



CONTENTS

INTRODUCTION	1
Section One: AIDS and STDs Some Basic Information	2
History	2
The Origin of the HIV	2
What is AIDS?	2
What is HIV?	3
The HIV Continuum	4
Diagnosis of HIV and AIDS	5
HIV Transmission	7
Prevention of HIV	8
STDs	9
Safer Sex	10
Treatment of HIV related Infections	11
Section Two: AIDS and Society in India	13
AIDS in India	13
Women and AIDS	15
Human rights, AIDS and the Indian legal system	18
Living with AIDS - living positively	20
Section Three: Working on AIDS	22
Working on Preventing the spread of HIV	22
Working on HIV/AIDS care and support	23
Some Innovative Projects	24
Section Four: Resource Section	26
Further Reading	26
Resource Organisations	27
Useful Websites	29

INTRODUCTION

Acquired Immuno-Deficiency Syndrome, or AIDS, is today one of the most insidious threats facing humankind. From Africa to the USA, from the Cameroon to India, the virus has spared no nation. Today, vigorous and determined prevention efforts have begun bringing down the infection rate in several countries like Uganda, USA and Thailand. However, in developing countries like India, where the epidemic is just beginning to take root, the situation is worrisome. Indeed, thanks to its enormous population, India has the dubious distinction of having the second highest HIV positive population in the world. AIDS is a special disease in many ways. It is incurable; there is no vaccine in sight. It is easily communicable. And the spread of the virus is closely linked with human sexual acts, sexual risk-taking behaviour, intravenous drug use, and even the simple process of giving birth. As a result, HIV/AIDS has never been an easy subject to broach within society. And the epidemic's spread has always been accompanied by a surge of discrimination, stigmatisation and ostracisation. Today, HIV/AIDS is acknowledged to be a social epidemic first, and then a medical one. Its prevention and control require changes in our social value system, relationship structures, attitudes and behaviour. The disease has several ramifications, including social, medical, clinical, legal, human rights, and economic ones.

Sexually Transmitted diseases (STDs) or Sexually Transmitted Infections as they are often called are one of the most widely occurring diseases in the world. The emergence of AIDS as one of the main scourges of mankind has focussed the attention on STDs because they share an important route of spread, and the presence of STDs increases the vulnerability to AIDS manifold.

In this booklet we shall look at what is known today about AIDS, HIV and STDs within the framework of India's social, and finally at some aspects of AIDS programming for those wishing to work in this area.

SECTION ONE

AIDS and STDs: Some Basic Information

History

In June 1981, doctors in New York were baffled by what they were sure was the outbreak of a dreadful new disease, when 41 patients, all in their twenties, all men, all gay were affected by the same condition. It was a rare skin cancer called *Kaposi's sarcoma*, found only in the Mediterranean region, amongst people who were 80 years or older. Closer examination revealed that the immune systems of these young men were also severely impaired.

As similar reports started pouring in from all over America and then Western Europe, the disease was dubbed the 'Gay Cancer'. The right wing promptly called it the curse of God on people who commit the sin of homosexuality. But within a year it was clear that heterosexuals were getting infected too. America was at the peak of its revolution of sexual permissiveness and this information came as a rude shock. In the year 1982, the disease was re-named the Acquired Immuno-Deficiency Syndrome or AIDS. During the following year, 1983, the virus causing AIDS was first discovered and named the HIV or the Human Immuno-deficiency Virus. Since then two major types (HIV- 1 and 2) and several strains within these types have been isolated.

The Origin of the Human Immuno-deficiency Virus (HIV)

There have been several theories on the origin of the HIV virus. From 'green monkeys in Africa' to 'germ warfare developed by the US army' to 'a secret virus developed by the US government to finish the American gay population'. Findings presented at the Sixth Conference on Retroviruses and Opportunistic Infections held in Chicago from January 31 to February 4, 1999, provide the strongest evidence to date that HIV-1 originated in non-human primates, probably chimpanzees. Researchers from the University of Alabama at Birmingham presented evidence identifying a new isolate of a retrovirus affecting a chimpanzee sub-species (*Pan troglodytes*) and showed that this and other chimpanzee isolates are related to the different groups of HIV-1 affecting humans. According to Dr. Hahn and colleagues, the establishment of HIV-1 in humans is likely to have resulted from cross-species transmission.

What is AIDS?

AIDS stands for Acquired Immuno-Deficiency Syndrome. An HIV-infected person receives a diagnosis of AIDS after developing one of the AIDS indicator illnesses defined by the Center for Disease Control, USA. An HIV-positive person who has not had any serious illnesses also can receive an AIDS diagnosis on the basis of certain blood tests (CD4+ counts). A positive HIV test result does not mean that a person has AIDS. A diagnosis of AIDS is made by a physician using certain clinical criteria (e.g., AIDS indicator illnesses). Infection with HIV can weaken the immune system to the point

that it has difficulty fighting off certain infections. These types of infections are known as "opportunistic" infections because they seize the opportunity a weakened immune system provides to cause illness. Many of the infections that cause problems or may be life threatening for people with AIDS are usually controlled by a healthy immune system. The immune system of a person with AIDS is weakened to the point that medical intervention may be necessary to prevent or treat serious illness. Today there are medical treatments that can slow down the rate at which HIV weakens the immune system. There are other treatments that can prevent or cure some of the illnesses associated with AIDS. As with other diseases, early detection offers more options for treatment and preventive care.

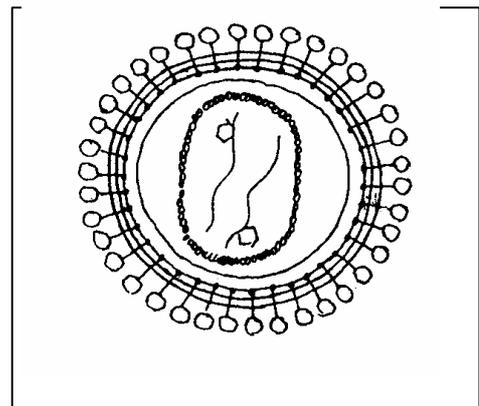
The World Health Organisation has produced a clinical case definition that is used in India for diagnosing a person as having AIDS. According to this if the person has

- Two major signs, including a ten per cent loss of body weight within a short period, chronic diarrhoea persisting for more than a month and chronic fever for more than one month,
- At least one minor sign, including persistent cough for more than a month, dermatitis, shingles, oral thrush, chronic herpes simplex and generalised enlargement of the lymph nodes,
- And no other known causes of immuno suppression, s/he may be suspected to have AIDS.

What is HIV?

HIV, as has been earlier mentioned, is the virus that causes AIDS. When a person is infected with HIV but has not yet developed AIDS, the person is known as HIV positive. Thus a person with HIV infection need not necessarily be suffering from AIDS, which leads to the use of the composite term HIV/AIDS.

Two types of HIV have been identified to date: HIV-1 and HIV-2. HIV-1 is the predominant HIV type in the United States and throughout the world. HIV-2 is primarily found in West Africa. As mentioned earlier, the origin of HIV-1 is from primates, most possibly from chimpanzees. The origin of HIV-2 has been identified as being another monkey species, the sooty mangabey (*Cercocebus atys*).



HIV is relatively less infectious as compared to the Hepatitis B virus. Furthermore, the ability of the HIV to survive in the external environment is also low, e.g. simple drying kills the virus, a temperature of 56 degrees Centigrade is fatal, chlorination, and bleaching and even plain detergent also kills the virus. This knowledge is very useful in prevention of the disease.

The HIV Continuum

As mentioned earlier, infection with HIV does not immediately lead to the development of AIDS. The period from the HIV infection to the development of full-blown AIDS is known as the HIV Continuum.

Early Symptoms

Many people do not develop any symptoms when they first become infected with HIV. Some people, however, have a flu-like illness within a month or two after exposure to the virus. They may have fever, headache, malaise and enlarged lymph nodes (organs of the immune system easily felt in the neck and groin). These symptoms usually disappear within a week to a month and are often mistaken for those of another viral infection. People are very infectious during this period, and HIV is present in large quantities in genital secretions.

More persistent or severe symptoms may not surface for a decade or more after HIV first enters the body in adults, or within two years in children born with HIV infection. This period of 'asymptomatic' infection is highly variable. Some people may begin to have symptoms in as soon as a few months, whereas others may be symptom-free for more than 10 years. During the symptomatic period, however, HIV is actively multiplying, infecting and killing cells of the immune system. HIV's effect is seen most obviously in a decline in the blood levels of CD4+ T cells (also called T4 cells) — the immune system's key infection fighters.

As the immune system deteriorates, a variety of complications begin to surface. One of the first such symptoms experienced by many people is large lymph nodes or "swollen glands" that may be enlarged for more than three months. Other symptoms often experienced months to years before the onset of AIDS include a lack of energy, weight loss, frequent fevers and sweats, persistent or frequent yeast infections (oral or vaginal), persistent skin rashes or flaky skin, pelvic inflammatory disease that does not respond to treatment, or short-term memory loss. Some people develop frequent and severe herpes infections that cause mouth, genital or anal sores, or a painful nerve disease known as shingles. Children may have delayed development or failure to thrive.

