

The HIV/AIDS Crisis in India

India is poised on the verge of a sharp escalation of the HIV/AIDS pandemic, with profound consequences for the state's society, economy and polity. This crisis will not affect India alone. In an increasingly interconnected world, the effects of such an epidemic will be globally felt, both directly in terms of the spread of infection, and indirectly in terms of the overall security and economic and political health of the region.

According to a September 2002 US National Intelligence Council (NIC) report, India is one of five "second wave countries", including Russia and China, where infections of the Human Immuno-Deficiency Virus (HIV) and cases of Acquired Immuno-Deficiency Syndrome (AIDS) is on the verge of a "breakout" -- a stage when the infection is no longer confined to "high risk" populations, and breaks out into the general population. The HIV/AIDS crisis presents a unique challenge for governance and leadership in India, and coordinated planning and policy implementation on a whole host of fronts simultaneously is vital to addressing the issue.

Not a numbers game: Getting accurate data on the prevalence of HIV infections in India is very difficult. The social stigma associated with the disease, a perception of the disease as a "private" problem, an unwillingness to talk about sex or drug use, lack of knowledge about the disease, uneven disease monitoring capabilities by states, and a focus on prevention rather than treatment of AIDS, all contribute to chronic underreporting. Both the Indian National AIDS Control program and the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimate that there were approximately 4 million reported AIDS cases in India in 2000/01. The NIC report put the number at between 5 and 8 million HIV infected people in 2002. This amounts to 0.90-1.40 percent of India's adult population. Even the lower number is very significant, and there is an urgent need to stabilize infection rates.

Two epidemics: While it is impossible to present a complete picture of HIV infection in India, some basic characteristics are known. HIV first appeared in India in the mid-1980s, in the urban centers of Mumbai, Chennai and Bangalore. It was primarily located in traditional high-risk groups, such as prostitutes and truck drivers. The majority of HIV infections spread through heterosexual sex. In the intervening years, the distinction between "high risk" and other groups has become increasingly blurred. Infections have spread to rural areas, as well as from marginalized populations to mainstream ones, such as housewives in middle class households. India's size, diversity and the varying capability of its different states presents a formidable challenge in fighting HIV/AIDS, and it is important to disaggregate the problem. There are two main HIV/AIDS

epidemics in India, with very different dynamics and uneven geographic impact.

The first epidemic is the classic "migratory AIDS" pattern, carried by truck drivers and sex workers. This epidemic is most severe in Maharashtra and in the three southern states of Tamil Nadu, Karnataka, and Andhra Pradesh – ironically, those whose economic prospects are in other respects most promising. Even within those states, however, there are important differences from one locality to another reflecting the presence or absence of highways, migrant labor, or areas from which men traditionally go away to find work.

The second epidemic is driven by intravenous drug use in India's more sparsely populated northeastern states, immediately adjacent to the "golden triangle" opium-growing areas in Burma and Thailand. While the northeast is geographically cut off from the rest of the country, HIV/AIDS infections can spread into the rest of the country, especially to eastern India, through the same sources of migration as in the first epidemic.

Compounding factors: Malnutrition and pre-existing infectious diseases, including sexually transmitted diseases, significantly decrease resistance to HIV infection and life expectancy after the onset of AIDS. India has many of these risk factors. According to World Bank data for the year 2000, 28.6 percent of the population lives below the poverty line. There are many competing needs for the public health infrastructure, and one of the challenges is to ensure that HIV/AIDS neither undercuts resources and efforts to deal with other killers like tuberculosis (TB), malaria and diarrhea, nor gets marginalized. There are compelling reasons to address these infections in tandem. TB and HIV are fueling each other. Almost 30 percent of people with HIV are also infected with TB. TB is the most common opportunistic infection among people with HIV and is a leading cause of death among people who are HIV positive. But unlike TB and malaria, HIV/AIDS does not have a cure, and affordable treatment is far on the horizon at this stage.

The dimensions of a "break out": The NIC report predicts that there will be 20 to 25 million HIV positive Indians by 2010. The Government of India considers these figures alarmist. However, even if one projects forward from the lower estimates of current infection rates, continuation of current trends will have a dramatic impact.¹

Even if the cost of anti-retroviral drugs continue to fall, the cost of treating this number of patients, including both paying for drugs and supervising treatment, will be astronomical. In the absence of a vaccine or drastically more affordable treatment, patients will simply wait to die. Social and humanitarian

problems will get exacerbated, and vulnerable populations such as women, children, and youth will be prey to a host of problems. Medical vulnerability is linked to economic vulnerability, and magnified by other pre-existing social imbalances, particularly those of gender. Economic and social problems caused by HIV/AIDS will unleash a vicious circular dynamic, by adding to the risk factors that make people prone to HIV infection.

