Type D	Total
1	Andhra Pradesh	22	0	1	0	23
2	Andamans & Nicobar	0	1	0	1	2
3	Arunachal	0	0	8	8	16
4	Assam	0	1	12	10	23
5	Bihar	0	3	30	5	38
6	Chandigarh	0	1	0	0	1
7	Chattisgarh	4	0	6	6	16
8	D&N Haveli	0	0	0	1	1
9	Daman and Diu	0	1	1	0	2
10	Delhi	1	4	4	0	9
11	Goa	1	1	0	0	2
12	Gujarat	2	4	13	6	25
13	Haryana	0	0	19	0	19
14	Himachal	1	0	3	8	12
15	Jammu & Kashmir	0	1	7	7	15
16	Jharkhand	0	0	8	14	22
17	Karnataka	27	0	0	0	27
18	Kerala	0	4	10	0	14
19	Lakshadweep	0	0	1	0	1
20	Madhya Pradesh	3	1	25	19	48
21	Maharashtra	29	1	5	0	35
22	Manipur	9	0	0	0	9
23	Meghalaya	0	0	7	0	7
24	Mizoram	3	1	4	0	8
25	Nagaland	11	0	0	0	11
26	Orissa	1	2	22	5	30
27	Pondicherry	0	1	0	3	4
28	Punjab	2	0	15	0	17
29	Rajasthan	2	5	10	15	32
30	Sikkim	1	0	2	1	4
31	Tamil Nadu	16	7	5	2	30
32	Tripura	0	1	2	1	4
33	Uttar Pradesh	3	2	64	2	71
34	Uttaranchal	0	0	13	0	13
35	West Bengal	3	4	12	0	19
	Total	**141**	**46**	**309**	**114**	**610**

Annex 14: Documents in the Project File
Third National HIV/AIDS Control Project

Project Background Documents

- World Bank, 2006, AIDS in South Asia, Understanding and Responding to a Heterogeneous Epidemic, World Bank, Washington DC
- World Bank, 2004, Country Strategy for India, World Bank, Washington DC
- World Bank, 2004, Attaining the Millennium Development Goals in India: How likely and what will it take?, World Bank, Washington DC
- World Bank, 2001, Raising the Sights: Better Health Systems for India's Poor, World Bank, Washington DC

Government Documents

- NACO, 2005, National AIDS Control Program Phase III, 2006-2011, Strategic Framework, National AIDS Control Organization, Ministry of Health and Family Welfare, India
- NACO, 2006, National AIDS Control Program Phase III, 2006-2011, Strategy and Implementation Plan, National AIDS Control Organization, Ministry of Health and Family Welfare, India
- Ministry of Health and Family Welfare, National Program Implementation Plan for the Reproductive and Child health Project II, Ministry of Health and Family Welfare, India

Project Preparation Documents

- NACO, Revised Strategic Framework NACP Phase III, October 14, 2005
- NACO, Reports of Fourteen Working Groups for Design of NACP Phase III, October 14, 2005
- Draft Note for Monitoring and Evaluation Arrangements for NACP Phase III, October 14, 2005
- Social Assessment of HIV/AIDS Among Tribal People in India, July 2006
- Draft Institutional Arrangements for Implementing the NACP Phase III, October 14, 2005
- Draft Financial Management for NACP Phase III, October 14, 2005
- NACP III Programme Implementation Plan, A Draft Note on Human Resource Requirements (A Tentative Estimate), October 14, 2005
- Enhancing the Role of Civil Society in the NACP Phase III, National Consultation by Civil Society held in Delhi 14-15 October, 2005
- Report from The National Consultation the "Three Ones in India" (presentation) by NACO and UNAIDS, October 10 and 11, 2005
- Report on Stakeholder's Consultation on Environmental Assessment (Infection Control and Waste Management Plan) for NACP Phase III, May 8, 2006 by PRIA
- Report on Procurement Capacity Assessment of NACO & Other Implementing Agencies under NACP Phase III – Volume I & II Executive Summary with recommendations, May 7, 2006

Annex 15: Statement of Loans and Credits
Third National HIV/AIDS Control Project

Project ID	FY	Purpose	Original Amount in US$ Millions				Cancel.	Undisb.	Difference between expected and actual disbursements	
			IBRD	IDA	SF	GEF			Orig.	Frm. Rev'd
P073651	2005	Disease Surveillance	0.00	68.00	0.00	0.00	0.00	65.67	-1.28	0.00
P073370	2005	Madhya Pradesh Water Sector Restructuring	394.02	0.00	0.00	0.00	0.00	371.82	-10.53	0.00
P075058	2005	TN Health Systems	0.00	110.83	0.00	0.00	20.06	81.99	-7.50	0.00
P077856	2005	Lucknow-Muzaffarpur National Highway	620.00	0.00	0.00	0.00	0.00	620.00	0.00	0.00
P077977	2005	Rural Roads	99.50	300.00	0.00	0.00	0.00	376.96	7.84	0.00
P094513	2005	India Tsunami ERC	0.00	465.00	0.00	0.00	0.00	452.69	0.00	0.00
P086518	2005	IN SME Financing & Development	120.00	0.00	0.00	0.00	0.00	79.40	-7.27	0.00
P084792	2005	Assam Agric Competitiveness	0.00	154.00	0.00	0.00	0.00	148.98	-10.50	0.00
P084790	2005	MAHAR WSIP	325.00	0.00	0.00	0.00	0.00	325.00	0.00	0.00
P084632	2005	Hydrology II	104.98	0.00	0.00	0.00	0.00	104.98	4.23	0.00
P078550	2004	Uttar Watershed	0.00	69.62	0.00	0.00	0.00	66.54	-3.35	0.00
P082510	2004	Karnataka UWS Improvement	39.50	0.00	0.00	0.00	0.00	39.50	14.70	0.00
P050655	2004	Rajasthan Health Systems Development	0.00	89.00	0.00	0.00	0.00	87.59	17.00	0.00
P079865	2004	GEF Biosafety	0.00	0.00	0.00	1.00	0.00	0.90	0.12	0.00
P055459	2004	Elementary Education (SSA)	0.00	500.00	0.00	0.00	0.00	372.73	14.04	0.00
P073776	2004	Allahabad Bypass	240.00	0.00	0.00	0.00	0.00	199.68	46.08	0.00
P073369	2004	Mahar RWSS	0.00	181.00	0.00	0.00	0.00	186.25	9.51	0.00
P073094	2003	AP Comm Forest Mgmt	0.00	108.00	0.00	0.00	0.00	78.76	-5.87	0.00
P072123	2003	Technician/Engineering Quality Improvement	0.00	250.00	0.00	0.00	40.11	225.98	57.96	0.00
P071272	2003	AP Rural Poverty Reduction	0.00	150.03	0.00	0.00	0.00	87.37	74.46	0.00
P067606	2003	UP Roads	488.00	0.00	0.00	0.00	0.00	409.29	109.50	0.00
P076467	2003	Chatt DRPP	0.00	112.56	0.00	0.00	20.06	94.46	6.38	0.00
P075056	2003	Food & Drugs Capacity Building	0.00	54.03	0.00	0.00	0.00	55.10	18.49	0.00
P050649	2003	TN Roads	348.00	0.00	0.00	0.00	0.00	308.71	34.47	0.00
P050647	2002	UP WSRP	0.00	149.20	0.00	0.00	0.00	149.05	111.71	0.00
P072539	2002	Kerala State Transport	255.00	0.00	0.00	0.00	0.00	176.21	12.55	0.00
P074018	2002	Gujarat Emergency Earthquake Reconstruct	0.00	442.80	0.00	0.00	80.23	200.80	315.28	-21.93
P050668	2002	Mumbai Urban Transport	463.00	79.00	0.00	0.00	0.00	451.68	119.93	0.00
P071033	2002	Karnataka Tank Mgmt	0.00	98.90	0.00	0.00	0.00	98.56	31.79	0.00
P069889	2002	Mizoram Roads	0.00	60.00	0.00	0.00	0.00	44.74	5.63	0.00
P040610	2002	Rajasthan WSRP	0.00	140.00	0.00	0.00	15.04	111.15	70.00	0.00
P050653	2002	Karnataka RWSS II	0.00	151.60	0.00	0.00	15.04	130.08	56.30	0.00
P071244	2001	Grand Trunk Road Improvement Project	589.00	0.00	0.00	0.00	0.00	329.42	251.09	0.00
P070421	2001	Karnataka Highways	360.00	0.00	0.00	0.00	0.00	190.85	86.85	0.00
P067216	2001	Karnataka Watershed Management	0.00	100.40	0.00	0.00	20.06	74.34	74.16	0.00
P035173	2001	Power Grid II	450.00	0.00	0.00	0.00	0.00	122.61	93.61	18.63
P010566	2001	Gujarat Highways	381.00	0.00	0.00	0.00	31.00	167.71	167.38	108.02
P050658	2001	Technician Education II	0.00	64.90	0.00	0.00	0.00	25.30	10.33	-6.26
P055454	2001	Kerala RWSS	0.00	65.50	0.00	0.00	10.00	34.33	19.44	0.85

