FOIA Number: 2007-1550-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21064

FolderID:

Folder Title:
India [2]

Stack:	Row:	Section:	Shelf:	Position:
S	66	6	8	2

NGO Monthly Reports

Notwithstanding this presumed linkage between APAC's performance and BSS data, other data sources were examined to corroborate the changes reflected in the BSS. It was noted that each of the 35 participating NGOs submitted process data on a monthly basis to APAC. Most of the information in these reports is used by APAC for monitoring purposes and to facilitate feedback to the NGOs regarding their performance. Information reported includes numbers of counseling sessions held, training sessions conducted, and advocacy meetings held. From these process data, the assessment team selected four data sets, which when viewed over time, could serve as generally reliable indicators of the project's progress toward achieving its behavior change objectives. Importantly, since these data are specific to APAC–supported NGOs, they can provide a more accurate estimate of the direct effects of the project.

The selected indicators included condom distribution, number of STD referrals, and number of STD cases treated (as reported by health care providers collaborating with the project). These data are shown in annex E. Despite several dips and peaks in the monthly numbers, all of the indicators show a consistent rising trend during the two-year (1998–99) period covered by the reports. They clearly suggest that the APAC project is achieving the changes for which it was designed.

PERFORMANCE: PROJECT COMPONENTS

Promotion and Distribution of Condoms

	Outputs
Planned:	1. Total condom sales in Tamil Nadu increased by 15 percent per year.
	2. Sustained condom distribution in at least 55,000 retail outlets and in 80 percent of NGOs that are involved in AIDS prevention.
Achieved:	1. Commercial sales of condoms in Tamil Nadu (statewide) have increased from 12.6 million pieces per year in 1995 to 27.9 million pieces (estimated) in 1999. Sales increased by 23 percent in 1995–96, 56 percent in 1996–97, 13 percent in 1997–98, and 4 percent in 1998–99. (See Findings below for an explanation of the reduced rate of increase.)
	2. Condom retail outlets increased from 17,600 in 1996 (actual number of outlets where condoms were available) to 35,400 in 1999. (Source: Operations Research Group Retail Audit Report, 1999)

The condom is the only effective means available (aside from abstinence) to prevent the transmission of HIV. The success of the APAC project therefore rests in large measure on its ability to increase the condom-using practices of the project's target population groups. APAC tries to effect these changes via a two-pronged approach, including a generic condom promotion campaign designed by Hindustan Thompson Associates in

close collaboration with APAC and a series of initiatives intended to increase the availability of and preference for condoms. Major activities under the latter component include an initiative managed by J.K. Ansell Ltd. (JKAL) to increase the number of commercial outlets for condoms, a retailer training program implemented by the National Institute of Sales (NIS), and a training program, conducted by the Centre for Entrepreneur Development (CED) in Madurai, to improve the condom social marketing skills of NGO staff. APAC also supports, with technical assistance from Family Health International (FHI), the periodic testing of condom quality.

FINDING

The project has produced significant increases in commercial sales of condoms. Those sales figures are beginning to plateau, however. Apparent reasons include inadequate commercial sector interest in expanding total condom sales, especially in peri-urban and rural areas, the need for more training of NGO staff in the social marketing of condoms, inadequate training for nontraditional vendors, and the broad availability of free condoms.

Private Sector Collaboration

Sales of fully priced (commercial) condoms in Tamil Nadu have increased significantly since 1995 (see annex F). The biggest jump in sales, however, occurred during 1996–97, when both JKAL and Hindustan Latex, Ltd. (HLL), participated in a pilot condom marketing effort—an expanded version of which is currently being implemented by JKAL alone under a three-year (1998–2001) contract with APAC. Since that one-year sales increase of 56 percent, the rate of increase in commercial sales has been modest and was almost flat (4 percent) in 1999. APAC's view is that the earlier increase (1996–97) owed much to the competition at the time between JKAL and HLL, implying that the former is becoming complacent in its current efforts. JKAL believes that its cooperation with APAC is advancing the firm's corporate interests, as evidenced by its commitment to finance 60 percent of the cost of the marketing program. JKAL acknowledges, however, that its primary interest in the activity is to increase its market share in southern India—an objective which may or may not contribute to an increase in the total demand for condoms.

Social Marketing Training

APAC believes (correctly in the view of the evaluation team) that the long-term sustainability of HIV–prevention efforts in Tamil Nadu requires a sustained increase in the use of condoms **purchased from commercial sources**. Thus, in addition to the JKAL–managed initiative to expand the number of commercial outlets for condoms, APAC is encouraging its participating NGOs to adopt a vigorous social marketing approach to condom promotion. In this instance, social marketing does not refer to activities (e.g., the Nirodh program) that involve the sale of condoms at subsidized prices. Rather, it means that APAC urges NGO peer counselors and other NGO outreach personnel to convince their clients to purchase condoms at retail outlets. The CED social marketing training program in Madurai was established specifically to reinforce the promotional skills of NGO staff. Assessment team observation of the course—as well as interviews with faculty, participants, and APAC consultants—found that the training is

thorough, well-conceived, and valued by its participants. However, virtually no follow-on training was taking place back at the participants' home NGOs, and many had little direct contact with frontline peer educators. Without such follow up, the potential value of the training is being diminished.

NIS Training

The National Institute of Sales in Chennai was contracted by APAC to motivate and train nontraditional retailers to market condoms. NIS trained 2,125 retailers during its first year of activity (1998–99) and will train an additional 2,700 retailers under a one-year contract extension currently being negotiated with APAC. Follow-up surveys of the first graduates found that only 10.8 percent of them decided to stock condoms after having attended the 1–week training program. Another 28 percent stated that they would consider stocking condoms if a reliable wholesale source were available. Yet despite this very low success rate among its trainees, NIS has done nothing to revise its curriculum for the next round of training.

Free Condoms

Almost 50 percent of the condoms distributed each year in Tamil Nadu are free. The total number, moreover, is rising annually—mirroring the rate of increase in commercial sales—even to the extent of echoing the commercial sector's recent plateau effect. Indeed, with the exception of 1997, distribution of free condoms has exceeded sales of fully priced condoms every year since 1995. (Supply and marketing problems have reduced the Nirodh program to an insignificant role in Tamil Nadu.) Even the NGOs affiliated with APAC are themselves distributing an ever-increasing number of free condoms, despite APAC's strong promotion of the retail sector as the source of choice. There is, of course, a positive aspect to these trends: overall condom use is increasing, and as pointed out previously, the APAC project is no doubt responsible for much of this increase. The negative effect of free distribution is that it continues to slow a commercial response to clients' needs and ultimately undercuts prospects for long-term sustainability of an NGO–based HIV–prevention program.

Finally, it should be recalled that APAC's coverage in Tamil Nadu is relatively modest—probably reaching no more than 5 percent of the state's population with intervention programs. The recommendation offered below suggests ways to increase commercial sales of condoms **within the current scope of the APAC project**. To significantly expand those sales, however, will require an expansion of the project to additional geographic areas and/or target groups.

Recommendations: APAC should increase condom sales in its project areas by

- identifying a second condom manufacturer/distributor (e.g., TTK) to participate in a condom marketing initiative;

- strengthening the NGO social marketing training program by

- limiting participation in CED training programs to NGO staff who are directly involved in condom promotion and who are likely to conduct second-generation training of colleagues in their respective NGOs,

- revising the CED curriculum to include training in the skills that NGO trainees will need to conduct this follow-on training, and

- instructing APAC consultants to monitor/reinforce the NGOs' social marketing efforts; and,

- Extensively reworking the NIS curriculum—based on the findings of the trainee follow-up survey—to focus on training content found to be most successful in enlisting additional (nontraditional) vendors for condoms.

In addition, USAID and APAC should create new markets for condom sales by extending the project to additional NGOs and to additional target groups (i.e., industrial workers), as discussed in section VI, New Directions.

STD Management

	Outputs
Planned:	1. STD case management and counseling module developed.
	2. Five hundred individuals trained in STD clinical management and counseling.
Achieved:	1. Five STD care modules developed for pharmacists, registered indigenous medical practitioners, auxiliary nurse midwives, allopathic medical practitioners, and community health workers.
	2. Over 3,536 health care personnel trained in STD management and counseling.

The objective of APAC's STD strategy is to increase access to STD services and to improve the quality of STD care for high-risk groups. Key interventions are to

- provide NGO grants for behavior change communication focused on CSWs, truckers and related stakeholders in the sex industry, tourists and women in prostitution in tourist towns, and individuals at high-risk living in urban slum areas;

- build the capacity of five continuing education and training centers (CETCs) to train a range of health care providers[2] in quality STD case management,

[2] These include allopathic (Western medicine trained) medical practitioners (AMPs), registered Indian medical practitioners (RIMPs, which also includes practitioners with no formal training in any of the Indian systems of medicine), pharmacists, auxiliary nurse midwives (ANMs), and community health workers (CHWs). Only the AMPs are trained in the syndromic approach; the rest are expected to refer patients with symptoms of STD, but provide information on condom use and partner notification.

comprising syndromic approach, partner notification, counseling, condom promotion, and follow up;

- conduct operations research studies of models for delivering STD care through community-level projects (i.e., through integrated maternal and child health/family planning [MCH/FP] interventions); and,

- set up model clinics to demonstrate a comprehensive approach to STD care in a hospital setting (clinic-based intervention projects, or CLIPs).

In addition, behavioral and biomedical research is conducted both at baseline and at periodic intervals to track progress and inform modifications in project strategies. The project agreement includes two additional components: ongoing surveillance for common clinical presentations and drug resistance patterns, and increasing access to rapid laboratory tests for STD diagnosis. However, these have not been incorporated into APAC's present STD strategy, as training of providers and behavior change communications were considered higher priority.

FINDING
APAC has developed a comprehensive model of STD care for high-risk groups that combines the use of innovative behavior change strategies to raise the demand for quality STD services with a training program for providers to meet this demand.

APAC has developed and is implementing a comprehensive model to improve STD case management. Its key components include an intensive communication effort through mass media, interpersonal communication, and peer education; training of providers in areas where APAC-supported NGOs promote quality STD care; and, an aggressive condom promotion strategy. Routine monitoring data show an increasing trend in the number of patients referred for treatment and those that actually seek care for STDs. In addition, BSS Wave 3 data show that reported treatment-seeking behavior for STDs in truckers is about 80 percent (up from 64 percent in Wave 1, 1996).

FINDING
APAC-supported NGOs have built referral linkages for STD care with appropriate providers.

