CHAPTER - IV
HIV / AIDS SCENARIO IN INDIA

4.1 Prevalence of the infection

The Acquired Immuno- deficiency Syndrome (AIDS) and its etiological agent - the Human Immuno-deficiency Virus (HIV) erupted into the world scene in the early 1980s. In a relatively short time, the virus has affected a large number of people across the globe. After the middle of the twentieth century HIV infection developed into a serious epidemic in a number of countries mainly in Africa. By 1985, HIV/AIDS had developed into a full scale pandemic around the world with a significant presence in every continent and by 2002, some 3 million had died of AIDS. AIDS is a global problem, has global consequences, no region of the world has been spared. AIDS has evolved from a mysterious illness to a global pandemic which has infected more than tens of million in less than 25 years.

The HIV epidemic is truly global and no region is immune. From 2004 to 2006, the number of people who are HIV-positive increased in every world region. It is not simply regions which have high HIV prevalence that must be concerned about HIV since, once HIV gains a foothold, only a concerted effort can stop its spread.

From 2004 to 2006, UNAIDS estimates that the number of people living with HIV/AIDS rose from 36.9 to 39.5 million. The number of new HIV infection of adults and children also increased from 3.9 to 4.3 million from

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2. Ibid, p.262
2004 to 2006 as did the number of adults and children who died from AIDS, from 2.7 to 2.9 million. In countries, the rise of HIV has been turned back particularly where its presence was recognized early on. HIV has no assurance of winning provided that the fight against it is vigorous and sustained. South and South-East Asia are now an epicentre of the HIV epidemic.

India is only second to South Africa in the estimated total number of persons with HIV infection. The HIV/AIDS epidemic represents the most serious public health problem in India. There is no denial of the enormity of the problem. The prevalence of the infection in all parts of the country highlights the spread from urban to rural areas and from high risk to the general population. Migration of labour, low literacy levels leading to low awareness, gender disparities, prevalence of sexually transmitted diseases and reproductive tract infections are some of the factors attributed to the spread of HIV/AIDS.

Routes of transmission for young unmarried adults include sexual relations with multiple infected partners, commercial sex workers (CSWs), lack of use of condoms and un-admitted homosexual relations. The projection of the World Health Organisation indicate that by 2010, half of the AIDS patients in the world will be from India. When India’s first case of AIDS was reported in 1986, there were around 20,000 reported cases

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5. Ibid. p.6.
6. Ibid.
of AIDS worldwide.\textsuperscript{11} Since then the epidemic has grown into a public health problem of unprecedented magnitude and has become a threat to human survival and development.\textsuperscript{12} Women and children have become the worst sufferers.\textsuperscript{13} The epidemic is marked by heterogeneity, It is made up of a number of epidemic and in some places within the state. The epidemic shifts from the high risk population to bridge population (clients of sex workers, STD patients and partners of drug users), and then to the general population. There is a time of 2-3 years between the shift from one group to another.

The epidemic continues to shift towards women and towards young people with an accompanying increase in vertical transmission and pediatric HIV. Low levels of infections in a large population like India can translate into large number of new infections.\textsuperscript{14} Since 1990, 90 percent of new cases of HIV infection in adults globally occurred through heterosexual transmission.\textsuperscript{15} In addition, transfusion of unsafe blood can cause infection among no-risk general population.

India has a population of 1 billion, around half of whom are adults in the sexually active age-group. The spread of HIV in India has been diverse, with much of India having a low rate of infection and the epidemic being most extreme in the southern half of the country and in the far north-east. The highest HIV prevalence rates are found in Maharashtra, Andhra Pradesh

\textsuperscript{12} Dzenovska, D., Rasheed, N., Sandkjaer, B.,(2005), "HIV/AIDS and Development : The matic Guidance Note UNDP.
\textsuperscript{13} UNDP (2005), "Who's got the power ! Transforming health systems for women and children ," UN Millennium Project.
and Karnataka in the south; Manipur, Mizoram and Nagaland in the north-east.¹⁶

Four southern states, Andhra Pradesh, Maharastra, Tamil Nadu and Karnataka account for around 63 percent of all people living with HIV in India.¹⁷ In the southern states, HIV is primarily spread through heterosexual contact, whereas infections are mainly found amongst injecting drug users and sex workers in the north-east.

