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- Started BLUE (better living with understanding and education) Clinics - comprehensive HIV counseling, testing, care centres with Govt. of Goa in Panaji and Govt. of Uttar Pradesh in Lucknow.
- Responsible for creating public awareness on issues related to sex workers and public opinion for their welfare.
- Responsible for repeal of the Goa Public Health Act; which violated rights of PLWHA by requiring mandatory HIV testing and discriminated against them by isolation.
- 90% reduction in Devadasi System, wherein young girls are dedicated to Goddess Yellamma and forced into prostitution, in Maharashtra & Karnataka.
- Responsible for the rescue of 130 children from prostitution directly and more than 3000 indirectly.
- Responsible for 50% reduction in child prostitution in India.
- Created AIDS Awareness among 50 million people in 12 years.
- Distributed more than 70 million condoms in seven years and prevented at least 360,000 people from getting infected with HIV. On an average a million condoms are distributed every month in the redlight areas.
- Conducted nearly 7200 programs on prevention of AIDS.
- Organised 18 mega and 640 small Exhibitions on AIDS worldwide.
- Organised 30 rallies/marches on AIDS Awareness with cine stars.
- Conducted 800 advocacy meetings with policy makers and planners.
- Screened nearly 22,000 people with high risk behaviour for HIV.
- Detected, counseled, cared for over 14,000 HIV infected people.
- Published 125 scientific publications, more than 550 newspaper articles and referenced in thousands of news reports worldwide.
- Organised a World Congress on AIDS in 1990 in Mumbai and 9 International workshops on AIDS and Child Prostitution
- Has 19 branches in eight states and covered 320 towns of for HIV/AIDS awareness/ training programs.
- Provided technical guidance to more than 100 NGOs in India and 60 NGOs in Nepal, Bangladesh, Pakistan and other countries.
- Publish Asia's only newsletter "AIDS ASIA" for NGOs and medicos since 1993.
- Publish Asia's only newsletter for Sex Workers "Sakhi-Saheli" since 1993.
- Produced 12 booklets and four training manuals on AIDS.
- Distributed 5 million brochures in 10 languages on AIDS.
- Made/displayed over 3500 banners on AIDS on different occasions.
- Over 11,000 wall paintings on AIDS slogans in 8 years.
- Published and displayed 42,000 posters of 29 types on HIV/AIDS.
- Produced training slides on AIDS and STDs
- Initiated self help group "Positive People" for PLWHA.
- Provided emergency medicare during floods of Junagadh, Konkan and Marathwada in 1983; Bhiwandi - Communal Riots in 1984; Bombay - Communal Riots of 1992-93 and Latur Earthquake in 1993.

NGO With The Largest Coverage On AIDS Education

IHO

Indian Health Organisation
Municipal School Bldg., J. J. Hospital Comp.,
Mumbai - 400 008.
☎ : 371 9020 ● Fax : 386 4433
e-mail: ihoaids@bom3.vsnl.net.in

Donations to IHO are exempt under Section 80-G of Income Tax Act of Government of India.

HELP US HELP HUMANITY

Bombay / Madras / Manipur (Imphal)

Indian Health Organisation (IHO), spearheading the crusade against AIDS in India since 1985, was established by Dr.I.S.Gilada on April 7, 1982, the World Health Day. Since then IHO has whipped up an unparalleled campaign to provide succour and hope to the poor and hapless. IHO is a registered, non-profit, non-government, apolitical and secular organisation with 19 branches in 8 states of India and has consistently proved to be a superior institution possessing powerful, creative energy, persistence in programming and an amazing drive to succeed. It has been responsible for bringing India on the AIDS control map of the world.

INDIA : IN POPULATION SECOND TO ONE ; IN HIV SECOND TO NONE !

With close to a billion people, which is one sixth of global population, India has 7 million HIV infections, which is one fifth of global HIV infections. Though in many spheres India has progressed a great deal, it lags behind in facilities to care and rehabilitate people living with HIV/AIDS (PLWHA), in training its human resource as care givers and in AIDS research. With a supportive social background most PLWHA will possibly be cared for in the community set-up and IHO is in the forefront for protecting PLWHA from discrimination in society and health settings. However, there will be many HIV infected and affected, particularly sex workers, widows and orphans who will need institutional and comprehensive care in a humane atmosphere.

CURRENT AIDS SCENARIO IN INDIA

India's entry into the third phase of the HIV epidemic, as envisaged from the increasing trend of HIV infections among housewives and children, is signaling a major AIDS crisis in the offing. The first phase of HIV was recognized when the rising trend of the HIV prevalence was established among sex workers in 1988 and among professional blood donors in 1989. The second phase started after 1989, when clients of sex workers and transfusion recipients were found to be HIV infected.

The denial of such a trend, complacency and inaction by the government and society at large in the early phases of the epidemic has made India top the world in HIV infections. Most international agencies like WHO, UNAIDS, World Bank and even the health officials in India have endorsed IHO estimates and projections from time to time. Through persistence and dedication, IHO has received support from various organisations all over the world.

IHO's primary objective is to educate and create awareness about HIV and AIDS related issues by targeting college students, sex workers, truck drivers, and other at-risk populations. IHO also works for the prevention and control of HIV/AIDS and provides cost-effective models of medical care.

THE LARGEST NGO IN AIDS AWARENESS

IHO is the single largest NGO in the world in terms of the total population covered on education-awareness of HIV/AIDS and consequently its prevention. Though this contribution is small in proportion to the size of the country and the current HIV problem, it amounts to 'a drop in the desert' and not 'a drop in the ocean'. IHO conducts a tremendous number of activities with a very limited resource base.

IHO HAS MANY FIRSTS TO ITS CREDIT :

India's
- first AIDS Awareness campaign,
- first AIDS Clinic,
- first Mobile AIDS Clinic,
- first successful AIDS intervention project "Saheli" for sex workers,
- first AIDS Counseling Centre,
- first AIDS Hotline and
- first Anonymous HIV testing centre.

Inspite of a severe financial crunch (a shoe-string budget of Rs 20 lakh annually) and consequent shortage of staff (a third of what it had in 1992-93); IHO has not only been successfully managing its projects but expanding them also. To the great surprise of its admirers, IHO functions from a two-room office provided by the Bombay Municipal Corporation in one of it's school buildings and is in dire need of premises in Central Bombay. The future is pregnant with hope and endless possibilities.

IHO seeks to establish a Comprehensive Health Care Training, Research and Rehabilitation Centre. This would help to rehabilitate HIV-positive sex workers, their children, orphans, HIV-positive couples and homosexuals, providing employment, medical, social and psychological assistance. The center would be self-sustaining five years from its opening and would generate enough income through its activities to be at least partially self-sustaining from the start. The land surrounding the complex would be used to grow crops that would be used for the residents. Upon completion, this would be the first center of its kind in Asia.

The drive is there. So is the fire, the energy and the enthusiasm! If IHO is not backed by the government and society, it will end-up fighting a losing battle.

MAJOR ACHIEVEMENTS

- SAHELI PROJECT for HIV intervention among sex workers has been acclaimed as 'The Bombay Model' at Berlin in 1993.
- IHO-Wadia Model for HIV intervention among women and children, the largest study of its kind in Asia and has become a replicable model; counseled and screened 60,000 women for HIV, detected 568 positive women, traced 90% of spouses, provided care to 450 families.

UNAIDS
UNICEF • UNDP • UNFPA
UNESCO • WHO • WORLD BANK

Joint United Nations Programme on HIV/AIDS

UNAIDS/PCB(7)/98.6 RECS
11 December 1998

PROGRAMME COORDINATING BOARD

Second *ad hoc* thematic meeting
New Delhi, 9-11 December 1998

DECISIONS, RECOMMENDATIONS AND CONCLUSIONS

1. The PCB recorded its thanks to the Government of India for its excellent support to the meeting, and particularly for the field visits.

The Indian Response

2. The PCB also appreciated the energy, innovation and political commitment of the Government of India in addressing the epidemic in India.

In addition, the PCB welcomed:

- the Government of India plans for more decentralized and participatory programme planning, particularly at state level;
- the development of Technical Resource Groups to strengthen the technical base at national and state level;
- the development of new technical collaboration approaches with UN and bilateral agencies, including the development of appropriate funding mechanisms;
- the interest of the Government of India in vaccine development.

Agenda Item 1: Report of the Executive Director

3. The PCB welcomed the report of the Executive Director and noted with concern the escalation of the epidemic. It urged the UNAIDS Cosponsors and Secretariat, national governments and donor agencies to intensify efforts aimed at addressing the problem in a holistic manner, including advocacy, prevention, improving access to care and therapy, vaccine and other research.

4. The PCB welcomed the announcement that UNDCP has indicated its interest in becoming a Cosponsor. It is recommended that UNAIDS Secretariat and its Cosponsors

~~Issued~~ Corrected
India

develop criteria for cosponsorship. The PCB noted that the UNAIDS Secretariat and Cosponsors' approach to drug issues, including work on harm reduction and demand reduction, would remain.

5. The PCB welcomed the initiation of a partnership for intensified action on HIV/AIDS in Africa. It emphasized the importance of participation by all key players and requested a proposal describing the initiative from the UNAIDS Secretariat and Cosponsors at the next PCB.

Agenda Item 3: Young people and HIV/AIDS: Strategic framework

6. The PCB welcomed the development of a global strategic framework, including the seven priority action areas described. The PCB further emphasized that the strategy development process needs to involve the participation of governments, young people, civil society, including religious and cultural organizations, with the goal of increasing participation and commitment of all stakeholders.

