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SCENARIO OF HIV/AIDS IN INDIA AND BANGLADESH

In this section, the scale and nature of HIV/AIDS in India and Bangladesh will be presented. Responses from the Government of India (GoI), the Government of Bangladesh (GoB), international organizations, NGOs and civil society will also be outlined.

HIV/AIDS prevalence and national responses in India

Scale

About 5.7 million Indians were living with HIV in 2005, which indicated that there were more people with HIV in India than in any other country in the world (UNAIDS, 2006). However, the National AIDS Control Organization (NACO), which was established in 1992 in India, claims that the actual figure is lower. NACO conducted the HIV Sentinel Surveillance together with the support of two national institutes: the National Institute of Health and Family Welfare and the National Institute of Medical Statistics, ICMR, New Delhi. Over the years, the numbers of sentinel sites were increased from 180 in 1998 to 703 in 2005. This was expanded greatly for the 2006 surveillance, round to a total of 1,122 sites, to cover all the districts of the country. Based on the revised estimates, the total people living with HIV/AIDS (PLHIV) in the country are estimated to be 2.5 million. Out of these, 0.97 million (39.3%) are women and 0.09 million (3.8%) are children. The estimated adult prevalence in the country is 0.36 per cent (0.27%–0.47%). Among them, 88.7 per cent are adults (15–49 years), 7.5 per cent are aged 50 and above, while 3.8 per cent are children (<15 years). The

proportion of infections among children and adults above 50 years of age has been increasing during the last five years (NACO, 2006).

According to the NACO (2006), India's highly heterogeneous epidemic is largely concentrated in six states in the industrialized south and west, and in the northeastern tip (Map 3). The highest number of PLHIV is in Andhra Pradesh and Maharashtra, with nearly 0.5 million PLHIV each. Along with Tamil Nadu and Karntaka, the four south Indian states contributed 63 per cent of all the PLHIV in the country. Though Manipur and Nagaland have the highest HIV prevalence in the country, due to their small population size, the estimated number of PLHIV in these two states is around 25,000. Of the six high prevalence states, West Bengal, Gujarat and Uttar Pradesh have greater burden of the epidemic with more than 0.1 million PLHIV in each of these states. Similarly, the states of Kerala, Bihar, Rajasthan, Orissa, Chhattisgarh, Madhya Pradesh and Haryana have around 50,000 PLHIV each though HIV prevalence in these states is low.

Nature of HIV

The Indian epidemic continues to be concentrated in populations with high-risk behaviour characterized by unprotected paid sex, anal sex and injecting drug use with contaminated injecting equipment. Several high-risk groups have high HIV prevalence, and sexual networks are wide and inter-digitizing. According to India's National AIDS Control Organization (NACO), several factors put India in danger of experiencing the rapid spread of HIV. Sexual transmission is responsible for 84 per cent of reported HIV cases and HIV prevalence is high among sex workers (both male and female) and their clients. A large proportion of women with HIV appear to have acquired the virus from regular partners who were infected during paid sex. Condom usage is particularly limited when commercial encounters take place in "risky" locations with low police tolerance for this activity. Surveys in 2005 revealed that 42 per cent of sex workers in Haryana thought they could tell whether a client had HIV based on his physical appearance. At the same time, another study in Mysore revealed that only 14 per cent of sex workers used condoms consistently with clients and that 91 per cent of them never used condoms during sex with their regular partners (NACO, 2006).

No reliable information is available about the role of sex between men in India's HIV epidemic, but the few studies that have examined this subject have found that a significant proportion of men in India have sex with other men. Among men who have sex with other men, a high prevalence of HIV is recorded

in the states of Karnataka (19.2%), Maharashtra (15.6%), Manipur (12.4%), Delhi (12.3%), Gujarat (11.2%) and Andhra Pradesh (10.3%). Overall, eight states have shown more than five per cent HIV prevalence among men who have sex with other men , while four states have HIV prevalence between one per cent and five per cent. The remaining states recorded less than one per cent prevalence among men who have sex with other men. Moreover, urban areas of the country such as Delhi, Pune, Bangalore, Surat, Vadodara, Rajkot and Kolkata recorded very high HIV prevalence among men who have sex with other men (NACO, 2006).

Injecting drug use is the main risk factor for HIV infection in the north-east, especially in the states of Manipur, Mizoram and Nagaland), and features increasingly in the epidemics of major cities elsewhere including Chennai, Mumbai and New Delhi. Using shared injecting drug equipment is the main risk factor for HIV infection in northeast India and features increasingly in the epidemics of cities in other states.