The recent estimates with improved methodology put the number of HIV-infected individuals in all ages at 2.5 million where previous estimates based on a cruder methodology put the number at between 4 and 5 million. Overall adult prevalence is 0.36 percent being more in males (0.43 percent) than in females (0.29 percent).¹⁸ Over 35 percent of all reported AIDS cases in India occur in the ages group of 15-24 years.¹⁹ Table No. - 1 shows the estimated number of people living with HIV/AIDS, 2007.²⁰

| TABLE - 1 |
| ESTIMATED NUMBER OF PEOPLE LIVING WITH |
| HIV/AIDS IN INDIA, 2007 |
| People Living with HIV/AIDS | 2.4 million |
| Adult (15 years and above) HIV Prevalence | 0.3 % |

The national adult HIV prevalence is 0.36 percent. Prevalence trends in India vary greatly between states and regions. Even in the four southern

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¹⁷ Ibid
states (Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu) where the large majority of people living with HIV are residing. HIV prevalence varies and the epidemic tends to be concentrated in certain districts (NACO, 2005 : World Bank, 2005).\textsuperscript{21} Reported adult HIV prevalence in six states included in the recent national population - based survey (NFHS - 3, 2007) varied from 0.07 percent in Uttar Pradesh to 0.34 percent in Tamil Nadu, 0.6 percent in Maharashtra, 0.69 percent in Karnataka, 0.97 percent in Andhra Pradesh and 1.13 percent in Manipur. Prevalence in all states together was 0.13 percent.\textsuperscript{22} Analysis of sentinel surveillance data also showed that HIV prevalence in southern states overall was about 5 times higher than in northern states in 2000 - 2004. Figure-1\textsuperscript{23} shows the distribution of

\textbf{Figure - 1}

\textit{Distribution of People Living With HIV/AIDS among High Burden States: 2006}

\begin{itemize}
  \item Andhra Pradesh: 22%
  \item Karnataka: 11%
  \item Tamil Nadu: 10%
  \item Maharashtra: 20%
  \item Remaining States: 37%
\end{itemize}

\textsuperscript{22} Ibid, p . 26
\textsuperscript{23} Ibid,p.27
people living with HIV/AIDS among High Burden States: 2006. High HIV Prevalence (mainly among population groups at high risk of exposure to HIV) have also been identified in states where overall prevalence is generally low, warning against complacency.

Mizoram and Goa have an estimated adult HIV prevalence as high as 0.70-0.80 percent each, close to the HIV prevalence in some of the high burden states. Pondicherry and Gujarat also have an estimated adult HIV prevalence of around 0.5 percent. ²⁴

The highest number of people living with HIV/AIDS are in Andhra Pradesh and Maharastra, with nearly 0.5 million people living with HIV/AIDS each. Along with Tamil Nadu and Karnataka, the four south Indian states contribute 63 percent of all the people living with HIV/AIDS in the country.²⁵ Though Manipur and Nagaland have the highest prevalence in the country, due to small population size, the estimated number of people living with HIV/AIDS in these two states is around 25,000. Overall, the six high prevalence states contribute 65 percent of all people living with HIV/AIDS in the country. West Bengal, Gujarat and Uttar Pradesh have higher burden of the epidemic with greater than 0.1 million people living with HIV/AIDS in each of the states. Similarly, the states of Kerala, Bihar, Rajasthan, Orissa, Chattisgarh, Madhya Pradesh and Haryana have around 50,000 people living with HIV/AIDS each though the HIV prevalence in these states is low.²⁶

Result from National Family Health Survey - 3 indicate female-to-male ratio is higher in urban areas (0.71) than in rural areas (0.56). The HIV prevalence rate is 40 percent higher in urban areas than in rural areas.

²⁴. Ibid, p.27
²⁵. Ibid, p.28
²⁶. Ibid, p.32
and prevalence rate are higher for men than for women in every age group except 15-19, where the rates are very low overall. Women and men have similar age patterns, with HIV prevalence increasing with age up through age 30-34, 0.45 percent of women and 0.64 percent of men are HIV-positive. By education, the HIV prevalence rate for men is highest for those who have no education. The highest rates of HIV prevalence are for women and men who are divorced, separated or deserted and for women who are widowed, although the precision of the estimated for these group is low due to the small number of cases. Among youth, HIV prevalence is higher for women age 20-22 and for men age 23-24. For youth, the highest levels of HIV prevalence among the five high HIV prevalence states are found in Manipur and Karnataka for women and in Andhra Pradesh and Manipur for men.