The population that is most sexually active and hence most likely to contract HIV is also India's most economically productive population (between the ages of 15-49). Spreading infection will affect not only India's per capita productivity and labor supply, but it will also result in the loss of primary bread winners in families, and leave dependent members vulnerable to a host of social and developmental problems. The burden of looking after disabled patients will fall on the state. The combination of these two costs—loss of productivity and the cost of patient care—could significantly affect India's growth and the role it aspires to play in the world. It could also affect political stability.

Role of Central and State Governments: India is currently in the second phase of a 10-year government program to combat the spread of HIV. The government has set up a response mechanism in which the central government essentially has a coordinating role, with the bulk of the work being done at the state level. This reflects the uneven impact of the disease around India; it also tends to reduce the visibility of the problem in national politics, and to push down to the state and local level the distasteful need to talk about the sensitive subjects of sex and drugs that are at the heart of AIDS transmission.

State governments, not surprisingly, have an uneven track record in dealing with AIDS, but some have been quite effective and creative. In general, the government's response has emphasized prevention over treatment. This is a wise priority, but without making some provision for treatment, it will be very difficult to persuade potential carriers to undergo AIDS testing, a procedure that is central to a serious prevention effort.

Averting catastrophe: India's best chance for changing the current alarming trends lies in a more dynamic partnership between the national and state governments and India's vibrant NGO sector. Looking further ahead, India's world-class scientific talent, and institutions such as the National AIDS Research Centre and the National Institute of Virology, offer the promise of a more vigorous scientific response, not just in India but around the world.

A host of vigorous and committed NGOs are already working both independently and in close cooperation with state governments to educate populations in both rural and urban areas, work with high-risk communities to change risky patterns of behavior, and provide medical access and services to AIDS patients. This vibrant and embedded civil society involvement was one of the primary reasons that Thailand, probably the most notable success story for AIDS in Asia, was so successful in stabilizing its infection rate. NGOs also encourage government transparency in dealing with HIV/AIDS, thus promoting trust in

the government and openness to its initiatives. This was the other key ingredient in the Thai success story.

HIV/AIDS in elsewhere in South Asia: Pakistan, Bangladesh, Sri Lanka and Nepal have lower rates of HIV infection, but have varying patterns of HIV transmission, some more threatening than others. Data collection is problematic in all states. In Pakistan, HIV transmission is primarily through intravenous drug use. Bangladesh and Nepal share the combination of high-risk behaviors and factors that characterized the epidemic in India, Myanmar and Thailand. Large numbers of young males and sex workers from these countries go work in Indian cities and travel home frequently. In Sri Lanka, which has the most effective health system in the region, infection has been detected in only a couple of surveillance sites. The governments of all these countries have a chance to deal effectively with all aspects of HIV/AIDS at this juncture. Effective public education campaigns are key, but have often been a problem in the South Asia context because of an unwillingness to talk openly about risk factors.

Issues for the United States and the world: In the past few years, responding to the HIV/AIDS problem has become a major international effort. The Global Fund to Fight AIDS, Tuberculosis and Malaria has raised over \$3 billion, and has developed a creative mechanism for channeling money to the most effective programs. The United States has come to look on the HIV/AIDS epidemic as a security issue in ways that are different from other international health problems. President Bush's decision to ask Congress to appropriate \$15 billion over five years to battle AIDS, tripling current US spending, is the clearest indication that the United States believes it cannot afford to be a bystander in the fight against HIV/AIDS.

In India, the main avenues for U.S. support for AIDS prevention are bilateral assistance programs (both from AID and from the Center for Disease Control), research efforts by the National Institutes of Health, and the work of foundations and NGO's, notably the Bill and Melinda Gates Foundation. India has also received a substantial grant from the Global Fund. Taken together with the work of the Indian government, scientists and NGOs, these resources have a chance of reversing today's alarming trends. Success in this effort would mean not only averting a human catastrophe on an unprecedented scale, but also spreading the knowledge developed in India to other countries facing the same danger.

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ⁱ For detailed projections, read 'The Future of AIDS' by Nicholas Eberstadt in *Foreign Affairs*. November/December 2002. He predicts that depending on the magnitude of infection, there will be somewhere between 30 million to 140 million new HIV cases in India between 2000-2025. For the NIC report, see http://www.cia.gov/nic/pubs/other_products/ICA%20HIV-AIDS%20unclassified%20092302POSTGERBER.htm

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