### I. Project Context

#### Country Context

1. India, with a population of 1.21 billion, is going through rapid demographic and epidemiological transitions, facing the unfinished agenda of maternal mortality, childhood illnesses, malnutrition and communicable diseases on one hand, and the emerging burden of non communicable diseases, as a result of increased life expectancy and life style changes, on the other hand. In 2006-2007, 19 percent of India’s population were living below the poverty line and 21 percent of the poor resided in rural areas. Malnutrition rates remain very high, and although infant mortality rate (IMR) has declined slightly from 58 (2005) to 53 deaths in 2008, it is well behind the Millennium Development Goal (MDG) target of 28 deaths per 1,000 live births. The Maternal Mortality Ratio (MMR) remains high with 212 women aged 15-49 years dying due to maternal causes per 100,000 live births in 2007-2009 and it is unlikely that the MDG of 100 deaths per 100,000 live births will be reached by 2012.

2. India is on track to meet the MDG for HIV and AIDS, which is to halt and reverse the epidemic. However, with 2.4 million people between the ages of 15-44 years living with HIV and AIDS, the national burden of HIV and AIDS in India ranks third globally after South Africa and Nigeria. The Indian HIV epidemic scenario is characterized by concentrated epidemics among high risk groups (HRG). It is a highly diverse and heterogeneous epidemic scenario, driven by sex work, unprotected sex among men having sex with men, and injecting drug use. The national HIV prevalence started to level off in the late 1990s - early 2000s, with declines in HIV prevalence in some states and districts and among some high risk groups, and with a more rapid decline during the last decade in districts with high coverage of targeted prevention interventions. There is, therefore, a mixed picture, ranging from some states that face a mature epidemic with HIV prevalence trends leveling off or declining, to some states that still face emerging epidemics among HRG with a high risk of escalation, especially where injecting drug use and sex work intersect.

### II. Sectoral and Institutional Context

3. India launched the first National AIDS Control Program (NACP I) in 1991, focusing on blood safety, prevention among high risk groups, raising awareness in general population and improving surveillance. In the second phase, (NACP II, 1999-2006), India continued to expand the program at state level, with greater emphasis on targeted interventions and involvement of NGOs. In the third phase, (NACP III, 2007-2012), India has scaled up targeted HIV prevention interventions for most at risk population groups and further expanded the surveillance system.

4. The NACP III has made steady progress towards the national goal to halt and reverse the HIV epidemic. The HIV estimates for 2008-09 showed an overall reduction in adult HIV prevalence from 0.39% (2.6 million people living with HIV and AIDS, i.e., PLWHA) in 2004, to 0.31% (2.4 million PLWHA) in 2009. The estimated trend of new infections shows a reduction in HIV incidence of more than 50% over the past decade from about 0.27 million (2000) to 0.12 million (2009). Preliminary data suggest that these rates have further declined (HIV Sentinel Surveillance, unpublished) in 2010-11. The targeted prevention interventions have reached 81% of female sex workers (700,000), 66% of men having sex with men (274,000), and 71% of injecting drug users (126,000). Anti-retroviral treatment for adults increased by 30% between 2009-10 and 2010-11, and the estimated annual deaths from HIV have steadily declined from 199,502 (2006) to 172,041 (2009). An impact evaluation conducted in 2011 has shown progress in the decline of HIV among female sex workers associated with increase in condom use. A cost effectiveness analysis, also conducted in 2011, estimates that 3 million HIV infections will have been averted under the national program (by 2015) through targeted prevention interventions alone.

5. Although the overall progress towards reversal of the epidemic has been impressive, progress has been uneven within and between states, and there are districts and vulnerable population groups with increasing or uncertain HIV trends. The population groups most at risk are young sex workers and their clients, injecting drug users not yet accessing services and their partners, and men having unprotected sex with men, especially transgender groups. Although India is a low HIV prevalence country, there are three risks to development associated with the current status of HIV and AIDS: (i) the risk of escalation of concentrated epidemics; (ii) the economic welfare costs due to the disproportionate impact on vulnerable population groups and the inability of households to cope with chronic illnesses such as AIDS, and the associated stigma and other structural amplifiers increasing the marginalization of those affected households; and, (iii) the fiscal cost of scaling up treatment.
These economic development risks can be effectively addressed by accelerating and institutionalizing the effective prevention focus of the Indian response, contributing to inclusive growth.

6. During NACP III, efforts were made by the National AIDS Control Organization (NACO) of the Department of AIDS Control, and the National Rural Health Mission (NRHM) of the Ministry of Health and Family Welfare, to strengthen convergence of essential program components that were common to HIV/AIDS and other diseases, conditions or programs, with the aim to increase both effectiveness and efficiency in service delivery. For example, joint implementation plans and division of responsibilities and budgets were agreed on for the scaling up of the management of sexual transmitted infections, provision of safe blood, reproductive health services and testing and counseling facilities. To increase the effectiveness of targeted interventions (TI) to most at risk population groups, non government organizations (NGOs) and community based organizations (CBOs) were contracted to deliver the services, and technical support units helped to support and monitor the quality of the TIs. The NACP III was well resourced through the contributions of a wide consortium of development partners providing both technical and financial support to all aspects of the national program.

7. In the fourth phase, NACP IV, India aims to accelerate the reversal of the epidemic and to further integrate the response by: 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 program components – generating knowledge and lessons learned for India and beyond. The national program has four major components; (i) prevention, (ii) care, support and treatment, (iii) institutional strengthening of program management, and (iv) strategic information systems. This will be a transformational phase of the national response, ensuring that the national program remains effective and sustained, while integrating selected program elements, i.e., shifting more of the responsibilities for the financing, management and implementation of critical components and activities (such as facility based testing and treatment and blood safety and other health services), from the National AIDS Control Organization (NACO) and State AIDS Control Society (SACS) to the National Rural Health Mission (NRHM) and government health services. While by the end of the five year plan, universal access to antiretroviral treatment (ART) will be integrated under NRHM, the HIV prevention program that relies on effectively reaching HRG and vulnerable populations through peer outreach will continue to be separately managed through the contracting of NGOs and CBOs under NACO.

III. Project Development Objectives

The Project Development Objective (PDO) is to increase safe behaviors among high risk groups, thus contributing to the national goal of reducing the incidence of HIV infections by 50%, by 2017.

IV. Project Description

Component Name
Prevention
Institutional capacity and program management

V. Financing (in USD Million)

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<td>FOREIGN SOURCES (UNIDENTIFIED)</td>
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VI. Implementation

VII. Safeguard Policies (including public consultation)

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VIII. Contact point

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