Pattern of discordance is seen for the high HIV prevalence states. In each of these states, when there is discordance, the man is much more likely than the woman to be HIV-positive. In the five high HIV prevalence states combined, men are almost six times as likely to be HIV-positive than women when the couple has discordant results. About 1 percent of all married couples in Manipur, Karnataka, and Andhra Pradesh have discordant HIV results. Manipur has the highest percentage of couples in which both marital partners are HIV-positive (0.62 percent) and the highest percentage in which at least one of the marital partners is HIV-positive (1.61 percent).

28. Ibid, p. 394
29. Ibid, p. 402
30. Ibid, p- 404
Table No - 2 shows the HIV prevalence among couples by State.

**TABLE - 2**

**HIV PREVALENCE AMONG COUPLES BY STATE**

<table>
<thead>
<tr>
<th>State</th>
<th>Both HIV positive</th>
<th>Man HIV positive, woman HIV negative</th>
<th>Woman HIV positive, man HIV negative</th>
<th>Both HIV negative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andhra Pradesh</td>
<td>0.38</td>
<td>0.83</td>
<td>0.13</td>
<td>98.66</td>
<td>100.0</td>
</tr>
<tr>
<td>Karnataka</td>
<td>0.34</td>
<td>0.82</td>
<td>0.15</td>
<td>98.69</td>
<td>100.0</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>0.32</td>
<td>0.58</td>
<td>0.11</td>
<td>98.99</td>
<td>100.0</td>
</tr>
<tr>
<td>Manipur</td>
<td>0.62</td>
<td>0.89</td>
<td>0.10</td>
<td>98.39</td>
<td>100.0</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>0.14</td>
<td>0.29</td>
<td>0.04</td>
<td>99.53</td>
<td>100.0</td>
</tr>
<tr>
<td>Total for five high prevalence states</td>
<td>0.31</td>
<td>0.64</td>
<td>0.11</td>
<td>98.95</td>
<td>100.0</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>0.00</td>
<td>0.10</td>
<td>0.05</td>
<td>99.85</td>
<td>100.0</td>
</tr>
<tr>
<td>Total for five high prevalence states and Uttar Pradesh</td>
<td>0.21</td>
<td>0.47</td>
<td>0.09</td>
<td>99.23</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*All other states*¹

| Not including Uttar Pradesh | 0.03         | 0.20   | 0.05     | 99.72     | 100.0 |

| Including Uttar Pradesh    | 0.02         | 0.18   | 0.05     | 99.74     | 100.0 |
| Except Nagaland            |              |        |          |           |       |


4.2. Level of HIV epidemic among different population groups

The overall HIV prevalence among different population groups in 2006 continues to portray the concentrated epidemic in India, with a very high prevalence among High Risk Groups- Intravenous Drug Users, Men Having Sex With Men, Female Sex Worker, Sexually Transmitted Disease, Clinic attendees and very low prevalence (<1 percent) among antenatal clinic attendees. Figure 2 depicts the concentrated nature of HIV epidemic in India. Injecting drug use emerged as an important mode of HIV
transmission, with highest HIV prevalence among IDUs. Homosexual route of transmission among men also emerged to be significant in different parts of the country.\textsuperscript{31}

\textbf{Figure - 2}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure2}
\caption{HIV Prevalence Group Among Different Population Group, India 2006}
\end{figure}

\begin{tabular}{|c|c|}
\hline
Population Group & Percent Positivity \\
\hline
ANC (Antenatal Clinic) & 0.60 \\
STD (Sexually Transmitted disease) & 3.74 \\
IDU (Injecting Drug Users) & 6.92 \\
MSM (Men Having Sex With Men) & 6.41 \\
FSW (Female Sex Worker) & 4.90 \\
\hline
\end{tabular}

\textsuperscript{31} Ibid, p.401
The National Family Health Survey conducted between 2005 and 2006 measured HIV prevalence among the general adult population of India, as presented in Table No - 3. The survey found the rate among men to be considerably higher than among women.