APAC NGOs have taken the initiative to build and nurture referral linkages with providers in their area to ensure that target populations are able to obtain high-quality STD care. Currently, a collaborative spirit of partnership exists between NGOs and local governments in the implementation of STD/HIV/AIDS programs, and NGOs have used the opportunity to ensure services for their target populations. CSWs who can afford the services of private providers are referred to those trained by APAC. Others are linked to public sector providers, who have been trained by TNSACS in STD case management. In addition, NGOs have recruited and trained counselors who are then located in government hospitals which lack counseling services.

Recommendation: APAC should capitalize on the prevailing environment of collaboration to actively work with TNSACS to ensure that a uniform training procedure

for STD case management is adopted and APAC's comprehensive strategy is incorporated into the public sector system.

FINDING

APAC support has built capacity in five institutions around the state to serve as training centers for STD case management and to reach out to community-based organizations. Certain elements of the training strategy need strengthening.

APAC initiated the training of providers in STD case management through CETCs in July 1997. Training targets were based on the capacity of the training institutions, and participants were selected randomly from each CETC catchment area. Since February 1999, CETCs and NGOs have collaborated more systematically in identifying for training those providers located in the areas served by APAC NGOs. This change in focus has enabled CETCs to train providers who are actually accessed by the target groups for STD case management.

RIMPs and pharmacists are expected to refer patients with symptoms of STD to AMPs. The CETCs and NGOs provide lists of trained providers to facilitate this referral.

CETCs use participatory training processes that are generally appreciated by the trainees. However, the response of AMPs who attended the training has not been enthusiastic. Feedback from providers suggests that, to hold their attention, training time be shortened from the present two half-days and that the technical content include more information on recent advances in STD/HIV/AIDS diagnosis and management. In addition, RIMPs and pharmacists would like information on medical treatment of patients with STDs. They are not content with only being trained to counsel and refer patients.

A recent evaluation shows that about 60 percent of AMPs were using the syndromic approach to treat STDs. About 30 percent of RIMPs and 66 percent of pharmacists (who are expected to refer cases) were prescribing drugs for STDs. Moreover, pharmacists did not appear to be aware of the right dosages and duration for the drugs they prescribed. The prescription of antimicrobial drugs without the correct application of the syndromic approach could fuel already existing drug resistance problems.

The quality of follow up of trained providers is also an issue. One CETC has been able to follow up about 75 percent of providers they have trained, while the others have followed up about half of all trainees. The CETCs use social workers for follow-up visits, a problem with AMPs who do not perceive them as peers. In addition, the structured questionnaires used for follow up do not enable CETCs to identify gaps in learning and restructure training content. Annual alumni meetings for providers do not attract a high proportion of trainees.

The ratio of male to female providers trained is about 3:1. Considering that about 50 percent of STDs are asymptomatic in women, and that women prefer to be examined by female providers, the lack of trained female providers could seriously hamper women's access to high-quality services.

Recommendation: APAC should review the strategy for training providers, using the findings from the CETC evaluation report and feedback from the evaluation of the targeted intervention projects. Major targets should be to

- set realistic targets for each category of provider;
- select appropriate strategies to capture the interest of each category of provider;
- conduct follow up on trained providers with appropriate personnel, supplemented by technical update mailings;
- update training modules in accordance with current findings and technical advances relating to the diagnosis and management of STDs;
- emphasize problems of drug resistance in training modules for RIMPs and pharmacists to discourage inappropriate drug prescription;
- recruit and train female doctors to make them sensitive to the prevalence and appropriate management of symptomatic and asymptomatic STDs in women; and,
- train NGO staff members working with CSWs to alert them to the necessity of periodic screening (internal examinations) for STDs, even in the absence of symptoms.

FINDING
Without substantial technical support, operational research (OR) projects on integrating STD services with community-based MCH services and CLIPs could potentially evolve into conventional intervention projects, and lose the OR focus.

Maternal and Child Health/Family Planning (MCH/FP) Projects

Seva Nilayam has been successful in obtaining community support for discussion of STDs and raising awareness about condom use and has been well supported by APAC in collecting and reporting data on a periodic basis. Regarding management of STDs, some issues persist. At the present time, most women with complaints of discharge are being treated using only the syndromic approach, increasing the possibility of incorrect diagnosis of STDs, overtreatment, and the erroneous assumption of high-risk behavior among monogamous women and/or their husbands. Risk assessment criteria have not been developed as yet. Although laboratories are usually equipped to conduct basic laboratory investigations, the data suggest that not all women are screened for STDs. One of the risk behavior correlates identified in the STD community prevalence study is medical termination of pregnancy, which is widely practiced in Tamil Nadu. The OR project should include the implications of this finding in community education.

CLIPs

Two CLIPs serve as referral centers for APAC NGOs implementing targeted interventions. The third is a stand-alone center, in a general hospital setting. The caseload is small, mainly because patients prefer the anonymity of a private clinic despite the lack of laboratory investigations, counselors, and condom distribution/promotion. More effort is needed to market STD clinics among private providers, government dispensaries, and subcenters to increase referrals. CLIPs should be able to offer an evaluative approach for women which includes a bimanual examination, a speculum examination, and microscopy of vaginal and cervical secretions and culture, in addition to counseling, condom promotion, and partner notification. Demonstration clinics should serve to link the approach to STD care with better understanding of microbial etiology and rational choice of antimicrobials.

Recommendation: Operations research projects (see annex G) should supplement the syndromic approach in MCH/FP clinics by simple laboratory tests and risk assessment protocols. In addition, APAC should provide technical support to OR projects in order to ensure that all research questions are effectively addressed through interventions. APAC should consider CLIPs as partners in validating current syndromic approach protocols by linking them with an APAC–supported central reference laboratory.

NGO Capacity Building

	Outputs
Planned:	A network of at least 100 NGOs actively involved in AIDS prevention activities.
Achieved:	1. One-year grants executed with 40 NGOs (small grants for single programs or to pilot projects).
	2. Three-year grants executed with 35 NGOs.

At the core of the APAC project is the development of the capacity of NGOs in Tamil Nadu to reduce the incidence of STDs and AIDS through targeted interventions with groups at high risk of infection. These include commercial sex workers, truck drivers, tourists, slum residents, and persons suffering from STDs. Starting with a rigorous and selective grant-making process, APAC develops close working partnerships with its NGOs, which range from voluntary organizations and educational institutions to charitable societies and trusts, providing them with the training, technical assistance, and other inputs required for their success.

Since the project's inception, APAC has developed long-term (minimum three years) working relationships with 35 NGOs. It has awarded 47 three-year grants to these NGOs and other institutions: 31 in the "medium" category, defined as being between 3 and 21 lakhs, and 16 "large" grants of over 21 lakhs. Grants were awarded to NGOs and training institutions in targeted urban areas throughout Tamil Nadu. In addition, 109 "small" grants (under 3 lakhs) were awarded to NGOs and others for a wide range of activities in

support of the interventions, including OR projects, AIDS awareness and prevention campaigns, and World AIDS Day celebrations.

The Capacity-Building Process

FINDING

APAC has succeeded in building the technical and management capacity of its partner NGOs, in the process developing their confidence and self-esteem as significant contributors to a critical mission. It has done so by instituting rigorous and transparent NGO selection and grant application procedures, by providing high-quality training in all intervention categories, and by ensuring ongoing technical and moral support for the duration of grant activities. The "APAC NGO model" has set an important standard for productive partnerships with private sector institutions.

APAC's intensive approach to developing and supporting targeted interventions in the private sector has a number of distinguishing features:

- Carefully designed criteria for NGO partner selection, including presentation of a good concept paper, legal NGO status, effective interactions with other NGOs and government, an adequate administrative structure on which to build, and at least three years experience in the field;

- A detailed and demanding NGO grant application process, which assesses not only proposal quality but the applicant's track record with health-related activities, with an emphasis on STD and AIDS prevention and community outreach work;

- Assistance to NGO partners in strengthening their management and accounting systems, project monitoring capabilities, and use of information, education and communication (IEC) materials, which it makes available in quantity; and,

- Designation of 2 of the 43 consultants with whom APAC has ongoing contractual relationships to provide each NGO with ongoing technical assistance over the life of a grant, through a schedule of quarterly visits and other contacts, as needed.

The APAC project's commitment to capacity building is especially evident in the range of training opportunities it provides for various levels of NGO personnel and for others who play related roles in promoting STD/AIDS awareness and prevention. Based on an assessment of the skills required to reach high-risk groups with information, services and counseling, it offers training at five continuing education training centers (CETCs) and other sites to NGO managers, health personnel, counselors, social workers, and volunteers. Depending on the audience, training is provided in areas ranging from social marketing to STD/HIV/AIDS counseling to syndromic management of STDs. Training of trainers is provided in peer education and street theater. Barbers, pharmacists and community health workers have all benefited from APAC training initiatives. The project has also published a wide range of training modules and materials, which it updates on a regular basis.

To date, over 14,000 people have received training in connection with the APAC project, at a strikingly modest average cost of less than 900 rupees (US $22 per trainee).

Training provided under APAC is further reinforced by a number of monitoring and technical assistance mechanisms. These include participatory site visits; regular experience sharing and review meetings (ESRM) for NGO representatives, keyed to particular thematic interventions (Women in Prostitution [WIP] projects, Prevention Along the Highways [PATH] projects); cluster meetings, which bring together NGOs in particular geographic areas for exchange of experiences and ideas; and, specially arranged visits between projects and/or NGOs for exposure to individual success stories and new ideas and models.

Networking

FINDING
APAC has succeeded in establishing excellent, supportive networks among its NGOs at thematic and cluster levels. As they have matured, APAC NGOs have also developed effective working relationships with nonproject NGOs and with the public sector.

Networking is accomplished at the following three levels, and contributes substantially to capacity building among the participating NGOs.

1. Networking among APAC–supported NGOs is one of the principal goals of the ESRMs, organized every 6 months for NGOs working in a particular thematic area (e.g., WIP, PATH). ESRMs are typically attended by NGO project staff, consultants, and APAC technical and financial management staff. Performance of each project is reviewed and problems and ideas for their solution are exchanged and discussed. Minutes are kept for continuing reference. NGO representatives contacted during this midterm evaluation were unstinting in their praise of these meetings as aids to their work and a boost to their morale.

2. Networking among APAC NGOs in each of the eight geographic clusters into which they are divided is achieved by bringing together individuals and NGOs involved across all thematic interventions in that cluster. These meetings are also convened on a 6–month basis and serve as a valuable opportunity for participants to be exposed to and learn from the full range of APAC STD/HIV/AIDS–prevention activities.

3. Finally, most NGOs establish working relationships with other, non–APAC NGOs, private health care practitioners, retailers, community leaders, and public sector entities active in their areas. In fact, many receive funding from other sources as well as APAC. While they universally rate APAC's approach to NGO capacity building above all others, they also benefit from resources such as training programs offered by TNSACS and from being able to refer clients to practitioners in the area.

