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India Responds to

N CO

National AIDS Control Organisation

Ministry of Health & Family Welfare
Government of India

FUNDING FOR AIDS IN INDIA

FY2000

Total: $8.5 million

- $5.5 Regular bi-lateral funding
- $3 LIFE

FY2001

Requested Total: $11 million

FY2002

Requested Total: $10.5 million

Also: Multi-year commitment for 2 programs (in two specified regions): $51.5 million

DRAFT FY 1998-2000 HIV/AIDS Funding (in $000)

Country Operating Unit	FY 1998 TOTAL	FY 1999 Core	FY 1999 AIDS Orphans Supp	FY 99 TOTAL	FY 2000 Core	FY 2000 LIFE Initiative	FY 2000 Total	DCOF * (CHS Account)	FY 2000 AIDS Children Supp. **	FY 2000 TOTAL	Title II Food Aid (BHR)	FY 2001 Recommended SEE FOOTNOTE
ANGOLA	0	0		0	1,000		1,000	500		1,500		1,500
BENIN	1,500	1,200		1,200	1,025	0	1,025			1,025		2,054
CONGO	1,000	1,914		1,914	1,500	0	1,500			1,500		3,500
ERITREA	500	217		217	500	0	500			500		1,000
ETHIOPIA	5,125	5,540		5,540	5,000	1,700	6,700	400		7,100		7,500
GHANA	3,700	4,000		4,000	4,000	-	4,000			4,000		4,500
GUINEA	1,300	1,200		1,200	1,725	-	1,725			1,725		2,225
KENYA	3,200	3,300	1,150	4,450	3,200	2,500	5,700	500		6,200		7,500
LIBERIA	0	0		0	-							500
MADAGASCAR	500	500		500	800	0	800			800		1,500
MALAWI	2,600	2,600	85	2,685	2,200	2,800	5,000	500		5,500		6,000
MALI	2,400	2,220		2,220	2,500	-	2,500			2,500		3,000
MOZAMBIQUE	3,200	2,820		2,820	3,000	2,100	5,100			5,100		6,200
NAMIBIA	0	0		0	1,000		1,000			1,000		1,500
NIGERIA	1,900	2,000	815	2,815	3,300	3,450	6,750			6,750		11,897
RWANDA	500	2,000	1,000	3,000	1,500	2,000	3,500			3,500		4,700
SENEGAL	100	2,774		2,774	1,700	2,000	3,700			3,700		4,700
SOMALIA	0	0		0	-	-	0					
SOUTH AFRICA	2,000	1,500	1,450	2,950	900	4,800	5,700	750		6,450		8,000
TANZANIA	3,600	4,000		4,000	3,500	2,500	6,000			6,000		7,000
UGANDA	4,900	6,010	1,000	7,010	4,400	2,500	6,900		2,200	9,100		10,762
ZAMBIA	2,700	3,250	1,000	4,250	3,500	3,500	7,000	1,000		8,000		10,000
ZIMBABWE	1,950	1,550	300	1,850	2,000	3,000	5,000			5,000		6,000
RCSA	0	0		0	-	-	0					
REDSO/E	360	250		250	200	1,000	1,200			1,200		1,700
REDSO/WCA	3,465	3,405	200	3,605	5,700	1,700	7,400			7,400		7,700
AFR/SD	2,500	3,000		3,000	1,850	1,450	3,300			3,300		3,800
Southern Africa	0	750		750	500	1,000	1,500			1,500		4,000
SAHEL	100	0		0	100	-	100			100		
UNAIDS	2,000	0		0								
TOTAL AFR	51,100	56,000	7,000	63,000	56,600	38,000	94,600	3,650	2,200	100,450	-	128,738
India (LIFE)						3,000						
G/PHN (LIFE)***						4,000						
Sri Lanka (DCOF AIDS Orphans)								350				
GRAND TOTAL - LIFE						45,000					10,000	
GRAND TOTAL - DCOF AIDS Orphans								4,000				
GRAND TOTAL - AIDS Children Supplemental (Recoveries)									6,000			
USAID Global Bureau Attribution for Africa	15,950			18,000						17,375		
(USAID Africa TOTAL)****	[67,050]			[81,000]						[119,825]**		
USAID Agency HIV Total	[121000]			[135,000]						[200.000]		

* = DCOF for AIDS orphans

*** = About 50% of the G/PHN LIFE amount is attributable to Africa

** = $3.8 m still to be allocated

**** = Total of AFR and G/PHN attribution for Africa (including $2 m of $4 m of G/PHN LIFE); $10 m in food aid not included yet; $3.8 m in recoveries not included yet (potential total for 2000 is thus $133,625,000)

Revised 01/06/00 Alex Ross, AFR/SD

FY 2001 FOOTNOTE: DOES NOT INCLUDE ANY DCOF OR AIDS CHILDREN SUPPLEMENTAL

USAID HIV/AIDS Funding Levels ($000's)

Operating Unit	FY 1997	FY 1998	FY 1999	FY 2000
Africa Bureau	51,101	51,100	56,000	94,600
Asia and the Near East Bureau	14,070	22,800	19,000	25,550
Latin America and the Carribean Bureau	16,061	14,250	13,000	14,500
Europe and the New Independent States Bureau	---	---	---	---
Global Bureau*	35,269	31,900	36,000	38,750
Other Central Bureaus	999	950	1,000	6,600
Children affected by AIDS (CAA)	---	---	10,000	10,000 **
Title II	---	---	---	10,000
TOTALS	**117,500**	**121,000**	**135,000**	**200,000**

* Approx. 50% of the Global HIV/AIDS activities are for the Africa region.

** Includes $4 million from DCOF and $6 million recoveries.

INDIA AND HIV/AIDS

TALKING POINTS

Cited as one of the global focal points for HIV/AIDS, India has the largest number of HIV-infected persons in the world.

- India now has an estimated 3 to 5 million people infected with HIV.
- Between 0.5 to 0.8 percent of the adult population are already infected.
- Surveillance data reflect the epidemic is growing outside the high-risk groups to include members of the general population and that the epidemic is moving from urban to rural districts.

Although the total number of AIDS cases reported to the National AIDS Control Organization (NACO) is greatly underestimated, the annual number has been steadily increasing since the first case was reported in 1986. A total of 2,020 cases was reported in 1997, compared with only 953 a year earlier, with a cumulative total of 5,204 by March 1998. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 430,000 cases of AIDS and 350,000 AIDS-related deaths have occurred in adults and children since the beginning of the epidemic.

WOMEN AND HIV/AIDS: One in four cases of HIV is among women. At the end of 1997, an estimated 1 million women (15 to 49 years old) were living with HIV/AIDS. Although prevalence rates among pregnant women vary throughout the country, ranging from 0 to 2.4 percent infected, sentinel surveillance studies carried out in 1998 found HIV-seropositivity rates greater than 1 percent in 5 of the 32 states/territories surveyed.

CHILDREN, YOUTH AND HIV/AIDS: According to UNAIDS, approximately 48,000 children under the age of 15 were living with HIV/AIDS at the end of 1997, and 120,000 children have become orphans due to AIDS since the beginning of the epidemic. India's infant mortality rate is projected to increase almost 2 percent between now and the year 2015 due to AIDS.

NATIONAL RESPONSE: A well-managed prevention program at the state and municipal level, could keep HIV infection below 2 percent of the adult population and prevent the kind of devastation affecting many countries on the African continent.

DONORS: **USAID** is a major donor to HIV/AIDS prevention, with a commitment of more than $50 million for HIV/AIDS prevention in India. USAID's AIDS Prevention and Control activity in Tamil Nadu supports nongovernmental organizations (NGOs) to design and implement community-based prevention programs targeting high-risk populations, including sex workers and their clients and sexually transmitted infection (STI) patients. USAID is expanding to include a $41.5 million seven-year project in Maharashtra.

INSTITUTIONAL INTERVENTIONS

INDIA

Organization	Advocacy	Behavior Change Intervention	Care (Home & Community-Based)	Training	Condom Distribution	Social Marketing	Stigma & Discrimination	IEC Activities	Mother-to-Child Transmission	Research	STD Services	Policy	Voluntary Counseling & Testing	Orphans & Vulnerable Children	TB Control	Blood Safety	Other
Cooperating Agencies																	
Johns Hopkins University								X									
Population Services International (PSI)	X	X	X	X	X	X	X	X		X	X	X	X				
Int'l HIV/AIDS Alliance			X														X
Family Health Int'l, IMPACT Project										X							
Population Council, HORIZONS Project										X							
PVOs/NGOs																	
Institute for Development Training	X	X		X				X					X			X	
Contraceptive Research and Development Program										X							
Project Concern		X		X	X	X	X	X									
Catholic Relief Services (CRS)	X	X	X	X			X	X				X	X	X	X	X	
Christian Children's Fund	X	X	X	X													

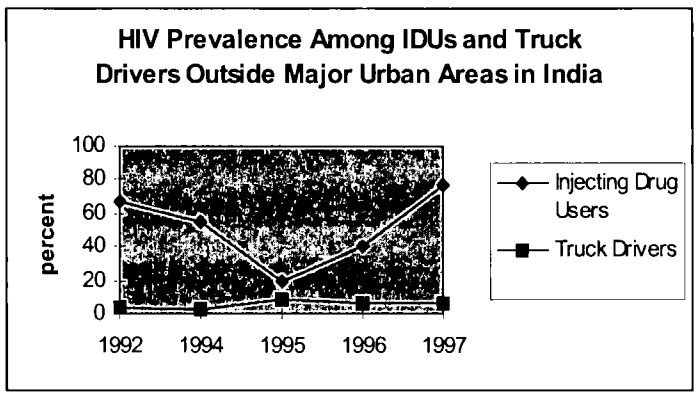
INDIA AND HIV/AIDS

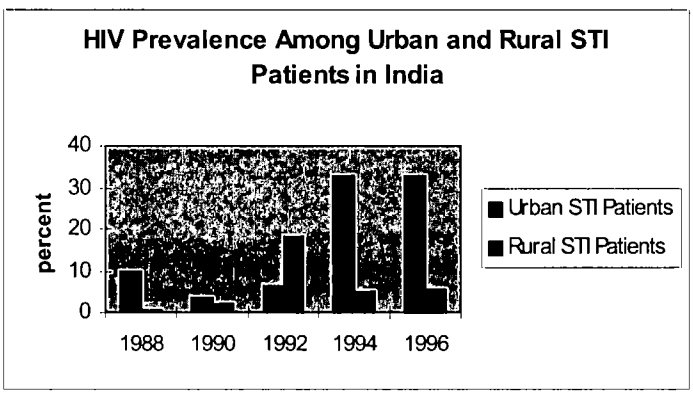
COUNTRY PROFILE

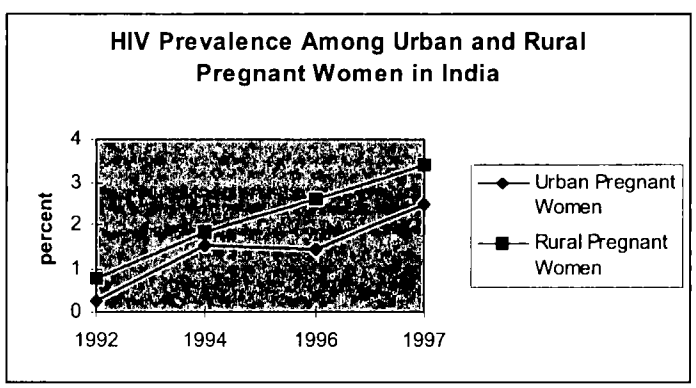
India is the second most populous country in the world, accounting for 16 percent of the world's population. More than 300 million of its citizens live in poverty, the largest concentration of poor in the world. Despite food production gains, half of India's children are malnourished. With nearly a billion people, India is vital to successfully addressing the global issues of climate change, population growth and emerging diseases. India is the sixth largest and second fastest growing producer of greenhouse gases, and three of India's largest cities rank among the 10 worst polluted cities in the world. Environmental pollution in India costs the country billions of dollars each year.

While the number of Indian scientists and engineers is among the highest in the world, India as a whole faces unacceptably high levels of illiteracy and low learning achievement. According to official government statistics, in 1991 over 60 percent of all women over 7 years old were illiterate. Sixty-two percent of boys were enrolled in primary school in 1994/1995, compared to only 47 percent of girls.

Although declining, largely preventable diseases such as leprosy, tuberculosis, cataract blindness, and malaria continue to account for a large percentage of reported illness. Pollution in cities causes premature deaths, chronic respiratory disease and the emergence of communicable diseases due to crowding and lack of access to clean water and sanitation. As of 1997, the government of India (GOI) reported maternal and infant mortality rates of 570 and 71 deaths per 1,000 births, respec-







tively. Life expectancy at birth is 58 years for males and 59 years for females (as of 1991).

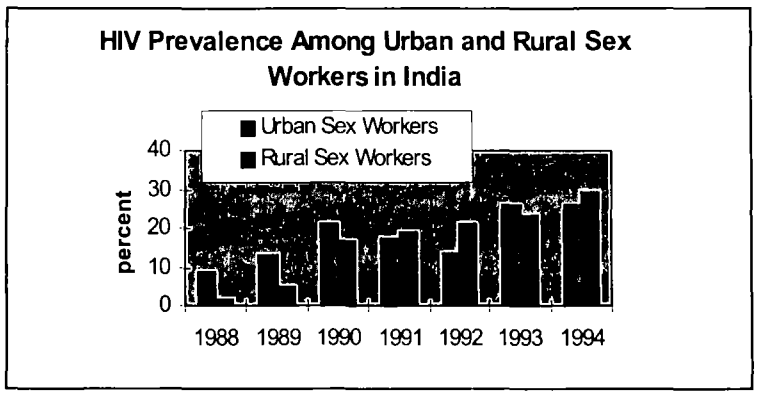
HIV/AIDS IN INDIA

Cited as one of the global focal points for HIV/AIDS, India now has an estimated 3 to 5 million people who are HIV positive, more than any other country in the world. Although HIV prevalence remains low in comparison to many other countries worldwide (estimated at under 1 percent of the adult population), it is well over 10 times higher than in neighboring China.

