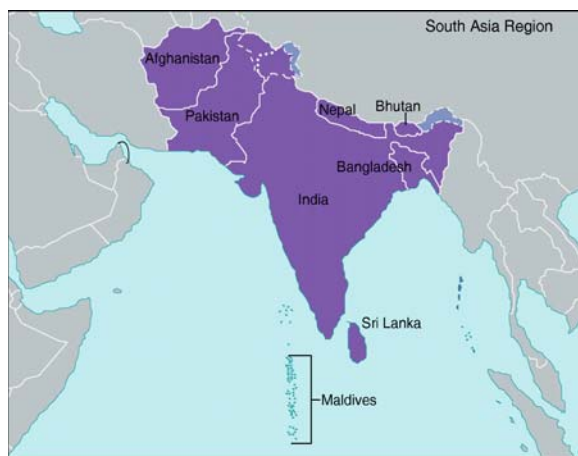


HIV/AIDS in India

THE WORLD BANK

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The World Bank in South Asia

Afghanistan
Bangladesh
Bhutan
India
Maldives
Nepal
Pakistan
Sri Lanka

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STATE OF THE EPIDEMIC

The Government of India estimates that in 2006 about 2.45 million Indians were living with HIV (1.75 - 3.15 million) with an adult prevalence rate of 0.41 percent. India's highly heterogeneous epidemic is largely concentrated in six states—in the industrialized south and west and in the north-eastern tip. On average, HIV prevalence in those states is 4–5 times higher than in the other Indian states. HIV prevalence is highest in the Mumbai-Karnataka corridor, the Nagpur area of Maharashtra, the Nammakkal district of Tamil Nadu, coastal Andhra Pradesh, and parts of Manipur and Nagaland.

The Indian epidemic continues to be concentrated in populations with high-risk behavior characterized by unprotected paid sex, anal sex, and injecting drug use with contaminated injecting equipment. Several high-risk groups have high HIV prevalence, and sexual networks are wide and inter-digitating. According to India's National AIDS Control Organization (NACO), the bulk of HIV infections in India occur during unprotected heterosexual intercourse. Consequently, and as the epidemic has matured, women account for a growing proportion of people living with HIV (38 percent in 2005), especially in rural areas. The low rate of multiple partner concurrent sexual relationships among the wider community seem to have, so far, protected the larger body of people with 99 percent of the adult Indian population being HIV negative. However, although overall prevalence remains low, even relatively minor increases in HIV infection rates in a country of more than one billion people could translate into large numbers of people becoming infected.

Recent data suggests there are signs of a decline in HIV prevalence among sex workers in areas where focused interventions have been implemented, particularly in the southern states, although overall prevalence levels among this group continues to be high. Data also indicate that there is a slow decrease in HIV prevalence among the general population in southern states. Although more analysis is required, this probably means that the number of people becoming infected with HIV is decreasing. This decrease is more perceptible in states such as Tamil Nadu where the intensity of HIV prevention efforts has been high.

RISK FACTORS

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

Unsafe Sex and Low Condom Use: In India, sexual transmission is responsible for 84 percent of reported HIV cases, and HIV prevalence is high

among sex workers (both male and female) and their clients. In Mumbai and Pune, for example, 54 percent and 49 percent of sex workers, respectively, were found to be HIV-positive (NACO, 2005). A large proportion of women with HIV appear to have acquired the virus from regular partners who were infected during paid sex. HIV prevention efforts targeted at sex workers are being implemented in India. However, the context of sex work is complex, and enforcement of outdated laws often act as a barrier against effective HIV prevention and treatment efforts. Indeed, condom use is limited especially when commercial encounters take place in “risky” locations with low police tolerance for this activity. In addition, interventions tend to primarily target brothel-based sex workers, who represent a minority of sex workers. HIV information and awareness among sex workers appears to be low, especially among those working in the streets. Some prevention programs run by sex workers’ cooperatives—in Sonagachi, Kolkata, for example—have encouraged safe paid sex practices and have been associated with lower HIV prevalence (Kumar, 1998; Jana et al., 1998).

Men Who Have Sex with Men (MSM): Relatively little is known about the role of sex between men in India’s HIV epidemic, but the few studies that have examined this subject have found that a significant proportion of men in India do have sex with other men. In two states where data have been collected, HIV prevalence of 6.8 percent and 9.6 percent were found among MSM in Chennai and Mumbai, respectively (NACO, 2004). More recently, HIV prevalence of 12 percent was found among MSM seeking voluntary counselling and testing services in Mumbai, and 18 percent prevalence was found at 10 clinics in Andhra Pradesh. In some areas, a substantial proportion of MSM also sell sex. Poor knowledge of HIV has been found in groups of MSM. The extent and effectiveness of India’s efforts to increase safe sex practices between MSM (and their other sex partners) will play a significant role in determining the scale and development of India’s HIV epidemic.