Project ID	FY	Purpose	Original Amount in US$ Millions				Cancel.	Undisb.	Difference between expected and actual disbursements	
			IBRD	IDA	SF	GEF			Orig.	Frm. Rev'd
P055455	2001	Rajasthan DPEP II	0.00	74.40	0.00	0.00	0.00	41.54	13.19	0.00
P059242	2001	MP DPIP	0.00	110.10	0.00	0.00	20.06	50.42	38.23	12.51
P038334	2001	Rajasthan Power I	180.00	0.00	0.00	0.00	2.02	63.30	64.99	-2.72
P055456	2000	Telecommunications Sector Reform TA	62.00	0.00	0.00	0.00	20.00	11.47	31.47	5.02
P059501	2000	TA for Econ Reform	0.00	45.00	0.00	0.00	12.03	22.95	4.38	10.20
P010505	2000	Rajasthan DPIP	0.00	100.48	0.00	0.00	0.00	53.17	41.55	16.26
P050667	2000	UP DPEP III	0.00	182.40	0.00	0.00	0.00	32.89	32.43	21.88
P050657	2000	UP Health Systems Development	0.00	110.00	0.00	0.00	30.09	50.79	57.64	0.00
P009972	2000	National Highways III	516.00	0.00	0.00	0.00	0.00	224.20	215.69	-25.80
P067330	2000	Immunization Strengthening	0.00	142.60	0.00	0.00	0.00	1.29	-87.22	0.00
P049770	2000	Renewal Energy II	80.00	50.00	0.00	0.00	18.00	60.47	60.79	39.11
P045049	2000	AP DPIP	0.00	111.00	0.00	0.00	0.00	31.76	7.90	0.00
P045050	1999	Rajasthan DPEP	0.00	85.70	0.00	0.00	0.00	20.64	17.83	17.83
P041264	1999	Watershed Mgmt Hills II	85.00	50.00	0.00	0.00	0.00	4.12	6.65	0.00
P050651	1999	Maharashtra HEALTH SYS	0.00	134.00	0.00	0.00	35.01	17.50	47.31	8.56
P050646	1999	UP Sodic Lands II	0.00	194.10	0.00	0.00	0.00	47.85	39.91	0.14
P045051	1999	2nd National HIV/AIDS Control	0.00	191.00	0.00	0.00	0.00	27.77	24.78	-5.36
P035827	1998	Women and Child Development	0.00	300.00	0.00	0.00	25.07	64.98	78.43	23.88
P049385	1998	AP Economic Restructuring	301.30	241.90	0.00	0.00	0.00	76.08	72.63	38.27
P010561	1998	National Agriculture Technology	96.80	100.00	0.00	0.00	18.00	4.78	27.80	-10.28
P038021	1998	DPEP III (Bihar and Jharkhand)	0.00	152.00	0.00	0.00	30.09	22.84	43.49	21.85
P010496	1998	Orissa Health Systems	0.00	76.40	0.00	0.00	0.00	20.71	14.95	9.94
P044449	1997	Rural Women's Development	0.00	19.50	0.00	0.00	6.72	3.59	11.07	3.71
P010511	1997	Malaria Control	0.00	164.80	0.00	0.00	46.50	25.94	71.82	25.43
P010473	1997	Tuberculosis Control	0.00	142.40	0.00	0.00	13.04	35.90	53.02	39.63
		Total:	6,598.10	6,742.15	0.00	1.00	528.23	8,164.13	2,785.26	349.37

INDIA
STATEMENT OF IFC's
Held and Disbursed Portfolio
In Millions of US Dollars

FY Approval	Company	Committed				Disbursed			
		IFC				IFC			
		Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
2005	ADPCL	42.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2005	AP Paper Mills	35.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
2005	APIDC Biotech	0.00	4.00	0.00	0.00	0.00	0.00	0.00	0.00
2002/03	ATL	1.33	0.00	0.00	0.00	1.00	0.00	0.00	0.00
2003	BHF	10.98	0.00	10.98	0.00	10.98	0.00	10.98	0.00
2001/04	BILT	0.00	0.00	15.00	0.00	0.00	0.00	15.00	0.00
2001	BTVL	48.03	5.00	0.00	0.00	44.60	5.00	0.00	0.00