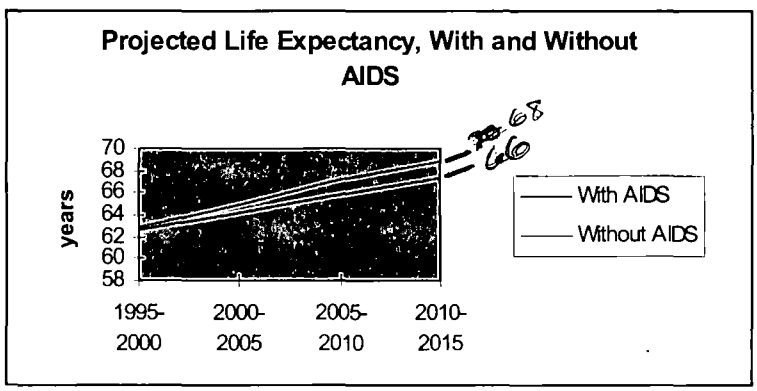
The 1997-1998 annual report of the National AIDS Control Organization (NACO) reported the following:

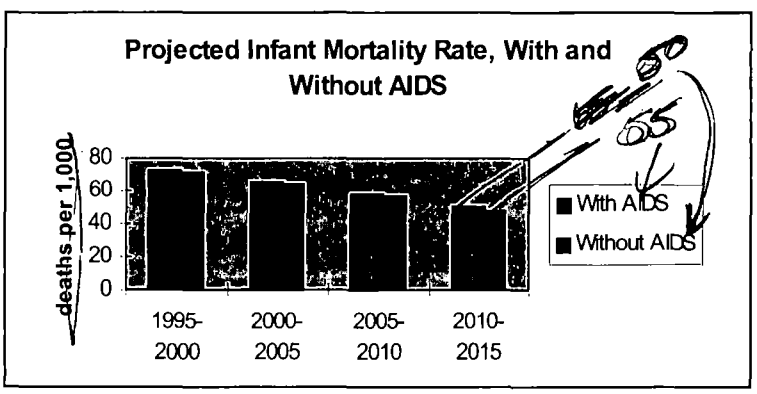
- Approximately 4 million adults ages 15 to 49 are living with HIV/AIDS, representing 0.5 percent of the adult population.
- In five states, more than 1 percent of the population are already infected with HIV.
- Since the beginning of the epidemic (through March 1998), 5,204 AIDS cases have been reported in adults and children.
- The total number of reported cases increased from 924 in 1996 to 2,020 in 1997.

Until recently, it was commonly assumed that HIV infection in India was concentrated in urban areas among high-risk groups, such as commercial sex workers and their clients, including truck drivers, and injecting drug users (IDUs) living in a few states. However, the March 1998 round of sentinel surveillance in antenatal clinics shows that in at least



HIV has spread to women whose only risk behavior is having sex with their own husbands. In a study of nearly 400 women attending STI clinics in Pune, 93 percent were married and 91 percent reported never having sex with anyone but their husband. All of these women were infected with a STI, and an alarming 13.6 percent of them tested positive for HIV.





five states, more than 1 percent of pregnant women are now infected, reflecting a shift into the general population. Published reports have also indicated a rapid escalation of the epidemic in some areas among selected groups.

- Among clinic patients with sexually transmitted infections (STIs) in Pune, Maharashtra, yearly incidence of HIV was 10.2 percent.
- Among truck drivers in the southern state of Tamil Nadu, HIV prevalence quadrupled from 1.5 percent in 1995 to 6.2 percent just one year later.
- In the northeastern state of Manipur, where the epidemic took off quickly among male IDUs, some drug clinics registered HIV rates as high as 70 percent in 1998.
- In sentinel surveillance studies carried out in March 1998, more than 5 percent of STI clinic attendees in 8 states were HIV infected, with rates greater than 10 percent in 3 of the 8 states.

It is estimated that social marketing as a distribution channel accounts for approximately 85 percent of the total number of condoms provided throughout India, with 9 major companies and at least 4 nonprofit organizations involved in distribution through a network of over 300,000 outlets.

India's rural areas, home to about 70 percent of the country's population, were thought to be relatively spared by the epidemic, until recent studies which show HIV has become as common in some rural villages as in cities. A recent survey of randomly selected households in Tamil Nadu found that 2.1 percent of the adult population living in the countryside had HIV, as compared with 0.7 percent of the urban population. Considering that nearly 10 percent of the people surveyed had gonorrhea, syphilis or another STI, HIV clearly has fertile ground for further spread.

WOMEN AND HIV/AIDS

Worldwide, women are becoming infected at faster rates than men and the total number of HIV-infected women is approaching that of men. Young women are particularly vulnerable; it is estimated that 70 percent of women infected with HIV are between 15 and 24 years of age.

- According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates, at the end of 1997, 1 million women in India (ages 15–49) were living with HIV/AIDS.
- In five states, more than 1 percent of pregnant women surveyed were HIV infected.
- Yearly incidence of HIV among commercial sex workers (CSWs) attending STI clinics in Pune was 26.1 percent.
- In one study in Mumbai, HIV–infection rates among CSWs increased from 1 percent in 1986 to 72 percent in 1997.

Women have less decision-making power in sexual relationships; this coupled with lower levels of education, greater biological susceptibility to infection, and limited access to resources, make women particularly vulnerable to HIV infection.

CHILDREN, YOUTH AND HIV/AIDS

The HIV epidemic has a profound impact in children, causing high morbidity and mortality rates among infected children and orphaning many others. Unless checked, the HIV epidemic has the potential to reverse the progress that has been made in lowering India's infant mortality rate, as has been demonstrated in other countries.

- According to UNAIDS, an estimated 48,000 children under the age of 15 were living with HIV/AIDS at the end of 1997
- an estimated 120,000 children have become orphans due to AIDS since the beginning of the epidemic.

SOCIOECONOMIC EFFECTS OF HIV/AIDS

About 90 percent of reported AIDS cases are among 20 to 45 year olds. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise (even in low-wage, labor-intensive industries) as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less labor-intensive crops. In many cases, this implies switching from export crops to food crops, thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. AIDS also adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level, there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children, and in the absence of grandparents, young children often become heads of households.

INTERVENTIONS

NATIONAL RESPONSE

In 1992, the GOI developed the National HIV/AIDS Control Program (NACP) to be implemented by NACO of the Ministry of Health and Family Welfare (MOHFW). NACO has provided national leadership and facilitated the development of State AIDS Societies in all states across India. Knowledge about HIV/AIDS, especially in urban areas, has increased significantly. NACO has recently developed the next phase of the NACP with additional assistance from the World Bank. The objectives of this phase will be to:

- Reduce the spread of HIV infection in high-risk populations,
- Reduce the spread of infection in low-risk populations,

- Strengthen the impact and sustainability of national, state and local programs,
- Build capacity for provision of low-cost, community-based care, and
- Promote intersectoral links.

In this last phase, NACP will emphasize and enhance the technical leadership role of NACO, while devolving service delivery responsibility to state-, district- and municipal-level organizations.

DONOR RESPONSE

Multilateral and bilateral donors are actively engaged in India.

In the last two years, 104 NGOs have been funded by USAID to work with high-risk groups on HIV/AIDS prevention. Among these are 11 NGOs that work at strategic locations on interstate highways and provide behavior change education to approximately 1.5 million truck drivers who travel through these locations each month. A training module was designed for training physicians in the diagnosis and management of STIs. Five institutions in Tamil Nadu have also been supported to train 1,400 physicians over the next three years in providing high quality care for STIs.

USAID began support for India's HIV/AIDS program in 1990. With a commitment of more than 50 million dollars, USAID is one of the largest donors in India. Operational in 1995, USAID's AIDS Prevention and Control (APAC) activity in Tamil Nadu was the first state-specific intervention program in India. This multiyear, $10 million project supports NGOs and technical institutions to design and implement community-based prevention programs to reduce sexual transmission of HIV. Working closely with NACP and the Tamil Nadu State AIDS Society, the program includes targeted interventions for behavior change, expanding access to and utilization of high-quality condoms, expanding access to and utilization of quality STI treatment, and behavioral and operations research to improve program planning and shape intervention strategies. APAC was the precursor of other donor-funded, state-specific HIV-prevention programs.

In 1999, USAID expanded its activities to Maharashtra where, in addition to intervention programs, the $41.5 million seven-year project, called AVERT, will support activities related to care and support of HIV-infected individuals. Modeled after APAC, the three major components of AVERT include:

- Improving the availability and quality of information, products and services to reduce transmission and mitigate the impact of HIV/AIDS and related infectious diseases;
- Strengthening the capacity of state and municipal organizations; and,
- Increasing the availability and use of data for advocacy and decision-making.

In 1999, USAID also initiated a series of projects to support activities for children affected by HIV/AIDS in Delhi, Tamil Nadu and Maharashtra. In addition, USAID supports NACP by providing financial and technical assistance to national programs and supporting the evaluation of programs, such as the Family Health Awareness Week, an annual activity to create awareness about STIs and the need for diagnosis and treatment.

USAID also supports the Program for Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH) which provides financial support and technical assistance to commercial and

private sector organizations to expand the marketing and distribution of condoms. To improve the quality of condom production in India, PACT/CRH assists the Drug Controller of India to strengthen the government's quality control and monitoring capacity and to work with manufacturers to improve condom packaging. PACT/CRH also supports the private and commercial sectors to create new diagnostic products and improve the quality and marketing of existing products.

USAID also supports the Population Council's activities to assess the economic impact of HIV/AIDS, increase decentralization of HIV/AIDS cases, improve affordable and appropriate care and support services for persons living with AIDS (PLWAs) in South India, and reduce stigma and discrimination against PLWAs in clinical settings.

USAID regional activities, which include India, promote best practices in preventing HIV transmission and providing care to AIDS victims and their families. Activities include condom social marketing, crossborder prevention activities, capacity building for local authorities and NGOs to undertake surveillance and reporting on HIV/AIDS in high-risk areas, behavior change surveys, improved management of STIs, and support for improved national policy frameworks.

The **Australian Agency for International Development, AusAID**, supports a project for the counseling and care of PLWAs and prevention activities focusing on women and children's health and capacity building. AusAID funding to India for HIV/AIDS activities for 1997-2000 is Aus$43,000. AusAID is currently developing proposals for state-based programs in Mizoram, Meghalaya, Manipur, and Delhi.

The European Union (EU) supports NGO activities in HIV/AIDS prevention and care, and funds the Lawyers Collective to implement a project on human rights, ethics and law.

Japan supports blood safety and surveillance components of state government programs, in addition to providing funds to UNAIDS in support of interstate and international study tours.

The Netherlands supports several NGO awareness programs and capacity building in care and support.

The British Department for International Development (DfID) supports three major programs on HIV/AIDS: Interventions for Sexual Health, West Bengal Sexual Health Project, and a countrywide Health Highway project targeting truck drivers and their partners. DfID's total project budget for 1995-2000 is 8 million pounds sterling.

The Swedish International Development Agency (SIDA) provides direct support to NGOs in Nagaland and Manipur for IDU projects, support to home-based care in the North East, support to the Bombay Municipal Corporation for a project targeting sex workers, and assistance to state governments for the integration of adolescent sexual health and HIV/AIDS programs in the health sector. SIDA provided 500,000SK to India for activities in 1997.

UNAIDS established a Theme Group and Technical Working Group on HIV/AIDS to coordinate the response of United Nations agencies to the epidemic and provide assistance to the GOI in the strategic development of activities. The Theme Group is comprised of members from the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF),

United Nations Development Fund for Women (UNIFEM), United Nations Information Centre (UNIC), the United Nations International Drug Control Programme (UNDCP), the International Labour Organization (ILO), the World Health Organization (WHO), and the World Bank.

UNAIDS activities include:

- Establishment of a national HIV/AIDS information exchange mechanism and resource centers;
- Technical assistance to NACO in the development of a national advocacy program;
- Technical assistance to GOI in the design and planning of the next phase of NACP;
- Technical assistance in the design and establishment of technical resource groups;
- Collation and documentation of existing literature, reports, and studies on HIV/AIDS;
- Facilitation of a school-based HIV/AIDS education program and a project aimed at reducing drug use and HIV/AIDS/STI among street children; and,
- Promotion of wider media coverage through workshops for journalists and dissemination of information packages to the media, and collaboration with entertainment media to promote HIV/AIDS information targeting youth.

UNICEF supports operations research on pediatric HIV/AIDS and vertical transmission, training of health workers on prevention and care for PLWAs, HIV/AIDS education for school-based and out-of-school youth, projects to reduce risk behavior related to drug use among street children, and regional workshops on the Rights of the Child.

UNFPA activities include District Reproductive Health projects, awareness-raising among out-of-school adolescent girls, training of health workers, strengthening of laboratories to provide testing and counseling, condom quality assurance, research in syndromic management of STIs, and support to social marketing programs.

UNESCO is involved in school-based education programs, advocacy, peer education, and empowerment of women.

WHO is working to strengthen STI prevention and control through training, operations research and technical assistance to NACO; improve the provision of condoms through quality assurance protocols and studies on the female condom; ensure safe blood supply; improve the clinical management of HIV/AIDS; improve HIV/AIDS surveillance; increase support to PLWAs; and increase the capacity of NGOs to implement prevention activities.

The World Bank provided $100 million to NACO to support the development of the national response to the epidemic. The World Bank has also recently pledged $191 million to the GOI to support building India's capacity to respond to the epidemic and prevention efforts, specifically IEC, condom promotion, STI treatment and peer counseling targeting sex workers, migrant workers, IDUs, truck drivers, and other high-risk groups.

India has an opportunity to learn from the successes and mistakes of other countries. Thailand acted early with interventions targeted at groups at highest risk and was able to stabilize adult HIV/AIDS prevalence at about 2 percent. Zimbabwe did not act early and prevalence rates are now over 17 percent. India must act now with an expanded response.

PRIVATE VOLUNTARY ORGANIZATIONS (PVOS) AND NONGOVERNMENTAL ORGANIZATIONS (NGOS)

A number of PVOs/NGOs implement activities funded by multilateral and bilateral donors. NGOs also receive funding from a variety of sources and carry out most of the HIV/AIDS prevention and care activities in India.

The International HIV/AIDS Alliance is working in India to build and link existing capacity and expertise in HIV-related programming and NGO support. Activities include strengthening the technical skills of Centers of Excellence which provide technical support services to other NGOs in care and support; developing, evaluating, documenting, and disseminating model approaches to HIV/AIDS service delivery (including services for IDUs and men who have sex with men); and, promoting involvement of PLWAs in prevention activities.

CHALLENGES

India faces considerable challenges in its fight against HIV/AIDS:

- GOI policy and implementation commitment at the national, state, district, and municipal levels is necessary. Commitment, advocacy, and resource allocation by all states are urgently needed.
- GOI must take innovative, community-based approaches to preventing new infections, starting with those groups at highest risk, within a broad-based strategy that helps build India's capacity to respond to long-term challenges.
- States unaware of the HIV threat or with poor capacities should be strengthened.
- Low-cost community-based care without stigmatization is urgently needed for those already suffering from AIDS.
- Intervention programs must respond to special needs of the target populations, including low literacy and social marginalization.
- Dialogue needs to focus on curtailing the epidemic with strategic choices and strengthening the public system.

FUTURE ACTIONS NEEDED

HIV/AIDS reduces life expectancy, increases the demand for medical care, worsens other illness (like tuberculosis), and exacerbates poverty and inequality. Estimates indicate there are more HIV-infected people in India than any other country in the world. With a well-managed prevention program put into place now, HIV infection could stay below 2 percent of the adult population. Without a successful intervention, India could be faced with the same devastation that many countries in Africa face today.

The growth of the epidemic is determined largely by sexual transmission to and from groups at highest risk (sex workers and their clients, and IDUs). However, in no country has the infection remained within these groups; it will eventually affect all of India.

IMPORTANT LINKS AND CONTACTS

1. NACO, Mr. J.V.R. Prasada Rao, Project Director; Tel/Fax: (91) 3011-7706, E-mail: nacodel@del2.vsnl.net.in.

2. UNAIDS, Mr. Alexander Gordon, Senior Country Program Adviser, UNICEF House, 55 Lodi Estate, New Delhi 110 003; Tel. (91) 11-464-9892, Fax: (91) 11-464-9895, E-mail: gordon.alexander@undp.org.