**TABLE - 3**

**HIV PREVALENCE AMONG THE GENERAL ADULT POPULATION OF INDIA**

<table>
<thead>
<tr>
<th>Age group</th>
<th>HIV Prevalence ( % )</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>15 -19</td>
<td>0.01</td>
<td>0.07</td>
<td>0.04</td>
</tr>
<tr>
<td>20 - 24</td>
<td>0.19</td>
<td>0.17</td>
<td>0.18</td>
</tr>
<tr>
<td>25 - 29</td>
<td>0.43</td>
<td>0.28</td>
<td>0.35</td>
</tr>
<tr>
<td>30 - 34</td>
<td>0.64</td>
<td>0.45</td>
<td>0.54</td>
</tr>
<tr>
<td>35 - 39</td>
<td>0.53</td>
<td>0.23</td>
<td>0.37</td>
</tr>
<tr>
<td>40 - 44</td>
<td>0.41</td>
<td>0.19</td>
<td>0.30</td>
</tr>
<tr>
<td>45 - 49</td>
<td>0.48</td>
<td>0.17</td>
<td>0.33</td>
</tr>
<tr>
<td>Total age 15-49</td>
<td>0.36</td>
<td>0.22</td>
<td>0.28</td>
</tr>
</tbody>
</table>


Although the reporting of cases of AIDS is incomplete, it is clear that HIV predominately spreads through India by sexual contact. In some states of the North-east, it is likely that HIV is contracted by drug users who share needles before moving into the general population. Unsafe blood transfusion and perinatal, or mother-to-child transmission, can play a significant role. Thus far, reported AIDS cases have primarily been among males. This pattern has often been observed globally but, as the epidemic progresses, the proportion of infected females typically rises. The current pattern of reported cases by sex suggests that India is in an early stage of an epidemic, offering a real opportunity to keep HIV in check.32

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The Route of Transmission Categories is shown in Table No - 4

TABLE - 4
ROUTE OF TRANSMISSION CATEGORIES

<table>
<thead>
<tr>
<th>Transmission Categories</th>
<th>No. of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual</td>
<td>106,669</td>
<td>86%</td>
</tr>
<tr>
<td>Mother to Child</td>
<td>4,755</td>
<td>4%</td>
</tr>
<tr>
<td>Blood and blood products</td>
<td>2,563</td>
<td>2%</td>
</tr>
<tr>
<td>Injecting drug users</td>
<td>2,930</td>
<td>2%</td>
</tr>
<tr>
<td>Others (not specified)</td>
<td>8,078</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>124,995</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>


HIV prevalence among antenatal clinic attendees remained greater than 1 percent in Andhra Pradesh (1.26 percent), Manipur (1.25 percent) and Karnataka (1.0 percent). Nagaland showed close to 1 percent HIV prevalence. In addition, Mizoram showed a HIV prevalence of 1 percent among antenatal clinic attendees. Maharashtra and Tamil Nadu showed HIV prevalence of 0.75 percent and 0.25 percent respectively among antenatal clinic attendees. Goa, Gujarat, Bihar and Orissa have shown a HIV prevalence of 0.5 percent among antenatal clinic attendees.

At the district level, a total of 118 districts have shown HIV prevalence greater than 1 percent among antenatal clinic attendees. Out of these, 26 districts are in low prevalence states - Gujarat (6), Madhya Pradesh (4), Orissa (4), Uttar Pradesh (3), Mizoram (2), West Bengal (2), Arunachal Pradesh (1), Bihar (1), Chhattisgarh (1), Haryana (1) and Rajasthan (1). 14 districts have shown a very high prevalence of greater than 3 percent among antenatal clinic attendees.
Among the Sexually Transmitted Disease clinic attendees, HIV prevalence is very high in Andhra Pradesh (24.4 percent) followed by Maharashtra (10 percent), Goa (8.6 percent), Tamil Nadu (8 percent) and Karnataka (7.5 percent). 12 other states have shown HIV prevalence between 1 percent and 5 percent among Sexually Transmitted Disease clinic attendees. Remaining states showed less than 1 percent prevalence.

At the district level, 48 districts have HIV prevalence greater than 5 percent among Sexually Transmitted Disease clinic attendees, out of which 13 districts are in low prevalence states - Gujarat (3), Goa (2), Delhi (2), Madhya Pradesh (2), Mizoram (1), Rajasthan (2), Pondicherry (1).