		Committed				Disbursed			
		IFC				IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
2003	Balrampur	16.01	0.00	0.00	0.00	16.01	0.00	0.00	0.00
2001	Basix Ltd.	0.00	0.98	0.00	0.00	0.00	0.98	0.00	0.00
1984	Bihar Sponge	7.26	0.00	0.00	0.00	7.26	0.00	0.00	0.00
2001/03	CCIL	1.55	0.00	0.00	0.00	0.64	0.00	0.00	0.00
1990/92	CESC	13.09	0.00	0.00	29.18	13.09	0.00	0.00	29.18
2004	CGL	15.00	0.00	0.00	0.00	8.00	0.00	0.00	0.00
2004	CMScomputers	10.00	10.00	2.50	0.00	10.00	0.00	0.00	0.00
2002/05	COSMO	0.00	4.20	0.00	0.00	0.00	4.20	0.00	0.00
2004	Cairn Energy	40.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1995/05	Centurion Bank	0.00	0.07	0.00	0.00	0.00	0.07	0.00	0.00
2005	DCM Shriram	30.00	0.00	0.00	0.00	15.00	0.00	0.00	0.00
2003	DQEL	0.00	1.50	1.50	0.00	0.00	1.50	1.50	0.00
2003	Dewan	12.95	0.00	0.00	0.00	12.95	0.00	0.00	0.00
	EXB-STG	0.31	0.00	0.00	0.00	0.31	0.00	0.00	0.00
2001	GTF Fact	0.00	1.20	0.00	0.00	0.00	1.20	0.00	0.00
1994	GVK	0.00	7.45	0.00	0.00	0.00	7.45	0.00	0.00
1998	Global Trust	0.00	0.00	3.00	0.00	0.00	0.00	3.00	0.00
1994	Gujarat Ambuja	0.00	0.61	0.00	0.00	0.00	0.61	0.00	0.00
2003	HDFC	100.00	0.00	0.00	100.00	100.00	0.00	0.00	100.00
1998	IAAF	0.00	1.13	0.00	0.00	0.00	0.96	0.00	0.00
1995/00	ICICI-SPIC Fine	0.00	2.23	0.00	0.00	0.00	2.23	0.00	0.00
1998	IDFC	0.00	15.46	0.00	0.00	0.00	15.46	0.00	0.00
2001	IIEL	0.00	3.20	0.00	0.00	0.00	2.06	0.00	0.00
1990/93/98	IL & FS	0.00	0.84	0.00	0.00	0.00	0.84	0.00	0.00
1992/95	IL&FS VC	0.00	0.18	0.00	0.00	0.00	0.18	0.00	0.00
1996	India Direct Fnd	0.00	1.10	0.00	0.00	0.00	0.63	0.00	0.00
2001	Indian Seamless	6.00	0.00	0.00	0.00	6.00	0.00	0.00	0.00
1993	Indo Rama	5.24	0.00	0.00	0.00	5.24	0.00	0.00	0.00
1996	Indus II	0.00	0.86	0.00	0.00	0.00	0.86	0.00	0.00
1992	Indus VC Mgt Co	0.00	0.01	0.00	0.00	0.00	0.01	0.00	0.00
1992	Info Tech Fund	0.00	0.39	0.00	0.00	0.00	0.39	0.00	0.00
2005	K Mahindra INDIA	22.00	0.00	0.00	0.00	22.00	0.00	0.00	0.00
2003	L&T	50.00	0.00	0.00	0.00	50.00	0.00	0.00	0.00
1990/93	M&M	0.00	0.01	0.00	0.00	0.00	0.01	0.00	0.00
2002	MMFSL	10.09	0.00	8.01	0.00	10.09	0.00	8.01	0.00
2003	MSSL	0.00	2.29	0.00	0.00	0.00	2.20	0.00	0.00
2001	MahInfra	0.00	10.00	0.00	0.00	0.00	0.70	0.00	0.00
1996/99/00	Moser Baer	19.38	9.68	0.00	0.00	19.38	9.68	0.00	0.00
1997	NICCO-UCO	1.88	0.00	0.00	0.00	1.88	0.00	0.00	0.00
2001	NIIT-SLP	8.69	0.00	0.00	0.00	0.05	0.00	0.00	0.00
2003/04	NewPath	0.00	3.00	0.00	0.00	0.00	2.33	0.00	0.00
2003	Niko Resources	37.78	0.00	0.00	0.00	37.78	0.00	0.00	0.00
2001	Orchid	0.00	3.03	0.00	0.00	0.00	3.03	0.00	0.00
1997	Owens Corning	8.59	0.00	0.00	0.00	8.59	0.00	0.00	0.00
2004	Powerlinks	77.76	0.00	0.00	0.00	32.14	0.00	0.00	0.00

		Committed				Disbursed			
		IFC				IFC			
FY Approval	**Company**	**Loan**	**Equity**	**Quasi**	**Partic.**	**Loan**	**Equity**	**Quasi**	**Partic.**
1995	Prism Cement	10.90	1.96	0.00	5.45	10.90	1.96	0.00	5.45
2004	RAK India	20.00	0.00	0.00	0.00	15.00	0.00	0.00	0.00
1995/04	Rain Calcining	10.00	0.00	0.00	0.00	10.00	0.00	0.00	0.00
2001	SBI	50.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1997/00	SREI	8.00	0.00	0.00	0.00	8.00	0.00	0.00	0.00
1995	Sara Fund	0.00	4.16	0.00	0.00	0.00	4.16	0.00	0.00
2004	SeaLion	5.15	0.00	0.00	0.00	5.15	0.00	0.00	0.00
2001/03	Spryance	0.00	1.00	0.00	0.00	0.00	1.00	0.00	0.00
2004	Sundaram Finance	45.74	0.00	0.00	0.00	45.74	0.00	0.00	0.00
2000/02	Sundaram Home	9.53	0.00	0.00	0.00	9.53	0.00	0.00	0.00
1998	TCW/ICICI	0.00	1.12	0.00	0.00	0.00	1.12	0.00	0.00
2002	TML	50.00	0.00	0.00	0.00	50.00	0.00	0.00	0.00
2004	UPL	17.50	0.00	0.00	0.00	17.50	0.00	0.00	0.00
1996	United Riceland	7.50	0.00	0.00	0.00	7.50	0.00	0.00	0.00
2002	Usha Martin	21.00	3.34	0.00	0.00	21.00	3.34	0.00	0.00
2001/05	Vysya Bank	0.00	3.51	0.00	0.00	0.00	3.51	0.00	0.00
1997	WIV	0.00	0.57	0.00	0.00	0.00	0.57	0.00	0.00
1997	Walden-Mgt India	0.00	0.01	0.00	0.00	0.00	0.01	0.00	0.00
	Total portfolio:	886.32	104.09	40.99	134.63	633.31	78.25	38.49	134.63

		Approvals Pending Commitment			
FY Approval	Company	Loan	Equity	Quasi	Partic.
2005	AP Paper Mills	0.00	0.01	0.00	0.00
2000	APCL	0.01	0.00	0.00	0.00
2005	Allain Duhangan	0.00	0.01	0.00	0.00
2005	Bharat Biotech	0.00	0.00	0.00	0.00
2004	CGL	0.01	0.00	0.00	0.00
2004	CIFCO	0.00	0.00	0.02	0.00
2001	GI Wind Farms	0.01	0.00	0.00	0.00
2004	Ocean Sparkle	0.00	0.00	0.00	0.00
2005	SRF Ltd.	0.02	0.00	0.00	0.00
2005	URL Expansion	0.01	0.00	0.00	0.00
2001	Vysya Bank	0.00	0.00	0.00	0.00
	Total pending commitment:	0.06	0.02	0.02	0.00

Annex 16: Summary of Research Studies for NACP III
Third National HIV/AIDS Control Project

HIV/AIDS and Men Who Have Sex with Men In India: A Desk Review

Description: This report presents a desk review of Men who have sex with Men (MSM) literature and interventions from India to provide recommendations for NACP III planning process. The objectives of the study are to familiarize policymakers and program implementers with issues related to MSM behaviors and persons; review reports and recommendations of the working groups set up by NACP III, particularly those on targeted interventions, communication and advocacy, greater involvement of people living with HIV/AIDS, human rights, and legal and ethical issues; review literature/reports on the recent developments, initiatives, and interventions related to MSM; examine the social and sexual profiles of men who engage in same-sex activities, and the nature of their sexual behaviors and sexual networks.