Prepared by TvT Associates, Inc.
under The Synergy Project
October 1999

HIV/AIDS *Briefs*

USAID Responds to the Worldwide Epidemic

INDIA AND HIV/AIDS

TALKING POINTS

Cited as one of the global focal points for HIV/AIDS, India has the largest number of HIV-infected persons in the world.

- India now has an estimated 3 to 5 million people infected with HIV.
- Between 0.5 to 0.8 percent of the adult population are already infected.
- Surveillance data reflect the epidemic is growing outside the high-risk groups to include members of the general population and that the epidemic is moving from urban to rural districts.

Although the total number of AIDS cases reported to the National AIDS Control Organization (NACO) is greatly underestimated, the annual number has been steadily increasing since the first case was reported in 1986. A total of 2,020 cases was reported in 1997, compared with only 953 a year earlier, with a cumulative total of 5,204 by March 1998. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 430,000 cases of AIDS and 350,000 AIDS-related deaths have occurred in adults and children since the beginning of the epidemic.

WOMEN AND HIV/AIDS: One in four cases of HIV is among women. At the end of 1997, an estimated 1 million women (15 to 49 years old) were living with HIV/AIDS. Although prevalence rates among pregnant women vary throughout the country, ranging from 0 to 2.4 percent infected, sentinel surveillance studies carried out in 1998 found HIV-seropositivity rates greater than 1 percent in 5 of the 32 states/territories surveyed.

CHILDREN, YOUTH AND HIV/AIDS: According to UNAIDS, approximately 48,000 children under the age of 15 were living with HIV/AIDS at the end of 1997, and 120,000 children have become orphans due to AIDS since the beginning of the epidemic. India's infant mortality rate is projected to increase almost 2 percent between now and the year 2015 due to AIDS.

NATIONAL RESPONSE: A well-managed prevention program at the state and municipal level, could keep HIV infection below 2 percent of the adult population and prevent the kind of devastation affecting many countries on the African continent.

DONORS: **USAID** is a major donor to HIV/AIDS prevention, with a commitment of more than $50 million for HIV/AIDS prevention in India. USAID's AIDS Prevention and Control activity in Tamil Nadu supports nongovernmental organizations (NGOs) to design and implement community-based prevention programs targeting high-risk populations, including sex workers and their clients and sexually transmitted infection (STI) patients. USAID is expanding to include a $41.5 million seven-year project in Maharashtra.

USAID

Center for Population, Health and Nutrition

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HIV/AIDS *Briefs*

USAID Responds to the Worldwide Epidemic

INSTITUTIONAL INTERVENTIONS

INDIA

Organization	Advocacy	Care (Home & Community Based)	Condom Distribution	Stigma & Discrimination	Mother-to-Child Transmission	STD Services	Voluntary Counseling & Testing	TB Control	Other
Intervention									
Cooperating Agencies									
Johns Hopkins University				X					
Population Services International (PSI)	X	X	X	X	X	X	X	X	
Int'l HIV/AIDS Alliance			X						X
Family Health Int'l, IMPACT Project					X				
Population Council, HORIZONS Project					X				
PVO/NGO									
Institute for Development Training	X	X		X		X			
Contraceptive Research and Development Program					X				
Project Concern		X		X	X	X	X	X	
Catholic Relief Services (CRS)	X	X	X	X		X	X	X	X
Christian Children's Fund	X	X	X	X					

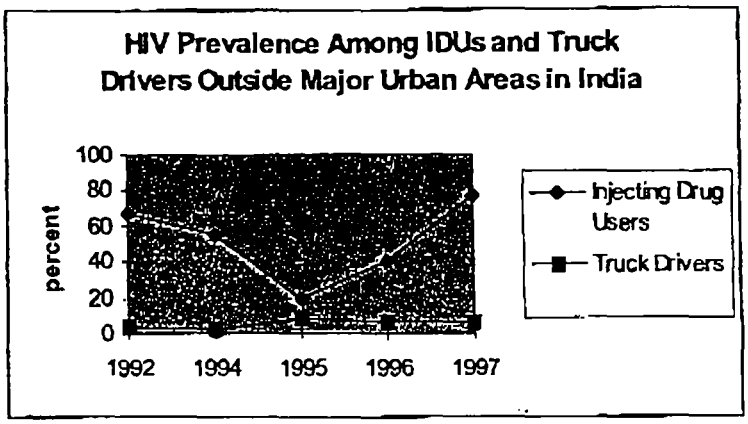
INDIA AND HIV/AIDS

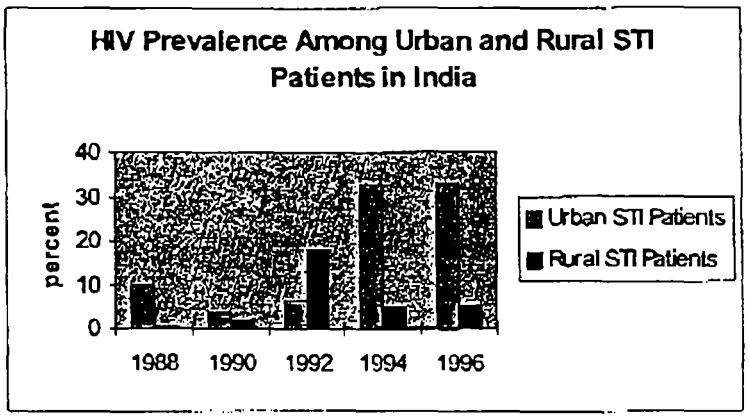
COUNTRY PROFILE

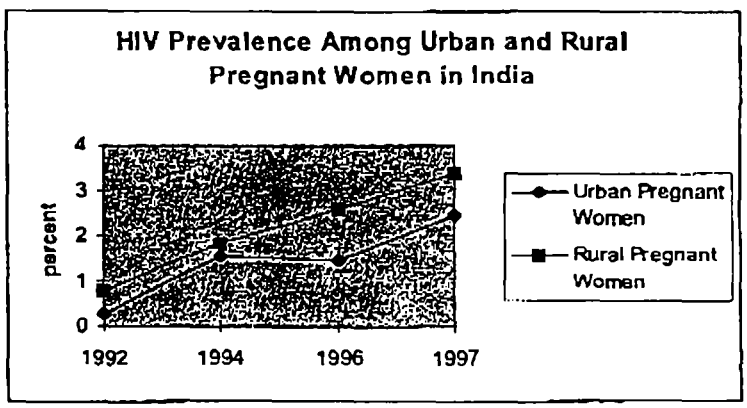
India is the second most populous country in the world, accounting for 16 percent of the world's population. More than 300 million of its citizens live in poverty, the largest concentration of poor in the world. Despite food production gains, half of India's children are malnourished. With nearly a billion people, India is vital to successfully addressing the global issues of climate change, population growth and emerging diseases. India is the sixth largest and second fastest growing producer of greenhouse gases, and three of India's largest cities rank among the 10 worst polluted cities in the world. Environmental pollution in India costs the country billions of dollars each year.

While the number of Indian scientists and engineers is among the highest in the world, India as a whole faces unacceptably high levels of illiteracy and low learning achievement. According to official government statistics, in 1991 over 60 percent of all women over 7 years old were illiterate. Sixty-two percent of boys were enrolled in primary school in 1994/1995, compared to only 47 percent of girls.

Although declining, largely preventable diseases such as leprosy, tuberculosis, cataract blindness, and malaria continue to account for a large percentage of reported illness. Pollution in cities causes premature deaths, chronic respiratory disease and the emergence of communicable diseases due to crowding and lack of access to clean water and sanitation. As of 1997, the government of India (GOI) reported maternal and infant mortality rates of 570 and 71 deaths per 1,000 births, respec-







tively. Life expectancy at birth is 58 years for males and 59 years for females (as of 1991).

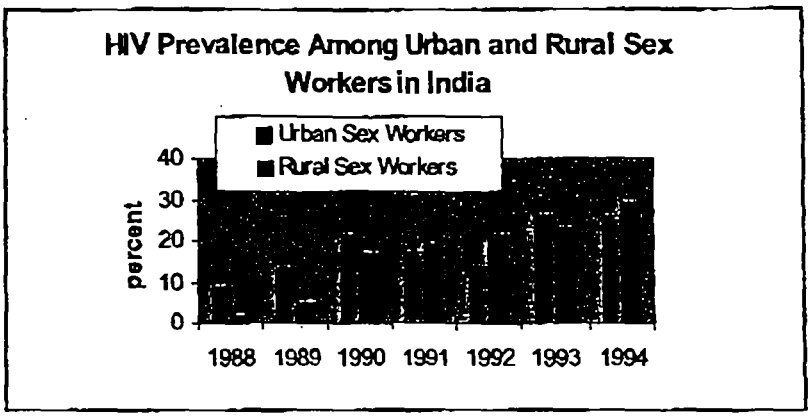
HIV/AIDS IN INDIA

Cited as one of the global focal points for HIV/AIDS, India now has an estimated 3 to 5 million people who are HIV positive, more than any other country in the world. Although HIV prevalence remains low in comparison to many other countries worldwide (estimated at under 1 percent of the adult population), it is well over 10 times higher than in neighboring China.

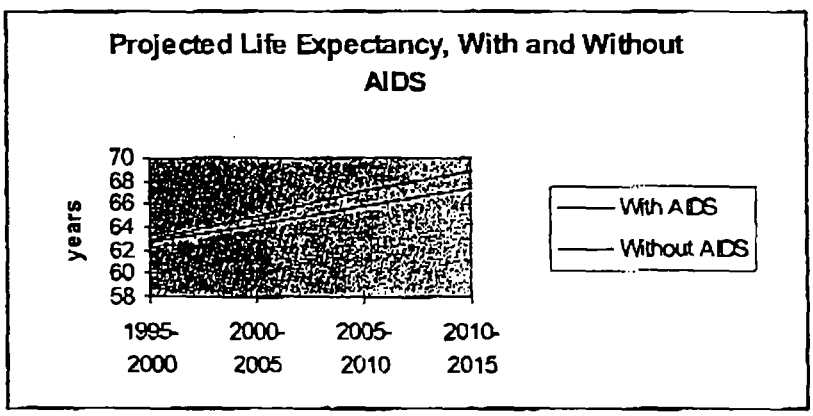
The 1997-1998 annual report of the National AIDS Control Organization (NACO) reported the following:

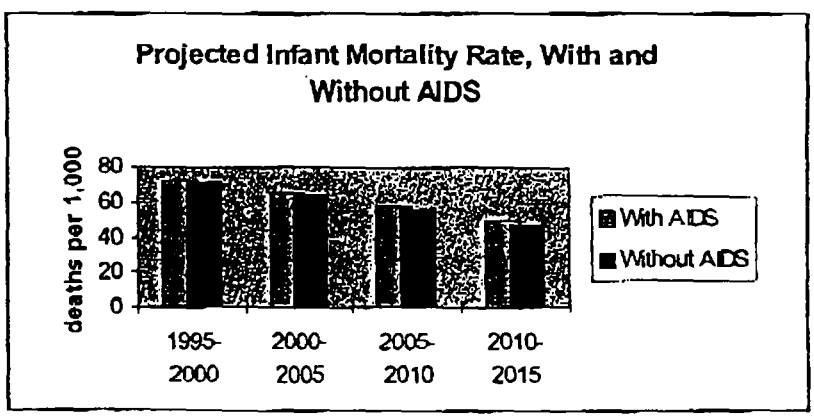
- Approximately 4 million adults ages 15 to 49 are living with HIV/AIDS, representing 0.5 percent of the adult population.
- In five states, more than 1 percent of the population are already infected with HIV.
- Since the beginning of the epidemic (through March 1998), 5,204 AIDS cases have been reported in adults and children.
- The total number of reported cases increased from 924 in 1996 to 2,020 in 1997.

Until recently, it was commonly assumed that HIV infection in India was concentrated in urban areas among high-risk groups, such as commercial sex workers and their clients, including truck drivers, and injecting drug users (IDUs) living in a few states. However, the March 1998 round of sentinel surveillance in antenatal clinics shows that in at least



HIV has spread to women whose only risk behavior is having sex with their own husbands. In a study of nearly 400 women attending STI clinics in Pune, 93 percent were married and 91 percent reported never having sex with anyone but their husband. All of these women were infected with a STI, and an alarming 13.6 percent of them tested positive for HIV.





five states, more than 1 percent of pregnant women are now infected, reflecting a shift into the general population. Published reports have also indicated a rapid escalation of the epidemic in some areas among selected groups.

- Among clinic patients with sexually transmitted infections (STIs) in Pune, Maharashtra, yearly incidence of HIV was 10.2 percent.
- Among truck drivers in the southern state of Tamil Nadu, HIV prevalence quadrupled from 1.5 percent in 1995 to 6.2 percent just one year later.
- In the northeastern state of Manipur, where the epidemic took off quickly among male IDUs, some drug clinics registered HIV rates as high as 70 percent in 1998.
- In sentinel surveillance studies carried out in March 1998, more than 5 percent of STI clinic attendees in 8 states were HIV infected, with rates greater than 10 percent in 3 of the 8 states.

It is estimated that social marketing as a distribution channel accounts for approximately 85 percent of the total number of condoms provided throughout India, with 9 major companies and at least 4 nonprofit organizations involved in distribution through a network of over 300,000 outlets.

India's rural areas, home to about 70 percent of the country's population, were thought to be relatively spared by the epidemic, until recent studies which show HIV has become as common in some rural villages as in cities. A recent survey of randomly selected households in Tamil Nadu found that 2.1 percent of the adult population living in the countryside had HIV, as compared with 0.7 percent of the urban population. Considering that nearly 10 percent of the people surveyed had gonorrhea, syphilis or another STI, HIV clearly has fertile ground for further spread.

WOMEN AND HIV/AIDS

Worldwide, women are becoming infected at faster rates than men and the total number of HIV-infected women is approaching that of men. Young women are particularly vulnerable; it is estimated that 70 percent of women infected with HIV are between 15 and 24 years of age.

- According to the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates, at the end of 1997, 1 million women in India (ages 15–49) were living with HIV/AIDS.
- In five states, more than 1 percent of pregnant women surveyed were HIV infected.
- Yearly incidence of HIV among commercial sex workers (CSWs) attending STI clinics in Pune was 26.1 percent.
- In one study in Mumbai, HIV–infection rates among CSWs increased from 1 percent in 1986 to 72 percent in 1997.

Women have less decision-making power in sexual relationships; this coupled with lower levels of education, greater biological susceptibility to infection, and limited access to resources, make women particularly vulnerable to HIV infection.

CHILDREN, YOUTH AND HIV/AIDS

The HIV epidemic has a profound impact in children, causing high morbidity and mortality rates among infected children and orphaning many others. Unless checked, the HIV epidemic has the potential to reverse the progress that has been made in lowering India's infant mortality rate, as has been demonstrated in other countries.

- According to UNAIDS, an estimated 48,000 children under the age of 15 were living with HIV/AIDS at the end of 1997
- an estimated 120,000 children have become orphans due to AIDS since the beginning of the epidemic.

