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HIV/AIDS control in India – Lessons learned from Tamil Nadu

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HIV/AIDS CONTROL IN INDIA - LESSONS FROM TAMIL NADU

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SUMMARY

India's HIV/AIDS epidemic is now over a decade and half old. Current estimates indicate that there are about 3.5 million Indians living with the virus. Though this translates to an adult prevalence of less than one percent, the epidemic is growing rapidly in most parts of India.

Tamil Nadu (TN), a large state in the southern part of India with a population of about 62 million, was one of the states where HIV infections and AIDS cases were first detected in India in1986. Once considered one of the "hot spot" states for the epidemic, along with Maharashtra and Manipur, TN has been implementing vigorous HIV/AIDS control programs since the mid-1990s. There is increasing evidence to show that substantial behavior change has occurred in TN among the high-risk behavior/core-transmitter groups, which is a pre-requisite for a slowing down of the epidemic. Data from the latest round of sentinel surveillance in ante-natal clinics seem to indicate that the epidemic may in fact be slowing down. However, these data must be viewed with caution and it is too early to say with any certainty that the epidemic in TN is leveling off.

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The paper describes what worked in TN that brought about this behavior change. The major factors listed are political commitment, awareness campaigns, identification of the core transmitter groups, targeted interventions among them and care and support activities. All these programs are being implemented by two major organizations in TN: the World Bank funded, government sponsored Tamil Nadu State AIDS Control Society (TNSACS) and the USAID funded AIDS Prevention and Control Project (APAC). The paper describes in detail the strengths of TNSACS and APAC and the synergy between them that led to the rapid behavior change in TN. Lessons for other Indian states are also listed. The TNSACS model has now been replicated in the rest of India since 1999.

The paper cautions that there is no reason for complacency in TN and recommends that current programs should continue to be implemented, with a flexible approach to address emerging evidence.

HIV/AIDS CONTROL IN INDIA-LESSONS FROM TAMIL NADU

Introduction

Tamil Nadu (TN) is one of the larger states of India (estimated population in 2000: sixty two million), in the southern part of the country. It is considered among the economically and socially more developed states.

The first HIV infections and AIDS cases in India were detected in TN and Maharashtra in 1986. The Madras Medical College Hospital at Chennai, the capital city of the state (Madras), the Christian Medical College Hospital at Vellore, a district town about 130

kilometers west of Chennai, and in Mumbai (Bombay) recorded these. This was possible because of the HIV surveillance system initiated by the government through the Indian Council of Medical research (ICMR) a few months before this, following reports about AIDS in the West (Prema Ramachandran, 1989).

Current Status of the Epidemic in India:

It has been estimated that there were about 3.5 million HIV infected persons in India around 1998-99, next only to South Africa. However, unlike many countries in sub-Saharan Africa, this number implies a HIV prevalence rate of slightly less than one percent among the adult population in India. Yet, this is not a cause for comfort because the growth of infection in some areas is among the fastest in the world. Further, there are indications that the epidemic has moved from the urban to the rural areas and from the high-risk behavior groups to the general population (NACO, 1999).

There is great variability among the different States of India in HIV prevalence: Maharashtra, Karnataka and Andhra Pradesh (AP) have adult prevalence of over two percent; TN and Manipur, between one and two percent and the rest of the country, below one percent. While the main route of HIV transmission in most parts of India is through unprotected heterosexual sex, it is through shared needles among injecting drug users in the thinly populated north-eastern states like Manipur and Nagaland. Data on blood transfusion as a route of HIV transmission is sparse; however, 5.5% of total cases of reported cases of AIDS are among transfusion recipients (NACO, 2000).

There is widespread discrimination against HIV infected people, making it difficult for them to access healthcare. The low income levels of most of the infected preclude the widespread use of highly active anti-retroviral therapy (HAART). Consequently, morbidity and mortality of those infected continues to be very high in India (NACO, 1999).

Widespread poverty, illiteracy, poor nutritional and health status of the population, social inequalities based on caste and gender, poor health infrastructure, public perception of sex as a taboo subject, lack of strong political commitment and a still-persistent denial about AIDS in many states are factors that make India especially vulnerable to a devastating AIDS epidemic. If effective control measures are not implemented immediately and sustained over a long period of time, there are projections warning of an adult HIV prevalence rate of five percent within the next five years. This would mean a total of nearly 25 million HIV infected in India by the year 2006, roughly equal to the number of current infections in sub-Saharan Africa (World Bank, 1999). TB is the most common opportunistic infection in India - nearly two-thirds of the HIV infected persons are affected by TB. Since TB is already a major killer in India, HIV is likely to worsen it. Already there is evidence from Mumbai City in Maharashtra about the increasing role of AIDS as a cause of death, mainly due to TB (Hira, 1999).