Groups at Risk: Men who have sex with men include groups identified as *kothis, hijras, panthis/girias/parikhs,* and masseuses. Other groups that occasionally engage in MSM behavior include truckers (2 to 40 per cent), street children, and prison populations. The size of the MSM population for the whole country is estimated to be 2,352,133 and MSM sex workers are estimated to be 235,213. The size of high risk MSM populations (those with 5 or more than 5 partners) is two times bigger than the size of the female sex worker population. Community-based studies show that men who have sex with men are more likely to have different partners and are likely to have more female partners than heterosexual men.

Key Results: The main results from this desk review are that (i) the extent of MSM behavior appears to vary widely by region, although accurate prevalence estimates are not available; (ii) sexual networking and behaviors of MSM place them and their partners at high risk of HIV/STI infection; (iii) low condom use and inappropriate use of lubricants exacerbates HIV/STI risk due to perceptions that the infection is transmitted only through heterosexual intercourse, particularly with sex workers; (iv) poor social acceptance of sexual diversities results in high levels of stigma, discrimination, and violence against MSM; (vi) criminalization of homosexuality further marginalizes MSM.

Program Recommendations

(i) Increase the number of targeted interventions for the most visible MSM populations such as kothis and hijras as a potential means to reach 'invisible' MSM clients and female sex workers. Separate interventions for Hijras should be instituted given their unique identity;
(ii) Identify and institute programs for MSM groups that are hidden and unorganized such as male sex workers, masseurs, and hotel boys;
(iii) Address bisexual men in the general population by identifying places or contexts that promote and sustain homosexual activities such as male student hostels, beaches, lodges, prisons and public toilets;

(iv) Mainstream MSM intervention programs to reach married men and youth from the general population. Anal sex issues should be an integral component of sexual health promotion strategies and education materials;
(v) Create a network of NGOs/CBOs working on MSM issues that will ensure the protection of human rights, reduce stigma and violence, enhance visibility and help build community organization, provide platforms for organized care and support service delivery, and act as channels for capacity building and monitoring of activities.
(vi) Develop innovative BCC programs and specific IEC materials for MSM programs to provide sensitive non-judgmental messages on the risk of multi-partner sex and the benefits of reducing the number of partners among MSMs;
(vii) Reduce stigma and eliminate violence against MSMs through media sensitization on responsible reporting of MSM issues, promoting interactions between MSM groups and other community members, organizing public speakers forums for MSMs, and organizing film festivals, exhibitions of paintings on HIV themes, and recitation of poems.
(viii) Initiate strong advocacy programs for legal reforms on MSM issues. There is an urgent need to undertake legal reforms that repeal Section 377 of the Indian Penal Codes which criminalizes MSM sexual activity.

Prevention Recommendations

(i) Appropriate condoms for anal sex and sachets of water-based lubricants should be made widely available at public and private locations by community-based agencies.
(ii) Health care providers should be trained and sensitized to diagnose and manage anal and oral STIs. Improving access to STI services for MSM should be an integral part of this program.
(iii) Medical curriculum in the country should be reviewed and updated to include training on diagnosis and treatment of anal and oral STIs.
(iv) VCT services should be made MSM-friendly so that MSMs are encouraged to access these services to learn their status and access care and treatment services if needed.
(v) Existing drop-in centers for NGOs can actively provide counseling services for MSMs.

Care and Support Recommendations

(vi) Current care and support efforts of MSM groups, PLHIV networks, and NGOs/CBOs working with MSM population to utilize drop-in centers and forge linkages with mainstream service delivery systems should be carefully monitored.
(vii) MSM PLHIV groups should be initiated and efforts should be made to link them with PLHIV networks in the country.
(viii) Current care and support interventions should provide counseling support to MSM PLHIVs to address the stigma faced by them in society. Efforts can be made to involve families of MSM PLHIVs in care giving if approved by the individual.

(ix) Health care providers should be sensitized to the needs and rights of MSM PLHIVs. This is essential to ensure that MSM PLHIVs have access to ARTs and adhere to treatment.

Assessment of Extent of HIV/AIDS Prevalence Among Central Police Force and Paramilitary Forces

Description: The study examines the extent of HIV/AIDS among paramilitary forces in India. It consists of a KAP survey and focus group discussions with paramilitary personnel, in depth interviews with medical officers, and case studies with HIV infected patients in the paramilitary forces.

Groups at Risk: Groups at risk include paramilitary forces and their families. This includes members of the Assam Rifles, Border Security Force, Central Industrial Security Force, Central Reserve Police Force, Indo-Tibetan Border Police, and Rashtriya Rifles.

Key Results: (i) Estimated crude prevalence rate among the different battalions ranges from 1.35 to 3.57; however, there were several limitations regarding the calculation of this estimate; (ii) There are no separate STD/HIV/AIDS clinics in any of the sector/ zonal/base hospitals of the paramilitary forces, and most hospitals do not have standard test kits or systematic blood testing for HIV; (iii) Behavior patterns and data from focus groups reveals a propensity for risky behavior; (iv) Awareness levels varies with CRP personnel being generally less aware and BSF personnel being generally more aware; (v) Awareness regarding the sexual spread of the infection is generally low among all forces as compared to awareness of spread through infected needles, breastfeeding, blood transfusions; (vi) There is a lack of awareness of condoms as a preventive intervention and it is generally used for family planning purposes. In addition, the strong focus on the 'sanctity of the family' makes it difficult to aggressively market condoms. Condoms are more regularly used for cohabitation with spouses as compared to during extra marital interactions with potentially HRG; (vii) Audio-visual media is considered a more important source of information on HIV/AIDS than print media; (viii) Most paramilitary personnel disapprove or discriminate against HIV infected patients. There is an almost complete isolation of HIV affected patients and their families; (ix) ART pharmaceuticals are in short supply and there is no reimbursement on drug expenditure. Most patients rely on homeopathic or ayurvedic treatment.

Recommendations

(i) Assessment of prevalence should be undertaken on a regular basis using NACO approved methodology. Record keeping and reporting should be standardized.
(ii) A working group should be set up in MHA to coordinate efforts and disseminate guidelines on interventions for the paramilitary forces.
(iii)Senior staff (especially battalion commanders) should be sensitized to HIV. There should be a focus on safe sex practices including use of condoms. Existing channels of communication can be augmented through the dissemination of informational pamphlets.

(iv) ARTs should be available for forces through local SACS. Condoms should be made available at easily accessible places where anonymous transactions are possible (telephone booths, entry of battalion, toilets). They can also be part of weekly or monthly rations. VCT facilities should be available at all centre hospitals.
(v) Care and treatment of affected populations should be addressed through tie ups with local NGOs that provide such services, use of referral hospitals, and transfer to centre/ sector headquarters for appropriate follow up.
(vi) Medical officers and paramedical staff should be trained in STI/HIV/AIDS treatment. Barbers should be given training in safe practices regarding blades and razors.

Assessment of the Vulnerability of Rural Populations to HIV/AIDS

Description: This study assesses the vulnerability of rural populations to HIV/AIDS.

Groups at Risk: According to 2003 estimates, rural India accounted for 59 per cent of HIV infections in India affecting 29.80 lakh people of which 10.95 lakh were women. Women and youth are especially at risk in rural areas due to a low level of knowledge about HIV/AIDS.