SOCIOECONOMIC EFFECTS OF HIV/AIDS

About 90 percent of reported AIDS cases are among 20 to 45 year olds. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise (even in low-wage, labor-intensive industries) as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less labor-intensive crops. In many cases, this implies switching from export crops to food crops, thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience a reduced ability to provide for the family when forced to care for sick family members. AIDS also adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level, there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children, and in the absence of grandparents, young children often become heads of households.

INTERVENTIONS

NATIONAL RESPONSE

In 1992, the GOI developed the National HIV/AIDS Control Program (NACP) to be implemented by NACO of the Ministry of Health and Family Welfare (MOHFW). NACO has provided national leadership and facilitated the development of State AIDS Societies in all states across India. Knowledge about HIV/AIDS, especially in urban areas, has increased significantly. NACO has recently developed the next phase of the NACP with additional assistance from the World Bank. The objectives of this phase will be to:

- Reduce the spread of HIV infection in high-risk populations,
- Reduce the spread of infection in low-risk populations,

- Strengthen the impact and sustainability of national, state and local programs,
- Build capacity for provision of low-cost, community-based care, and
- Promote intersectoral links.

In this last phase, NACP will emphasize and enhance the technical leadership role of NACO, while devolving service delivery responsibility to state-, district- and municipal-level organizations.

DONOR RESPONSE

Multilateral and bilateral donors are actively engaged in India.

In the last two years, 104 NGOs have been funded by USAID to work with high-risk groups on HIV/AIDS prevention. Among these are 11 NGOs that work at strategic locations on interstate highways and provide behavior change education to approximately 1.5 million truck drivers who travel through these locations each month. A training module was designed for training physicians in the diagnosis and management of STIs. Five institutions in Tamil Nadu have also been supported to train 1,400 physicians over the next three years in providing high quality care for STIs.

USAID began support for India's HIV/AIDS program in 1990. With a commitment of more than 50 million dollars, USAID is one of the largest donors in India. Operational in 1995, USAID's AIDS Prevention and Control (APAC) activity in Tamil Nadu was the first state-specific intervention program in India. This multiyear, $10 million project supports NGOs and technical institutions to design and implement community-based prevention programs to reduce sexual transmission of HIV. Working closely with NACP and the Tamil Nadu State AIDS Society, the program includes targeted interventions for behavior change, expanding access to and utilization of high-quality condoms, expanding access to and utilization of quality STI treatment, and behavioral and operations research to improve program planning and shape intervention strategies. APAC was the precursor of other donor-funded, state-specific HIV-prevention programs.

In 1999, USAID expanded its activities to Maharashtra where, in addition to intervention programs, the $41.5 million seven-year project, called AVERT, will support activities related to care and support of HIV-infected individuals. Modeled after APAC, the three major components of AVERT include:

- Improving the availability and quality of information, products and services to reduce transmission and mitigate the impact of HIV/AIDS and related infectious diseases;
- Strengthening the capacity of state and municipal organizations; and,
- Increasing the availability and use of data for advocacy and decision-making.

In 1999, USAID also initiated a series of projects to support activities for children affected by HIV/AIDS in Delhi, Tamil Nadu and Maharashtra. In addition, USAID supports NACP by providing financial and technical assistance to national programs and supporting the evaluation of programs, such as the Family Health Awareness Week, an annual activity to create awareness about STIs and the need for diagnosis and treatment.

USAID also supports the Program for Advancement of Commercial Technology/Child and Reproductive Health (PACT/CRH) which provides financial support and technical assistance to commercial and

private sector organizations to expand the marketing and distribution of condoms. To improve the quality of condom production in India, PACT/CRH assists the Drug Controller of India to strengthen the government's quality control and monitoring capacity and to work with manufacturers to improve condom packaging. PACT/CRH also supports the private and commercial sectors to create new diagnostic products and improve the quality and marketing of existing products.

USAID also supports the Population Council's activities to assess the economic impact of HIV/AIDS, increase decentralization of HIV/AIDS cases, improve affordable and appropriate care and support services for persons living with AIDS (PLWAs) in South India, and reduce stigma and discrimination against PLWAs in clinical settings.

USAID regional activities, which include India, promote best practices in preventing HIV transmission and providing care to AIDS victims and their families. Activities include condom social marketing, crossborder prevention activities, capacity building for local authorities and NGOs to undertake surveillance and reporting on HIV/AIDS in high-risk areas, behavior change surveys, improved management of STIs, and support for improved national policy frameworks.

The **Australian Agency for International Development, AusAID**, supports a project for the counseling and care of PLWAs and prevention activities focusing on women and children's health and capacity building. AusAID funding to India for HIV/AIDS activities for 1997-2000 is Aus$43,000. AusAID is currently developing proposals for state-based programs in Mizoram, Meghalaya, Manipur, and Delhi.

The European Union (EU) supports NGO activities in HIV/AIDS prevention and care, and funds the Lawyers Collective to implement a project on human rights, ethics and law.

Japan supports blood safety and surveillance components of state government programs, in addition to providing funds to UNAIDS in support of interstate and international study tours.

The Netherlands supports several NGO awareness programs and capacity building in care and support.

The British Department for International Development (DfID) supports three major programs on HIV/AIDS: Interventions for Sexual Health, West Bengal Sexual Health Project, and a countrywide Health Highway project targeting truck drivers and their partners. DfID's total project budget for 1995-2000 is 8 million pounds sterling.

The Swedish International Development Agency (SIDA) provides direct support to NGOs in Nagaland and Manipur for IDU projects, support to home-based care in the North East, support to the Bombay Municipal Corporation for a project targeting sex workers, and assistance to state governments for the integration of adolescent sexual health and HIV/AIDS programs in the health sector. SIDA provided 500,000SK to India for activities in 1997.

UNAIDS established a Theme Group and Technical Working Group on HIV/AIDS to coordinate the response of United Nations agencies to the epidemic and provide assistance to the GOI in the strategic development of activities. The Theme Group is comprised of members from the United Nations Development Programme (UNDP), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF),

United Nations Development Fund for Women (UNIFEM), United Nations Information Centre (UNIC), the United Nations International Drug Control Programme (UNDCP), the International Labour Organization (ILO), the World Health Organization (WHO), and the World Bank.

UNAIDS activities include:

- Establishment of a national HIV/AIDS information exchange mechanism and resource centers;
- Technical assistance to NACO in the development of a national advocacy program;
- Technical assistance to GOI in the design and planning of the next phase of NACP;
- Technical assistance in the design and establishment of technical resource groups;
- Collation and documentation of existing literature, reports, and studies on HIV/AIDS;
- Facilitation of a school-based HIV/AIDS education program and a project aimed at reducing drug use and HIV/AIDS/STI among street children; and,
- Promotion of wider media coverage through workshops for journalists and dissemination of information packages to the media, and collaboration with entertainment media to promote HIV/AIDS information targeting youth.

UNICEF supports operations research on pediatric HIV/AIDS and vertical transmission, training of health workers on prevention and care for PLWAs, HIV/AIDS education for school-based and out-of-school youth, projects to reduce risk behavior related to drug use among street children, and regional workshops on the Rights of the Child.

UNFPA activities include District Reproductive Health projects, awareness-raising among out-of-school adolescent girls, training of health workers, strengthening of laboratories to provide testing and counseling, condom quality assurance, research in syndromic management of STIs, and support to social marketing programs.

UNESCO is involved in school-based education programs, advocacy, peer education, and empowerment of women.

WHO is working to strengthen STI prevention and control through training, operations research and technical assistance to NACO; improve the provision of condoms through quality assurance protocols and studies on the female condom; ensure safe blood supply; improve the clinical management of HIV/AIDS; improve HIV/AIDS surveillance; increase support to PLWAs; and increase the capacity of NGOs to implement prevention activities.

The World Bank provided $100 million to NACO to support the development of the national response to the epidemic. The World Bank has also recently pledged $191 million to the GOI to support building India's capacity to respond to the epidemic and prevention efforts, specifically IEC, condom promotion, STI treatment and peer counseling targeting sex workers, migrant workers, IDUs, truck drivers, and other high-risk groups.

India has an opportunity to learn from the successes and mistakes of other countries. Thailand acted early with interventions targeted at groups at highest risk and was able to stabilize adult HIV/AIDS prevalence at about 2 percent. Zimbabwe did not act early and prevalence rates are now over 17 percent. India must act now with an expanded response.

PRIVATE VOLUNTARY ORGANIZATIONS (PVOS) AND NONGOVERNMENTAL ORGANIZATIONS (NGOS)

A number of PVOs/NGOs implement activities funded by multilateral and bilateral donors. NGOs also receive funding from a variety of sources and carry out most of the HIV/AIDS prevention and care activities in India.

The International HIV/AIDS Alliance is working in India to build and link existing capacity and expertise in HIV-related programming and NGO support. Activities include strengthening the technical skills of Centers of Excellence which provide technical support services to other NGOs in care and support; developing, evaluating, documenting, and disseminating model approaches to HIV/AIDS service delivery (including services for IDUs and men who have sex with men); and, promoting involvement of PLWAs in prevention activities.

CHALLENGES

India faces considerable challenges in its fight against HIV/AIDS:

- GOI policy and implementation commitment at the national, state, district, and municipal levels is necessary. Commitment, advocacy, and resource allocation by all states are urgently needed.
- GOI must take innovative, community-based approaches to preventing new infections, starting with those groups at highest risk, within a broad-based strategy that helps build India's capacity to respond to long-term challenges.
- States unaware of the HIV threat or with poor capacities should be strengthened.
- Low-cost community-based care without stigmatization is urgently needed for those already suffering from AIDS.
- Intervention programs must respond to special needs of the target populations, including low literacy and social marginalization.
- Dialogue needs to focus on curtailing the epidemic with strategic choices and strengthening the public system.

FUTURE ACTIONS NEEDED

HIV/AIDS reduces life expectancy, increases the demand for medical care, worsens other illness (like tuberculosis), and exacerbates poverty and inequality. Estimates indicate there are more HIV-infected people in India than any other country in the world. With a well-managed prevention program put into place now, HIV infection could stay below 2 percent of the adult population. Without a successful intervention, India could be faced with the same devastation that many countries in Africa face today.

The growth of the epidemic is determined largely by sexual transmission to and from groups at highest risk (sex workers and their clients, and IDUs). However, in no country has the infection remained within these groups; it will eventually affect all of India.

IMPORTANT LINKS AND CONTACTS

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Prepared by TvT Associates, Inc.
under The Synergy Project
October 1999

AIDS In India Demands Our Immediate Attention

By SANDRA THURMAN

Just two months ago, President Clinton traveled to India to begin to build a new partnership between Americans and Indians. He is the first American President to visit India in over two decades, and together with Prime Minister Vajpayee created an alliance to confront the complex issues facing our emerging global community in the new millennium. It is an alliance that reinforces the understanding that we are indeed one world with a shared destiny. Now, our shared vision is one of peace and prosperity, of democracy and freedom.

Yet as we work to make that vision a reality, a new challenge looms large. While many of us have witnessed the tragedy of AIDS through the loss of our own friends, and loved ones, it is almost impossible to grasp the magnitude of this

Sandra Thurman

epidemic in communities around the world.

AIDS poses a tremendous threat to India's ability to sustain progress on a variety of economic, civil, and political fronts, and to maintain its position as a global power. While AIDS now remains a silent killer in India, as in so many other parts of the world, the devastation it is capable of causing is anything but invisible.

We have seen the tragic impact of AIDS in sub-Saharan Africa where in just a few short years AIDS has wiped out decades of hard work and steady progress in development. Infant mortality has doubled, child mortality has tripled, and life expectancy has been slashed by 20 years or more.

Productivity, trade and investment are dramatically impacted as AIDS continues to strike down workers in their prime, to drive up the cost of doing business while driving down GNP. The impact on security and stability in the region is unprecedented.

With an estimated 3 to 5 million people living with HIV, India now represents the largest number of HIV infections of any country in the world, and with no vaccine or cure in sight, is set to follow Africa's tragic lead.

AIDS in India is indeed a global emergency that demands our immediate attention.

Both President Clinton and Prime Minister Vajpayee have sounded the alarm on the AIDS crisis in India. Our two countries released a "Joint Leadership Statement on HIV/AIDS", thereby pledging to work together through research, prevention and care to bolster our fight against AIDS.

The statement calls for the highest levels of each government to work with the private sector to raise awareness and to lessen the stigma faced by those living with HIV and AIDS. While this is a necessary and critically important first step in recognizing the magnitude of India's AIDS epidemic, there is much more that we need to do together.

As we know all too well from our efforts to respond effectively to AIDS here in the United States, one-size-fits-all solutions do not work. While the components of an effective HIV/AIDS strategy remain constant (education, voluntary counseling and testing, care and support), how these strategies are implemented will differ greatly from New York to New Delhi, from Mumbai to Madras. Surveillance of the disease is particularly difficult in India as cultural norms, gender inequities, and stigma continue to drive the epidemic underground. As a result, AIDS cases in India are thought to be under-diagnosed, and therefore, poorly treated. In addition, keeping pace with the epidemic in a population of 1 billion, and in a country with such remarkable diversity, poses an enormous challenge.

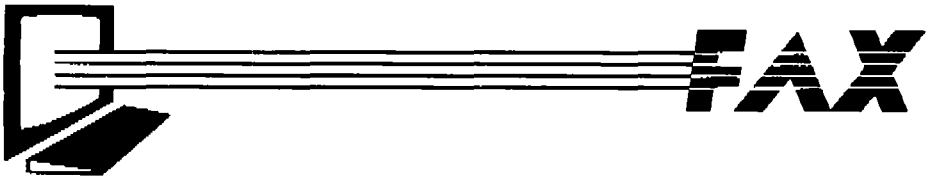
Fortunately, there is both hope and opportunity on the horizon. We have developed useful knowledge and effective skills. We have seen model programs implemented both here at home and across Africa, and have proven that they can and do work. Now, we must bolster our efforts to ensure that the legacy of AIDS is not one of loss and regret, but one of hope and triumph.

We must be ready to commit time, energy, and crucial resources if we are to turn the tide on this relentless pandemic.

In the words of the revered Mahatma Gandhi, "We must become the change we wish to see."

This is a time of great challenge. However, past experience has shown us that by joining forces, together, we can indeed make remarkable progress in our fight against this global pandemic. I am confident that by continuing in this spirit of collaboration and commitment, there will be a day when the children of India, and the children of the world, can look to their futures without fear of AIDS.

Sandra Thurman is the Director of the White House Office on National AIDS Policy



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Msg: QJKA-8008-8199
From: CFSL-COL.SVP/SIMALIN/SMA
To: (FAX:0012024562438) (URGENT) (RECEIPT) (DELIVERY)

Ms Sandra L Thurman
Director
Office of National Aids Policy

Dear Ms Thurman,

I write this letter to introduce our Company "CALSITA FUTURISTIC SERVICES LIMITED" based in Baroda, Gujarat State, India, involved in the area of HIV diagnostics. As an American living in India and being aware of the HIV issue in India, I would like to inform you that significant level of awareness and intervention is required for India to successfully manage and control the spread of HIV within the population of India.

We are also associated with a Company who are in the process of developing a therapeutic vaccine for HIV infected individuals.

I am reproducing below a letter which has been sent by me to The President, which brings out the possible attention that can be given to this issue during The President's visit to India.

It would be of great interest to me if there is an opportunity to interact with the staff or delegates on this issue and cooperate in creating and developing a non-governmental citizen based program in India through your office.