AIDS

The term AIDS applies to the most advanced stages of HIV infection. In 1993, the Centre for Disease Control, Atlanta, USA, revised its definition of AIDS to include all HIV-infected people who have fewer than 200 CD4+ T cells. (Healthy adults usually have CD4+ T-cell counts of 1,000 or more.) In addition, the definition includes 26 clinical conditions that affect people with advanced HIV disease. Most AIDS-defining conditions are opportunistic infections, which rarely cause harm in healthy individuals. In people with AIDS, however, these infections are often severe and sometimes fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses and other microbes.

Although children with AIDS are susceptible to the same opportunistic infections as adults with the disease, they also experience severe forms of the bacterial infections to which children are especially prone, such as conjunctivitis (pink eye), ear infections and tonsillitis.

People with AIDS are particularly prone to developing various cancers, especially those caused by viruses such as *Kaposi's sarcoma* and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS.

A small number of people (less than 50) initially infected with HIV 10 or more years ago have not developed symptoms of AIDS. Scientists are trying to determine what factors may account for their lack of progression to AIDS, such as particular characteristics of their immune systems, or whether they were infected with a less aggressive strain of the virus or if their genetic make-up may protect them from the effects of HIV. Scientists hope that understanding the body's natural method of control may lead to ideas for protective HIV vaccines and use of vaccines to prevent disease progression.

Diagnosis of HIV and AIDS

Since early HIV infection often causes no symptoms, it is primarily detected by testing a person's blood for the presence of antibodies (disease-fighting proteins) to HIV. HIV antibodies generally do not reach detectable levels until one to three months following infection and may take as long as six months to be generated in quantities large enough to show up in standard blood tests. This initial period when the person is infected but does not have enough antibodies to be detected as HIV positive is known as the "window period". HIV testing may also be performed on saliva and urine samples, in addition to blood samples.

Testing for HIV

ELISA Test -This test actually looks for antibodies produced by the body to fight HIV. Most people will develop detectable antibodies within three months after infection, the average being 25 days. In rare cases, it can take up to 6 months. For this reason, currently testing is recommended six months after the last possible exposure (unprotected vaginal, anal, or oral sex or sharing needles). It is important, during the six months between exposure and the test, to protect oneself and others from further possible exposures to HIV.

Western Blot -This more specific (and more expensive) second test can differentiate between HIV antibodies and other antibodies that cause the ELISA Test to display a false positive result. Although false positive ELISA results are uncommon, they can occur when the test mistakes other antibodies that the body has manufactured to fight other foreign substances for those produced to fight HIV. A repeatedly reactive result from the ELISA, confirmed by the Western Blot test, is taken to indicate the presence of HIV antibodies; only then is the individual tested considered to be infected.

In addition to the ELISA test, and Western Blot other tests now available include:

* Radio-immuno-precipitation assay (RIPA): A confirmatory blood test that may be used when antibody levels are very low or difficult to detect or when Western Blot test results are uncertain. An expensive test, the RIPA requires time and expertise to perform.

* Rapid latex agglutination assay: A simplified, inexpensive blood test that may prove useful in medically disadvantaged areas where there is a high prevalence of HIV infection.

* Dot-Blot immuno-binding assay: A rapid-screening blood test that is cost-effective and that may become an alternative to conventional ELISA and Western blot testing.

* P24 antigen capture assay: Also known as the HIV-1 antigen capture assay.

* Polymerase chain reaction (PCR): A specialized blood test that looks for HIV genetic information. Although expensive and labor-intensive, the test can detect the virus even in someone only recently infected. To further protect the blood supply, the FDA has indicated that the development and implementation of tests for HIV genetic material such as PCR is warranted.

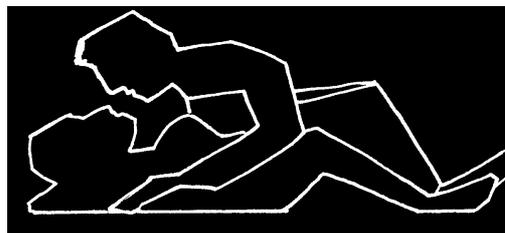
People exposed to HIV should be tested for HIV infection as soon as they are likely to develop antibodies to the virus. Such early testing will enable them to receive appropriate treatment at a time when they are most able to combat HIV and prevent the emergence of certain opportunistic infections (see **Treatment** below). Early testing also alerts HIV-infected people to avoid high-risk behaviour that could spread the virus to others. HIV testing is done in many health clinics and should be accompanied by counseling. Home-based test kits are available in developed countries, which can be obtained by telephone order or over the counter at pharmacies.

If a person is highly likely to be infected with HIV and yet both ELISA and Western Blot tests are negative, a doctor may test for the presence of HIV itself in the blood, through the PCR test or by a viral culture. The person also may be told to repeat antibody testing at a later date, when antibodies to HIV are more likely to have developed.

Babies born to mothers infected with HIV may or may not be infected with the virus, but all carry their mothers' antibodies to HIV for several months. If these babies lack symptoms, a definitive diagnosis of HIV infection using standard antibody tests cannot be made until after 15 months of age. By then, babies are unlikely to still carry their mothers' antibodies and will have produced their own, if they are infected. New technologies to detect HIV itself are being used to more accurately determine HIV infection in infants between age three months and 15 months. A number of blood tests are being evaluated to determine if they can diagnose HIV infection in babies younger than three months.

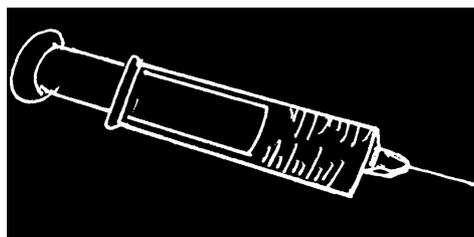
HIV transmission

HIV transmission can occur when blood, semen (including pre-seminal fluid), vaginal fluid, or breast milk from an infected person enters the body of an uninfected person. HIV can enter the body through a vein (e.g., injection drug use), the anus or rectum, the vagina, the penis, the mouth, other mucous membranes (e.g., eyes or inside of the nose), or cuts and sores. Intact, healthy skin is an excellent barrier against HIV and other viruses and bacteria. These are the most common ways that HIV is transmitted from one person to another:



by having unprotected sexual intercourse (anal, vaginal, or oral sex) with an HIV-infected person

- by sharing needles or injection equipment with an injection drug user who is infected with HIV

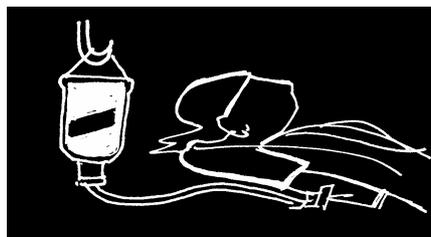


- from HIV-infected women to babies during gestation, during delivery, or before or during birth, or through breast-feeding after birth
- HIV also can be transmitted efficiently through transfusions of infected blood.

HIV cannot be transmitted through

- Social contacts like touching, hugging, etc.
- Light kissing
- Sharing foods, clothes etc.
- Mosquito or other insect bites
- Using public toilet, telephone, swimming pool, etc.

An estimated 95% of recipients become infected from transfusion of a single unit of infected whole blood. The per-contact probability of transmission from an HIV-infected source is much lower for injecting-drug-use and sexual exposures. The risk for HIV transmission per episode of intravenous needle

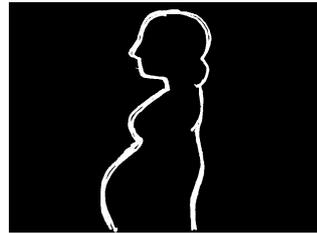


or syringe exposure is estimated at 0.67%. Prospective surveillance studies indicate that the risk per episode of percutaneous exposure (e.g., a needle-prick) to HIV-infected blood is estimated at 0.4%. The level of risk associated with the exposure of non-intact skin or mucous membranes to

HIV-infected blood is far less than that associated with needle-prick exposures.

Some health-care workers have become infected after being pricked with needles containing HIV-infected blood or, less frequently, after infected

blood contact with the worker's open cut or through splashes into the worker's eyes or inside their nose. There has been only one instance of patients being infected by an HIV-infected health care worker. This involved HIV transmission from an infected dentist to six patients.



The risk for HIV transmission per episode of receptive penile-anal sexual exposure is estimated at 0.1%-3%; the risk per episode of receptive vaginal exposure is estimated at 0.1%-0.2%. No published estimates of the risk for transmission from receptive oral exposure exist, but instances of transmission have been reported.

