



Map data sources: WHO/UNAIDS
Epidemiological Fact Sheets
and the United States Census Bureau
Map production: WHO

0 300 600 Kilometers

1. Demographic and socioeconomic data			
	Date	Estimate	Source
Total population (millions)	2004	1 081	United Nations
Population in urban areas (%)	2003	28.2	United Nations
Life expectancy at birth (years)	2002	61	WHO
Gross domestic product per capita (US\$)	2001	471	United Nations
Government budget spent on health care (%)	2001	3.1	WHO
Per capita expenditure on health (US\$)	2001	24	WHO
Human Development Index	2001	0.590	UNDP

3. Situation analysis

- Epidemic level and trend and gender data.** Annual national surveillance rounds show that the prevalence of HIV among adults is increasing in all 25 states. Of these, six states (four southern: Tamil Nadu, Maharashtra, Karnataka and Andhra Pradesh; and two north-eastern: Nagaland and Manipur) have generalized epidemics with a high intensity of transmission. In the four southern states, the predominant mode of transmission is sexual, whereas the predominant mode in the two north-eastern states is injecting drug use. In addition, eight states (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chattisgarh, Jharkhand, Uttaranchal and Orissa) are especially vulnerable, as reflected by low economic performance indicators, low health status, high mobility, the presence of tribal communities with limited access to health services and, for Uttar Pradesh and Bihar, very large populations. Together these 14 states account for 89% of all reported AIDS cases and 70% of the country's population. Three states (Goa, Pondicherry and Gujarat) have concentrated epidemics, and the remaining states are experiencing low-level epidemics. The proportion of women among reported AIDS cases is increasing in all states, reflecting the greater vulnerability of women to HIV/AIDS, especially in rural areas. In the six high-prevalence states, the HIV prevalence among pregnant women exceeds 1%.
- Major vulnerable and affected groups.** Vulnerable groups include injecting drug users, female sex workers, men who have sex with men, migrants and other mobile groups such as truck drivers. The epidemic is spreading from "high-risk" groups to the general population and from urban to rural areas. Factors contributing to this increase include increasing migration to high-prevalence areas for employment opportunities, high rates of sexually transmitted infections, low levels of awareness in rural areas, low condom use and rising levels of unsafe sex among young people.

2. HIV indicators			
	Date	Estimate	Source
Adult prevalence of HIV/AIDS (15–49 years)	2003	0.4 – 1.3%	WHO/UNAIDS
Estimated number of people living with HIV/AIDS (0–49 years)	2003	2 200 000 – 7 600 000	WHO/UNAIDS
Cumulative number of reported AIDS cases	2001	8 438	WHO/UNAIDS
Reported number of people receiving antiretroviral therapy (15–49 years)	June 2004	21 000	WHO
Estimated total number needing antiretroviral therapy in 2005	2003	710 000	WHO/UNAIDS
HIV testing and counselling sites: number of sites		not available	
HIV testing and counselling sites: number of people tested at all sites		not available	
Prevalence of HIV among adults with tuberculosis (15–49 years)	2002	4.6%	WHO

- Policy on HIV testing and treatment.** The government has issued a comprehensive HIV testing policy indicating that no individual should undergo mandatory testing for HIV; that mandatory HIV testing should not be imposed as a precondition for employment or for providing health care facilities during employment; that adequate voluntary testing facilities with pretest and post-test counselling should be made available throughout India in a phased manner; and that each district should have at least one HIV testing centre with proper counselling facilities. Any person who wishes to know his or her HIV status should have access to all necessary facilities, and the results should be kept confidential. In marriage, if one of the partners insists on a test to check the HIV status of the other partner, such tests should be carried out by the contracting party to the satisfaction of the person concerned. For HIV testing facilities in private sector hospitals, clinics, nursing homes and diagnostic centres, the state governments should adopt legislative and other measures to ensure that these testing centres conform to the national policy and guidelines related to HIV testing. In December 2003, the government announced a strong policy and programme commitment to provide antiretroviral treatment to 100 000 people living with HIV/AIDS, free of charge, with implementation starting on 1 April 2004. The main target subgroups of this programme are seropositive mothers who have participated in the programme for the prevention of mother-to-child transmission; seropositive children under 15 years; and people with AIDS who seek treatment at the designated hospitals.
- Antiretroviral therapy: first-line drug regimen, cost per person per year.** Recommended first-line antiretroviral regimens for adults and adolescents include stavudine + lamivudine + nevirapine or zidovudine + lamivudine + nevirapine or stavudine + lamivudine + efavirenz or zidovudine + lamivudine + efavirenz. The stavudine + lamivudine + nevirapine combination costs US\$ 160 per person per year.



