1. Demographic and socioeconomic data

<table>
<thead>
<tr>
<th>Date</th>
<th>Total population (millions)</th>
<th>Date</th>
<th>Population in urban areas (%)</th>
<th>Date</th>
<th>Life expectancy at birth (years)</th>
<th>Date</th>
<th>Gross domestic product per capita (US$)</th>
<th>Date</th>
<th>Government budget spent on health care (%)</th>
<th>Date</th>
<th>Per capita expenditure on health (US$)</th>
<th>Date</th>
<th>Human Development Index</th>
</tr>
</thead>
</table>

**Total population (millions)**
- Date: 2004
- Estimate: 1 081
- Source: United Nations

**Population in urban areas (%)**
- Date: 2005
- Estimate: 28.7
- Source: United Nations

**Life expectancy at birth (years)**
- Date: 2003
- Estimate: 62
- Source: WHO

**Gross domestic product per capita (US$)**
- Date: 2002
- Estimate: 484
- Source: United Nations

**Government budget spent on health care (%)**
- Date: 2002
- Estimate: 4.4
- Source: WHO

**Per capita expenditure on health (US$)**
- Date: 2002
- Estimate: 30
- Source: WHO

**Human Development Index**
- Date: 2003
- Estimate: 0.602
- Source: UNDP

2. HIV indicators

<table>
<thead>
<tr>
<th>Date</th>
<th>Adult prevalence of HIV/AIDS (15-49 years)</th>
<th>Date</th>
<th>Estimated number of people living with HIV/AIDS (0-49 years)</th>
<th>Date</th>
<th>Reported number of people receiving antiretroviral therapy (0-49 years), 2005</th>
<th>Date</th>
<th>Estimated number of people needing antiretroviral therapy (0-49 years), 2005</th>
<th>Date</th>
<th>HIV testing and counselling sites: number of sites</th>
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</thead>
<tbody>
<tr>
<td>2003</td>
<td>0.4 - 1.3%</td>
<td>2003</td>
<td>2 200 000 - 7 600 000</td>
<td>Dec 2005</td>
<td>24 000*</td>
<td>Dec 2005</td>
<td>785 000</td>
<td>Dec 2005</td>
<td>833</td>
</tr>
</tbody>
</table>

**Adult prevalence of HIV/AIDS (15-49 years)**
- Date: 2003
- Estimate: 0.4 - 1.3%
- Source: WHO/UNAIDS

**Estimated number of people living with HIV/AIDS (0-49 years)**
- Date: 2003
- Estimate: 2 200 000 - 7 600 000
- Source: WHO/UNAIDS

**Reported number of people receiving antiretroviral therapy (0-49 years), 2005**
- Date: Dec 2005
- Estimate: 24 000*
- Source: NACO**

**Estimated number of people needing antiretroviral therapy (0-49 years), 2005**
- Date: Dec 2005
- Estimate: 785 000
- Source: WHO/UNAIDS