I look forward to your response on this matter and would appreciate if you could kindly coordinate a meeting with the appropriate persons visiting India to discuss the same.

I would also appreciate if you could send me your e-mail address by return mail to enable me to contact you further in the matter.

With warm regards,

SUNIL PATEL
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sunilcom@hotmail.com

Subj: Mr President's visit to India
Dear Mr President,

The foremost thing on my mind as I write this message is to receive the attention for a very important issue facing India today. The plethora of staff and persons analyzing the issues to be taken up during your visit to India should consider an HIV message to be included in the agenda for India.

The reason for this requires due cognizance and considerations.

Besides the high priority issues and sensitive concerns of the people of India with respect to bilateral ties with the US, the foreign policy issues affecting governance in south east Asia, the economic co-operation possible between the countries, the agenda on trade, defense, non-proliferation policies etc.. India also happens to the "hot spot of an HIV/AIDS epidemic."

I am an American living in India. After completion of my undergraduate work at Georgetown University and graduate work at George Washington University, I migrated to India. Being an Indian by origin, I desired to participate and contribute to the economic and regional growth in the State of Gujarat. Our work includes contributions in the field of HIV diagnostics based on an oral test for HIV and an advanced concept of developing a therapeutic vaccine for HIV infected persons worldwide.

The company we represent is small but certainly committed to research and solution finding mission for the HIV menace. We are also looking to address a program for voluntary testing in India by evoking a sense of pride among Indians to test for HIV and be proud of having a negative status - under an organization name "YES - A HIV Free India".

In the US, the process of enlightened governance combined with a political will has successfully contained the spread of HIV in the general populace. The awareness levels today are high and visible. The level of commitment you and your office provides to find a permanent solution to the HIV menace by year 2007 is not only commendable but also enviable. The will is clearly defined and efforts to find solutions are being effectively addressed.

The question now arises as to whether the level of awakening and will to create a plan of action in other developing and underdeveloped countries meets with your vision of arresting and solving the HIV/AIDS crisis in the world?

It is felt, that your vision needs to be emphasized to the other nations. The message can acquire a global meaning and create unified efforts required to weed out HIV from its very existence. Your visit to India could be an opportunity to create a platform for seeking active intervention in checking

the spread of HIV.

Recent initiatives by Rev. Jesse Jackson on personally taking an oral HIV test and by calling on the people in the US to volunteer for such a test mark a new era in HIV management. Such measures in India could go a long way in arresting the spread of HIV incidence.

I thank you and your associates to hear this appeal and look forward to receiving a response and a possible interaction during your visit to India to discuss solutions we have engineered towards a global effort to resolve the HIV menace.

We are looking forward to a new era of relationship between the two great democratic countries in forging groundbreaking paths for this century.

With warm regards,

SUNIL PATEL
Managing Director
CALSITA FUTURISTIC SERVICES LIMITED
2nd floor, Megh Dhanush
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May 11th, 2000

Dear Director Thurman,

Thank you for contributing to this Special Issue. I think it will help raise awareness about HIV/AIDS in India. Please keep us in mind as you finalize plans for your trip to India.

Sincerely,

Neil Parekh

New York: 244 Fifth Avenue, 4th Floor, New York, NY 10001 • Tel: (212) 481-3110 • Fax: (212) 889-5774 • E-mail: newsindia1@aol.com
Washington: 7304 Carroll Ave, PMB 133, Takoma Park, MD 20912 • VM (202) 478-2124 • Fax (202) 478-2124 • E-mail: nparekh@newsindia-times.com

REGIONAL HIV/AIDS INITIATIVE PROPOSED BY WHITE HOUSE

ANE is pleased to hear that the President and the Agency have recognized the seriousness of the growing HIV/AIDS problem in India. India has one of the fastest growing incidence of HIV/AIDS infections in the world and within the next five years will have more HIV/AIDS cases than any other country of the world.

ANE Bottom Line: ANE takes the HIV/AIDS pandemic in India very seriously. In FY 1999, we allocated $6.5 million to India's program, with plans for $6.5 - $7.0 million in FYs 2000-2001. While the Bureau would welcome an additional $10-$12 million for HIV/AIDS activities, and wants India retained on the proposal's priority list, this funding--and correspondent OE costs--must be additional.

Mission notes:

USAID/India could effectively utilize new and additional HIV/AIDS funds to combat the spread of this pandemic disease. However, the resources must be additive to their current OYB and must be accompanied with additional management staff and operating expense resources if the mission is to effectively utilize the funds.

1. USAID India could obligate an additional $10-12 million bilateral funding for HIV/AIDS if they expand their program to a third state for program interventions. That would require additional staff. The mission does not have the OE for new staff nor are they "flush" enough within existing staff levels to redeploy people away from other HPN interventions to work on HIV/AIDS.

2. Other ways to absorb the additional HIV/AIDS funding are either not priorities within the mission's or USAID's HIV/AIDS strategies (blood banking, commodity assistance, e.g. test kits) and/or are not within USAID/India's expertise to design and manage (additional biomedical research).

3. If a decision is made to move forward with this initiative, ANE and USAID/India must be assured funding for the initiative for at least five years.

4. If the mission had to absorb at least one half of the proposed $10-12 million ($5-6 million) from within

their existing OYB, it would likely come from the Population account, given that is where most of their funding is received. (Over 98% of India's OYB comes from earmark/directive accounts.) It should be recognized that by accepting the HIV/AIDS increase within the OYB, the Agency would be making a "policy determination" as to the relative importance of reproductive health versus HIV/AIDS.

5. Project Concern has submitted an excellent proposal. It's for about $1 million per year. They have proposed a mix of monetized Title II and actual food. The mission is trying to discourage their entry (and any other USPVO) into the food aid arena, given how tough and labor intensive it is both for the PVOs and USAID and because the prospects for massive monetization are dim--not just from the Washington perspective but from the GOI perspective. Project Concern has a good track record on HIV/AIDS in India.

6. Most of India's Title II program is managed by CRS/CARE. As far as the mission is aware, CARE does not have any comparative advantage in the HIV/AIDS business. The mission believes that CARE is already becoming somewhat overextended with the other donor funding they are receiving together with all the additional sectors the mission has asked them to consider i.e. child labor. CARE's potential interest and involvement in HIV/AIDs work should NOT be taken as a given, however, because we haven't asked them, and don't plan to until we hear more about the parameters on the use of these funds. Given the Vatican's condom policy, we presume CRS is not interested in working on HIV/AIDS.

7. Substantial additional funding from Title II food would at best be difficult given the need for GOI approval and the length of time needed to negotiate agreement from all parties. Any Title II food aid that is diverted from CARE and CRS for monetization will further reduce the food for 7 million needy women and children.

8. The mission could use additional HIV/AIDS funds (but not at the level proposed) for additional activities at the national level, e.g. behavior sentinel surveys in states other than their priority states, additional

operations research into HIV/AIDS related issues, the Project Concern proposal. (probably $5 million or less)

ANE comments:

1. ANE could not absorb an additional $10-$12 or even $5-6 million in HIV/AIDS funds without curtailing other on-going programs in the family planning/maternal child health/infectious disease arena. If additive CSD funds were not available for this initiative, programs that could potentially be curtailed include:

   - Graduation/transition FP/MCH program in Morocco
   - FP/MCH program in Nepal
   - Transition of the FP program in the Philippines to the private sector

2. If CSD funds are not available and the initiative would be required to funded from discretionary DA, ANE would:

   - Reduce its annual contribution to PRIME to -0-.
   - Curtail the DG/local governance program in the Philippines
   - Eliminate funding for the DG program in Bangladesh

3. Any new initiatives must include funding for operating expense and staff. Mission and Bureau staff absorptive capacity for this initiative is non-existent. The Bureau would need to receive at least one additional USDH workforce ceiling to ensure adequate management and oversight of this program.

Out-of-box Approach:

Has USAID considered using the "additional" funding in some way to globally leverage increased availability of AIDS treatment drugs in the third world? Could we assist local companies to purchase licenses to produce these drugs? Matching funds (corporate and foundation) for buying supplies of drugs? While this is a touchy WTO issue, and in countries like India the only solution eventually is local production, in smaller countries USAID could perhaps make a real difference? If USAID is going to have to reprogram a substantial amount of funds into more HIV/AIDS funding, it might be better to look at what we could do

globally than piecemeal at the margin country by country--given all the other constraints we have at the country level.

US-ASIA CROSS-OVER ISSUES

- By 2020, the Census Bureau projects 20 million AAPIs living in the US;
- Filial piety – the family obligation may amplify shame and cause an individual to hide their status, fail to seek treatment, or reject social services;
- Language barriers not only to treatment and prevention, but to a global response that is culturally accessible;
- Taboo subjects of sex, illness, homosexuality, drugs and death;
- The need for culturally sensitive 'traditional healing' options;
- Asian refugees in the US do not have access to treatment and social services;

RESPONDING

- **Enhanced services**:
  - Drugs, access and treatment;
  - It is undeniable that local ASOs have provided critical support, but their chronic lack of resources and high levels of staff burnout constantly threaten their very existence;
- Enhanced prevention:
  - Including reduction of stigma, disrcimination;
  - Increased education, advertising, discussions;
- **Enhanced leadership**:
  - The former Indian Prime Minister, Shri Atal Bihari Vajpayee, on December 12 1998, appealed to parliamentarians to take up AIDS awareness as a priority in their constituencies;
  - Thailand has had some of the same successes that we've seen in Uganda and Senegal;
- **Surveillance:**
  - Systematic, continuous & quality sentinel surveillance of HIV/STD will provide not only the indications of an emerging epidemic but its progress over time as well. This will benefit policy formulation, planning and resource allocation;
  - India has recently made a major effort to expand and improve its surveillance system;
  - For sex workers, confidentiality, community participation and protection against stigmatization should be integral components of surveillance activities;
- Enhanced global resources.

Draft comments ASAP

Sandy

JOINT STATEMENT ON HIV/AIDS

The HIV/AIDS epidemic is not ~~only~~ an Indian problem, ~~it is not only~~ an American problem, it is a global crisis, ~~seriously impacting every country~~. It burdens our health systems, our economies and, most importantly, the lives of too many of our citizens. But the AIDS epidemic can be ~~can~~ slowed, ~~stopped and prevented~~ through ~~behavior change,~~ raising awareness, and development of new technologies including – eventually – a vaccine.

India and the United States are working ~~closely~~ together ~~involving the public, academic, business and non-governmental~~ sectors for the benefit of both our great nations, and the world. In the area of research, India and the United States have access to some of the world's finest scientists and facilities. It is appropriate ~~then~~ that the United States and India have agreed to expand ~~our~~ collaborative research efforts in HIV/AIDS prevention, as described in the Joint Statement, which has just been signed by the US Secretary of State and the Indian Foreign Minister [assuming they sign]. Together we will apply our nations' substantial public health expertise and scientific capacities to fight the global pandemic.

An example of our joint collaboration is President Clintion's Leadership and Investment in Fighting an Epidemic (LIFE) initiative. The initiative will support Indian efforts to: establish an HIV/AIDS resource center within the National AIDS Control Organization (NACO); establish a business coalition for employer-based HIV prevention activities with private and public sector employers; support NGO activities for children affected by AIDS; and sensitize journalists to HIV/AIDS issues. NACO is the Prime Minister's organization which coordinates HIV/AIDS policy formulation and implements prevention and control programs in India with Indian and external cooperation. USAID is the major supporter of NACO's programs in Maharashtra and Tamil Nadu States.

The world's struggle against HIV/AIDS has proven that science alone will not end this crisis. It requires ~~the kind of~~ leadership ~~demonstrated by our two governments. The Prime Minister's speeches on HIV/AIDS and NACO's determined implementation of his programs, and the US Presidential LIFE Initiative in India demonstrate our resolve and support for these programs.~~ We hereby commit to our continued, personal involvement ~~to stopping~~ AIDS in India ~~and~~ the United States, and ~~through our joint efforts,~~ ~~contributing to its control in the rest of the world.~~

that seriously impacts us all.

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or

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of society with the all

therefore

around the world

in preventing

William Jefferson Clinton President United States of America	Atal Bihari Vajpayee Prime Minister India

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Global Health Council

Fax

To: Sandra Thurman **From:** Nils Daulaire, MD, MPH
President and CEO

Phone: 202.456.2437 **Date:** March 10, 2000

Fax: 202.456.2439 **Pages:** 2

Re: India Trip

☐ **Urgent** x **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Global Health Council

March 10, 2000

President William Jefferson Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear President Clinton:

In the aftermath of your White House meeting on vaccines to which you invited me on March 2, I am writing to urge you to keep HIV/AIDS at the top of the agenda in your upcoming trip to India. The impact of AIDS on years of development is devastating economies and the trend in Africa toward increased infant mortality and decreased life expectancy is likely to be repeated in India.

As you are probably aware India is now home to the largest number of AIDS cases in any one country. The infection rates is expected to double every 14 months. Of the one million orphans living in Asia, half live in India. Trends in recent surveillance data indicate that India may well surpass Africa in number of new infections.

Stigma is also a large issue. In some areas health care workers refuse to treat people living with HIV. Their own families often cast out women when it is discovered they are positive for HIV. Local Indian organizations like the Indian Network of People Living with AIDS need to be supported in the work they do to decrease stigma and increase awareness.

On behalf of our members from around the world, I urge to address these issues when you are speaking with Prime Minister Atal Bihari Vajpayee. HIV/AIDS prevention, research, care and support are important components in a successful public health approach. The people of India can only benefit if the Prime Minister is willing to support such programs, as you have forcefully in the U.S.

The Global Health Council is working with the Congressional Task Force on International HIV/AIDS to hold a briefing on AIDS in India later this spring. We continue to appreciate your demonstrated commitment to global health and thank you for your hard work and dedication.

Sincerely,

Nils Daulaire, M.D., M.P.H.
President and CEO

cc: Madeline Albright
Brady Anderson
Sandra Thurman

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Did you get a complete, clear transmission? If not, please call:

Chris Keenan at
(202) 456-9394

From: **Kenneth W. Bernard**
International Health Affairs
Phone: 202 456-9391, Fax: 202 456-9390

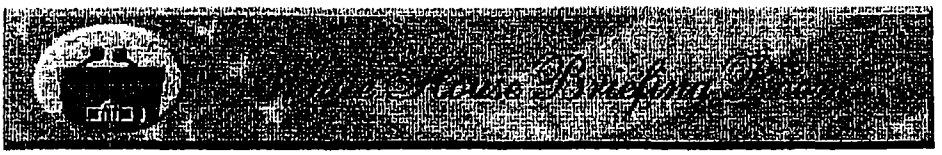
To: **Sandy Turman, ONAP**

Fax: **6-2439**

Date/Time: **March 27, 2000**

No. of pages to follow: **8**

Message: **FYI**



March 24, 2000

REMARKS BY THE PRESIDENT AT VACCINE EVENT

11:30 A.M. (L)

THE WHITE HOUSE

Office of the Press Secretary
(Hyderabad, India)

For Immediate Release March 24, 2000

REMARKS BY THE PRESIDENT
AT VACCINE EVENT

Mahavir Trust Hospital
Hyderabad, India

11:30 A.M. (L)

THE PRESIDENT: Thank you very much. Good morning, Chief Minister Naidu. Thank you for welcoming me today to your state and to this magnificent city. Dr. Aruna, thank you for your remarks and for your work. Dr. Kolluri, to Ms. Rachel Chatterjee, the Minister of Health and the other ministers of the government that are here. To the staff of the Mahavir Trust Hospital. I thank you all for your dedication and for making me and our American delegation so welcome.

