HIV and AIDS

LOOKING BEHIND AND BEYOND NUMBERS

Sahaj
Resource Group for Women and Health

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Glossary

ANM	Auxiliary Nurse and Midwife
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Anti Retro Viral
CAG	Comptroller and Auditor General
CBOs	Community Based Organizations
FSW	Female Sex Workers
FWP	Family Welfare Programme
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDA	International Donor Agencies
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
GOI	Government of India
MOHFW	Ministry of Health and Family Welfare
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NFHS	National Family Health Survey
NGOs	Non-Governmental Organisations
PLHA	Person Living with HIV and AIDS
RTIs	Reproductive Tract Infections
SACS	State AIDS Control Societies
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
TIs	Targeted Interventions
WB	World Bank

Introduction

This is the first of a series of briefs where various aspects of the HIV and AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) epidemic in India will be discussed. In this brief, the overall scenario with regard to the epidemic will be described and analysed followed by a more specific discussion of the way HIV and AIDS is unfolding among women and the gender-related dimensions of transmission. This will be further explored by a brief analysis of the National AIDS Control Program (NACP). The focus here will be to examine the effectiveness of the existing programme based on available data as well as identify gaps. In each of the sections information will be interspersed with analysis (refer discussion) to provoke critical thinking about aspects of the epidemic as well as illustrate linkages with other dimensions of health and socio-cultural factors (patriarchy and social arrangements) that mediate the spread of the epidemic.

A socio-cultural approach which is inclusive of a gender and rights perspective is imperative to effectively addressing HIV and AIDS . However, such an approach entails dealing with a complex set of issues that include among other things, diversity of religion, language, values and social laws that are part of people's lives in India and finding a way to effectively combine these with epidemiologically driven public health goals and programmes. There also needs to be explicit recognition and integration of the role of gender and sex, both key determinants of a person's vulnerability, that in turn have a significant bearing in the way heterosexual transmission of HIV and AIDS[1] takes place. This is key to understanding how women might be infected or affected by the epidemic. Along with gender, a culture specific construct; and sexuality, a socially determined way of being; the epidemic has manifested in a diverse fashion in different geographic settings within and across countries. However, in most countries, as a result of gender and power based inequities that circumscribe women's status and autonomy, women remain disproportionately affected. The Indian context is

1 Heterosexual transmission remains the most significant route through which the virus spreads. Infection also spreads through intraveneous or injecting drug use (IDU), blood transfusion and as a result of mother to child transmission. The focus in this brief will however be primarily on the gendered dimensions of heterosexual transmission

no different where there has been a growing trend of women being increasingly infected. In addition, the fact that in the early stages of the epidemic or in concentrated epidemics infection occurs mainly among populations that practice risky behavior e.g. sex workers, results in it being correlated with promiscuity, paid sex, etc. which has resulted in the 'stigmatisation' the persons who find themselves infected this way and seen as vectors of the disease, as well as a faulty perception that all those women who are married and monogamous are not at risk (WHO; 2003). Mother to child transmission too has largely been addressed within a framework where preventing infection to the child has received greater attention than the prevention, care and treatment needs of women.

These issues provide the guiding perspective for the analysis in this brief.

HIV and AIDS Epidemic in India

Prevalence

Overall, India remains a low prevalence country with infections remaining less than one percent (NACOb; 2005:2). However, according to the National AIDS Control Organization (NACO) the disease is assuming "epidemic" proportions (when infection range between one to four percent) in 111 districts in India. The epidemic is often described as a "number of distinct epidemics," occurring sometimes within the same state, with different vulnerabilities, stage of maturity and impact (CSIS;2004). While UNAIDS estimates place the total number of persons infected with HIV and AIDS currently (July, 2006) at 5.7 million, making India the country with the highest number of persons living with HIV/AIDS (PLHA), NACO estimates place it slightly lower at 5.2 million.