- *Assessment of overall health sector response and capacity.* The National AIDS Control Organization (NACO) is responsible for coordinating the overall health sector response to HIV/AIDS, supported by the state AIDS control societies at the state level. The National AIDS Control Programme, first launched in 1987, is now in its second phase (1999–2004). Its objective is to reduce the transmission of HIV through a decentralized and comprehensive programme of generating awareness, changing behaviour, targeting vulnerable groups with intervention and conducting research. In December 2003, the government also committed to expanding access to treatment for people living with HIV/AIDS. India has a sizeable pool of physicians and other health professionals and well-developed health service infrastructure. Training in HIV care is now part of all medical and nursing curricula, and national guidelines on antiretroviral therapy are in the process of being finalized. India also has the advantage of an established domestic drug manufacturing base.
- *Critical issues and major challenges.* Key issues include ensuring the quality and safety of antiretroviral therapy, strengthening systems to procure medicines and diagnostics and to supply them to treatment centres and increasing access to and the quality of voluntary counselling and testing services. Equally important is engaging private sector providers in scaling up access to antiretroviral therapy and strengthening the integration of services with other prevention, care and support interventions as well as public health programmes such as programmes for sexually transmitted infections and tuberculosis. National systems for monitoring and evaluation and surveillance of drug resistance need to be strengthened. Women and vulnerable populations must be empowered to increase access to and use of antiretroviral therapy.

4. Resource requirements and funds committed for scaling up antiretroviral therapy in 2004–2005

- WHO estimates that the total funding required to support scaling up antiretroviral therapy to reach the WHO “3 by 5” treatment target of 355 000 people by the end of 2005 is between US\$ 234 million and US\$ 300 million.
- National budgetary allocations for HIV/AIDS programmes have increased over the years. The five-year budget of the National AIDS Control Programme has increased from US\$ 100 million for the first phase (1992–1997) to US\$ 300 million in the second phase (1999–2004).
- In 1999, a loan of US\$ 191 million was signed with the World Bank for implementing the second phase of the National AIDS Control Programme.
- The Global Fund to Fight AIDS, Tuberculosis and Malaria granted US\$ 26.1 million over two years in Round 2 with a focus on preventing mother-to-child transmission, implementing a comprehensive care package for mothers living with HIV/AIDS and their infants and partners and enhancing access to antiretroviral therapy through public-private partnerships.
- India submitted a successful Round 3 proposal to the Global Fund to address HIV and tuberculosis coinfection, with two-year approved grant funding of US\$ 2.6 million.
- The Country Coordinating Mechanism has submitted a proposal to the Global Fund for US\$ 165 million over five years in Round 4, with a focus (80% of the total budget) on launching a large-scale, phased initiative on antiretroviral therapy access closely linked to expanded prevention and support and on increasing the engagement of the private sector and the civil society sector, including people living with HIV/AIDS.
- Other key bilateral and multilateral sources of funding for activities related to HIV/AIDS include the United Kingdom Department for International Development, the United States Agency for International Development, UNDP, UNICEF, the Australian Agency for International Development and the Bill & Melinda Gates Foundation.
- Taking into account all funds committed to date to support scaling up antiretroviral therapy, WHO estimates that the total funding gap for India to reach 355 000 people by the end of 2005 is between US\$ 19 million and US\$ 72 million.