**HIV testing and counselling sites: number of sites**
- Date: Dec 2005
- Estimate: 833
- Source: NACO**

3. Situation analysis

Epidemic level and trend and gender data
India's population surpassed 1 billion in 2001; 67% live in rural areas and 33% in urban areas. India is estimated to have the second largest population of people living with HIV/AIDS, next to South Africa. An estimated 5.13 million individuals currently live with HIV across all states in India. In areas that are more severely affected, the epidemic has started to challenge recent development achievements and to raise fundamental issues of human rights concerning people living with HIV/AIDS. The HIV/AIDS epidemic in India is heterogeneous; it seems to be following the type 4 pattern, where the epidemic shifts from the most vulnerable populations (such as sex workers, injecting drug users and men who have sex with men) to bridge populations (clients of sex workers, people with sexually transmitted infection and partners of drug users) and then to the general population. The shift usually occurs when the prevalence in the first group exceeds 5%, with a two- to three-year time lag between shifts from one group to another. The National AIDS Control Organization (NACO) estimated that the number of people infected with HIV in India increased from 2.86 million in 2000 to 5.13 million in 2004. As of 2004, about 39% of people living with HIV/AIDS were women and about 58% lived in rural areas where HIV/AIDS services are poor. By the end of November 2005, the total number of reported AIDS cases in India was 116 905, of which 34 177 were women. These data also indicate that about one third of reported AIDS cases are among people younger than 30 years. However, many more AIDS cases go unreported. Only 809 700 total AIDS deaths have been reported as of December 2005. This is because many deaths due to AIDS-related causes go unreported because of stigma, discrimination and problems in claiming life insurance coverage. The spread of HIV is as diverse as the societal patterns between India's different regions, states and metropolitan areas. A total of 111 districts in 18 states are currently considered high prevalence districts. The transmission route is predominantly heterosexual (more than 85%), except in the northeastern states, where injecting drug use is the main route of HIV transmission. Injecting drug use has increased significantly during the past four years, with drug users switching from inhaling to over-the-counter injecting drugs. The other routes of transmission, by order of proportion, are perinatal, infected needles and syringes and unsafe sex and blood products.

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 who travel the major south-north highways. The epidemic, however, is increasingly spreading from vulnerable groups to the general population and from urban to rural areas. Factors contributing to this increase include increasing migration to high-prevalence areas in search of 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, who comprise most of the group migrating for employment opportunities. India accounts for almost 1.4 million of the estimated 1.6 million young people living with HIV in the WHO South-East Asia Region. Another growing problem is orphans and vulnerable children and, although official figures are not available, UNAIDS estimates that more than 170 000 children under 15 years are living with HIV/AIDS.

Policy on HIV testing and treatment
UNAIDS targets the implementation of policies and strategies that will ensure universal access to antiretroviral therapy by the year 2010, including in countries that are not yet able to implement such programmes. UNAIDS estimates that more than 170 000 children under 15 years are living with HIV/AIDS.
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 during employment; that adequate voluntary testing facilities with pretest and post-test counselling should be made available to the public in a bid to realize one HIV testing centre per town or district; and that an individual should know his or her HIV status should have access to all necessary facilities, and the results should be kept confidential. For HIV testing facilities in private-sector clinics, hospitals, 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 services.

• Antiretroviral therapy: first-line drug regimen, cost per person per year

Recent estimates of the antiretroviral regimens for adults and adolescents include stavudine + lamivudine + nevirapine; zidovudine + lamivudine + nevirapine; stavudine + lamivudine + efavirenz; or zidovudine + lamivudine + efavirenz. The stavudine + lamivudine + nevirapine combination costs US$ 146 per person per year from generic manufacturers in India.