Discussion

- The predominant route of transmission is the heterosexual route. Effective prevention programmes that promote safe sex can significantly help in containing prevalence and prevent HIV and AIDS from becoming a more generalized epidemic in the country. However, this route of transmission is also the most difficult area to address. Issues of sex and sexuality are integral to unpacking and addressing heterosexual transmission across different population groups. However, all of these remain shrouded in secrecy, stigma and taboo at both the individual and societal level. In addition, gender-based inequities profoundly impact the way women (and men) negotiate sexual behavior and practice at the inter-personal level, and also the way sexuality is expressed. All of these present tremendous challenges with regard to effective implementation of programmes. It is also important to highlight that in the context of those seen to be vulnerable to infection as a result of risky sexual behavior it is imperative that their choices, right to privacy and dignity as individuals is not violated while designing and implementing prevention interventions with them.

- The epidemic is currently concentrated among those who occupy the most marginalised and stigmatised in our society – sex workers, men who have sex with men and injecting drug users. All are in conflict with law either as a result of their sexuality (MSM) or because of their profession (sex workers), etc. The gay, lesbian, bisexual and hijra communities, face a high level of discrimination and rejection from society at large and are unable to speak of or often exercise their sexual choice. Added to this there are laws like section 377 that criminalise all non-procreative sexual acts, and thereby add to the marginalisation and forces them to stay away from services which might require them to speak of their sexuality. Health care, especially with respect to sexual and reproductive health, becomes increasingly difficult for these communities to access (Voices 2004).

- Even though India remains a low-prevalence country many contend that the situation might be worse than what is projected by the current estimates. The southern states are currently designated as the high prevalence states partly as a result of better surveillance and reporting compared to the states in North India. In recent years, despite scanty data, it is becoming evident that the 'second wave'[2] of the epidemic is beginning to manifest in the poorer states where various factors that have a correlation with the spread of HIV and AIDS are present. Some of this includes high levels of migration to more prosperous states; poor health infrastructure, inadequate surveillance systems to report the disease; and low levels of awareness. In addition, major highways link some of these states to the metros and a large population from these states is part of the transport industry: a population seen to be at higher risk of infection (IHO;2004;4).

- Operationalising and strengthening surveillance has been one of the core components of the national programme since its beginning in the late eighties. Surveillance is critical to determining prevalence and is integral in the designing of effective evidence based programmes. However, the soundness of the methodology used, the scale of surveillance (number of sites), the estimates themselves have all been the subject of much controversy between the Government of India and external agencies like UNAIDS, Global Fund, etc. The fact that NACO itself has listed 111 districts as already reaching epidemic proportions

2 Countries in Africa are considered to be the first wave of the epidemic where a significant percentage of the population is infected. Experts believe that the second wave of the epidemic is will manifext in Asia specifically China and India (CSIS;2004:iv)

clearly demonstrates that there are large areas in this country where the response needs to be on an emergency basis and the overall low-prevalence tag should not be any reason for complacency.

- Allocation of funds for health programmes writ large, and HIV and AIDS in particular, need to be developed based on existing prevalence rates and projections of how the epidemic will unfold in the future. India already has one of the highest numbers of PLHA and it has been estimated that currently 500,000 (Over and Haywood; 2004) PLHA require treatment in the absence of which they will die. Allocation of adequate funds for health has been an area that governments have repeatedly chosen to ignore over the years. India has one of the highest per capita expenditure for private /paid healthcare. This includes those living in poverty and has resulted in further exacerbating indebtedness in these populations. HIV and AIDS prevention and treatment goals will have to be viewed within this existing reality. In the specific context of PLHA and their need for treatment the Government has been particularly slow in rolling out treatment (till recently i.e. April 2004, it was not part of the national programme).

- Typically most of the large disease prevention programmes in India have been based on applying a standardized approach across the country. However, given the diverse nature of the epidemic and the variations in prevalence across states (and sometimes even between districts) and within populations, such an approach will prove to be ineffective.

Trends

In India, the predominant mode of transmission is the heterosexual route (over 85 percent, UNIFEM 2003). In recent years the disease has been spreading at a faster pace in rural areas than in urban centres. Rural areas now account for 50 percent of the cases as against 30 percent some years ago (The Hindu; July 15, 2004). There is simultaneously also a growing trend of infection among monogamous, married women. More than 38 percent of those living with HIV in India are women, most having acquired the virus from regular partners who were infected during paid sex (NACO 2006, UNAIDS and WHO; 2006) Currently, one in every four AIDS cases reported is a woman (NACO3a;2004:14; CSE; 2004:iv).