Efficiency of HIV transmission by various routes in South East Asia		
Region	Route of Transmission	Efficiency % of
	Total	
	Sexual	0.1 - 1.0% 80 - 90%
	Blood Transfusion	>90% 3 - 5%
	Injecting Drug Use	5 - 10% 5 - 10%
	Equipment/ Needles	< 0.5% <0.1%
	Perinatal	15 - 45% <0.1%

Source - WHO

Prevention of HIV

There are no effective cures for HIV/AIDS and thus prevention remains the most important tool in the fight against this disease. Some of the preventive strategies are outlined below.

Through sexual route:

- Celibacy
- Having sex only within marriage, if the spouse is HIV negative
- Having sex with only one faithful sexual partner who is HIV negative.
- If unable to do the above, use safer-sex techniques like proper and regular use of condoms.

Through Blood

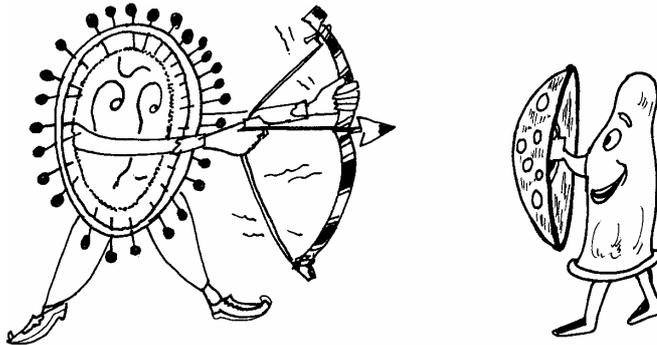
- Avoiding blood transfusion except in cases of emergencies. Check with the doctor whether the requirement is for whole blood or a blood component, such as platelets or plasma.
- If the hospital permits and you have sufficient advance notice of the need for blood transfusion, then the safest route for you is auto-transfusion, in which you donate your own blood for later transfusion back into yourself. The hospital must label your blood with your name, and you should verify that the same blood is being supplied to you.
- If you have sufficient time, arrange for donors from among friends and relatives who to your knowledge are not likely to have indulged in high-

risk behaviour. In addition, make sure their donated blood is tested HIV free and is labelled clearly for later transfusion back into you.

- Sterilising the needles, syringes, and other surgical instruments before using on another person. Use only disposable needles and syringes.
- Taking oral drugs instead of IV drugs. Not sharing needles/syringes when taking IV drugs. If one has to share these, both needle and syringe should be properly sterilised.
- Sterilizing tattooing equipment and those used for piercing body parts after each use.

Prevention through awareness -

- IEC campaigns in the mass media for the general public
- Training of healthcare personnel at all levels
- Change attitudes towards sex and sexuality
- Creating a demand in the community for safer medical and related services



Risk behaviour- AIDS recognizes no barriers and it can strike at any age. However, some men and women are more vulnerable because of risky behaviour. These risk behaviours include- engaging in sex with multiple partners, inability to negotiate safer sex practices like use of condom, sharing unclean and used injecting equipment like syringes and needles, transfusion of blood or blood products that have not been screened for HIV antibodies

STD/STI

Sexually Transmitted Diseases (or infections) are those diseases, which are transmitted through sexual contact with another person. These are among the commonest diseases in the world. According to estimates of the WHO, over 300 million new cases of STDs occur every year in the world. This makes them the fourth most common infectious disease after diarrhoea, malaria and acute respiratory tract infection. The commonest micro-organisms causing these are chlamydia, trichomona, syphilis and gonorrhoea. Most STDs are now treatable if treatment is sought in time. AIDS is an exception, which has no cure.

STD symptoms in men

The most common STD symptoms in men include:

- Pain when passing urine

- Yellow discharge from the penis.
- Sores and blisters in the genital area, including the anus. These sores can be painful or painless.
- Itching in the genital area
- Discharge and irritation, caused by infection of the anus
- Enlargement of groin lymph nodes

STD symptoms in women

STDs may not always show symptoms in women. If present they include:

- Burning feeling when passing urine
- Unusual vaginal discharge
- Discharge and irritation cause by infection of anus
- Pain in the lower abdomen
- Sores, blisters etc. around the genital areas including the anus. These sores may or may not be painful.
- Enlargement of groin lymph nodes

If STDs are not treated in time, they can lead to several incurable disabilities, including, sterility, blindness, impotence, etc. and can even be fatal.

Some of the common STDs are:

* Gonorrhoea	* Pubic lice
* Syphilis	* Scabies
* Herpes	* AIDS
* Genital warts	* Hepatitis B

Having an STD increases the chances of a person for getting infected with HIV by upto 10 times.

Prevention of STDs:

The best way to prevent STDs is of course to have safer-sex including proper and regular use of condoms. In the case of STDs there is also a concept of secondary prevention in which the effort is to restrict spread from one infected person and the measures that can be taken include- seeking early medicare, early diagnosis and treatment and partner notification.

Safer Sex

Since no vaccine for HIV is available, the only way to prevent infection by the virus is to avoid behaviours that put a person at risk of infection, such as sharing needles and having unprotected sex. Because many people infected with HIV have no symptoms, there is no way of knowing with certainty whether a sexual partner is infected unless he or she has been repeatedly tested for the virus or has not engaged in any risky behaviour. CDC recommends that people either abstain from sex or protect themselves by using male latex condoms whenever having oral, anal or vaginal sex. Only male condoms made of latex should be used, and water-based lubricants should be used with latex condoms.

Although some laboratory evidence shows that spermicides can kill HIV organisms, in clinical trials, researchers have not found that these products can prevent HIV. The risk of HIV transmission from a pregnant woman to her foetus is significantly reduced if she takes AZT during pregnancy, labour and delivery, and her baby takes it for the first six weeks of life.

Given below is a list of some commonly practiced sexual activities and the risk of HIV transmission they involves

NO RISK	Masturbation, seeing pornographic movies, fantasising, erotic massage, etc., using sex toys that are clean and not shared.
VERY LOW RISK	Mutual masturbation, petting, kissing, etc., using sex toys that are shared but cleaned.
LOW RISK	Deep kissing, oral intercourse with condoms, vaginal/anal intercourse with condoms.
HIGH RISK	Vaginal/anal intercourse without condoms, oral intercourse without condoms.

Treatment of HIV related infections

When AIDS first surfaced in the United States, no drugs were available to combat the underlying immune deficiency and few treatments existed for the opportunistic diseases that resulted. Over the past 10 years, however, therapies have been developed to fight both HIV infection and its associated infections and cancers. The Food and Drug Administration of the USA has approved a number of drugs for the treatment of HIV infection. The first group of drugs used to treat HIV infection, called nucleoside analog reverse transcriptase inhibitors (NRTIs), interrupt an early stage of virus replication. Included in this class of drugs are zidovudine (also known as AZT), zalcitabine (ddC), didanosine (ddI), stavudine (D4T), lamivudine (3TC) and abacavir succinate. These drugs may slow the spread of HIV in the body and delay the onset of opportunistic infections. Importantly, they do not prevent transmission of HIV to other individuals. Non-nucleoside reverse transcriptase inhibitors (NNRTIs) such as delavirdine, nevirapine and efavirenz are also available for use in combination with other antiretroviral drugs.

A third class of anti-HIV drugs, called protease inhibitors, interrupts virus replication at a later step in its life cycle. They include ritonavir, saquinavir, indinavir and nelfinavir. Because HIV can become resistant to each class of drugs, combination treatment using both is necessary to effectively suppress the virus. Currently available antiretroviral drugs do not cure people of HIV infection or AIDS, however, and they all have side effects that can be severe. AZT may cause a depletion of red or white blood cells, especially when taken in the later stages of the disease. If the loss of blood cells is severe, treatment with AZT must be stopped.

The most common side effects associated with protease inhibitors include nausea, diarrhoea and other gastrointestinal symptoms. In addition, protease inhibitors can interact with other drugs resulting in serious side effects. Also, investigators have recently reported cases of abnormal redistribution of body fat among some individuals receiving protease inhibitors. A number of drugs are available to help treat opportunistic infections to which people with HIV are especially prone. These drugs include foscarnet and ganciclovir, used to treat cytomegalovirus eye infections, fluconazole to treat yeast and other fungal infections, and TMP/SMX or pentamidine to treat *Pneumocystis carinii pneumonia* (PCP).

Alternative medicine and HIV

Many alternative forms of medicines have offered relief (not cure) to people living with HIV virus. These medicines work in two ways. On one hand they help replenish the depleted immune system and also reduce further spread of HIV, and on the other hand they provide a psychological benefit. These alternative forms of medicine often make use of ancient knowledge and practices. These include Ayurveda, acupuncture, yoga, Reiki, etc. These alternative medicines or healing should not be used on their own, but only as complementary to more established forms of treatment. However there have been no scientific clinical trials using alternative medicine drugs

Quackery and HIV

Even though there are no cures for HIV virus, many quacks in India and elsewhere have been claiming to cure people with AIDS or to develop special cures. They exploit the helplessness felt by many people living with AIDS as far as a cure is concerned. There is no truth whatsoever in such claims. At present there is no law in India to deal with such quacks.

