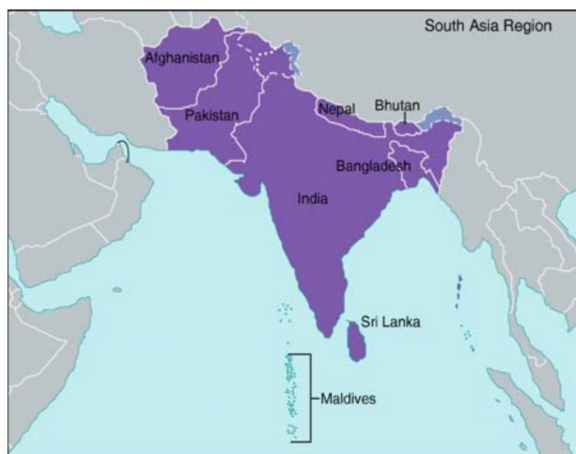
HIV/AIDS in India

THE WORLD BANK **February 2009**



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 2007, about 2.31 million Indians were living with HIV (1.8 – 2.9 million) with an adult prevalence of 0.34 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 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 of the most at-risk groups continue to have high HIV prevalence in 2007: injecting drug users (7.2 percent), men having sex with men (7.4 percent), female sex workers (5.1 percent), and attendees of sexually transmitted disease clinics (3.6 percent). 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 (39 percent in 2007), especially in rural areas. The low rate of multiple partner concurrent sexual relationships among the wider community seems 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 1 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 newly 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. Rising trends among the general population were observed in some low and moderate prevalence states in 2007, especially in Gujarat, Rajasthan, Orissa, and West Bengal. Increasing trends in the North East suggest a dual nature of the epidemic.

RISK FACTORS

Several factors put India in danger of experiencing 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, Thane, and Pune, for example, over 30 percent of female sex workers were found to be HIV positive (NACO, 2007). 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):** Recent expansion of surveillance among MSM has identified new pockets of the epidemic. While nationwide HIV prevalence is 7.4 percent, the prevalence mounts especially high among MSM in Karnataka (17.6 percent), Andhra Pradesh (17 percent), Manipur (16.4 percent), and Maharashtra (11.8 percent) (NACO, 2007). Moreover, urban areas of the country recorded very high HIV prevalence among MSM, and rising HIV trends have been observed in the southern states. 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. Similarly, interventions for wives of MSM (estimated 35 percent of MSM in India are married) need to be designed in view of increased HIV prevalence among MSM.

• **Injecting Drug Use (IDU):** Injecting drug use is the main risk factor for HIV infection in the North East (especially in Manipur, with an IDU prevalence of 17.9 percent) and features increasingly in the epidemics of Maharashtra (24.4 percent) and Tamil Nadu (16.8 percent). High prevalence among IDU persists also in the Punjab, Delhi, Chandigarh, and West Bengal. 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. While trends amond IDU are on a decline in Manipur, Nagaland, and Chennai, possibly reflecting impact of interventions, rising trends have been noted in other states. Interventions targeting IDU have been scaled up in 2008, resulting in the provision of 6,000 out of the 10,000 targeted IDU with oral substitution therapy, but overall interventions still tend to be small, and capacity of NGOs limited.

• **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. While interventions targeting migrants covered 45 percent of the estimated target group by the end of 2008, more 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 both within and outside of marriage, thereby increasing their vulnerability.

• **Widespread Stigma:** Stigma towards 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 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 been 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 Third Phase of NACP (NACP 3) is now almost two years old. The program is dramatically scaling up targeted interventions in order to achieve a very high coverage of the most at-risk groups. At the end of 2008, targeted interventions covered 931,643 most at-risk people, which stands for 52 percent of the target (49 percent for FSW, 65 percent for IDU, and 66 percent for MSM). Under NACP 3, surveillance and strategic information management also receive a big boost, which resulted in improved estimates of HIV prevalence as of 2006. While for NACP I the main focus was on safe blood and general prevention, NACP 2 established the State AIDS Control Societies and started working with NGOs. Now with NACP 3, government will build further on these partnerships with civil society organizations but 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, e.g., through provision of ART, STI services, and treatment of opportunistic infections through the National Rural Health Mission. NACP 3 is also shifting the focus from states to districts, based on the new evidence provided through a better surveillance system. The district focus allows not only the development of decentralized response to the epidemic but might lead to a greater convergence with the health systems and a higher coverage of the most at-risk groups.

Nongovernmental and Community-Based Organizations (NGOs and CBOs): There are numerous NGOs and CBOs working on HIV/AIDS issues in India at the local, state, and national levels. Projects include targeted interventions with most at-risk groups, direct care of people living with HIV, 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.

ISSUES AND CHALLENGES: PRIORITY AREAS

Limited Capacity: There are institutional constraints, both structural and managerial, to scale up at the national, state, and district levels. It is critical that these factors be addressed as the program expands and decentralizes its response to the epidemic. NACO will need to change in its role and responsibilities to provide the 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. Tailored capacity-building activities have been initiated, and many of the states are now supported by technical support units. Consistent support for the implementation of interventions by NGOs and decentralized activities by districts stays, however, crucial. In addition, the program also experiences high turnover of state-level key staff, resulting in limited continuity and variability in performance across states.

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.

Convergence with the Other Health Programs: While NACP 3 and the national health flagship program National Rural Health Mission provide a good framework for linkages between various services such as integrated counseling and testing, targeted intervention for groups at risk, treatment and prevention of sexually transmitted infection, tuberculosis, antenatal care and prevention of parent-to-child transmission of HIV, these linkages need to be strengthened to achieve the overall goals of the programs. Although coordination among different health programs has increased over the last year, real convergence and common monitoring of progress in cross referral and other linkages remains a challenge.

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 was 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 and 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 community-based organizations to deliver about half of all interventions targeting high risk groups.

The Bank has 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. In close collaboration with NACO, the World Bank currently also carries out an impact evaluation of the targeted interventions, supports capacity building activities for MSM groups in the South Asia region, and carried out a situation analysis of the Life Skills program in India.

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