Discussion

- Much has been written about the poor state of health care delivery in rural areas. Health systems remain distant in most states and there is severe shortage of skilled human resource to respond to various health needs. Those at the frontline of health delivery (ANMs) remain overburdened and poorly compensated for the tasks already at hand. Within this scenario, it is impossible to imagine how a viable rural strategy for HIV and AIDS prevention is feasible if the current situation remains unchanged. At the same time, the government has been implementing health sector reforms where privatization rather than strengthening of the public health system seems to be the core focus. The inadequacies of the health system to be able to respond to the needs generated by the epidemic have already been starkly revealed in the context of the ARV roll out at the district level. Lack of trained providers, equipments, drugs, access and information have served to create conditions where very few are able to obtain treatment, and even when they can, adherence remains a serious concern as a result of one or more of these factors.

- The epidemic is deeply influenced by migration and mobility of core population groups that are currently seen to be most at the risk of infection. This adds to the complexity of how it can be best addressed. However, it remains imperative that linkages (rural-urban and inter-state) between various programmes be creatively devised and implemented so that mobile populations and their families are reached across locations. Community-based programmes are being implemented by NGOs that demonstrate effective ways of addressing these needs but have not been scaled up. This is mostly because they are seen to be cost and labour intensive and therefore not seen to be a viable option for integration as part of large-scale public health programmes. Migrant labour (mostly male) continue to addressed in isolation (typically reached through targeted interventions at their work sites), while families of these persons, particularly wives, are not reached and continue to be unaware of the risks that they face. This lacunae, in part, has contributed to the growing trend of infections among married women particularly in rural areas.

- 38 percent of those living with HIV in the country are women – (NACO 2006, UNAIDS and WHO; 2006). As a result of which women with single partners, most of them married women, are emerging as a population with growing infection rates. Owing to this trend the notion of who is

vulnerable is beginning to undergo some change. From being a "sex workers and truckers disease", HIV is now being assessed through a broader lens that takes stock of those who have traditionally not been seen as being "high risk". This in turn has shifted the spotlight on the need to address the limited access to health services, unequal status and various other social discriminations and their vulnerabilities that women experience.

Affected Populations

HIV remains concentrated mostly among the marginalized sections of society, most of whom also face severe economic disadvantage. Female sex workers , injecting drug users (IDUs), men who have sex with men (MSM) and migrant labourers remain the most at risk of infection and therefore the focus of prevention efforts. In Mumbai and Pune for example, 54 percent and 49 percent of sex workers, respectively, have been found to be HIV-infected (NACO;2005c). In the Mumbai and Chennai where data has been collected, HIV prevalence of 6.8 percent and 9.6 percent were found among men who have sex with men (NACO; 2006). 16 percent prevalence was also found in the Andhra Pradesh sentinel surveillance conducted among men who have sex with men in 2004 (APSACS; 2004). 38 percent women – married or women with single partners and sex workers – have HIV and AIDS.

Discussion

- While addressing HIV and AIDS among women it is necessary to view it as part of a continuum of risks that women continue to face. HIV infection adds to a long list of debilitating often life-threatening conditions or episodes that is often part of women's everyday reality in this country. These include unsafe childbirth, crude abortions, poor quality sterilizations and related complications, recurring RTIs and STIs, among others. Therefore, the vulnerabilities and risks that women encounter as a result of sexual intercourse within marriage or as part of paid or transactional sex need to be seen not as distinct risks but as part of this continuum.

- In the context of married women, there is a need to view marriage not as a value neutral but a gendered space that acts both as a system of support but also an arrangement that has direct bearing on women's vulnerabilities and risks. Age of marriage is an important marker of the level and kind of vulnerabilities and risks women will encounter while

married. Despite of legislation making marriage of girls before 18 years a punishable offence, a large percentage of girls are married prior to attaining that age. According to the National Family Health Survey(NFHS), 1998-99, of the women surveyed, the median age at marriage among women aged 20-49 was 16.7 years (ORC Macro and IIPS:1998:1). Low age of marriage is a major causal factor associated with women's increased vulnerability and lack of autonomy with regard to making informed and safe sexual and reproductive choices. Within this context it is possible to see how heterosexual transmission of HIV and AIDS has become more widely prevalent among married women.