SECTION TWO

AIDS and Society in India

AIDS in India

The first case was reported in 1986, more than five years after it was first discovered in the US. However, we have failed to make use of the early warning. Thus, despite many millions of dollars being spent in “raising awareness” about HIV/AIDS during the last decade, India’s first reaction, as every other nation that has come face to face with the prospect of AIDS for the first time, was also a ‘no’ and a shrug. Fortunately, however, in its earliest days the programme was guided by the global experience of those who had already seen how bad it was going to get. The AIDS control initiatives that India launched between 1992 and 1997, whose outcomes have now been evaluated by the National AIDS Control Organisation (NACO) and other agencies, have made considerable inroads against HIV/AIDS.



The efforts were largely based on the assumption that individuals will make a rational choice and adopt the steps prescribed as protection, once they are convinced about their susceptibility to HIV and the details of the threat they face from AIDS. Accordingly, Information–Education–Communication (IEC), and its concomitant ‘awareness-raising’ have been the cornerstones of public communication. We have passed through a phase of a sort of carpet-bombing of the public consciousness with the ‘facts about HIV and AIDS’. IEC has helped to move the hitherto taboo topics of HIV infection and AIDS into the public domain. HIV/AIDS education is now a part of primary school curriculums. In important and influential communities, one no longer hesitates to talk about AIDS, or admit ignorance about it, or even openly ask a question relating to personal sexuality. NACO assesses the levels of awareness of HIV/AIDS in urban India to be around 70% now, though in rural areas it is much less

Targeted interventions – The primary focus of HIV/AIDS related work in India has been with what are identified as high risk behaviour groups. These include commercial sex workers, communities of injecting drug users, professional blood donors, truckers and blood banks. The logic behind this approach is that people with these behaviours harbour the infection and controlling the virus in such ‘reservoirs’ will control the infection overall. While this approach may sound epidemiologically sound it ignores the fact that HIV/AIDS is also a disease of poverty and social exclusion, targeting vulnerable groups may lead to further marginalisation of these groups.

Donated blood becomes safe - In the last five years, donated blood has also started becoming safer in India, with the phasing out of unlicensed blood banks and professional blood donors, as well as a vigorous drive to increase voluntary blood donations. In the years ahead, regional blood banks with state-of-the-art facilities for collecting, processing and storing whole as well as component blood will bring the prospect of safer blood closer to every Indian.

The virus is still winning – The prevalence of HIV has slowly increased over the years and by 2003 HIV prevalence among sex workers in Mumbai reached 55%, 10 % in sentinel STD clinics and over 1 per cent among women attending antenatal clinics (ANCs). The prevalence in women attending antenatal clinics, an indicator for the prevalence in general population, has breached the 1% barrier in the states of Andhra Pradesh, Maharashtra, Manipur, Karnataka, Mirzoram, and Nagaland. The epidemic has now beyond its initial focus among sex workers and sub-epidemics are evolving among groups of injecting drug users (IDUs) and among Men having Sex with Men (MSM).

In the last few years the epidemic has also spread across the southern and western states of India in addition to the IDUs in the North Eastern states. There has been a sharp increases in Andhra Pradesh and Karnataka. In other parts of the country, the overall levels of HIV are still low, however with high levels of Sexually Transmitted Diseases (STDs), the presence of sexual networks and phenomena like migration and gender bias these areas continue to be very vulnerable.

HIV Prevalence among various risk groups
(Selected states 2003)

Name of State/UT	HIV Prev. (%)FSW	HIV Prev (%)MSM	HIV Prev. (%) IDU	HIV Prev (%)STD	HIV Prev. (%)ANC
Andhra Pradesh	19.4	13.2	-	19.6	1.25
Delhi	2.0	-	14.4	7.20	0.13
Goa	30.1	-	-	14.30	0.50
Gujarat	-	-	-	4.50	0.40
Karnataka	14.4	10.8	2.8	10.40	1.25
Kerala	2.29	-	-	4.00	0.33
Mumbai	54.29	18.8	24.8	18.40	1.25
Manipur	12.4	29.2	24.4	13.00	1.25
Tamil Nadu	8.8	4.4	-	9.20	0.75
Tripura	-	5.26	-	0.00	0.00
West Bengal	6.45	-	2.70	1.45	0.50

(From NACO)

Highest prevalence in areas of maximum focus:

Hidden within the numbers, are also trends that reveal *increases particularly in areas that have been receiving much attention as 'centres of spread'*. These are the regions where the hot light of international focus has shone brightly, such as Manipur, and Mumbai's sex district, Kamathipura. Among sex workers in Mumbai, HIV prevalence rates have increased from 1% in

1986 to 15% in 1989 to 50% in 1994. The manager of Kamathipura's oldest targeted intervention project estimates that today's figure may be over 60%. Though data from Kamathipura is still controversial and sparse, the bulk of these infections are likely to have occurred concurrent with prevention efforts. "There is a very high rate of sex worker turnaround within brothels," says the manager of one of Kamathipura's earliest interventions. "If a sex worker is found HIV positive, the community will generally expel her as soon her health and earning ability begin to decline. She will be sent home. Prevalent figures are more likely to indicate infection among newcomers."

Among injecting drug users, HIV prevalence in Manipur seems to have stabilised at around 65%, but serosurveys among IDUs in Calcutta and Chennai show that the number is still increasing. HIV prevalence among STD patients in Chennai and Mumbai rose from 17% in 1996 to 33% in 1997; it is presumably even higher now.

Women and AIDS

The incidence of HIV and AIDS among women is rising - In 1990, the World Health Organisation estimated that there were between 8 and 10 million people worldwide infected with HIV. More than 3 million of these people are women. Even more alarming is the rate at which infection among women has been increasing. The number of infected women rose sharply during the second half of the 1980's and, in some areas of Africa, Latin America and the Caribbean, there was more than a fourfold increase over a period of between two and four years. It is estimated that during the next decade the prevalence of HIV infection among women will equal and, in some cases, overtake that of men. The World Health Organization estimates that during the 1990's, the number of women and children dying of AIDS will rise to 3 million. In most central African cities and in some major cities in America and Western Europe, AIDS is already the leading cause of death for women between the ages of 20 and 40. In sub-Saharan Africa over the next few years, infant mortality is expected to increase by up to 30% as a result of perinatal transmission of HIV.

It is estimated that approximately 80% of the total number of women and children currently infected with HIV are in sub-Saharan Africa. In this region, one in every twenty adult women is thought to be infected, and women represent more than 50% of the total number of AIDS cases. The majority of infected women are of childbearing age, opening the way for perinatal HIV transmission to these women's children on a large scale. UNDP has estimated that over 85% of the cases of pediatric infection in Africa have resulted from perinatal transmission. For the Caribbean the estimate is 97.5%. Even where the children do not themselves have HIV infection, the number of children orphaned by AIDS is increasing rapidly. World Health Organization has estimated that as many as 10 million children in sub-Saharan Africa will be orphaned by the epidemic by the end of the 1990's.

Why women are at increased risk and are more vulnerable- The primary HIV risk activity for women globally is sexual activity. Over 90% of women

currently infected with HIV have been infected as a result of transmission through vaginal intercourse. Efficacy of transmission is increased where women have poor general health and suffer from genital lesions, inflammation, secretions and scarification. Women are also at increased risk of being infected with HIV infection through contaminated blood and injections because of the high incidence of blood transfusions and injections associated with pregnancy, childbirth and post-pregnancy haemorrhage or treatment for anaemia caused by repeated pregnancies.

The World Health Organisation has admitted that its estimates of the levels of infection among women and children should be viewed as very conservative. It is likely that under-reporting of HIV infection and AIDS in parts of Africa, the Caribbean and Asia, where women make up a large proportion of the infected population, has helped to conceal the true levels of infection. However, even the estimates currently available leave no doubt as to the magnitude of the impact of the HIV epidemic on women.

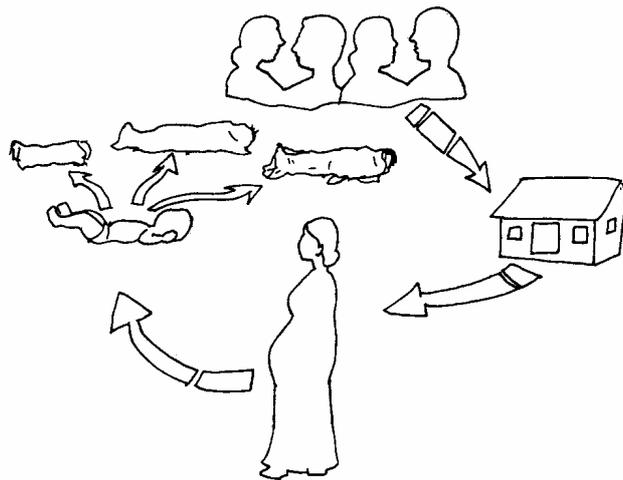
Physiologically speaking, women in general are more vulnerable than men because women receive semen from men, and it stays in the vaginal canal for sometime, giving the virus time to take root. Women also have a more extensive surface area of mucus membrane in the vagina and on the cervix. Young women are at an especially high risk of contracting HIV. Women in the 15-25 year age group have the highest rate of HIV. The corresponding age group for men is 25-30 years. In young women the vagina is not well lined with protective cells, the cervix may be more easily eroded and tearing of the hymen during first intercourse can cause bleeding. Similarly, women going through menopause will often have a thinning of the vaginal mucus that make them more susceptible.

