INDIA

Targeted and Evidence-based Prioritization is Needed for Continued HIV Efforts in India: HIV Sentinel Surveillance (HSS) among Antenatal Clinic (ANC) Attendees

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01 PROBLEM

HIV sentinel surveillance (HSS) has been implemented among antenatal care clients in India since 2003.

Information gained from surveillance is necessary for strategic and evidence based management of the National AIDS Control Programme.

THE KEY OBJECTIVES OF HSS

Monitor trends in HIV prevalence over time

Monitor distribution and spread of HIV in different subgroups and geographical areas

Identify emerging pockets of HIV in the country

02 PROCESS

Antenatal care clinic clients are a proxy for the general population. During a three month period in 2012-13,

294,732 pregnant women attending ANC clinics were consecutively sampled

15-49 years old

741 sentinel surveillance sites

Pregnant woman attending ANC for the first time during the current round of surveillance.

Serum was collected anonymously through venous blood specimen and tested twice if the first test was HIV positive. Information on age, education, occupation, spouse´s occupation, residence, and spouse´s migration status was collected, and trends over time were analyzed using three-year moving averages.
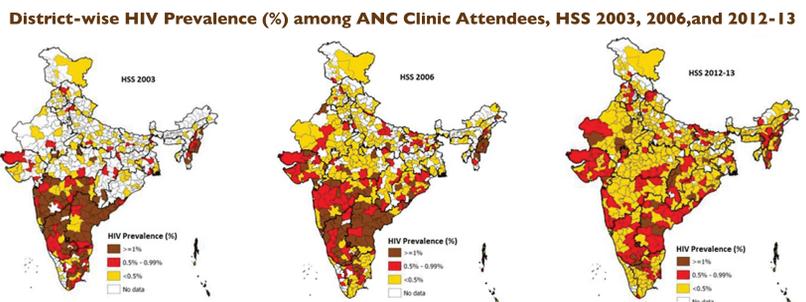
03 RESULTS

HIV prevalence among ANC clients in India was 0.35%. However, prevalence ranged from 0.00% in the states of Andaman & Nicobar Islands, Chandigarh, Dadra & Nagar Haveli, and Puducherry, to 0.88% in Nagaland. At district level, there was even greater variation. 37 districts had HIV prevalence of 1.00% or more and another 130 districts had moderate HIV prevalence between 0.50% and 1.00%.
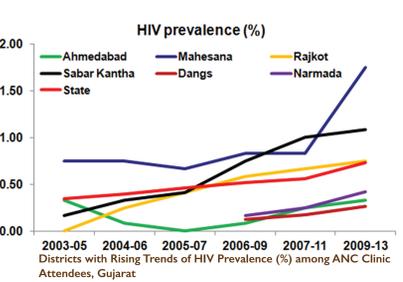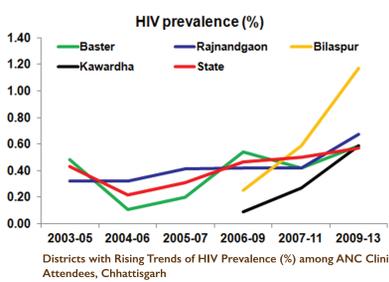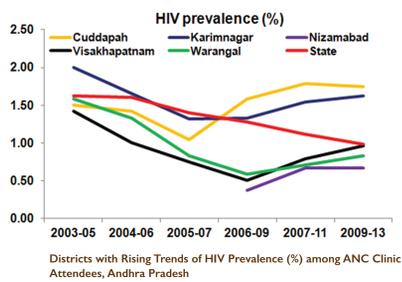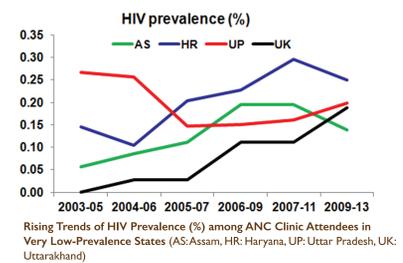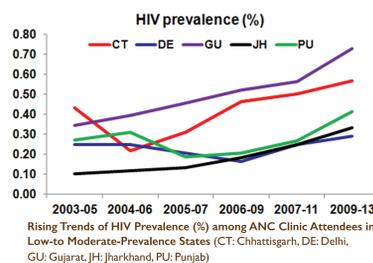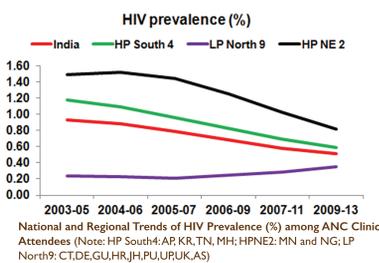
The regions or pockets that hitherto had high HIV prevalence have now achieved lower levels of HIV, while several newer pockets have emerged with high prevalence.