- Lack of autonomy in making informed decisions about one's own health as well as accessing services is a major barrier that continues to impinge on women's well-being. This has shown little change over the years. In a recent survey (NFHS-2) more than half of the women surveyed (married women aged 15-49 years) reported not having the right to make decisions about their own health care. In the context of HIV and AIDS for example, this can mean not been able to seek treatment for STIs which is seen as a major factor in the spread of HIV.

- Violence is another key factor that further exacerbates women's vulnerability. As an example, women in marriage face shockingly high levels of spousal violence. As part of the recently conducted National Family Health Survey, 2005-06, ever-married women aged 15-49 were asked if they had experienced spousal violence. In Uttar Pradesh 42.4 percent; in Tamil Nadu 43.9 percent and in Manipur 41.9 percent, reported having encountered some type of spousal violence (IIPS:2006). For decades , women's health activists have argued that public health and reproductive health programmes remain ineffective unless redressal of gender-based violence is made an integral part of these interventions. Screening for violence, particularly sexual violence, is imperative to address heterosexual transmission of HIV and AIDS.

- It is also important to note that among the high-risk populations that have already been explicitly linked to the epidemic and are part of ongoing prevention efforts, women in sex work remain disproportionately affected. They bear the double burden of being women coupled with the severe stigma and discrimination that is associated with sex work. At the same time present laws continue to criminalize and stigmatize sex workers. Treatment and care has received negligible attention despite data, showing high rates of infection among sex workers. This demonstrates clearly that sex workers continue to be seen solely as

victims of the disease and have little entitlement or even recognised as PLHA. Most PLHA groups have little or no representation from the sex worker community.

- Little or no attention has been paid to young unmarried women who might be sexually active. Even where young women (and men) are being addressed, this has mainly been through messaging on abstinence and delaying sexual debut. The only sections of women "outside marriage" that current programmes address are sex workers. The focus of these interventions is prevention of transmission of infection to clients by promoting 100 percent condom use and there is little else undertaken to address issues that add to their vulnerability to infections and transmission.

- With regard to the MSM population despite being identified as being at risk, there has been little research on the role of sex between men in India's HIV epidemic. It has also been noted that a large percentage of MSM activity takes place within the context of transactional or paid sex something that is often not explicitly addressed in policy and programme planning.

- Similarly there are other indicators of the presence of multiple risks. There is also evidence that many female sex workers who inject drugs, are also the least likely to use condoms while selling sex" (MAP:2005a:10). All of the above serve to illustrate that those who engage in high-risk behavior might engage in more than one of them. Therefore, interventions need to be designed in a manner that they can address the multi-dimensional nature of risks.

The National AIDS Control Programme

The National AIDS Control Programme (NACP) is a 100 percent centrally sponsored programme. The first phase of the NACP (1992-99) was funded primarily by World Bank IDA(International Donor Agencies) credit amounting to US $84 million (see Table II for funding details). During the first phase, various institutional mechanisms to assist policy planning and programme implementation were set up – National AIDS Committee, National AIDS Control Board, National AIDS Control Organization (NACO) and the state AIDS cells [subsequently registered as State AIDS Control Societies (SACS)]. In addition, emphasis was placed on strengthening the HIV surveillance system.

National AIDS Control Program – Timeline

1989 – With support from the World Health Oranisation (WHO) a Medium Term Plan for AIDS Control developed with a US$10 million budget to be provided by external sources.

1992 – Government of India secured IDA credit of US$84 million from the World Bank to support the first phase of the National AIDS Control Programme (NACP-I) for a five year period (Sept. 1992-Sept. 1997). Subsequently extended to March, 1999.

1992 – Government of India established the National AIDS Control Board (NACB) and the National AIDS Control Organisation (NACO). The latter was to function as an executive body in the Ministry of Health and Family Welfare (MOHFW). Simultaneously, State AIDS Cells were also constituted in all States and Union Territories. These were later registered under the Societies Act and are currently known as State AIDS Control Societies (SACS).

1999 – NACP, second phase launched with a total budget of Rs 1425 crores. Of this Rs 1155 came from IDA credit from the WB including a contribution from the GOI. In addition, USAID provided Rupees 166 crores assistance for the AVERT project in Maharashtra and DFID provided Rupees 104 crores assistance for the Sexual Health Project for Andhra Pradesh, Gujarat, Kerala and Orissa.