I am honored to be joined today by my daughter, by the American Ambassador to India, Mr. Celeste, and his wife, Jacqueline Lundquist; by the Secretary of Commerce Bill Daley, and the Administrator of our Agency for International Development Brady Anderson; and by six distinguished members of our Congress -- Congressman Gary Ackerman and Representative Nita Lowey from New York; Congressman Jim McDermott from Washington; Congressman Ed Royce from California; Congressman Sheila Jackson Lee from Texas; and Representative Jan Schakowsky from Illinois. We are delighted to be here and we are very interested in what you are doing and impressed. And we thank you. (Applause.)

We come today to celebrate a success story and to join with you in meeting a new challenge. As Dr. Aruna said, the success story is the virtual complete eradication of polio from the face of the Earth. In 1987, India reported 27,000 cases of this crippling disease. Today only 1,000 Indians are afflicted, and as you have just heard, there are no reported new cases this year.

India has collaborated in this effort with Rotary International, with

the Gates Foundation, with UNICEF, the World Health Organization, and with the U.S. Agency for International Development, or AID.

I would like to say just a special word of appreciation to our Agency for International Development. It has meant a great deal to America's partnership on a very human level with people all across the world and especially here in India. It has guided our efforts to fight diseases that threaten children; to launch the Green Revolution that helped India achieve self-sufficiency in agriculture and even more; to provide education, so that parents in India and throughout the world can determine the size of their families and keep their children in school; and to support great Indian universities, like IIT.

Now, we believe that USAID will be just as critical and just as active as India and the United States embark on a dynamic new partnership, as we face new challenges, like developing the sources of clean energy, bringing the Internet to rural India so all its children can reach out to the world.

So I'd like to say a special word of thanks today to our AID Administrator, Brady Anderson, and B.A. Rudolph and the other members of the AID team who are here. They are devoted to the cause of India and I thank them for their work. (Applause.)

I would also like to acknowledge, though, that on this polio eradication effort, the vast majority of the funding division and the work has come from India. And the whole world admires greatly what you have achieved.

Now, for the challenge. Today is World Tuberculosis Day. It marks the day the bacteria which causes TB was discovered 118 years ago. And, yet, even though this is 118-year-old knowledge, in the year 2000, TB kills more people around the world than ever before, including one almost every minute here in India.

Malaria is also on the rise here and in Southeast Asia and in Africa. And while the AIDS infection rate here is still relatively low, India already has more people infected than any other nation in the world. These are human tragedies, economic calamities, and far more than crises for you, they are crises for the world.

The spread of disease is the one global problem for which, by definition, no nation is immune. So we must do for AIDS, for malaria, for TB what you have done for polio. We must strengthen prevention, speed research, develop vaccines and ultimately eliminate these modern plagues from the face of the Earth. It can be done -- you have proved it with polio -- if governments, foundations and the private sector work together.

With AIDS in particular, it also takes leadership. I want to commend Prime Minister Vajpayee for his efforts to focus India's attention on the urgency of this challenge. In every country and in any culture it is difficult to talk about the issues involved with AIDS. I know a lot about this because it's been a problem for a long time in America, and now it's a big problem for you. But I would submit to you it is much easier to talk about AIDS than to watch another child die. And we have to face up to our responsibilities for preventing this disease, especially because there is not yet a cure.

I am gratified that India is not waiting to act and I am proud that the United States is supporting your efforts here. I am happy to announce that we will contribute another $4 million this year to programs to prevent AIDS and care for victims here in India, and another $1 million for TB research. I also want to thank -- (applause) -- I want to thank the Gates Foundation and, in particular, Patty Stonesifer, because they are also announcing a number of new contributions today. No private foundation in America and, as far as I know, anywhere in the world has made remotely the

commitment that the Gates Foundation has in the world struggle against infectious disease, and I thank them for that. (Applause.)

Earlier this year, I asked Congress to support a $1-billion initiative to encourage the private sector to speed the development of vaccines for diseases that particularly affect the developing world -- malaria, TB and AIDS -- and then to take steps to make those vaccines affordable to the poorest people in the world who need them. I am going to work hard to obtain support for that initiative in Congress. And again, I thank the members of our Congress who are here from both parties for their interest and commitment to India and to the public health.

The fight against infectious disease should be a growing part of our partnership with you. Indians already are trailblazers in vaccine research. India pioneered treatments for TB being used today in America. Many of the problems we have talked about are present here in India, but the solutions can be found here, as well -- in the dedication of men and women like those who work in this clinic, and in the genius of your scientists, and in the elected officials and their commitment -- from Delhi, to Hyderabad, to countless towns and villages across this country.

Many years ago, India and the United States helped to launch the Green Revolution, which freed millions of people from the misery of hunger. If we can join forces on health, determined again to place science and the service of humanity, we can defeat these diseases; we can give our children the healthy and hopeful lives they deserve in this new century.

Thank you very much. (Applause.)

END 11:37 A.M. (L)

Back to summary page

March 24, 2000

U.S.-INDIA JOINT LEADERSHIP STATEMENT ON HIV/AIDS

THE WHITE HOUSE

Office of the Press Secretary
(Hyderabad, India)

For Immediate Release
March 24, 2000

U.S.-INDIA JOINT LEADERSHIP STATEMENT ON HIV/AIDS

The HIV/AIDS epidemic is not only an Indian problem, it is not only an American problem, it is a global crisis, threatening every country. It burdens our health systems, our economies and, most importantly, the lives of too many of our citizens. But the AIDS epidemic can be slowed, and ultimately reversed by raising awareness, changing behavior and developing new technologies including - eventually - a vaccine.

To that end, India and the United States are working closely together, involving our public, academic, business and non-governmental sectors for the benefit of our nations, and the world. India and the United States are home to some of the world's finest scientists and facilities. We intend to expand collaborative research efforts in HIV/AIDS prevention. Together we are applying our nations' substantial public health expertise and scientific capacities to fight the global pandemic.

India's Ministry of Health and Family Welfare, through the National AIDS Control Organization (NACO), which coordinates HIV/AIDS policy formulation and implements prevention and control programs, has recently launched a new phase of its National AIDS Control Program. With a substantial commitment from the Indian Government, bolstered by additional resources from the World Bank, USAID and other donors, NACO is now working with State health authorities and non-governmental organizations to reduce high-risk behaviors and increase awareness in the general population.

USAID is the major supporter of HIV/AIDS prevention programs in Maharashtra and Tamil Nadu States. Additionally, the United States (under its "LIFE" initiative) will support Indian efforts to prevent infection, care for the affected, and build capacity. Planning for these efforts include: establishing an HIV/AIDS resource center; establishing a business coalition for employer-based HIV prevention activities with private and public sector employers; supporting NGO activities for children affected by AIDS; and sensitizing journalists to HIV/AIDS issues.

Science alone will not win the world's struggle against HIV/AIDS. This will require leadership, which India and the United States are determined to provide. We hereby commit our continued, personal involvement to stopping

AIDS in India, the United States, and around the world.

###

To comment on this service, send feedback to the Web Development Team

March 24, 2000

FACT SHEET

THE WHITE HOUSE

Office of the Press Secretary
(Hyderabad, India)

For Immediate Release

March 24, 2000

FACT SHEET

India and the United States: Partners for a Healthy World

Today, at Mahavir Hospital in Hyderabad, President Clinton will join with local doctors, public health and government officials, foundation and NGO representatives and the people of Hyderabad to highlight the successes and future challenges for ensuring a healthy India and a healthy world. He will focus on three areas of joint India-U.S. efforts: eradication of polio, control of tuberculosis, and preventing the spread of HIV/AIDS. He will also highlight his Millennium Vaccine Initiative, which will encourage research and development of vaccines for the major killers: TB, malaria and HIV/AIDS.

Polio Eradication

In 1987, India reported over 28,000 cases of polio. The eradication program in India has since reduced the number of cases to just over 1000 in 1999, and total eradication now is in sight. Using successive rounds of "Pulse Polio Immunization Days" in which every child under 5 years old is immunized, the country is rapidly becoming polio-free. In January 2000, in the largest single public health effort in history, more than 149 million children were immunized within 3 days. Tomorrow, two more immunization rounds will be started in the 8 highest risk states in the North.

As part of this effort, The United States, along with WHO, Rotary International, UNICEF, the Bill and Melinda Gates Foundation and the UN Foundation, and many others have assisted in polio eradication activities in India and around the world.

This year, the U.S. Government, through the Center for Disease Control and Prevention (CDC) and the Agency for International Development (USAID), has contributed $120 million to the international campaign, including $15 million and substantial technical assistance and personnel to assist India in its efforts.

Tuberculosis

March 24 is "World TB Day," which commemorates the date in 1882 when Robert

Koch announced the discovery of the bacteria that causes tuberculosis. Today, 118 years later, TB kills more than ever before. One third of the world's population is infected, although many are without symptoms. Each year TB kills over 400,000 Indians and costs the economy $3 billion. But India is beginning to succeed in stopping this disease -- it will soon have started more than 250,000 people on treatment, and the program has already saved more than 40,000 lives. By the end of this year, India's National Tuberculosis Control Program could cover a quarter of India and a population the size of the entire United States.

India pioneered the outpatient treatment of tuberculosis; a strategy now used throughout the world and helped lead to the control of TB in the United States. The treatment regimen, "DOTS," or "directly observed treatment, short course," combines accurate diagnosis, direct observation of treatment over a 6-8 month period, and systematic monitoring of patients in homes and outpatient clinic settings.

The U.S. has been a part of India's renewed efforts to conquer a disease that still afflicts 2 million per year in India. CDC and USAID have been long involved with TB activities, supporting a Model DOTS Project in collaboration with WHO and the Tuberculosis Research Centre in Tamil Nadu. USAID has just committed an addition $1 million annually for TB research in Chennai.

The National Institutes of Health (NIH) globally funds over $80 million in TB research for development of new vaccines, drugs, and diagnostics that will be of great use in India and other countries highly affected by TB.

HIV/AIDS

Because of its size, India has more HIV-infected people than any country in the world -- over 3.5 million. However, this is still less that 1 percent of the population of the country. Some have predicted that, if uncontrolled, within the next 10-20 years the number of HIV/AIDS cases in India could surpass the total in all the countries in Africa combined.

But the Indian government, led by Prime Minister Vajpayee, has taken an aggressive and outspoken leadership role raising awareness of a disease that knows no political or geographic borders. Aggressive efforts at implementing prevention programs and widespread public awareness can prevent 3.5 million cases from becoming 35 million over the next decade.

In 1992, the GOI formed the National AIDS Control Organization to combat the onslaught of the epidemic more effectively. The U.S., led by USAID, has focused on high-risk groups in India and on the states with the highest number of reported cases.

Today, India and the United States will release a "Joint Leadership Statement on HIV/AIDS," pledging that our two countries will work to stop the global spread of HIV/AIDS through joint efforts at research, prevention, changing behavior, and patient care. Most importantly, the highest levels of government pledge to work with the private sector to take bold leadership steps to raise awareness and avoid stigmatization of those affected.

Last year, as one of India's largest donors, USAID committed $41.5 million to the HIV/AIDS program in Maharashtra, and is continuing its $10 million, 10-year commitment to prevention and control programs in Tamil Nadu. In addition, through President Clinton's new "Life" Initiative (Leadership and Investment in Fighting an Epidemic), USAID and CDC will contribute another $4 million this year for primary prevention, improved home and community-based care and treatment, care of children affected by AIDS, and infrastructure development.

In the past 10 years, the NIH, through the Fogarty International Center's AIDS International Training and Research Program, has supported the training and research of 64 Indian scientists and health professionals to establish critical biomedical and behavioral science expertise to combat the disease.

Millennium Vaccine Initiative

Malaria, TB and HIV/AIDS together kill over 5 million people worldwide each year. In his speech to the UN General Assembly last September, President Clinton called for comprehensive efforts to find ways to accelerate the development and delivery of vaccines for malaria, TB and AIDS - vaccines for which there is huge need, but little market incentive for industry to develop. In his State of the Union address this year, he proposed the following actions to address this need:

? $50 million to the Global Alliance for Vaccines and Immunization to purchase existing high-tech vaccines for developing countries;

? Sharp increases in NIH vaccine research;

? A $1 billion tax credit for sales of vaccines for malaria, TB and AIDS when they are developed;

? Call to the World Bank to dedicate an additional $400-900 million in concessionary loans for health;

? Call to the G-7 and other countries to join us in meeting the challenge.

And in March, the President hosted a White House meeting to advance his vaccine initiative. For diseases disproportionately affecting India and many developing countries, the initiative is intended to help spur research into development of new vaccines - by far the most cost-effective long-term approach to control. As NIH and CDC have a longstanding relationship with Indian researchers, these agencies intend to bolster our joint work with India on developing new vaccines and drugs for these diseases.

# # #

Back to summary page

Date 8/31/99

ROUTING AND TRANSMITTAL SLIP

TO: (Name, office symbol, room number, building, Agency/ Post)	Initials	Date
1. Ms. Thurman		
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REMARKS

Sandy:
I would appreciate your thoughts
Chad

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FROM: (Name, org. symbol, Agency/ Post)	Room No. — Bldg.
Charles A. Gardner	Phone No.

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Embassy of the United States of America

New Delhi
August 31, 1999

Ms. Sandra Thurman
Director
Office of National AIDS Policy
White House

Dear Ms. Thurman:

Greetings from India; Sharon and I have pretty well settled in here and are enjoying ourselves. We've had spectacular adventures in Jaisalmer, Udaipur and Ladakh, and are about to head off for a little R&R in Thailand. Sharon is working for Katie McGinty and her husband Karl Hausker, and we've all become close friends. Our most exciting news involves a special deliverable expected next February--Sharon is carrying most of the burden on that. I am writing now on the advice of Eric Goosby to keep you up to date on our thinking for the President's visit to India and the other kind of deliverable.

As you know, it can take years to get anything cleared through the byzantine labyrinths of the Indian bureaucracy, but we have succeeded: our new agreement for Indo-US Collaboration on HIV/AIDS and STD Prevention is now completely approved by NACO, the Ministry of Health and the Government of India. The Joint Statement is ready to be signed by either the President or Secretary Shalala if she comes with him. One benefit from the agreement is that it will streamline the clearance process for HIV/AIDS and STD joint projects involving the U.S. Department of Health and Human Services and the Indian Ministry of Health and Family Welfare.

I am now suggesting to anyone who will listen that some of the "LIFE" funds would give this new Indo-US Program some muscle, and would give the President something significant to deliver during his visit. I know people are looking more at Africa, but the absolute numbers (more than 5 million infected) are here in India, and the inflection point in the growth of the epidemic is nowhere in sight. Now is the time when interventions can have the greatest impact in India. Now is also the time when HIV/AIDS sufferers in the United States could most benefit from Indo-U.S. cooperation to develop low-cost approaches.