Migration for work takes people away from the social environment of their families and community. This can lead to an increased likelihood to engage in risky behaviour. Infection rates have been on the increase among women and infants in some states as the epidemic spreads through bridging population groups. As in many other countries, unequal power relations and the low status of women, as expressed by limited access to human, financial and economic assets, weakens the ability of women to protect themselves and negotiate for safer sex both within and outside of marriage, thereby increasing their vulnerability (NACO, 2006).

National responses

Government

Shortly after reporting the first AIDS case in 1986, the government of India established a National AIDS Control Programme (NACP), which was managed by a small unit within the Ministry of Health and Family Welfare. The programme's principal activity was then limited to monitoring HIV infection rates among risk populations in select urban areas.

In 1991, the scope of NACP was expanded to focus on blood safety, prevention among high-risk populations, raising awareness in the general population and improving surveillance. A semi-autonomous body, the National AIDS Control Organization (NACO), was established under the Ministry of Health and

Family Welfare to implement this programme. This "first phase" of the National AIDS Control Programme lasted from 1992 to 1999. Screening of donated blood became almost universal by the end of this phase. However, performance across states remained variable.

The Indian government has said that, in the future, it would build further on partnerships with civil society organizations and also work towards greater active involvement of the target groups themselves as part of its AIDS programme. There will be greater integration of the medical response to the epidemic, for example, through provision of ART, STI services, and treatment of opportunistic infections through the National Rural Health Mission. The surveillance system of the NACP was also greatly improved over the course of the first and second phase and will be further enhanced under the third phase (NACO, 2006 and World Bank, 2006).

NGOs and CBOs

There are numerous NGOs and CBOs working on HIV/AIDS issues in India at the local, state and national levels. Projects include targeted interventions with high-risk groups; direct care of people living with HIV; general awareness campaigns; and care for children orphaned by AIDS. In some states that are supported by bilateral projects, NGOs receive capacity building and supportive supervision to implement targeted and tailored interventions. In other states without such support, the state AIDS control societies assume the responsibility, but most have only one staff member (the NGO adviser) to manage all NGOs implementing not only targeted prevention interventions but also care and support activities. Although all targeted interventions should include STI services as a component, NGOs generally face challenges in implementing and promoting high-quality STI services, including functional referral, as part of their projects. As a result, many members of high-risk groups, for example, female sex workers and their clients, men who have sex with other men and IDUs, do not have access to adequate STI services (World Bank, 2006 and YouthAIDS, 2006).

Development partners

India receives technical assistance and funding from a variety of UN partners and bilateral donors. Bilateral donors such as USAID, CIDA, and DFID have been involved since the early 1990s at the state level in a number of states.

USAID has committed more than US$70 million since 1992, CIDA US$11 million and DFID close to US$200 million. The number of major financers and the amount of funding available has increased significantly in the last year. Since 2004, the Bill and Melinda Gates Foundation has pledged US$200 million and the Global Fund has approved US$54 million for HIV/AIDS. DFID (GBP107 million) is providing pooled financing together with the World Bank (US$250 million) in overall support to India's HIV/AIDS programme NACP. Other donors include the Clinton Foundation, various UN agencies, DANIDA, SIDA and the European Union (NACO, 2006; USAID, 2006; YouthAIDS, 2006; World Bank, 2006).

Major challenges

According to the World Bank (2006) and USAID (2006), the major challenges in India for combating against HIV/AIDS are the following.

- There are institutional constraints, both structural and managerial, to scale up at the national and state levels. It is critical that these factors be addressed as the programme expands its response to the epidemic.
- NACO will need to change its role and responsibilities to provide the leadership and direction for a stronger multi-sector response for the next phase in India's fight against HIV/AIDS while the states will need to provide implementation capacity to put a robust programme into place.
- The capacity to mount a strong programme is weakest in some of the poorest and most populated states.
- There is a need for tailored capacity-building activities and for more attention to be paid to performance-based financing approaches. In addition, the programme also experiences high turnover of state-level project directors, resulting in limited continuity and variability in performance across states.
- There are over 32 large donor agencies working with NACO in different states and on different programmes, apart from many more that support NGOs in states. Each donor comes with its own mandate and requirements, as well as areas of focus. The transaction costs to the Indian government are huge. There is a need for better coordinating mechanisms among the donors and clear leadership by the government to reduce the transaction costs.