2006-07 – Planning process for the third phase of NACP (NACP-III). Likely to be approved and launched early 2007.

Reference: Lok Sabha: 28857

The second phase of the NACP was initiated in 1999 once again with IDA World Bank funding. The two key objectives of NACP – II have been to

reduce the rate of growth of HIV/AIDS in India and to strengthen the country's response to the epidemic. The three broad components of the program are surveillance, prevention and care. It was during this phase that the bulk of the Targeted Interventions (TIs) among the high-risk population groups was launched with a focus on the six high prevalence states[2].

NACP-II – The 5 Key Components

Component 1 – Targeted Interventions for communities at higher risk
Component 2 – Prevention of HIV transmission among the general population
Component 3 – Provision of low cost AIDS care
Component 4 – Strengthening Institutional Capacities
Component 5 – Intersectoral Collaboration

During the first two phases of the national program the bulk of funds were allocated for prevention. During NACP-I, 69 percent of the total resources was allocated for prevention, 22 percent for surveillance and 9 percent for care. During NACP-II this changed to include a higher allocation for care - 52 percent for prevention, 29 percent for care and 28 percent for surveillance (Sadhana Rout , Inaugural Address at a seminar organised by Oxfam GB Monitoring Access: Can Care Propel HIV Prevention?).

Table II

Funding Agency	Resources (in Rupees, crores)	
	Phase I	Phase II
Government of India	57.34	196.00
World Bank	222.66	959.10
USAID (AVERT)	-	166.00
DFI (SHP)	-	104.00
Total	**280.00**	**1425.10**

Note: Rupees 280 crores includes USAID assistance of Rupees 28 crore for APAC in Tamil Nadu.

Reference: Lok Sabha; 2005:9

NACP III is again funded through IDA World Bank credit. The objectives for this phase of project implementation include halting and reversing the HIV/AIDS epidemic by 2011 through the integration of prevention and care,

2 Andhra Pradesh, Karnataka, Tamil Nadu, Maharashtra, Manipur and Nagaland.

support and treatment programs. The core programme strategies include preventing new infections in high-risk groups and vulnerable populations; increasing the proportion of persons receiving care, support and treatment among those living with HIV/AIDS; strengthening the infrastructure, systems and human resources for prevention and treatment programs at district, state and national levels; and establishing a nationwide strategic planning, program management, monitoring and evaluation (M&E) system.

Targeted Interventions (TIs) are a specific set of interventions in AIDS Control Programme. TIs specifically refer to interventions that work with high risk behavior groups. This includes core groups seen to be most vulnerable and at the risk of infection like sex workers, injecting drug users and men who have sex with men. In addition TIs also address the bridge population which includes truckers, migrant labour and street children. Central purpose is to provide services that target populations need to practice safe behaviour that reduce transmission of HIV. Two core components of effective TIs are the creation of an enabling environment and community mobilisation

Reference: NACOc; 2004:8

Discussion

- As part of NACP-II, till March, 2004, a total of 933 TIs were undertaken by NGOs funded by the SACS. Although the objective of the programme has been to attain saturation in terms of coverage of the high-risk groups till date only 50 percent of that population is being reached. Despite over 50 percent of funds being allocated for prevention and mostly for targeted interventions the inability of the programme to reach large numbers of the populations calls for a reassessment of the NACP III goal of halting and reversing the epidemic.

- Operationalisation of the Government's comprehensive approach will however, pose tremendous challenges. First and foremost the AIDS programme is a vertical program with little horizontal integration/linkage with other programmes – like TB control, Family Welfare Programme (FWP) etc. This has been unfortunate as the existing infrastructure; networking, referral system and expertise of the more established disease control programs would have greatly benefited in operationalising and scaling up AIDS prevention, care and treatment. While admittedly specialised systems and institutions are needed to address the distinct issues related to any disease and its prevention it is anticipated that this would serve as a bridge to meet specific gaps and

not necessarily the main strategy. However, this lack of integration and linkages is not just a charecteristic of NACP, most of the large disease control programmes are vertically designed and implemented . Primary health care, as the first point of contact for individuals to seek and receive services, needs to viewed as the principle site where women (and men) receive information and obtain services or referrals with regard to family planning, reproductive health and HIV and AIDS. The vertical programmes that are currently in place often use the primary health care workers for most of their outreach work, but separately. This results in burdening the workers to respond to these competing demands and reporting requirements but also leads to mixed messages being delivered to the same population.

