

National Aids Prevention and Control Policy

1. INTRODUCTION

1.1 In India the Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic is now 15 years old. Within this short period it has emerged as one of the most serious public health problems in the country. The initial cases of HIV/AIDS were reported among commercial sex workers in Mumbai and Chennai and injecting drug users in the north-eastern State of Manipur . The infection has since then spread rapidly in the areas adjoining these epicenters and by 1996 Maharashtra , Tamil Nadu and Manipur together accounted for 77 per cent of the total AIDS cases with Maharashtra reporting almost half the number of cases in the country. Even though the officially reported cases of HIV infections and full-blown AIDS cases are in thousands only, it was realised that there is a wide gap between the reported and estimated figures because of the absence of epidemiological data in major parts of the country. The latest estimate for the HIV/AIDS infected adult population in the country is 3.8 million in 2000. The overall prevalence in the country is still, however, very low, a rate much lower than many other countries in the Asia region.

Adults HIV prevalence rate (15-49 years) in some selected countries in Asia .	
Cambodia	2.77
Myanmar	1.99
Thailand	1.85
India	0.75
Malaysia	0.36
Nepal	0.30
Vietnam	0.29
Pakistan	0.10
Indonesia	0.09
Sri Lanka	0.07
China	0.08
Bhutan	0.01

1.2 The available surveillance data clearly indicates that HIV is prevalent in almost all parts of the country. In the recent years it has spread from urban to rural areas and from individuals practising risk behaviour to the general population. Studies indicate that more and more women attending ante-natal clinics are testing HIV-positive thereby increasing the risk of perinatal transmission. About 85 per cent of the infections occur from the sexual route (both heterosexual and homosexual), about 4 per cent through blood transfusion and another 8% through injecting drug use. About 89% of the reported cases are occurring in sexually active and economically productive age group of 18-49 years. One in every 4 cases reported is a woman. The attributable factors for such rapid spread of the epidemic across the country today are labour migration and

mobility in search of employment from economically backward to more advanced regions, low literacy levels leading to low awareness among the potential high risk groups, gender disparity, sexually transmitted infections and reproductive tract infections both among men and women. The social stigma attached to sexually transmitted infections also holds good for HIV/AIDS, even in a much more serious manner. The effects of stigma are devastating. Discrimination against People Living With HIV/AIDS denies them access to treatment, services and support and hinders effective responses. It creates a climate in which decisive action from the government may be side stepped. There have been cases of refusal of treatment and other services to AIDS patients in hospitals and nursing homes both in Government and private sectors. This has compounded the misery of the AIDS patients. More often it is mistaken to be a contagious disease and patients are isolated in the wards creating a scare among the general patients. In the workplace there are cases of discrimination leading, on some occasions, to loss of employment. The active part played by some non-Governmental organisations in bringing out public interest litigations against such cases of discrimination and the judicial pronouncements by courts in support of the rights of such people has partly helped in alleviating the misery of the affected persons. People Living With HIV/AIDS have provided the best response to the stigma and the denial that shroud the epidemic. They bring faces and voices to the realities. Only clear and candid information about how HIV is and is not transmitted will alleviate unnecessary fear and discrimination. Efforts need to be made to train all medical and Para medical health care workers to create a congenial environment where HIV/AIDS patients are admitted and treated without any fear and scare. The treatment options are still in the initial trial stage and are prohibitively expensive. While there is no vaccine in sight, multi-drug anti retroviral therapy, popularly known as 'cocktail therapy', is not a cure to the disease and may help only in prolonging the life of the patient . Standardisation of treatment regimens for these drugs is still evolving and there are fears of patients developing drug resistance and side effects if the therapy is not administered under proper medical supervision. There are instances of quacks taking advantage of the situation and promising cures and defrauding unsuspecting people who are infected with the virus of large sums of money.

1.3 Transmission of the disease through blood, though limited to 4% of the cases down from 8% in 1992, is also a serious issue as unsuspecting population can get infected through this route if safe blood is not ensured. Existence of a large number of small and medium blood banks, many of them in the private sector, also compounds the problem. The Supreme Court directive of May, 1996 has helped in phasing out unlicensed blood banks by May, 1997 and professional blood donors by December, 1997. Mandatory testing of blood for HIV along with Syphilis, Malaria Hepatitis B and C has helped in checking transmission of HIV virus through blood transfusion.

1.4 Transmission among injecting drug users is also one of the major causes for the spread of HIV/AIDS in the country. Even though the cases are more prevalent in the north-eastern States, incidence of HIV through injecting drug use is evident from many parts of the country, specially the urban areas.

1.5 Harm reduction programmes which involve exchange of syringes and needles, coupled with peer education, community outreach, access to health services and a range of treatment

modalities from abstinence to oral drug substitution have been adopted by other countries to effectively reduce transmission of HIV through injecting drug use. In India the harm-reduction approach is yet to find wider acceptability because of ethical and moral considerations. Although transmission of HIV through use of needles, razors and other cutting instruments in beauty parlors, hair-cutting saloons and dental clinics is insignificant, lack of hygienic practices in majority of these establishments also poses a health risk to the unsuspecting general population who visit these places every day. There is an urgent need to bring these establishments to acceptable standards of hygiene to minimise and almost eliminate the chances of HIV transmission through the use of needles and sharp cutting instruments.

1.6 With a high prevalence of TB infection in India the problem of HIV/TB co-infection also poses a major challenge. Nearly 60% of the AIDS cases are reported to be opportunistic TB infection cases. Treatment of TB among the HIV-infected persons is a new challenge to the National TB Control Programme which has now adopted Directly Observed Treatment Short-course(DOTS) strategy for control of TB infection. Some of the drugs which are recommended for TB treatment pose complications in cases of HIV-infected persons and had to be withdrawn in areas of high HIV prevalence. At the same time looking for HIV among TB infected persons will also cause the problem of scaring away a large number of TB infected cases in the country from seeking treatment under the DOTS strategy. There is no risk of any TB patient getting infected with HIV unless he or she practises high risk behaviour or gets infected from transfusion of HIV-infected blood.

1.7 HIV/AIDS is not a disease which spreads randomly and is transmitted as a consequence of a specific behavioural pattern and has strong socio-economic implications. It not only costs huge sums of money in terms of controlling the opportunistic infections such as TB, Pneumonia and cryptococcal meningitis, but seriously affects individuals in their prime productive years causing serious economic loss to them and their families.