Assessment of overall health sector response and capacity

The NACO is responsible for coordinating the overall response to HIV/AIDS, including that of the health sector, supported by the state AIDS control societies at the state level. The National AIDS Control Programme, launched in 1987, is now in its second phase of implementation (1999-2006), its objective is to reduce the transmission of HIV through a decentralized and comprehensive programme of generating awareness, changing behaviour, targeting vulnerable groups and conducting research. Specifically, the Programme has established targets of providing 80% coverage of vulnerable groups through targeted interventions, 90% of schools and colleges through education programmes, 80% awareness among the general population in rural areas, reducing HIV transmission through blood to less than 1% and establishing at least one voluntary counselling and testing centre in every district. A package of integrated voluntary counselling and testing, prevention of mother-to-child transmission, services for treating sexually transmitted infections and care and treatment of opportunistic infections will ultimately be provided in primary health care at the third level in the phase of the National AIDS control programme (2008-2011). In 2002, the government’s National AIDS Control Policy and National Blood Policy established the main goals of the country's HIV/AIDS interventions: controlling sexually transmitted diseases; promoting condom use; providing testing, counselling, care and support for people with HIV/AIDS; conducting surveillance; minimizing harm for injecting drug users; providing blood and blood products, and supporting research and product development. The policy documents also reiterate the government's commitment to decentring HIV/AIDS control activity, to strengthening programme management at all levels and to enhancing collaboration with national, bilateral and multilateral partners. A systematic sentinel surveillance system has been operating since 1994, with 750 sentinel surveillance sites at the end of 2005. Prevention activities within the health sector are increasingly supported through the contributions of the private sector and other sectors and within the projects funded by bilateral donors. The armed forces have established their own prevention and care organization and have an ongoing information, education and communication programme as well as training for their health personnel. The Railways also have established a comprehensive programme for moving people and private organizations, including sex workers, and health workers and health care facilities to expand the facility level; increasing access to the quality of counselling and testing services; ensuring high-quality support and counselling for treatment adherence; and issues related to HIV drug resistance and providing second-line antiretroviral therapy. Additional health care services need to be trained to deliver high-quality care, support and treatment services at a decentralized level. 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 reproductive and child health, sexually transmitted infections and tuberculosis. Monitoring and evaluation systems for monitoring and analysing the data and experience of resistance need to be strengthened. Vulnerable populations must be empowered to increase their access to antiretroviral therapy, especially women. Stigma and discrimination remain powerful impediments.

4. Resource requirements and funds committed for scaling up treatment and prevention in 2004-2005

• WHO estimates that between US$ 289.9 million and US$ 307.2 million was required to support scaling up antiretroviral therapy to reach the WHO “3 by 5” target of 355 000 people by the end of 2005.

• Funding: budgetary allocations for HIV/AIDS programmes have increased over the years. The five-year budget of the National AIDS Control Programme increased from US$ 100 million for the first phase (1992-1997) to US$ 230 million in the second phase (1999-2006). The government proposes to increase the allocation of funds for HIV/AIDS programmes by 30% per year for the next five years.

• The Global Fund to Fight AIDS, Tuberculosis and Malaria approved a grant of 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 people with HIV/AIDS and their infants and partners and enhancing access to antiretroviral therapy through private-public partnerships.

• The World Bank’s Richard Jewitt Round 3 proposal to the Global Fund to support HIV and tuberculosis cofinancing, with a total five-year funding request of US$ 14.8 million and two-year approved grant funding of US$ 2.6 million.

• India also submitted a successful Round 4 proposal to the Global Fund for US$ 140.8 million over four years. US$ 4.1 million has been granted to the Population Foundation of India for two years to implement the Action on the Right to Know project and another US$ 21.6 million to the Economic Affairs Division. Together, they focus on 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. Component 1 (Population Foundation) supports the Indian government's comprehensive antiretroviral treatment strategy with HIV/AIDS in six high-prevalence states (Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Nagaland and Manipur), including establishment of treatment and counselling services and comprehensive care and support. Component 2 addresses scaling up antiretroviral therapy services in six high-prevalence states and Delhi, with a declared target of 51 000 people receiving antiretroviral therapy in the first two years through 120 centres, CD4 technology for 50 centres and CAGE training for 50 centres. Over 11 100 people with advanced HIV/AIDS received antiretroviral therapy by the end of 2004.

• Multilateral partners such as the World Bank, UNDP, UNAIDS and UNICEF also provide support to India for activities related to HIV/AIDS. In 1999, the World Bank granted a loan of US$ 191 million for implementing the second phase of the National AIDS Control Programme. India is now in the process of developing a National AIDS Control Programme Phase III proposal for World Bank funding.