I have attached a draft Executive Summary to the Joint Statement, and would appreciate your thoughts. You can reply to gardnerca@state.gov, or fax: 91-11-419-0018.

With best regards,

Sincerely,

Charles A. Gardner, Ph.D.
Science Attaché

DRAFT

Indo-US Collaboration on Prevention of HIV/AIDS and STDs

JOINT STATEMENT

Executive Summary

The purpose of this Joint Statement is to stimulate cooperation and coordination among experts in India and the United States to develop and test cost-effective prevention methods to combat HIV/AIDS and STDs, including (1) culturally appropriate interventions to reduce risk behavior, (2) microbicides and antiviral agents, and (3) vaccines. Activities may include operational and behavioral studies; disease surveillance and epidemiology; clinical trials; technology transfer and training and other forms of capacity building for Indian institutions. This Program will also serve as a forum to engage policy makers and to translate technical findings into effective public policy.

Rationale: Roughly 5 million people in India are now infected with HIV, more than any other country in the world. While the epidemic has begun to plateau elsewhere, including many African countries, in India it is still growing rapidly. This is a critical time for India. It is now that behavioral and medical prevention measures will be most effective and are most urgently needed. This pending crisis is made all the more ominous by a high prevalence of sexually transmitted diseases which facilitate the spread of HIV. Grim though the situation may at first appear, India also possesses a large community of well-trained health experts who are able to collaborate with their American counterparts as equal partners to address these problems.

While India has only recently come to recognize the magnitude of its problem, it has the potential to become a world leader in the development and implementation of cost-effective HIV/AIDS prevention strategies that are appropriate for developing countries. Even with massive World Bank and USAID support to India for HIV/AIDS programs (currently over $300 million), the latest antiviral treatments are still unattainably expensive for the vast majority of HIV-positive people in India. This Joint Statement provides a commitment by the U.S. Department of Health and Human Services and the Indian Ministry of Health and Family Welfare to develop new low-cost behavioral interventions, medicines and vaccines to prevent infection--an investment for the future in one country which could payoff worldwide.

Bullet Points on HIV/AIDS in India

- Copy details from the Press Statements
- Comment on the opportunity for improved ability to combat other STD's and communicable diseases such as TB that are also highly prevalent in India
- From the ONAP Report to the President
- Haravard AIDS Institute (AIDS in India)
- National Intelligence Council Report
- LIFE Initiative and what proportion of these efforts will be targeted towards India specifically---tie this in with recent remarks by the President on how the U.S. will continue to partner with India on this issue
- India's economic growth and the potential impact on productivity of the labor force,
- Major and distinguishing factor for India is the near 1 billion people which reside there; this enormous population is intricately interconnected yet complex in its many religious and cultural practices, which makes combating a disease like HIV/AIDS an enormous challenge
- Cited as increasingly the future epicenter for HIV/AIDS (the National Intelligence Council Report), India has the largest number of infected persons in the world.

    - India now has an estimated 3 to 5 million people infected with HIV
    - Between 0.5 to 0.8 percent of the adult population are already infected (but that is of 1 billion people) contrast this to the population of sub-Saharan Africa and the state of the epidemic there—don't want India to follow that same disastrous course and we are currently given the same warning signs as we were for Africa

- Until recently, it was commonly assumed that HIV infection in India was concentrated in urban areas among high risk groups, such as commercial sex workers and their clients, including truck drivers, and injecting drug users (IDUs) living in a few states. However, the March 19998 round of sentinel surveillance in antenatal clinics shows that in at least five states, more that 1 percent of pregnant women are now infected, reflecting a shift into the general population. Published reports have also indicated a rapid escalation of the epidemic in some areas among selected groups.

- India's rural areas, home to about 70 percent of the country's population, were thought to be relatively spared by the epidemic, until recent studies that show HIV has become as common in some rural villages as in cities. Considering that other STD's also remain quite prevalent throughout all of India, HIV clearly has fertile ground for further spread.

- Worldwide, women are becoming infected at faster rates than men and the total number of HIV infected women is approaching that of men. Young women are particularly vulnerable; it is estimated that 70 percent of women infected with HIV are between 15 and 24 years of age.

    - According to UNAIDS estimates, at the end of 1997, 1 million women in India (ages14-49) were living with HIV/AIDS.
    - In five states, more that 1 percent of pregnant women surveyed were HIV infected.
    - Yearly incidence of HIV among commercial sex workers (CSWs) attending STI clinics in Pune was 26.1 percent.
    - In one study in Mumbai, HIV-infection rates among CSWs increased from 1 percent in 1986 to 72 percent in 1997.

• Women have less decision-making power in sexual relationships; this coupled with lower levels of education, greater biological susceptibility to infection, and limited access to resources, make women particularly vulnerable to infection.
• The HIV epidemic has a profound impact in children, causing high morbidity and mortality rates among infected children and orphaning many others. Unless checked, the HIV epidemic has the potential to reverse the progress that has been made in lowering India's infant mortality rate, as has been demonstrated in other countries. (find stuff from past written things and insert)

• An estimated 120, 000 children have become orphans due to AIDS since the beginning of the epidemic

• Socioeconomic Effects of HIV/AIDS link this to current state of India's economy and the President's recent visit—talks on trade, etc, labor

• Need to mention the need for sound public health policies which minimize negatives social consequences, tie this into what lessons we have learned and effective interventions that have worked have provided respect for individual rights and an aggressive public awareness campaign that helps to eliminate the stigma and misperceptions regarding HIV/AIDS. Policies that protect individuals from being harmed or discriminated against due to their HIV status.

• Critical to the success of any of these interventions is the ability to improve affordable care and support services for persons living with AIDS (PLWAs), and reduce stigma and discrimination against PLWAs in clinical and non-clinical settings.

• India has an opportunity to learn from the successes and mistakes of other countries. Thailand acted early with interventions targeted at groups at highest risk and was able to stabilize adult HIV/AIDS prevalence at about 2 percent. India must act now with an expanded response.

CHALLLENGES

• GOI policy and implementation commitment at the national, state, district, and municipal levels is necessary. Commitment, advocacy, and resource allocation by all states are urgently needed.

• GOI must take innovative, community-based approaches to preventing new infections, starting with those groups at highest risk, within a broad-based strategy that helps build India's capacity to respond to long-term challenges.

• States unaware of the HIV threat or with poor capacities should be strengthened.

• Low-cost community based care without stigmatization is urgently needed for those already suffering from AIDS.

• Human rights violations such as prohibiting the right to marry due to serostatus and other legislative mandates are counterproductive to public health efforts.

• HIV/AIDS reduces life expectancy, increases the demand for medical care, worsens other illness (like tuberculosis), and exacerbates poverty and inequality. Estimates indicate that there are more HIV infected people in India than any other country in the world. With a well-managed prevention program put into place now, HIV infection could stay below 2 percent of the adult

population. Without a successful intervention, India could be faced with the same devastation that many countries in Africa face today.

- Elaborate more on CHILDREN, NUMBER OF PEOPLE, Human rights violations and women and the ECONOMY! DEVELOPMENT OVERALL in context of India's robust economy

Saha AmaraSingham <saha@tvtassoc.com>
06/05/2000 12:38:30 PM

Please respond to Saha AmaraSingham <saha@tvtassoc.com>

Record Type: Record

To: Cheryl S. Bauerle/OPD/EOP

cc:
Subject: India - Tamil Nadu APAC Project Evaluaiton Report:

Cheryl

Attached is the mid-term evaluation report for the Tamil Nadu APAC Project that was recently completed by a team from Synergy ... it may be helpful in Sandra Thurman's presentation at the briefing on HIV/AIDS in India being hosted by Representative Jim McDermott and Sam Gejdenson on the Hill on Wednesday

Saha

Saha AmaraSingham, PhD, MPH
Monitoring & Evaluation Specialist
The Synergy Project
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-----Original Message-----
From: Cheryl_S._Bauerle@opd.eop.gov <Cheryl_S._Bauerle@opd.eop.gov>
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- USAID India Final Report May 2000 - Tamil Nadu APAC Mid-Term Evaluation.doc

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MIDTERM EVALUATION

AIDS PREVENTION AND CONTROL PROJECT (APAC)

Submitted by:
The Synergy Project
TvT Associates, Inc.

Gerard R. Bowers
K.C. Malhotra, Ph.D.
Eliot T. Putnam, Jr.
Rajani R. Ved, M.D.

Submitted to:
The United States Agency for International Development/India
Under Contract No. HRN-C-00-99-00005-00

May 2000

THE SYNERGY PROJECT

The *Midterm Evaluation: AIDS Prevention and Control Project (APAC)* was made possible through support provided by the United States Agency for International Development (USAID)/India under the terms of Contract Number HRN-C-00-99-0005-00.

Additional copies of this report may be obtained by writing to:

THE SYNERGY PROJECT

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(202) 842-2939
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or via e-mail at tvt@tvtassoc.com.

ACKNOWLEDGMENTS

The midterm AIDS Prevention and Control Project (APAC) evaluation team is grateful to USAID and APAC colleagues and other partners for having made this assignment a most positive experience. It helped, of course, that the project being assessed has been remarkably successful. Evaluating an initiative that is serving as a dynamic model and laboratory for new approaches to preventive health care is clearly more gratifying than looking at one which has no positive lessons to teach the world. But beyond that, the work was made stimulating and enjoyable by the people and offices who supported the team at every juncture.

The team is also grateful for the comprehensive assistance given us, from the moment the assignment was first conceived, by Saha AmaraSingham, Caroline Curtis, Lena Thompson, Mona Feldman, and the staff of TvT Associates in Washington, D.C., who were unfailingly responsive to all of our needs. The team is also most appreciative of the generous help and guidance provided by the USAID Mission in New Delhi, especially Dora Warren, Victor Barbiero, Anitha Ravishankar, and Sathi Anand. Their careful scheduling and attention to detail, not to mention their probing questions, helped the team make the most of its time in New Delhi.

Finally, the team wants wholeheartedly to thank the APAC staff members for their warm welcome to Chennai. They tirelessly answered all questions and arranged a rich and varied exposure to the people, institutions and nongovernmental organizations that are the essence of APAC, as well as to those whose lives it is improving. The staff is rightly proud of what it has accomplished and is committed to achieving even greater impact in the years ahead.

ACRONYMS AND FOREIGN TERMS

AIDS	Acquired immune deficiency syndrome
AMP	Allopathic (Western medicine trained) medical practitioners
ANM	Auxiliary nurse midwives
APAC	AIDS Prevention and Control Project
ARM	Association for Rural Mass Media
BCC	Behavior change communication
BSS	Behavioral Surveillance Survey
CED	Centre for Entrepreneur Development
CETC	Continuing education training center
CHW	Community health worker
CLIP	Clinic-based intervention project (APAC intervention)
CSW	Commercial sex worker
DFID	Department for International Development (United Kingdom)
ESRM	Experience sharing and review meeting
FFW	Female factory worker
FHI	Family Health International
FP	Family planning
GOI	Government of India
HIV	Human immunodeficiency virus
HLL	Hindustan Latex, Ltd.
HPN	Health, Population and Nutrition Office (USAID)
HTA	Hindustan Thompson Associates, Ltd.
ICWO	Indian Community Welfare Organization
IEC	Information, education and communication
JKAL	J. K. Ansell, Ltd.
MCH	Maternal and child health
MFW	Male factory worker
MMHRC	Meenakshi Mission Hospital and Research Centre
NACO	National AIDS Control Organization
NGO	Nongovernmental organization
NIS	National Institute of Sales
OR	Operations research
PATH	Prevention Along the Highways (APAC intervention)
PMC	Project management committee
PVOH II	Private Voluntary Organizations in Health (2nd project)
RIMP	Registered Indian medical practitioner
SRC	State Resource Centre
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TH	Truck drivers and helpers
TNSACS	Tamil Nadu State AIDS Control Society
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing center
VHS	Voluntary Health Services
WIP	Women in Prostitution (APAC intervention)

CONTENTS

ANNEXES

EXECUTIVE SUMMARY

In the early stages of an acquired immune deficiency syndrome (AIDS) epidemic, the greatest impact on the spread of the disease is achieved by focusing prevention activities on groups at high risk of becoming infected with human immunodeficiency virus (HIV). In Tamil Nadu, these groups include commercial sex workers and their clients, truck drivers and other transportation workers, slum dwellers, and sexually transmitted disease (STD) patients. The AIDS Prevention and Control (APAC) project concentrates its activities on these core transmitters of HIV, specifically by introducing and reinforcing preventive behavior, by promoting the sale and use of condoms, and by enhancing STD services and counseling.

When the project was designed in 1991–92, it included several features which were novel at the time in India. These included a thematic approach that targeted interventions on high-risk population groups, selection of one state (Tamil Nadu) as a project site, and a decision to implement the activity through Indian nongovernmental organizations (NGOs). Partners in the government of India (GOI) and Tamil Nadu state government had several reservations about this approach, even while the United States Agency for International Development (USAID) remained confident in the correctness of its strategy. The successful resolution of these differences took 26 months—valuable time which was lost to the HIV–prevention effort, but which was very useful to the further refinement of the project design and to the achievement of the parties' consensus around the key principals advocated by USAID. The project was formally launched in February 1995, following the signing of a tripartite agreement between USAID, the GOI National AIDS Control Organization (NACO), and the implementing organization, Voluntary Health Services (VHS) of Chennai, Tamil Nadu.

The project is being managed by an APAC project office within VHS and is implemented through approximately 40, mostly urban, NGOs and technical support organizations in the state.

The midterm evaluation team reviewed the project to

- determine its overall impact in promoting behavior change among the target population groups;
- assess the project's specific performance in furthering each of its key objectives: increase condom availability and use, improve the accessibility and quality of STD services, and improve the capacity of the NGOs participating in the project; and,
- assess the effectiveness of the project's implementation arrangements; and,
- identify lessons and areas for future activity on the part of USAID, NACO and VHS/APAC.

OVERALL IMPACT

The project is succeeding in meeting its objectives. In fact, it has already achieved most of the benchmarks identified in the tripartite agreement. Two data sets were examined to assess the project's overall impact. These included data from three waves (1996–97–98) of the HIV–Risk Behavioral Surveillance Survey (BSS) in Tamil Nadu, and data selected from the monthly reports submitted by participating NGOs. The data are consistent and show that not only is meaningful behavior change under way in the state, but that much of that change can be attributed directly to the APAC project. Key behavior changes taking place among target population groups include an increase in condom use, an increase in STD treatment-seeking behavior, and decreases in sexual contacts with nonregular partners.

SPECIFIC PERFORMANCE

Condom Sales

Commercial sales of condoms in Tamil Nadu have more than doubled since 1995, from 12.6 million pieces that year to 27.9 million pieces in 1999. More recently, the rate of increase in commercial sales has plateaued, achieving a modest 4 percent increase during the 1998–99 period. Factors appear to include a decline in the vigor of the project's cooperative effort with Indian condom manufacturer J.K. Ansell to market condoms through additional, nontraditional outlets; some weaknesses in condom promotion for NGO staff and marketing training for potential retailers; and, the continued availability of a plentiful supply of free condoms in Tamil Nadu. APAC activities to date have been very effective in making the topic of condoms less sensitive in Tamil Nadu and in introducing the notion of condom use into the popular vocabulary in the project area.