Injecting Drug Use (IDU): Injecting drug use is the main risk factor for HIV infection in the north-east (especially in the states of Manipur, Mizoram, and Nagaland) and features increasingly in the epidemics of major cities elsewhere, including in Chennai, Mumbai, and New Delhi (MAP, 2005; NACO, 2005). Using shared injecting drug equipment is the main risk factor for HIV infection in the north-east and features increasingly in the epidemics of cities in other states. Products injected include legal pharmaceuticals (e.g., buprenorphine, pentazocine, and diazepam) in addition to heroin. Current interventions targeting IDU tend to be inconsistent and too small and infrequent to yield demonstrable results. Harm-reduction programs need to be extended and expanded as a matter of urgency in those parts of India with serious drug injecting-related HIV epidemics.

Migration and Mobility: Migration for work takes people away from the social environment of their families and community. This can lead to an increased likelihood to engage in risky behavior. Concerted efforts are needed to address the vulnerabilities of the large migrant population. Furthermore, a high proportion of female sex workers in India are mobile. The mobility of sex workers is likely a major factor contributing to HIV transmission by connecting high-risk sexual networks.

Low Status of Women: Infection rates have been on the increase among women and infants in some states as the epidemic spreads through bridging population groups. 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 their vulnerability.

Widespread Stigma: Stigma toward people living with HIV 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 scope of NACP was expanded 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 ended in March 2006. Under this phase, India continued to expand the program at the state level. Greater emphasis was 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. In order to induce a sense of urgency, the classification of states has focused on the vulnerability of states, with states being classified as high and moderate prevalence (on the basis of HIV prevalence among high-risk and general population groups) and high and moderate vulnerability (on the basis of demographic characteristics of the population).

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.

Preparations for the third included a comprehensive consultative process including state-specific and nationwide consultations with Indian national stakeholders such as PLWHA networks, local and international NGOs, experts and practitioners of HIV control initiatives, as well as international development partners. The transition from NACP 1 to NACP 2 and now NACP 3 is one of a gradually more comprehensive response.

While for NACP 1 the main focus was on safe blood and general prevention, NACP 2 established the State AIDS Control Societies and started working with NGO. Now with NACP 3, the government will build further on these partnerships with civil society organizations, but will also work towards greater active involvement of the target groups themselves in the program. There will be greater integration of the medical response to the epidemic, for example, through provision of ART, STI services, and treatment of opportunistic infections through the National Rural Health Mission. The surveillance system of the NACP was also greatly improved over the course of the first and second phase and will be further enhanced under the third phase.

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. 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.

Nongovernmental Organizations and Community-Based Organizations (NGOs and CBOs):

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 children orphaned by AIDS. Funding for nongovernment and community-based groups 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, and the Global Fund has approved US\$54 million for HIV/AIDS for projects in rounds two, three, and four. DfID (GBP 107 million) is providing pooled financing together with the Bank (US\$250 million) in overall support to India's HIV/AIDS program NACP 3. Other donors include the Clinton Foundation, various UN agencies, DANIDA, SIDA, and the European Union.

ISSUES AND CHALLENGES: PRIORITY AREAS

Limited Capacity: There are severe institutional capacity constraints, both structural and managerial, to scale up at the national and state levels. It is critical that these factors be addressed as the program expands its response to the epidemic. NACO will need to change its role and responsibilities to provide the necessary leadership and direction for a stronger multi-sector response for the next phase in India's fight against HIV/AIDS while the states will need to provide implementation capacity to put a robust program into place. 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 attention to performance-based financing approaches. In addition, the program also experiences high turnover of state-level project directors, resulting in limited continuity and variability in performance across states.

Donor Coordination: At present there are over 32 donor agencies working with NACO in different states and on different programs apart from many more who support NGOs in states. 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 informing 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. Stigma and denial undermine efforts to increase the coverage of effective interventions among high-risk groups such as men having sex with men, 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: The results from the 2005 BBC World Service Trust KAP survey (17 states, 22,800 respondents) showed 89 percent of the urban population and 82 percent of the rural population had heard of HIV/AIDS. However, sentinel site behavioral surveillance (2001) showed that although there were high basic awareness levels (82.4 percent in males and 70 percent in females), 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. 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. The use of State AIDS Societies to speed the distribution of funds at the state level helped increase the pace of implementation. Most recently, the Bank worked closely with the Government of India and other donors on the preparation of the third National HIV/AIDS Control Project (US\$250 million) which was signed in July 2007. NACP 3 will focus on coordinating all donor and NGO activities within the scope of the country's program on AIDS control, in consonance with the Three Ones. It proposes higher coverage of groups with high-risk behavior (NACP 2 covered 10-60 percent of groups with high-risk behavior; NACP 3 envisages covering 80 percent of the high-risk groups). NACP 3 also clearly differentiates activities that must be delivered through general health services and places responsibility on those relevant government health programs. It will also further support CBOs to deliver about half of all interventions targeting high-risk groups.

India

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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). The Bank has also carried out sector work on the economic consequences of the HIV/AIDS epidemic on India. In April 2007, the Bank, together with UNODC, AusAID, and SIDA, sponsored an inter-country consultation on preventing HIV among injecting drug users.

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