4.3. Trends of HIV Epidemic

Based on the revised estimates, the HIV epidemic in the country has been declining. The estimated adult HIV Prevalence in the country has declined from 0.45 percent in 2002 to 0.36 percent in 2006. The total number of People Living With HIV/AIDS in the country is also declining from 2.73 million in 2002 to 2.47 million in 2006. The percent of People Living With HIV/AIDS who are females continues to be around 39 percent. Figure 3 shows the trends of adult HIV Prevalence and the number of People Living
Trends among different population groups at national as well as state level are derived based on the HIV prevalence at consistent sites from 2003 to 2006. At all level, the trends of HIV prevalence among antenatal clinic attendees as well as among Intravenous Drug User and Female Sex Worker show a decline, while among MSM, it is stable.

4.4. Epidemiological Patterns of HIV Epidemic in India

Recent estimates of HIV infection show that, of the 2.5 million People Living with HIV/AIDS in 2006, 88.7 percent are adults (15-49 years), 7.5 percent are aged 50 and above, while 3.8 percent are children (<15 years). The proportion of infections among children and adults above 50 years age has been increasing during the past five years.
Females constitute 39.3 percent of the PLHA in the country. Figure 4 and 5 shows the distribution of PLHA in India by age and gender respectively.

**Figure 4.**
Percentage distribution of PLHIV by age, India, 2006

**Figure 5.**
Percentage distribution of PLHIV by gender, India, 2006
HIV infections are greater among the urban population than in the rural population. However, some states such as Punjab, Uttar Pradesh and Tamil Nadu have shown higher HIV Prevalence among rural populations.

4.5 Awareness of HIV/AIDS

NACO has conducted two national Behavioural Surveillance Surveys (BSS), one in 2001 and the second in 2006, to investigate a wide variety of issues related to HIV/AIDS. The surveys show the significant progress India has made in informing the population of the threat of HIV. From 2001 to 2006, the percentage of survey respondents who said that they had heard of HIV/AIDS rose from 67 percent to 80 percent. But both the level of knowledge and the increase from 2001 to 2006 varied greatly from state to state.\(^{33}\)

In some states, the level of awareness of HIV/AIDS varies considerably between men and women, particularly where the overall level of knowledge is low. In every state, HIV/AIDS knowledge is lower among women than among men. This lack of awareness increases the risk of contracting the disease among women, particularly if their husbands act as a "bridge," infecting them with HIV. However, the surveys also show that the national level of awareness among women did rise from 59 percent in the 2001 BSS to 73 percent in 2006, a larger increase than among men (from 76 percent to 87 percent).\(^{34}\)

Simply having heard of the existence of HIV is not sufficient. One must also be aware of the ways in which it can be contracted. While the


\(^{34}\) Ibid, p.16.
must also be aware of the ways in which it can be contracted. While the majority of people in India did express awareness of the principal means by which HIV spreads and the proportion has improved since 2001, large numbers of people are not aware of the transmission paths. In several states - Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh and Rajasthan - less than half of women were aware that HIV spreads through sexual contact. Additionally, awareness that HIV can be passed to a child by breastfeeding was particularly low, expressed by only about half of the respondents in both surveys. This is especially tragic since that mode of transmission can be easily avoided.\textsuperscript{35}

Beyond knowledge of the existence of HIV and the ways in which it spreads, knowledge of the steps one can take to avoid infection is clearly necessary. While awareness on this vital issue has been rising, the BSS indicates that one-third of people in India are still unaware of several fundamental ways to avoid HIV. Further, the BSS also shows that such knowledge remains lower for women than for men.\textsuperscript{36}

Awareness of the condom and its role in avoiding HIV has become nearly universal in some states of India although, in others, there is much more work to be done. Condom awareness has shown a particularly sharp rise in the northe-astern states where HIV often spreads through intravenous drug users who share needles, a group that may be more difficult to reach.\textsuperscript{37}

Knowledge of HIV infection, its routes of transmission and ways to avoid it is more widespread among those with higher levels of education. Virtually all of those who are graduate or with higher education were aware

\textsuperscript{35} Ibid, p.17
\textsuperscript{36} Ibid, p.17.
\textsuperscript{37} Ibid, p.18
of the condom in the 2006 BSS while only a little more than half of illiterates. While such a disparity may not be unexpected, it shows that public education programmes must use a wide variety of techniques to reach a population with very diverse educational and literacy levels.  

