



HIV/AIDS HEALTH PROFILE

HIV and AIDS Estimates	
Total Population*	1.2 billion (mid-2010)
Estimated Population Living with HIV/AIDS**	2.4 million (2009)
Adult HIV Prevalence**	0.3% [0.3–0.4%] (2009)
HIV Prevalence in Most-at-Risk Populations**	IDUs: 9.2% (New Delhi) (2009) MSM: 7.3% (New Delhi) (2009) FSWs: 4.9% (New Delhi) (2009)
Percentage of HIV-Infected People Receiving Antiretroviral Therapy***	36–55% (estimates, 2009)

*U.S. Census Bureau **UNAIDS and UNGASS ***WHO/UNAIDS/UNICEF *Towards Universal Access*, 2010

The first HIV/AIDS case in India was identified in Chennai, the capital of Tamil Nadu state, in 1986. Twenty-four years later, 2.4 million Indians are HIV positive, according to an estimate from the National HIV Sentinel Surveillance (United Nations General Assembly Special Session [UNGASS], 2010). Between 2001 and 2009, however, HIV incidence fell by more than 25 percent, and estimated national prevalence remains below 1 percent. This figure is significantly lower than previous estimates that used only sentinel surveillance data but is considered more accurate because it is based on a national household survey (National Family Health Survey, 2005–2006, [NFHS-3]). It is also supported by expanded national surveillance efforts, which estimate a national adult prevalence of 0.29 percent (UNGASS, 2010).

According to the 2010 UNGASS HIV country report, India’s epidemic is concentrated within most-at-risk-populations (MARPs), with prevalence substantially higher among these populations than in the general population. Prevalence also varies dramatically by district, state, and region, with numerous isolated pockets of high prevalence. Approximately 60 percent of people living with HIV/AIDS (PLWHA) live in the six high-prevalence states, although prevalence in the general adult population of these states has recently experienced an overall decline. Even in states with low prevalence, there are pockets of high prevalence, and some are seeing increases in new infections. Rising trends among antenatal care (ANC) clinic attendees have been observed in the low- and moderate-prevalence states of Gujarat, Rajasthan, Orissa, Uttar Pradesh, Bihar, and West Bengal. At the national level, trends among ANC clinic attendees and female sex workers (FSWs) appear to be on the decline, although in some parts of southern India, up to 15 percent of FSWs are HIV positive. Trends among injecting drug users (IDUs) vary, with considerable differences between regions. Trends of increasing HIV prevalence among men who have sex with men (MSM) are generating concern, with estimates from the 2008–2009 National HIV Sentinel Surveillance at 7.3 percent in New Delhi, up from 6.4 percent in 2006. Particularly high HIV prevalence among MSM has been reported in parts of southern India (between 7 and 18 percent) and in rural areas of Tamil Nadu state (9 percent).

According to the 2010 report of the Joint United Nations Program on HIV/AIDS (UNAIDS), sexual intercourse is the primary mode of HIV transmission in India, accounting for about 90 percent of new HIV infections. More than 90 percent of infected women acquired the virus from their husbands or intimate partners. In most cases, women are at an increased risk not due to their own sexual behavior, but because their partner is an IDU or also has FSWs or MSM as other sex partners. Injecting drug use is the main mode of transmission in the northeastern states, although sexual transmission is increasing. Prevalence rates among IDUs are on the rise in many states, with new regions, such as southern India, also showing upward trends in this group.

Among FSWs, prevalence trends show an overall decline in the south, where targeted program interventions have had a greater reach and achieved broader coverage in terms of raising awareness, testing, and condom use. The 2009 Behavioral Surveillance Survey conducted in five states (Karnataka, Uttar Pradesh, Andhra Pradesh, Tamil Nadu, and Manipur) has shown an increasing trend in consistent condom use among both FSWs and MSM. Similarly, the 2010 UNAIDS report found an increase in condom use at last higher-risk sex among both women and men, at greater than 75 percent. India is a major destination for trafficked girls under age 16 (especially from Bangladesh and Nepal). Trafficked women and girls are particularly vulnerable to HIV infection because they are often unable to negotiate condom use and are often subjected to violent sex. In 2008–2009, FSWs in 47 districts had HIV prevalence rates higher than 5 percent.