Economic Impact

The effects of the epidemic radiate from the household across society. In Cote d'Ivoire, urban households that have lost at least one family member to AIDS have seen their income drop by 52-67%, while their expenditure soared four fold. To cope up, they have to cut their food consumption by about 41%. Rural households facing similar predicaments in Thailand are seeing their agricultural outputs shrinking by half. In 15% of the cases, children are removed from schools to take care of family members who are ill and to regain lost income.

Some companies in Africa have already felt the impact of HIV on their bottom line. Managers at one sugar estate in Kenya said they could count the cost of HIV infection in a number of ways: absenteeism, lower productivity (a 50% drop in the ratio of processed sugar recovered from raw cane between 1993 and 1997) and higher overtime costs for workers obliged to work longer hours to fill in for sick colleagues. Direct cash costs related to HIV infection have risen dramatically in the same company: spending on funerals rose fivefold between 1989 and 1997, while health costs rocketed up by more than 10-fold over the same period, reaching KSh 19.4 million (US\$ 325000)

in 1997. The company estimated that at least three-quarters of all illness is related to HIV infection. Indeed, illness and death have jumped from last to first place in the list of reasons for people leaving a company, while old-age retirement slipped from the leading cause of employee drop-out in the 1980s to just 2% by 1997.

1.8 While addressing the problem of HIV/AIDS among the economically productive and sexually active sections of population, specific emphasis needs to be given not only to high risk groups like commercial sex workers and injecting drug users, but also to specific groups in general population like students, youth, migrant workers in urban and rural areas, women and children. Migration of economically productive sections of population from rural to urban areas in search of employment is a common phenomenon all over the country. Most of the migrant labour are in the unorganised sector, are highly mobile and live in unhygienic conditions in urban slums. Long working hours, relative isolation from the family and geographical social mobility may foster casual sexual relationships and make them highly vulnerable to STDs/HIV/AIDS. All these aspects provide an unusual challenge of spread of HIV infection through various routes which comes with its long period of invisibility and subsequent manifestation through opportunistic infections. In India with a large population and population density, low literacy levels and consequent low levels of awareness, HIV/AIDS is one of the most challenging public health problems ever faced by the country.

2. RESPONSE

2.1 Soon after reporting of the first HIV/AIDS case in the country, the Government recognised the seriousness of the problem and took a series of important measures to tackle the epidemic. A high-powered National AIDS Committee was constituted in 1986 itself and a National AIDS Control Programme was launched a year later. In the initial years the programme focussed on generation of public awareness through mass communication programmes, introduction of blood screening for transfusion purposes and conducting surveillance activities in the epicentres of the epidemic. In 1992 the Government formulated a multi-sectoral strategy for the prevention and control of AIDS in India . It is implemented through the National AIDS Control Organisation at the national level and State AIDS Cells at the State/UT levels. The programme concentrated on the following areas which conform to the global AIDS prevention and control strategy:-

- i. Programme Management
- ii. Surveillance and research
- iii. Information, Education and Communication including social mobilization through Non-Governmental Organisations (NGOs)
- iv. Control of Sexually Transmitted Diseases
- v. Condom Programming

vi. Blood Safety; and

vii. Reduction of impact.

2.2 Eight years into the programme, the Government can look back with a measure of satisfaction for its success in important areas like generation of awareness about HIV/AIDS among the urban and rural population of the country. Awareness levels which were almost insignificant at the beginning of the epidemic have substantially increased in urban areas even though the level of awareness in rural areas continues to remain low. The Behavioural Surveillance Survey (BSS) carried out by Government of India in 2000-01 general population in various states clearly indicated that the overall awareness about HIV/AIDS among people in reproductive age group (15-49 years) was 76.1%; males –82.4% and females-70%. In the urban areas, 89.4% respondents had heard of HIV/AIDS as against 77.3% in rural areas. However, the lowest awareness rates were recorded among rural women in Bihar (21.5%), Gujarat (25%), Uttar Pradesh (27.6%), Madhya Pradesh (32.3.%) and West Bengal (38.6%). More than half of the respondents in the country (57%) were aware that having one faithful and uninfected partner could prevent transmission of HIV/AIDS. Some very successful intervention programmes among the high risk groups like commercial sex workers in the Sonagachi area of Calcutta , men having sex with men in Chennai and injecting drug users in Manipur were carried out through the dedicated involvement of non-Governmental organisations. Emphasis has been laid on control of STDs by strengthening STDs clinics at the district level by early diagnosis and proper management of STDs. Availability of good quality condoms through social marketing has made a significant increase in the last three years.

2.3 Several important actions have been taken to ensure blood safety by modernisation and strengthening of blood banks, introduction of licensing system for blood banks and gradual phasing out of professional blood donors. Introduction of component separation facilities has also helped in proper clinical use of blood for transfusion. The percentage of infections occurring through blood transfusion has reduced from 8% in 1994 to 3- 4% in 2001.

2.4 HIV/AIDS is not merely a public health challenge, it is also a political and social challenge. Behaviour change will not occur without a significant change in the social and political environment. Unequal gender and power relations, taboos in frank and open communication about sexual health and stigma and discrimination are particularly significant obstacles to an effective response. The economic impact of AIDS epidemic needs to be acknowledged. The largest economic cost of a death due to HIV/AIDS is usually lost income as those who die from AIDS are generally younger and in their most productive years.

2.5 There are still many gaps left in the programme and many lessons have been learnt. The inexorable spread of the disease from the initial epicenters to the rest of the country underscores the immediate need to have a paradigm shift in the response against HIV/AIDS at all levels making it imperative to formulate a comprehensive national policy on HIV/AIDS in order to cope effectively with the changed nature of the HIV/AIDS problem. The entire programme of prevention and control of HIV/AIDS needs to adopt a more holistic approach looking at AIDS as a developmental problem and not as a mere public health issue.

3. OBJECTIVES AND GOALS

The general objective of the policy is to prevent the epidemic from spreading further and to reduce the impact of the epidemic not only upon the infected persons but upon the health and socio-economic status of the general population at all levels. The policy envisages effective containment of the infection levels of HIV/AIDS in the general population in order to achieve zero-level of new infections by 2007. The specific objectives of the policy are:

(i) to reiterate strongly the Government's firm commitment to prevent the spread of HIV infection and reduce personal and social impact.