7. *Strategy Preparation*

7.1 The PCB requests the UNAIDS Secretariat, working in partnership with the Cosponsors, to further develop the strategic framework.

7.2 The development of the strategy should be undertaken in consultation with relevant parts of the UN system, in particular the Office of the UN High Commissioner for Human Rights (OHCHR) and the Committee of the Rights of the Child (CRC) to help ensure a rights based approach.

7.3 The PCB requested a broad strategy to be supported by a more detailed description of more targeted efforts, based on age and other determinants of vulnerability including disability.

7.4 The PCB and its members have different and important roles in the strategic development process:

- country level consultations with young people should be carried out through the Theme Groups and other appropriate consultative mechanisms, in particular in countries of PCB members (with a view to reporting back to the next PCB meeting);

- the collection of background information and the preparation of the working draft should be undertaken by the Cosponsors and the Secretariat.

7.5 The strategy development should be completed and reported to the PCB within one year.

7.6 The development of indicators should occur simultaneously with that of the strategy.

Strategy promotion

8. As a powerful advocacy tool, the strategy should be presented to the governing boards of the Cosponsors and other relevant UN agencies. Members have a responsibility to advocate within these governing boards for appropriate action.

Strategy Content

9. The points in attachment 1 were recommended by the PCB working groups to be taken into consideration in the development of the strategy paper.

Agenda Item 4: UNAIDS Monitoring and Evaluation Plan

10. The PCB endorsed the approach and priorities described within the Monitoring and Evaluation Plan (UNAIDS/PCB(7)/98.4), welcoming the emphasis within the plan on the further elaboration of the specific roles and responsibilities of the Secretariat and the Cosponsors. The PCB further urged the Secretariat and the Cosponsors to accelerate the implementation of the plan, including initiating global monitoring at each of the four levels of the logical framework, using the best available indicators.

11. The PCB requested that the Secretariat and Cosponsors continue to collaborate in the further development of the plan, taking into consideration the need for:

- further distinction of those efforts focussed on the monitoring and evaluation of the global response to HIV/AIDS from that of the performance of the UNAIDS Cosponsors and Secretariat;
- closer linkage with the UN Development Assistance Framework (UNDAF) including attention to the relationships between HIV/AIDS and development policy and programme efforts;
- further development of core indicators at each level of the logical framework;
- social indicators which enable a better understanding of the disparities within communities;
- greater emphasis on a gender and young people perspective with attention to the disaggregation of data by age and sex; and
- further development of mechanisms to monitor HIV/AIDS related programmes financing at national, regional and global levels.

12. The PCB requested an intensification of current efforts to develop the UN System Integrated Workplan and Budget for the 2000-2001 biennium at the global and regional levels in order to further define the responsibilities of the UNAIDS Cosponsors and Secretariat, including their monitoring and evaluation responsibilities.

13. The PCB noted with appreciation the decision of the CCO to complete UN System Integrated Workplans in all countries through the Theme Group Mechanism by the year 2000. The PCB requested that the CCO directly monitor progress in completing these workplans and to regularly report to the PCB on this key benchmark of interagency collaboration at country level.

14. The PCB encouraged its Members to raise within the governing boards of the Cosponsors the need for further commitment to their individual and collective responsibilities in the response to the HIV/AIDS epidemic, emphasizing the clarification of roles and responsibilities required to improve accountability for programme performance and implementation.

15. The PCB encouraged the Cosponsors to strengthen the internal monitoring and evaluation of their HIV/AIDS related programmes. The PCB further requested the Secretariat to work closely with the Cosponsors to coordinate their internal, external and joint monitoring and evaluation efforts on HIV/AIDS, emphasizing a common framework, formats and indicators.

16. The PCB encouraged national governments to strengthen their monitoring and evaluation efforts and to intensify collaboration with the UNAIDS Cosponsors and Secretariat in reporting regularly on the status and response to the global epidemic.

17. The PCB requested that the Secretariat report annually on progress made in the further development and implementation of the Monitoring and Evaluation Plan as a part of the Executive Director's Report to the PCB.

Agenda Item 5: Migration and HIV/AIDS

18. The PCB welcomed the background paper and reaffirmed their strong interest in the thematic area of Migration and HIV/AIDS. It recommends:

18.1 That future work should emphasize the importance of protecting the rights of migrants (to work, to health, to other social services, non-discrimination and so forth) and their needs, in its response to the problem of HIV among migrant groups.

18.2 That the UNAIDS Secretariat documents and draws on experience from expert bodies (including governments and other bodies) to inform its ongoing work.

18.3 That the UNAIDS Secretariat and Cosponsors identify their comparative advantages and that of other UN bodies in taking forward work on migration and AIDS.

18.4 That the regional dimension of migration and HIV/AIDS is included in subsequent work, in addition to other country-level work.

Agenda Item 6: Next PCB Meeting

19. The PCB recommended that its next meeting take place on 28 and 29 June 1999 in Geneva.

ATTACHMENT 1

Agenda Item 3: Young People and HIV/AIDS

Points for inclusion in the final report of the second ad hoc thematic meeting of the PCB

1. The full participation of young people, including those with HIV/AIDS, recognizing their diversity, is a fundamental principle.

2. This participation needs to be supported by skills development - including life skills - and be without discrimination.

3. The role of adults (parents, teachers, religious and cultural leaders) in supporting young people needs to be developed.

4. Programmes must go beyond school-based awareness into the provision of social and health services that are accessible, confidential and credible for a whole range of youth groups

5. Programmes also need to broaden the base of potential partners at country level, especially community based organizations.

6. Programme efforts must recognize the diversity of contexts, including cultural and religious factors, and urban and rural environments.

7. Programmes addressing young people should recognize the importance of family.

8. Messages should be positive, not threatening. Sexual health should be seen in the context of health development, which in turn needs to be seen within the context of broader personal development.

9. Services should be delivered within the context of day to day concerns of young people and should include other high risk behaviours.

10. The strategy must recognize obstacles for implementation including: context, lack of data, and weak implementation systems. The importance of political commitment and the role of government is particularly noted.

11. The strategy should seek to strengthen gender issues within the seven priority action areas.

12. The strategy should recognize the importance of strengthening basic education and health systems.

13. The strategy should include interventions to decrease vulnerability (social, cultural, economic), as well as special issues of migration.

14. The strategy should recognize the capacity of other institutions to reach young people, including prisons, mental institutions and the military service.

15. The strategy should recognize the needs and rights of young people living with HIV/AIDS.

16. The strategy should facilitate acceptance, support and services for young people of different sexual orientations.

UNAIDS
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Joint United Nations Programme on HIV/AIDS

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Ms Sandra Thurman
Director
Office of National AIDS Policy
The White House
736 Jackson Place, N.W.
Washington, D.C. 20503
United States of America

With the compliments of
Director, External Relations

Avec les compliments du
Directeur, rélations extérieures

Please find attached the Decisions, Recommendations and Conclusions from the second *ad hoc* thematic meeting of the Programme Coordinating Board, held in New Delhi, India from 9-11 December 1998.

Veuillez trouver ci-joint les Décisions, Recommandations, et Conclusions de la deuxième réunion thématique *ad hoc* du Conseil de Coordination du Programme qui a eu lieu à New Delhi, Inde du 9-11 décembre 1998.

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UNICEF • UNDP • UNFPA
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Joint United Nations Programme on HIV/AIDS

Telephone line: 791 4762

Reference: exr/pcb7

To PCB Members and Observers
attending the second ad hoc thematic
meeting of the PCB

18 December 1998

Dear PCB Member/Observer,

Thank you for joining us at the second ad hoc thematic PCB meeting in New Delhi last week. I think you can see by the attachment that the Government of India and its Prime Minister have taken a real step forward in the fight against AIDS with his speech to the Parliament on 12 December.

I am sure that the awareness we have raised in India by having our meeting there, as well as the call on him by the Chairman of the meeting, Mexican secretary of health Dr Juan Ramon de la Fuente, and Peter Piot on 10 December, have contributed to this hopeful outcome.

Hoping that you had a safe and speedy return home and wishing you all the best in the New Year.

Sally G. Cowal
Director, External Relations

20, avenue Appia • CH-1211 Geneva 27 • Switzerland • Tel: (+4122)791.3666 • Fax: (+4122)791.4187 • e-mail UNAIDS@UNAIDS.ORG

Address by

Prime Minister

Shri Atal Bihari Vajpayee

at the meeting on

National Programme for Prevention and Control of HIV/AIDS

New Delhi—December 12, 1998

Since Independence India has acquired considerable experience in prevention and control of both communicable and non-communicable diseases. While we could successfully eradicate many deadly diseases like small pox and guinea worm and are on the verge of eliminating leprosy, we are now facing the problem of resurgence of serious communicable diseases like Malaria and Tuberculosis.

While we thought that we had eradicated Malaria from the country, it has now come back in a highly virulent form of Malaria falciparum that is almost fatal. So far as TB is concerned, roughly about fifteen million Indians are infected with the disease and every year more than 1.2 million are getting added. Hundreds of thousands die of TB each year.

However, the most serious public health challenge that the country is facing today is of HIV/AIDS that is just a decade old in this country. AIDS is a global problem—sadly, with a strong Indian dimension.