The epidemic is shifting from the most vulnerable populations (IDUs, FSWs, and MSM) to “bridge” populations, primarily migrant workers and truckers (UNGASS, 2010). HIV is becoming more common among women and rural inhabitants, who accounted for 39 and 67 percent of PLWHA in 2009, respectively. Historically, these groups have been more difficult to reach with public education campaigns, but awareness is on the rise. The NFHS-3 found that 61 percent of women ages 15 to 49 had heard of AIDS, compared with 84 percent of men. Smaller percentages (20 percent of women and 36 percent of men) had comprehensive, correct knowledge of HIV/AIDS.¹ Young women living in urban areas were more than twice as likely as those in rural areas to have comprehensive knowledge of HIV/AIDS. Only 40 percent of pregnant women knew that HIV/AIDS can be transmitted from mother to child, and just 15 percent knew that taking certain drugs can reduce the likelihood of transmission.

Many Indians, including health care providers, consider AIDS a disease that affects only people with unorthodox lifestyles. This attitude reflects the stigma and discrimination directed toward Indians affected by

HIV/AIDS and contributes to the inadequate health care services they receive. Compounding the problem, negative attitudes from health care staff cause anxiety and fear among many PLWHA who, as a result, hide their HIV status and thereby miss the opportunity to avail themselves of treatment and other services. Gender inequality has also contributed to the epidemic, as women often lack the power to negotiate or assert their rights in regard to their sexual choices and, more broadly, their access to education, economic opportunity, and health care.

According to the World Health Organization (WHO), India is one of the world’s 22 high-burden countries for tuberculosis (TB), with 170 cases per 100,000 population in 2008. The HIV-TB co-infection rate of adults testing HIV positive among incident TB cases is 6.7 percent. HIV-TB co-infections pose a challenge to providing treatment and care for both diseases.

National Response

India’s National AIDS Control Organization (NACO) was established in 1992 to formulate HIV policy and monitor prevention and control projects. The same year, the Government launched the first phase of its National AIDS Control Programme (NACP-I). NACP-I (1992–1999) included HIV surveillance and related activities, screening of blood and blood products, and a public education campaign. The second phase, NACP-II (1999–2006), shifted the focus away from raising awareness toward interventions promoting behavior change. Currently in its third phase, NACP-III (2007–2012) is designed to reverse the spread of HIV/AIDS by placing the highest priority on prevention efforts while also seeking to integrate care, support, and treatment strategies.

Since being elected in 2004, Prime Minister Manmohan Singh’s Government has taken an aggressive stance toward combating HIV/AIDS. The National AIDS Council was established under the leadership of the Prime Minister, bringing together the heads of different ministries. The Indian Government provides free antiretroviral therapy (ART) to more than 322,000 adults and more than 19,500 children across 28 states and four Union Territories (NACO, 2010). It also has exceeded its target of providing free ART to 300,000 PLWHA by 2011. The Government is also providing free second-line ART to nearly 1,000 PLWHA.

In mid-2005, the World Economic Forum released *Business & HIV/AIDS: A Healthier Partnership*, reporting that many Indian companies did not provide adequate prevention programs for their employees. Since then, some local businesses have started to address the epidemic. In 2005, CoRE-BCSD India, a 52-company conglomerate dedicated to sustainable development, added “strengthening industry’s response to HIV/AIDS” to its mission. In 2006, the Confederation of Indian Industry and the Global Business Coalition on HIV/AIDS, with the support of Prime Minister Singh, initiated a project to engage corporations that outsource their work to India.