Research

	Outputs
Planned:	Fifteen behavioral and operations research studies completed and the findings disseminated to policy makers and program managers.
Achieved:	Seventeen research studies conducted; results disseminated.

FINDING

APAC's research agenda is carefully crafted. About 17 formative and evaluative biomedical and behavioral research studies have been carried out so far. APAC has also systematically documented and disseminated the results of these studies. Data from APAC-supported research studies are valued within NACO and the state government.

The design of the condom promotion program and the behavior change communications strategy were based on formative research studies, conducted much before the strategies were conceptualized. The BSS measures trends in sexual behavior over time. BSS data reflect the impact of APAC's interventions and also capture changes in other areas. The health facility survey was the basis of the training program for health care providers in STD case management. The STD–prevalence study is one of the few community-based studies of its kind in India.

In terms of the future, an urgent indepth analysis of data is needed to establish, for example, the correlation between symptoms and microbiologic etiology, especially in women, and to study influencing factors, such as higher prevalence in women with a history of a medical termination of pregnancy. In addition, the data should be introduced into the public domain to enable access to researchers and planners from other parts of India to design and implement similar studies.

APAC has contracted with commercial research firms to implement the research studies, but maintains stringent quality control over data collection, analysis, and report writing.

Information, Education and Communication (IEC)/Behavior Change

FINDING

APAC's Communications Program provides its partner NGOs with creative technical assistance and a broad spectrum of tools with which to reach their target populations. Its approach effectively complements the communications initiatives of other organizations. Where it is in need of some strengthening is in the area of training and follow up of counselors, so as to maximize the potential of one-to-one interactions in changing high-risk behaviors.

By all accounts, as illustrated elsewhere in this report, significant amounts of behavior change, in the direction of increased awareness of STDs and AIDS and their prevention, have occurred in Tamil Nadu among high-risk groups as the direct result of APAC project interventions. Contributing to this result have been APAC's innovative communications strategies. These include developing a range of print materials providing

information, much of it refreshingly frank and explicit, on AIDS, STDs, and their prevention. Flyers, posters, stickers, handouts, booklets, and an APAC newsletter are all available in quantity to all NGOs and other project collaborators and are widely distributed. Their strength lies in the number and variety of the messages they transmit, constituting a cafeteria approach to information dissemination and ensuring that there will be an appropriate and effective message for all audiences.

As with much of its work, rather than building up its staff beyond sustainable levels, APAC relies on a private contractor for technical input in the development of its communications strategies, as well as for all materials production. Hindustan Thompson Associates, Ltd. (HTA), is sufficiently impressed with APAC's professionalism and pleased with the working relationship to have recently renewed its contract despite the fact that, for reasons described below, payment for services has often been delayed. In addition to print materials, HTA has also produced two spots for television broadcast, each in long and short versions targeted at adolescents and young married couples. These were less focused on high-risk groups than the print materials; this area could be left to TNSACS, which has a significant commitment to disseminating awareness and prevention messages in electronic media. Otherwise, contrary to suggestions that APAC's IEC initiatives might duplicate other agencies, they filled an important niche, complementing rather than competing with the efforts of others.

A particularly innovative element in APAC's IEC/behavior change communication (BCC) inventory is the development and production of street dramas by community groups in slums and rural areas. APAC contracts with the quasi-governmental State Resource Center (SRC) in Chennai to train writers and producers, who then train community groups to make dramatic presentations, often quite graphic, of the impact of STDs and AIDS on Indian lives. Follow-up surveys conducted by the players themselves indicate that this is a particularly effective way to transmit messages to audiences that, by virtue of being illiterate or lacking access to other media, would otherwise not receive them.

One area in need of strengthening is behavior change counseling. Sensitive, focused, one-to-one counseling can be one of the most effective, if not *the* most effective, means of convincing individuals to change their behavior. The information being transmitted by NGO counselors to their clients is somewhat stilted, reflective of knowledge of the facts and consequences of high-risk behaviors, but inflexible in responding to individualized concerns. This observation was confirmed by others with whom the assessment team spoke and is not surprising, given the skill needed to provide advice and comfort in such a sensitive area. Nonetheless, it points to inadequacies in the training being provided by the counseling training center (CTC) at Christian Medical College/Vellore, and the need for secondary training and careful follow up.

Recommendation: Review existing counseling training curricula for areas needing improvement. Develop detailed refresher training and follow-up protocols with which to monitor and strengthen skills of counselors once they are in the field. Also, consider requiring APAC staff and consultants to receive basic counseling training.

PROJECT IMPLEMENTATION

The actual implementation of the APAC project was assessed from three perspectives. The first had to do with its funding under the bilateral agreement signed in 1992 between USAID and the government of India, and the shortcomings of a system of funds disbursement which has been, at best, unpredictable. The second assesses the quality and effectiveness of the management of the project by VHS/APAC. The third looks at the partnerships at state, national and donor levels that have been the most instrumental to the functioning of the project.

The Funding of APAC

> *FINDING*
> ***Interruptions and inconsistency in the flow of funds to APAC have severely affected its operations, risking loss of momentum and demoralization of NGO partners when the project is at its most productive. At the heart of the problem is inadequate implementation of the revolving fund called for in the January 1995 tripartite agreement signed between the government of India, USAID and Voluntary Health Services, the purpose of which was to ensure continuity in financial support that would be critical to such an innovative undertaking.***

Notwithstanding the remarkable success of APAC interventions to date, and the genuinely high regard in which the project is held by the NGOs it supports and the institutions and contractors with whom it collaborates, there is on all sides an underlying unease about its, and their, ability to continue. The reason is that for the better part of a year, funding flows from NACO to APAC have been, at best, inconsistent. From November 1999, until the time of this evaluation, there had been no disbursements at all. The result is that training sessions have had to be cancelled, consultant visits curtailed, monitoring activities postponed, and new grants and contracts put on indefinite hold. The intensity and quality of support that are so integral to the project's impact are in jeopardy.

Many NGOs have been severely affected by APAC's inability to meet its financial commitments to them. While unabashedly proud of what they have accomplished, and willing to carry on voluntarily in the hope that the situation will improve, they cannot do so indefinitely. Some NGO staff in whose training and nurturing the project invested have already been lost. In general, NGOs understand that the problem is not of APAC's doing, and remain committed to its approach. If financial uncertainties persist, however, NGO loyalty and survivability will be tested.

At the core of the matter is the fact that the APAC revolving fund concept, agreed to in 1995 by all parties, has not been effectively implemented. Since VHS/APAC, as an umbrella NGO, would serve as the engine through which the capacity of a large number of smaller NGOs to engage in STD/AIDS prevention initiatives was developed, it had to be in a position to provide financial resources to those NGOs. Hence, the unique agreement, developed after long negotiation between NACO, VHS and USAID, to establish a replenishable, revolving fund from which APAC could support training, start-up, and monitoring activities of its NGOs, many of them small and financially weak.

Annual revolving fund limits for each project year, from 1995 to 2001, were specified in the APAC project tripartite agreement document. The fund was to be replenishable up to these limits, on a quarterly basis, on presentation of appropriate statements. However, this system was never fully implemented. Especially in the last year, reimbursement of APAC by NACO has been beset with delays and partial payments. The result is that uncertainty has for some time been the dominant feature in APAC's financial picture.

A number of explanations are offered for this situation. In its early years, APAC's financial commitments were lower than projected, which is not surprising, given its newness and complexity. As a result, NACO may not have adequately budgeted for increasing budgetary requirements, and was subsequently unable to rapidly readjust when the project gained momentum and expenditures increased. Also, in the project's early years, VHS management made an investment of APAC project funds in an unauthorized bank account in Tamil Nadu. Although the funds were fully reimbursed and systems were installed to preclude similar episodes in the future, lingering doubts about APAC financial management may have influenced NACO's disbursement decisions. Finally, the APAC project management committee (PMC), normally scheduled to meet every quarter, had not been convened since September 1999. As the principal project interface with the GOI (membership includes NACO, TNSACS, USAID. and VHS), the PMC, if it had met on schedule, might at least have been able to help ease cash flow problems.

Whatever the reasons, what is certain is that the system by which APAC funding is projected and disbursed needs to be rationalized, through full implementation of the revolving fund designed for the purpose. The project has accomplished much despite funding uncertainties and deserves to have that burden removed. USAID leadership and persistence in working with the government and VHS to hammer out the original APAC model and support system was exemplary. No less is required at this important juncture in helping all parties understand each other's needs and remove impediments to a productive partnership.

Recommendation: USAID, in consultation with APAC/VHS, should clarify and reaffirm with NACO the terms of the APAC project tripartite agreement, especially regarding the functioning of the revolving fund, which was established by the agreement "to facilitate rapid and effective project implementation." It should do so with the goal of permanently removing impediments to project operations resulting from funding uncertainties.

The Management of APAC

> ***FINDING***
> ***APAC project management is sound. The flexibility and efficiency of the administration of its main office and personnel in Chennai are evident as well in the guidance and support that it gives to NGOs in developing their capacity to design and implement STD/AIDS education and prevention activities for high-risk populations. Staff recruitment and grant application procedures developed by APAC have set a high standard for its NGOs, as well as for other projects.***

There is little to criticize in APAC's management of its central office. At this point in its life, it has resolved problems resulting from administrative growth and modest staff

turnover. This is notably the case in financial management, now in very capable hands with detailed and effective systems in place. Overall, APAC is operated by a committed, adaptable team with a commendable degree of frugality. APAC offices are comfortable but spartan. Administrative policies keep unsustainable expenses to a minimum. There are, for example, no APAC vehicles, and travel expense allowances for staff and consultants are kept at the basic level. At the same time, APAC/VHS has worked diligently to provide the project with the best guarantee of success—a talented and hard-working staff.

From the start, and with USAID's urging and guidance, APAC/VHS designed an open, rigorous staff recruitment process, one that invited applications from qualified individuals in both the public and private sectors. The result is a staff that combines entrepreneurial skills of private business, technical and idealistic attributes of nonprofit organizations and professions, and political and administrative skills gleaned from government service. The mix permits a holistic approach to program planning, monitoring and evaluation, and a capacity for change as circumstances dictate.

Merging public and private sector perspectives in a new initiative dealing with complex issues was not always easy. In the words of one staff member, "it took us almost a year for us to trust each other, and there was a lot of frustration," but now "APAC is a family affair." The project was also wise in its selection of senior staff. In its first director, APAC benefited from the leadership of a skilled government technical expert, who was able to give full rein to his team's creative skills while maintaining cordial, nonconfrontational, public sector relationships. His replacement has the interpersonal skills and substantive experience (including his role as the first APAC NGO coordinator) to continue the growth process at both a staff and program level.