The Government's Response to the Epidemic:

The Indian Government's response came soon after the first case was reported in 1986. AIDS prevention efforts in the initial years of the epidemic were confined to the "hot spots" such as Maharashtra, TN and Manipur states and selected big cities. However,

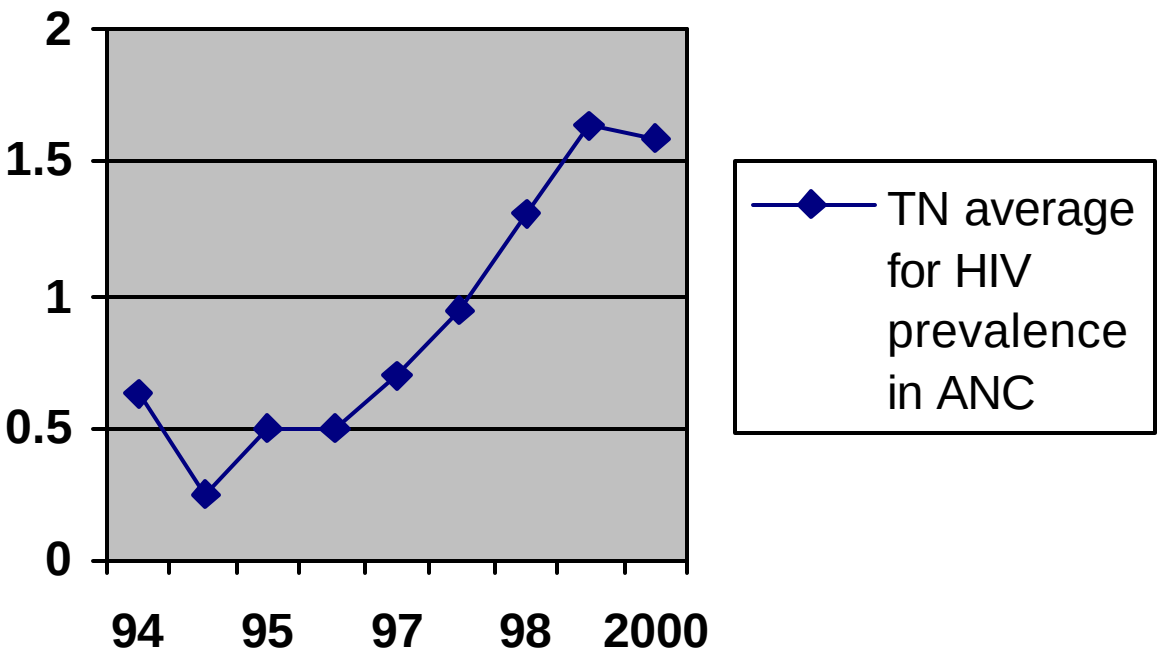
since 1992, the World Bank has been funding a countrywide National AIDS Control Project. The first phase of this Project (1992-1999), with an IDA credit of US $ 84 million from the Bank, focussed on strengthening blood banks and STD clinics, surveillance and increasing awareness, implemented by State AIDS Cells, functioning under the apex National AIDS Control Organization (NACO). Targeted interventions among high-risk behavior groups were implemented in few states, with the notable exception of TN. Similarly, care and support activities received little attention in the first phase, with Manipur and TN being the only exceptions. An innovation in the form of an autonomous "society" in TN recorded considerable success, resulting in its replication in the rest of India during the Bank funded second phase, launched in 1999, with an IDA credit of US $ 190 million. With much more information about the epidemic becoming available since the mid-1990s and by learning from the experience of the first phase, the second phase focuses on targeted interventions among high-risk behavior groups. The management structure of the state level projects is based on the success of the TN model. Consequently, there is increasing decentralization and ownership of the project by the respective states (NACO, 1999).

Success **in Tamil Nadu?**

Annual rounds of HIV sentinel surveillance in ante-natal clinics (ANC) across the country serve as a proxy for determining HIV prevalence in the general adult population. TN started with two ANC centers in 1994 (Coimbatore and Salem). Three centers (Namakkal, Madurai and Chennai) were added in 1998 and a sixth one (Tirunelveli) was added in 1999. There is great variability in HIV prevalence levels among these six centers. For example, in 1999, it varied from a low of zero in Coimbatore and Salem to

6.50 percent in Namakkal. This fact has to be kept in view while interpreting the state "average" for HIV prevalence in ANC centers.

Chart-1: Trend in HIV Prevalence in A.N. clinics in Tamil Nadu (1994-2000)