Key Results: (i) Correct and complete knowledge on transmission and prevention is still low, particularly in Haryana and Eastern U.P. Youth, men and educated people are better informed**.** Radio and television, posters, banners, skits, and interactions with health personnel are the sources of knowledge. (ii) Sexual behaviors in rural areas are varied and range from pre-marital to extra-marital, oral to anal to vaginal, homosexual to heterosexual, and consensual to forced sex**.** Instances of multiple sexual relations among rural communities are often found which are mostly unprotected encounters since people know each other and have mutual trust**.** Poor women and girls are highly vulnerable and sexual exploitation by land owners and construction contractors is rampant; (iii) Since HIV is often regarded as the 'Disease of others' perception of risk is low. STI is often seen as a sign of virility, hence men are reluctant to get treated; (iv) Condoms are primarily used as family planning interventions. However, condom use is comparatively higher among high risk populations than the general population. Use of condoms is less among the uneducated, poor and MSM groups. Quality, non availability, and rupture of condoms, and religious beliefs are cited as the reasons for not using condoms; (v) AIDS has had a multi-dimensional social, psychological and economic impact of HIV/AIDS on rural populations. Access to public health services in rural areas is limited and people depend largely on unqualified doctors and quacks.

Recommendations

a) A "key influencer" or a person who wields influence on the village community such as a teacher, a panchayat member, or SHG representative should be identified. The training for key influencers may be organized by the district administration in consultation with the District AIDS Officer and would include explaining the benefits of spreading awareness about HIV/AIDS in villages, ways of communication with people including unmarried adolescents about the modes of transmission of HIV/AIDS, ways to avoid myths and misconceptions regarding HIV, associated health problems of HIV infection, ways to eliminate stigma and discrimination, means to support infected individuals, ways

to prevent HIV, and promotion of abstinence from pre/extra marital sex and safe sex practices.

b) The key influencer should identify and train 4-6 people to form a HIV support group which would spread awareness about modes of transmission, prevention, and sexual risk (HIV/STI) reduction to the village population.
c) The AIDS control society should plan and conduct a study to understand local sexual networks. These networks should be targeted for AIDS interventions.
d) Messages on HIV designed by the AIDS control society or local level organizations need to be culture-specific and should target a wide range of the population. Messages should be delivered initially to the women groups or other welfare groups present at the village level followed by other populations. Use of fear based communication messages such as "*AIDS ek jaanleva bimari hai"* should be shunned to eliminate stigma and discrimination in rural areas. Use of standardized folk media would be ideal to give information on HIV to rural illiterate population.
e) Increasing rates of trafficking and exploitation of girls in various sectors are of immediate concerns in rural areas. Prevention of trafficking must be given a priority in HIV prevention programs. There must to be synergy with state and central government run social welfare programs such as poverty alleviation, universal education, and gender equity to protect women against trafficking and exploitation.
f) Increase the training of local doctors on Reproductive Tract Infection (RTI)/STI. Knowledge of the doctors on the treatment of sexually transmitted diseases is limited. Since, health care providers at the local level are seen as important sources of information by the residents of village, in each district efforts should be made to train the private health care providers on syndromic management of STDs.
g) Adequate and regular supply of pharmaceuticals for STD treatment should be made available in sub-centers/PHCs/CHCs. If feasible, a mechanism may be developed by district health authority to keep essential pharmaceuticals for STDs with the local private health care providers as is done in case of tuberculosis management.
h) Currently available testing centers for STDs and HIV/AIDS are not adequate. The state health departments along with the state AIDS control societies should increase the number of testing centers and VCTs so that people who need services can get easy access. Partner notification and treatment for STDs should be encouraged. Necessary steps may be taken to strengthen couple counseling and testing of positive clients.
i) Dual protection of condoms should be advertised. Easy access to quality condoms and instruction for usage and disposal should be made available. Condoms should be promoted through HIV support groups, SHGs, PRIs and other non-conventional access channels.
j) Family members of the infected individuals and the society at large should be educated about HIV to reduce stigma and discrimination; however, special efforts should be made by the state AIDS cell through the district authority to provide care and support to the infected individuals. Treatment of OIs, counseling services, and ARTs should be available to all patients.

Rapid Survey of Health Workers Awareness and Attitudes to People Seeing HIV/AIDS Testing, Care and Support

Description: The study aims to understand the attitudes of medical and paramedical personnel towards persons seeking HIV/AIDS related services and towards HRG. It consists of a literature review on available information on this topic, and a survey in six states (1 high prevalence, 2 moderate prevalence, 2 highly vulnerable, 2 vulnerable) and in two districts with in each state (1 high prevalence, 1 low prevalence). 932 staff members were respondents for this study. Semi structured interviews, key informant interviews, focus group discussions and a survey was administered to subsets of the respondents.

Groups at Risk: Study deals with medical and paramedical personnel who deal with groups determined high risk according to state specific context.

Key Results: (i) *Awareness:* Awareness with regards to signs and symptoms of HIV is inadequate in vulnerable states. There is especially inadequate knowledge on mother to child transmission of HIV through breast feeding. Health workers are unaware of the existence of voluntary counseling and blood testing facilities; (ii) *Capability of Health Workers:* Grass root health workers usually have only twelve years of general education or BA level of education which may make them unable to perform complex health functions; (iii) *Communication*: Mass media is generally the most important source of information regarding HIV/AIDS for general population as also the health workers; (iv) *Supplies of Materials:* Audio-visual materials do not appear to be in adequate supply. Condom supply was generally satisfactory with more availability in high and moderate prevalence states. However there does not appear to be a continuous and uninterrupted availability of condoms. (v) *Institutional and Organisational Systems and Networking*: There is no clarity or guidelines in terms of roles and responsibility of different health functionaries whether in urban hospitals, PHCs or sub-centres, in respect of AIDS Control Programme. Communication with the clinical and field staff especially in rural areas is ad hoc and unstructured and mostly through random personal interactions with the dedicated AIDS Control Programme staff. The institutional arrangements and networking for delivery of services for the AIDS Control Programme is yet to be put in place except in high population capital cities such as Ahmedabad and Bangalore.

Recommendations

(i) *Role and Responsibility of Health Workers***:** The role of health workers in rural areas with respect to HIV/AIDS should be formalized and limited to advise persons whom they suspect to be HIV+ to report to the district or the nearest VCTC for counselling; to keep and distribute IEC material in areas having inadequate mass media presence; to send details of such persons periodically to the VCTC so that the referred persons who do not approach the VCTC can be contacted individually and counselled/tested if willing. The role of Medical officers in PHCs/CHCs/Sub Divisional Hospitals/District Hospital could be the same as indicated above i.e. referring and reporting people to the nearest VCTC/VCTC having jurisdiction.

(ii) *Orientation and Training of Health Workers:* To enable extension staff to perform their new role effectively, they should be educated/exposed/trained clinical and physical symptoms of HIV/AIDS/STI and opportunistic infections. Pamphlet and guidelines on safety precautions including disposal of waste should be circulated and workshops should be held periodically with the aim of covering all hospital and clinical staff at

least once a year. All clinical institutions (PHC etc.) must have such material at their institutions. All institutions in the health department including sub centres should have IEC material in printed form and where feasible (PHCs etc.) audio visual material at all times. It may be difficult to assess individual needs for so many centres and norms for supply could be fixed for every six months. It has been suggested that an interactive phone service should be made available at each district headquarter so that calls from field health institutions for supply of IEC material can be provided immediately.

