HIV and AIDS in India

India has the third largest HIV epidemic in the world. In 2013, HIV prevalence in India was an estimated 0.3%. This figure is small compared to most other middle-income countries but because of India's huge population (1.2 billion) this equates to 2.1 million people living with HIV. In the same year, an estimated 130,000 people died from AIDS-related illnesses.1

Overall, India’s HIV epidemic is slowing down, with a 19% decline in new HIV infections (130,000 in 2013), and a 38% decline in AIDS-related deaths between 2005 and 2013. Despite, this 51% of deaths in Asia are in India.1

HIV prevalence in India varies geographically. The five states with the highest HIV prevalence (Nagaland, Mizoram, Manipur, Andhra Pradesh and Karnataka) are in the south or east of the country. Some states in the north and northeast of the country, report rising HIV prevalence.2

Key affected populations in India

Among key affected populations, sex workers and men who have sex with men have experienced a recent decline in HIV prevalence while the number of people who inject drugs living with HIV has remained stable.2

However, transgender people are emerging as a group at high risk of HIV transmission. This is despite all four of these groups being prioritised in the Indian national AIDS response since its inception in 1992.1

Sex workers and HIV

There are 868,000 female sex workers in India, and 2.8% are living with HIV, although this figure varies between states.2 For example, one study found HIV prevalence among sex workers ranged between 2% and 38% (averaging at 14.5%) among districts in the south Indian states of Andhra Pradesh, Maharashtra, Tamil Nadu and Karnataka.3

Although sex work is not strictly illegal in India, associated activities - such as running a brothel - are. This means that the authorities can justify police hostility and brothel raids. Stigma and discrimination against sex workers restrict their access to healthcare.4 However, it is thought that 84.5% have been reached with HIV prevention activities.2

Male sex workers are a group particularly vulnerable to HIV. One study in suburban Mumbai
reported an HIV prevalence of 33% among this group and 13% had never used a condom.5

Men who have sex with men (MSM) and HIV

There are 427,000 men who have sex with men (MSM) in India, and 4.4% are living with HIV.2

In December 2013, India's Supreme Court re-criminalised adult consensual same sex sexual
conduct after the Delhi High Court decriminalised it in 2009. This has raised fears about access to
HIV prevention and treatment for MSM.6 7

Stigma and discrimination act as significant barriers that make this group hard to reach with HIV
information, although 70.6% report having received some information.2 Moreover, outreach
workers and peer educators working with MSM have frequently been harassed or arrested by the
authorities.8

Hijras/transgender people and HIV

Hijras, (also known as Aravani, Aruvani or Jagappa in other areas) are names given to individuals in
South Asia who are transgender. The number of hijras in India is unknown, but their traditional
background is linked to high-risk behaviours such as alcohol and substance abuse, and low literacy
rates.2 9

In India, past surveillance and monitoring of groups at a high risk of HIV transmission have not
considered transgender people as a distinct group, often including them in MSM data. However,
since 2012, the National AIDS Control Programme has collected data and surveillance about hijras
separately, finding that 8.8% are living with HIV.2

In April 2014, the Indian Supreme Court recognised transgender people as a distinct gender. Many
hope this ruling will lead to a decline in the stigma and discrimination faced by hijras and increase
their access to HIV services.10

Indeed, evidence of this improved reach is clear: 83% of hijras were reached with HIV prevention
activities in 2013, and 9 out of 10 report access to HIV testing services. Special health and welfare
programmes to support their needs have been set up since the recognition of transgender as a third
gender.1

People who inject drugs (PWID) and HIV

HIV prevalence among people who inject drugs (PWID) in India has remained largely unchanged
since 2007, at around 7% of the 177,000 people in this population.2 HIV prevalence among female
PWID is twice that of male PWID, with the relationship between sex work and drug use likely to
account for this large difference.1