More than twenty out of hundred adults in Africa face death in the next ten years. In one African country, population growth will halt in the next four years. In another African country, life expectancy will drop from a high of 61 years in 1990 to only 41 years next year.

What is happening?

What is happening is being compared by senior United Nations public health officials to the bubonic plague that wiped out one-third of Europe's population in the 14th century.

According to the South African Government, fourteen percent of their population of 32 million is infected with HIV, which leads to AIDS and death, and 1,500 more are daily diagnosed with the virus. President Nelson Mandela has, early this month, said,

"Although AIDS has been a part of our lives for fifteen years or more, we have kept silent about its true presence in our midst", adding, "We have too often spoken of it as some one else's problem."

That is South Africa's situation and there is President Madela's recent statement.

I have taken the liberty of referring to Africa and quoting President Mandela because our situation is also alarming, and could become frightening, and we too speak of **AIDS as some one else's problem.**

Look at our own AIDS situation.

The Health Ministry puts the figure of HIV infections in the country as of now at three million to four million. In some states, the infection rate is one percent of the population. Since we have these three to four million infections today from a base of just a few infections in 1986, imagine what the scene will be like in another twelve years from the base now of three million to four million. I shudder even to contemplate the numbers. **And mind you, currently there is no cure for HIV/AIDS.**

Because HIV afflictions take till ten years in healthy circumstances to blow into AIDS and AIDS patients live till two more years, people do not take the virus seriously. In unhealthy conditions, the timeframe is much shorter.

Another reason why people do not take AIDS seriously is because it is diabolical; one comes to know one is HIV positive only if one goes and takes an HIV test, the Elisa test. In absence of the Elisa test, one could be carrying the virus for six or seven years not knowing about it and passing it on to one's spouse and the wife to the newborn through breast-feeding, without any of them knowing. This is the crux of the problem.

However, these are just figures and figures do not convey the human tragedy that is taking place in many parts of the country today.

A man or a woman has diarrhea or fever or weakness that medicines fail to subdue. He or she goes to a doctor. The doctor suggests a blood test. The person tests HIV positive. The test is repeated. The HIV infection is confirmed. **However, it is too late. The person's partner is already infected and the couple's child is also infected from breast feeding. The first infection is almost five to six years old. There is no cure. All three must die. And I know they die. How many such nuclear families are already condemned to death in our country today? How many will be condemned to death in the next decade?**

When HIV appeared in India in 1986, everybody thought that it is a Western disease that will be contacted only by sex workers in red light areas, gay men, and injecting drug users. The consequences of that myopic view are now upon us.

In India, sexually transmitted diseases are already a serious problem, and what is significant, fully forty percent of such diseases occur in middle-class segment of our population. More significantly, persons already suffering from sexually transmitted diseases are more prone to HIV infections. What will this catastrophe mean to business and industry in, say, the year 2005?

Since the HIV/AIDS affliction is mostly in the productive age group of eighteen to forty, this could have grim consequences for our economy. Already, half the new infections in India are in this age group. Business and industry must take a hard and urgent note of this reality and act to increase awareness about AIDS and spread the message about its prevention.

For AIDS is preventable. You cannot prevent a common cold, but yes, you can prevent AIDS by taking precautions. HIV is transmitted through unprotected sex with an infected person, transfusion of infected blood and blood products, use of contaminated needles and syringes, and from an infected mother to her child via birth, and also through breast-feeding by infected mothers. **AIDS is preventable through awareness. Awareness is the key to prevention.**

However, unless we put in all out efforts to increase voluntary blood donation and meet the shortage of blood, we will not be able to achieve total blood safety in the country. I urge all of you to involve yourself in promotion of voluntary blood donation campaigns in your areas or constituencies and motivate the younger sections of society to make voluntary blood donating a habit. **Donating blood is a healthy habit. It is also a redeeming habit.**

Millions of HIV-positive persons and AIDS sufferers are afraid to talk or seek medical help because they are burdened with undue guilt and stigma. Millions more Indians, hundreds of thousands of worried families want to know more about HIV/AIDS, but are afraid to ask.

They want almost fool-proof confidentiality and anonymity. Victims of HIV/AIDS are seeking information in privacy. The extent of this quest for information in privacy about HIV/AIDS is demonstrated by the fact that the Central Government-run HOTLINE on AIDS in New Delhi (Number 1097) received 21,500 telephone calls in just

the first fifty days of its starting in October 1997. **My Government has decided to make the AIDS HOTLINE number 1097 available in all cities and big towns of India toll-free.**

Awareness is the only weapon we have today against AIDS. There is no single strategy for creating awareness. We must use every available medium of communication to spread the message across the country whether it is electronic media, print media, and even the folk media.

Cinema is a powerful tool of mass communication and education. After this meeting, a new Hindi film, *Nidaan*, is being screened. I have seen the film and it is a good film even without its subtle awareness message about HIV/AIDS. The awareness aspect makes it a powerful film.

Any campaign for awareness should not be the responsibility of Governmental agencies alone. We must involve community leaders, NGOs, and elected representatives of the people at various levels in this program.

My appeal to the Members of Parliament is to take up the work of AIDS awareness on a priority basis in their constituencies. I would also urge the Chief Ministers of all the States to take up awareness campaigns personally by meeting Members of Legislative Assemblies, Chairpersons of Zilla Parishads, Panchayats, District Collectors, municipal Corporation Chairpersons, NGOs, and community-based organizations.

As I have mentioned earlier, the section of the population most affected by HIV/AIDS is young people. They are highly impressionable and require proper education and awareness about reproductive issues including safe sexual behavior.

There is a debate as to whether children of this age group should be taught about reproductive health. Information about sexual and reproductive health and right sexual behaviour can help the children in developing a necessary value system and face any eventuality, with courage and understanding.

I do not think we should hesitate to tell the children about the process of growing up and its implications. The growing threat of HIV/AIDS in the country points to the urgency of doing this sooner rather than later.

As the disease has spread in the last five years across the length and breadth of the country, we now have about three million to four million HIV infected people in our

midst. Many of them are still asymptomatic but sooner than later they will develop into full-blown AIDS cases. I hear distressing stories of AIDS patients being thrown out of their homes, ostracized by their own families and society, and even denied admission and medical care in hospitals.

These acts are practised not just by ignorant people, but even by those who are knowledgeable and know how HIV/AIDS is spread or not spread. The medical profession has a special responsibility in this area.

It is the responsibility of people who are aware and who have the knowledge to fight against discrimination of HIV/AIDS-infected persons in the society. We should ensure that they have the same rights to education in schools and colleges, to employment, and for a rightful place in the society. We must respect their privacy with sympathy and understanding.

There is pressure from certain sections of the community to go for mandatory screening of HIV/AIDS. Nothing can be more shortsighted than this.

The moment we start mandatory screening, the infected persons will not come forward to avail of even the minimum amenities of care and support that are provided by the health care delivery system in the country. This will aggravate rather than solve the problem of HIV/AIDS in the country.

In the meantime, and since the Government has now accepted the figure of three million to four million infections currently, there is no need for a debate in the country as to the accuracy of these figures. We must accept the fact that a large number of our people are infected, and that there is no cure at present and also that prevention is the only long-term remedy.

Only awareness can help prevention.

I am confident that India will be able to overcome this problem, provided we take it seriously from now onwards. We have demonstrated our inherent infrastructural strength in taking up a number of socially relevant programs; the latest being the polio immunization campaign in which twelve to thirteen million children have been given polio drops in a single day.

There is no reason why we should not be able to control HIV/AIDS in India. It requires all out efforts by both the Government and the community; let us make a beginning towards this goal today.

We also need to develop our own, type-specific, anti-HIV vaccine. There are ongoing major international efforts to identify the various strains of HIV and develop a type-specific vaccine for cure and control. We must actively join this global effort. We must collaborate in currently promising research with other agencies worldwide to discover such a vaccine.

We have developed successfully a vaccine for Hepatitis-B. Efforts are on to develop a vaccine for Hepatitis-C also. There is no reason why we should not succeed in developing an HIV vaccine in India. We have the Indian Council of Medical Research, the Department of Biotechnology, the CSIR, and other institutes doing excellent work on various aspects of vaccine development. We have to bring these groups together in a "Mission-mode" to synergize their efforts.

I would request the Health Minister who is present here today to take the lead and organize a national team to explore the possibility of developing an indigenous vaccine in the most cost-effective fashion and do this urgently.

In light of all that we know about this diabolical virus, and, that currently there is no vaccine against it, India needs to act vigorously to dramatically enhance awareness. We also need to relentlessly search for an anti-HIV vaccine as a task of high priority and urgency.

In the meantime, we all will have to bring out the best in each one of us by way of compassion, understanding, and love for those who are afflicted and already affected. India can do no less.

Thank you.