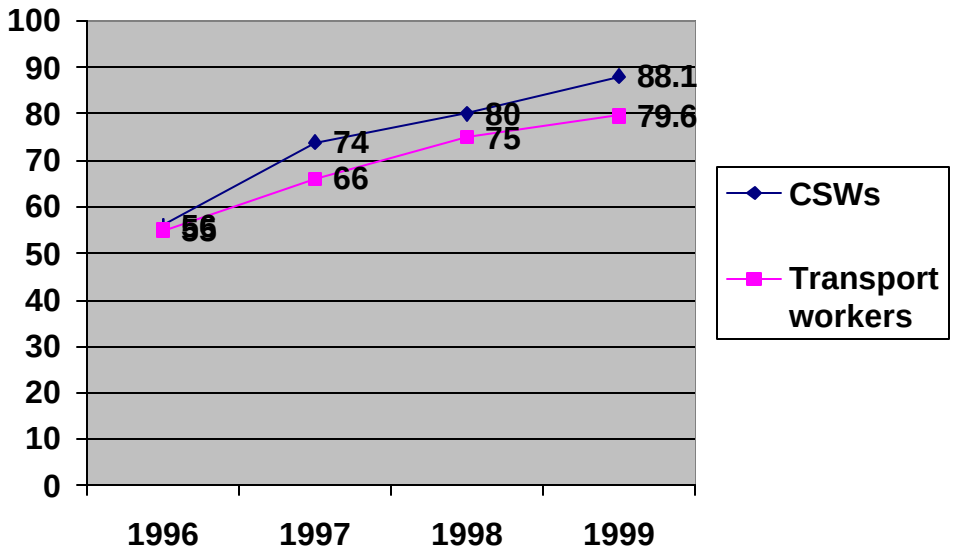


(Source: TNSACS)

In contrast, HIV prevalence is rising rapidly in many other parts of India, where the prevalence in ANC is over one percent. For example, in the states of Andhra Pradesh (AP) and Karnataka, HIV prevalence in A.N. clinics has crossed two percent, exceeding the level in TN (NACO, 1999). Once again, we must remember that there is variability among the different ANC surveillance centers in these states. But the important fact to be noted is that just three years ago, these two states had ANC prevalence levels lower than that in TN.

The main source of evidence for behavior change among the core transmitter groups, which is a pre-requisite for the slowing down of the epidemic, is the findings from four rounds of behavior surveillance surveys (BSS) conducted by the USAID funded AIDS Prevention and Control (APAC) project in TN. For example, condom use among commercial sex workers (CSWs) went up from 56 percent in 1996 to 88 percent in 1999. Similarly, condom use during paid sex among transport workers rose from 55 percent in 1996 to 80 percent in 1999 (APAC, 2000).

Chart-2: Trend in Condom Use in Selected Core Transmitter Groups in TN



(Source: APAC-BSS data)

Thailand is considered the most successful country in AIDS control efforts in Asia, where the epidemic appears to have leveled off below three percent of adult prevalence mainly due to rapid increases in condom use among sex workers. As indicated above, similar rapid behavior changes are occurring in TN, which may eventually result in the leveling off of the epidemic in TN at a fairly low level of adult prevalence, if recent trends

continue. Both Thailand and TN have roughly the same population. While the expenditure on AIDS control efforts in Thailand were of the order of one US $ per capita/year, it has been less than a tenth of one US $ in TN. Consequently, observers have appreciated the TN "model" of AIDS control in several forums. Now the World Health Organization (WHO), as a part of its ongoing work under its Commission for Macroeconomics and Health (CMH), has commissioned this report on the Tamil Nadu experience in controlling AIDS.

This paper, therefore, seeks to examine what brought about such rapid behavior change in TN, which is a pre-requisite for containing the spread of HIV, in a relatively short period of time and at a low cost. The paper also attempts to draw lessons from Tamil Nadu for the rest of India and for other developing countries.

TNSACS and APAC

Any study of HIV/AIDS control efforts in Tamil Nadu would need to focus on two major programs: the government sponsored Tamil Nadu State AIDS Control Society (TNSACS) and the USAID funded AIDS Prevention and Control Project (APAC).

TNSACS

The State AIDS Cell (SAC) in TN was set up in 1992 with World Bank funding under the National AIDS Control Program of the Central Government. A wing of the Directorate of Medical Education, its early activities centered around strengthening blood banks with required equipment and testing kits for HIV and Hepatitis-B. But the TN Government soon realized that the AIDS control activities of the SAC were not

proceeding at the required pace. At the same time, there was increasing evidence to show that the spread of HIV was reaching epidemic proportions. Therefore, the government ordered the conversion of the State AIDS Cell into a Registered Society, namely the Tamil Nadu State AIDS Control Society, in May 1994.

The Health Secretary of the TN State Government, a senior civil servant of the Indian Administrative Service (IAS), is the President of the TNSACS. Another IAS officer is the Project Director and Member-Secretary. TNSACS has established an Executive Committee (EC), whose members include the Secretaries of Government Departments like Finance, Education, Social Welfare and Planning as well as the heads of the various Health and Medical Directorates. The Executive Committee wields administrative and financial powers to ensure prompt and effective implementation of AIDS control activities in Tamil Nadu.

A unique feature of TNSACS is that, since inception, representatives of three non-governmental organizations (NGOs) involved in AIDS control efforts are members of the EC. More recently, one of three NGO slots is reserved for an HIV infected person working in the sector. The NGO members participate in the EC meetings and contribute to the decision-making process. This active involvement of NGOs has played an important role in the successful implementation of AIDS control activities in TN.

The major areas of activity of TNSACS are awareness campaigns, targeted interventions among high-risk groups through NGOs, blood safety, STD control, and the care and support of people affected by HIV/AIDS (TNSACS, 1998).