STD Management

APAC has developed a comprehensive STD care strategy which focuses on raising demand for STD care and creating a large pool of providers trained in quality STD case management to meet the increased demand. Project data show that increasing numbers of patients are being referred for STD care and are receiving treatment from medical practitioners associated with and/or trained by the project. APAC–supported NGOs have established strong referral networks with public and private sector treatment facilities. Some elements of the training and follow-up strategy need refinement; APAC needs to ensure that operations research projects carried out under the project focus on research issues, and that they not be managed as intervention projects.

NGO Capacity Building

APAC provides a comprehensive package of technical, organizational and evaluative support for its participating NGOs. The management and staff of virtually every NGO contacted by the evaluation team pointed to this intensive, nurturing relationship with APAC as singularly important to improvement of the NGOs' competence—both in HIV prevention and in their overall effectiveness as community-based service organizations.

PROJECT IMPLEMENTATION

Management of the APAC project is sound, operating on a basic philosophy which minimizes unsustainable expenses. The key to its success is its excellent staff, assembled through a rigorous and open recruitment process, which has meshed skills and experience gleaned from both public and private sectors into a total commitment to APAC's mission. The partnership between VHS and the Tamil Nadu State AIDS Control Society (TNSACS) has been mutually supportive, emphasizing complementarity of roles within the overall context of the state STD/HIV/AIDS agenda. On a national level, NACO acknowledges APAC's importance and has used the APAC model as a reference point for targeted interventions in India. Its failure, however, to facilitate an uninterrupted flow of funds to the project has been a source of deep concern. Finally, the APAC partnership with USAID/India has been one of the project's strengths. The Mission negotiated vigorously with the GOI over key elements of the APAC tripartite agreement. It then invested much time and energy in helping the project develop its systems and launch its activities, a process which, while difficult at times, is generally acknowledged (especially by APAC) to have been critical to its successes. USAID will have to maintain this activist posture relative to NACO if it is to develop a durable solution to the project's financial problems.

FUTURE DIRECTIONS

APAC is positioned to extend its successful performance to additional parts of Tamil Nadu (by engaging additional NGO partners), to reach out to population groups not covered by the current activity (e.g., industrial workers), to add services (e.g., community-based care) not presently included in the project, and to improve its STD diagnosis and treatment capacity through an STD reference laboratory. The APAC project should be extended to March 2005—and project funding increased—to create the temporal and financial means for these new elements.

I. INTRODUCTION

AIDS PREVENTION AND CONTROL (APAC) PROJECT DATA	
Project Approved:	September 1992
Project Begun (Tripartite Agreement Signed):	February 1995
Project Ends:	March 2002
	(US $ millions)
Total Project Funding:	10
Amount Obligated:	6.42
Amount Committed:	4.735
Accrued Expenditures:	3.514

THE APAC PROJECT

The AIDS Prevention and Control (APAC) Project is intended to prevent and control the spread of acquired immune deficiency syndrome (AIDS) in the state of Tamil Nadu by supporting the efforts of nongovernmental organizations (NGOs) to undertake human immunodeficiency virus (HIV)–prevention activities among high-risk groups. The project was designed to focus on interventions demonstrated as having the greatest impact on preventing the transmission of HIV, such as increased condom use and the treatment of sexually transmitted diseases (STDs). The APAC project is implemented by Voluntary Health Services (VHS), a nongovernmental hospital and community health service organization located in the state capital, Chennai.

The United States Agency for International Development (USAID)/India and the government of India (GOI) executed a bilateral agreement for the APAC project in August 1992. Project activities did not begin, however, until February 1995, when the parties agreed to key implementation arrangements proposed under the project.

PURPOSE OF THIS EVALUATION

When it was designed, the APAC implementation model was unique in India. It was the first wholly private sector approach to address HIV prevention in Tamil Nadu, and it was the first HIV-prevention activity to focus on specific population groups especially vulnerable to HIV infection. USAID/India seeks to ascertain whether the hypotheses and assumptions made during the project design process are still valid, to determine whether the project is achieving its objectives, and to identify lessons which the project might offer for application elsewhere in India.

Although taking place relatively late in APAC's planned seven-year (1995–2002) project, this evaluation is technically a midterm assessment, the findings and recommendations of which may be used to improve project performance over the remaining period of project activity.

METHODOLOGY

The APAC assessment team was composed of four persons, including an evaluation specialist/team leader, an NGO specialist, a program management specialist, and an STD specialist. Team members reviewed APAC documents, reports, studies and research papers prior to the beginning of the evaluation and throughout the assessment process. (See annex A.) They interviewed personnel from USAID/Washington, USAID/India, representatives of the Indian government in New Delhi and in Tamil Nadu, representatives of other donor organizations, APAC staff, NGOs affiliated with the APAC project, and officers of private firms and contractors retained by VHS/APAC to provide support services for the project. (See annex B.) Following initial work in New Delhi, the team undertook fieldwork for two weeks in and around Chennai and Madurai. The team returned to New Delhi for report preparation and presentation of key findings and recommendations to USAID and to the GOI National AIDS Control Organization (NACO). The assessment was carried out during the period January 24–February 19, 2000.

To keep this report succinct, much of the descriptive content that might ordinarily be included in a midterm evaluation is not included. The report was prepared for a relatively small readership, comprised of persons who are already familiar with the APAC project. The report's findings and recommendations, moreover, are generally limited to matters of direct concern to project managers at USAID, NACO and VHS/APAC. The APAC project is a highly innovative and successful initiative which has important lessons for other HIV–prevention efforts in India. As noted in the report, the APAC experience should be more fully documented—preferably by Indian experts—and disseminated to a broad audience, in India and throughout the world.

II. BACKGROUND AND CURRENT ENVIRONMENT

India's HIV/AIDS epidemic is well into its second decade. The epidemic is still strongly driven by heterosexual transmission, and the initial concentration among high-risk groups is being followed by rising prevalence in the general population. Although HIV prevalence is low in a majority of states, the overall number of infections is high. Estimates of HIV infection at the national level are about 3.5 million cases. Implementing effective prevention, control, and care programs while tracking the epidemic are major challenges.

The period from 1986 to 1997 marked a passage from denial of the threat of HIV to sporadic efforts at HIV prevention spread unevenly across the country. The focus was on creating high levels of awareness, infrastructure strengthening and blood safety. The National AIDS Control Organization (NACO) was established in 1992. Now, with committed leadership from NACO and support from bilateral and multilateral donors, India has shaped a national response that encompasses government and civil society and is characterized by decentralized program management at the state level. The major components of the national program are targeted interventions among high-risk groups, prevention of HIV transmission in the general population, models of low-cost care, strengthening institutional capacity, and intersectoral collaboration.

In Tamil Nadu, a responsive state government took action in early 1993 to initiate HIV/AIDS prevention, focusing mainly on mass media campaigns and support to NGOs to create awareness through street plays and interpersonal communication. In addition, programs for blood safety were implemented. There was little systematic effort at targeting high-risk groups, among whom HIV prevalence was steadily climbing. Despite all these efforts, a community-based prevalence study conducted by APAC in 1997 showed that the overall prevalence of HIV in the community was about 1.8. The prevalence among women was 2.0. The study in Tamil Nadu also showed an STD prevalence of 9.7. These data substantiate the fact that STDs and HIV are no longer restricted to core groups but are moving rapidly into the general population, and that the former facilitates transmission of the latter.

DONOR SUPPORT

The World Bank, the Department for International Development (DFID) and USAID are the principal donors providing support for HIV/AIDS in Tamil Nadu. While the World Bank's Phase II project is implemented through the Tamil Nadu State AIDS Control Society (TNSACS), which is focused largely on the public sector, USAID's APAC project is wholly within the private sector. Apart from these two donors, DFID supports a few trucker interventions as part of its Healthy Highways project.

III. THE USAID RESPONSE: THE APAC PROJECT

RATIONALE

The APAC project was designed at a time (1991–92) when the World Bank and GOI were attempting to launch Phase I of a World Bank loan that was focused primarily on the control of STDs and assurance of a safe blood supply. However, as USAID conducted its own research preparatory to the design of a USAID–assisted HIV–prevention project, it became clear that heterosexual transmission of HIV was by far the most important factor in the spread of the virus in India, accounting for approximately 90 percent of the cases in the country. The evidence available from other countries' experiences further demonstrated that in the early stages of an AIDS epidemic, the greatest impact on the spread of the disease could be achieved by focusing prevention activities on groups at high risk of becoming infected with HIV. In Tamil Nadu, these groups were subsequently determined to include commercial sex workers (CSWs) and their clients, STI patients, and persons with multiple sex partners, such as truck drivers and other workers in the transportation industry. USAID consequently decided to pursue a project approach that would reduce the transmission of HIV by promoting behavior change among high-risk population groups.

In addition, three other factors influenced USAID/India's thinking about the project's overall design. The first was a belief that government agencies were ill equipped to carry out programs addressing sexual behavior. Second, the Mission had concluded from its experience with the Private Voluntary Organizations in Health (PVOH)–II project that NGOs were often unable to receive funds in a timely manner when those funds were transited or disbursed by GOI institutions. Third, USAID determined that financial, management and operational constraints limited the feasible project area to one state.[1] On the basis of these considerations, USAID decided to develop an NGO–based project, focused on the promotion of behavior change among high-risk population groups in one state, with a project structure which allowed for greater flexibility in managing and disbursing project funds. The project would be developed in close consultation with the GOI, specifically NACO, to ensure its consistency with India's national HIV/AIDS–prevention strategy.

PROJECT STRUCTURE

The project that emerged from the foregoing conceptual framework had the following features:

[1] Tamil Nadu was selected as the project site by USAID and the GOI following a review process and in accordance with selection criteria which, for brevity's sake, will not be discussed in this report.

Goal

To reduce sexual transmission of HIV in Tamil Nadu.

Purpose

To introduce and reinforce HIV–preventive behavior in high-risk populations. APAC was designed to accomplish this by enabling NGOs to educate target populations, promote and sell condoms, and enhance STD services and counseling. The project also included provision for research needed to ensure effective implementation and monitoring of the project.

Outputs

Several outputs were established for the project, including, most notably,

- Increased awareness of HIV/STD preventive measures and increased condom use among high-risk populations, due to NGO activities that reach 3 million people over the life of the project;
- A network of at least 100 NGOs actively involved in AIDS prevention activities;
- A 15 percent increase in total condom sales in Tamil Nadu;
- Sustained condom distribution in at least 55,000 retail outlets;
- Development of an STD clinical management and counseling module and at least 500 people trained in STD clinical management and counseling; and,
- Fifteen behavioral and operations research studies completed and results disseminated to policy makers and program managers.

Strategic Approach

To take advantage of the window of opportunity now open in India—that is, the critical few years during which transmission of the virus might be stopped within the population of core transmitters, thereby minimizing a spread into the general population.

The project was to be implemented by an NGO that would in turn manage a program of subgrants, technical assistance and oversight for approximately 100 indigenous NGOs in Tamil Nadu.

PRE-LAUNCH PHASE (1992–95): CREATING A FRAMEWORK FOR SUCCESS

The project design summarized above was new—even novel—in India at the time, and was not immediately perceived by Indian counterparts as an appropriate response to the country's HIV challenge. Innovative features, which both the central and state governments had reservations about, included

- the first-ever notion of a bilateral, donor-supported activity directed at the state, rather than national level;
- the use of thematic interventions concentrated on high-risk groups;

- implementation of the project through a network of Indian NGOs; and,

- USAID's insistence on a simplified funding mechanism for the project.

GOI counterparts objected to the diminished role of the central government in the review and disposition of project resources. Tamil state officials had reservations regarding the project's focus on high-risk groups (as opposed to the general population), and on a limited, mostly urban project area (as opposed to being a statewide activity).

Despite these objections, USAID held firm—for 26 months—to the project's defining characteristics, until the central and Tamil Nadu state governments agreed in 1995 to let the activity go forward essentially as designed. To be sure, this breakthrough was due in large measure to USAID's strength of conviction in its project design. But it also came about only after technical and strategic thinking at both levels of the Indian government had evolved, narrowing the conceptual distance between the parties' views of the project's potential usefulness. Indeed, by the time the project was officially launched in early 1995, both central- and state-level governments had assumed constructive partnership roles in relation to the new activity.

Valuable time was certainly lost during this protracted negotiation phase—time which could have been used to begin an urgently needed activity. Despite the lapse, there were positive outcomes. Basic understandings and project refinements that the various parties worked out during those 26 months have subsequently proven to be singularly important to the success of the APAC project. Some—including the use of an NGO umbrella organization to manage the project and the project's emphasis on NGO capacity building—have been crucial to APAC's good performance and credibility in Tamil Nadu.

Of special significance during this period was the agreement of all parties to the principle that **the project should function within a strategic framework established by the GOI and Tamil Nadu state government, but without the encumbrances generally associated with government-funded programs**. This understanding, while not stated explicitly in the tripartite agreement of 1995, was the defining principle of that agreement and a sine qua non of the project. Events over the past year—most notably the funding crisis and an increased intensity of NACO oversight of the project—lead to the conclusion that **this basic understanding is being eroded, to the extent that the future success of the project may be compromised**. (See discussion in section IV below.)

IV. KEY FINDINGS AND RECOMMENDATIONS

OVERALL IMPACT

Finding
The APAC Project is succeeding.

The APAC project is by design a relatively compact activity in terms of its geographic and population coverage. The 48 predominately urban clusters covered by the project compose about 20 percent of Tamil Nadu's 60 million inhabitants. Of the 12 million people in that project area, high-risk population groups targeted by APAC total approximately 1,000,000 persons (commercial sex workers, STD patients, transport workers, and high-risk groups living in slum areas). APAC reaches these people through the outreach programs of 35 NGOs, each of which focuses on one or more high-risk groups within its cluster area (see the map in annex C).

The evaluation team attempted to assess the results to date of the APAC project by examining two different data sets: data from the longitudinal Behavioral Surveillance Survey (BSS) for Tamil Nadu, and selected data from monthly reports that participating NGOs submit to APAC for routine monitoring purposes. (Other data sources were also reviewed, along with the findings of APAC–supported research, to assess the performance of the project's various components. These component-specific findings are discussed in separate sections of this report).

BSS Data

The BSS was never intended to serve as a direct measure of APAC performance; rather, it was designed to track trends over time in the sexual behavior of the vulnerable population groups targeted by the project. It should be noted that no other organization has been or is undertaking comprehensive thematic interventions in the APAC project area (DFID is supporting only modest truckers' interventions), such that BSS data can in fact be viewed as a fairly reliable indicator of the APAC project's performance per se. Those data (BSS Waves 1 through 3) have been reported elsewhere and will not be repeated or analyzed in this report, except to note that they show significant and sustained changes over time in the sexual behavior of the high-risk groups targeted by the project (annex D).

Interestingly, the most dramatic behavior changes reported by the BSS have occurred among the two groups most regularly reached by APAC–supported NGOs—commercial sex workers and truckers—while desired behavior change is markedly less among two target groups (male and female factory workers) not regularly served by the project (except for industrial workers reached via the slum-based projects). These differences support the argument that most of the behavior change occurring among commercial sex workers (CSWs), truckers and slum-based workers can be attributed primarily to APAC–supported interventions.