This is especially true if he can correct one weakness perceived by the evaluators in staff management. This was the lack of systematic communication between APAC technical and management units of the details of program priorities and activities. With no regularly scheduled staff meetings, and because they are so busy, senior staff members are often insufficiently aware of each other's current activities. A second weak spot lies in inadequacies observed in the follow up of individuals who participate in the various training programs offered by APAC–supported CETCs. Follow up does occur, but to date has not been used to the maximum to refresh trainees' retention of material and identify additional training needs. (This point, with an accompanying recommendation, is addressed elsewhere in this report.)

In general, however, sound management practices at the top have led to sound technical assistance to NGOs in developing their interventions. As noted in an earlier section of this report, there was wide appreciation among project NGOs for the intensive, responsive support rendered by APAC staff and consultants. NGOs find that APAC's grant application process, while detailed and demanding, makes them better stewards of their grants when awarded. They are grateful for "APAC's systematic way of doing things," and for the regular opportunities for exchange through staff monitoring, consultant visits, and ESRMs. In contrast, with the projects of most other donors, they find that "there is not much training and very little follow up."

Recommendations: Senior management should institute a system of regular staff meetings, at least on a monthly basis, preferably biweekly. The purpose would be to improve intraoffice communication, especially with respect to the sharing of technical and programmatic priorities and activities.

Given its proven success and wide endorsement, the APAC NGO model of project implementation, built around targeted, thematic approaches and intensive support for NGO capacity building, needs to be documented. As a whole and in its individual parts, the model has much to teach STD/HIV/AIDS awareness and prevention initiatives, in India and elsewhere in the world.

Partnerships

> *FINDING*
> ***Partnerships at state, national, and donor levels have been instrumental in the launching and successful maturation of the APAC project. Each partner has played an important role in ensuring the comprehensiveness of the APAC approach. Meanwhile, the partnership that most embodies APAC's unique contribution to STD/AIDS prevention is that between itself and the NGOs whose capacities it seeks to build. As reflected elsewhere in this report, that relationship has much to teach the world.***

With the exception of the unauthorized financial transaction noted above, APAC's partnership with VHS has been harmonious and productive. Indeed, because of its success, the approach of creating an umbrella NGO within an existing institution with an established presence in the community is being adopted for STD/HIV/AIDS prevention projects in Maharashtra and elsewhere. By all reports, VHS has been a cordial and benevolent host to the project, giving it full freedom to pursue its objectives while not hesitating to express itself on matters of policy and donor involvement when needed; hence, for example, the VHS secretary's strong appeal to USAID/India in December for help in resolving with NACO the debilitating issue of APAC funding interruptions, described above.

On balance, the partnership with USAID has also been positive. First and foremost, the Mission from the beginning committed itself totally to negotiating a strong, workable project collaboration with NACO. It refused to obligate funds until an acceptable tripartite agreement was signed, almost two and a half years after the September 1992 signing of the original bilateral agreement, which gave birth to the APAC initiative. It is hoped (see above) that USAID/India can bring the same level of involvement to reaffirming terms for which it originally fought so hard.

At an operational level, criticism was reported to the assessment team from some respondents that the Mission, especially in the early stages of the project, had been guilty of "micromanaging." Indeed, from the APAC staff perspective, USAID was more involved than they would have liked at the time. It became "painful to us" and prompted a request to the Mission director that APAC be given more room to maneuver.

Ultimately, however, the staff has concluded, as has the evaluation team, that this level of early USAID involvement was valuable, even essential. Given the newness of the project,

not to mention the sensitivity of its mission, there was much at stake for all concerned. USAID's involvement in monitoring staff recruitment, NGO selection, and proposal solicitation, among other functions, was instrumental in helping APAC develop the systematic, comprehensive approach to project implementation for which it is now praised. A more laissez-faire approach on the part of the Mission might have resulted in a significantly lower return on its investment.

APAC's relationship with TNSACS has been cordial and mutually supportive, emphasizing complementarity of roles. TNSACS operates statewide, makes more NGO grants of generally shorter duration than APAC, and at the central level focuses on blood safety and broad STD/HIV/AIDS awareness raising and prevention communication strategies. APAC's involvement at points of intervention is far more intense, its IEC/BCC activity focused on high-risk groups with more explicit messages than TNSACS is able to disseminate. The team did not agree with those who suggested that APAC's communications activities duplicate those of TNSACS, except perhaps in videotape production (see above). In general, there is room for both.

There is good communication between staffs, who often benefit from each others' training offerings. APAC's evaluation and research specialist has provided technical assistance on research models to TNSACS and there is regular exchange of information on NGO grants, especially where NGOs are receiving support from both sources. The one critical observation of TNSACS is that in its most recent annual report, which purports to provide an overview of the battle against STDs, HIV and AIDS in Tamil Nadu, no mention is made of APAC.

APAC's partnership with NACO has, for the most part, been mutually supportive. APAC staff has supported NACO in training programs and in the development of the Phase II program. However, NACO's difficulty in systematically replenishing a revolving fund for project disbursements, as mandated in the tripartite agreement, is a hindrance to current operations and a worry for the future. NACO has a huge role to play in coordinating the battle against AIDS in India. It must oversee numerous donor agreements, led by the $191 million Phase II loan from the World Bank, and has determined it will do so without increasing staff. APAC may be the most innovative, effective AIDS prevention activity in the country, but it may also be the smallest player in financial terms; hence, there is a need to confer with NACO without delay, to remove complications from the project funding process and, in so doing, make the most of the APAC/NACO partnership.

Finally, it should be noted that FHI's support to APAC has been timely and appreciated. Especially in the project's first two to three years, FHI's responsiveness and technical assistance in systems development was, by staff account, of great value. That its role now is perceptibly smaller (although FHI remains available as needed) speaks well for the APAC capacity that it helped build. The BSS model, created with FHI's technical leadership, has proven to be a unique tool for assessing project impact. (Indeed, the BSS has been adopted by NACO as the primary device for monitoring STD/HIV/AIDS prevention activities countrywide.) The fourth wave sentinel survey, now underway in nine target urban areas in Tamil Nadu, is testimony to the continuing importance of FHI's contribution to APAC's mission.

V. PROJECT SUSTAINABILITY

One of the more obvious lessons to emerge from the APAC project is that **it does not take large sums of money to effect meaningful change in HIV prevention**. Far more important are a carefully designed and well-executed project, frugality in project administration, and reliance on existing institutions that share a common commitment to the project's objectives.

APAC's NGO capacity-building efforts have contributed substantively to the strengthening of a large number of increasingly experienced NGOs and to the development of the skills of the personnel who work in and for these organizations. Assuming (realistically) that donor fatigue in the field of HIV prevention is not likely to set in soon, **the human and organizational resources being developed by APAC will be in place and ready to perform well under a variety of donor-funded initiatives in the future**.

Beyond the immediate parties to the project, the APAC project **concept** has demonstrated a degree of sustainability unusual for any development activity: **virtually every major HIV–prevention program now under way or being designed in India incorporates the core features of the APAC project**. These include a focus on vulnerable population groups, adoption of a public-private partnership model of program implementation at the state level, reliance on Indian NGOs as change agents in the campaign against HIV, and a consensus around the notion that state-level programs require considerable autonomy and flexibility in order to succeed under varying conditions at the local level. If APAC ended today, most of its key elements would survive within the framework of these other programs.

Notwithstanding APAC's success—or perhaps because of it—the question arises as to how long the APAC intervention model will be needed in Tamil Nadu. That model—with its attendant costs for materials development, staff training, and intense project management—is designed to reach and convince high-risk population groups to change their sexual behavior. By one scenario, the type of interventions now employed by APAC could eventually become counterproductive—that is, once most clients in the target population groups adopt the behavior changes promoted by the project, subsequent interventions become more annoying than helpful and produce increasingly fewer increments in behavior change per rupee expended. It is tempting to forecast, for example, the eventual **conversion of the current "crusade" model of the project into a lower-cost, less staff-intensive "maintenance" model** (conceding the unfortunate comparisons to the malaria eradication experience).

Finally, the longest term test of the durability of APAC's efforts will be the extent to which its genuinely novel ideas are taken up by the larger health and community welfare sector in India. APAC has shown, for example, that a relatively modest project can achieve something previously considered beyond the capacity of most primary health care systems—that **highly mobile segments of the community (truckers, migrant CSWs, STD patients) can be reached with primary health care information and**

services on a sustained basis. APAC has made a powerful demonstration of an idea which, if broadly adopted by the country's primary health care and community outreach systems, might obviate the need for future "APACs."

VI. NEW DIRECTIONS

NEW INITIATIVES

A number of options, changes and/or new initiatives have been identified that warrant favorable consideration by USAID, NACO, and APAC.

1. **Extend the project:** By one measure, APAC has already achieved the major outputs called for under the tripartite agreement. Much remains to be done, however, as neither the project nor other HIV–prevention activities in Tamil Nadu have yet reached and convinced a "critical mass" of high-risk persons to permanently change their sexual behavior. Moreover, APAC's readiness to expand its coverage (i.e., by engaging additional competent NGOs and by launching new initiatives—see below) is constrained by life-of-project considerations which bar any new activity from having a duration of more than two years. It is strongly recommended that the parties extend the project by three years, to March 2005. APAC would use that additional time to further improve and consolidate its current program, to expand its coverage (as described below), and to help ensure long-term sustainability of the program after 2004.

2. **Increase the number of participating NGOs:** One of the keys to APAC's success has been its careful attention to the caliber and competence of the NGOs that participate in the project. The importance of this factor was demonstrated early in the project, when APAC's eagerness to sign up NGO partners in the manner of TNSACS (for one-year grants) led to the involvement of some overly fragile and ultimately nonperforming NGOs. The lesson was learned, however—such that APAC now estimates that, in addition to the 35 NGOs currently working on the project, only 25 or so additional NGOs in Tamil Nadu would meet APAC's strict standards for participation in the project. (Some observers estimate that up to 1,000 nominal NGOs may exist in the state.) APAC would "graduate" some of the current 35 NGOs as it initiated new subgrants with the new NGOs.

3. **Develop "nodal" NGOs:** Even if APAC were given the additional time mentioned above, they would be hard pressed to support many additional NGOs in the labor-intensive, hands-on manner which accounts for so much of APAC's success to date. In addition, regional differences and logistic constraints argue for some measure of devolution of APAC tasks to other, especially strong, NGOs in the state. At least initially, such tasks would fall short of subgrant approvals and financial oversight, but would include provision of technical assistance, staff training and follow up, and project monitoring. The key to this process would be the engagement of regional NGOs that have close links to their communities, which are already perceived by smaller NGOs to be effective, and which have the skills and experience which the smaller NGOs need to succeed. Over time, these "nodal" NGOs could assume the character of—in the words of APAC staff supportive of the idea—"mini-APAC's"—which might attract their own financial support to continue interventions on regional bases after the end of the APAC project.