International HIV/AIDS Alliance

Supporting Community Action on AIDS in Developing Countries

Information as per your request

Post-it® Fax Note 7671	Date 9/1/98	# of pages ▶ 20
To Alba Hishra	From Julie Mittron	
Co./Dept. NCIH-Global Aids Prog	Co. Fam	
Phone #	Phone #	
Fax # 202-833-0077	Fax # 537-2955	

International NGOs and the Response to AIDS in India
Draft Seminar Notes

Friday, June 12 1998
9.30am - 12.30pm
at
Prince of Wales Business Leaders Forum
15-16 Cornwall Terrace
Regent's Park
London

The International HIV/AIDS Alliance's work in India is funded by the Ford Foundation and the John D and Catherine T MacArthur Foundation

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1.0 Welcoming Remarks and Agenda Review

The Chairperson, Dr Anne Scott (International HIV/AIDS Alliance) and Julian Parr (Prince of Wales Business Leaders Forum) welcomed the meeting participants, thanking in particular the representatives of the Government of India, Ms Neelam Kapoor, and the World Bank, Mr. Prabhat Jha and Ms. Julianne Mittman, for travelling so far to attend the meeting. Apologies were extended on behalf of Calle Almedal, UNAIDS, who was unable to attend the meeting due to an illness. Best wishes for a successful meeting were extended on behalf of Jeff O'Malley, Executive Director of the International HIV/AIDS Alliance. The Chairperson reviewed the meeting's objectives as follows:

- to update International NGOs (INGOs) on the overall HIV strategies currently envisioned by the Government of India and its supporters,
- to update INGOs on how they can most effectively contribute to both planning efforts and implementation of HIV/AIDS services in India; and
- to provide an opportunity for INGOs to familiarise each other, the Government of India, UNAIDS and others regarding what they have to offer.

2.0 Introductions

The Chairperson invited INGO representatives to introduce themselves and to briefly explain their organisations' mandates and current activities in India. The participants introduced themselves as follows:

Lucinda Dowson, Marie Stopes International (MSI).
MSI works with a local partner in India. Sexual and reproductive health is the primary focus of their 32 health clinics, although limited HIV/AIDS counselling services are also offered. MSI plans to increase its HIV/AIDS activities in India, particularly in Orissa, where they hope to implement an HIV testing programme for men.

Hester Kapur, Oxfam.
Oxfam has been working in India for about 30 years. With three local partner organisations, they support approximately 350 projects in a variety of areas. Oxfam has submitted a proposal to the European Union to work on HIV/AIDS with eight local partner organisations in several States, including Orissa and Tamil Nadu. Oxfam's objectives for HIV/AIDS programming are: to facilitate training and promote experience sharing within India and other South Asian countries; to develop models for prevention and care which are appropriate to local conditions and suitable for the various target groups; to ensure a gender focus in interventions; and to explore ways of measuring the impact of interventions.

Sue Lucas, UKNGO AIDS Consortium.
The Consortium does not work directly in any country; rather, it brings together UK-based NGOs working on HIV/AIDS in developing countries.

Jerker Edström, International HIV/AIDS Alliance.
The Alliance supports community action on AIDS in developing countries. Since its creation in 1993, the Alliance has supported over 600 initiatives with over 400 NGOs in 14 countries. The Alliance has developed a variety of different approaches to community support according to local needs and resources. Nevertheless, a common theme throughout the Alliance's work is the building of sustainable local capacity to deliver NGO support and to ensure appropriate development of the NGO sector alongside government and private sector partners.

Monica Dolan, CAFOD.
Traditionally CAFOD has not worked extensively in India. However, CAFOD has recently developed a small number of partnerships with NGOs in Tamil Nadu and Karnataka to carry out an integrated programme of work focusing on children's and women's rights, and human rights. CAFOD see this focus as particularly important, as individuals who undertake HIV testing are very often stigmatised by their communities as a result. CAFOD is increasingly concerned about issues of consent and confidentiality related to HIV testing.

Nel Druce, AHRTAG/Healthlink Worldwide.
AHRTAG (shortly to be renamed Healthlink Worldwide) works in partnership with government and non-government agencies in Africa, Asia and Latin America to ensure access to relevant and appropriate information around HIV/AIDS and sexual health.

Indira Kapoor, International Planned Parenthood Federation (IPPF)
IPPF was founded in Bombay over two decades ago, and now has an extensive network in India. They support 30 projects, and provide approximately half a million US dollars to the Indian Family Planning Association each year. IPPF's strategy until the year 2002 focuses on sexual and reproductive health. IPPF has begun to address HIV/AIDS by providing pre- and post- test counselling and general information through its sexual health clinics.

David Sunderland, Charities Aid Foundation (CAF).
A UK-based organisation, CAF's mission is to increase the flow of resources from funders to charities. CAF has recently established a representative office in New Delhi, to help facilitate an increase in the flow of private funding for HIV/AIDS to India and within India.

Cat Plewman, International Family Health.
IFH works primarily in India and Africa, supporting the reproductive health activities of its partner organisations. In Rajasthan, IFH works with 45 sex work communities, integrating rural development issues with HIV/AIDS. In

Tamil Nadu, IFH works with a truckers project and highway communities, providing HIV/AIDS information through 9 truck stops. It is hoped that this project, which forms the major component of IFH's HIV/AIDS work in India, will soon include a mobile component. In addition to its programme work, IFH runs a Consultancy Service Programme, sourcing specialised consultants to work on DFID-funded projects.

Susan Perl, International AIDS Vaccine Initiative (IAVI).
Ms. Perl explained that IAVI, founded by the Rockefeller Foundation, has a mission to accelerate the development of AIDS vaccine initiatives worldwide. IAVI funds specific scientific research into effective AIDS vaccines. Much of IAVI's work is related to advocacy, ensuring the flow of adequate support for a vaccine to be found. IAVI recently conducted a visit to India to investigate ways in which the country could be included in IAVI's work.

Julian Parr, Prince of Wales Business Leaders Forum.
The Prince of Wales Business Leaders Forum is an international network of business leaders who support good corporate citizenship and sustainable development. It was created on the personal initiative of The Prince of Wales, and includes 57 member companies from Europe, North and South America, and Asia. HIV/AIDS is a development priority for member companies, many of whom are located in South Asia. PWBLF is now working in partnership with UNAIDS to mobilise the private sector resources in the fight against AIDS in six priority countries, including India, Thailand, Zimbabwe, South Africa, Brazil, may be Indonesia. PWBLF has a particular focus on building partnerships between business and other sectors, and on educating business leaders on why it is important to respond to the epidemic.

Anne Scott, International HIV/AIDS Alliance.
Anne Scott explained that she was an associate consultant for the Alliance, and team leader for their India programme activities. To add to Jerker Erdström's introduction, she mentioned that the Alliance has been providing technical support to a number of Ford Foundation NGO grantees in India. In the coming months, the Alliance will recruit a representative in India, and assist several leading NGOs throughout India to become Centres of Excellence in HIV/AIDS capacity building. Using models developed by Alliance linking organisations elsewhere in Asia, the Centres of Excellence will co-ordinate increased technical exchange and sharing of ideas among Indian NGOs and other sectors, within the overall collaborative framework that the NACO and its donor partners are developing. This work will be supported by a grant from the MacArthur Foundation.

3.0 **Responding to HIV/AIDS in India** (Neelam Kapoor, Deputy Director for Information, Education, and Communication, NACO)

The Chairperson invited the Government of India's representative, Ms Neelam Kapoor, to update the meeting participants on the overall HIV strategies currently envisioned by the Government of India's National AIDS

Control Organisation and its supporters.

Ms. Kapoor began with an overview of how the epidemic had evolved over the past few years. She mentioned that, twelve years after the first case was detected in 1986, the epidemic is still growing and changing. The spread of HIV is not uniform, and some areas have very high prevalence. Ms. Kapoor cited recent government sentinel surveillance data for various States and regions of India, to give a picture of the current HIV epidemiology there.

The National AIDS Control Organisation (NACO) began in 1987, and was supported by a World Bank loan. Health is a responsibility of individual states in India, and the first programme put in place a state level infrastructure. Ms. Kapoor mentioned that in the beginning the NACO faced common problems of denial and people not having access to the public health infrastructure. The NACO set up state level AIDS cells, and a sentinel surveillance system, which it is still developing. Originally, surveillance was targeted at 'high risk groups', but now NACO is extending this to include groups traditionally classified as low risk. HIV/AIDS is no longer a problem, which is limited to urban areas. It has moved from high risk to low risk groups and from urban to rural areas. While people in urban areas are now more aware of HIV/AIDS, people in rural areas are still unaware of the disease. In urban areas, while awareness has increased, issues of stigmatisation remain.

NACO has now closed all unlicensed blood banks and professional blood donation, and will remain vigilant on this issue. Transmission is basically through the heterosexual route, but approximately six percent of HIV cases occur due to blood contamination.

A national AIDS policy has been developed and circulated to state governments, NGOs and other partners. NACO hopes that the parliament will ratify the policy before the end of the year.

The second phase of the national programme started in March of last year. A key difference between the first and second phases is a movement from centralised to decentralised planning, and an increased emphasis on developing a multi-sectoral response. Unless the response is multi-sectoral, and those involved approach HIV/AIDS as a development problem, the national programme will not be able to manage the scale up required to meet the demands of a growing epidemic. Strategic planning is state specific, because each state has its own languages and needs.

It is hoped that the second phase of the NACO will have a strong programme for NGOs, who have had relatively little participation until now. Previously, NACO has funded NGOs directly, but from now on, NGO support will be provided through state level programmes. NACO is aware and concerned that many state level programmes have not yet worked out how to support NGOs, and Ms. Kapoor emphasised that we need to think together about how to operationalise this objective.

To this end, NACO organised a meeting with NGOs in January, and many smaller discussions with NGOs have also been carried out in various states. Some of the priorities for operationalising NGO support at state level, which were identified at these meetings, include: simpler funding procedures, more encouragement of NGO participation, more effective monitoring and evaluation systems, and resources for capacity building of NGOs and state government. Ms. Kapoor also stressed the need to involve NGOs that are working on a variety of related health and development issues, not just on HIV/AIDS as a separate issue.