In addition to awareness of the condom itself and its role in preventing HIV, it is also essential for those who need them to be aware of a source where condoms can be procured or purchased. From 2001 to 2006, there was a sharp increase in the percentage of respondents who said that condoms were easily available in their area. It should be kept in mind, however, BSS surveys results do show that informational programmes about the condom have had a considerable effect.  

In India, risky sexual behaviour is the primary cause of the spread of HIV infection. In many states, respondents in the BSS reported rather high levels of sex with non-regular partners. The risk of HIV infection is not confined to those who engage in such behaviour but also endangers a regular partners, such as a spouse or an unborn child or a young child being breastfed. Males reported sex with non-regular partners much more frequently than females, but the BSS notes that female respondents may have under-reported their sexual activity. In states with high proportions of male reporting sex with non-regular partners, such as Andhra Pradesh and Tamil Nadu, similarly high percentages reported sex with commercial sex workers.

There has, however, been a sharp increase in those reporting consistent condom use with non-regular partners, giving evidence that

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38 Ibid, p.18
40 Ibid, p. 20
condom promotional programmes can and do meet with success. The BSS indicates that overall condom awareness has risen, the proportion of those using them in risky sex has increased and that sex workers are more likely to insist upon their use. But, despite the rise, India remains far from the goal of universal, consistent condom use during risky sex.\(^{41}\)

Spending time away from one’s home increases the likelihood of having sex with a non-regular partner, often with a commercial sex worker. Those in transport occupations reported the largest frequency of non-regular sex and it is probable that the migratory population’s experience in similar. Condom use with a non-regular partner appears to be greatly influenced by exposure to media messages, giving evidence of the value of such outreach campaigns. Media exposure of cultivators in rural areas is likely to be somewhat less frequent and BSS responses do reflect lower condom use among that group.\(^{42}\)

4.6 NATIONAL AIDS CONTROL ORGANISATION (NACO)

The Government of India, immediately, following the first report of HIV-positive case from Chennai constituted the National AIDS Control Programme in 1987, which aimed at containing the spread of HIV in order to reduce the future morbidity and mortality. The focus of the programme was on increasing the awareness of HIV/AIDS, screening of blood for HIV and testing of HIV for individuals practicing high risk behaviours. In 1992, The National AIDS Control Organization (NACO) was established by the Ministry of Health and Family Welfare to manage the programme. In the same year, the comprehensive phase - I AIDS Control Programme was launched with the financial assistance of US dollar 84 million from the World

\(^{41}\) Ibid, p. 20

\(^{42}\) Ibid, p. 21

Bank for a period of five years. Later it was extended upto March 1999.\textsuperscript{43}

In 2002, NACO II stepped up its effort against HIV/AIDS with a revised strategy and implementation plan and is committed to prevent further spread of AIDS epidemic and strengthen India's capacity to respond to HIV/AIDS epidemic in long term basis. NACO promotes an expanded response to HIV/AIDS through a range of activities focussing on technical areas including research, advocacy, targeted interventions, greater involvement of people living with HIV/AIDS and care and support.\textsuperscript{44} NACO also provide policy direction so that prevention and care initiaturs, throughout the country are focussed on the most critical challenge. NACO assists the development of programme in all 35 states and union territories, with six of these states considered high priority. India's National AIDS Policy strongly reiterates the government commitment to prevent the spread of HIV infection and reduce the impact of the epidemic on communities and individuals. The policy clarifies that no individual should undergo mandatory testing for HIV.\textsuperscript{45}

Beginning in 1992, India established the National AIDS Control Programme which will begin its third phase (NACP-3) in 2007. Also in 1992, a State AIDS cell was established in Tamil Nadu to improve programme effectiveness at the state level. Today, there are AIDS Control Societies in cities throughout India which are able to operate efficiently and allocate funds quickly.\textsuperscript{46} NACP-3 target high risk groups, access to condoms to be expanded and universal access to blood screening and safe blood to be ensured, more hospitals to provide treatment to prevent transmission of HIV/AIDS from mother to child, provision for AIDS Control Programme to be


\textsuperscript{45} Ibid.