In 2006, the U.S. and Indian Governments launched the Indo-U.S. Corporate Fund for HIV/AIDS, a large public-private partnership to increase private sector involvement in HIV prevention. Private business owners in India and the United States have made monetary contributions, and the Fund matches contributions to HIV prevention and treatment programs in India. To date, the Fund has received more than \$1.3 million in pledges, and its first project was initiated in March 2008.

¹ Comprehensive knowledge of HIV is measured by the ability to identify consistent condom use and fidelity as the two major ways of preventing sexual HIV transmission and to identify mosquito bites and sharing food as the two most common misconceptions about HIV/AIDS transmission.

Support from the Global Fund to Fight AIDS, Tuberculosis and Malaria is an integral part of India's national HIV/AIDS, TB, and malaria programs. India has been awarded a total of \$1.1 billion in grants for the three diseases. Of this amount, \$770 million was awarded for comprehensive HIV/AIDS programming, including support for ART; counseling and testing; prevention of mother-to-child transmission (PMTCT) of HIV; and community care centers and for building institutional capacity. The U.S. Government (USG) provides nearly 30 percent of the Global Fund's total contributions worldwide.

Acceleration of ART programming is anticipated in the next few years. India has only recently begun to scale up its programs, and the country has high treatment needs. WHO estimates that as of 2009, 36 to 55 percent of those in need of ART were being treated, and 80 percent of those receiving ART were still in treatment 12 months after initiation. ART among IDUs in the northeastern states was much lower, at 1.4 percent, an alarmingly low percentage considering the high rate of infection from injecting drug use in this region. Currently, 17 to 48 percent of pregnant women in need of treatment receive PMTCT services. However, more than two-thirds of women provided ART for PMTCT were offered single-dose nevirapine rather than the combination therapy recommended by WHO's treatment guidelines. Within the framework of the NACP-III, the Indian Government aims to provide ART to 62 percent of adults and children with advanced HIV infection and to provide PMTCT treatment to all pregnant women by 2010.

USAID Support

Through the U.S. Agency for International Development (USAID), India received \$21.94 million in fiscal year (FY) 2009 for essential HIV/AIDS programs and services. USAID's HIV/AIDS programs in India are implemented as part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Launched in 2003, PEPFAR is the USG initiative supporting partner nations around the world in responding to HIV/AIDS. Through PEPFAR, the USG has committed approximately \$32 billion to bilateral HIV/AIDS programs and the Global Fund through FY 2010. PEPFAR is the cornerstone of the President's Global Health Initiative (GHI), which commits \$63 billion over six years to support partner countries in improving and expanding access to health services. Building on the successes of PEPFAR, GHI supports partner countries in improving health outcomes through strengthened health systems, with a particular focus on improving the health of women, newborns, and children.

Historically, USAID and PEPFAR activities in India have emphasized HIV prevention in high-prevalence states and among at-risk groups; care and support for HIV-affected and -infected people; and engagement of the private sector in the fight against HIV/AIDS. Indian and U.S.-based companies, for example, are being encouraged to support HIV/AIDS programs for their workers and communities as part of an effort to develop a broader coalition of private partners to support national AIDS efforts. NFHS-3, conducted with USG assistance, was the first National Family Health Survey to include HIV/AIDS prevalence estimates among the general population, and it is now accepted as the key data source for providing new national HIV prevalence estimates. USAID has also focused on children affected by AIDS, HIV surveillance, and voluntary testing and counseling.

USAID has supported these priorities through several major programs that have provided financial and technical assistance to nongovernmental organizations (NGOs), as well as to the national and state governments. Among the longstanding USAID bilateral programs with the Indian Government are the AIDS Prevention and Control Project (APAC), launched in 1992, which works in Tamil Nadu and Pondicherry, and the Avert project, launched in 1999, in Maharashtra. In its third and final phase of implementation, APAC works primarily in five technical areas: sexual prevention, adult care and support, orphans and vulnerable children (OVC), strategic information, and health systems strengthening. It also addresses several crosscutting areas, including gender, economic strengthening, and human resources for health, and maximizes impact through linkages and integration with other programs. The assistance provided by the project has helped Tamil Nadu reach a large number of at-risk individuals and limit the spread of the HIV epidemic. Prevalence among attendees of APAC ANC clinics, for example, declined from 1.13 percent in 2001 to 0.13 percent in 2009. APAC has also achieved significant success with condom use by Tamil Nadu's MARPs, which more than doubled from 44 percent in 1996 to 96 percent in 2009 (Behavior Surveillance Survey report, APAC).