(ii) to generate a feeling of ownership among all the participants both at the Government and non-Government levels, like the Central Ministries and agencies of the Government of India, State Governments, city corporations, industrial undertakings in public and private sectors, panchayat institutions and local bodies to make it a truly national effort

(iii) To create an enabling socio-economic environment for prevention of HIV/AIDS, to provide care and support to people living with HIV/AIDS and to ensure protection/promotion of their human rights including right to access health care system, right to education, employment and privacy.to mobilise support of a large number of NGOs/ Community Based Organisations (CBOs) for an enlarged community initiative for prevention and alleviation of the HIV/AIDS problem.

(iv) To decentralise HIV/AIDS control programme to the field level with adequate financial and administrative delegation of responsibilities.

(v) To strengthen programme management capabilities at the State Governments, municipal corporations, panchayat institutions and leading NGOs participating in the programme.

(vi) To bring in horizontal integration at the implementation level with other national programmes like Reproductive and Child Health, TB Control, Integrated Child Development Scheme and with the primary health care system.

(vii) To prevent women, children and other socially weak groups from becoming vulnerable to HIV infection by improving health education, legal status and economic prospects

(viii) To provide adequate and equitable provision of health care to the HIV-infected people and to draw attention to the compelling public health rationale for overcoming stigmatisation, discrimination and seclusion in society

(ix) To constantly interact with international and bilateral agencies for support and cooperation in the field of research in vaccines, drugs, emerging systems of health care and other financial and managerial inputs.

(x) To ensure availability of adequate and safe blood and blood products for the general population through promotion of voluntary blood donation in the country.

(xi) To promote better understanding of HIV infection among people, especially students, youth and other sexually active sections to generate greater awareness about the nature of its transmission and to adopt safe behavioural practices for prevention.

4. STRATEGY

4.1 The national AIDS control policy principally aims at the following strategy for prevention and control of the disease:-

I. Prevention of further spread of the disease by

(i) Making the people aware of its implications and provide them with the necessary tools for protecting themselves.

(ii) Controlling STDs among vulnerable sections together with promotion of condom use as a preventive measure

(iii) Ensuring availability of safe blood and blood products; and

(iv) Reinforcing the traditional Indian moral values among youth and other impressionable groups of population.

II. To create an enabling socio-economic environment so that all sections of population can protect themselves from the infection and families and communities can provide care and support to people living with HIV/AIDS.

III. Improving services for the care of people living with AIDS in times of sickness both in hospitals and at homes through community healthcare.

5. POLICY INITIATIVES

One of the biggest lessons learnt globally as well in the country is that national responses should not wait for HIV/AIDS cases to soar. Policies should not wait at a time when crucial prevention and care information and services are needed. HIV is particularly fuelled by situations of injustice and poverty and its impact is felt beyond health sectors. Another important lesson learnt is that a multi sectoral response must be designed in the context of the overall development strategy to ensure its sustainability and effectiveness. A substantial component of AIDS

prevention and care relies on strong public health infrastructure in order to mount a more effective health sector response to AIDS. They include early diagnosis and treatment of sexually transmitted infections using the syndromic approach, blood transfusion safety, epidemiological surveillance and research and a continuum of HIV/AIDS care linking health institutions, community and home. It can only be achieved if the programme is decentralized and owned up completely by States/U.Ts for implementation. NGO's and private sector have an equally critical role to play in an effective response. The challenge is to identify appropriate, locally relevant interventions and experienced community based organisations to work with poor and marginalized populations who are particularly vulnerable to HIV infections. HIV/AIDS control programme however well planned and designed at the central level remains ineffective unless they reach out where people live, work, study and access health and other welfare services including information services.

For this purpose the policy recognizes the following issues as critical for bringing in a paradigm shift in the response to HIV/AIDS at all levels both within and outside Government.

5.1 Programme Management

5.1.1 AIDS control programme has hitherto been seen as a public health matter dealt by the Ministry of Health and Family Welfare. However, because of the behavioral nature and the strong socio-economic implications, the disease requires to be treated as a developmental issue which impinges on various economic and social sectors of Governmental and non-Governmental activity. As economically productive sections of the population are the most susceptible to the disease, participation of Ministries like Railways, Surface Transport, Heavy Industry, Steel, Coal, Youth affairs & Sports and other public sector undertakings employing large workforce require to be actively involved in the programme. Organised and unorganised sector of industry needs to be mobilised for taking care of the health of the productive sections of their workforce. Ministries like Social Justice & Empowerment, Women and Child Welfare, Human Resource Development, etc. should devise and own up the HIV/AIDS control programmes within their own sectoral jurisdiction. There should be strong budgetary and managerial support to these sectoral programmes from within these Ministries.

5.1.2 The State Governments at their levels should develop strong ownership of the HIV/AIDS prevention and control programme. As the prevalence of the disease and its implications vary from State to State, the State Governments should devise their own strategies and action programmes for tackling the disease keeping the national objectives in view. For smooth flow of funds to the programme and for greater functional autonomy, the State Governments have already adopted the Society model by forming State AIDS Control Societies with proper representation from NGOs, experts in the field and organisations of people living with HIV/AIDS. The Societies are provided with adequate number of technical and managerial personnel for effective management of the programme. As high prevalence of the disease is directly related to the degree of urbanisation and consequent high risk behaviour among groups like commercial sex workers, drug users, and men having sex with men, the municipal corporations of large metropolitan cities should be encouraged to draw up their own programme strategy for AIDS prevention and control.

Direct funding of programmes undertaken by the municipal corporations can go a long way in reducing the administrative bottlenecks and help in effective control of the disease.

5.1.3 As HIV/AIDS is relatively new to the country, there has been no effective field organisation at the district or sub-district level to tackle the problem. In diseases like leprosy, TB, etc. the district level Societies play a very active role in implementing the programmes and receive funds directly from the national programmes. There is an urgent need to use this infrastructure at the district level for prevention and control of HIV/AIDS. This will not only help in quick channelisation of funds but bring in participation of elected representatives of the people from the 3-tier panchayati raj system and urban municipalities. The district administration headed by the District Magistrate/Collector and the Chief Medical Officer of Health should be able to provide the necessary administrative and technical infrastructure for supporting the programme. Amalgamation of State and District level Societies formed for various disease control programmes will bring in synergy in efforts at disease control, and ensures optimal resource utilization.