30% of PWID reside in north-eastern states where injecting drug use is the major route of HIV
transmission. However, HIV prevention efforts in this region have been effective in reducing the
number of new infections.11 By contrast, HIV prevalence among PWID in north-western states is
increasing.12 This is despite national HIV prevention activities coverage of 80.7% and 150,000
needles and syringes distributed per PWID per year.2

Research has emphasised the need for early interventions for PWID in India. Indeed, many embark
on a ‘drug career’ in their early teens using widely available substances such as tobacco and
alcohol before progressing on to illegal drugs through a non-injecting route (e.g. orally or smoking)
and eventually using shared needles and syringes putting them at risk of HIV transmission. It is
only at this point that PWID are typically reached by harm reduction services.13 14

Migrant workers and HIV

Research worldwide has linked migration to increases in HIV transmission. There are 7.2 million
migrant workers in India, of whom 1% are living with HIV - much higher than the national prevalence of 0.3%.2

In India, migrants are a bridge population, forming a link between urban and rural areas, and high-risk and low-risk groups.15 In fact, 75% of women testing positive in India have a husband who is a migrant labourer.1 0.9% of people who have migrated from a rural to an urban area are HIV-positive.1

Despite being an important driver of the HIV epidemic in India, data on migrant sexual behaviour is limited. Moreover, migrants have been found to have low risk perception of HIV transmission compared with other high-risk groups. For example, one study in Andhra Pradesh found that 60% of female sex workers acknowledged their risk to HIV infection compared with just 5% of male migrants.16 One study from south-west India has suggested that targeting migrants locally as well as at their destination could have 1.6 times the impact of only targeting migrants at their destinations.17 In 2013, only 41.3% were reached with HIV prevention activities.2

Truck drivers and HIV

A number of studies from India have reported high vulnerability of truckers to HIV transmission. Many engage in high-risk behaviours, for example paying for sex - an estimated 36% of sex worker clients are truckers. Time away from home on the road, marital status, alcohol use, and income level have all been associated with visiting sex workers.18 19

As a result, 2.6% of the two million truckers in India are living with HIV.2 Moreover, knowledge of how HIV is transmitted is low among this group. One study from Uttar Pradesh reported a number of misconceptions including that HIV can be transmitted by mosquito bites, living in the same room, shaking hands and sharing food.20 This is not entirely surprising considering only 48.4% have been reached with HIV prevention activities.2

These factors, in combination with inconsistent condom use, mean truckers are also a bridge population, with HIV transmitted to their regular sexual partners and into the general population.20

HIV testing and counselling (HTC) in India

In 1997, there were just 67 HIV testing and counselling (HTC) sites in India. By 2014, there were nearly 15,000 healthcare facilities offering HTC. In the same year, 13 million general users and 9.7 million pregnant women accessed HTC respectively against a target of 10.2 million for each group.2 Despite this progress, only 13% of people living with HIV in India are thought to be aware of their status.21
In order to address this issue, one study proposed universal testing of the general population and more intensive testing of high-risk groups on a five-year cycle. More people would know their status and therefore actively seek treatment before developing AIDS-related illnesses, encouraging behaviour change and decreasing viral load. This would be more cost-effective than the current situation in India.

**HIV prevention in India**

The National AIDS Control Organisation (NACO) is the body responsible for formulating policy and implementing programmes for the prevention and control of the HIV epidemic in India.

The current programme, NACP-IV (2012-2017), aims to reduce annual new HIV infections by 50% through the provision of comprehensive HIV treatment, education, care and support for the general population and build on targeted interventions for key affected groups and those at high risk of HIV transmission.

**Targeted interventions for key affected groups**

A key component of the NACP-IV is the prevention of new HIV infections by achieving 80% coverage of key affected groups with targeted interventions (TIs).

TIs are implemented on the premise that prevention of HIV transmission from key affected groups such as sex workers to their male clients (for example) will lower HIV transmission among their sexual partners - e.g. women in the general population.