- It is also important to note that while TIs are a good fire-fighting tool during the early stages of the epidemic and if implemented effectively, which has not been the case (refer CAG report) can infact reduce transmission to the rest of the population. However since the epidemic has already moved into this area, a more generalised and effective prevention strategy needs to be developed in addition to TIs.

- Care and treatment and issues surrounding them have also not recieved the attention it merits. The government launched a treatment programme in 2004 to provide free Anti Retroviral Therapies (ARTs) to 100,000 infected persons the six high-prevalence states. As a result of that care and treatment issues have gained some visibility. Positive Peoples networks across the country have also been instrumental in bringing these issues to light. Though policy and programmatic guidelines for delivery of ARTs has been finalised, NACO has been lagging behind with regard to the non-medical components e.g. strategy for social mobilization for demand generation of ARTs. In addition, roll out has been extremely slow, the government now says it will reach its 100,000 treatment target only by 2007. Even in centers, typically district level hospitals, where treatment is available many are reporting drug stock out.

- According to medical experts persons going through treatment, after a few years develop resistance/toxicity to their first set of medications need to be switched to a newer 'second line' drug regimen. . The WHO in August, 2006 updated its anti-retroviral guidelines for HIV and AIDS treatment in developing countries and recommends newer drugs for first and second line regimens. India has been slow in integrating these guidelines as part of its treatment programmes. It still does not include

a second line regimen as part of its treatment portfolio. As the epidemic in the country matures and more people seek treatment it remains incumbent on the government to respond to the critical life-saving needs of positive people.

- It is also important to note that although Indian companies have been pioneers in manufacturing generic versions of life-saving AIDS drugs most of the AIDS medication remains unaffordable for its own people. There is great urgency to make drugs available at affordable costs, as a large number of people are symptomatic and in urgent need of ART.

- A more comprehensive approach has been proposed for NACP-III that will seek to integrate a range of interventions that address the prevention-care-treatment continuum. Till now, policy and programmes have an artificial compartmentalisation between care and prevention. Integration of the various components is vital and particularly so if the objective is to promote voluntary testing among those at risk as well as the rest of the population. Treatment often acts as a catalyst for more people to come forward for testing. When large numbers of people from both within the at risk population as well as those who do not necessarily fall into the vulnerable category come forward for testing this serves to normalise the disease and helps to alleviate the stigma and discrimination that is typically associated with the virus.

Programme Appraisal

The Comptroller and Auditor General (CAG) of India undertook a performance appraisal of the NACP-II and submitted its report to the Indian parliament in July 2005. The CAG noted with particular concern the poor utilisation of the funds – less than 30 percent – that have been allocated for this phase of the programme. NACP-II was slated for completion October, 2005. Since that time the project has been extended and will now be completed early 2007. In addition, CAG also noted misuse of funds in the implementation of TIs. Funds for example were allocated to organizations who have little or no track record of undertaking this type of work. Some concerns that emerge out of the review of NACP and CAG's performance appraisal are looked at here.

- It is worth noting that some of the states with the highest taxpayer balance are the high prevalence states. In addition several states that are at the cusp of the 'second wave' of the epidemic – Uttar Pradesh, Gujarat, Goa – also showed a high rate of non-utilisation of available

funds (Lok Sabha; 2005:15) Poor utilization of funds is indicative of the fact that many of the components of the programme for which the funds were allocated were not undertaken or not scaled up as anticipated. Misuse of funds like non-utilisation of funds has a direct and profound impact on the quality of interventions that are being undertaken.