5.2 Advocacy and Social Mobilisation

5.2.1 In spite of the strong IEC campaign on HIV/AIDS, there is still inadequate understanding of the serious implications of the disease among the legislators, political and social and religious leaders, bureaucracy, media, leaders of trade and industry and professional agencies not to speak of the medical and paramedical personnel engaged in health care delivery system. A strong advocacy campaign needs to be launched at all levels for these opinion leaders, policy makers and service providers to make them understand and motivated about the need for immediate prevention of the disease and also for adopting a humane approach towards those who have already been infected with HIV/AIDS. The Government emphasises the need to start advocacy from the topmost level and spread it down throughout the country.

5.2.2 There is still a serious information gap about the causes of spread of the disease even among a large number of medical and paramedical personnel both within the Government and outside. This occasionally leads to discrimination of HIV/AIDS-infected persons in hospitals, dispensaries, workplaces and the community at large. There is a strong need for advocacy at all levels to eliminate such discrimination and hostility against HIV/AIDS-infected people.

5.2.3 In educational institutions AIDS education should be imparted through curricular and extracurricular approach. The programme of AIDS education in schools and the 'Universities Talk AIDS' (UTA) programme should have universal applicability throughout the country in order to mobilise large sections of the student community to bring in awareness among themselves and as peer educators to the rest of the community. Non-student youth should also be addressed through the large network of youth organizations, sports clubs, National Service Scheme (NSS) and Nehru Yuvak Kendras spread across the country. AIDS prevention education should also be integrated into the programmes of workers education and schemes of social development.

5.2.4 Electronic and print media has almost reached universal coverage for dissemination of information in India . The impressive rise in the levels of awareness about HIV/AIDS in the general community can be partly attributed to the electronic media which has taken this message

right up to the village level. While there is general awareness about the disease, specific aspects like mode of transmission, method of protecting oneself from getting infected, etc. are still not known to a large section of the population. There is therefore an urgent need to generate appropriate programmes which lay stress on interpersonal communication for targeted groups like students, youth, women, migrant workers and children. The electronic media should evolve a well-coordinated media policy for dissemination of information on all aspects of HIV/AIDS including reinforcement of positive cultural and social values like love, warmth and affection within the family. The newspapers, magazines and other print media should be used for conducting campaigns for social mobilisation to generate awareness about prevention and for sharing information and expertise. The media should in general play a positive role in generating an enabling environment for AIDS prevention and control and care of the HIV-infected people. The best communication talents available in Government and private sector should be utilised in designing these media campaigns which should be developed in local languages and ethos. Media campaigns in rural areas should lay emphasis on local traditions and cultures and should be conducted through folk dances, jatras, puppet shows, street plays, etc. The Family Health Awareness Campaigns which lay stress on community mobilisation for awareness generation and utilisation of primary health care services for control of STDs/ RTISs should be conducted at frequent intervals throughout the country .

5.2.5 The corporate sector should be encouraged to undertake AIDS prevention activities including provision of services for their employees both at the workplace and outside as a part of their social responsibility. Industrial units in organised sector should evolve workplace intervention programmes for industrial workers with the active involvement and participation of trade unions. The intervention programmes should have all the important components of the prevention and control strategy for HIV/AIDS. The large network of ESI hospitals and dispensaries under the Employees State Insurance Scheme should be effectively used to spread the message of prevention of the disease and providing service to HIV/AIDS infected workers and their families.

5.2.6 Because of faster economic development in certain regions of the country in the last few decades, there has been significant migration of population from rural to urban areas, both inter-State and intra-State. Migration of rural population in search of employment has also led to increase in the number of slums with poor public health infrastructure in urban and semi-urban areas. Migration is mostly single with the workers living alone in substandard living conditions. The separation from families for long periods also result in high risk behaviour among these migrant workers. These workers, after they get infected with HIV, do also infect their unsuspecting housewives when they go home for vacation or for agricultural operations. The problem therefore has to be addressed both at the place of origin and the place of migration. The problem of these migrant workers needs special IEC and intervention programmes for provision of services like STDs clinics, condom distribution centres and access to health care. All these measures should be able to increase the awareness levels of the general population both in urban & rural areas to more than 90% in the next five years .

5.3 Participation of NGOs/CBOs

5.3.1 Non-Governmental organisations have made significant contribution in the health sector by their innovative approach in the areas of public health, family welfare and in arresting the spread of communicable diseases. It is essential to continue to encourage the involvement of the voluntary sector in HIV/AIDS. The National AIDS Control Programme has recognised the importance of NGOs participation in the Programme for providing community support to people living with HIV/AIDS and their families and for providing the required care and counselling. NGOs bring with them their experience of community level work in enhancing people's participation by adopting an interpersonal approach with sensitivity and thus benefit the HIV/AIDS programme immensely.

5.3.2 Government commits itself to large-scale involvement and participation of NGOs/CBOs in NACP in the following manner:

- i. Involvement of NGOs at the policy making level through regular interaction and adequate representation in national and State level bodies.
- ii. Extending their participation to new areas like provision of medical facilities including home-based care, opening of community care centres, etc. apart from the conventional areas of awareness, counselling and targeted interventions among risk groups.
- iii. Greater efforts to undertake training and capacity building programmes for the NGOs to empower them to take up these additional responsibilities.
- iv. Periodical updating of guidelines issued by NACO for involvement of NGOs to facilitate greater participation of NGOs and for better accountability.

Encourage networking among NGOs to avoid duplication of efforts in some of the areas. Efforts will be made to identify nodal NGOs in different States for coordinating the work of all the NGOs working in that State. State Governments also need to address the problem of motivation among Government officials towards involvement of NGOs in the programme.

5.4 Control of Sexually Transmitted Diseases (STDs)

5.4.1 The large prevalence of STDs in Indian population is cause for concern as presence of STDs, specially with ulcer or discharge, facilitates transmission of HIV infection. The risk of transmission is 8 to 10 times higher in case of persons with STDs compared with others. As the risk behaviour of persons with STDs and HIV is the same, Government attaches top priority to the prevention and control of STDs as a strategy for controlling the spread of HIV/AIDS in the country. The following approach will be adopted by the Government for STDs control:-

- i. Management of STDs through syndromic approach (management of sexual transmitted diseases based on specific symptoms and signs and not dependent on laboratory investigations) would be incorporated into the general health service.