Some of the most high profile interventions are listed below.

- **Project Pehchan**
  
  Project Pehchan was launched in October 2010 in order to tackle the HIV epidemic among MSM, transgender people and hijras (MTH) in India. Supported by the Global Fund, the five-year project works with roughly 200 community-based organisations across 17 states to reach over 450,000 MTH members.

  Pehchan advocates for policy to create an enabling environment where MTH can easily access HIV and other sexual and reproductive health services.

- **Avahan**
  
  The Avahan project works to reduce HIV transmission among sex workers, MSM and transgender people through the provision of education as well as condom promotion, sexually transmitted infection (STI) management, behaviour change communication, community mobilisation and advocacy.

  The programme has been highly effective with 36-68% of new HIV infections averted across the four focus states in a seven-year period. In 2013, it was announced that over the previous 10 years, Avahan had averted 57% of HIV infections in southern India. Avahan is internationally recognised as a cost-effective, successful, targeted HIV prevention programme.

- **The Sonaguchi Project**
  
  The Sonaguchi Project promotes the use of healthcare services by sex workers to reduce HIV prevalence among this group. The project employs peer educators to provide information, distribute condoms, promote behaviour change and refer sex workers to health clinics.

  Sex workers participate in all areas of the project and since 1999, have been responsible for its operation. In the same year, the Durbar Mahila Samanwaya (DMSC) evolved out of the project as a union representing sex worker rights. The project has been promoted as a model of ‘best
practice’ for other sex worker projects around the world.

- **Project Kavach**

Project Kavach has been working to stop the spread of HIV among truckers and other high-risk populations. The project reaches out to 21,000 truckers annually in Punjabi Bagh and Mangol Puri and encourages behaviour change through street plays, magic shows and peer education. It also provides healthcare services such as HIV and STI treatment, HIV testing and counselling as well as condom promotion.

**HIV education and awareness**

- **Link Worker Scheme**

The Link Worker Scheme, supported by the UNDP, is a community-based outreach strategy working to address HIV prevention, treatment, care and support of hard-to-reach groups in rural India.

Specifically, the scheme provides information resources on HIV and STI prevention, condom promotion and distribution, HTC and referral to treatment. Since the introduction of HTC in 2003, there has been a ten-fold increase in those identified as living with HIV in rural Chhattisgarh. The project currently operates in 163 districts across 17 states.

- **The Red Ribbon Express**

Launched in 2007, the Red Ribbon Express is an HIV and AIDS awareness campaign train run by Indian Railways.

By 2013, the train had visited 23 states reaching more than 10 million people with messages about HIV prevention in rural parts of India. The train now also provides HIV testing and counselling (HTC) services and treatment for sexually transmitted infections (STIs).

- **The Condom Social Marketing Programme (CSMP)**

The Condom Social Marketing Programme (CSMP) aims to promote safer sex by improving the availability of condoms and by utilising multimedia to encourage behaviour change. To date, two mass media campaigns have been launched in Hindi as well as other regional languages. By 2014, the CSMP had distributed over 560 million condoms across 15 states.

**Harm reduction**

Under the NACP-IV, harm reduction in India is delivered through a number of means including needle and syringe programmes (NSPs), opioid substitution therapy (OST) and peer education in a variety of healthcare settings. These interventions are typically delivered by non-government organisations (NGOs) but are financially supported by the Indian government. Roughly 80% of an estimated 186,000 PWID are thought to be covered by existing programmes.

NACO actively distributes free needles and syringes to PWID through peer educators working for a number of TIs. PWID are strongly encouraged to return used injecting equipment and exchange it for new, clean equipment. In 2012, 44% of equipment was returned.

Opioid Substitution Therapy (OST) was incorporated into the harm reduction programme in 2008. To date, there are 150 OST centres supporting nearly 18,000 PWID. There are plans to increase this number to over 300 equating to a 20% OST coverage for PWID.