Advantages of the TNSACS model:

The autonomy, flexibility and the participatory nature of decision-making are the unique advantages of the TNSACS model. These have resulted in the faster utilization of funds, a large number of targeted interventions through NGOs and an effective and sustained awareness campaign (Ramasundaram, 1997).

Faster utilization of funds:

Prior to the setting up of TNSACS in 1994, AIDS control activities in TN were implemented by the SAC, which was under the State Medical Education Directorate. The SAC was headed by a senior doctor of the Medical Education Directorate and supported by two other medical professionals for STD control efforts and epidemiology and training. While less than 100, 000 rupees was utilized in the year 1992-93, it improved sharply to 7.85 million rupees in 1993-94. But this was well below the quantum of funds allotted by the National AIDS Control Organization (NACO) of the Government of India (GOI). One of the major reasons for the slow absorption of funds during the SAC phase was the fact that every financial decision had to be obtained from the State Government, since the SAC was a part of a government department.

On the other hand, when TNSACS was set up as an autonomous society in 1994, full financial powers were delegated to its EC, which has the Finance Secretary or his representative as a member. Consequently, the approval of proposals and the release of funds were made in the monthly meetings of the EC, presided by the Health Secretary. This resulted in a much faster utilization of funds by TNSACS, as shown in Table-1. Until 1999, TNSACS was the only

Table-1: Trend in Utilization of Funds by TNSACS (1992-2000)
(Rupees million)

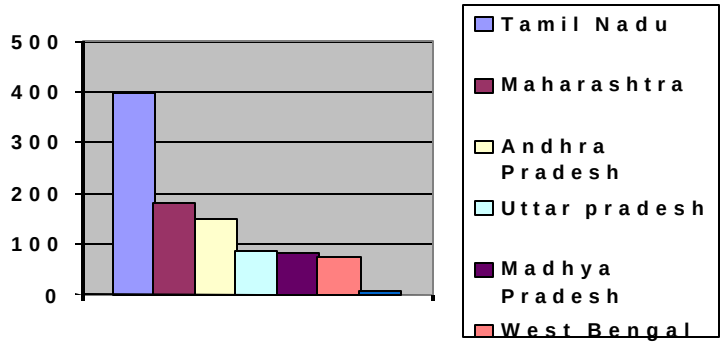
Year	Expenditure
1992-93	0.088
1993-94	7.850
1994-95	22.779
1995-96	67.973
1996-97	129.780
1997-98	172.259
1998-99	146.076
1999-2000	130.091

(Source: TNSACS)

autonomous society at the state level in India. Due to its better utilization of funds, NACO allotted unspent funds from other states to TNSACS, especially during 1996-99, thereby making more funds available for AIDS control efforts in TN. With the formation of such TN model societies in other states after 1999, the utilization of funds has improved all over India, resulting in a decline in the funds allotted to TN. Chart-3 indicates how TN was ahead of all other states in the utilization of funds allotted by NACO under the first phase of the World Bank funded AIDS-1. It must be noted that the second best utilization is by Maharashtra, a much larger state compared to TN and has the highest adult HIV prevalence in India. Yet, it had utilized funds less than half the level in Tamil Nadu.

Chart-3: Utilization of NACO funds by major states (1992-98)

(rupees million)



(Source: NACO)

Yet another feature of the TNSACS model was the appointment of a generalist administrator from the IAS as the Project Director and Member-Secretary, in the place of the senior medical professional who was the Project Leader of the SAC. In other states, this position was called the State AIDS Program Officer (SAPO) before the societies were formed. A general administrator as the leader of team changed the project's approach from a medical one to a broad-based one. For example, nearly two-thirds of the total funds at the national level in the first phase were spent on blood safety, though this was a minor route of HIV transmission compared to the heterosexual route that accounted for three-fourths of the HIV transmissions. But in Tamil Nadu, expenditure on blood safety accounted for only 14 percent of the total, as shown in Table-2. The high priority accorded to awareness campaigns and targeted interventions through NGOs in Tamil Nadu is clear.

Table-2: TNSACS expenditure by components (1992-2000)
(rupees million)

Awareness Campaigns	50.41%
Blood Safety	14.13%
Targeted Interventions	10.14%
STD Control	8.43%
Training	7.68%
Program Management	5.32%
Continuum of care	3.00%
Hospital Infection Control	0.59%
Surveillance	0.30%

(Source: TNSACS)

Targeted interventions through NGOs:

There were no targeted interventions through NGOs during the SAC phase. There is now ample evidence to show that in a sexually driven HIV epidemic, targeted interventions among the high-risk behavior groups or core transmitter groups is the best strategy to contain the further spread of HIV (World Bank, 1997). TNSACS established a transparent system of funding NGOs for targeted interventions. All proposals were evaluated by a screening committee consisting of TNSACS officials and the NGO members of the EC. Those short-listed by this committee were inspected by a TNSACS official for a verification on the ground. The final stage of approval was at the monthly EC meetings. Generally, a decision on a NGO proposal was taken in about three months. Consequently, a large number of NGOs were funded by TNSACS after 1994. By 1998, TNSACS had funded more NGOs than the total number of NGOs funded by all other states of India (TNSACS, 1998). Table-3 shows the trend in NGO funding from 1992 through 2001.