\textsuperscript{46} Population Foundation of India, Joint United Nations Programme on HIV/AIDS (UNAIDS), Population Reference Bureau,(2007) HIV/AIDS in India, p.32

The National AIDS Control Organisation (NACO) in Delhi is the nodal agency for coordinating the national HIV strategy. Its many functions include:

- Public HIV Education
- National Media Campaigns
- Condom Promotion
- Blood Safety
- Sentinel Site Testing Programme
- HIV/AIDS/STD Prevention and Control
- Care and Support for People Living with HIV/AIDS
- Targeted Interventions among High-risk Groups
- National Family Health Awareness Campaign
- Prevention of Mother to Child Transmission
- Voluntary, Confidential, Counseling and Testing
- National Behavioural Surveillance Surveys
- Programme Financing
- Financing of and Coordination with State AIDS Control Society
- Monitoring and Evaluation
- Research and Development.

Under India’s Tenth Five-Year Plan, HIV/AIDS targets were set as follows:

- 80 percent coverage of high risk groups through targeted interventions
- 90 percent coverage of schools and colleges through education programmes

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49. Ibid, p.34
- 80 percent awareness among the general population in rural areas
- Reducing transmission through blood transfusion to less than one percent
- Establishing at least one voluntary testing and counseling centre in every district
- Expansion of prevention of mother-to-child transmission to the district level
- Achieving zero level increase of HIV/AIDS by 2007

Under India's Eleventh Five-Year Plan, HIV/AIDS targets were set as follows.\(^5^0\)
- Institute special provisions to increase rural women's and children's access to anti-retroviral treatment (ART)
- Increase allocation of funds for ART and treatment for women living with HIV/AIDS
- Health insurance to cover chronic illnesses such as HIV/AIDS and TB, as well as morbidity
- Introduce sex education in school curriculum with full support from central and state mechanisms.
- Encourage voluntary testing for HIV/AIDS.

National AIDS Control Programme -2 had two main strategies: first, cost-effective interventions among commercial sex workers, injecting drug users, migrant workers, men having sex with men and STI/STD clinic attendees, along with interventions for the general community and low cost AIDS care. And, second, strengthening institutions, such as the State AIDS Control Society and intersectoral collaboration with NGOs and experts in


\(^{51}\) Ibid, p. 34
In order to achieve the national goals, NACO works with the national media and elected representatives and assists states in developing informational activities appropriate for their local audiences. To ensure a safe blood supply, over 2,200 blood banks were established by 2006. The External Quality Assessment Scheme (EQAS) was established in 1999 to ensure uniform standards to blood testing and to continue qualitative improvement. The National Institute of Biologicals (NIB) in Noida, Uttar Pradesh is the Apex Laboratory for the EQAS programme. With a goal of providing Voluntary Counseling and Testing Centres (VCTCs) in every district, model VCTCs have been set up in Chennai, Imphal and Mumbai to demonstrate best practices in HIV testing and psychological support and to standardize procedures. In addition, pregnant women receive antenatal care and HIV testing at Integrated Counselling and Testing Centres (ICTCs). In 2006, the number of women tested rose to over 1.5 million. A key component of NACP-3 will be the involvement of tribal communities. A Social Assessment has been carried out and a Tribal Action Plan (TAP) prepared by NACO.\(^52\)

NACO is responsible for policy level guidance, overseeing the programme, allocation of public funds to the states, approval of proposed control activities and co-ordination with other donor partners. The objectives of the National HIV/AIDS policy were.\(^53\)

1) Prevent the spread of HIV/AIDS and reduce its personal and social impact. The main activities include control of STIs; promotion of condom use; provision of HIV testing and

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\(^{52}\) Ibid, p.35  
\(^{53}\) GOI, "Burden of Disease in India, Background papers of the National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, New Delhi, September 2005, p.47.
counselling, care and support for people with HIV/AIDS; surveillance; harm reduction for injecting drug users, provision of safe blood and blood products and support for research and development.

2) Generate ownership of the control programme by government organizations at the national, state and local levels.

3) Create an enabling environment for prevention and treatment efforts.

4) Decentralize HIV/AIDS control activities.

5) Strengthen programme management at all levels, promote introduction of control activities in other government programme.

6) Provide support to vulnerable groups.

7) Provide support including treatment to people with HIV/AIDS.

8) Work with multilateral and bilateral donors.