NACO is looking at approaches that are cost-effective, and that state government can effectively mobilise and manage. NACO has noted that many state governments have had a positive experience working with bilateral donors, particularly DFID. Together, bilateral donors and state governments have worked to create partnerships with NGOs and state AIDS cells. In building programmes, collaboration, communication, planning, and the flow of ideas are important. State governments are also crucial to providing sustainable structures for responding to the epidemic. An important focus of the second phase is therefore building sustainable management structures that can facilitate open communication and collaboration among a variety of partners.

The second phase also has a twin focus on targeted interventions, because particular areas and populations are more vulnerable than others, and capacity building of state governments, NGOs and other institutions. Targeted interventions is a focused approach to providing technical assistance. NACO also wants to keep the majority of the population, which has not yet been touched by HIV/AIDS, safe. NACO is especially concerned about young people, as they are a large and important segment of the Indian population. They are the future of the response to HIV/AIDS, and India's future as well.

3.1 Questions and Comments

Monica Dolan, CAFOD: Will the focus on young people be differentiated according to gender?
Neelam Kapoor, NACO: This will be worked out at the state level. In general, we are looking to develop basic information flow among all people, but the different needs of men and women can be addressed through targeted interventions.

Jerker Edström, The Alliance: In a recent meeting of NGOs working on HIV/AIDS in South Asian and other countries, the need for intensive support for capacity building, and for linking financial and technical support, came out strongly.

Julian Parr, PWBLF: Do you have a report on the first phase of the national programme?
Neelam Kapoor, NACO: We are now preparing several assesssments, on different topic areas, which will be ready by the end of the year.

Julian Parr, PWBLF: Cross-sector collaboration in India has largely been confined to the public sphere. In our experience we have found it more difficult to build public-private sector partnerships, especially those involving state-run industries, like the India railways. Do you have any thoughts on how to encourage private sector participation in the response?
Neelam Kapoor, NACO: To date the private sector response has been minimal. We have looked at working with the sector to mobilise a basic awareness programme, but have not yet gone beyond that. NACO is very interested in greater involvement of the private sector, and hopes that the technical resource groups that have recently been set up can come up with some innovate ideas. They are perhaps the best people to spearhead this kind of initiative. The role of the private sector as a partner in a broad-based response is very important, but it is hard to make the argument. Economic impact on business is not always straightforward and labour is still very mobile, so the response from the private sector has not been great or deemed urgent. NACO is especially concerned about unorganised labour, and we would especially like to start awareness programmes with small and medium scale businesses and industries.

Susan Perl, IAVI: This is a wonderful opportunity to get the government, INGOs and donors together. In my experience, it is very difficult to decide how to balance resources between the general population and targeted populations, particularly if vulnerable groups feel they are being 'targeted', making their difficult life even more difficult. On the other hand, if you try to spread resources more widely, you can be accused of not spending resources where they are most needed. I am wondering how NACO has thought about this common problem.
Neelam Kapoor, NACO: We see our strong presence and massive infrastructure in the social sector as an asset. We have specialised programmes for children, and health workers down to the village level, for example. We want to work with this infrastructure to reach out to the greater population in a relatively efficient and cost-effective manner, and balance that with more targeted interventions, which may be more costly and intensive, but which can meet the needs of vulnerable groups.

Indira Kapur, IPPF. When I was working with NACO, we had a definite strategy for working with NGOs. We also worked with the presumption that everyone is at high risk. Much work was done on these topics at the time. Have you evaluated the work of NACO under the first phase of the national programme, to assess the strategies that were used? Also, will any checks be put in place so that these new strategies for NGO support and targeted interventions can move forward?

AIDS was seen as such a big epidemic, many people wanted to take

NACO out of government, so that it would be on its own. This delays addressing the issue, by making it separate. We have such an extensive infrastructure in place already in other areas.

Neelam Kapoor, NACO: NACO is a part of the government, and we have a good institutional memory, so we do consider past approaches and other departments. Yes, we have always supported NGOs, but NGO participation has been very peripheral. They have taken up awareness activities, and we have an evaluation report for this. Now we want to look at HIV/AIDS interventions as a whole, and find improved, comprehensive mechanisms for programming in this area.

Prabhat Jha, the World Bank: NACO functions within the government system with a degree of autonomy. In reality, the intent of NACO was to create a flexible but linked organisation. Within that, NACO doesn't report to the Secretary of Health, but to the National Health Control Board.

3.2 Section Summary

The Chairperson summarised the session with NACO by listing some key themes arising out of Ms Kapoor's presentation and the related discussions:

- **Capacity building** for NGOs and state government. What do INGOs have to offer in this area, both individually and as a group?
- **Scale-up** of the overall government programme and of effective programme activities. How do we measure their effectiveness and incorporate them?
- **Partnership-building.** By what means can many sectors be included in a broad-based, civic response to the epidemic?
- **Sharing lessons learned.** What are the challenges and successes of programme implementation? AHRTAG/Healthlink added an additional question. How do we communicate lessons in a practical, appropriate and visible way?
- **"Dovetailing".** How do we situate HIV/AIDS programme activities within the existing government infrastructure and the broader, voluntary sector? What are some of the ways we can link related activities, and reach out to government and non-government institutions working in these areas?

4.0 Roles of International NGOs in developing the new AIDS project

The Chairperson invited representatives of the World Bank and the Department for International Development to update the meeting participants on how they could most effectively contribute to both planning efforts and implementation of HIV/AIDS services in India.

4.1 The World Bank's Perspective (Mr. Prabhat Jha, Health Specialist, Human Development Network)

Prabhat Jha began by stating that both the World Bank and NACO would like to have a sharper second phase, so that the leadership and importance of the public sector in mobilising a response to HIV/AIDS in India could be fulfilled. The long-term response will need to be financed largely by the public sector, and it has a responsibility to set up a framework within which this can happen. We have a framework now that emphasises decentralisation, broad advocacy, and intersectoral collaboration. Since a 1997 meeting held in Paris, the Government of India has increasingly recognised that HIV/AIDS is a problem, and that they will need help in addressing it. We now need to move on implementing the framework in an efficient and co-ordinated way.

The World Bank's mandate is to work with the public sector. The recent national HIV/AIDS policy paper was pitched at the state level governments, and less so to an international audience, which is appropriate given the size of India and the depth of the public sector. Leadership and political commitment from NACO is there, and this is largely attributable to the strong and dedicated presence of Mr. Prasada Rao and his capable team.

Mr. Prabhat Jha elaborated on four main themes relating to the collaborative framework for responding to HIV/AIDS:

- **Moving from awareness to intervention.** There is clearly consensus that building awareness alone will not suffice to keep people safe from HIV. Changing behaviours, particularly in marginalised groups, is a real priority. The epidemic is growing rapidly. We need to learn from lessons elsewhere. It is clear that interventions to change behaviour in vulnerable populations are vital and can be successful, if they are part of a broader response.

- **Decentralisation.** The second phase of the national programme will be implemented at the state and municipal level. We want to identify areas where special support for HIV/AIDS programming and capacity building is needed In Manipur, we need to find good approaches to working with injecting drug users. In Mumbai, we need to reach out to commercial sex workers. These efforts cannot be organised from Delhi. The Indian government is supportive of local level interventions. However, not all functions can be decentralised. Central communication for research and development needs to be maintained. Decision making around decentralisation will influence how the Bank will fund the second phase.

- **Engaging other sectors.** This challenge involves both epidemiological and administrative considerations. How can we mobilise other sectors in areas where administrative capacity is high, and extend that to overlapping areas where administrative capacity is low, but HIV risk and prevalence are high? As follow up to a workshop with the private sector, the national

government has asked four industrial groups to design intervention programmes which are linked to state level programmes. This is a relatively new area, which will grow in importance.

How does all this relate to what the Bank will finance? We have reached broad agreement with the Government of India, but the specifics have not all been worked out yet. We want to work out financing mechanisms that support institutional strengthening, targeted interventions, intersectoral collaboration, decentralisation, and the development of capacities for low cost and sustainable care. We also want NACO to be engaged at the national level. For this, we are considering some cost-sharing arrangements, where NACO could contract on specific technical inputs under larger programmes implemented by the state.

The government in essence has a credit card, and can use it according to articulated indicators. We will carry out an appraisal process at national, state and municipal levels. The goal is essentially to assess ability to implement programmes. We have drafted indicators for this, which should be finalised soon. The lessons learned from the first phase will not be a great surprise: one third of the States did well; one third did moderately well; and one third did poorly. Lessons will also highlight how the states have conducted their own reviews.

- **Shared responsibility**. If the national programme is to be sustainable and have ownership, it needs to be India led and driven. It will take time to build that up - we should remember that the malaria programme, for example, was started over fifty years ago.

What can external partners do? The answer to this question is two-fold. They can help us to draw upon lessons learned. My personal opinion, based upon what I know of lessons learned from World Bank programmes in Africa, is that much of the funding has gone to build programmes that are relatively strong on paper, but have not had a huge and demonstrable impact. This is a sobering realisation, and underscores the importance of having a broad programme. As guests of India, we need to be more critical about our own advice as to what should or should not be supported.

External partners can also help us build the response within the existing structures. How to work with these structures is a more difficult topic. It is easier to collaborate under a demonstration project, but this is difficult to scale up. Broad participation and experiments are welcome, but there needs to be a consensus about what this means in terms of impact. That dialogue can be influenced by how we organise our work with external partners. There are points of entry through the technical resource networks, and the collaborative framework, which supports community led work.