**Preventing mother-to-child transmission (PMTCT)**

The Indian government is committed to eliminating new HIV infections among children by 2015.
India’s Prevention of Parent to Child Transmission of HIV/AIDS (PPTCT) programme started in 2002. To date, there are over 15,000 sites offering PPTCT services. Based on 2013 WHO Guidelines, the programme aims to initiate antiretroviral treatment for all pregnant and breastfeeding women living with HIV regardless of CD4 count or stage of HIV infection.

However, in 2013, 35,000 pregnant women were living with HIV, and only 18% received PMTCT treatment. As a result, 13,000 children were born with HIV.

**Antiretroviral treatment (ART) in India**

Free antiretroviral treatment (ART) has been available in India since 2004. At ART clinics, people living with HIV can access testing and counselling (HTC), nutritional advice and treatment for HIV and opportunistic infections. Patients are required to take a CD4 count test every six months. Moreover, the country is now rolling out reminders to people about their testing appointments with the aim of increasing overall attendance.

However, in 2013, only 36% of adults eligible for ART received treatment, alongside 30% of children. Indeed, many people living with HIV have difficulty accessing the clinics emphasising the importance of initiatives such as the Link Workers Scheme to link people to healthcare.

The introduction of the new 2013 WHO treatment guidelines has made many more people eligible for ART, forcing treatment access to be a priority area. NACP-IV aims to make second-line ART free, although a shortage of both first-line and second-line ART has become a feature in recent years.

**HIV stigma and discrimination in India**

In India, as in many other parts of the world, people living with HIV and AIDS face stigma and discrimination in a variety of settings including households, the community and workplaces. For example, parents and in-laws may blame women for infecting their husbands, while children can be denied the right to go to school. Key affected groups such as sex workers, hijras and MSM are stigmatised for being members of a socially marginalised group as well as their HIV status.

Stigma and discrimination is also very common within the healthcare sector. Negative attitudes among healthcare staff prevent many people from disclosing their status, while others will not seek treatment altogether.

Establishing an HIV and AIDS management policy, sensitising healthcare workers, mainstreaming HTC and making post-exposure prophylaxis available to staff have all been suggested as ways of reducing stigma and discrimination among healthcare workers in India.

NACP-IV has made the elimination of stigma and discrimination a major focus, aiming to utilise mass media campaigns and existing interventions such as the Red Ribbon Express.

**Funding the HIV response in India**

Previously, efforts to tackle the HIV epidemic in India relied heavily on international funding. However, India has increasingly taken responsibility for financing its HIV response and in 2012, committed to financing 90% of its HIV and AIDS programmes.

The vast majority (67%) of the NACP-III budget was spent on HIV prevention, with 17% going to treatment, care and support.

**The future of HIV and AIDS in India**

Over the past decade, India has made significant progress in tackling its HIV epidemic, especially in comparison with other countries in the region. For example, while new HIV infections have fallen...
by more than half since 2001, the number of new HIV cases in neighbouring Pakistan has increased eight-fold.45

A major reason for the country's success has been the sustained commitment of the Indian government through its National AIDS Control Programme, which has been particularly effective at targeting high-risk groups such as MSM, sex workers and PWID. However, better HIV surveillance and targeted interventions are needed for groups such as transgender people, migrants and truckers, with the latter acting as gateways for HIV into the general population.

While antiretroviral treatment is free, uptake remains low and requires a dramatic scaling up especially in the wake of the new 2013 WHO treatment guidelines. Moreover, stigma and discrimination remains a significant barrier preventing key affected groups and those at high risk of HIV transmission from accessing vital healthcare services.

In early 2014, an HIV/AIDS Bill was finally passed after being submitted in 2006. The Bill prohibits discrimination in employment, education, healthcare, travel and insurance and calls for a legal commitment by the government to provide free HIV treatment. Moreover, it recognises that a person living with HIV has the right to privacy and confidentiality about their HIV status.46 47

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