- There remains a need for greater use of data for decision-making, including programme data and epidemiological data. A lot of data that is being generated is not adequately used for managing the programme or in policy formulation and priority setting. Results-based management and linking incentives to the use of data should be explored.
- Stigma and discrimination against people living with HIV/AIDS and those considered to be at high risk remain entrenched. Stigma and denial undermine efforts to increase the coverage of effective interventions among high-risk groups, such as men who have sex with other men , sex workers and injecting drug users. Harassment by police and ostracism by family and community drives the epidemic underground and decreases the reach and effectiveness of prevention efforts.
- New approaches need to be tried to reach rural communities with information about HIV/AIDS, safe sex and how to prevent and treat HIV and AIDS.

HIV/AIDS prevalence and national responses in Bangladesh

Scale

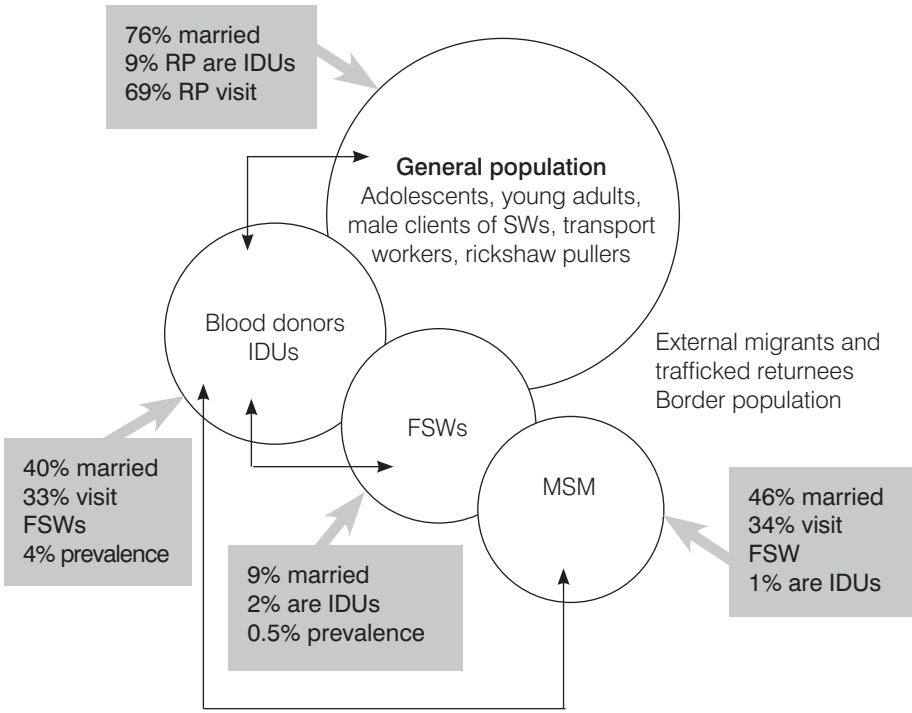
With a prevalence rate of less than one per cent, HIV/AIDS in Bangladesh may initially not look like a major threat. However, as the Bangladeshi population exceeds 140 million, a mere one per cent rise would mean the addition of more than one million infected sufferers. The first patient with AIDS was diagnosed in Bangladesh in 1989. However, until December 2007, only 1,207 new HIV positive cases were reported officially. Of these, 365 have developed AIDS and 123 have died (Table 3.1). According to the National AIDS/STD

TABLE 3.1
Total reported HIV and AIDS cases in Bangladesh

Cases	Number, end 2005	Number in 2006	Number in 2007	Total
New HIV cases	658	216	333	1,207
AIDS cases	134	106	125	365
AIDS deaths	74	35	14	123

Source: NASP, Director General of Health Services, GoB, 2005

FIGURE 3.1
Risk situation in Bangladesh



Programme (NASP) of GoB in 2006, out of 216 new HIV positive cases, 142 were male, 73 were female and one was unknown. Of the new cases of HIV, 68.06 per cent were aged above 25 years and 31 per cent were migrants. The educational status of the new HIV positive cases was very low; only 28 per cent of new cases were literate, 23.61 per cent had studied up to primary level and 26.85 per cent had studied to secondary level.