The link between powerlessness and the risk of exposure to HIV provides the key to understanding the source of women's vulnerability to HIV infection. It is the reason why HIV infection is increasingly a condition of all women, regardless of race, colour or economic status. In more developed countries, the full impact of these social and cultural dynamics was not apparent in the early years of the epidemic when the majority of reported cases were homosexual men. With dramatic increases in infection levels in women in both the developed and the developing world, however, there has been a shift in the global demographics of HIV infection. This shift has forced a reassessment of the role of socio-economic factors in the spread of HIV in order to address the ways in which women are being affected by the epidemic.

The need to redefine AIDS – The male-centric understanding of the epidemic to date is evident in the way HIV-related illnesses and AIDS have been defined. The case definition of AIDS issued by the United States Centres for Disease Control and used worldwide focuses on the marker diseases that are characteristic of HIV-related illness in men and omits conditions that often signify the onset of HIV-related conditions and AIDS in women, including pelvic inflammatory disease, cervical cancer, vaginal candidiasis and conjunctivitis. This has had serious consequences for women, leaving many women undiagnosed or wrongly diagnosed, delaying diagnosis

and treatment and denying women access to disability and other benefits and services because they have not been diagnosed with AIDS.

Women, AIDS and gender – The patterns of social and economic dependency that render women vulnerable to HIV infection are manifested in many different ways. First and foremost, they lead to women being deprived of the power to determine the basis upon which their sexual relationships with men take place. For many women, sexual intercourse is not a question of choice but rather a question of survival. Cultural attitudes and norms leave no place for unmarried or childless women. A woman's fertility and her relationship to her husband will often be the source of her social identity. Moreover, for many women, marriage provides forms of economic and social support that would not be available to them if they were to remain single. Similar social constructs also dictate that a married woman has little or no power to negotiate the basis upon which her sexual relationship with her husband will take place. Once married, women are usually expected to remain faithful to their husbands but are unable to compel fidelity in return. In many parts of the world, multiple sexual relationships on the part of men



are actively condoned or at least regarded as an acceptable practice. The tendency for men to have sexual relationships outside their marriage is reinforced by male migration and mobility common in many developing countries where men leave the village to obtain work elsewhere.

Women have little alternative but to accept the risk that sexual intercourse with their husband entails. They usually have little or no means of support for themselves and their children other than by remaining within the marriage. Even if condoms were available to them at an affordable price, most women would not be able to ensure that their husbands used them. Although it is almost invariably the husband who is the vector of HIV infection for wives, a married woman who is found to be infected with HIV will often be expelled from the family unit by the husband. The husband will then seek a new wife, often a younger woman who is believed to be uninfected and therefore safe and who, in turn, will be exposed to HIV. In some parts of Africa, there have been reports of increased rape of young girls, because they are believed to be free of HIV infection.

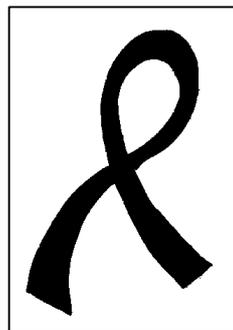
AIDS and Commercial Sex Workers- Commercial sex work is often the only means of support for deserted, separated, divorced or unmarried older women, highlighting once again the close link between financial need and exposure to HIV infection. There has been a serious distortion of the understanding of the way this epidemic has affected women because of the

singling out of sex workers by epidemiologists, researchers and national HIV/AIDS programmes as a target or high-risk group. The overwhelming majority of women are not sex workers and the largest groups of women at high risk of infection are wives. Recent data from Mexico indicate that only 0.8 per cent of all reported AIDS cases have been among sex workers and 9 per cent among housewives. Similar figures can be found in other countries, both developed and developing. In Senegal, where the epidemic is still in its infancy (less than 2 per cent of the adult population infected), modes of transmission to women in one infectious diseases ward were 20 per cent acquired iatrogenically, 30 per cent occupationally (sex workers) and 50 per cent had no risk factor other than being a wife. As the epidemic proceeds, the proportion of wives to all infected women increases and that of sex workers and iatrogenically acquired transmission decreases.

The targeting of sex workers encourages blame, stigma and discrimination not only against them but also against all women. It allows others, both the men who infect sex workers and the wives of these men, to deny that they are at risk. However, it has brought some benefits to some sex workers. HIV prevention programmes which have provided counselling, support and services for these women and their children and which ensure women access to affordable, quality condoms have assisted women to adopt condom usage in their work. In some cases, sex workers have been empowered through collective action and instituted condoms-only policies in their area of operation.

Human rights, AIDS and the Indian legal system

An agenda for change within the Indian legal system has been the mandate of Mumbai's Lawyers Collective, a small but energetic and highly visible crusading body of lawyers. It has set up an HIV/AIDS unit to respond to the legal needs of people living with HIV/AIDS by providing them with free legal services and undertaking advocacy to lobby for an enabling legal environment. Their studies have identified the following issues as needing advocacy efforts for bringing about legislative change and more effective implementation:



1. The HIV status of a person should not be a ground for divorce or judicial separation or for the denial of custody, maintenance, inheritance, guardianship, adoption etc. Amendments in the law are necessary to remove the ground of venereal disease as grounds for divorce.
2. The activity of commercial sex work should be decriminalised, and there should be strict enforcement against trafficking in women/girls.
3. The National Drugs and Psychotropic Substances Act should be comprehensively reviewed in the medium term, but in the short term there is an immediate need to decriminalise the use of 'soft drugs', and institute appropriate amendments in the law to promote 'clean needle exchange' programmes.
4. Section 377 of the Indian penal Code, which criminalises homosexual practices, must be repealed.

5. Section 376 of the IPC, relating to rape, should be amended to include offences relating to rape, sexual offences and non-sexual intercourse between two persons, as against offences by a man against a woman, which is what it deals with currently. It must also be amended to include non-consensual sexual intercourse, and sexual assault within marriage as offences.

6. A statute that specifically addresses the needs of HIV positive people and People Living With HIV/AIDS (PLWHA) should be enacted, with the following provisions:

- ◆ A person shall not be discriminated against on the grounds of his or her seropositivity;
- ◆ Being seronegative shall not be a condition for appointment to a job, or for continued employment, education, getting medical treatment, availing of travel facilities, benefits of services and so on.
- ◆ HIV seropositivity shall not be considered a continued illness within the meaning of Section 2 of the Industrial Disputes Act (1947), or be a ground for the termination of employment.
- ◆ A person shall not be denied any medical treatment or insurance cover on the ground of his or her seropositivity.
- ◆ All health care workers shall be provided with all the necessary protective gear and equipment, and be insured against all occupational diseases, including HIV.
- ◆ The practice of testing babies for HIV prior to adoption must be discontinued.

7. The law relating to obscenity must be amended to strengthen the exceptions to Section 299 of the IPC, and thus allow for the dissemination of messages related to safer sex.

8. The law must also provide for the prohibition of claims of remedies for HIV infection and AIDS without the claimant following a procedure to be prescribed by law, with punitive consequences for defaulters.

9. The law and the procedure must be amended to allow for HIV positive litigants to litigate without disclosing their identity and to also prevent their identity from being disclosed or published.

Gaps in the legal framework - While this forms the broad basis for an agenda, two important environmental constraints are beyond its scope:

- ◆ It cannot reach individuals whose rights have been violated unless they come forward with a case.
- ◆ In order for people to step up with cases and complaints, they must be aware of their rights, and also know where to turn for help.

Both of these have long been endemic features of the Indian legal climate, ones which have frustrated activists and lawyers. Not only is it a long hard road of diligent advocacy to bring about changes in the statutes, but it is an even more arduous process to ensure that those who need the laws know about them, and know where to go for redress.

Because violations of human rights are going to occur even as lobbies mount pressure for re-framing the laws, advocacy strategies must focus squarely at the level of society where the inequities are going to occur, and look for

working, immediate solutions that are within the powers of the affected communities.