9) Promote better understanding of HIV/AIDS, specially among high-risk groups.

The Indian Ministry of Social Justice and Empowerment has established 450 drug de-addiction centres in partnership with NACO. NACO supports harm-reduction activities provided by NGOs. Common activities include Needle and Syringe Exchange Programme (NSEP) substitution therapy, de-addiction, peer education and outreach, primary health care, counselling, drop-in-centres and vocational rehabilitation programme. NACO had approved Needle Syringes Exchange Programme operating in Manipur, New Delhi, Mumbai, Kolkata and Chennai. Substitution therapy with the use of sublingual buprenorphine is currently ongoing in five major Indian cities, New Delhi, Kolkata, Imphal, Mumbai and Chennai.\(^\text{54}\)

\(^{54}\) Ibid, p. 48.
NACO has been expanding Voluntary Counselling and Testing Centres (VCTC) since 1998. Significant progress has been made with the technical support of World Health Organization and United Nations Programme on HIV/AIDS. All districts in the six high-prevalence states have at least one VCTC. NACO is planning to expand VCTC to the subdistrict level in all states to improve the accessibility of services. A monitoring and Supervision system for the performance and quality of VCTC has now been established.\(^{55}\)

With the support of UNICEF, NACO launched the national prevention of parent-to-child transmission (PPTCT) programme. The key components included antenatal care, HIV counselling and testing, safe delivery practices, administering nevirapine (NVP) to the mother and baby and counselling for infant feeding options. The programme covers 286 institutions including nationwide private and governments medical colleges and all the districts in the six-high prevalence states of India.\(^{56}\)

12 percent of NACO's budget has been allocated to care and support for People Living With HIV/AIDS (PLWHA). Substantial amount of HIV/AIDS care and support is provided by NGOs and community based organizations, including associations of People Living With HIV/AIDS. These organizations deliver nutrition information, counselling for People Living With HIV/AIDS and their families, school fee support, vocational training and in some cases provision of drugs for opportunistic infections.\(^{57}\)

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\(^{55}\) Ibid, p.49.

\(^{56}\) Ibid, p. 49

\(^{57}\) Ibid, p.50
India made impressive progress since the announcement of a free ART programme on 1st December 2003 and free ART programme was launched in April 2004 at eight tertiary hospitals in the six high-prevalence states of India plus the capital city, Delhi. Antiretroviral drugs were procured with the help of World Health Organization.\footnote{Ibid, p.50.}

A key element in the campaign against HIV is the treatment of HIV-positive persons. ART greatly improves the quality of life for HIV-positive people, extends their life span and helps to remove the stigma against them when it is seen that they can live normal lives. When ART is fully integrated into mainstream health services, patients are likely to seek treatment more readily and others, who may only suspect that they are HIV-positive, will be more willing to come for a test.\footnote{Population Foundation of India, Joint United Nations Programme on HIV/AIDS (UNAIDS), Population Reference Bureau,(2007) HIV/AIDS in India, p.36}

Yet, ART is a complex treatment process that must be continuously maintained. The programme must also overcome logistical difficulties, such as delivering services to the rural population as well as the urban. This will be a major goal of NACP-3. In 2007, the number of NACO-supported ART centres passed 100, in addition to 10 centres involving public-private partnerships and funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. This phase includes scaling up prevention of Parent-to-Child Transmission of HIV (PPTCT), strengthening the over 1,800 PPTCT centres and expanding PPTCT services to Community Health Centres.\footnote{Ibid n.38}

There are 307 Government Prevention of Mother to Child Transmission facilities in 15 states providing comprehensive services. In 2008, second-line antiretroviral treatment was initiated for an estimated
3000 people who have become resistant to first line drugs. Only about 95,000 people (less than 15 percent of those in need) were receiving HAART by the end of 2006, a form of treatment which delays progress to AIDS through antiretroviral second line treatment is estimated to be available to only a marginal proportion of those in need.\textsuperscript{61}

India currently has no law to protect People Living with HIV/AIDS against discrimination. The proposed HIV/AIDS bill proposes protection of inheritance and property rights as well as protection against discrimination in health care/education/employment, and discusses creating a health ombudsperson in all districts to curb growing stigma.\textsuperscript{62}

In the next chapter HIV/AIDS scenario in Manipur has been presented.

\textsuperscript{62} Ibid.