• Key bilateral sources of funding for activities related to HIV/AIDS include the United Kingdom Department for International Development, the United States Agency for International Development (USAID) through the International HIV/AIDS Initiative, and the Bill & Melinda Gates Foundation. The United Kingdom Department for International Development supports a programme of targeted interventions in Andhra Pradesh, Gujarat, Kerala and Orissa and a sexual health project in West Bengal (recently renewed to a total of US$ 150 million). The United Kingdom Department for International Development has recently added the states of Bihar and Uttar Pradesh for intervention and capacity-building. The Bill & Melinda Gates Foundation funds the Avahan programme (US$ 200 million over five years), which focuses on the six high-prevalence states, targeting sex workers and injecting drug users and mobile populations along highways. The United States Agency for International Development has recently added its Tamil Nadu AIDS Prevention and Control Programme for US$ 19 million to 2005. These supports have been accompanied by coordination, as well as awareness, and sexually transmitted infections and tuberculosis. The United States Agency for International Development also provides US$ 40 million for the Maharashtra programme of prevention and care activities of AVERT, an international nongovernmental organization. The United States Centers for Disease Control and Prevention is supporting the states of Tamil Nadu and Andhra Pradesh in strengthening antiretroviral therapy centres, health systems, decentralization of HIV health services and training of health care providers. The William J. Clinton Foundation is training private practitioners on managing HIV and opportunistic infections. The Foundation has pledged to help NACO train up to 1500 doctors over the next few years as well as strengthening the organisational capacity of NACO.

• The Government of India funds the states of Rajasthan and Karnataka through the India-Canada Collaborative HIV/AIDS Project in targeted and prevention interventions and health systems strengthening, especially care, support and treatment.

• India was the eighteenth country to receive financial support under the United States President's Emergency Plan for AIDS Relief.

5. Treatment and prevention coverage

• In 2003, WHO/UNAIDS estimated India's total treatment need to be 710 000 people, and the WHO “3 by 5” target was calculated to be 355 000 people by the end of 2005 (based on 50% of estimated need). In 2005, WHO/UNAIDS estimated that India’s total treatment need had risen to 785 000 people.

• In November 2003, India declared a national target of providing antiretroviral therapy free of charge through the public sector to 100 000 people by 2007. Implementation of the programme began in the second quarter of 2005, with 1000 people receiving antiretroviral therapy through the public sector by the end of 2005.

• Overall, 60 000 people are estimated to be receiving antiretroviral therapy as of December 2005, including people enrolled through private facilities. NACO reports a total of 24 000 people (December 2005) receiving free antiretroviral therapy from 60 government centres and about 10 000 from the intersectoral partners such as Employees State Insurance Scheme, Railways and Defence.

• 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 offer antiretroviral therapy services to its employees.

• The Round 2 grant from the Global Fund plans 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 137 000 adults and children with antiretroviral treatment through public services by the end of 2009.

6. Implementation partners involved in scaling up treatment and prevention interventions

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Leadership and management
NACO, placed within the Ministry of Health and Family Welfare, coordinates all prevention, care and treatment activities related to HIV/AIDS. It is supported by the state AIDS control societies. Various ministries and departments, private-sector organizations and nongovernmental organizations implement HIV/AIDS programmes in collaboration with the NACO. WHO and UNAIDS support the development of national plans, the “three ones” policy (one national strategic framework for HIV/AIDS; one national AIDS coordinating authority; and one national monitoring and evaluation mechanism) and coordination in general. The government has established a National Council on AIDS headed by the Prime Minister and including ministers from all relevant ministries as well as representatives from civil society.

Service delivery
NACO provides leadership in delivering HIV/AIDS services, including antiretroviral therapy, voluntary counselling and testing, preventing mother-to-child transmission, treatment for sexually transmitted and opportunistic infections, procurement and supply chain management, developing guidelines, training of health workers and laboratories and diagnostics. The state AIDS control societies support implementation at the state level. WHO provides support for developing technical guidelines facilitating the capacity-building of health workers, including training, strengthening state AIDS control societies, decentralizing HIV services, monitoring and evaluating antiretroviral therapy provision and programmes and the procurement and supply management of drugs. UNICEF provides support for preventing mother-to-child transmission. The Australian Agency for International Development supports prevention and care projects for injecting drug users. The Bill & Melinda Gates Foundation supports prevention services and treatment of sexually transmitted infections for, among others, mobile populations along the major highways. The William J. Clinton Foundation provides support for training health workers and negotiating drug prices. The United Kingdom Department for International Development and the United States Centers for Disease Control and Prevention also provide support for HIV prevention and care. The Confederation of Indian Industries provides support to develop workplace interventions and to strengthen public-private partnerships.