Once the STDs case management is integrated in peripheral health system, unnecessary referral can be avoided leaving the specialised services free for management of complicated cases, operational research (the systematic study, by observations and experiment, of the working of a system, e.g. health services with a view to improvement.) and supervision of sites where STDs patients are treated.

ii. STDs among women though highly prevalent, are suppressed because of the social stigma attached to the disease. It has therefore been decided to integrate services for treatment of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs) at all levels of health care. Department of Family Welfare and NACO should coordinate their activities for an effective implementation of such integration. STDs Clinics at district/block/First Referral Unit (FRU) level would function as referral centres for treatment of STDs referred from peripheries. STDs clinics in all district hospitals, medical colleges and other centres would be strengthened by providing technical support equipment, reagents and drugs. A massive orientation-training programme would be undertaken to train all the medical and paramedical workers engaged in providing STDs/RTIs services through a syndromic approach. All STDs clinics would also provide counselling services and good quality condoms to the STDs patients. Services of NGOs would be utilised for providing such counselling services at the STDs clinics.

5.5 Use of Condoms as a HIV/AIDS Prevention Measure

5.5.1 Condoms were advocated earlier as a safe method of population control under the Family Welfare Programme. Use of condoms now assumes special significance in the AIDS-related scenario, as it is the only effective method of prevention of HIV/AIDS through the sexual route apart from total abstinence. Government feels that there should be no moral, ethical or religious inhibition towards propagating the use of condoms amongst sexually active people specially those who practise high-risk behaviour.

5.5.2 The Government has adopted a conscious policy of use of condoms through the social marketing and community-based distribution system. The social marketing strategy has helped in increasing the use of condoms in the country at large. There is greater need to ensure availability of condoms at places and times where they are needed. Hospitals, STDs clinics, counselling centres, nursing homes and even private clinics of medical practitioners should have adequate supply of condoms for use of the patients. General availability of condoms in the community drug stores, important road and railway junctions, public places, luxury hotels, etc. should also be ensured for use among sexually active people. This will help in achieving the twin purposes of control and prevention of HIV and for promoting the small family norm. Government would promote development of culturally acceptable information packages about the efficacy of condoms to achieve both these objectives.

5.5.3 While ensuring availability of condoms, it is equally necessary to see that the quality and reliability is also guaranteed. 'Condom' has recently been included in Schedule 'R' of the Drugs and Cosmetics Act for ensuring adequate quality control in their manufacture and distribution. There are adequate numbers of manufacturers both in the public and private sectors in the country to take care of the increased demand for condoms in the community.

5.6 HIV testing

5.6.1 There is an active debate in the country on the issue of mandatory testing of people suspected of carrying HIV infection. Considerable thought has been given to this issue. The Government feels that there is no public health rationale for mandatory testing of a person for HIV/AIDS. On the other hand, such an approach could be counter-productive as it may scare away a large number of suspected cases from getting detected and treated. HIV testing carried out on a voluntary basis with appropriate pre-test and post-test counseling is considered to be a better strategy and is in line with the WHO guidelines on HIV testing. Government of India has earlier issued a comprehensive HIV testing policy and the following issues are reiterated here:-

- i. No individual should be made to undergo a mandatory testing for HIV.
- ii. No mandatory HIV testing should be imposed as a precondition for employment or for providing health care facilities during employment. However, in the case of Armed Forces, before employment, HIV screening may be carried out voluntarily with pre-test and post-test counselling and the results may be kept confidential.
- iii. Adequate voluntary testing facilities with pre-test and post-test counselling should be made available throughout the country in a phased manner. There should be at least one HIV testing centre in each district in the country with proper counselling facilities.
- iv. In case a person likes to get the HIV status verified through testing, all necessary facilities should be given to that person and results should be kept strictly confidential. Such results should be given out to the person and with his consent to the members of his family. Disclosure of the HIV status to the spouse or sexual partner of the person should invariably be done by the attending physician with proper counselling. However, the person should also be encouraged to share this information with the family for getting proper home-based care and emotional support from the family members .
- v. In case of 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.

5.6.2 The HIV testing policy adopted is found to be appropriate for different types of testing done under the programme. At present people are tested for -

- a) Screening in blood banks
- b) Epidemiological surveys; and
- c) Confirmatory testing for clinical management and voluntary testing.

In the case of screening for blood donation, a single test of ERS (ELISA/Rapid/Simple) is conducted to eliminate HIV sero-reactive blood. In the case of epidemiological surveys, two tests either with ELISA, or Rapid or Simple will be done. In both these cases the testing is unlinked and anonymous. In the case of diagnosis of clinically suspected cases and for voluntary testing, the testing will be done with 3 ERS using HIV kits with different antigens. HIV testing under these conditions will be carried out with proper pre-testing and post-testing counselling with informed consent of the individual and with proper follow up facilities.

5.6.3 In case of HIV testing facilities in the 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 relating to HIV testing.

5.7 Counseling

Counselling services for suspected cases of HIV infection and for people living with HIV/AIDS (PLWHAs) should be expanded to increase their reach to those who need them. All hospitals, HIV testing centres, blood banks, STDs Clinics and organisations formed by PLWHAs should have counselling services manned by trained and professional counsellors. Government will extend all necessary help to create necessary infrastructure for establishment of these centres and in training counsellors in large numbers to man these counselling centres. Group counselling among PLWHAs which has proved to be very effective will be encouraged by giving necessary financial and other incentives.

5.8 Care and support for People Living With HIV/AIDS (PLWHAs)

5.8.1 With the spread of the infection across the country, there will be a sharp increase in the number of HIV-infected persons in the society who may belong to different social and economic strata. Apart from providing counselling before declaring the HIV status, the Government would try to ensure the social and economic well being of these people by ensuring (a) protection of their right to privacy and other human rights, and (b) proper care and support in the hospitals and in the community.

