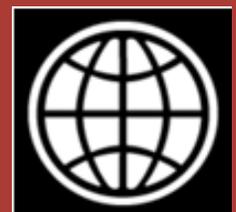




# National AIDS Control Support Project (NACSP)

## Project Launch

August 24, 2013  
New Delhi



### Basic project details and milestone

Total project cost	USD 510 million INR 2550 crores
Total IDA financing	USD 255 million INR 1275 crores
Project implementation period	5 Years
Bank Approval	1-May-2013
Approval by CCEA	23-May-2013
Signing of financing agreement	18-June-2013
Project effectiveness	22-July-2013
Project closure	31-December-2017







## I. The World Bank's association with the National AIDS Control Programme

India has been a long-term partner and recipient of World Bank funding, starting with the first National AIDS Control Project in 1991 through to the current phase of National AIDS control programme. In the early 1990s, the NACP focused on blood safety, prevention among high risk groups, raising awareness in general population and improving surveillance.

*National adult (15-49 years) HIV prevalence which was estimated at 0.33% (0.29%-0.37%) in 2007, has declined to 0.27% (0.22%-0.33%) in 2011.*

In the second phase of NACP (1999-2006), India continued to expand the programme at state level, with greater emphasis on targeted interventions and involvement of NGOs. In the third phase, India has scaled up targeted HIV prevention interventions for most at risk populations and further expanded the surveillance system. The surveillance and analytical work has helped the government know its heterogeneous epidemic,

identify Indian states which were most affected by HIV and population groups which were most at risk.

### **Partnership:**

The World Bank and DFID were pooling partners with the Government of India in the Third National AIDS Control Project. A large consortium of development partners have worked in partnership with the Government of India, contributing significantly to the national AIDS response by harmonizing their inputs. In support of the principle of Three Ones – One National Strategy, One Coordinating Authority, One Monitoring Framework - of the National AIDS Control Programme, they participated annually in a joint implementation review, including the Bill & Melinda Gates Foundation, Clinton Health Access Initiative, DFID, GFATM, USG (USAID, CDC and PEPFAR), UNAIDS, UNFPA, UNICEF, UNDP, WHO and the World Bank. The development partners have also provided technical support to the states and direct support to targeted interventions, to contribute to scaling up and ensuring quality of the targeted interventions. GFATM has complemented Bank support by financing expansion of counseling, testing & treatment as well as building capacity of community networks.

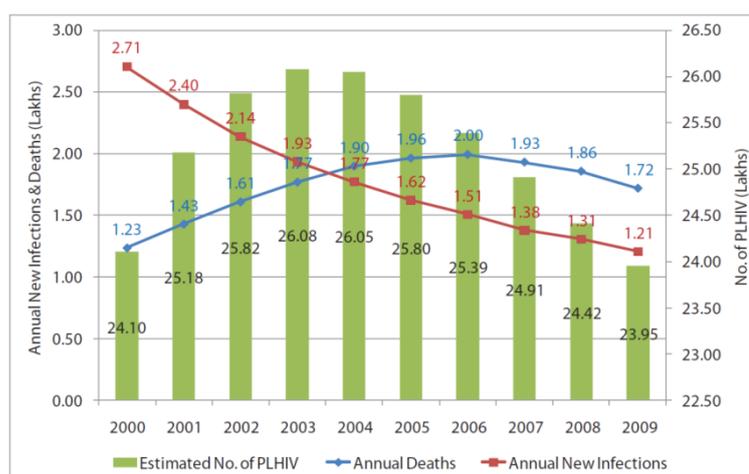


## II. Key achievements made by programme

The National AIDS Control Programme continues to make progress toward the MDG 6, halting and reversing the HIV epidemic. The adult HIV prevalence at national level has continued its steady decline from estimated level of 0.41% in 2001 through 0.35% in 2006 to 0.27% in 2011. Similar consistent declines are noted among both men and women at national level. National adult (15-49 years) HIV prevalence which was estimated at 0.33% (0.29%-0.37%) in 2007, has declined to 0.27% (0.22%-0.33%) in 2011.

Declining trends in adult HIV prevalence are sustained in all the high prevalence states (Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu) and other states such as Mizoram and Goa. However, the low prevalence states of Assam, Arunachal Pradesh, Chandigarh, Chhattisgarh, Delhi, Jharkhand, Meghalaya, Odisha, Punjab, Tripura and Uttarakhand have shown rising trends in adult HIV prevalence.