4.2 DFID's Perspective (Ms. Julia Cleves)

Julia Cleves outlined the evolution of DFID's programme in India, which highlights themes that are similar to those raised by Prabhat Jha and Neelam Kapoor. Specifically, the DFID programme has undergone five shifts

The first step was parallel programming and creating excellence. DFID picked up a few model programme approaches, such as Sonogachi, and also built up the West Bengal Sexual Health Project as a model of state level governance. These have been successful models, but they have been 'islands of excellence', and done relatively little to develop capacity within the public sector.

In consultation with NACO, ODA then decided to work with Kerala and Gujarat as potential partners, using the West Bengal model to start with. It become clear that this model was not going to work and the only way of creating a cohesive programme was to work in partnership with government. The second shift was to say that we wanted to work with state AIDS machinery, and follow their lead in deciding what DFID should invest in. This includes support for strategic planning, and a range of partners and capacity building activities.

The third shift came when DFID realised that, if it worked only with NGOs, it would miss opportunities for working with other public sector organisations. We began using the term 'managed networks', which is a way of capturing in language the concept of co-ordinated partnership with a range of organisations.

The fourth shift came when DFID began thinking seriously about sustainability, and scale. We acknowledged that, if we looked solely at the NGO sector to deliver on interventions, we would have some scattered successes, but always on a very small scale. Sonogachi is great, but it does not do very much for the rest of West Bengal. How do we scale up interventions like this, and fairly rapidly? Through contracting and other requirements, we began to ask that NGOs work with public and private practitioners, and build good relations with government.

The fifth shift is to the idea of a collaborative framework. DFID wishes to work clearly within this enabling framework and ensure that its monitoring indicators are in line with those developed by the state government. This also means working more closely with the Bank and other bilateral donors, and finding ways to share tools and approaches under the national framework DFID's programme also continued to grow with the inclusion of Andhra Pradesh and Orissa states.

4.3 The UNAIDS Perspective (brief overview by Julia Cleves, UNAIDS consultant)

In the beginning, there were many changes at the national and local level in India, and UNAIDS did not respond particularly well to them. It is now clear

that India is a country of extreme importance. As events unfolded at the end of 1997, UNAIDS was able to map out ways of contributing to the national response in India. They have played a major role in convening the technical advisory groups of the national programme, and in convening the NACO workshop for developing a collaborative framework. They also play an ongoing role in areas of work being done in India where UNAIDS has particular expertise.

4.4 Questions and Comments

Julian Parr, PWBLF: It seems that state level programming and partnerships with bilateral donors are proceeding well in some of the States with larger capacity. Where does that leave poorer states, such as Bihar? How do you reach out to and include the States that have larger challenges in capacity building to face?

Neelam Kapoor, NACO: First, we are looking at structural approaches that will support states in responding. We have made it mandatory that State AIDS Cells register as societies, so that they can have organisational and operational authority. We hope that this will help each Cell to map its own priorities, and be able to operationalise. We hope to create flexibility and autonomy, which has been a problem in other programmes.

Prabhat Jha, World Bank: India is so vast that a two pronged approach to reaching states with low and medium capacity is reasonable. Neelam raises an interesting point. State AIDS Cells, which are Societies, have an efficient flow of funds as the government systems do not work very well. They also have a governance structure, with the ability to have NGOs and people living with HIV/AIDS on the board, offering a possibility for flexibility within the government structure. But what happens when the boundaries are blurred? We need to know more about this, as it does not quite mesh completely with the idea of decentralisation.

Anne Scott, the Alliance: In Indonesia, I was the programme director for an INGO that was providing support for capacity building to the state government, under a government decentralisation programme funded by the World Bank. This was the first time that our organisation had ever provided support for capacity building to government. Previously, we had always worked directly with NGOs, in collaboration with government and donors. I think we learned that it is a very different undertaking to provide capacity building support to state government. It has priorities, experiences, and mandates that are very different from those of NGOs. On the other hand, it was a tremendous opportunity to build partnerships with state government, and ultimately to foster better government-NGO collaboration. Many of us have much experience in providing support for capacity building to NGOs, but I think that we have to share lessons and critically appraise what we can offer in terms of capacity building support to state government.

Julianne Mittman, World Bank: This is a great opportunity to hear what all the INGOs are doing. HIV/AIDS is a global problem, and we can build on experience internationally. The top challenges for the World Bank in working with NGOs are: working within the state programme framework, technical and organisational capacity building, NGO networking, sustainability of NGO programme activities. INGOs can help local NGOs to make strategies for accessing local resources.

In terms of targeted interventions, we need to find a strategic place where capacity building could happen. To this end, forums are a great place for information sharing, capacity building, and getting the view of the public and private sector. Maintaining dialogue between the states and NACO is also important.

Neelam Kapoor, NACO: This mechanism already exists at the state level in other areas such as street children and IV drug use. I am thinking of a forum which is not a formal structure, but a group of people who come together as a kind of think tank, in order to look at priorities, think through replication and scale up, and carry out monitoring and evaluation. INGOs could provide very important inputs at this level.

Julia Cleves, DFID: At the workshop in May, we mapped external investment for HIV/AIDS, and most of it was confined to the south and the centre. The north was not covered. The states were also concerned that the collaborative framework would be a 'straight jacket', and so they came up with the idea of an 'un-stitched jacket', with the tailoring to be done at the state level. One potential approach that was also mentioned was that external investors might put money into a trust fund that can be used to purchase technical and organisational support. Another idea was that some consortium arrangements might be set up, which states could use to access a range of support services.

Julian Parr, PWBLF: The private sector can be mobilised as well. It is good to mobilise NGOs, donors and government, but also important and harder to mobilise the state owned sector, and there has to be national level support to the State level for this. The emphasis on inter-sectoral collaboration is good, but we must follow up with clear strategies for engaging other sectors.

Susan Perl, IAVI: With respect to the shifts in DFID's thinking, I want to push a bit more on the issue of donor collaboration. Are we still facing a situation where government modalities are making it difficult for a coming together at a national level? Is the donor community open to involving the private sector?

Prabhat Jha, World Bank: There is a government structure around NACO, in that it reports to the National AIDS control board and committee, which have some NGO representation and a say in the involvement of NGOs. NACO has a structure around it to ensure that they play a consistent role within the broad programme, in the same way that the enabling framework is there for the

states to sign up.

Julia Cleves, DFID. In practice, donors do not always make it easy for governments to co-ordinate as they have. We are talking about a willingness to allow for this kind of collaboration or co-ordination. Certainly as far as DFID is concerned, I think we have been too influenced by sectoral thinking in the past.

Anne Scott, the Alliance. I think the intent to collaborate is genuine, and the strategic shift in how donors and government work together is real. I should also note here that both the EU and USAID representatives expressed support for this meeting, but were unable to attend. They have asked for a report on its outcomes.

Cat Plewman, IFH: How might we carry the results of this meeting forward? What kinds of mechanisms do we have to build on what has been spoken about here? The theme of co-ordination has come up again and again, and I wonder if the UKNGO AIDS Consortium could help us to share ideas and plan together.

Sue Lucas, UK NGO AIDS Consortium: The Consortium could play a role in taking forward some of the messages from this meeting, especially in terms of the importance of co-ordinating the role of NGOs at State level. The Consortium does also have a linking role, and many lessons learned from around the world about effective networking, so it may well be able to play a role in sharing such lessons and strategies.

Prabhat Jha, World Bank: Yes, we are thinking of better linkages to the government structure. Second, more work needs to be done when the national policy is finalised, on how to act with reference to lessons learned in other countries. Also, it would be helpful if INGOs could co-ordinate, so that there are not too many different messages.

Neelam Kapoor, NACO: We need that dialogue with a nodal agency, the Alliance or another organisation. INGOs can also help State government to think through practical ways of helping NGOs to formulate grant applications, in the context of local assessments. If a set of options were presented to NACO through one nodal group, they would certainly be welcomed.

5.0 Summary, Items for Follow-up, and Concluding Remarks.

The Chairperson concluded that a possible next step would be the organisation of a follow up meeting through the UKNGO AIDS Consortium, to decide on which organisation can play the role of a nodal agency, and how INGOs can co-ordinate and share lessons learned within the framework of the India national programme. Remarking that many of the INGOs in attendance at the meeting have local representation in India, she suggested that the base of co-ordination could eventually be shifted there.

Neelam Kapoor, NACO, noted that all such co-ordination should be linked to multi-sectoral state level forums, and the secretariat role played by UNAIDS in this respect.

By way of closing this meeting, the Chairperson returned to the question of the 'value added' which INGOs can offer. She summarised the range of the meeting participants' responses to this question, as follows:

- facilitating networking among NGOs and collaboration among sectors,
- targeted interventions: what is known to work and how to replicate this, particularly in the areas of moving beyond awareness and appropriate approaches to care;
- sharing excellence and lessons learned;
- documentation, monitoring and evaluation, within existing indicator frameworks;
- supporting NGO self sufficiency in accessing local resources, (deining 'resources' as broadly as possible);
- training and skills building for a variety of partners;
- building government-NGO partnerships at the state level;
- co-ordination of the efforts of INGOs both within the UK and the India national programme framework; and
- acting strategically according to the different areas of strength of each INGO.

Thanking everyone for the their participation, the Chairperson closed the meeting at 12.45pm.