5.8.2 The HIV-positive person should be guaranteed equal rights to education and employment as other members of the society. HIV status of a person should be kept confidential and should not in any way affect the rights of the person to employment, his or her position at the workplace, marital relationship and other fundamental rights.

5.8.3 HIV-positive women should have complete choice in making decisions regarding pregnancy and childbirth. There should be no forcible abortion or even sterilisation on the ground of HIV

status of women. Proper counselling should be given to the pregnant women for enabling her to take an appropriate decision either to go ahead with or terminate the pregnancy. The prophylaxis for prevention of mother to child transmission will be introduced to cover all infected mothers as a part of the National programme. This facility will be entirely voluntary on the basis of informed consent.

5.8.4 The Government would actively encourage and support formation of self-help groups among the HIV-infected persons for group counselling, home care and support of their members and their families. Social action through participation of NGOs would be encouraged and supported for this purpose.

5.8.5 As regards the treatment care and support for PLWHAs, the policy is to build up a continuum of comprehensive care comprising of clinical management, nursing care, access to drugs, counselling and psychosocial support through home-based care without any discrimination. Resources from Government and private sectors will be mobilised for this purpose.

5.8.6 Government has initiated intensive advocacy and sensitisation among doctors, nurses and other paramedical workers so that PLWHAs are not discriminated, stigmatised or denied of services. Government expresses serious concern at instances of denial of medical treatment by doctors in their clinics, nursing homes and in hospitals which causes enhanced stigmatisation to the PLWHAs. With updated knowledge available on the risks or absence of risk of HIV transmission, such denial of medical care to needy victims is inappropriate and regrettable. The Government would expect the health service sector to display necessary concern for the welfare of the community of PLWHAs and ensure proper medical care and attention. The professional organisations of medical and paramedical health workers should disseminate information about HIV/AIDS to their members up to the field level. Training of health care personnel in diagnosis, rational treatment and for follow up of HIV-related illness should continue with greater vigour.

An efficient referral system would be established starting from testing centres and counseling sites to hospitals or clinics, community-based services and home-based care. PLWHAs would be given adequate information for home care in the form of books and documents to enable them to lead a healthier life and to promote self-help.

5.8.7 Clinical management of HIV/AIDS requires strict enforcement of biosafety and infection control measures in the hospitals as per the universal safety precaution guidelines. Treatment of AIDS cases do not require any specialised equipment than what is necessary for treatment of the opportunistic infections arising out of HIV/AIDS. Government would ensure adequate supply of essential drugs for treatment of these opportunistic infections. Adequate facilities would also be created for proper disposal of plastic and other wastes and injecting needles used for treatment of HIV-infected persons.

5.8.8. Although, HIV/AIDS still defies a cure, infection can no longer be equated with imminent death. Advances in management of opportunistic infections, and the development of effective anti-retroviral therapies mean that the illness associated with HIV infection can be treated. People Living With HIV/AIDS can now live longer and better quality of

lives. Government at present provides financial support to States/UTs for the treatment of opportunistic infections in all public sector hospitals. But ante-retroviral therapies are not supported by the Govt. in the programme because of their prohibitive costs on account of indefinite period of treatment and other supportive investigations required for monitoring the progress of the disease. Govt. as a matter of policy has been progressively reducing the excise and custom duties on Anti Retroviral Drugs to make them available to PLWAs at reasonable price. Govt. would review its policy on ante-retroviral therapies from time to time in order to assess their affordability and provision under the National AIDS Control Programme.

5.9 Surveillance

5.9.1 To adopt the right strategy for prevention and control of HIV/AIDS/STDs, it is necessary to build up a proper system of surveillance to assess the magnitude of HIV infections in the community. The surveillance system would include:-

- (a) HIV Sentinel Surveillance
- (b) AIDS Case Surveillance
- (c) STDs Surveillance; and
- (d) Behavioral Surveillance.

(a) HIV Sentinel Surveillance: The Government would enlarge and refine the present surveillance system for obtaining data on HIV infections in high risk as well as low risk groups of population in rural and urban areas for monitoring the trends of the epidemic. An in-built quality control mechanism will be evolved and adopted in order to have reliable and good quality data. Government is aware of the inadequacy of comprehensive epidemiological data on the prevalence of HIV/AIDS in India which will be addressed through a proper and consistent sentinel surveillance mechanism.

(b) AIDS Case Surveillance: To assess the incidence of AIDS cases in the country, information will be collected from all hospitals having trained Physicians with standard AIDS case definition in Indian context. Efforts will be made to evolve a proper reporting system so that most of the AIDS cases are reported from public and private institutions and health care providers.

(c) STDs Surveillance: Although National Venereal Disease Control Programme was in place since early 1950s with institutional surveillance system, it remained patchy and incomplete. Due to close link of STDs with HIV/AIDS, there is a need to strengthen this system to know the incidence and prevalence of various STDs. Government would establish etiological-based surveillance system through all STDs clinics while syndromic-based surveillance system will be established through peripheral health institutions in a phased manner.

(d) Behavioral Surveillance: To assess the changing pattern of behaviour in different risk groups of population behavioral sentinel surveillance will be instituted initially on pilot basis which will be expanded as per the needs of the programme from time to time.

5. 10 HIV and Injecting Drug Use

The problem of injecting drug use through needles has emerged as a serious problem firstly in Manipur and other North-Eastern States and in metropolitan cities like Mumbai, Chennai, Calcutta and Delhi . The problem of HIV/AIDS has added a new dimension as sharing of injection equipment for narcotic drug use is one of the most efficient routes of HIV transmission and is considered to be much more risky than unprotected sexual contact. While most of Injecting Drug Users (IDUs) are male, their female partners are not known to be in the habit of injecting drug use. The latter therefore suffer the risk of sexual transmission from HIV-infected IDUs without their knowledge. It has also been noticed that majority of the IDUs are youth in their most productive age group of 15-25. Government therefore considers it as a serious issue and is committed to adopt appropriate strategies for preventing the risk of transmission through injecting drug use.