(iii) *Supplies and Services - Availability of Condoms***:** There is need to develop a new model for ensuring effective availability of condoms, outside the public domain though public sector facilities. The basic requirement is to make condoms easily accessible/available in anonymous surroundings. While it has not been examined in detail, one obvious possibility for urban areas is to ask all banks to install condom vending machines at the ATMs which are open 24 hours. The Banks could even be asked to install the machines at their cost and subsidise the price in public interest as a promotional activity. This will ensure competition and thus quality of condoms.

(iv) *Institutional and Organisational Capacity and Networking:* Each district, irrespective of prevalence/vulnerability, should have at least one AIDS Control Centre which can be run as VCTC also. This should be a specific formal/legal entity as is the case at the state level. A VCTC set up within the PHC will not be the appropriate institutional mechanism for providing various services. Each District AIDS Control Centre/VCTC should have 5 to 10 paramedical staff under a dedicated AIDS Control Programme Officer who are well trained in AIDS related issues and will be in charge of the detection/testing/care and support aspects of the affected persons for the whole district. A fully equipped autonomous team at the district headquarters is likely to be much more cost and result effective. The centres should be authorized if necessary to contract out the care and support functions, to carefully screened NGOs. The district centres should make use of their extensive network of land lines and mobile phones. 24 hours help lines have been installed at the state headquarters and are good for providing information but are not interactive. Each district VCTC/AIDS Control Center could be given a number (as for police control rooms) which in the same all over India and initially it can start operating within defined hours, if not for 24 hours. Finally, the risk groups in any district should be the direct responsibility of District AIDS Control Centres and the programmes in respect to these categories can be (as is being done even at present), implemented by the NGOs. Patch work interventions such as ad hoc distribution of condoms to petrol stations for distribution to truckers may not be effective.

Moving Ahead: Assessment of Current Communication Efforts and Strategies for HIV/AIDS

Description: This study reviews available information, education, and communication (IEC) material on HIV/AIDS. The study evaluates the quality and effectiveness of present IEC/BCC strategies of NACO, SACS and Partners under NACP II; the extent to which these strategies and interventions are evidence-based; and the extent to which they are coordinated and comprehensive. Based upon this analysis, it provides recommendations for a comprehensive IEC/BCC strategy and its implementation in NACP III.

Key Results

(i) There is a mismatch between the national driven BCC framework and the capacity achievable on the ground i.e. at the Panchayat, community, district and state level; (ii)Long and short term goals of NACO are not being woven into the present BCC strategies. The prevailing belief is that these goals are too broad and are beyond the scope of the program; (iii) NACO has formulated a good set of BCC guidelines in its IEC/BCC framework (2004) which should be operationalized into its communication activities; (iv) There has been a continuing shifting in communication messages at the national level (from an emphasis on condoms, to women, to youth), that makes consistent BCC messages difficult to formulate.

Recommendations

(i) **Technical Input:** Second generation technical input should shift from essential service delivery to service demand/ utilization. A strategy should be developed to reduce the impact of the epidemic in rural areas. As a result, the approach should shift from "hot spots" to sexual networks or clusters. Front-end advocacy should be formulated to create an "empathetic attitude" towards PLHIVs. Stigma should be reduced though greater involvement of people living with HIV/AIDS and respect for their human rights.

(ii) **STI/RTI:** Misconceptions persist about sexual health among rural women which needs to be addressed. The perception of the poor quality of government services also needs to be changed to increase demand. Early identification of STI/RTI through BCC will help with the control of HIV. BCC should be focused on men to increase their perception of risk.

(iii) **Condom Use:** BCC activities should be focused to reduce myths and embarrassment about condom use.

(iv) **Service Delivery:** Risk perception needs to be increased and community outreach should take place through HCPs. Communication efforts should target the general population.

(v) **Mainstreaming advocacy:** Advocacy attempts should dovetail with existing platforms and create new platforms. Religious leaders should be involved in advocacy attempts. Inter-departmental/ ministerial collaboration should take place with technical support from NACO/SACS.

(vi) **Research and Knowledge Management:** The evidence based response should be strengthened with increased capacity building for communications research. Also capacity of communications NGOs should be built.

(vii) **Gender, Youth, Adolescents, Children:** A large percentage of youth have misconceptions about HIV. In addition, existing services do not cater to youth. There should be an effort to reach out to youth and mitigate their vulnerabilities. Contraceptives are presently positioned for married couples, but should also be positioned for youth.

(viii) **Care Support and Treatment:** Vulnerabilities of PLHIV should be mitigated through advocacy efforts at the state and national level. IEC should be available for ART use, treatment of OIs, and care and support of patients.

Social Marketing Plan for NACP III

Description: This study outlines a social marketing plan for NACP III and asks for a highly analytical leadership role in NACO and the SACS as interpreters of the environment and designers of good targeted social marketing programs. A second capacity required by NACO will be as a large-scale contract manager for social marketing implementation at the state level or at the level of highly vulnerable districts. The study aims to provide a brief overview of social marketing and its application in India, including under the NACP thus far; outline opportunities for increased social marketing investment under NACP III; and create a plan for actions to be taken to support behavior change through social marketing.

Groups at Risk: Priority groups for social marketing are the widely-dispersed, bridge populations who require intensive communication, condom and STI/VCT service provision on a large scale. Social marketing also is supportive of educational interventions among the general population and efforts among core risk populations through the provision and promotion of condoms, service franchises, and VCT.

Summary of Plan

Preparation: In order to develop such a large-scale social marketing approach, the NACP III team will require a preparatory period to put in place a number of key elements:

- Adequate human resources to lead intensive social marketing project management.
- Assessment and revision where necessary of social marketing policies which may require adjustment to make possible adequate support for HIV/AIDS prevention.
- Funding and contracting mechanisms will need to be secured prior to major programming.
- Orientation at state level on the capacity and role of social marketing.
- Condom and other product procurement standards and mechanisms.
- Segmentation of districts by prevalence and risk behaviour.

Program Design: Project designs will be led by NACO's central team with strong collaboration with the states. Priorities for funding and intensity of social marketing efforts will be allocated by the level of need identified by the district. Four categories of districts are identified with various inputs and investments suggested:

- Focus Districts: High Risk Districts in high prevalence states
- Vulnerable Districts: High risk behaviour districts in low prevalence states
- Diffusion Districts: Low risk behaviour districts with high prevalence nonetheless
- Low Risk Districts: These districts display neither the prevalence level nor the risk profile to sustain an epidemic.

Implementation: Social marketing is an outsourced activity which will require:

- A precise tendering, selection and contracting process
- Persons at the state level to advocate for and support social marketing projects, facilitating necessary approvals, supporting networking and collaboration with other aspects of the effort.
- Monitoring to track the reach and effectiveness of activities

Evaluation: This is the final component of the plan and is necessary to establish the success of social marketing efforts in bringing about the desired behaviour change.