5. Antiretroviral therapy coverage

- India's total treatment need for 2005 is estimated to be 710 000 people, and the WHO “3 by 5” treatment target is 355 000 people by the end of 2005 (based on 50% of need).
- As of June 2004, an estimated 21 000 people were receiving treatment, mostly through the private sector.
- The Round 2 grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria is expected to provide antiretroviral therapy to nearly 4500 women and their partners and children. The objective of the Global Fund Round 4 proposal is to provide 180 000 people with antiretroviral therapy in the public sector and 200 000 people with antiretroviral therapy in the private sector by the fifth year.
- The government is committed to providing treatment to 100 000 people living with HIV/AIDS, starting on 1 April 2004.
- Some treatment is provided through the private not-for-profit and the corporate sectors. The Employees State Insurance Scheme in the public sector and the Central Government Health Scheme also provide antiretroviral therapy services to employees.

6. Implementation partners involved in scaling up antiretroviral therapy

- *Leadership and management.* The NACO coordinates all prevention and control activities related to HIV/AIDS. Various ministries and departments, private sector organizations and nongovernmental organizations implement HIV/AIDS programmes in collaboration with the NACO. WHO and UNAIDS provide support in developing national plans, coordinating implementation and making policy. A joint Programme Committee consisting of senior representatives of the NACO, the consortium of nongovernmental organizations and co-opted experts has been set up to ensure that the efforts undertaken by partners are harmonized. At the state level, activities will be coordinated by the State Antiretroviral Therapy Programme Implementation Committee, under the leadership of the state AIDS control societies.
- *Antiretroviral therapy service delivery.* The NACO provides leadership in delivering antiretroviral therapy services, including procurement and supply chain management, developing guidelines, building capacity and laboratories and diagnostics. WHO, UNAIDS, UNICEF and the United States Centers for Disease Control and Prevention support activities.
- *Community mobilization.* More than 800 nongovernmental organizations are involved in prevention, care and support interventions across India. A consortium of nongovernmental organizations was created recently to manage subgrants to community-level nongovernmental organizations. People living with HIV/AIDS are also extensively involved in national prevention and treatment programmes. They refer people for antiretroviral therapy, provide support and peer counselling to people on antiretroviral therapy, help maintain high rates of adherence and provide psychosocial support to the families and friends of people living with HIV/AIDS. The private sector also works in partnership with the public health system and nongovernmental organizations to support workplace interventions.
- *Strategic information.* The NACO coordinates monitoring and evaluation of HIV/AIDS programmes, supported by WHO, the United States Centers for Disease Control and Prevention and the Indian Council for Medical Research. The NACO has developed monitoring tools for scaling up antiretroviral therapy in consultation with various stakeholders, including United Nations and bilateral agencies. The tools have been field-tested and are being used by implementing institutions. The Indian Council for Medical Research conducts drug resistance surveillance.

7. WHO support for scaling up antiretroviral therapy

WHO's response so far

- Conducting a WHO scoping mission in December 2003 in collaboration with UNICEF, UNAIDS and national partners to identify opportunities and challenges for scaling up antiretroviral therapy and to identify areas for WHO support
- Providing support to the NACO to develop the Round 4 proposal for the Global Fund to Fight AIDS, Tuberculosis and Malaria
- Providing technical assistance to review and finalize national antiretroviral therapy guidelines and the national operational plan for scaling up antiretroviral therapy

Key areas for WHO support in the future

- Establishing a “3 by 5” country team to support the government and all partners in scaling up antiretroviral therapy
- Providing technical assistance to the NACO to finalize antiretroviral therapy training modules
- Providing technical assistance to the NACO to strengthen programme monitoring and evaluation and drug resistance surveillance
- Providing technical assistance in developing communication on programmes for scaling up antiretroviral therapy

Staffing input for scaling up antiretroviral therapy and accelerating prevention

- Current WHO Country Office staff responsible for HIV/AIDS and sexually transmitted infections include one National Programme Officer for HIV/AIDS, and the recruitment of an international “3 by 5” Country Officer is currently underway.
- Additional staffing needs identified include a National Programme Officer, a technical officer and national consultants.

For further information, please contact:

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This country profile was developed in collaboration with national authorities, the WHO Country Office for India and the WHO Regional Office for South-East Asia.