- One of the core components of the TIs is condom promotion and this in particular showed poor results. There has been little change in consistent use of condoms (CAG;2004). Even among high-risk groups such as commercial sex-workers, condom use was less than 25 percent according to surveys conducted by the independent Opinion Research Group and cited in the CAG appraisal and condom distribution was found to be inadequate in STI clinics

- Inspite of close to two decades of TIs with female sex workers particularly in red-light districts HIV/AIDS infection rates remain high ranging between 50-70 percent. One of the key focus areas for intervention has been promoting 100 percent condom use. While condom use with clients has shown some improvement the programme have not been effective in creating the same sense of risk among sex workers with their regular partners or change the conditions that make them unable or reluctant to negotiate condom use with partners (Amin; 2004:10).

- Findings of the NFHS-2 showed that condom use among the general population remains extremely low. Among ever-married women aged 15-49 condom use is as low as 2.3 in Manipur and 4.2 in Tamil Nadu. Both these states are high-prevalence states.

Excerpted from Lok Sabha, 2005, Nineteenth Report – Public Accounts Committee, National AIDS Control Programme

The Committee are constrained to observe that the programme has achieved limited success as it has failed in generating sufficient awareness among the masses. Besides, there was very slow progress in implementation of its various components. Target groups in many States have remained unidentified due to non-completion of mapping exercises; the scheme of social marketing of condoms was found lacking as NACO could not procure and distribute the targeted number of condoms. The Committee are disturbed to find that the programme could not achieve the targets relating to setting up of Sexually

Transmitted Disease clinics, modernised blood banks and voluntary counseling and testing centres in every district of the country... 22 out of 37 Societies [SACS] during FHAC February 2002 failed to attract even 20 percent of the targeted population. Community Care Centres and Drop-in-Centres have been established in very few States and the effectiveness of their functioning remained unassessed. Grants-in-aid were released to inter-sectoral collaborators without proper assessment of requirement for implementing the various activities of the programme resulting in poor utilization of the grants allocated to them. Besides, NACO has no mechanism to monitor procurement of equipments and testing kits.

- The CAG report noted that most of the STI clinics spread across the country had very few attendees and most did not have trained personnel (77 percent) and even fewer had the services of a gynaecologist (17 percent) (CAG;2005). STD prevention is one of the core components of TIs along with condom promotion. There is substantial evidence of the link between STIs and the spread of the HIV virus. First and foremost the absence of the services of a gynaecologist in STI clinics is of particular concern given that infection is spreading at a faster rate among women. In addition, female sex workers are also disproportionately affected. STI clinics are not only functioning inadequately with regard to delivery of services but appear to mostly fail in their outreach activities to encourage women to seek STI treatment and also in creating awareness about the link between STI prevalence and HIV infections. The level of knowledge about the linkage remains low at 21 percent – this includes both the general population as well as the high–risk groups. To quote the CAG report this "pointed towards the failure to educate the general public as well as those in the various risk groups about the linkage."

- The other critical component of any effective TI and creating awareness about various aspects of HIV and AIDS transmission is communication. Intensive communication efforts can not only raise awareness levels but also bring about behavior change. The CAG cited surveys that showed communication on various aspects of the infection and modes of transmission remained inadequate. A review of the information, education and communication (IEC) material that is currently in circulation shows that a lot of messaging is fear-based, confusing, gender insensitive and at times gives conflicting messages. All of this together can also serve as a barrier for people to accept information on HIV and AIDS. In addition, because of the two decade long focus on

marginalised populations who are seen to be most at risk the general perception amongst those who do not fall into this category is that they are unlikely to get infected.

- Till now prevention within the general population has been mostly addressed through awareness generation for which the main strategy has been mass media campaigns. This has shown limited results in actually resulting in behavior change or changing risk perception among the general public.

- NFHS-3, 2005-06, collected information on knowledge about the epidemic in general and specific awareness that consistent condom use can prevent infections. Among ever-married women aged 15-49, only 40 percent in Uttar Pradesh and 49 percent in Gujarat had heard about AIDS. Levels of awareness were much higher in the high-prevalence states with Tamil Nadu recording 94 percent and Manipur 99 percent. However, when the same set of women were asked if they knew that consistent use of condom can reduce the chances of getting HIV/AIDS the results were dramatically different. In Tamil Nadu where 94 percent women reported they had heard about AIDS only 42 percent knew that condoms can prevent infections. In Uttar Pradesh this was 27percent, Manipur 80 percent and in Gujarat 36 percent. Actual condom use is well below 10 percent in most states.