Table-3: Trend in TNSACS Funding of NGOs for Interventions (1992-2001)

Year	Number of NGOs funded
1992-1994	Zero
1994-1995	17
1995-1996	18
1996-1997	50
1997-1998	106
1998-1999	95
1999-2000	42
2000-2001	71

(Source:TNSACS)

Awareness Campaigns:

As Table-2 above shows, the largest share of TNSACS expenditure (just over 50 percent) was on awareness campaigns. This strategy was driven by two factors:

- awareness about AIDS was very low in the early 1990s, as shown by the first round of the National Family Health Surveys (NFHS), conducted in 1992-93 by the Ministry of Health and Family Welfare of the Government of India in collaboration with USAID (IIPS, 1994).
- The increasing reach of the mass media would make it possible to deliver awareness messages to the people very effectively.

Once again, a transparent and competitive system of selecting professional agencies to carry out the awareness campaigns was put in place by TNSACS. Electronic media like television and radio, print media, rural folk arts, street plays and several innovative methods were used by TNSACS to create awareness among specific high-risk behavior

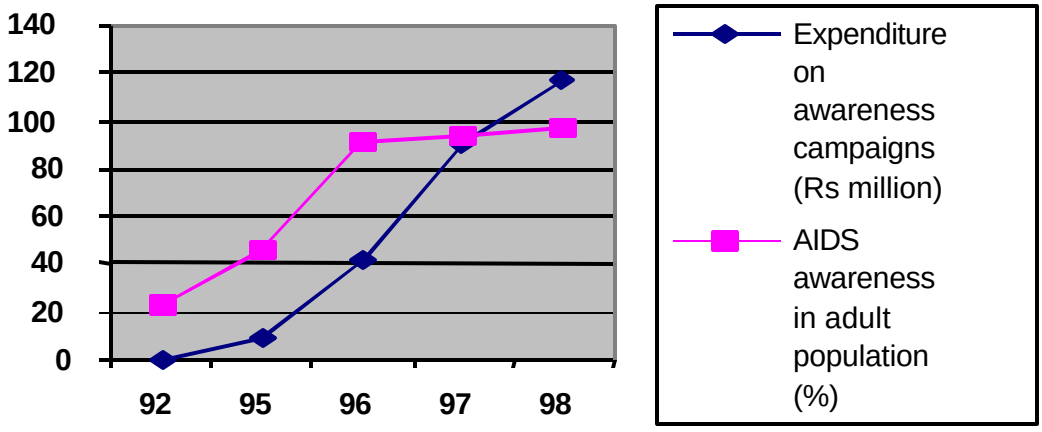
groups and among the general public. Annual surveys on awareness commissioned by TNSACS, a prevention indicator survey conducted by NACO in 1996 and the annual behavior surveillance surveys (BSS) by APAC have all shown a rapid rise in the levels of awareness of the modes of transmission and methods of preventing HIV transmission among specific high-risk behavior groups and the general public. Table-4 shows the rapid rise in AIDS awareness since 1992 through data collected by different sample surveys.

Table-4: Trend in AIDS Awareness in the General Adult Population in TN

Year	% of sample who had heard of AIDS	Source	Sample
1992	23.4	NFHS	Ever married women
1995	46.5	TNFHS	Ever married women
1996	91.7	TNSACS	General adult population
1997	93.5	TNSACS	General adult population
1998	97.0	TNSACS	General adult population
1999	87.3	NFHS	Ever married women

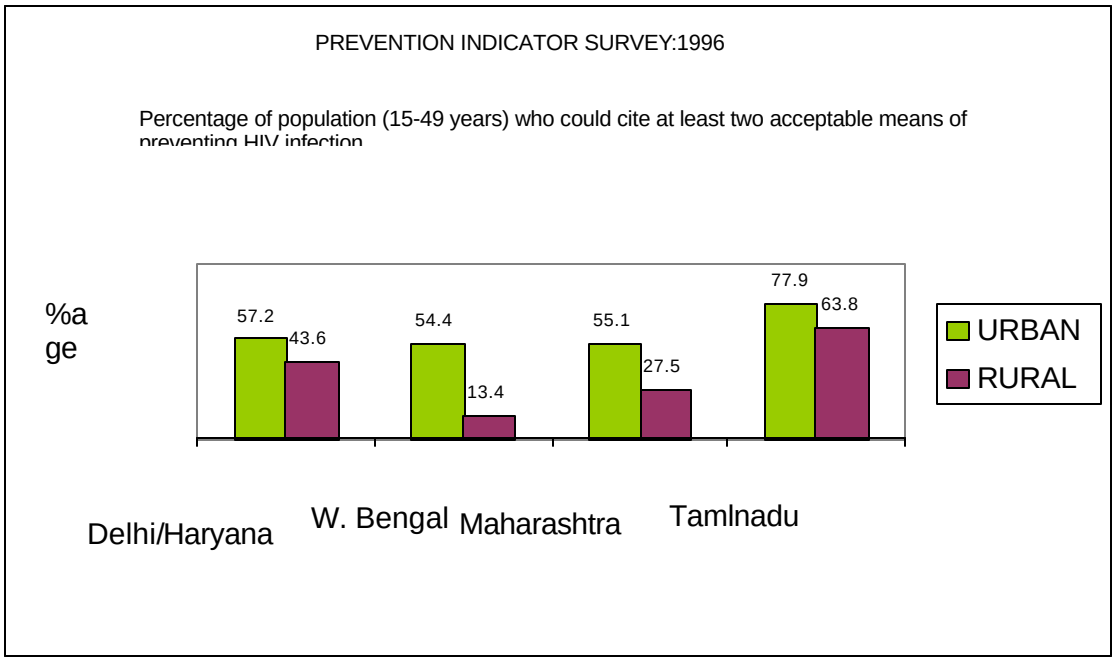
Chart-5 shows that increases in funding for awareness programs have resulted in corresponding increases in awareness among the people.

