

HIV/AIDS in India

THE WORLD BANK

JUNE 2005



The World Bank in South Asia

Afghanistan
Bangladesh
Bhutan
India
Maldives
Nepal
Pakistan
Sri Lanka

*This map was produced by the Map Design Unit of The World Bank. The boundaries, colors, denominations and any other information shown on this map do not imply, on the part of The World Bank Group, any judgment on the legal status of any territory, or any endorsement or acceptance of such boundaries.

India has among the highest number of persons living with HIV/AIDS in the world today, although the overall prevalence remains low. Some states experience a generalized epidemic with the virus transmitted from high-risk groups into the general population. A major challenge is to strengthen and decentralize the program to the state and district levels to enhance commitment, coverage and effectiveness.

STATE OF THE EPIDEMIC

There are more than 5.1 million individuals infected with HIV in this country of over 1 billion people (UNAIDS 2003). The total number of AIDS cases in 2002 was estimated to be about 550,000. Seven states – Andhra Pradesh, Goa, Karnataka, Maharashtra, Manipur, Mizoram, and Nagaland – already have generalized epidemics, as indicated by a 1 percent or higher prevalence rate among pregnant women in prenatal clinics. These seven states represent 22 percent of the population.

RISK AND VULNERABILITY

Several factors put India in danger of experiencing a rapid spread if effective prevention and control measures are not scaled up and expanded throughout the country. These risk factors include:

- **Unsafe Sex and Low Condom Use:** In India, sexual transmission is responsible for 84 percent of reported AIDS cases. HIV-prevalence rates are highest among sex workers and their clients, injecting drug users, and men who have sex with men (many of whom are married). When surveyed, 70 percent of commercial sex workers in India reported that their main reason for not using of condoms was because their customers objected.
- **Migration and Mobility:** Migration for work for extended periods of time takes migrants away from the social environment provided by their families and community. This can place them outside the usual normative constraints and thus more likely to engage in risky behavior. Concerted efforts are needed to address the vulnerabilities of the large migrant population.
- **Injecting Drug Use (IDU):** Studies indicate that many drug users are switching from inhaling to injecting drugs. This phenom-

There are significant structural and socioeconomic factors which put South Asia at risk for a full-blown AIDS epidemic.

More than 35 percent of the population lives below the poverty line;

Low levels of literacy;

Porous borders;

Rural to urban and intrastate migration of male populations;

Trafficking of women and girls into prostitution;

High stigma related to sex and sexuality;

Structured commercial sex and casual sex with non-regular partners;

Male resistance to condom use;

High prevalence of sexually transmitted diseases (STDs);

Low status of women, leading to an inability to negotiate safe sex.

learn more at www.worldbank.org/saraids

enon is more localized in the Northeastern states of India, and injecting drug users show sharp increases in HIV prevalence. Forty-one percent of IDUs in a national survey reported injecting with used needles or syringes. Of those who cleaned their needles and syringes, only three percent used an effective method such as alcohol, bleach, or boiling water. Appropriate strategies are also needed to address the double impact of drug use and unsafe sexual practices.

. Low Status of Women: Infection rates have been on the increase among women and infants in some states. As in many other countries, unequal power relations and the low status of women, as expressed by limited access to human, financial, and economic assets, weakens the ability of women to protect themselves and negotiate safer sex, thereby increasing vulnerability.

. Widespread Stigma: Stigma towards people infected

with HIV/AIDS is widespread. The misconception that AIDS only affects men who have sex with men, sex workers, and injecting drug users strengthens and perpetuates existing discrimination. The most affected groups, often marginalized, have little or no access to legal protection of their basic human rights. Addressing the issue of human rights violations and creating an enabling environment that increases knowledge and encourages behavior change are thus extremely important to the fight against AIDS.

NATIONAL RESPONSE TO HIV/AIDS

Government: Shortly after reporting the first AIDS case in 1986, the Government of India established a National AIDS Control Program (NACP) which was managed by a small unit within the Ministry of Health and Family Welfare. The program's principal activity was then limited to monitoring HIV infection rates among risk populations in select urban areas.

In 1991, the strategy was revised to focus on blood safety, prevention among high-risk populations, raising awareness in the general population, and improving surveillance. A semi-autonomous body, the National AIDS Control Organization (NACO), was established under the Ministry of Health and Family Welfare to implement this program. This "first phase" of the National AIDS Control Program lasted from 1992 -1999. It focused on initiating a national commitment, increasing awareness and addressing blood safety. It achieved some of its objectives, notably an increased awareness. Professional blood donations were banned by law. Screening of donated blood became almost universal by the end of this phase. However, performance across states remained variable. By 1999, the

program had also established a decentralized mechanism to facilitate effective state-level responses, although substantial variation continued to exist in the level of commitment and capacity among states. Whereas states such as Tamil Nadu, Andhra Pradesh, and Manipur demonstrated a strong response and high level of political commitment, many other states, such as Bihar and Uttar Pradesh, have yet to reach these levels.

The second phase of the NACP began in 1999 and will run until March 2006. Under this phase, India continues to expand the program at the state level. Greater emphasis has been placed on targeted interventions for high-risk groups, preventive interventions among the general population, and involvement of NGOs and other sectors and line departments, such as education, transport and police. Capacity and accountability at the state level continues to be a major issue and has required sustained support. Interventions need to be scaled up to cover a higher percentage of the population, and monitoring and evaluation need further strengthening. The Government has done away with the classification of states based on prevalence to avoid inducing complacency among states categorized as low prevalence, and has since focused on the vulnerability of states, hence creating a sense of urgency.