India has demonstrated an overall reduction of 57% in estimated annual new HIV infections (among adult population) during the last decade from 2.74 lakh in 2000 to 1.16 lakh in 2011. This is important evidence on the impact of the various interventions under National AIDS Control Programme and scaled-up prevention strategies. Major contribution to this reduction comes from the high prevalence states where a reduction of 76% has been noted during the same period.



The total number of people living with HIV/AIDS (PLHIV) in India is estimated at 21 lakh (17.2 lakh–25.3 lakh) in 2011. Children (under 15 yrs.) account for 7% (1.45 lakh) of all infections, while 86% are in the age – group of 15-49 years. Of all HIV infections, 39% (8.16 lakh) are among women. The estimated number of people living with HIV in India maintains a steady declining trend from 23.2 lakh in 2006 to 21 lakh in 2011.

The programme data indicates that ART services for adults increased by 30% between 2009-10 and 2010-11. Wider access to ART has led to 29% reduction in estimated annual AIDS-related deaths during NACP-III period (2007-2011). Greater declines in estimated annual deaths are noted in states where significant scale up of ART services has been

achieved. In high prevalence states, estimated AIDS-related deaths have decreased by around 42% during 2007 to 2011. As on July 2013, around 6.76 lakh PLHIV are receiving free ART across the country.

The coverage of targeted interventions with services for HRGs has significant improvement. Presently, 84% of female sex workers (FSW), 87% of men-who-have-sex-with-men (MSM) and 84% of injecting drug users (IDU) have access to prevention interventions. According to an Integrated Biological & Behavioral Assessment in high prevalence districts in six states, consistent condom use among FSW increased from 74% in 2006 to 88% in 2009. On other hand, an impact evaluation (2011) shows that the progress in the decline of HIV among FSW is attributable to the national programme focus on targeted interventions; with an estimated 3 million HIV infections projected to be averted by the national program by 2015 through targeted prevention interventions alone.

*The World Bank support to the fourth phase of the programme will fill the gaps in the areas of prevention among high risk groups and continue to support institutional strengthening for effective programme management.*

**Moving forward:** Although the overall HIV prevalence rates among high risk groups are declining, they remain high (2010-11): 7.14% among injecting drug users, 4.43% among men-who-have-sex-with-men and 2.67% among female sex workers, and there are significant variations across states and within, which warrants scaling up of efforts to reach the hard to reach populations in these areas. Moving forward with the preparation for the fourth phase of the national response, 2012–2017, the Government of India is mobilizing domestic financial support and seeking sustained support from development partners, including the World Bank. The national programme will continue to innovate and generate lessons from its performance management system and disseminate the best practices across the world.

### **III. Background of the World Bank assisted project**

The goals of the fourth phase of the NACP are aligned with the Government of India's Twelfth Five Year Plan (2012-2017) goals of inclusive growth and development for long term sustainability. The national programme goals are to accelerate reversal of the HIV epidemic and integrate the response over the next five-year phase. The programme aims at reaching out to the hard-to-reach population groups at high risk with targeted prevention interventions through innovative approaches; increasing access to comprehensive care, support and treatment; expanding information, education and communication with a focus on behavior change, demand generation and stigma reduction; further strengthening the institutional capacity and process of integration; and, continuing to innovate across programme components – generating knowledge and lessons learned for India and beyond.



The National AIDS Control Support Project (NACSP) will support the Strategic Plan of the fourth phase of NACP 2012–2017, with a focus on outcomes. The Project will improve the delivery of public services and contribute to inclusive growth by reaching out to the

most vulnerable and marginalized population groups, increasing their access to, and utilization of services, and reducing stigma and discrimination through the TIs and behavior change communication.

### ***Project Development Objectives***

The Project Development Objective is to increase safe behaviors among high risk groups in order to contribute to the national goal of reversal of the HIV epidemic by 2017.

### ***Project components***

The Project will contribute to three of the five strategies of the National AIDS Control Programme IV: (i) the prevention component, (ii) the behavior change component, and (iii) the institutional strengthening component. The two other components, namely, the provision of care, treatment and support to people living with HIV and AIDS (PLWHA) and strategic information systems (SIMS), including disease surveillance, will be supported by the national budget, with technical and financial support from other donors. The main support of the Project will be provided for the scaling up of HIV prevention interventions, with a focus on the high impact and cost-effective targeted interventions for population groups at high risk, and part of IEC including behavior change and demand generation. The Project will also support the Department of AIDS Control in further strengthening its project management including



human resource support and technical support for TIs. The project will support the following three components:

**Component I- Scaling Up Targeted Prevention Interventions** (total estimated cost - US\$440 million): This component will support the scaling up of TIs with the aim of reaching out to the hard to reach population groups who do not yet access the prevention services of the programme, and saturate coverage among the HRGs. In addition, this component will support the bridge population, i.e. migrants and truckers. Component I includes the following two subcomponents:

**1.1 Scaling up coverage of TIs among HRG:** This will be implemented through a large number of successfully proven TIs with a focus on FSW, MSM<sup>1</sup> including Transgender/Hijra population, and IDU, through the contracting of NGOs and CBOs. This sub-component will support the continuation of ongoing TIs as well as launching additional new TIs. The interventions under this sub-component will include: (i) the provision of behavior change interventions to increase safe practices, testing and counseling, and adherence to treatment,

*The project aims to reduce new HIV infections by expanding reach and coverage of quality targeted prevention interventions among HRGs over the next five years.*

and demand for other services; (ii) the promotion and provision of condoms to HRG to promote their use in every sexual encounter; (iii) provision or referral for STI services including counseling at service provision centers to increase compliance of patients with treatment, risk reduction counseling with focus on partner referral and management; (iv) needle and syringe exchange for IDU as well as scaling up of Opioid Substitution Therapy (OST) provision from 79 existing centers to 350 across

the country and increasing the number of patients on OST from about 5,000 to 36,000 over 5 years. This sub-component also includes the financing of operating costs for about 25 State Training Resource Centers as well as participant training costs over a period of 5 years.

**1.2 Scaling up of interventions among other vulnerable populations:** Vulnerable population groups include partners of sex workers, partners of IDUs, bridge populations which include migrants and long distance truckers moving between high and low prevalence areas and engaging in unsafe practices.

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<sup>1</sup> The definition used by Department of AIDS Control for MSM is high-risk MSM.

The activities under this subcomponent will be guided by the information from peer networks in order to improve their access to prevention services, and will include: (i) risk assessment and size estimation of migrant population groups and truckers at transit points and at workplaces, e.g. For migrants, an assessment of interventions at source, transit and destination points would also be carried out to tailor TIs; (ii) behavior change communication (BCC) for creating awareness about risk and vulnerability, prevention methods, availability and location of services, increase safe behavior and demand for services as well as reduce stigma; (iii) promotion and provisioning of condoms through different channels including social marketing; (iv) development of linkages with local institutions, both public and NGO owned, for testing, counseling and STI treatment services, which will be an important area of public-private partnerships; (v) creation of “peer support groups” and “safe spaces” for migrants at destination; (vi) establishment of need-based and gender-sensitive services for partners of IDUs; and (vii) strengthening networks of vulnerable populations with enhanced linkages to service centers and risk reduction interventions, specifically condom use.



**Component 2 - Behavior Change Communication** (total estimated cost US\$40 million):

This component will include: (i) communication programmes (media campaigns, creative development campaigns and short films) for risk reduction and safe behavior including advocacy, social mobilization and BCC to integrate PLWHA and HRG into society and to encourage normative changes aimed at reducing stigma and discrimination in society at large, and in health facilities specifically, as well as to increase demand and effective utilization of testing and counseling services; (ii) financing of a research and evaluation agency to assess the cost-effectiveness and program impact of behavior change



communication activities; and (iii) establish and evaluate a helpline at the national and state level to further increase access to information and services.

**Component 3- Institutional Strengthening (total estimated cost US\$30 million):** This

*This component will support innovations to enhance performance management including fiduciary management, such as the use of the computerized financial management system, at national and state levels.*

component will support programme steering, coordination and managerial roles in managing the prevention component of the programme, during the transformational phase of NACP IV. This component will support innovations to enhance performance management including fiduciary management, such as the use of the computerized financial management system, at national and state levels. The support for institutional capacity will also help strengthen procurement and supply chain management, including training on supply chain management. This

component will finance the staff and operating costs of Technical Support Units (TSU) to ensure the oversight of the quality of TIs through monitoring and supportive supervision, build capacity of states and assist them in effective use of available information in support of evidence-based planning, programme roll out and performance monitoring. This sub-component will also support the services of a procurement agent for the purposes of procuring OST during project implementation. The dissemination of best practices and innovations from the project at the national and state levels through annual knowledge dissemination forum will also be financed by this sub-component. This component will also finance the necessary project audits (external, internal and the audits of NGOs).