Chart-5: Investments in Awareness Campaigns and Results in TN



In 1996, NACO commissioned a survey through an external agency to assess the awareness levels in four states: Delhi/Haryana, Maharashtra, TN and West Bengal. This survey (Chart-6) also indicated that awareness levels in both in rural and urban areas of TN was much higher than those in the other three states.

Chart-6 : Prevention indicator survey - 1996



(Source: NACO)

APAC's four rounds of BSS also indicates sharp rise in the awareness levels of high risk populations in TN, as shown in Table-5.

Table-5: Trend in AIDS Awareness in Selected Population Groups in TN

Population group	Percentage of sample aware of two methods of preventing HIV/AIDS			
	1996	1997	1998	1999
CSWs	86	98	99	98
Transport workers	95	97	96.1	96.5
Male factory workers	93	98	97.9	98.8
Female factory workers	81	94	89.1	90.7

(Source: APAC-BSS data)

The data in the tables and charts above clearly show that, by the late 1990s, awareness about AIDS was nearly universal in the general adult population and selected high-risk/core-transmitter groups like CSWs and transport workers in TN. Further, awareness levels in TN were also higher than in any other part of India. This was made possible by the allocation of additional funds to TNSACS by NACO by diverting the unspent funds from other states. In fact, during the years 1995-1998, the expenditure on awareness campaigns in TN was more than the total expenditure for such campaigns in the rest of India. This universal awareness created an enabling environment for targeted interventions to be very successful in TN, which brought about the behavior change that is a pre-requisite for slowing down of the epidemic.

Care and support:

Yet another area where TNSACS clearly leads the other states is in care and support of people infected by HIV. TNSACS has been supporting positive people's networks like INP Plus and TNP Plus since their formative stages. Further, as mentioned earlier, one of

the three non-official members of the EC of TNSACS has been a HIV positive person. This has resulted in the concerns and views of people living with HIV/AIDS (PLWAs) getting included in the decision-making process. The Positive Women's Network has also been an outcome of the efforts of TNSACS. As a symbolic gesture, in 1997, TNSACS employed two HIV positive women, both widows of transport workers who died of AIDS. Since 1998, TNSACS has laid down a condition of employing at least one HIV infected person for NGOs to qualify for funding (TNSACS, 1998).

Another major effort in the area of care and support is the setting up of the AIDS wards in the Government Hospital for Thoracic Medicine (GHTM), at Tambaram, a southern suburb of Chennai. Due to the commitment of the medical professionals and the support staff of this hospital and the financial support of TNSACS, GHTM has now houses the largest number of AIDS patients at any one place in India. Due to the discrimination against AIDS patients in other parts of India, GHTM has several patients from outside TN (TNSACS, 1998; <*http://education.vsnl.com/thoracic*>). This high priority for the care of PLWAs in TN has encouraged people in getting tested for HIV and in reducing the stigma associated with HIV and AIDS. Consequently, as of 31 December 2000, of the total number of 16,722 AIDS cases reported to NACO, 8,570 cases were reported from TN, accounting for more than 50 percent. States with larger populations and higher HIV prevalence in the general population such as AP (48) and Maharashtra (3720) reported far fewer cases. (Source: TNSACS)

APAC

APAC, administered by the Voluntary Health Services (VHS), Chennai, was set up in February 1995, with financial assistance of US $ ten million from USAID under a bilateral agreement with the Government of India. VHS, as the name indicates, is a large health services delivery NGO with a proven track record of over fifty years. APAC functions under the overall direction of the Project Management Committee (PMC) with the Health Secretary of the Government of Tamil Nadu as Chairman and the Project Director, TNSACS, as alternate Chairman. The Secretary of VHS, the Project Director of APAC and representatives of NACO and USAID are the other members of the PMC. The PMC provides overall guidance on policies and project strategies.

APAC was set up with the specific purpose of reducing the sexual transmission of HIV infection in Tamil Nadu. To achieve this objective, APAC has focussed on targeted interventions through NGOs to bring about behavior change among selected high-risk behavior/core-transmitter groups after a detailed mapping exercise. In the last six years of implementation, APAC has evolved several new strategies and has also designed and modified approaches to STD/HIV/AIDS prevention.