In brief, while the government's response has scaled up markedly over the last decade, major challenges remain in raising the overall effectiveness of state-level programs, expanding the participation of other sectors, and increasing safe behavior and reducing stigma associated with HIV-positive people among the population.

The Government of India is currently in the early stages of preparing for the third phase of the National AIDS Control Program (NACP 3), for which a multi-disciplinary design team has been constituted to lead the preparation. The design of NACP 3 envisages a complex consultative process including nationwide consultations with various national stakeholders, as well as international development partners.

Non-Governmental Organizations (NGOs): There are numerous NGOs working on HIV/AIDS issues in India at the local, state, and national levels. Projects include targeted interventions with high risk groups; direct care of people living with HIV/AIDS; general awareness campaigns; and care for AIDS orphans. Funding for NGOs comes from a variety of sources: the federal or state governments of India, international donors, and local contributions.

Donors: India receives technical assistance and funding from a variety of UN partners and bilateral donors. Bilateral donors such as USAID, CIDA, and DFID have been involved since the early 1990s at the state level in a number of states. USAID has committed more than US\$70 million since 1992, CIDA US\$11 million, and DFID close to US\$200 million. The number of major financiers and the amount of funding available has increased significantly in the last year. Since 2004, the Gates Foundation has pledged US\$200 million for the next five years, the Global Fund has approved US\$26 million for Prevention of Mother-to-Child Transmission (PMTCT) and about US\$7 million for TB/HIV co-infection, and is considering another round of proposals, and USAID is considering the inclusion of India as its 15th priority country. DFID has also increased its financing and is considering the inclusion of additional states. Other more recent donors include DANIDA, SIDA, the Clinton Foundation and the European Union.

HIV/AIDS in India - A Threat to India's Development

Localized epidemics within high-risk groups already exist in some locations in India, and the virus is spreading to the general population in some states. India is second only to South Africa in number of HIV cases in a single country. Given India's large population, a mere 0.1 percent increase in the prevalence rate would increase the number of adults living with AIDS by over half a million persons. Only through immediate and vigorous action to improve and step up control efforts will the country prevent the spread of HIV/AIDS among high risk groups, and into the general population.

ISSUES AND CHALLENGES: PRIORITY AREAS

Limited Overall Capacity: There are severe institutional capacity constraints, including managerial, at the national and state levels. These are critical factors to address as the program attempts to scale-up the national response. NACO will require a change in its role and responsibilities to provide the necessary leadership and steering role for a stronger multisector response for the next phase in India's fight against HIV/AIDS.

Variable Ability to Implement Responses Across States: The capacity to mount a strong program is weakest in some of the poorest and most populated states with significant vulnerability to the epidemic. There is a need for tailored capacity-building activities and the introduction of some performance-based financing approaches.

Institutional arrangements and personnel turnover: There is a high turnover of state level project directors, resulting in limited continuity and variability in performance across states. This puts program growth at risk.

Donor Coordination: At present there are over 32 donor agencies working with NACO in different states and on different programs. Each donor comes with its own mandate and requirements, as well as areas of focus. The transaction cost to the government as a result of attending to the various demands of the donors is huge. There is a need for better coordinating mechanisms among the donors and clear leadership by the Government to reduce the transaction costs.

Use of Data for Decision Making: There remains a need for greater use of data for decision making, including program data and epidemiological data. A lot of data that is being generated is not adequately used for managing the program or inform policies and priorities. Results-based management and linking incentives to the use of data should be explored.

Stigma and Discrimination: Stigma and discrimination against people living with HIV/AIDS and those considered to be at high risk remain entrenched. A lot of this is a result of inadequate knowledge. For instance, more than 75 percent of Indians mistakenly believed they could contract HIV from sharing a meal with a person who has the disease, according to a recent study. Stigma and denial undermine efforts to increase the coverage of effective interventions among high risk groups such as men having sex with men, commercial sex workers and injecting drug users. Harassment by police and ostracism by family and community drives the epidemic underground and decreases the reach and effectiveness of prevention efforts. Though there is significant increase in awareness, due to efforts by the government, there is much room for improvement.

Low Awareness in Rural Areas: Sentinel site behavioral surveillance, completed in 2001, showed high HIV/AIDS basic awareness levels (82.4 percent in males and 70 percent in females). However, rural women demonstrated very low rates of awareness in Bihar (21.5 percent), Gujarat (25 percent), and Uttar Pradesh (27.6 percent). New approaches need to be tried to reach rural communities with information about HIV/AIDS, safe sex and how to prevent and treat HIV/AIDS.

WORLD BANK RESPONSE

In 1991, the Government of India and the World Bank expanded their collaboration on infectious disease control programs and by 1992 the first National AIDS Control Project was launched with a World Bank credit of US\$84 million. The project helped the government to broaden prevention efforts and to establish institutions and procedures necessary to curb the spread of HIV/AIDS. Building upon lessons learned from the first project, India requested World Bank financing for a follow-on project. With a World Bank credit of US\$191 million, the Second National HIV/AIDS Control Project was started and this is increasing the pace of implementation through the use of State AIDS Societies to speed the distribution of funds at the state level.

The Bank has also undertaken analytical work to strengthen the national response, including an analysis of the full array of costs and consequences likely to result from several plausible government policy options regarding funding for anti-retroviral therapy (ART). Currently, the Bank is carrying out sector work on the economic consequences of the HIV/AIDS epidemic on India and is actively supporting the design of the third National AIDS Control Program.

India

Mr. Sudip Mozumder

☎ 91-11 246-17241

✉ smozumder@worldbank.org

Washington, DC

Mr. Benjamin Crow

☎ 1-202-473-5105

✉ bcrow@worldbank.org

www.worldbank.org/in
www.worldbank.org/sar aids