The risk of transmission of HIV through different modes

Route	Efficiency (%)
Sexual	0.01 to 1
Transfusion of blood/blood products	>90
Sharing of needles/syringes	3-5
Percutaneous exposure	0.4
Muco-cutaneous exposure	0.05
Mother to child transmission	25-30

The most important strategy to combat the problem of intravenous drug use and its serious consequences in transmission of HIV/AIDS would be the ‘Harm Minimisation’ approach which is now being accepted world wide as an effective preventive mechanism. Harm minimization aims to reduce the adverse social and economic consequences and health hazards by minimizing or reducing the intake of drugs leading to gradual elimination of their use. Harm minimization in the context of Intra Venous (IV) drug use would require not only appropriate health education, improvement in treatment services but in most practical terms, providing of bleach powder, syringes and needles for the safety of the individual. An appropriate Needle Exchange Programme with proper supervision by trained doctors/counsellors, etc. will be required. Government will encourage NGOs working in the drug de-addiction programmes to take up harm minimization as a part of the HIV/AIDS control strategy in areas, which have a large number of drug addicts.

Greater convergence will be brought about between the NGOs based programmes for drug de-addiction and the hospital-based de-addiction programmes run by the Government.

5.11 Safety of blood and blood products

5.11.1 To minimise the risk of transmission of HIV infection through blood and blood products, Government has taken a series of measures:

(i) The Drugs and Cosmetics Rules provide mandatory testing of blood for HIV in addition to other blood-transmissible diseases namely Hepatitis B Surface Antigen, Hepatitis 'C', Malaria and Syphilis.

(ii) Under Supreme Court directives, licensing of blood banks is mandatory and operation of unlicensed blood banks has been banned.

(iii) The system of collection of blood from paid donors has been phased out completely. To ensure availability of blood, Government has undertaken large scale mobilisation efforts to increase voluntary blood donation through involvement of governmental and non-governmental agencies.

(iv) Government would ensure establishment of adequate blood banking services at the State/District levels including provision of trained manpower.

(v) To ensure proper clinical use of blood, more blood component separation facilities would be established in the country which would improve availability of adequate blood components and their use instead of whole blood.

(vi) Government has set up National and State Blood Transfusion Councils to oversee blood transfusion services as autonomous bodies. The facility of 100% tax exemption for contributions to these Councils has also been given. These Councils will play a very important role in augmenting blood transfusion services in the country and to ensure safe blood to the people. To ensure generation of adequate medical and para medical personnel specialised in blood banks, States are required to upgrade blood banks located in medical colleges and to be named as Department of Transfusion Medicine.

5.11.2 With the modernisation of blood bank services, it is expected that the demand for blood and blood components will be fully met through a modernised and efficient network of blood banks in the public, private and voluntary sectors thus minimising the risk of HIV transmission through blood.

5.11.3.1 A comprehensive National Blood Policy encompassing all the aspects of the operation of blood banks including voluntary blood donation programme and appropriate clinical use of blood and blood products has been prepared and annexed with this document .

5.12 Research and Development

5.12.1 The research and development efforts in the field of HIV/AIDS have hitherto been very limited in the country. Government recognises the need to encourage and support research and development in the following areas:-

i. The Government will look out for collaborative research with scientific groups in developed countries for development of vaccines suitable for the strains of HIV prevalent in India . Development and trials of each vaccines will be subject to standard ethical guidelines developed and adopted by the Indian Council of Medical Research.

ii. In the last few years a number of anti-retroviral drugs were introduced in USA and other developed countries which help in reducing the viral load in the body of the infected person and thus ensure greater longevity. The efficacy of anti-retrovirals like Azidothymidine (AZT) and Nevirapine in reduction of HIV transmission from mother to child has also been recently proved in drug trials in USA and Thailand . Pilot studies have been conducted in established medical institutions in India on efficacy of AZT and Nevarapine prophylaxis on HIV-positive pregnant women.

iii. As regards use of antiretroviral drugs for clinical use, it is recognised that these drugs are not only extremely expensive even by the standards of developed countries, but also result in adverse side effects and drug resistance in case of improper use. There is however a great need to indigenise the technology for manufacture of these drugs which will result in their cheaper availability to the HIV-infected people. Government would pursue all available means to encourage indigenous drug manufacturers to take up manufacture of antiretroviral drugs within the country .

iv. For creating epidemiological data base on HIV/AIDS and other related subjects, Government would identify the institutions to pursue cohort and cross sectional studies.

v. Government would also encourage indigenisation of the HIV-related equipment like test kits which will help in reducing the cost of service to a considerable extent.

5.13 Indigenous Systems of Medicine (ISM)

5.13.1 There is an urgent need to look for a cost-effective alternatives to antiretroviral drugs in the indigenous system of medicine like Ayurveda, Unani and Siddha apart from Homoeopathy. Some of the medicines in these systems have the potential of reducing the viral load in the body of the patient thus ensuring a healthier and longer life with the infection. The Government has sponsored research projects in Homoeopathic and Siddha systems of medicines and is receiving

encouraging response. It will pursue a policy of sponsoring research in ISM and Homoeopathy for development of drugs which can serve the purpose of anti-retrovirals, but at a much lesser cost.

5.13.2 At the same time it is necessary to be vigilant against unscrupulous persons claiming a cure for HIV/AIDS by magic remedies. Any medicine or system of treatment which cannot stand the test of scrutiny by professional organisations like the Ayurveda Council or the Homoeopathic Council cannot be accepted as a drug or a system of treatment in the country. The Drugs and Magic Remedies Act requires amendment to stringently deal with cases of unscrupulous persons taking advantage of the misery of HIV-infected persons and defrauding them of huge sums of money. A massive awareness campaign has also been launched to make people aware of the dangers of such medication by unqualified persons indulging in quackery.

5.14 Bilateral and International Cooperation

5.14.1 Government notes with satisfaction the active support provided by international agencies of the UN system and bilateral agencies from different countries in the developed world to its HIV/AIDS control efforts . The World Bank has participated in funding a major part of the national AIDS control programme during the last five years and has since expanded its funding in the second phase . The UN organisations which are constituent units of the UNAIDS Theme Group have all done work in India on various social & economic sectoral programmes. These organisations will have to take a relook at their programmes and priorities in the context of the increasing prevalence of HIV/AIDS among the economically productive and socially exploited sections of the population. The Joint United Nations programme on HIV/AIDS known as UNAIDS is expected to assume a larger role both in terms of providing financial as well as technical expertise to the programme. Government's policy is to promote international cooperation to ensure optimal utilisation of resources to avoid unproductive duplication of efforts. Bilateral cooperation which has been developed with countries like USA , UK , and others will be extended further to take up specific intervention programmes where the technical and managerial input from these countries can be put to optimum use. Government will promote mutual information sharing with these countries and the neighboring countries in the South Asia region on their national AIDS control plans. Cross country issues like drug use, labour migration, trafficking among women & children, etc. could be the common ground for regional cooperation among the neighbouring countries. Government would also be actively looking for technical inputs for development of vaccines, drugs and equipment for prevention and control of HIV/AIDS and would explore bilateral and multilateral collaboration towards this end.