Across India, HIV prevalence was found highest among women age 15-24, illiterate, rural residents, those who worked as hotel staff, and those who had spouses who were truckers or migrants.

HIV prevalence among ANC clients decreased overall in India from 2003 to 2013. However, in some regions, HIV prevalence remains high or is increasing.

District-wise HIV Prevalence (%) among ANC Clinic Attendees, HSS 2003, 2006, and 2012-13

HSS 2003 | HSS 2006 | HSS 2012-13

HIV Prevalence (%)
>=1%
0.5% - 0.99%
>0.5%
No data

Trends of HIV Prevalence among ANC Clinic Attendees at National, Regional, Selected State, and Selected District Levels from 2003-2013 in India

HIV prevalence (%) — India, HP South 4, LP North 9, HP NE 2
National and Regional Trends of HIV Prevalence (%) among ANC Clinic Attendees (Note: HP South4:AP,KR,TN, MH; HPNE2: MN and NG; LP North9: CT,DE,GU,HR,JH,PU,UP,UK,AS)

HIV prevalence (%) — CT, DE, GU, JH, PU
Rising Trends of HIV Prevalence (%) among ANC Clinic Attendees in Low-to Moderate-Prevalence States (CT: Chhattisgarh, DE: Delhi, GU: Gujarat, JH: Jharkhand, PU: Punjab)

HIV prevalence (%) — AS, HR, UP, UK
Rising Trends of HIV Prevalence (%) among ANC Clinic Attendees in Very Low-Prevalence States (AS:Assam, HR: Haryana, UP: Uttar Pradesh, UK: Uttarakhand)

HIV prevalence (%) — Cuddapah, Karimnagar, Nizamabad, Visakhapatnam, Warangal, State
Districts with Rising Trends of HIV Prevalence (%) among ANC Clinic Attendees, Andhra Pradesh

HIV prevalence (%) — Baster, Rajnandgaon, Bilaspur, Kawardha, State
Districts with Rising Trends of HIV Prevalence (%) among ANC Clinic Attendees, Chhattisgarh

HIV prevalence (%) — Ahmedabad, Mahesana, Rajkot, Sabar Kantha, Dangs, Narmada, State
Districts with Rising Trends of HIV Prevalence (%) among ANC Clinic Attendees, Gujarat

KEY RECOMMENDATIONS

Continue to accord high priority to states, districts, and blocks with high or rising trends of HIV prevalence, greater vulnerability, and where HIV prevalence has not decreased over the last decade in spite of sustained efforts.

Undertake special studies to understand the reasons and drivers underlying the variations in HIV prevalence.

Focus on scaling-up coverage and improving quality of interventions in these pockets, by customizing program responses to specific key drivers.

Focus on younger age groups, illiterate groups, primi-gravida, women who work as skilled/semi-skilled labour in industries/factories, domestic servants and non-agricultural labourers, men who work as truck drivers/helpers, hotel staff, and auto/taxi drivers.

Strengthen capacities for epidemiological analysis, interpretation, and modeling in the country at national and state levels to ensure effective use of surveillance data.

Promote greater analysis and use of surveillance data for programme management at state and district levels.

CONCLUSION

HIV in India continues to decline with a national average of 0.35%. Variations exist at state and district levels. Regions that previously had high HIV prevalence have achieved lower levels, while new pockets of high prevalence have emerged. In high-prevalence states, there are still pockets where HIV did not decline in spite of sustained, focused interventions for more than two decades