Appendix:
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INFORMATION BRIEF

The World Bank

GLOBAL HIV/AIDS ACTIVITIES

THE WORLD BANK AND HIV/AIDS ACTIVITIES AT A GLANCE

- The Bank is one of the ***leading financiers of HIV/AIDS activities in the world.*** Since 1986, the Bank has committed *over* ***$800 million to HIV/AIDS*** related projects worldwide

- The Bank is an ***active co-sponsor of UNAIDS and has provided the largest financial contribution to UNAIDS of all the co-sponsors.*** The Bank strongly supports the multi-agency arrangement for combating AIDS that is coordinated by UNAIDS

- The Bank also ***funds regional AIDS initiatives which are either managed by UNAIDS or involve close collaboration with UNAIDS.*** Particularly ***successful country collaboration, using the UNAIDS Theme Groups,*** has recently taken place in Argentina, India, and China, to cite some examples

- The Bank ***participates in advocacy and public information activities, many of these led by UNAIDS,*** to raise awareness and draw attention to the growing epidemic

- The Bank ***is providing funding for research projects*** on alternative cost effective approaches to reduce the spread of HIV and mitigate the economic and social consequences of AIDS

- The Bank is part of a global coalition of organizations that has created and ***funded the International AIDS Vaccine Initiative (IAVI)*** to accelerate progress toward development of an AIDS vaccine

THE WORLD BANK'S ROLE IN GLOBAL HIV/AIDS ACTIVITIES

The World Bank is strongly committed to HIV/AIDS prevention, treatment and care and contributes to the international response to HIV/AIDS in developing countries in two major ways.

- The Bank is one of the six co-sponsors of UNAIDS, and is actively involved in the multi-agency efforts coordinated by UNAIDS to provide an expanded, multi-sectoral response to HIV/AIDS

- The Bank provides direct assistance to client governments in the form of loans, technical assistance, and policy guidance, to reduce the spread of the AIDS epidemic and help countries cope with the social and economic consequences of the epidemic.

Through its assistance to governments, other donors, civil society, and non governmental and private voluntary organizations, Bank activities complement the activities of the other UNAIDS co-sponsors and bilateral agencies including USAID. Each cosponsor brings a different comparative advantage and expertise to the UNAIDS partnership. UNAIDS is the secretariat that coordinates the agencies, channels their efforts toward a common set of strategic objectives, and monitors the epidemic and the performance of the other agencies.

In this partnership, the Bank's comparative advantage lies in its ability to engage in dialogue with client governments, enabling the creation of an environment for the development of sustainable and multisectoral prevention and care programs, and in its capacity to finance large national programs to combat HIV.

WORLD BANK COOPERATION WITH UNAIDS

Country Level Collaboration

The Bank is working closely with UNAIDS at country level, often using the local AIDS Theme Groups, in developing programs in a number of countries. Two examples:

India. The Bank is working with UNAIDS and other organizations to develop the second phase of the Government of India's national AIDS Control Program. Key features of this program are:

- **Reducing the spread of HIV infection in India by:**
  - Reducing the spread of HIV in poor, marginalized populations at highest risk of HIV infection (especially commercial sex workers, injecting drug users, migrant workers, etc.); and
  - Preventing the spillover of HIV into lower-risk populations.

- **Strengthening India's capacity to respond to the longer term challenges by:**
  - Strengthening the impact and technical, managerial and financial sustainability of National, State, and Municipal programs;
  - Building capacities for provision of low-cost community based care for AIDS cases; and
  - Promoting inter-sectoral links with public, private and voluntary sectors.

China. The Bank has actively participated in the United Nations Theme group on HIV/AIDS in China, which resulted in a needs assessment and identification of priority areas of action. A UNAIDS representative has been associated in each of the Bank's project preparation and implementation supervision missions. More recently, UNAIDS has been an important technical resource in the development of a large program for AIDS and STD prevention and control under the Bank's latest health project. UNAIDS technical experts are currently working with the Bank's pre-appraisal mission in China.

Regional Collaboration with UNAIDS

The Bank is providing grants for initiatives, which tackle the AIDS epidemic at the regional level, dealing with cross border issues such as migration and transport that are central to the spread of HIV. These regional programs covering Western Africa, Southern and Eastern Africa, South East Asia, and Latin America and the Caribbean, are managed by UNAIDS on behalf of the Bank. They aim to strengthen regional co-operation and improve the capacity for neighboring countries to consult and work jointly on policy and implementation issues.

African AIDS Initiative

As part of its commitment to the prevention and mitigation of HIV/AIDS, the World Bank, in collaboration with the UNAIDS secretariat and other co-sponsors, is developing an HIV/AIDS prevention initiative for the Africa Region. The objective of the multisectoral initiative is to create an effective subregional response to the epidemic among policymakers, government agencies, industry, NGOs, community organizations, and donor agencies, as well as to expand the Bank's involvement in HIV/AIDS support to Africa. The launch of this Initiative is planned for December 1, 1998 (World AIDS Day).

Workshops and Seminars

In January 1998, a jointly sponsored World Bank-UNAIDS workshop brought together experts to discuss the demographic impact of AIDS, and raise awareness of the devastating effects that AIDS is having on life expectancy, economic growth, and health and welfare of families in the developing world. Papers from this workshop have been published as a supplemental volume to the journal *AIDS* (Volume 12, June 1998).

The Bank has also developed numerous training courses designed to increase awareness among its staff of the need to address HIV/AIDS in an urgent, sustainable, and multisectoral manner. Bank staff remain active in disseminating the results of Bank-funded analyses and projects through participation in numerous global and regional conferences and workshops.

Advocacy and Public Information

The World Bank is working closely with UNAIDS and other organizations on the World AIDS Campaign (WAC) activities. In 1997, the Bank developed a Public Service Announcement which has been aired on CNN and many other international outlets to highlight the theme of 1997's WAC: Children Living in a World with AIDS.

On World AIDS day 1997, the Bank hosted a picture exhibit titled: "Dying Branches: The Impact of HIV-AIDS on the Villages of Mpondas, Malawi". The goal of the exhibition was to

portray both the vulnerability and resiliency of grandparents who are forced to provide for children who have lost one or both parents in a community devastated by HIV-AIDS.

The Bank is currently developing with UNAIDS an MTV documentary on this year's theme for World AIDS Day, entitled "*Youth— a Force for Change*".

WORLD BANK LENDING FOR HIV/AIDS

Most of the Bank's loans for HIV/AIDS are provided to governments on highly concessionary terms through the World Bank's concessionary lending arm, the International Development Association (IDA).

While the approval of new loans for HIV/AIDS fluctuates considerably from year to year, the Bank is continuing to expand its portfolio of HIV/AIDS projects and loan disbursements, which reflect efforts to implement AIDS control activities. The Bank has committed over $800 million to HIV/AIDS projects over the past decade, and there are indications that the pace of lending will rise in the next 3-5 years as more clients turn to the Bank for financial assistance to address HIV/AIDS in their countries.

The World Bank also incorporates HIV/AIDS components into other loans such as reproductive health and rural development programs. The Bank's commitment to HIV/AIDS is also reflected in its technical and operational assistance. The Bank attempts to ensure that HIV/AIDS strategies are effective and appropriate for the specific challenge facing each country. Although individual governments are ultimately responsible for project implementation, the Bank works closely with government officials in designing, monitoring and evaluating HIV/AIDS projects. The Bank also is increasingly focusing on capacity building as part of country specific responses to HIV/AIDS.

The Bank is involved in HIV/AIDS projects in all the developing regions:

- About 20.8 million people are living with HIV/AIDS in **Sub-Saharan Africa** and consequently nearly half of the HIV/AIDS projects now funded by the Bank are in this region.

- With an estimated 6 million people living with the virus in **Asia** today, UNAIDS predicts that Asia may soon surpass Africa in terms of the highest number of new infections per year. The epidemic has continued to spread throughout the region, which includes two of the world's most populous nations, China and India. The World Bank currently supports six HIV/AIDS projects in Asia and this number is expected to increase.

- The World Bank-funded projects in **Latin America and the Caribbean** focus on preventing the regional epidemic from expanding to proportions comparable to Africa's epidemic

- The Bank currently funds projects with STD-prevention and treatment components in the **Europe and Central Asia** region and is funding HIV/AIDS specific projects in Romania, Bulgaria, Georgia, and Kyrgyz Republic.

- In the **Middle East and North Africa,** the Bank is supporting health projects with HIV/AIDS components in Morocco and Yemen.

OTHER BANK-SUPPORTED ACTIVITIES

Vaccine Research

The devastating impact of the HIV/AIDS epidemic in many of the Bank's client countries has increased the priority for developing a preventive vaccine that will be effective and affordable in the developing world. In response, a World Bank Task Force is exploring the market failures leading to under-investment in an HIV/AIDS vaccine and to elaborate on the feasibility and optimal design of innovative financing instruments, which would stimulate private investment. The task force also is responsible for developing new World Bank instruments that will increase private incentives to invest in R&D for HIV/AIDS. At present, private investment in R&D for an HIV/AIDS vaccine for developing countries is extremely low, in large part because of uncertainty among the pharmaceutical industry about the potential market for such a vaccine in low-income countries.

The World Bank also is part of a global collaboration of organizations that has created and funded the **International AIDS Vaccine Initiative (IAVI)**, whose mandate is to accelerate progress towards an AIDS vaccine for use in developing nations where the epidemic is spreading most rapidly.