Annex 17: Multi Sector Mainstreaming – A Strategic Approach
Third National HIV/AIDS Control Project

Background

Multi sector mainstreaming is one of the approaches of the NACP IIII to scale up the prevention of HIV infections in HRG and in the general population, and to increase care, support and treatment of people living with HIV and AIDS. Mainstreaming is a *means* to maximize the benefits of a multi sector engagement in HIV and AIDS, drawing on the comparative advantages, different reach, and potential synergies between sectors. Accelerating progress and scaling up require that several key sectors make HIV and AIDS an integral part of their core business. With the current epidemic dynamics (i.e., concentrated epidemics among marginalized groups at high risk, vulnerable youth, urban/rural spread with feminization, mobility and migration, selling and buying sex, injecting drug use…) clearly the prevention and control of HIV and AIDS can not be achieved by one sector alone. AIDS is a health and development problem, several sectors are affected and some of them have key roles and responsibilities for stopping its spread and mitigating its impacts. The driving forces of the epidemic have to be tackled from different fronts including tackling the critical societal constraints and implementation obstacles (widespread stigma, discrimination, taboos) and other structural amplifiers (poverty, inequities, migration).

Definition of multi sector mainstreaming: Key sectors make HIV and AIDS their core business; incorporate HIV and AIDS as an integral part of their policies, products and processes; identify their added value, roles and responsibilities; develop plans and allocate budgets to contribute to the development objectives of the national program; and, coordinate their activities within one common national framework.

Rationale

Several factors underpin the NACP III decision to continue to involve multiple sectors in the fight against AIDS.

1. The inter-dependences of the many risks and vulnerabilities that influence the epidemic and require a multi sector response.
2. The possibilities to increase the program coverage of different segments of the population, such as, improving knowledge, life skills and changing attitudes among youth before they are exposed to risks; creating a workforce that is better informed and protected; and, enabling groups at high risk to access prevention, treatment and care without harassment.
3. The mainstreaming helps to institutionalize the response, and to develop shared ownership among key sectors and partners, such as, education, public and private health, labor, tribal development, public and private sector corporations, roads, railroad and transport, justice and legislative bodies, police and prisons, social protection, to name a few key sectors and agencies.

Situation Analyses

Under the NACP II the government established a high level multi sector National Council on AIDS, chaired by the prime minister. Among some of the achievements to date are initiatives taken to improve workplace policies, inform & educate and provide prevention, treatment and care services for employees, by the India Business Trust/CII, Steel Authority of India, National Highways Authority of India, Central Board of Workers Education (MOLE), Ministry of Defense, Home Affairs, Social Justice and Empowerment. But, many challenges remain: low overall prevalence can lead to complacency and lack of perceived threat; AIDS is often viewed as NACO/SACS exclusive agenda and as an add on activity to other organizations' work programs; and, lack of dedicated staff with technical support have resulted in lack of follow up action, and the inability to translate policies into action. Most ministries and organization do not have workplace policies, dedicated resources, staff or guidelines and they remain untapped resources to the national effort.

The Institutional Arrangements and NACO's Role

The National Council on AIDS with the membership of 31 Central Ministries, six State Chief Ministers and civil society provides the highest political support, leading the mainstreaming of HIV into the works of all organs of government, private sector and civil society. States will establish State Council on AIDS along the same pattern as the National Council on AIDS, to be chaired by the Chief Minister with the Minister of Health as Vice Chair. NACO and SACS have an important steering role and functions at national and state levels, respectively. The agreed on national strategic framework forms the basis for the National Council on AIDS, and it is envisaged that a DP partnership agreement would also support the multi sector mainstreaming.

To strengthen NACO's and SACS' steering role, it is proposed that they would have a dedicated senior core staff, with desk and team, serving as focal person for mainstreaming. A multi-stakeholder Technical Advisory group (TAG) of the National AIDS Council would help to share information and problem solve. NACO/SACS would be responsible for advocacy, capacity development and initial hands on support and facilitation – providing technical support. NACO would take the lead in developing a network of institutions and experts to draw on for these mainstreaming efforts. Identified key ministries and organization will have their own trained and dedicated units/focal person and a work plan, including benchmarks and indicators to measure progress.

Multi sector collaboration takes different forms, such as convergence of inter dependent programmatic areas or of programs reaching the same target audience (e.g., TB, HIV/AIDS, Reproductive health), stronger coordination to maximize the benefits, and integration of HIV/AIDS into existing programs and new national programs (e.g., youth, Rural Health Mission, Integrated Tribal Development Authorities) .

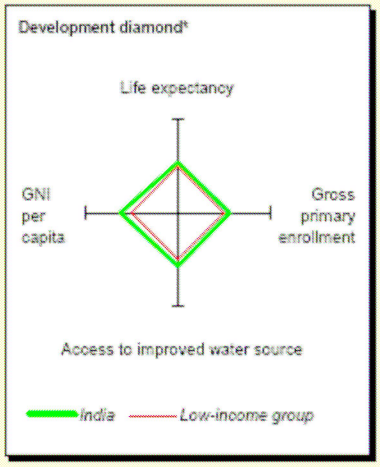
Strategic Objectives of Multi Sector Mainstreaming

The strategic objectives of the NACP IIII are: key government, non-government, private sector and labor organizations adapt core business to respond to the challenge of HIV and AIDS; internal resources are allocated; and, HIV is mainstreamed into the 11th five year plan of the GOI at state and national level.

Annex 18: Country at a Glance

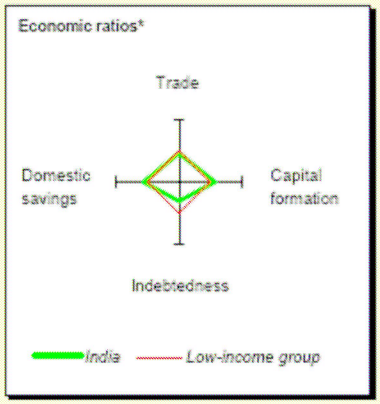
Third National HIV/AIDS Control Project

POVERTY and SOCIAL	India	South Asia	Low-income
2005			
Population, mid-year *(millions)*	1,094.6	1,470	2,353
GNI per capita *(Atlas method, US$)*	720	684	590
GNI *(Atlas method, US$ billions)*	788.1	1,005	1,364
Average annual growth, 1999-05			
Population *(%)*	1.5	1.7	1.9
Labor force *(%)*	1.9	2.1	2.3
Most recent estimate (latest year available, 1999-05)			
Poverty *(% of population below national poverty line)*	29	..	..
Urban population *(% of total population)*	29	29	31
Life expectancy at birth *(years)*	63	63	59
Infant mortality *(per 1,000 live births)*	62	66	80
Child malnutrition *(% of children under 5)*	47	45	39
Access to an improved water source *(% of population)*	86	84	75
Literacy *(% of population age 15+)*	61	60	62
Gross primary enrollment *(% of school-age population)*	116	110	104
Male	120	116	110
Female	112	105	99

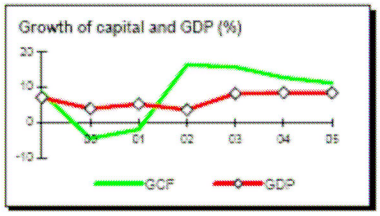


KEY ECONOMIC RATIOS and LONG-TERM TRENDS	1985	1995	2004	2005
GDP *(US$ billions)*	227.2	355.2	694.7	785.5
Gross capital formation/GDP	23.7	26.5	30.1	31.0
Exports of goods and services/GDP	5.4	11.0	19.0	21.1
Gross domestic savings/GDP	21.2	25.3	28.1	27.3
Gross national savings/GDP	21.7	26.6	30.4	29.6
Current account balance/GDP	-2.3	-1.8	-0.9	-1.4
Interest payments/GDP	0.6	1.2	0.4	..
Total debt/GDP	18.0	26.6	17.7	..
Total debt service/exports	23.0	27.8	12.6	..
Present value of debt/GDP	..	..	15.8	..
Present value of debt/exports	..	..	72.6	..