4. **Establish an STD reference laboratory:** Ongoing surveillance of STDs and antimicrobial resistance and validation of syndromic approach protocols need back-up support of a high-quality, STD reference laboratory which providers in both public and private sector can access. Tamil Nadu has several research laboratories, one of which can be strengthened to serve as such a reference laboratory. The Christian Medical College in Vellore and the Postgraduate Institute of Biomedical Sciences, for example, are organizations which have the requisite capacity and which are also linked to APAC. One of the most challenging aspects of establishing such a center is to develop its referral networks in the private and public sector which reach into the periphery to obtain the data for surveillance.

5. **Launch a small number of new thematic interventions:** VHS/APAC identified several initiatives which they propose (not all with the same priority) for inclusion in the project. Based on the evaluation team's discussions with APAC staff and observation of project activities, the following recommendations regarding these prospective activities (many of which are already familiar to USAID) are provided:

   - **HIV Information and Documentation Center at VHS:** VHS proposes to open such a center within the institution itself. While the idea of having more ready access to information in Chennai is appealing, given other information dissemination plans already under way as part of APAC, this is not seen as a necessary investment, and it could detract from other activities. **Recommendation: Do not approve the Center**.

   - **STD "model clinic" at the VHS hospital/expansion of CLIPs:** APAC proposes to set up a model STD clinic at VHS. There is little clarity in the concept of what such a clinic could accomplish beyond the function of the current CLIP projects. (Moreover, the tripartite agreement does not allow APAC to support any project interventions at VHS). APAC also proposes to increase the number of CLIPs, three of which have been established as demonstration STD clinics. The lessons from these three clinics need to be studied before APAC establishes any more models.
     Recommendation: APAC should not fund any demonstration STD clinics.

   - **Voluntary counseling and testing centers (VCTs):** Awareness levels regarding HIV/AIDS, including its etiology, are very high in Tamil Nadu. This has resulted in several centers offering HIV testing without pre- and postcounseling or confidentiality—key elements of testing protocols for HIV/AIDS. In response to this high demand for voluntary testing, APAC proposes to identify two private sector laboratories, each in major towns in APAC'S priority regions. The laboratory technicians would be trained in pre- and posttest counseling and in strengthening the quality of interpretation and reporting. Centers would also serve as testing facilities for APAC–supported NGOs. While there is a great need to set up high-quality, voluntary counseling and testing centers, the design of this proposal needs serious modifications. Major issues include the following:

- distinction between the roles of a laboratory technician and counselors,
- need for follow-up and refresher training of counselors and laboratory technicians,
- incentives for the laboratory to participate in such schemes, and
- sustainability of the VCTs.

Lessons learned from such VCTs (which have the potential of being financially viable) can be disseminated to stimulate the private sector/private hospitals to set up such centers.
Recommendation: APAC should support four demonstration VCTs after revision of the current concept.

- **Extend the project to Pondicherry:** APAC staff point to the cultural and linguistic similarities between Tamil Nadu and Pondicherry and acknowledge that much of the project's work could be extended to the latter with a minimum number of changes in operational methods, materials, and behavior change strategies. The evaluation team has concluded, however—with the concurrence of APAC staff—that extending the project into Pondicherry would be burdensome and disruptive to the APAC project. At the least it would require the engagement of another state health authority, another AIDS control society, and the probable inclusion of Pondicherry personnel on the project's executive committee. While such an extension would clearly reach out to additional high-risk populations, the added administrative burden might compromise APAC's ability to succeed in Tamil Nadu.
Recommendation: Do not extend the project to Pondicherry.

- **Extend the project to border areas:** This would introduce the same complications described above and for relatively marginal gains in project coverage. APAC agreed, however, that it should communicate closely with program managers in Andra Pradesh and Kerala to make them sensitive to the location and needs of migrant communities in those states. Special mention was made of APAC's responsibility to alert Andra Pradesh personnel to the needs of 16 specific communities in that state which provide over 50 percent of the CSWs working in tourist areas in Tamil Nadu.
Recommendation: Do not extend the project to border areas.

- **Home/community-based care and support:** APAC proposes to identify four of their current grantees (based on need and competence) and provide them with grants to implement community-based care and support programs. This initiative would draw on experience gained by similar projects in Tamil Nadu and abroad. The projects will focus on building community support for persons living with HIV/AIDS, for identification of opportunistic infections,

establishing referral linkages for hospital care and counseling support for affected individuals and their families.
Recommendation: APAC should support four existing organizations that have the community outreach and competence to set up care and support projects.

- **Industrial workers intervention:** USAID and APAC have already concurred in principle to the inclusion of this initiative in the APAC project, but it was deferred because of the limited time (two years) remaining in the project.
Recommendation: Launch the Industrial Workers Initiative once the time extension discussed above has been approved.

ESTIMATED COST OF NEW INITIATIVES

(All recommendation assume approval of a project extension to March 2005.)

Activity	Total Project Cost ($000)
Involve up to 25 more NGOs	1,000
Enlist four "Nodal" NGOs	200
STD Reference Laboratory	1,000
Four VCTs	40
Home/community-based care	300
Industrial Workers	375
Additional APAC staff (2)	80
TOTAL	**2,995**

VII. ISSUES

PROJECTED ALLOCATIONS AND EXPENDITURES

APAC expenditures are currently averaging approximately $375,000 per quarter, or $1.4 million per year. In the absence of any new activities or cost elements, the project's current allocations ($2.9 million) would cover costs for about 24 months.

Start-up costs for most of the new initiatives shown above would be relatively low over the next 12 months, probably amounting to less than $300,000 through calendar year 2000. New cost elements would include recruitment of two additional staff, the launch of some initial interventions with industrial workers, and initiation of work to establish an STD reference laboratory.[3]

By early 2001, APAC would be rapidly enlisting additional NGOs in the project while "graduating" others and it would begin to implement most of the other initiatives discussed above. Annual costs would likely increase to $1.8 million per year in 2001—during which time some of APAC's current NGO programs would be renewed, new NGOs would be brought into the project, and the STD reference laboratory would be fully operational.

Project costs would likely rise to approximately $2.5 million per year by 2002, and remain at that level through the end of the project. During this period, all of the new NGOs, plus some of the existing NGOs and the nodal/regional NGOs, would be fully engaged in the project. Total project costs for the period March 2000–March 2005 would be approximately $11.1 million, of which about $6.5 million is currently available to the project.

THE APAC MODEL: IMPLICATIONS FOR AVERT AND WORLD BANK, PHASE II

As discussed previously in this report, the USAID–supported AVERT project in Maharashtra state and the countrywide World Bank Phase II loan both incorporate many of the design and operational features of the APAC project. Managers of those other activities should take note, however, that the APAC model utilizes several features that are, so far, unique to the project, and have not yet been replicated in the two larger activities. The most noteworthy of these special features is the intense, hands-on support and nurturing relationship which APAC maintains with its affiliated NGOs. To a considerable extent, APAC's success has been a result of its willingness to invest the time and resources that these NGOs need to succeed.

[3] USAID might want to consider supporting the establishment of the STD reference laboratory as a discrete assistance activity, i.e., outside the framework of the APAC project.

USAID managers responsible for the AVERT project may be able to promote a similar ethos within that activity's project management unit. If that orientation does not emerge in the project management unit, the AVERT project may not be able to produce results commensurate with APAC's.

The Phase II program will face similar concerns—perhaps exacerbated by a World Bank working style which does not (indeed cannot) devote the kind of donor oversight and managerial input which has characterized USAID's support for APAC.

APAC has also demonstrated, in the course of its recent funding crisis, that it is especially vulnerable to lapses in communications with NACO and that it can be seriously compromised if funding falters due to such problems. NACO is about to take on a hitherto unparalleled challenge in managing the more than $300 million Phase II program and plans to do so without recruiting any additional staff. USAID should be attentive to ensure that the comparatively low-profile activity in Tamil Nadu does not fall below the field of vision of NACO managers.

STD DRUGS

Drug availability is an essential component of STD case management. Treating a patient at first encounter is a fundamental premise of syndromic management. However, in APAC–supported trucker projects, where target groups are counseled on condom use, treatment seeking for STDs and other preventive behaviors, no facilities exist for STD case management, including drug prescription. NGOs rely on patient referrals to trained providers in towns and cities, which may or may not be located at easy access points from the highway. Since truckers are a mobile population, it is practically impossible to ascertain if they have actually sought care from a trained medical provider. NGOs and APAC have suggested the possibility of setting up STD clinics at NGO intervention points along the highway. They have also requested that these clinics be stocked with STD drugs.

Recommendation: NGOs should explore the possibility of identifying providers who are located near intervention points and involve them (through sensitivity and other training) to provide high-quality STD services. These can then serve as referral centers.

ANNEXES

ANNEX A

SCOPE OF WORK

(from USAID/India)

AIDS PREVENTION AND CONTROL PROJECT (APAC)

MID-TERM EVALUATION

JANUARY 24 TO FEBRUARY 19, 2000

DELIVERY ORDER STATEMENT OF WORK

BACKGROUND:

USAID/India plans to conduct the first evaluation of its bilateral AIDS Prevention and Control (APAC) Project. It contributes to the result *of* ***"Reduced Transmission of HIV/AIDS and Related Infectious Diseases in Tamil Nadu"*** under the Strategic Objective " Reduced Transmission and Mitigated Impact of Infectious Diseases." The state of Tamil Nadu had been chosen for the interventions because it was one of the three states in the country demonstrating a rapid increase in HIV infection among high-risk groups. The activity was designed to change behavioral norms through selective interventions that have been identified as the most effective in reorienting populations to practice HIV preventive behavior. The planners of the activity intended that APAC project should target high-risk populations, including prostitutes and their clients, and STD patients. Grants to NGOs were envisaged to educate target populations, to promote and sell condoms, and to enhance STD services and counseling.

The bilateral agreement for APAC was signed on 8/30/92. However implementation began on 2/01/95 when the Government of India (GOI) agreed to key implementation arrangements proposed under the activity. The Agreement forged a tripartite arrangement between the GOI, USAID and a local NGO, Voluntary Health Services (VHS) (which was identified to implement the activity in Tamil Nadu). The activity is scheduled for completion in March 2002.

The implementation arrangements under APAC project specify that USAID will provide local currency, through the Ministry of Finance to the National AIDS Control Organization (NACO), a Government organization under the Ministry of Health and Family Welfare. NACO in turn will establish a revolving fund with VHS for implementing all the components of the activity. VHS was identified because it was known as a reputable and large NGO in Tamil Nadu and had/has the backing of the local medical fraternity. To implement the activity, VHS established an APAC unit, consisting of a Director and other professionals who oversee activities in condom promotion and sales, IEC, research, STD treatment, NGO grants, and finance.