Conclusion

It is evident that women are increasingly becoming the face of the HIV and AIDS epidemic in India. Since the eighties when the first HIV case was identified in Chennai, interventions by the National AIDS Control Organisation have been designed to contain the disease within the "high risk populations" and prevent its spread to the population at large. In this process sex workers have become the public face of the epidemic and are viewed as vectors , furthering their stigmatization.

In recent years, the epidemic has changed course and is now increasingly manifesting among the rural population as well as in larger numbers among married women. This growing trend has challenged the earlier understanding of risk and vulnerability. Today as a result of married women being increasingly infected, issues and concerns related to gender and rights are being articulated and propagated as core principles that need to be integrated into HIV programming. While on the one hand, sex workers as a result of their profession are seen as vectors, married women on the other are

seen as victims who unknowingly got infected by their husbands. The labeling in both contexts is problematic and simplifies and generalises what is in reality a complex problem.

Effectively addressing HIV and AIDS particularly among diverse groups of women requires an approach that extends beyond public health to encompass other socio-cultural and economic factors that mediate the spread and scale of the epidemic. Most significantly a large percentage of women are being infected through heterosexual transmission and the only adequate measures that can protect women is to create an enabling environment where they can make safe and healthy choices with regard to sexual behavior and practice. This in turn also means discussions need to be initiated on issues related to sex and sexuality among both men and women. Women's lack of autonomy in general and particularly in the context of sexual conduct whether in marriage or out of it is well recorded. Changing this within the context of HIV and AIDS prevention requires interventions that integrally address issues of gender and rights.

Specifically some core areas require special attention. First and foremost, stigma and discrimination of those infected and affected by the disease needs to be addressed. This presents profound challenges particularly for sex workers who are already stigmatised and discriminated against as a result of their profession. In the case of married women their existing low status in their marital homes and lack of autonomy creates difficult conditions within which to reach them with information and services. Lack of outreach in turn perpetuates the myths surrounding the disease and in turn results in severe stigma and discrimination for those who get infected.

HIV and AIDS in India is a diverse epidemic and a standardised approach cannot address the varied nature in which it is manifesting across the country and among different populations particularly women. From a conceptual standpoint risk and who might be considered to be vulnerable to disease needs to evolve and change and the programme should have the flexibility to adapt to the shifting dimensions of risk behaviour. Further, sound surveillance systems are imperative to gathering accurate data on the way the epidemic and provide the foundation on which programming can take place.

It is absolutely imperative that there is appropriate utilisation of funds. This has unfortunately not being the case during the earlier phases of the programme. The third phase has been launched recently with a significantly

higher budget and it is incumbent on both government and non-governmental organization to ensure that the funds are well-used and that programmes are designed and subsequently implemented that can effectively address the spread of the epidemic. In particular, the existing institutional mechanisms that currently undertake planning, funding and implementation of the policy and programme need to be guided by clear norms for monitoring and that ensure their accountability

Beyond the programme one also needs to develop an understanding of the impact that various other governmental policies programmes and law have . For example the ITPA criminalizes various components related to sex work though sex work per se is not illegal under the law. Similarly, in the case of married women the national family planning programme has for decades targeted them with services that almost exclusively focus on family planning for population control. Further, the means used to attain this goal has been primarily through sterilisation as a result of which condom use remains extremely low. As part HIV and AIDS prevention promoting condom use remains and important component and this often clashes with the competing goal for population control through sterilisation. Integration of these various vertical programmes with competing goals need to be strategically devised.

A gendered and rights based perspective and programme planning that has its ear to the ground is emerging as the need of the hour, and interventions governmental or non governmental need to take these considerations into account while devising programmes and policies on HIV in India.

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Sama- Resource Group for Women and Health, is a Delhi based women's group working from a feminist perspective that links women's well-being with issues not only of health, but also those integrated with livelihood, violence (sexual, familial, communal and national), and all other issues that affect people's lives, especially those of women. Sama works closely with NGOs, CBOs and other organisations, communities and the media, empowering through various aspects like Community Based Training, Action Research, Advocacy and Material Development. Sama is an active member of Jan Swasthya Abhiyan (Indian Chapter of People's Health Movement) and is part of the Asian Women's Ministers' Network.

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