#### IV. Expected results

The project intends to achieve the results in the area of behavior change among high risk groups, maintain/increase access to targeted interventions for prevention of HIV among populations at highest risk, scale-up prevention interventions for bridge population groups, strengthen the institutional capacity and programme management, and increase demand for HIV services through behavior change communication. The following are the specific results to be achieved during the project:

*About 80 % High Burden Districts will implement behavior change communication strategy*

- Improved behavior change among HRGs towards consistent use of condom (85 % of FSW and 65 % MSM reporting use of condom with their last client and 65 % IDU not sharing injecting equipment during the last injecting act)
- Considerable improvement in coverage of HRGs through targeted intervention (85-90 % HRGs to be reached by targeted interventions by 2017)
- For effective programme management, 75 % TIs will have validated high risk group size data and they will be graded according to the performance indicators of SIMS
- The improved supply chain management will bring down the condom stock out to 2 % in any given quarter
- About 90 % of planned prevention interventions shall be implemented as per plan
- About 90 % states submit audit reports and report on dashboard indicators to DAC/NACO within agreed time limits, by 2017
- About 80 % High Burden Districts will implement behavior change communication strategy
- About 50 % of HRGs will be counseled and tested for HIV regularly
- Reduce stigma and discrimination towards people living with HIV and AIDS by Health Care Providers

#### V. Implementation arrangement

The implementation structures and institutional arrangements of NACSP will remain the same as under NACP III, with the programme being managed by the Department of AIDS Control, at the central level, the State AIDS Control Societies (SACS) at state level, and the District AIDS Prevention Control Units (DAPCUs) at the district level.



The Technical Support Units (TSUs), that were established during NACP III to oversee the quality, mentoring, handholding and supporting the TIs in the states along with SACS, will continue to play a key technical role to ensure the quality of TIs. The

Project will finance the operating costs of TSUs as described above under Component 3. Along with providing technical support to TIs, TSUs will strengthen the capacity of respective SACS to ensure the sustainability of the program so that these functions are well incorporated in the SACS.

**States AIDS Control Societies (SACS):** During the NACP II, the national programme implementation was decentralized to the SACS, which are semi-autonomous societies implementing the state level annual action plans that are guided and financed by DAC. The deliverables, administrative control and financial agreement between the SACS and the NGOs/CBOs will be governed by contractual arrangements. The District AIDS Prevention Control Units (DAPCU) are the district level administrative structures under SACS, established in high burden districts in India with the objective of coordinating NACP activities at district level and facilitating multi-sector mainstreaming with other departments in the district.

DAC, through the SACS, will make available grants from the credit on a non-reimbursable basis to NGOs and/or CBOs for carrying out TI activities under Component I of the Project (Sub-project). NGOs/CBOs will be identified and selected in accordance with the criteria set forth in the NGO/CBO Guidelines of DAC. DAC, through the SACS, will enter into grant agreements with the selected NGOs/CBOs to implement targeted intervention projects.

## **VI. Key messages**

*“The World Bank assistance to the National AIDS Control Programme has aimed to create systems, allow innovations and most importantly to ensure better accountability and transparency in the overall programme management. The partnership with the World Bank will be an asset at a time when external donor support is limited. It is through this project that we all hope to address the changing needs of the programme. We look forward to the project further strengthening our response to HIV and AIDS.” – Mr. Lov Verma, Secretary, Department of AIDS Control*

*“The National AIDS Control Programme has mobilized all key stakeholders who are partnering with the Government in achieving programme goals. We have focused on most-at-risk populations and scaled up service delivery in a systematic manner. We have looked at evidence, been bold enough to innovate and are forever sensitive to the needs of communities and people living with HIV.” - Ms. Aradhana Johri, Additional Secretary, Department of AIDS Control*

*“India has made impressive progress and is on track to meet the Millennium Development Goal (MDG) of halting and reversing the HIV and AIDS epidemic. However, the low prevalence rate should not lull us into complacency. Without strongly sustained prevention programs among those at highest risk, the gains made in the fight against this epidemic could yet be lost. I hope the innovations implemented, tried and tested by India’s HIV program is widely disseminated across the globe.” – Mr. Onno Ruhl, Country Director, India, World Bank*

*“If you are planning for a year, sow rice; if you are planning for a decade, plant trees; if you are planning for a lifetime, educate people. India’s HIV program has reached a juncture, which has not only yielded concrete results in curbing the epidemic, but also creates demand for global learning from India’s experience. The World Bank’s project will strategically support the larger investment made by the Government of India and complement the greater systemic investments in effective program implementation and management. The Project’s components are aligned with the Government’s program, with a focus on high impact interventions and recognition of the demand for greater innovation and flexibility to find local solutions to implementation I congratulate the national program leaders for successful implementation of AIDS Program and looking forward to our continued productive collaboration.” – Ms. Julie McLaughlin, Manager, Health, Nutrition and Population, South Asia Region, World Bank*