UNAIDS estimated that approximately 11,000 Bangladeshis could have been living with HIV at the end of 2005. Bangladesh's sixth round of sentinel surveillance (2004–2005) showed an overall prevalence rate of 0.6 per cent (Table 3.2). The sixth round was carried out in five groups: injecting drug users (IDUs), female sex workers (FSW), men who have sex with other men (MSM), male sex workers (MSW) and bridge population groups (mobile men including rickshaw drivers, truckers and dockworkers).

TABLE 3.2
HIV prevalence rates over the rounds

Surveillance round	Numbers tested	HIV (%)
First round	3,886	<1% (0.4)
Second round	4,634	<1% (0.2)
Third round	7,063	<1% (0.2)
Fourth round	7,877	<1% (0.3)
Fifth round	10,445	<1% (0.3)
Sixth round	11,029	<1% (0.6)

Source: NASP, Director General of Health Services, GoB, 2005

Nature of HIV

Bangladesh is still considered as a country of low HIV/AIDS prevalence. However, the bordering countries of India, Myanmar, Nepal and Thailand—where the movement of people between these countries is easy and constant—have seen fast transmission rates of HIV/AIDS. Moreover, the behavioural patterns and extensive risk factors that facilitate the rapid spread of the infection are prevalent, making Bangladesh highly vulnerable to an HIV/AIDS epidemic. These risk factors include poverty, gender discrimination, a large commercial sex worker and brothel sex worker population, a large number of hidden and resident sex workers, lack of basic sexual knowledge and a lack of proper knowledge of sexually transmitted diseases (STDs/STI). Another major risk is that drug use increases the risk of HIV and can start at a young age; the danger of becoming infected with HIV by sharing needles is well documented and real.

In Bangladesh, IDUs are most likely to be potential carriers of HIV/AIDS among the vulnerable groups in the country. The sixth round of the national HIV and behavioural surveillance report (2004–2005) showed that the HIV infection rate among IDUs in central Bangladesh—mainly in Dhaka city—is now 4.9 per cent. This represents an increase from 1.4 per cent in 2000 to 1.7 per cent in 2001 and four per cent in 2002. These IDUs are not an isolated population, but are often married and are sometimes involved with prostitution. Data found that 44 per cent of female IDUs are also sex workers and had a higher prevalence rate of syphilis (9.2% prevalence rate compared with 2.9% of male IDUs). The population of IDUs who are most at risk often face homelessness, unemployment and

incarceration and they sell their blood professionally. Therefore, the illegal sale of blood by IDUs increases the threat of tainting the national blood supply (GoB, 2005).

There are over 100,000 sex workers in Bangladesh, including both men and women. Brothel-based female sex workers reportedly see around 18 clients per week, while street-based and hotel-based workers see an average of 17 and 44 clients per week respectively. There is a significant prevalence of sexually transmitted diseases (STDs) among sex workers in central Bangladesh, with approximately 43 per cent of female sex workers and 18.2 per cent of male sex workers having syphilis (UNAIDS, 2005).

The lack of knowledge of HIV/AIDS may be creating the potential for a future epidemic in Bangladesh. While knowledge of HIV is nearly universal among sex workers and their clients, awareness remains extremely low among the general population. Research has indicated that only 17 per cent of the populations most at risk are informed about HIV prevention, while misconceptions about HIV/AIDS range from 3.7 per cent among transgender (Hijra) to 36.6 per cent among brothel-based female sex workers (GoB, 2005).

Further, the high-risk behaviour of having unprotected sex is evidenced by the low use of condoms among FSWs and MSWs. Data shows that the overall condom use rate among all FSWs is 30.9 per cent, while the rate is only 24.1 per cent among street-based sex workers (ibid., 2005). Among transgenders, the condom use rate is much lower at 15.6 per cent. Brothel-based sex workers reported having unprotected sex with their clients on a regular basis. Among client groups, such as rickshaw pullers and truck drivers, roughly 83 per cent have never used condoms when buying sex. Data on condom use among MSMs during anal sex indicates that in non-commercial sex, the rate of condom use is 37 per cent, while in commercial sex, the rate is 49.2 per cent (ibid., 2005).

Gender violence and inequality exist in largely male-dominated Bangladeshi society, thereby placing women and girls at additional risk of HIV. A large number of the clients of sex workers are married men who put their wives at risk of HIV.