The APAC implementation model is unique to the state because it was the first wholly private sector approach to address the problems of AIDS in Tamil Nadu. The Tamil Nadu government has set up the Tamil Nadu State AIDS Control Society (TNSACS) to facilitate the implementation of the program in the state.

The principal interventions envisaged under the APAC project are: 1) Increase demand and access to condoms; 2) Promote behavior change to reduce sexual partners and high-risk sexual behavior; and, 3) Improve STD services. High-risk groups are targeted. In Tamil Nadu, these groups include prostitutes, their clients, truckers and helpers and other people with multiple sex partners who reside in urban and peri-urban areas.

The activity has four elements. The first element is administration. This element supports the administrative costs incurred by VHS in implementing the activity. The

second element is an NGO Grants activity. To date VHS has provided 104 Grants (small, medium and large grants up to ~$300,000). The third element is NGO Support and Development. Under this element activities include communication for behavioral change, STD services delivery and condom promotion. The fourth element is research. Priority areas include condom access and availability, the quality of condoms manufactured in India, and, a survey of STD care in health facilities. The authorized LOP level is $ 10 million. As of September 30, 1999 the Mission has obligated $ 6.420 million. The total commitments under the activity are $4.693 million and the expenditures are $3.086 million.

Technical progress is measured by three indicators namely: 1) cumulative number of APAC grants for AIDS prevention in Tamil Nadu; 2) percentage of individuals belonging to specified high-risk groups who report condom use in most recent sexual encounters with a non-regular partner; and, 3) percentage of population with symptomatic Sexually Transmitted Diseases (STDs) seeking care from qualified medical practitioners in Tamil Nadu. The data available so far indicate that the targets have been achieved.

The purpose of this evaluation is to better understand the contributions under APAC, ascertain whether conditions for sustainability and replicability related to USAID assistance exist, reexamine the validity of the hypotheses and assumptions taken when the activity was initially designed, determine whether the needs of intended customers are being served, and distill "lessons learned" which may be useful for the GOI and for USAID in other programs.

OBJECTIVE OF EVALUATION

To evaluate the APAC activity and make recommendations to USAID/India regarding the effectiveness, efficiency, impact, and sustainability and replicability of the activities. To provide insights in to the future directions for the Project and options for expansion (or curtailment) of USAID-HIV activities in Tamil Nadu.

STATEMENT OF WORK

The contractor shall conduct an evaluation and submit a report, which provides clear and concise findings, conclusions and recommendations. The evaluation report shall also provide a statement of lessons learned and future directions that may emerge from the exercise.

The key aspects of the Project to be addressed are listed below:

1. Approach:

The APAC interventions focus on promoting behavior change to reduce the frequency of different sexual partners and other high-risk sexual behaviors. In addition, the project aims at promoting the use of condoms and improving the quality of STD services. The principal approaches under APAC's activities have been to involve local non-governmental organizations, to focus resources on high risk groups in the state of Tamil Nadu, to study knowledge, attitudes and behaviors of the target populations, and, to reinforce messages through a variety of communication approaches including mass media, folk media, interpersonal communication and counseling to bring about behavior change.

Questions that should be addressed are:

- Are the interventions effectively applying the above strategies?
- Does the approach need to be revised or reinforced?
- How effective has the project been at integrating its components into health care systems at various levels?
- Is there any duplication of effort made in interventions between the Tamil Nadu State AIDS Control Society and APAC project?
- Is there room for expansion or has the area been saturated?

Primary Responsibility – Team Leader

2. Capacity Building/Partnership Development/Sustainability:

The project is partnering with several organizations to accomplish the objectives of the project. To date 104 NGO grants have been provided and 21 contracts for communication and research have been supported. Inherent in the strategy is

strengthening the capacity of various organizations, to effect behavioral change among high-risk groups in Tamil Nadu.

The Team should consider:

- What have been the efforts so far to create effective partnerships and what needs to be done to further these effects?
- Is capacity building taking place? What further efforts need to be taken?
- Are the effects of the project sustainable? If not, what further efforts are needed?

Primary Responsibility – NGO Expert

3. Implementation:

APAC was designed to support a nodal agency that will implement all the components of the project in Tamil Nadu. However, the workplans etc. are approved by a broader Project Management Committee (PMC) which meets quarterly in Tamil Nadu. The PMC consists of representatives from USAID, Government of Tamil Nadu, Tamil Nadu State AIDS Control Society (TNSACS), and the National AIDS Control Organization. The fund flow for the activities is from USAID to the GOI's Ministry of Finance to NACO, which in turn will pass it on directly to VHS.

Issues to consider include:

- Is implementation on track and achieving satisfactory progress towards its stated objectives?
- How effective have the partners been in implementing APAC (USAID, NACO, VHS and TNSACS)?
- Are the effects of the project being produced at an acceptable cost?
- Is the input level adequate or too high/low for the intended outputs? Has the absorptive capacity of implementers been reached?
- What has been the impact of Technical Assistance provided by local technical support organization and Family Health International (FHI) under APAC?
- How effective is the relationships between VHS and partner NGOs – does the monitoring of both the technical and financial aspects need strengthening?
- Are the technical and fiscal monitoring capabilities of APAC/VHS satisfactory?

Primary Responsibility – Program Management Expert / STD Expert

4. Attribution:

- Is the host country (which includes central/state governments, public sector and private sector) and/or other donors providing support in any of the APAC activity areas?
- If yes, what is the nature of their intervention and what is the amount of the resources involved?
- Does the project significantly influence the direction of the host country and/or other donor resources; i.e. did the USAID activities help to leverage funds? If yes, how did the project accomplish this?
- Are interventions under the project leading to replication of similar activities by the host country and/or other donors, i.e. did it have a demonstration effect?
- Based on these do the indicators accurately reflect the manageable interest of the project?

Primary Responsibility – Team Leader / NGO Expert

5. Host Country Contribution:

Evaluators are requested to report on the adequacy and reliability of the HCC as well as NGO contribution required from subrecipients.

Primary Responsibility – NGO Expert

6. Future Direction:

Based on the progress to date the Team is requested make recommendations regarding the initiation of new activities in the project. Such new activities could be: 1) expansion of APAC into other geographic areas such as Pondichery or border areas of Tamil Nadu in the neighboring states of Andhra Pradesh and Karnataka, 2) national level impact studies which impact on Tamil Nadu, 3) pilot activities such as care of the HIV patients especially children etc.

Primary Responsibility – Team Leader and Team Members

METHODOLOGY

In order to examine the above issues, the following methodology should be considered:

1. Review of documents such as project paper, project agreement, project amendments, project implementation letters, tripartite agreement, Result Review and Resources Request (R4) etc.;
2. Meetings and discussions with concerned officers at USAID, NACO, VHS, other donors;
3. Review of monitoring and evaluation reports;
4. Site visits to project-funded areas by APAC and other agencies;
5. Interaction with target groups;
6. Other information such as case studies, observational and anecdotal data may also be used as appropriate.

REPORTS

The contractor will submit an evaluation report, preferably under 20 pages, in accordance with the requirements specified below. Three days prior to departure from New Delhi the consultants will submit a draft report to USAID/India for review and discussion. They will also debrief VHS and NACO on the conclusions and recommendations. The team leader will ensure that all reasonable comments on the draft report are incorporated into the final draft report. The final report will be due 30 days after leaving Delhi.

The format for evaluation report is as follows:

- **Executive Summary** – concisely state the most salient findings and recommendations (2pp);
- **Introduction** – purpose, audience, and synopsis of task (1pp);
- **Background** - brief overview of HIV in India and Tamil Nadu (1pp);
- **USAID's Assistance Approach** – describe the USAID program strategy and activities implemented in response to the problem (1pp);
- **Findings/Conclusions/Recommendations** – for each SOW area (10pp);
- **Lessons Learned** (1pp)
- **Issues** – provide a list of key technical and/or administrative if any (1pp);
- Future Directions (2-3pp)
- **Annexes** – useful for covering evaluation methods, schedules, interview lists, and tables – should be succinct, pertinent and readable (not to exceed 25pp)

The report should be submitted to USAID/Delhi in hard copy and also provided on a diskette (12 point type should be used throughout and page margins should be 1-inch top/bottom, left/right. The report format should be restricted to MS Office products only. The report should contain the following information on the title page:

1) Title
2) Author names
3) Project Activity number
4) Contract Award Number
5) Sponsoring USAID Office
6) Contractor/Grantee Name
7) Date

DELIVERABLES

The following deliverables are included required:

- Final Draft of report prior to departure (hard and electronic copies)
- Technical Briefing to PHNO Staff
- Presentation of Findings to Indian Colleagues (VHS & NACO)
- Exit Briefing for Senior Mission Staff (Director/Deputy Director)
- PowerPoint Copies of all presentations/briefings for PHNO use

RELATIONSHIPS AND RESPONSBILITIES

The team will work under the direction of the APAC evaluation. This subgroup consists of Dr. Victor K. Barbiero (Director, Office of Population, Health and Nutrition), Mr. N.Ramesh (Office of Program), Dr. Dora Warren (Office of Population Health and Nutrition), and Anita Ravishankar (Office of Population Health and Nutrition). This group will coordinate all external meetings with NACO and other institutions.

PERFORMANCE PERIOD

The expected period of performance in India will be from January 24, 2000 through February 19, 2000.

WORK DAYS AND SCHEDULE

Position	Work Days
1. U.S.Expert/Team Leader	26
2. U.S. Expert	26
3. Indian Expert	24
4. Indian Expert	24

Work Days include travel and return from United States to New Delhi by two experts, travel and return to New Delhi by Indian . It will also include travel within India by all team members. Six-day workweek is recommended.