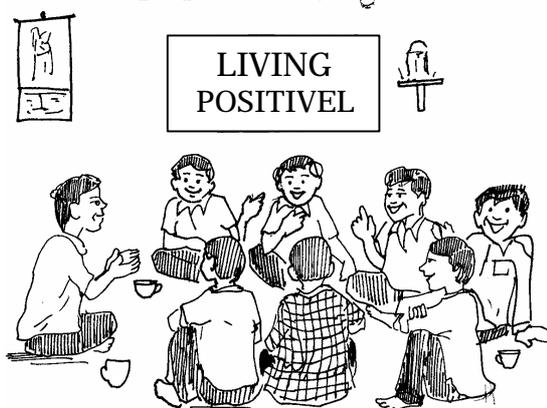
Living with HIV or AIDS — living positively

In India, there are a number of PLWHA (People Living With HIV and AIDS) groups who have been active since the 1990s. The Indian Network of Positive People (INP+) is the national PLWHA group, several years old, and equipped with government funding to hold national meetings. INP+'s leaders have been sent on study tours of Thailand, and has a work plan that addresses networking, skills building, representation and advocacy. A PLWHA is represented on NACO, but in the field, there is hardly any contact either between NGOs working in HIV, or between NGOs and groups of PLWHA.

Thematic issues around PLWHAs: The following thematic issues around PLWHAs were identified in 'Involvement of People Living with HIV/AIDS in Policy and Programme Development, a study conducted for the UNDP Regional Project on HIV & Development for Asia and the Pacific:

1. The need for a better conceptual understanding of the place of the PLWHA in the national response.

For most people working in HIV, and in most countries, there is no adequate conceptual framework within which they can apply and explore their efforts to encourage the greater involvement of PLWHA groups. This creates difficulties when advocating with policy makers to seriously consider initiatives in this area. It is difficult to shift people beyond seeing PLWHAs as patients in need of services; there are insufficient theories and models



to use for arguing for a broader form of understanding and response. While it is accepted that PLWHA involvement should occur, there is an urgent need to develop sophisticated analyses of why it is of benefit to focus upon the place of PLWHAs in, and their contribution to, the integrated response to the HIV epidemic. The Indian Network of Positive People (INP+) has drafted a national GIPA [Greater Involvement of PEOPLE living with HIV/AIDS] strategy and the National Aids Control Organisation (NACO) has promised to adopt it.

2. Understanding PLWHA organisational development as a process, not a structure. PLWHA groups must be treated as processes, not as structures or vertical, single-focus programmes. Understanding that the coming together of PLWHA to achieve common goals is a process, which means that the dynamic it creates allows for evolution and change, and is more prone to evolve creative responses in reaction to local needs and contexts.

3. The diverse roles and responsibilities of PLWHA groups. In the west, PLWHA movements have been shaped around notions of empowerment, activism and openness about one's HIV status. There are major difficulties while transferring this model to other countries. Even in Thailand, where PLWHA groups are large and active, many PLWHA from the middle classes are uninvolved, and not because they have well-developed coping mechanisms of their own. The strong fear of being socially ostracised that follows disclosure, the absence of any supportive or protective wider environment, the lack of sound, protective legal and health policies, are some of the reasons why many PLWHA hide from the public gaze.

4 PLWHAs as actors against the epidemic: It is necessary to develop and nurture PLWHA as players in the responses to the epidemic: not only as support or pressure groups but as resource people willing to speak or write publicly or anonymously, as members of decision-making groups at the community, state and national levels, as people themselves trained in counselling to work with others like themselves and to provide the insight that only they can have. In the words of one who has done work with such groups: "It is a long, painful process that requires taking on immense responsibility for the welfare of others who accept to place themselves in the danger of the public eye... and yet the successes are the most stunning, the most moving, the most effective of any we have seen, and well worth the uphill battle."

5 The role of government and NGOs. The government has particular key responsibilities including providing political leadership, namely making PLWHA involvement a priority; allocation of funds, appointing PLWHA to decision-making bodies and facilitating their participation; conducting campaigns to reduce stigma and misconceptions, thereby creating a national and social context compatible with what PLWHA are trying to achieve at a personal, family and community level; and the creation of appropriate laws and guidelines.

The link between NGOs and PLWHA groups is particularly important in environments where the PLWHA has no voice, is not active, or is still in the early stages of creating organisations. In such situations, the PLWHA's ability to express its needs and experiences in programme and policy forums will be low; NGOs could play the role of intermediaries or conduits at such stages in the process.

6. Developments in HIV medicine: Within western PLWHA communities it is now rare to hear of sickness, deterioration and death. Hospitals have had a massive decline in patient numbers. Many people who were invalids are now well, and PLWHA groups working to re-integrate them in the workforce and to plan for their future.

This is in complete contrast to the experiences of PLWHA in developing countries throughout the Asia-Pacific region. Many of them are well aware of these developments in the west but only small percentages are in a position to access these new treatments.

SECTION THREE

Working On AIDS

HIV/AIDS is one of the most urgent public health concerns today. But the prevention and control of AIDS cannot just be the sole responsibility of the health services. If we have to launch a successful campaign to combat the scourge of AIDS, it is essential that different sections of society like media, NGOs, activists, policy makers etc. all get involved. Our knowledge about the disease and its control is continuously evolving and different areas of work are getting increasingly specialised. Despite all this specialisation and the complexity of the subject, working on the issue of AIDS can be simplified into three areas: preventing the spread of the infection; reducing the physical, personal and social impact of the infection; and advocacy to mobilise national and international efforts against AIDS and to secure individual rights and entitlements for the affected. Some of the key features of each of these different approaches are being highlighted below.

Working on preventing the spread of HIV

Prevention of HIV infection remains the key to combating AIDS especially in a country like India where the infection remains relatively low, though the potential for spread is very high.

HIV/AIDS Prevention Package

- Promoting safer sex behaviour through education
- Condom promotion/provision
- STD diagnosis and treatment
- Safe blood transfusion
- Safe injecting behaviour

(Source: AIDS -- No Time for Complacency, WHO)

Information, education and communication (IEC)- IEC is a key to the prevention of AIDS, but what has to be kept in mind that the objective of this is to change behaviour, especially sexual behaviour. In order to have a



successful IEC strategy one must be courageous enough to address issues of sexual behaviour within our society, a subject which is usually not discussed in the open. At the same time the subject must be approached in a manner which does not make people defensive or openly hostile. Today there is a host of IEC material on AIDS available in the form of booklets, flashcards,

videos and so on. One must choose the material carefully depending upon the objective of one's programme.

Targeted interventions - This refers to activities targeted at specific population groups, which are considered vulnerable. It includes providing information and services to these groups. Some of the specific population groups with whom targeted interventions are being made include commercial sex workers, intravenous drug users, truck drivers, men who have sex with men, Hijras, and so on. While working on targeted interventions, one must not forget that the targeted population is not the only population at risk.

Two other prevention strategies include **control and treatment of sexually transmitted diseases** and **condom promotion and provision**.

Working on HIV/AIDS care and support

Care of the HIV infected person- Once a person starts developing the symptoms of the disease, the AIDS sufferer has a long haul before him. There will be periods of intensive medical care interspersed with periods at home. Programmes have been designed which help healthcare providers and family provide better care to the infected persons.

Counselling- HIV/AIDS infection is a condition with profound emotional, social and behavioural consequences. In such a situation, just providing medical care is not enough. The person who has the infection, or even may have the infection, needs tremendous support, and this support can be provided through counselling. The role of counselling begins before taking an HIV test (pre-test counselling) and is an important part of therapy.

Positive persons, support groups or PLWHAs - People Living With HIV/AIDS (PLWHA) is an important support system for people with the infection. Their roles have been discussed in an earlier section.

Advocacy

HIV/AIDS has introduced new challenges to the defence of human rights. Clear laws need to be framed which protect the rights of persons with HIV/AIDS and to prevent discrimination against them. The different issues, which need to be addressed, have been detailed clearly in the earlier section.

National AIDS Control Programme

The National AIDS Control Programme was initiated in India in 1987. This programme was designed to implement a preventive plan including health education and condom promotion among identified risk behaviour groups, and screening of blood and blood products. In 1991 a comprehensive nationwide Strategic Plan for the prevention of AIDS in India was drawn up with focus on research, surveillance, IEC, control of STD, condom promotion and blood safety. The programme was for five years (1992-97) and was funded by a soft loan from the World Bank. By 1992, the National AIDS Control Organisation was started under the Ministry of Health and Family Welfare, and was responsible for implementing this programme.

The Phase II of the National AIDS Control Programme became effective from 9th November, 1999. It is a 100% Centrally sponsored scheme implemented in 32 States/UTs and 3 Municipal Corporations namely Ahmedabad, Chennai and Mumbai through AIDS Control Societies. The National AIDS Control Project, Phase II has the following objectives

- To shift the focus from raising awareness to changing behaviour through interventions, particularly for groups at high risk of contracting and spreading HIV;
- To support decentralisation of service delivery to the States and Municipalities and a new facilitating role for National AIDS Control Organisation. Program delivery would be flexible, evidence-based, participatory and to rely on local programme implementation plans;
- To protect human rights by encouraging voluntary counselling and testing and discouraging mandatory testing;
- To support structured and evidence-based annual reviews and ongoing operational research ; and
- To encourage management reforms, such as better managed State level AIDS Control Societies and improved drug and equipment procurement practices. These reforms are proposed with a view to bring about a sense of 'ownership' of the programme among the States, Municipal Corporations, NGOs and other implementing agencies.