Targeted Interventions:

APAC's targeted interventions are based on a thematic approach. The major theme areas and the number of NGOs funded in each theme area are as follows:

- Prevention along the highways (PATH): 11
- Prevention among Women in Prostitution (WIP): 12
- Prevention among Slum Population (SIP): 8

- Prevention among Tourists and Women in Prostitution (TWIP):
- Clinical Intervention Program (CLIP): 3
- MCH/STD Integration Program: 2

The intervention programs are executed mainly through the NGO partners. APAC provides financial and technical assistance to 50 NGOs and other partners who build the capacity of the NGOs. APAC works in selected priority geographical areas for intervention based on the ethnographic study of high-risk population groups in the area. APAC has also prioritized certain population groups, especially commercial sex workers and transport workers who are at higher risk to contract and transmit HIV.

The various strategies adopted to address the population groups are prevention and control of STD, condom promotion and behavioral change with a specific emphasis on safer sex practices. APAC funded NGO partners adopted peer promotion and one to one interaction methods to educate various target communities. APAC has followed a transparent and competitive process for the selection of NGOs. After the selection, special efforts are taken to strengthen the capacity of the NGOs in implementing the targeted interventions. An innovative method of monitoring the performance of the NGOs through experience sharing review meetings (ESRM) has been developed by APAC.

Research and evaluation:

APAC's intervention efforts are complemented by research and evaluation. Behavior Surveillance Survey (BSS) is a monitoring and evaluation tool, which is adopted by APAC to monitor the impact of the intervention program systematically. APAC has

successfully completed four annual waves of BSS from the year 1996. The survey captures trends in behavior changes among various sub population groups in the state. Data from the four rounds of BSS clearly show sharp increases in condom use among high-risk groups such as commercial sex workers and transport workers, as already mentioned.

Technical Assistance-USAID's Global Experience:

It must be noted that APAC was not merely an additional source of funding for AIDS control efforts in TN. As the largest bilateral donor of AIDS control efforts at the global level, USAID has accumulated experience in sixty-nine countries. By bringing in technical experts with a global experience, USAID ensured that APAC followed an evidence-based approach to its programs, whether in targeted interventions or in research and evaluation. This maximized results in a short period of time and at a low-cost.

Synergy between TNSACS and APAC

TNSACS and APAC managements have institutionalized mechanisms for working together towards the common goal of containing the spread of HIV infection in Tamil Nadu. While the Health Secretary of the TN government and the Project Director of TNSACS are members of APAC's PMC, the Secretary of VHS and the Project Director of APAC participate in the EC meetings of TNSACS. This ensures that the efforts of TNSACS and APAC complement each other without duplication.

Even in terms of strategies, there has been a good degree of complementarity between the two agencies. The strengths of TNSACS are in awareness campaigns, targeted interventions through NGOs, blood safety and STD control programs in government

hospitals and the care and support of infected people. On the other hand, APAC has excelled in a thematic approach to targeted interventions after a detailed mapping exercise and in research and evaluation techniques. Following the APAC example of BSS in the urban areas, TNSACS has already completed one round of BSS is the rural areas of TN and is in the process of launching the second round. Similarly, APAC did not allocate sizable funds for awareness campaigns until recently because TNSACS was doing this adequately. However, with the declining trend in the allocation of funds to TNSACS for awareness campaigns due to the needs of other state societies, APAC is in the process of stepping up its funding for awareness campaigns. Further, APAC is also working with TNSACS to develop common messages.

Role of NGOs:

While TNSACS and APAC have been the nodal agencies leading the AIDS control efforts in TN, several NGOs have played important roles in this effort. Many NGOs have carried out targeted interventions, care and support activities and awareness campaigns with funding from TNSACS or APAC. Some NGOs have done commendable work through direct funding from external donors.

Political commitment:

In a taboo subject like AIDS, a sustained effort would not have been possible without the active support of the political leadership. This came quite early in 1994, when the proposal to convert the SAC into TNSACS was accepted by the Chief Minister of Tamil Nadu. The change of government in 1996 did not lead to a reversal of this decision nor in a slackening of the effort. On the contrary, the AIDS control program was intensified

with the next Chief Minister actively participating in World AIDS day events. The sustained high-visibility awareness campaign ensured that containing AIDS remained on the top of the agenda for the political leadership and the official machinery.

Conclusions

We need to answer two important questions at this point:

- What made things work in Tamil Nadu?
- What is special in Tamil Nadu that other states do not have?

The answer to the first question is a combination of factors listed below:

- Political commitment and recognition of AIDS as a problem before it was too late;
- Realizing the fact that SAC model did not function well and replacing it with the autonomous TNSACS in 1994 ;
- Empowering TNSACS with adequate financial and administrative powers;
- Specific strategies of TNSACS such as awareness campaigns, targeted interventions through NGOs and care and support activities;
- Launching of APAC in 1995 with a sharp focus on the prevention of sexual transmission of HIV and working with NGOs to achieve this;
- Specific strategies of APAC such as thematic approach to targeted interventions.
- Presence of a large number of NGOs in the development sector in TN.