Community mobilization
More than 800 nongovernmental organizations are involved in prevention, care and support interventions across India. The Population Foundation of India has established a consortium of nongovernmental organizations to manage major subgrants to community-level nongovernmental organizations. People living with HIV/AIDS are also extensively involved in national prevention and treatment programmes. The Indian Network for People Living with HIV/AIDS informs policy and provides care and support to people living and affected by the disease. They refer people for antiretroviral therapy, provide support and peer counselling to people receiving antiretroviral therapy, help to maintain high rates of adherence, provide psychosocial support to the families of people living with HIV/AIDS and address issues related to stigma and discrimination. The private sector works in partnership with the public health system and nongovernmental organizations to support workplace interventions.

Strategic information
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. NACO conducts annual surveillance rounds with technical support from WHO in HIV and TB/HIV. 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. NACO is also developing a HIV drug resistance surveillance and monitoring plan with technical assistance from WHO and together with the Indian Council for Medical Research.

7. Staffing input for scaling up HIV treatment and prevention

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 technical assistance to review and update national antiretroviral therapy guidelines and national programme implementation guidelines for scaling up antiretroviral therapy
• Developing training curricula for health workers on antiretroviral therapy, including tertiary and district or community packages
• Providing technical assistance in developing the counselling curriculum for counsellors staffing voluntary counselling and testing centres
• Supporting the strengthening of entry points to antiretroviral therapy, especially voluntary counselling and testing services and training of counsellors in antiretroviral therapy programmes in selected sites
• Providing technical assistance to NACO in procuring antiretroviral drugs and CD4 counters to launch the national antiretroviral therapy programme
• Providing technical assistance in state support through a network of WHO-funded state antiretroviral therapy consultants, initially in high-prevalence states and now expanding to medium- and low-prevalence states
• Providing technical assistance in developing a monitoring and evaluation framework together with other partner agencies
• Providing technical assistance for developing and disseminating tools for monitoring antiretroviral therapy provision and the training of key personnel at the national and state levels
• Providing technical assistance to the NACO in developing the Round 4 proposal for the Global Fund
• Providing technical assistance for implementing the Global Fund grants from Rounds 2, 3 and 4
• Providing technical assistance to policy planning for phase III of the National AIDS Control Programme
• Establishing an HIV/AIDS country team to support the government and all partners in scaling up antiretroviral therapy

Key areas for WHO support in the future
• Providing technical assistance for building the capacity of the health sector to deliver antiretroviral therapy at a decentralized level to the districts and substations
• Providing technical assistance in updating guidelines and developing the national comprehensive training curriculum for health care workers
• Providing technical support for enhancing high-quality prevention services within the health sector and linking prevention to treatment services
• Providing technical assistance to NACO, states and districts to strengthen strategic information systems, programme monitoring and evaluation
• Providing support for surveillance and monitoring of drug resistance
• Providing technical assistance in developing communication strategies for scaling up antiretroviral therapy
• Strengthening the country team with additional staff, including at the state level

Staffing input for scaling up HIV treatment and prevention
• Current WHO Country Office staff responsible for HIV/AIDS and sexually transmitted infections include one International HIV/AIDS Country Officer, one National Programme Officer for HIV/AIDS and one international Technical Officer.
• Additional staffing needs identified include two international Medical Officers for monitoring and evaluation, a Technical Officer for prevention and additional National Programme Officers.