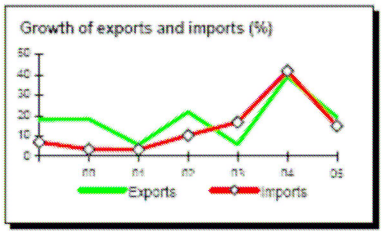
	1985-95	1995-05	2004	2005	2005-09
(average annual growth)					
GDP	5.6	6.0	8.5	8.5	7.7
GDP per capita	3.4	4.3	7.0	7.0	6.5
Exports of goods and services	10.9	14.2	39.3	19.3	21.2



STRUCTURE of the ECONOMY	1985	1995	2004	2005
(% of GDP)				
Agriculture	33.7	28.2	19.6	18.3
Industry	26.4	28.1	27.3	27.1
Manufacturing	16.4	18.1	16.0	15.9
Services	39.9	43.6	53.2	54.6
Household final consumption expenditure	67.4	63.8	60.7	60.6
General gov't final consumption expenditure	11.4	10.8	11.3	12.2
Imports of goods and services	7.8	12.2	21.0	24.8



	1985-95	1995-05	2004	2005
(average annual growth)				
Agriculture	3.5	2.0	0.7	2.3
Industry	6.5	5.7	8.6	9.0
Manufacturing	6.7	5.5	8.1	9.4
Services	6.7	8.1	9.9	9.7
Household final consumption expenditure	5.7	5.3	7.2	4.9
General gov't final consumption expenditure	4.2	6.0	9.2	15.6
Gross capital formation	5.4	6.5	12.8	11.3
Imports of goods and services	9.9	11.9	41.9	15.0

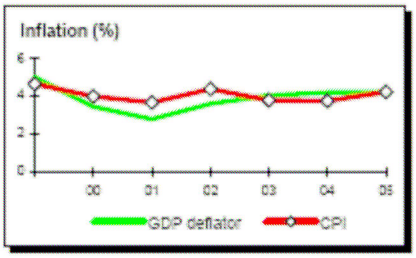


Note: 2005 data are preliminary estimates. 2005 represents Indian Fiscal Year 2005-06, which runs from April 1 to March 31.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

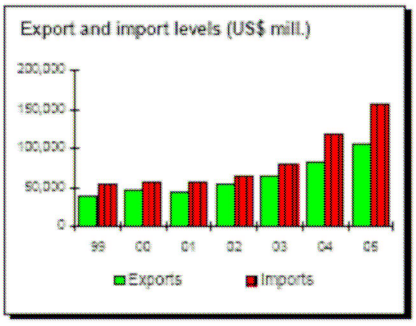
PRICES and GOVERNMENT FINANCE

	1985	1995	2004	2005
Domestic prices				
(% change)				
Consumer prices	5.6	10.2	3.8	4.2
Implicit GDP deflator	7.2	9.0	4.2	4.2
Government finance				
(% of GDP, includes current grants)				
Current revenue	19.2	17.9	19.6	19.8
Current budget balance	-1.7	-3.1	-4.2	-4.4
Overall surplus/deficit	-8.8	-6.7	-7.9	-9.0



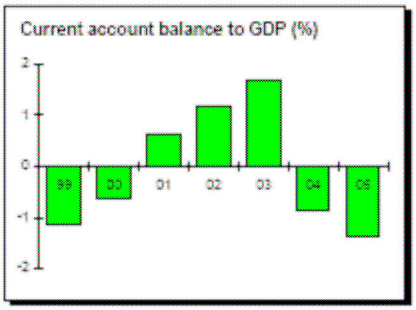
TRADE

	1985	1995	2004	2005
(US$ millions)				
Total exports (fob)	9,461	32,311	82,150	104,780
Marine products	334	1,011	1,268	..
Ores and minerals	544	1,175	4,193	..
Manufactures	5,580	23,747	58,168	76,762
Total imports (cif)	17,294	43,670	118,779	156,334
Food	1,310	970	3,014	..
Fuel and energy	4,261	7,526	29,844	..
Capital goods	3,338	10,330	22,567	26,982
Export price index *(2000=100)*	100	106	107	116
Import price index *(2000=100)*	115	102	101	114
Terms of trade *(2000=100)*	88	103	107	102



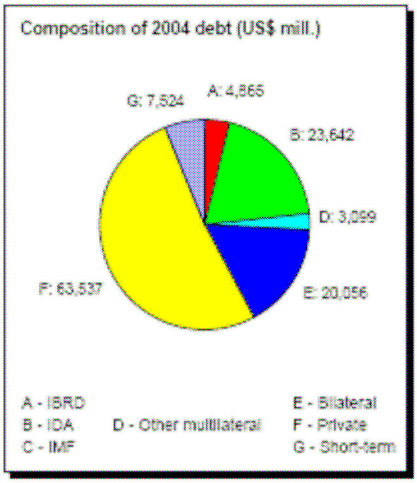
BALANCE of PAYMENTS

	1985	1995	2004	2005
(US$ millions)				
Exports of goods and services	12,777	39,657	128,181	165,390
Imports of goods and services	19,418	51,213	150,611	194,679
Resource balance	-6,641	-11,556	-22,430	-29,289
Net income	-776	-3,205	-3,814	-5,599
Net current transfers	2,207	8,506	20,253	24,095
Current account balance	-5,210	-6,255	-5,991	-10,793
Financing items (net)	4,720	2,490	34,114	25,311
Changes in net reserves	490	3,765	-28,123	-14,518
Memo:				
Reserves including gold *(US$ millions)*	6,520	21,687	140,076	154,589
Conversion rate *(DEC, local/US$)*	12.2	33.4	44.9	44.9



EXTERNAL DEBT and RESOURCE FLOWS

	1985	1995	2004	2005
(US$ millions)				
Total debt outstanding and disbursed	40,952	94,464	122,723	..
IBRD	2,397	9,849	4,865	5,557
IDA	9,750	17,499	23,642	23,363
Total debt service	3,531	13,566	19,095	..
IBRD	313	1,714	300	417
IDA	124	357	773	809
Composition of net resource flows				
Official grants	450	565	872	..
Official creditors	1,421	-1,048	944	..
Private creditors	2,273	1,254	3,682	..
Foreign direct investment (net inflows)	106	2,144	5,335	..
Portfolio equity (net inflows)	0	1,591	8,835	..
World Bank program				
Commitments	2,882	1,718	1,807	..
Disbursements	1,375	1,318	1,823	2,147
Principal repayments	157	1,170	784	843
Net flows	1,218	149	1,039	1,305
Interest payments	280	901	289	384
Net transfers	938	-752	750	921



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