The tentative schedule for the assignment will be as follows:

First Week
- New Delhi
- Meet with USAID/New Delhi staff
- Meet with NACO Staff
- Meet with Donor Agencies
- Desk review

Second & Third Week
- Chennai (with USAID Staff introductions)
- Meet VHS Staff
- Visit project sites

Fourth Week
- New Delhi
- Discussions with USAID staff and other related counterparts
- Report writing
- Preliminary presentation of technical findings, conclusions and recommendations
- Presentation of findings to NACO and PMC
- Presentation to Senior Staff
- Submission of final report – (preferably not more than 20 pages)

CONSULTANT QUALIFICATIONS

General Qualifications – Excellent writing, organizational and communication skills are also a key requirement for each Team Member. Familiarity with Microsoft Office (Word, PowerPoint, and Excel) is required.[4] Fluency in English is required. Knowledge of Hindi and/or Tamil is desirable as is knowledge/experience of India. Other qualifications for the team members are as follows:

Team Leader (TL) (U.S.) - The Team Leader (TL) will be responsible for the overall organization of the report and presentations. She/He will be the chief liaison with the Mission's PHN Office and staff. The TL will provide guidance to other Team Members, assign appropriate tasks, and ensure the timely completion of specific tasks as well as the entire evaluation. She/He should have extensive experience in team leadership and a strong technical grounding in the HIV/AIDS arena. Previous team leadership(s) is a prerequisite for this position. The TL must be able in provide technical as well are administrative leadership to the team. She/He should consult with PHNO staff regularly throughout this exercise to ensure progress is sound and key SOW issues are being addressed. The team leader should have 8-10 years of experience in AIDS sector, preferably in developing countries. She/He should also be well versed with the current developments in AIDS prevention. Although the TL should have a solid technical background, her/his strengths should accentuate the management skills and experience required in the SOW. The TL will be responsible for organizing and editing the entire evaluation, and making final editorial and technical adjustments, as necessary, based on the in-country reviews.

Program Management Expert (PME) (U.S.) – The PME should have robust operational experience on the implementation and program management of HIV/ADIS prevention and control programs. She/He should have 5-10 years of international experience and understand the complexities of project management, including start-up, procurement, staff recruitment and management, and logistics. The PME should be a seasoned individual who can assist the TL with report writing and the definition of key programming issues facing APAC in the future. It is envisioned she/he will take the lead on the implementation section of the SOW and provide insights into the success and shortcomings of the APAC project, including the fiscal and administrative aspects of project implementation. The PME will also contribute to the preparation of the "Future Directions" section of the evaluation.

NGO Expert (NGO/E) (Indian) - The NGO/E will be responsible for writing sections #2 and #5 of the SOW, and will contribute the Future Directions section with the rest of the Team. The NGO/E should have an in-depth knowledge of NGO activities in India, and particularly in Tamil Nadu. She/He should have 5-8 years of experience in the NGO community and fully understand the pros and cons of NGO involvement in HIV/AIDS prevention and control as well as the general role of NGOs in Tamil Nadu and India. This expert should be conversant with GOI policies in Tamil Nadu and fully understand impediments to NGO's in realizing their potential in Tamil Nadu and other States.

---

[4] The Team should travel with at least one laptop computer, preferably two or more.

STD Expert STD/E) (Indian) – The STD/E should be a senior person with a broad knowledge of STD programs in India. She/He must be familiar with the technical aspects of STD transmission and the latest approaches regarding the syndromic management of STIs. She/He should also understand the programmatic aspects of STI case management and the potential and limitations of diagnosis and treatment at the community level. The STD/E should command an in-depth knowledge of STD transmission in India and especially in Tamil Nadu. She/He should be able to assess the technical aspects of diagnosis and treatment in fixed facilities and also understand the potential medical barriers to expanded treatment, especially to target groups. The STD/E should understand the stigmas associated with STDs in the Indian context and potential political issues associated with diagnosis, treatment and information transfer regarding STD prevention and control. She/He should possess programming and clinical knowledge of STD prevention and be able to identify practical and innovative approaches to prevention and control within the Tamil Nadu context. The STD/E should have demonstrable technical, analytical, writing, communication and organizational skills. She/He will serve as the technical keystone for the team and provide technical backstopping to the other team members. The STD/E will contribute to Section #3 with the PME, and will have technical input into all SOW areas.

ANNEX B

PERSONS CONTACTED

PERSONS CONTACTED

NEW DELHI

Prasada Rao, Director, National AIDS Control Organization (NACO)
Neelan Kapur, Deputy Director, NACO
Dr. P. L. Joshi, Joint Director/Technical, NACO
S. Ramasundaram, former head, Tamil Nadu State AIDS Society (TNSACS)
Dr. K. Sudhakar, The World Bank
Peter Heywood, The World Bank
Dr. Dinesh Nair, Department for International Development (DFID), India
Gordon Alexander, Joint United Nations Programme on HIV/AIDS (UNAIDS)
Mr. Pradeep, UNAIDS
Rekha Masilamani, Pathfinder International
Tom Philip, Country Representative, Family Health International (FHI)
Linda Morse, USAID/India, Mission Director
Victor K. Barbiero, Acting USAID Health, Population and Nutrition (HPN) Director
Dora Warren, USAID Advisor, Infectious Diseases; APAC Project Manager
Peter Thormann, USAID Program Office Director
N. Ramesh, USAID Project Development Specialist
Rohini Gambhir, USAID Budget/Finance Office
Anitha Ravishankar, USAID HPN Program Officer
Barbara M. Bever, Communications Manager, USAID
Vathani Amirthanayagam, AVERT Program Officer
Charles Gardner, U.S. Embassy Science Attaché
and other USAID PHN and Mission staff

CHENNAI

Dr. N.S. Murali, Honorable Secretary, Voluntary Health Services (VHS)
Dr. P. Krishnamurthy, Director, AIDS Prevention and Control Project (APAC) and staff:
Dr. Bimal Charles, Assistant Director, NGO Programs; Acting Director 2/7/00
Dr. Zafrullah, Assistant Director, STD
Dr. Lakshmi Bai, Specialist, Monitoring, Evaluation and Research
S. Chandrasekhar, Manager, Finance, Contracts and Administration
P. Arvind Kumar, Specialist, Condom Promotion
A. Sivan, Specialist, Communication
S. Santhya, Administrative Officer
Dr. N. Kumarasamy, Medical Officer, Centre for AIDS Research and Education at VHS
Dr. Vimala Ramalingham, Blood Safety Advisor, TNSACS
Dhanika Chalam, Nongovernmental Organization (NGO) Advisor, TNSACS
U. Jayraj Rau, Vice President, Hindustan Thompson Associates Ltd., and staff
John A. Joseph, Director, State Resource Center (SRC), and staff
M. Sundaramurthy, Founder/Secretary, Bro. Siga Social Service Guild
Staff, Counsellors, and Street Performers of Bro. Siga Social Service Guild
Thiru K. Allaudin, Tamil Nadu Commissioner of Sugar; former Project Director, TNSACS
Aniruddah Deshmukh, Executive Director, J. K. Ansell Ltd.
S. Kalyanaraman, Senior Regional Manager, J. K. Ansell Ltd.
Dr. Ruben Jacobson, Director, Scudder Memorial Hospital
Dr. Manorama, Director, Community Health Education Society
Dr. Cranapathy, Dr. Mallika Johnson, and Dr. Kantraraj, Institute of Venereology
A.V. Surya, Assistant Research Manager, A.C.Nielsen (BSS survey firm), and staff

15 representatives of APAC–supported NGOs not directly visited by the evaluation team, convened for a roundtable discussion at APAC headquarters, February 4, 2000

9 consultants providing regular consultant services to APAC–supported NGOs, convened for a roundtable discussion at APAC headquarters, February 5, 2000

MAHABALIPURAM

A. J. Hariharan, Secretary, Indian Community Welfare Organization (ICWO)
Staff, commercial sex workers (CSWs), peer educators, counselors, medical doctors associated with ICWO interventions

VILLUPURAM

A. Bakthavatchalam, Executive Director, Association for Rural Mass Media (ARM)
Staff, CSWs, peer educators, registered Indian medical practitioners (RIMPs), lodge managers, and condom salespersons associated with ARM interventions
Dr. Subramaniam, STD Specialist

MADURAI

Dr. R. Jayaraman, Member Secretary, Centre for Entrepreneur Development (CED)
S. Gnana Haran, Senior Consultant, CED
Dr. N. Krishnamurthy, Director, Meenakshi Mission Hospital and Research Center (MMHRC)
Felix Raj, Program Officer, and physicians, administrators and staff of MMHRC
Jacob C. Varghese, M.J., M.S., Management Consultant, MMHRC
Dr. Neelakantan and Dr. Jayaraman, RIMPs
Mrs. Rita James, APAC Project Coordinator, Teddy Trust
Staff, Peer Counselors, Social Workers, CSWs and RIMPs associated with Teddy Trust interventions; also, DFID/Teddy Trust Highway Project Coordinator
Dr. Mallika, Medical Officer, Madurai Corporation dispensary
John Dalton, Satish Samuel and staff of Arokya Agam rural NGO
Dora Scarlett, Founder, Seva Nilayam Hospital and rural outreach program
Dr. Chandrasekhar, Medical Director, and CHWs, counselors and staff of Seva Nilayam

WASHINGTON

Denise C. Lionetti, Deputy Director, TvT Associates/Synergy Project
Saha AmaraSingham, Ph.D., Program Monitoring and Evaluation Specialist, TvT/Synergy
Lena Thompson, Office Manager, TvT/Synergy
Messaye Girma, Program Planning and Design Specialist, TvT/Synergy
Tony Bennett and Carol Laravee, FHI/Washington
Paurvi Bhatt, USAID/Washington, HIV–AIDS Division
Charles Llewellyn, USAID/Washington
Kai Spratt, USAID/Washington

ANNEX C

MAP OF NGO SUPPORT IN TAMIL NADU

ANNEX D

BSS DATA

ANNEX E

APAC PROJECT DATA

ANNEX F

PARTICULARS OF CONDOMS DISTRIBUTED IN TAMIL NADU

PARTICULARS OF CONDOMS DISTRIBUTED IN TAMIL NADU

Quantity in Lakh Pieces				
Year	**Fee Supply**	**Fully Priced**	**Subsidized**	**Total**
1995	156	126	52	**334**
1996	171	155	23	**349**
1997	214	241	41	**496**
1998	290	270	50	**610**
1999*	290	279	32	**600**

*Estimated

Source: For free distribution: *The Tamil Nadu Demographers Report*
For subsidized and fully priced: *Retail Audit Report of Operations Research Group*