MAKING ADIFFERENCE IN HIV/AIDS

BRAZIL: The Bank is funding an HIV/AIDS/STI project in Brazil, which has provided 400 grants totaling $100,000 to NGOs and CBOs who supply outreach education and other services to sex workers, street, children, and drug users, previously unreachable by AIDS prevention organizations. In addition, under this project, the World Bank assisted the Brazilian Ministry of Health in convincing the Ministry of Finance to lower the cost of condoms by eliminating taxes and tariffs. Taxes and tariffs previously increased the sales price of imported condoms and protected domestic manufacturers. Combined with social marketing and widespread condom distribution, the elimination of taxes has dramatically increased condom availability and affordability.

The Bank is now working with Brazil on a second AIDS and STD Control Project that builds on the first loan. The project will broaden prevention activities and strengthen evaluation capacity while working toward the sustainability of the program through devolution of some responsibilities to the states and municipalities. Consistent with the major role of the private sector in the provision of health services in Brazil, the project also promotes private sector (mainly through NGOs) participation in AIDS prevention and care.

UGANDA: The Sexually Transmitted Infections Project ($50 million for HIV/AIDS/STDs) in Uganda focuses on maintaining the observed reduction in HIV prevalence resulting from two previous Bank-funded primary prevention projects. The project is also focused on obtaining a better understanding of why there has been a decrease in HIV/AIDS incidence, and the development of a broader approach to HIV/AIDS prevention among Ugandan youth, particularly adolescent women. The project is expected to attract greater attention to the importance of incorporating HIV/AIDS prevention in reproductive health programs, and developing a more sustainable approach to prevention and mitigation of the disease.

ZIMBABWE: In Zimbabwe, a freestanding HIV/AIDS Bank-funded project focuses on prevention and cure of STDs—one of the most cost-effective interventions to inhibiting the spread of HIV. This project also attempts to bolster the nation's health care system by providing vehicles and essential equipment to manage the increased demands prompted by the pandemic. By financing condoms to stem the spread of STDs, diagnostics to help identify individuals in need of treatment for STDs and AIDS-opportunistic infections, and drugs to treat STDs and selected AIDS-opportunistic infections, the World Bank and the government are working together to mitigate the impact of the AIDS epidemic on the people of Zimbabwe.

Publications and Brochures

The Bank has authored numerous studies analyzing HIV/AIDS, which draws upon knowledge in the area of epidemiology, public health, and public economics in order to make recommendations on setting priorities and in measuring the impact of the disease and different strategies to confront it.

- *Investing in Young Lives: The Role of Reproductive Health. (World Bank Brochure)*
- *Expanding the Response: World Bank HIV/AIDS Activities. (World Bank Brochure)*
- *HIV and Human Development: The Devastating Impact of AIDS (World Bank Brochure)*
- *Confronting AIDS in Latin America and the Caribbean. (World Bank Backgrounder)*
- *HIV/AIDS in Africa: Highest Rates in the World Bank. (World Bank Backgrounder)*
- *HIV/AIDS in Asia: Without Further Action, a Looming Public Health Crisis. (World Bank Backgrounder)*
- *Confronting AIDS: Public Priorities in a Global Epidemic (World Bank Publication)*
- *World Bank HIV/AIDS Interventions: Ex-ante and Ex-post Evaluation(World Bank Publication)*
- *The Impact of AIDS on Capacity Building World Bank (1998) Africa Region*

World Bank HIV/AIDS Websites

The Bank has worked closely with UNAIDS in the development of an economics AIDS web site: *http://www.worldbank.org/aids-econ/arv/*

The site's goal is to support and encourage a better understanding of the economics of HIV/AIDS prevention and treatment and to provide links to papers and articles on HIV/AIDS.

In May, the AIDS Economics web site hosted an on-line conference on the topic: "ARV Treatment in Developing Countries: Questions of Economics, Equity and Ethics." The Conference summary, primary documents, background materials, a participant list, and discussion are available online.

Other Web sites:

- *http://www.worldbank.org/html/extdr/hivaids/default.htm*
- *http://www.worldbank.org/afrdr/hp/AIDS/aidspg1.htm*

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September 1998

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October 20, 1998

Dear colleagues,

The Global Health Council/NCIH is helping to put together a meeting to review the World Bank loan for India's HIV/AIDS control program. As a reminder, this meeting will be held from 10:30 a.m. to 12 p.m. on October 27, 1998 at The White House Office of National AIDS Policy, 736 Jackson Place on Lafayette Park.

Enclosed is a World Bank brief on India, an overview of The World Bank's global HIV/AIDS activities, an Indian Ministry of Health report on HIV/AIDS Programmes, and a copy of a similar meeting held last year in London that was sponsored by the International HIV/AIDS Alliance. Hopefully this material will provide you with some background information for the meeting.

The host of this meeting, Sandra Thurman, director of the White House Office on National AIDS Policy, will speak first, followed by J.V.R. Prasada Rao of the Government of India's National AIDS Control Organization. Following brief presentations will be a period for questions and discussion.

I would encourage you to bring with you 25 copies of a description of your organization's AIDS-related activities in India to share with the other attendees.

I look forward to seeing you there.

Sincerely,

Ron MacInnis
Global AIDS Program Director

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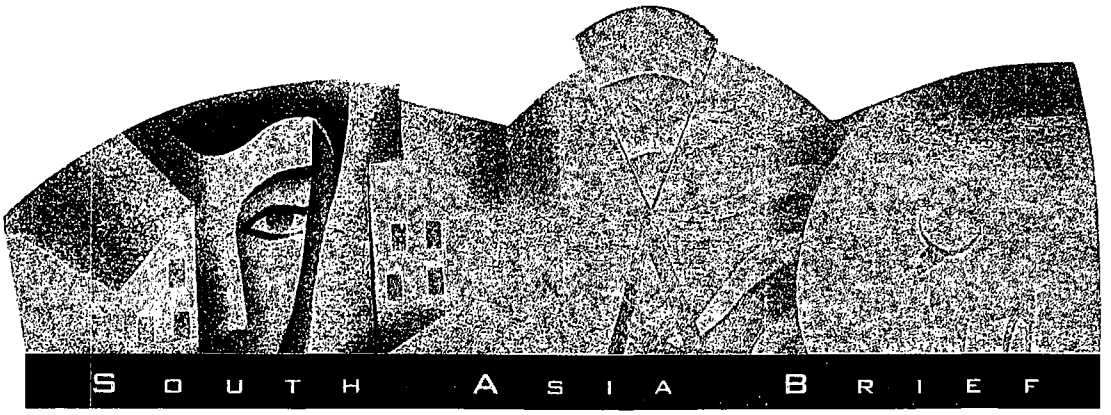
COUNTRY BRIEF



India

India is a country of striking contrasts and enormous ethnic, linguistic, and cultural diversity. There are more than 1,600 languages, nearly 400 of which are spoken by more than 200,000 people. Many of the 25 states that make up India's federation are larger than most countries. Thirteen states have more than 20 million people, six have populations of 60 million, three exceed 80 million, and one has more than 140 million people. These states differ vastly in terms of their natural resources, administrative capacity, and economic performance.

Agriculture plays an important, although diminishing role in the economy, accounting for 28 percent of the country's gross domestic product (GDP) in 1996 and 70 percent of total employment. Industry and manufacturing have expanded over the past decade, and now account for about 29 percent and 20 percent of GDP, respectively.

The service sector has strengthened, growing from 36 percent in 1980 to about 43 percent today. India's software subsector–one of the most dynamic in the world–has experienced a sustained rapid upswing, growing by 50 percent annually over the past three years.

India has made enormous strides since it achieved independence more than 50 years ago. The country's development strategy has helped it eliminate famines and bring down high illiteracy and fertility rates. India has also developed a diversified industrial base and a relatively large and sophisticated financial sector. These successes have taken place against a backdrop of India's well-established democratic system–the largest in the world–that has provided its population with an unusual degree of political freedom and stability.

Yet the development strategy that produced these results emphasized import substitution and government intervention, which ultimately over-extended the public sector and proved to be unsustainable. Protectionism isolated India from the rest of the world, and the country's share of world trade declined from 2 percent in the 1950s to less than half of one percent in the late 1980s. The strategy also discouraged exports, created recurrent shortages of foreign exchange, and made the balance of payments extremely vulnerable to sudden changes in international markets. With economic growth thus impeded, poverty reduction also lagged. By the early 1990s, India was in the midst of severe fiscal and trade imbalances and double-digit inflation, and was on the verge of defaulting on its external debt obligations.

Economic Developments

In June 1991, the country changed its course, effectively ending four decades of government-led growth. The new approach focused on stabilizing the economy; reforming the financial sector, public enterprises, and the investment, trade and tax regimes; and giving the private sector a much greater role in India's development.

This economic program produced appreciable results. Initially, growth declined sharply in response to the contractionary fiscal and monetary policies adopted to address the crisis. The reforms and good monsoons helped growth rebound to 5 percent in 1992–94. Between 1994–96 GDP grew at 7 percent, placing India among the world's best performing economies.

Underpinning the economy's strong performance were important structural transformations. The declining economic role of the public sector since the start of the reform program in 1991 is probably India's most fundamental structural change since independence. Areas that were previously the exclusive domain of the public sector–heavy manufacturing, banking, civil aviation, telecommunications, power generation and distribution, ports, and roads–are now opening to the private sector.

Equally important, the liberalization of the economy has reduced