The answer to the second question is largely the absence of the above "Tamil Nadu" factors in other states and can be listed as below:

- AIDS was not recognized as a major problem that needed priority attention and action from the government;

- This denial led to the low status of the SAC in most states; the Project Leader of the SAC in many states was a senior medical professional nearing retirement and who was not wanted in the health/medical directorate. Consequently, though the TNSACS model was disseminated at national level meetings since 1995, no other state adopted this model until NACO made this a pre-condition for receiving funds in 1999.
- The absence of a bilaterally funded project that complemented the efforts of the state society and brought in international technical assistance.

Lessons from the Tamil Nadu experience

Possibly the most important lesson from TN is the need for political commitment at the highest level for recognizing AIDS as a major problem requiring priority attention. If this is absent, it is still possible to convince the political leadership and other policy-makers through advocacy efforts and even awareness campaigns in the mass media. But it must be remembered that political commitment is a pre-requisite for an effective and sustained response to the epidemic.

Once this is achieved, the setting up of an autonomous agency with sufficient administrative and financial powers would be the first step in the fight against HIV/AIDS. This agency would be responsible for an effective surveillance system, both epidemiological and behavioral, to provide periodical markers on the epidemic. These serve as a basis for program planning as well as an instrument for monitoring the activities.

The next step would be to launch interventions based on an evidence-based approach. For example, while sex worker interventions may be the most important in many parts of

India, needle exchange programs will be the priority interventions in Manipur. Therefore, intervention programs need evidence collected through mapping of the risk behaviors and populations and epidemiological data, and from global best practice documents. Over the past two decades, a wealth of facts and experience has been gathered on AIDS related issues and, therefore, there is no justification for a trial and error approach that wastes precious time and scarce resources.

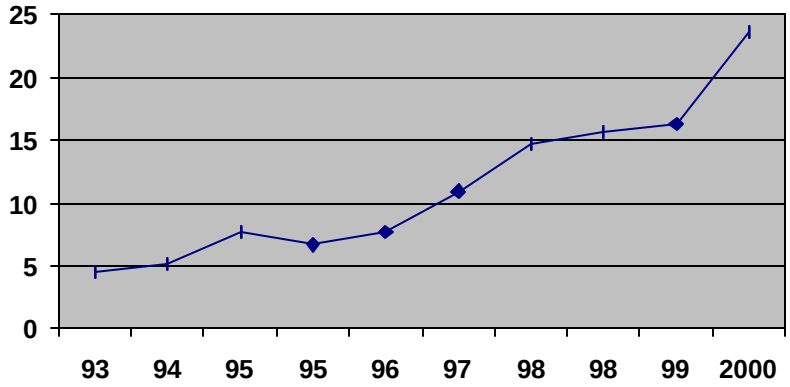
Even the combined outlays of TNSACS and APAC are only a fraction of the expenditure on AIDS control efforts in Thailand, widely hailed as a success story in Asia. Since Tamil Nadu and Thailand have roughly the same population, the Tamil Nadu experience shows that it is possible to implement HIV control programs at a low cost, which is very relevant in the Indian context.

Lessons *for* Tamil Nadu?

The battle against HIV/AIDS has not yet been won in TN. What we see is only the first signs of a possible slowing down of the epidemic. Given the scarcity of data, even this tentative conclusion must be viewed with caution. It is to be seen whether the flattening trend of the ante-natal HIV prevalence continues in the coming years. This is especially relevant in view of the findings from APAC's baseline study of community prevalence of STDs and HIV in 1997. This study indicated that the prevalence of HIV in the community was higher than the figure indicated by the ANC sentinel surveillance and also that HIV prevalence in the rural areas was the same as in the urban areas (APAC, 1997).

Secondly, data from the sentinel surveillance surveys show HIV prevalence among STD clinic attendees has been rising sharply, as shown in Chart-7. It is not known if this is due mainly to better attendance at the government STD clinics by high risk individuals as a result of awareness campaigns on STDs .

Chart-7: Trend in HIV Prevalence (%) among STD Clinic Attendees in TN (1993-2000)



Controlling STDs is an essential component of any program aimed at the prevention of sexual transmission of HIV. Rising HIV prevalence among STD clinic attendees is a cause for concern.

Therefore, there is hardly any justification for complacency in Tamil Nadu. What is needed is a sustained effort for many years to come. Program strategies need to be continually reviewed based on emerging new evidence on the epidemic. More importantly, thousands of people in Tamil Nadu have already been infected over the past decade and a half. Care and support programs for them will need to be scaled up quickly. Specific areas like TB control programs, caring for AIDS widows and AIDS orphans and the prevention of mother-to-child transmission need to be focussed on. Several countries

in Africa have gone through this inevitable sequence of AIDS related problems. Tamil Nadu can learn from them to cope with these problems, just as the rest of India can learn from Tamil Nadu's experience in achieving rapid behavior change which may lead to the slowing down of the spread of HIV in a short period of time and at a low cost.

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