ANNEX G

OPERATIONAL RESEARCH TOPICS FOR STI MANAGEMENT

OPERATIONAL RESEARCH TOPICS FOR STI CASE MANAGEMENT

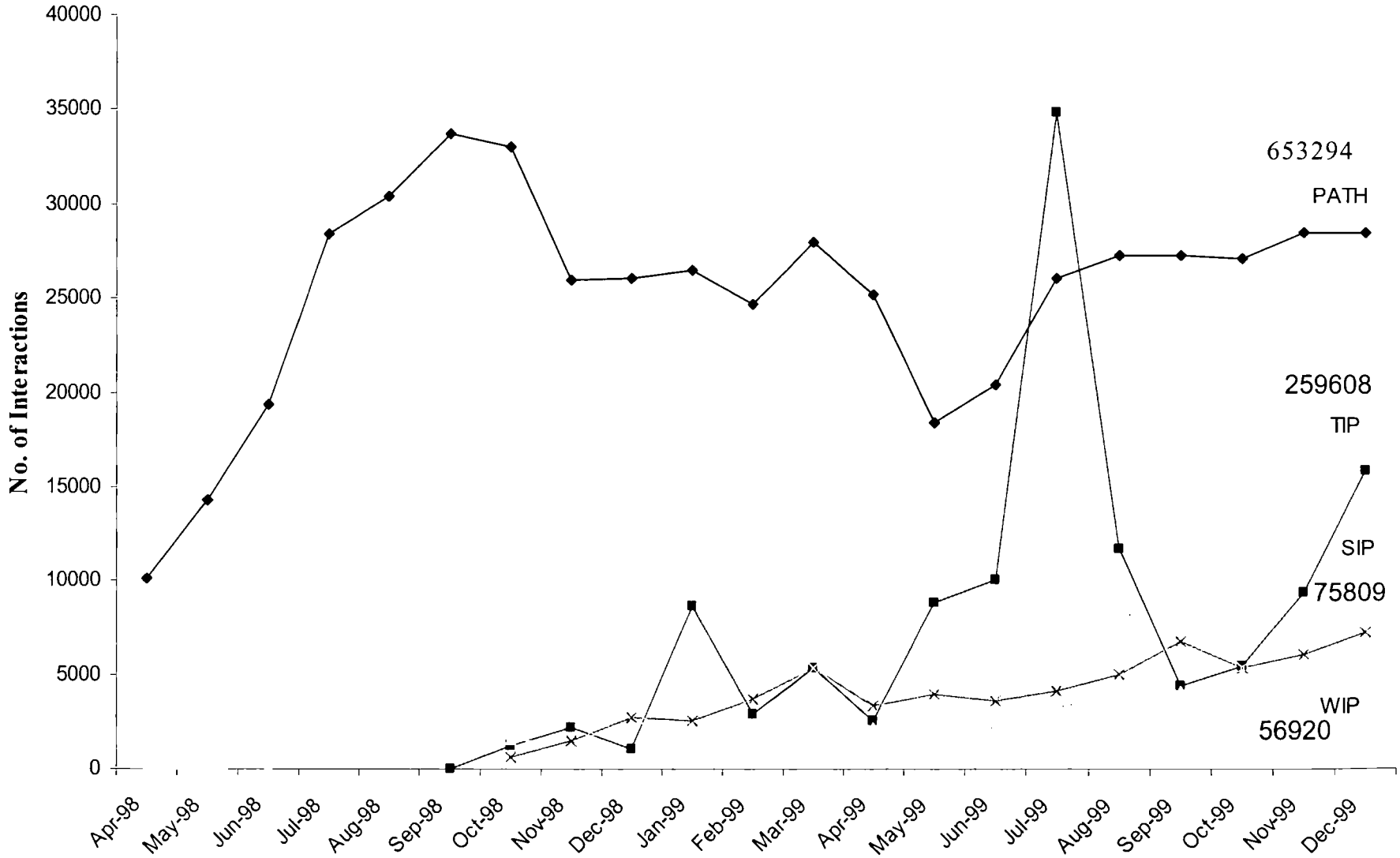
1. STD Risk Assessment: Feasibility of training community-level providers and referral-level providers in nonjudgmental, innovative ways of inquiry regarding sexual behavior of women and/or their partners.

2. Simple Screening Tests: Use of existing laboratory facilities in the present OR projects is sufficient (provided optimum standards are maintained) to diagnose selective conditions such as syphilis, gonorrhea, BV, trichomoniasis, and Candida. The OR projects need to make an attempt to use (and document) risk assessment, clinical examination, and laboratory tests to study correlations between symptoms and actual pathology. No additional resources to the projects are necessary. One-time training of staff members to orient them to this package and periodic technical assistance to support the documentation process and supervise quality control may be necessary.

3. Study ways to improve male responsibility in women whose STI is a result of their partner's high-risk behavior.

4. Development of effective linkages with private providers to improve referral to the OR study sites to both obtain larger coverage and provide high-quality care.

5. CLIPs: Study the possibility of converting the CLIPs into model clinics that offer a combination of high-quality clinic services and a community-outreach component with a substantial communication element in order to reach high-risk groups as well as vulnerable populations. The CLIPs are based in organizations that do have outreach services; thus, the second component only needs some communication support. The lessons learned from this study offer the potential of replication in several hospital-based NGOs across the country. In addition, the lessons learned from the clinic interventions (improved quality of care, including risk assessment and sensitive counseling methods) may benefit public sector programs.


Interactions - PATH, WIP, TIP, SIP
No. of Interactions
40000
35000
30000
25000
20000
15000
10000
5000
0
653294
PATH
259608
TIP
SIP
75809
WIP
56920
Apr-98
May-98
Jun-98
Jul-98
Aug-98
Sep-98
Oct-98
Nov-98
Dec-98
Jan-99
Feb-99
Mar-99
Apr-99
May-99
Jun-99
Jul-99
Aug-99
Sep-99
Oct-99
Nov-99
Dec-99

Mtg. with Indian

10/26 or 10/27 th

– Ram Nat'l. AIDS Coordinating Office

Summary of Loan from

10-12 am

INT – Countries – India – World Bank Mtg. (6/98)

PVOs

15

International HIV/AIDS Alliance

Supporting Community Action on AIDS in Developing Countries

Information as per your request

Post-it® Fax Note 7671	Date 9/1/98	# of pages ▶ 20
To Alka Mishra	From Julie Mittinson	
Co./Dept. NCIH-Global AIDS Pol	Co. Fax m	
Phone #	Phone #	
Fax # 202-833-0077	Fax # 532-2955	

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

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

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

Table of Contents

1.0 Welcoming Remarks and Agenda Review

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

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

2.0 Introductions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Control Organisation and its supporters.

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

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

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

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

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

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

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

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

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

3.1 Questions and Comments

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

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

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

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

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

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

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

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

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

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

3.2 Section Summary

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

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

4.0 Roles of International NGOs in developing the new AIDS project

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.2 DFID's Perspective (Ms. Julia Cleves)

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

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

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

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

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

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

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

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

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

4.4 Questions and Comments

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

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

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

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

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

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

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

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

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

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

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

states to sign up.

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

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

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

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

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

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

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

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

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

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

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

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

Appendix:
Participants' Contact Details

Julia Cleves-Mosse
Department for International Development (DFID)
94 Victoria Street
London SW1E 5JL
United Kingdom

Monica Dolan
CAFOD
2 Romero Close
Stockwell Road
London SW9 9TY
United Kingdom

Lucinda Dowson
Marie Stopes International (MSI)
153-157 Cleveland Street
London W1P 5PG
United Kingdom

Nel Druce
AHRTAG/Healthlink Worldwide
Farringdon Point
29-35 Farringdon Road
London EC1M 3JB
United Kingdom

Jerker Edström
International HIV/AIDS Alliance
Barratt House
341 Oxford Street
London W1R 1HB
United Kingdom

Prabhat Jha
Health Specialist
Human Development Network
The World Bank
1818 H Street, NW
Washington, Dc 20433
USA

Indira Kapoor
International Planned Parenthood Federation (IPPF)
Regent's College
Regent's Park
London NW1 4NS
United Kingdom

Neelam Kapoor, NACO
Deputy Director, IEC
Ministry of Health and Family Welfare
Mirman Bhawan
New Delhi 110011
India

Hester Kapur
Oxfam
274 Banbury Road
Oxford OX2 7DZ
United Kingdom

Sue Lucas
UKNGO AIDS Consortium
Fenner Brockway House
37-39 Great Guildford Street
London SE1 OES
United Kingdom

Julianne Mitman
Social Development Consultant
The World Bank
Population and Human Resources Operations Division
South Asia Country Department II
The World Bank
1818 H Street, NW
Washington, DC 20433
USA

Julian Parr
Prince of Wales Business Leaders Forum
15-16 Cornwall Terrace
Regents Park
London NW1 4QP
United Kingdom

International HIV/AIDS Alliance

Supporting Community Action on AIDS in Developing Countries

Information as per your request

Post-it® Fax Note 7671	Date 9/1/98	# of pages ▶ 20
To Alba Hushra	From Julie Mittman	
Co./Dept. NCIH-Global AIDS Pol	Co. FAM	
Phone #	Phone #	
Fax # 202-833-0075	Fax # 537-2955	

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

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

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

Table of Contents

1.0 Welcoming Remarks and Agenda Review

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

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

2.0 Introductions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Control Organisation and its supporters.

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

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

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

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

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

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

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

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

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

3.1 Questions and Comments

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

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

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

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

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

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

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

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

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

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

3.2 Section Summary

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

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

4.0 Roles of International NGOs in developing the new AIDS project

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.2 DFID's Perspective (Ms. Julia Cleves)

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

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

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

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

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

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

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

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

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

4.4 Questions and Comments

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

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

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

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

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

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

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

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

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

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

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

states to sign up.

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

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

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

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

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

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

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

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

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

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

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

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

Appendix:
Participants' Contact Details

Julia Cleves-Mosse
Department for International Development (DFID)
94 Victoria Street
London SW1E 5JL
United Kingdom

Monica Dolan
CAFOD
2 Romero Close
Stockwell Road
London SW9 9TY
United Kingdom

Lucinda Dowson
Marie Stopes International (MSI)
153-157 Cleveland Street
London W1P 5PG
United Kingdom

Nel Druce
AHRTAG/Healthlink Worldwide
Farringdon Point
29-35 Farringdon Road
London EC1M 3JB
United Kingdom

Jerker Edström
International HIV/AIDS Alliance
Barratt House
341 Oxford Street
London W1R 1HB
United Kingdom

Prabhat Jha
Health Specialist
Human Development Network
The World Bank
1818 H Street, NW
Washington, Dc 20433
USA

Indira Kapoor
International Planned Parenthood Federation (IPPF)
Regent's College
Regent's Park
London NW1 4NS
United Kingdom

Neelam Kapoor, NACO
Deputy Director, IEC
Ministry of Health and Family Welfare
Mirman Bhawan
New Delhi 110011
India

Hester Kapur
Oxfam
274 Banbury Road
Oxford OX2 7DZ
United Kingdom

Sue Lucas
UKNGO AIDS Consortium
Fenner Brockway House
37-39 Great Guildford Street
London SE1 OES
United Kingdom

Julianne Mitman
Social Development Consultant
The World Bank
Population and Human Resources Operations Division
South Asia Country Department II
The World Bank
1818 H Street, NW
Washington, DC 20433
USA

Julian Parr
Prince of Wales Business Leaders Forum
15-16 Cornwall Terrace
Regents Park
London NW1 4QP
United Kingdom