National responses

Government

In view of the pandemic that started in the early 1980s, the government of Bangladesh formed a National AIDS Committee in October 1985 for the pre-

vention and control of HIV/AIDS. The country's National Policy on HIV/AIDS and STD-related issues was drafted in 1996 and adopted in 1997. The national response has included the establishment of a National AIDS Committee (NAC) and Technical and Co-ordination Committees at the central level and committees at various peripheral levels. A number of activities have been implemented by the NAC, the Ministry of Health and Family Welfare (MOHFW) as well as by the Directorate General Health Services (DGHS).

Despite substantial work having already been undertaken, the government's response has been neither adequate nor satisfactory. The GoB's expression of commitment to AIDS prevention has yet to be translated into action at the ground level. The government has issued a plan of action to address HIV/AIDS within the framework of the Health and Population Sector Programme. The Strategic Plan (1997–2002) envisaged the involvement of community and religious leaders as well as student and youth leaders in HIV/AIDS prevention advocacy programmes.

While early commitment was limited and implementation of HIV control activities slow, Bangladesh has strengthened its programmes to improve its response. The government's 2005 Poverty Reduction Strategy Paper highlighted HIV/AIDS. The Government of Bangladesh also prepared a National Strategic Plan for HIV/AIDS for the period 2004 to 2010 under the guidance of NAC and with the involvement and support of different stakeholders. Efforts to mainstream HIV/AIDS in the public sector outside of the Ministry of Health and Family Welfare were initiated through the designation and training of focal points on HIV/AIDS in 16 government ministries (GoB, 2005 and 2006; World Bank, 2006; USAID, 2005). The priority strategies include the following.

- Preventing transmission of HIV through the expansion of interventions targeted among individuals with high-risk behaviours including sex workers and their clients, truck drivers and injecting drug users
- Strengthening STD case management to include a syndromic approach
- Increasing the availability, accessibility and use of quality condoms
- Providing information, education and communication activities targeted at policymakers and the general population
- Enabling legislation and the use of the media, and creating an enabling environment for people in general
- Rational use of blood/blood products and a thorough screening of donated blood for HIV and other pathogens

- Provision of counselling and other support including the expansion of voluntary testing facilities targeted at pregnant women or women contemplating pregnancy and breastfeeding mothers
- Implementing activities to include legal amendments to counter discrimination against people living with HIV/AIDS and towards improving community acceptance
- Establishing HIV/AIDS and STD surveillance to determine the present and future magnitude of the problem and to monitor HIV/AIDS and STD programmatic interventions and their effects
- Strengthening the capacity for diagnosing STD/HIV/AIDS

Development partners

Currently, U.K. Department for International Development (DfID), USAID, SIDA and GTZ are financing a number of HIV/AIDS-related programmes in Bangladesh. These include a social marketing programme; peer education and condom promotion activities; information, education and communication efforts; STI treatment; surveillance and operational research; and capacity building for NGOs. Three UN agencies are also assisting the government of Bangladesh in the implementation of three project components. UNICEF is managing the NGO service-delivery component; WHO is managing the blood safety activities; and UNFPA is managing the capacity-building component. A Global Fund grant for $40 million (Round 6) to promote prevention of HIV among adolescents and young people brings together the government and Save the Children, USA and is being implemented through NGOs. The FHI/USAID supported project ($13 million, 2005–2008) is also focusing on selected interventions for some high-risk groups, including expansion of VCT services (World Bank, 2006; UNAIDS, 2006).

Non-governmental organizations (NGOs)

More than 380 NGOs and AIDS service organizations have been implementing programmes/projects in different parts of Bangladesh. These initiatives focus on the prevention of sexually transmitted diseases among high-risk groups involving mostly female sex workers, MSM, IDUs, rickshaw pullers and truckers. NGOs are often in a better position than the public sector to reach high-risk groups, such as sex workers and their clients and injecting drug users. Building the capacity of NGOs, especially smaller organizations, and combining their reach with the resources and strategic programmes of the government is an effective

way to change the behaviour of high-risk groups and prevent the spread of the virus to the general public (World Bank, 2006; UNAIDS, 2006).

Major challenges

Although progress has been made in the above areas, the government of Bangladesh, World Bank, UNAIDS, USAID, WHO, UNICEF and UNFPA have identified several challenges to prevent the further spread of HIV in Bangladesh. These challenges include the following.