6. HIV/AIDS AND HUMAN RIGHTS

The wide spread abuse of human rights and fundamental freedom associated with HIV/AIDS has emerged as a serious issue in all parts of the world in the wake of the epidemic. Discrimination against people living with HIV/AIDS denies their rights to access health care, information and other social and economic rights granted by the constitution to its citizen. The protection of human rights is essential to safeguard human dignity in the context of HIV/AIDS. Public health interest does not conflict with human rights. On the contrary, it has been recognised that when human rights are protected, fewer people become infected and those living with HIV/AIDS and their

families can better cope with HIV/AIDS. Government recognises that without the protection of human rights of people, who are vulnerable and afflicted with HIV/AIDS, the response to HIV/AIDS epidemic will remain incomplete. Government will adopt the following measures to implement an effective rights based response.

(i) Government will review and reform criminal laws and correctional system to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.

(ii) Government will strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy, confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.

(iii) Government will ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and services.

(iv) Government will ensure support service that will educate people affected by HIV/AIDS about their rights, provide legal services to enforce these rights and develop expertise on HIV related legal issues.

(v) Government will promote wide distribution of creative, education, training and media programmes explicitly designed to change attitudes of community towards discrimination and stigmatization associated with HIV/AIDS.

(vi) Government in collaboration with and through the community will promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

(vii) Government will co-operate through all relevant programmes and agencies of the United Nations System, including UNAIDS, to share knowledge and experience concerning HIV related human rights issues and would ensure effective mechanisms to protect human rights in the context of HIV/AIDS at international level.

7. IMPLEMENTATION STRATEGY

7.1 The success of any implementation strategy for the prevention and control of HIV/AIDS would depend largely on the commitment of the political, administrative and community leaders

and their sensitization on the potential risks and consequences of a widespread HIV/AIDS epidemic in the country. HIV/AIDS therefore, should not be treated as a mere public health programme alone but must be viewed as a developmental issue to which a multisectoral response should be evolved.

7.2 The implementation strategy would, therefore, be mainly based on securing the involvement and participation of all sectors both in the Government and outside to integrate HIV/AIDS prevention and control activities in their ongoing programmes. In particular, the social sector Ministries such as Human Resource Development, Youth affairs, Women & Child development, Rural Development and large employer Ministries such as Defence, Railways, Steel Mines etc. must be involved in undertaking focused programmes on HIV/AIDS prevention and control. The involvement of the political leadership, particularly, the elected representatives of the three tier Panchayat system, the district administration and public health service providers, is critical in creating a conducive environment to reduce social stigma and discrimination and enable greater access to services. Since the socio-economic impact of a widespread epidemic can be severe in the employment sector, the involvement of industry and business is important. This should be facilitated through the formation of business coalitions at the national and State level.

7.3 For effective interventions it is necessary to empower the state Governments by decentralizing the entire delivery system to the State and district levels through autonomous State AIDS Control societies. While HIV/AIDS should have strong focus and identity as a line programme at the state level, it is necessary to integrate this into the general health care system at the district level and below. To ensure that the public health system as well as private health care providers are responsive and sensitized to the issue, intensive training programmes must be undertaken not only to create awareness but to also provide clinical care and treatment of HIV/AIDS cases in hospitals and community settings.

7.4 In India , majority of the population is still not infected with HIV. Prevention strategies must continue to be given primary focus through awareness campaigns and counselling facilities, which will lead to behavioral change. With the increase in awareness levels in the community, the demand for voluntary counselling and testing services would rise. Voluntary counselling and testing services must be set up in hospitals at various levels as part of the diagnostic facilities as this provides an entry point for prevention and care. Specific groups like students, out of school youth, sexual partners or migrant workers need specially packaged awareness programmes on the risk and vulnerability to HIV/AIDS.

7.5 As socially marginalized sections like commercial sex workers, injecting drug users, street children, men having sex with men, etc. are not normally accessible through the traditional Government machinery, involvement of non-Governmental organizations and CBOs should be secured to effectively reach these populations through a holistic approach of targeted intervention programmes. These programmes should aim at prevention and control of sexually transmitted diseases, deliver relevant IEC messages which are in the local idiom and are interactive in nature, promote condom use for effective prevention of the spread of HIV/AIDS and create an enabling environment that reduces vulnerability of these groups. NGOs and charitable organizations should

also be actively involved in organizing low cost care and support systems and outreach for people living with HIV/AIDS.

7.6 The programme should proactively promote formation of self help groups for PLWHAs and support drop-in centers where PLWHAs can get together and discuss their common problems.

7.7 With such a large decentralized programme in operation, it is essential to evolve a strong monitoring mechanism at every level to periodically monitor implementation of targeted intervention projects, care and support programmes, family health awareness campaigns, etc which are implemented by the State AIDS Control Societies. Periodic external evaluation should be a part of the monitoring and evaluation strategy to test effectiveness of the programme in controlling the spread of the infection.

8. CONCLUSION

Just as the HIV infection is transcending the boundaries of high risk groups and spreading into the general populace, prevention and care programmes have also reached a critical phase. Government of India is fully committed to prevent the spread of HIV/AIDS at the initial stage itself before it emerges into a catastrophic epidemic. Government of India looks at HIV/AIDS prevention and control as a developmental issue with deep socio-economic implications. It touches all sections of the population, both infected and affected, irrespective of their regional, economic or social status. By following a concerted policy and an action plan that emerges out of it, Government hopes to control the epidemic and slow down its spread in the general population within the shortest possible time. All participating agencies in the Governmental and non-Governmental sectors, international and bilateral agencies, would need to adopt policies and programmes in conformity with this national policy in their effort to prevent and control HIV/AIDS in India.

Source: <http://www.naco.nic.in> 04/15/2003