Some Innovative projects on STD, HIV/AIDS

There are a large number of organisations working on the different aspects of AIDS. In fact, many organisations, both governmental and non-governmental, have incorporated HIV/AIDS awareness within other programmes, be it health programmes, programme with adolescents or college-goers. In other situations, deliberate programmes have been designed to address the needs of commercial sex workers, truck drivers, industrial workers, youth and so on. An attempt is being made to provide a flavour of the different kinds of approaches being adopted by these organisations. Brief profiles of the work of three such organisations are being provided below.

Durbar Mahila Samanway Committee , Calcutta

This is perhaps the most well known STD/HIV project (originally called the STD/HIV Intervention Project) in the country, and is also known as the Sonagachi Project. This project started as a prevalence study of STDs in a red light district in Calcutta in 1992, but has since then developed into a full-fledged intervention. It was initially being implemented by the All India Institute of Public Health but is being currently managed by an autonomous committee, which has sex workers as members. The three main focal issues of the project include – sexual health services through clinics, education through peer educators and a campaign for rights of sex workers through an organisation of sex workers.

For further details please get in touch with:

Durbar Mahila Samanwaya Committee,
12/5 Nilmoni Mitra Street,
Kolkata 700006
Ph: +91-33-25437560/25306619
Fax: +91-33-25437777
Email: sonagachi@sify.com, ship@cal.vsnl.net.in
Contact Persons: Ms Roma Debnath (President, DMSC) and Mr. Mrinal Kanti Dutta (Program Director, Durbar).

Naz Foundation, New Delhi

The Naz Foundation (India) Trust was established in 1994. The main focus of Naz Foundation revolves around the development of HIV/AIDS and sexual health services. Activities of the Foundation include-training programmes (for schools, colleges, NGOs, hospitals), Healthy-Highway project (involving the mobile population of truck drivers), peer education (college students have been trained in HIV basics, and imparted skills in information dissemination. They pass on information to their peers, family and friends) and consultancies related to HIV/AIDS.

For further details please get in touch with:

The Naz Foundation (Trust),
D-44, Gulmohur Park,
New Delhi-
Phones 011-686 2422,685 1970,685 1971
Email- nazindia@bol.net.in
Contact person – Anjali Gopalan

Indian Network of People Living with HIV/AIDS (INP+)

INP + is the largest network of positive people in India, with regional offices in different states. It works on the legal and ethical rights of positive people. INP + also provides assistance to NGOs on developing strategies on HIV/AIDS related issues. For further details kindly contact -

INP +
Flat No 6, Kash Towers, 93 South West Boag Road, T Nagar, Madras 600 017, Tamil Nadu, India
Phone: 91-44-2432 9580
Email: inppplus@vsnl.com
Contact person: Abraham Kurien

SECTION FOUR

Resource Section

Further Reading

HIV/AIDS is a subject of considerable topical interest and there are a large number of books and newsletters on the subject. Some of the books that we have found useful in the preparation of this booklet are given below:

- | | | |
|--|------|---|
| Abha Bhaiya and Ratna Kapur | 1994 | Report of the National Workshop on Women, STDs, HIV and AIDS, New Delhi, Jagori |
| Dept. of Youth Affairs and Sports | 1993 | National Workshop on Youth Action and AIDS, A workshop report, New Delhi |
| Elizabeth Reid | 1993 | Placing Women at the Centre of the Analysis, New York, UNDP |
| Elizabeth Reid | 1993 | Sharing the Challenge of the HIV epidemic, New York, UNDP |
| Elizabeth Reid, Michael Bailey | 1993 | Young Women: Silence, Susceptibility and the HIV epidemic, New York, UNDP |
| Ellen Weiss, Geeta Rao Gupta | 1998 | Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention, Washington, ICRW |
| John Hubley, Shankar Chowdhury, V Chandramouli | 1995 | The AIDS, Bombay, Popular Prakashan |
| Julie Hamblin | 1993 | People living with HIV: The law, ethics and discrimination, New York, UNDP |
| KIT, SAfAIDS and WHO | 1995 | Facing the challenges of HIV, AIDS STDs: a gender –based response, Amsterdam, Harare, Geneva |
| Maggie Black | | AIDS and Asia: A development crisis, New York, UNDP |
| Marge Berer, T.K.Sundari Ravindran | 1995 | Reproductive Health Matters - Promoting Safer Sex, London, Blackwell Scientific |
| Moni Nag | 1996 | Sexual Behaviour and AIDS in India; New Delhi, Vikas Publishing House Pvt Ltd. |
| Sandip Bandopadhyay | 1997 | The Sonagachi Experience: An Intervention Project among commercial sex workers, New Delhi, VHAI |
| Sanjay Kapur and Jaiwanti P Dhaulta | 1997 | Handbook for Nurses on HIV/AIDS, New Delhi, Voluntary Health Association of India |

UNAIDS/WHO	1998	India: Epidemiological Fact sheet on HIV/AIDS and sexually transmitted diseases
Werasit Sittirai and Glen Williams	1994	Candles of Hope, London, Action Aid
WHO	1997	AIDS The Challenge, New Delhi,
WHO	1998	Clinical management of HIV and AIDS at the district level, New Delhi
WHO		Understanding and Living with AIDS, New Delhi
WHO	1992	AIDS Prevention
WHO	1996	Handbook on AIDS Home Care, New Delhi
WHO	1994	Let's Talk about AIDS, New Delhi
WHO	1995	Information, Education and Communication, New Delhi
WHO	1997	AIDS: No time for Complacency, New Delhi

Resource Organisations

There are a large number of organisations today that provide different kinds of resource support for NGOs wishing to incorporate working on HIV/AIDS in their work. This support could be in the nature of providing a library, publishing books, videos, pamphlets and other material for distribution, providing financial support and so on.

The single largest resource organisation is the **National AIDS Control Organisation (NACO)** and the related State AIDS Control Organisation/Society. The address of NACO is given below:

NACO

9th floor, Chandralok Building, 36, Janpath, New Delhi, 110001, India

Phone: 91-11-2332 5331/2373 1774

Email: info@nacoonline.org

website – www.nacoonline.org

Some of the International/UN bodies involved in working on the issue and from whom a large amount of material may be accessed include

UNAIDS

c/o UNDP, 55, Lodi Estate

New Delhi 110003

Tel. (91 11) 2464 9895

Email: unaids.in@undp.org

Website: www.unaids.org.in

Contact person - Dr. Kenneth Wind-Andersen

UNDP (REACH Beyond Borders, HIV & Development Programme)
Address: 13, Jor Bagh, Lodhi Estate, New Delhi 110 003, India
Phone: 91-11-2463 2339/2602
Email: webadmin.in@undp.org

UNIFEM
Address: 223, Jor Bagh, New Delhi 110 003, India
Phone: 91-11-2464 8497/2469 8297
Email: suneeta.dhar@undp.org
Contact person: Suneeta Dhar

Organisations within the NGO sector which can be approached for resource support include the following:

Aasha Mahila Samstha
Address: Gaurabai Clinic (Dawakhana), 13th Lane, Kamathipura, Nagpada Junction, Mumbai, Maharashtra, India
Phone: 0-98206 00350
Email: seemashroff@vsnl.com

Bhoruka Public Welfare Trust (BPWT)
Address: 63 Rafi Ahmad Kidwai Road, Calcutta 700 016, West Bengal, India
Phone: 91-33-2217 4019/2244 8092
Email: bpwt@cal.vsnl.net.in

Community Health Centre (CHC)
Address: No 367, Srinivasa Nilaya, Jakkasandra 1 Main, 1 Block, Koramangala, Bangalore 560 034, Karnataka, India
Phone: 91-80-2546 1920
Email: sochara@vsnl.com

Indian Network of People Living with HIV/AIDS (INP+)
Address: Flat No 6, Kash Towers, 93 South West Boag Road, T Nagar, Madras 600 017, Tamil Nadu, India
Phone: 91-44-2432 9580
Email: inplus@vsnl.com

Lawyer's Collective HIV/AIDS Unit
Address: 7/10, Botawala Building, 2nd floor, Horniman Circle, Mumbai 400 023, Maharashtra,
Phone: 91-22-2267 6213/9
Email: aidlaw1@ndb.vsnl.net.in , aidslaw@vsnl.com
Contact person: Vivek Divan

Naz Foundation (India) Trust
Address: D-45, Gulmohar Park, New Delhi 110 049, India
Phone: 91-11-2656 7049/3929
Email: nazindia@bol.net.in

Perna
Address: Kamathipura Municipal School, 7th Lane, Shuklaji Street,

Kamathipura, Bombay, Maharashtra, India
Phone: 91-22-2570 0128/0684

Positive Life

Address: 2 E, 3rd floor, Church Compound, Sukhdev Vihar, New Delhi 110 025, India
Phone: 91-11-2691 5321/2692 2839
Email: plife@vsnl.com

Samraksha

Address: No 522, 2nd Floor, Block 5, Ranka Park Apartments 4, 5 and 6, Lalbaugh Road, Bangalore 560 022, Karnataka, India
Phone: 91-80-2212 2492/3
Email: samraksha@vsnl.net.in/si@samraksha.org

Useful Websites

Indian

<http://health.groups.yahoo.com/group/AIDS-INDIA> - An electronic forum to foster communication and collaboration among those of who are involved or interested in AIDS related issues in India.