- The issue of mainstreaming HIV/AIDS into the Bangladeshi Poverty Reduction Strategy Paper (PRSP) and other frameworks and sectors has not been adequately addressed, as HIV/AIDS has been largely considered as a problem to be dealt with through the health sector.
- Sentinel surveillance remains key to following trends of HIV infection and behavioural changes, as well as for monitoring the outcome and impact of responses to HIV/AIDS. There is a need to increase the scale of behavioural change activities and health promotion interventions for high-risk behaviours and vulnerable groups, particularly IDUs and sex workers.
- Sensitize national and local leaders to the importance of addressing HIV/AIDS and to conduct advocacy to help leaders from all sectors understand their role as opinion leaders.
- To ensure the safety of blood transfusions, the government has established 98 centres throughout the country to screen blood for HIV, syphilis, malaria, Hepatitis B and Hepatitis C. In addition, efforts have been made to promote voluntary blood donation, as opposed to professional blood donation. To further support this, legislation for blood transfusions was put in place in 2002; currently, its enforcement and implementation remains a challenge.
- Only seven facilities have been established for the purpose of voluntary counselling and testing voluntary counselling and testing. However, efforts for expansion are underway through government collaboration with NGOs and development partners.
- To expand advocacy and awareness among the general population through multi-sectoral agencies; to promote the social acceptability of condom use; and to ensure the adequate supply and access to condoms.

- Reduce discrimination against those infected with HIV or groups engaging in high-risk behaviours through appropriate advocacy, policies and related measures.
- Strengthen the government's capacity for programme implementation, management and monitoring of programme activities.
- Promote NGO capacity for programme planning, implementation and supervision of interventions.
- Strengthen mechanisms for collaboration and coordination within and between the government, the non-governmental sector, development partners and other stakeholders.
- More effective mechanisms should be established for sharing strategic information necessary for policy and programming purposes on HIV/AIDS and these new mechanisms should be applied accordingly. Further, documentation and sharing of best practice should be an integral part of the national response.

Collaboration between India and Bangladesh

It was very difficult to find any ongoing partnership projects between India and Bangladesh for fighting against HIV/AIDS. Both the governments of Bangladesh and India have individually taken measures to prevent HIV/AIDS. A comprehensive national policy and a plan of action has been formulated in both India and Bangladesh, emphasizing targeted interventions and strengthening of STI management. However, not enough attention has been given by both countries to the implementation of interventions in the border areas.

However, at the regional level, SAARC Tuberculosis and HIV/AIDS Centre (STC) has been working for prevention and control of TB and HIV/AIDs in the region since 1992 by coordinating the efforts of the National TB Control Programmes (NTPs) and National AIDs Control Programmes (NACPs) of member countries. The objective of STC is to work for prevention and control of TB and HIV-related TB in the region by coordinating the efforts of the National Tuberculosis Control Programmes of the member countries. The following programmes were undertaken by STC in 2006.

- Public awareness and advocacy programmes on TB and HIV/AIDS
- Participation in international/regional meetings, seminars and conferences in the field of TB and HIV/AIDS and NTP Review in member countries

- Production and distribution of STC publications
- Strengthening of STC Library and strengthening and updating of their website
- Carry out situation analysis of TB and HIV/AIDS Control Programme Activities in India and Nepal
- SAARC Regional Meeting of Managers of National TB Control Programmes from SAARC member states
- SAARC regional training on leadership and strategic management in TB and HIV/AIDS Control
- SAARC regional training on data management applications for TB and HIV/AIDS managers
- Strengthening SAARC Regional Epidemiological Networking by developing software (Epi. Centre for TB and other for HIV/AIDS data management)

Conclusion

This section has attempted to highlight the scale, nature and national responses to HIV/AIDS in Bangladesh and India. It is seen that approximately 5.7 million Indians were living with HIV in 2005, of which 88.7 per cent are adults (15–49 years), 7.5 per cent are aged 50 and above, while 3.8 per cent are children (<15 years). Although the HIV prevalence rate is less than one per cent, approximately 11,000 Bangladeshis could have been living with HIV at the end of 2005. Nevertheless, the bordering countries of India, Myanmar, Nepal and Thailand have seen fast transmission rates of HIV/AIDS while the movement of people between these countries is easy and constant. Moreover, the behavioural patterns and extensive risk factors that facilitate the rapid spread of the infection are prevalent, making Bangladesh and India highly vulnerable to an HIV/AIDS epidemic. Both the governments of Bangladesh and India have taken measure to prevent an epidemic of HIV/AIDS but not enough attention has been given to the border areas between these countries.