The Avert project, now in its second phase, works in collaboration with the Maharashtra State AIDS Control Society to implement a comprehensive HIV prevention, care, and support program in five selected high-prevalence state districts. The project focuses on saturating MARP coverage, including FSWs, MSM, and migrants, and on implementing community mobilization activities to increase the uptake of counseling and testing and care and treatment services. The project has adopted a comprehensive prevention approach that includes behavior change interventions; sexually transmitted infection services tailored to MARPs; structural interventions to address violence and coercion; legal aid and linkages to social development programs; and referral linkages to counseling and testing and care and treatment services. Avert has trained more than 3,000 peer educators to implement behavior

change activities that have assisted MARPs. These activities resulted in an increase in consistent condom use among sex workers, from 70 percent in 2004 to 90 percent in 2008.

USAID initiated three new projects in 2006. The Samastha project focuses on comprehensive HIV/AIDS interventions and technical assistance approaches in 12 high-prevalence districts in Karnataka state and five districts in Andhra Pradesh state. The key achievements of the Samastha project include an increase in coverage of comprehensive HIV/AIDS services for rural sex workers from zero percent in 2006 to 81 percent in 2009. In addition, the loss to follow-up among HIV-positive pregnant women receiving PMTCT services was reduced from 23 percent to 4 percent in the same period. The Connect Project seeks to leverage and build public-private partnerships to increase use of prevention, care, and treatment interventions that will mitigate the effects of HIV/AIDS and TB. This project is being implemented nationally, with a specific focus on Karnataka and Andhra Pradesh states. Key achievements include the design of India's first group health insurance scheme for PLWHA through a public-private partnership. Currently, more than 5,300 PLWHA have been enrolled in the scheme across Andhra Pradesh, Karnataka, Tamil Nadu, and Maharashtra states.

Project Samarth specifically provides technical assistance to the NACO and State AIDS Control Societies (SACS) in Uttar Pradesh and Uttarakhand states, to ensure quality HIV/AIDS prevention, care, and treatment services at the national, state, and district levels. The project extends needs-based capacity building assistance to both government and nongovernment stakeholders through a variety of methods. Key achievements include development of a training module and plan for mentoring NACO and SACS technical staff and technical assistance in implementing the national pilot scheme for children affected by AIDS. In 2009, USAID projects served 48,682 PLWHA; 11,054 OVC; 18,147 pregnant women with PMTCT services; and 309 women with ART prophylaxis through USAID project linkages.

USAID is currently shifting support from direct implementation to technical support to both the NACO and SACS and decentralized district-level units called District AIDS Prevention and Control Units. Under NACP-III, USAID is assisting technical support units (TSUs) in Tamil Nadu, Pondicherry, Kerala, Maharashtra, Goa, Uttar Pradesh, and Uttarakhand states. The TSUs are taking lead roles in supporting SACS by providing technical guidance, training, supervision, and management of NGO programs, with the goal of transferring these responsibilities to the states within a few years. Technical assistance and health systems strengthening will underlie USAID/India's next generation of activities, which are to be designed and implemented through a new five-year Health Partnership Program Agreement with the Government of India.

Important Links and Contacts

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USAID HIV/AIDS Web site for India: http://www.usaid.gov/our_work/global_health/aids/Countries/asia/india.html.

For more information, see USAID's HIV/AIDS Web site: http://www.usaid.gov/our_work/global_health/aids.

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