<http://www.saathii.org> -SAATHI is a nongovernmental organization that carries out information dissemination, advocacy, networking, research, capacity building, care, support and treatment services

<http://www.apacvhs.org> - A collaboration between Chennai Voluntary Health Services, USAID, and the Indian Government, this organization works to reduce the sexual transmission of HIV, build capacity of NGOs involved in AIDS prevention activities, increase access to condoms and quality STD care services, and build political support for AIDS prevention and care programs.

<http://www.nacoonline.org> - This is the website of the National AIDS Control Organisation.

<http://www.thefreedomfoundation.org/aidshivmain.html> - Freedom Foundation was the first organization to provide rehabilitation services in India

<http://www.thoughtshopfoundation.org/HIVAIDS.html> - Thoughtshop Foundation is an organization that provides counselling services and develops multi-media HIV/AIDS prevention materials. Site details projects and campaigns.

<http://www.yrgcare.org/> - Y.R.Gaitonde Centre for AIDS Research and Education is an organization supports HIV/AIDS education, research, and training, while also providing non-coercive, non-stigmatized counseling and testing. Site links to related publications, projects, and help line.

<http://www.youandaids.org/Charca/index.asp> - The site provides details of the project which is a coordinated effort to increase capacities and reduce the vulnerability of young women in India to STIs and HIV infection.

<http://www.avert.org/aidsindia.htm> - Based in the UK, AVERT provides HIV/AIDS prevention and treatment services in countries with a high, or

rapidly growing rate of infection. Site discusses national epidemic, features HIV/AIDS statistics, youth information, and numerous other resources.

<http://lawyerscollective.org> - The website aimed at providing information resources relating to HIV/AIDS and the law.

International

<http://www.aidsmeds.com> - A health related website for providers and consumers containing a valuable information about the disease

<http://www.unaids.org>- UNAIDS is a joint programme of different UN agencies and is the main UN body advocating for a global action on HIV/AIDS

<http://www.aidsalliance.org> - International HIV/AIDS Alliance, is a development organisation specialised in supporting communities in developing countries to tackle the spread and impact of HIV/AIDS.

<http://www.youandaids.org> - HIV/AIDS portal for Asia Pacific. It contains country specific information, relevant databases, an online library and a host of other resources.

<http://www.popcouncil.org/horizons/horizons.html> - Horizons is a team of US-based and international organizations working to prevent the spread of HIV/AIDS and mitigate its impact on individuals and communities. Directed by the Population Council and funded by the USAID, the program designs, implements, and evaluates innovative service delivery strategies

<http://www.gbcaids.com> - The Global Business Coalition on HIV/AIDS (GBC) is leading the business fight against HIV/AIDS. With the support of global leaders in government, business and civil society, the GBC promotes greater partnerships in the global response to HIV/AIDS, identifying new, innovative opportunities for the business sector to join the growing global movement against this terrible disease.

[http:// www.aidworkers.net](http://www.aidworkers.net)- Aid Workers Network links relief and development field staff to share support, ideas and best practice. This web site aims to provide a comprehensive resource for busy field workers needing practical advice and proven resources to help with their current work.

[http:// www.aidsonline.com](http://www.aidsonline.com)- Online version of the official journal of the International AIDS Society.

[http:// www.aidsmap.com](http://www.aidsmap.com)- A comprehensive HIV/AIDS information site

[http:// www.womenchildrenhiv.org](http://www.womenchildrenhiv.org)- Women, Children, and HIV is a site which contains a library of practically applicable materials on HIV infection in women and children including resources on prevention of mother-to-child HIV transmission (PMTCT), infant feeding, clinical care of women and children living with HIV infection, and the support of orphans.

[http:// www.worldaidscampaign.org](http://www.worldaidscampaign.org)- The World AIDS Campaign is working with all sectors of society, supporting the collaboration of national efforts and acting as a catalyst for collective action. The Campaign also aims to ensure that governments and their leaders uphold the promises made in the United National General Assembly Special Session Declaration of Commitment on HIV/AIDS.

Networks of Positive People

Global Network of People Living with HIV/AIDS (GNP+) –
<http://www.gnpplus.net>

International Community of Women Living with HIV/AIDS –
<http://icw.org>

Indian Network of People Living with HIV/AIDS (INP+) –
<http://inppplus.net>

Positive Women Network (PWN+) – <http://pwnplus.net>

Asia Pacific PLWHA Resource Centre- www.plwha.org

Booklet prepared by -

Research and Text: Alok Srivastava, Jashodhara Dasgupta, Abhijit Das,
Paramita Guha

Reviewed by: C.Y.Gopinath, Amitrajit Saha and Venkatesh Chakrapani

Layout – Deepak

Illustrations - Ganesh

UNDERSTANDING REPRODUCTIVE HEALTH

A Resource Pack

This Resource Pack is an introduction for those who wish to learn about different facets of Reproductive Health. Reproductive Health as a concept is relatively new and , despite the name, is not exclusively a 'health' subject. In its ambit it involves social sciences, medical sciences, women's issues, human rights, population sciences, demography and so on. Thus it could be of relevance to individuals with a wide range of interests. Reproductive Health is an issue of interest to Government planners and managers because of the overwhelming concern for population. Reproductive Health is also a matter of great interest to the NGO sector, because of their concern for the health of women. Concern for women, their rights, well being and health is the underlying theme for the entire Resource Pack.

This Resource Pack has been designed as a series of booklets so that the interested reader may straight-away refer to the issue of her/his interest. The matter and presentation of the material in the different booklets has been kept simple as well as provocative as it is meant for the first-time user. Each booklet has been divided into four sections - the first dealing with theory and concepts, the second with issues of relevance, the third on best practices in the field. Keeping the interest of the practitioner in mind there is also a small resource section at the end of each booklet.

The booklets in this pack are as follows -

Booklet 1	An Introduction to Reproductive Health
Booklet 2	Understanding Numbers : Population and Demography
Booklet 3	Changing Paradigms : RH Policy and Advocacy
Booklet 4	Exploring New Frontiers : Reproductive and Sexual Rights
Booklet 5	Maternal health is still important
Booklet 6	The Promise of better health : Women's Health
Booklet 7	Beyond Family Planning : Contraception
Booklet 8	The Emerging Agenda : Adolescents
Booklet 9	Forging new partnerships : Men's Health and Responsibility
Booklet 10	Coming to terms with reality : HIV/AIDS and STDs
Booklet 11	Acknowledging ourselves : Sex and Sexuality
Booklet 12	Women have Minds Too! : Exploring the interface between Reproductive Health and Mental health
Booklet 13	Taking a stand : Violence, Women and Health
Booklet 14	Data Digest

**KRITI Resource Centre
for
Women's Health , Gender and Empowerment**

The KRITI Resource Centre, is involved in providing training support, production and distribution of material, and engaging in creative partnerships with other institutions to strengthen their work of empowering women at the grassroots level, enabling women to lead healthier lives. The primary activities of the KRITI Resource Centre for Women's Health, Gender and Empowerment are as follows

TRAINING - KRITI has considerable experience and expertise in trainings related to Women's Health and Gender and has provided training support to over 100 organisations as well as Government projects and departments in the states of UP, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Delhi, Rajasthan, Haryana and Himachal Pradesh. The Resource centre has been involved in partnerships with other gender training organizations like JAGORI, IWID, and the South Asian Network of Gender Trainers (SANGT).

PRODUCTION AND DISTRIBUTION OF LEARNING AND COMMUNICATION MATERIAL - KRITI is also involved in designing and producing appropriate material for the special needs of those involved in working with communities on these issues. Much of the material is in Hindi. Copiously illustrated material has also been produced keeping grassroots needs in mind. For the practitioners KRITI has produced newsletters, field manuals, training manuals and kits, briefing kits and information sheets on various relevant issues.

RESEARCH AND DOCUMENTATION - KRITI Resource Centre engages in field level documentation, to get a more holistic understanding of women's health and the socio-economic conditions that influence it. Some of the studies it has conducted and participated in include a study of traditional birthing practices, Abortion and women's health in rural areas of Uttarakhand, customs and practices around menstruation, the possibility of HIV/AIDS, implementing the Target Free Approach in Family welfare programmes in UP, quality of care of health care service in UP, violence against women and so on.

ADVOCACY - The resource centre is also actively involved with advocacy on the issues of Women's Health and Population Policies and Violence against Women. It is closely working with other networks and organisations working on these issues.

SERVICES PROVIDED BY KRITI RESOURCE CENTRE

- ❖ Library and documentation centre
- ❖ Books, posters and other materials
- ❖ Training and internship
- ❖ Support for developing gender sensitive community based interventions/training programmes