RF DIS-2Q.

>> THOUGHT

A gem is not polished without rubbing, nor is a man perfected without trials.

- Chinese proverb

HIV-positive patients move court against uncaring healthcare system

The Lawyers' Collective, an Indian legal cell working on AIDS/HIV, has filed a petition on behalf of the Delhi Network of Positive People (DNP) -- an organisation comprising people with AIDS -- to end the discrimination HIV/AIDS patients face at the hands of the medical community. The court has asked the DNP to provide it with details of the discrimination by July 23.

Legal and other experts advocating the rights of HIV-positive people stress that hospitals and healthcare centres in India routinely turn away people seeking medical treatment if they are suspected of having AIDS.

"Discrimination in healthcare is a huge problem in India," says Anjali Gopalan, the director of Naz I based organisation working on HIV and related issues. "Most HIV patients are treated in an abs she says.

The issue of denying care to HIV-positive people was taken up by the court recently when newspa an AIDS-afflicted patient who was forced to move from one Delhi hospital to another because doct

A government employee, the man was being treated for a urinary blockage at a well-known Del However, the hospital turned him away after blood tests showed he was HIV-positive.

The DNP, with the help of The Lawyers' Collective, filed a petition which states there are numerou patients being turned away by medical personnel. The organisation is preparing an exhaustive li positive people face to be presented in court.

"They are denied treatment for anything from routine tests to surgeries," says an AIDS worker with "They are turned (away) even if they need to get their teeth or eyes checked," she says.

AIDS workers point out that patients are discriminated against both directly and indirectly. Direc hospitals refusing to admit such patients; indirect bias is when a person is given a bed in a hospit that.

"A surgery, for instance, may keep getting postponed on some pretext or the other, forcing the treatment elsewhere," says the legal AIDS worker. "But they keep going round and round -- for ev same."

The government's National AIDS Control Organisation estimates that 3.97 million people are HIV-p

Experts say that one of the reasons for discrimination at healthcare centres is that Indian me equipped with the basic precautionary gear needed to protect themselves against the infect healthcare workers don't have disposable gloves or the thicker disposable bags that are needed fo AIDS worker.

The petitioners hope that once the court intervenes, guidelines will be framed and implemente personnel treating HIV-positive people.

Groups such as Naz stress that the court can do a lot to help remove the discrimination. "An HIV- medical help is usually suffering from something like tuberculosis. All that we are asking for is tha tuberculosis like any other patient," says Gopalan.

Source: southasia.oneworld.net

HIV/AIDS in India fol

May 28, 2003

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BMJ 2000;321:402 (12 August)

News

Indian agency admits publishing "wrong" HIV figures

Ganapati Mudur, New Delhi

India's top government agency responsible for tracking HIV infection has admitted it has published inaccurate figures of new HIV cases detected in the country over the past three years. The disclosure follows allegations by a non-government association that the agency, the National AIDS Control Organisation, has played down numbers in several states and that its reports "do not reflect reality."

Surveillance centres across the country have detected just over 98000 HIV cases on the basis of tests, but India is believed to have the largest number of HIV infected people worldwide. The National AIDS Control Organisation has estimated that 3.5 million people are infected, based on a sentinel screening programme aimed at determining the HIV prevalence rates among high risk communities and the general population. The organisation's surveillance figures suggest, however, that three Indian states—Kerala, Punjab, and West Bengal—have detected no new cases of HIV over the past two to four years.

In Kerala, for example, the number of HIV infected people has been reported as static at 215 since 1996, and in Punjab the number has remained unchanged at 65 for more than two years. The National AIDS Control Organisation has been "consistently churning out unreliable figures, while claiming that it reflects the HIV scenario in India," said Purshottaman Mulloli, an official of the Joint Action Council, the non-governmental association that has been monitoring the government's HIV programme. Doctors familiar with HIV infection in these states have called the figures "ludicrous."

Senior officials at the National AIDS Control Organisation are blaming the surveillance centres in the states for inaccurate reporting. "We've decided to stop publishing figures that we get from surveillance centres," said J V Prasada Rao, the organisation's director. "Beginning this year, [our organisation] will publish only prevalence figures from the sentinel screening programme," he said.

The Joint Action Council has also questioned the widely varying estimates of people infected with

HIV-AIDS in India file
In
1996

HIV in India suggested by UN agencies. The estimates range from 4 million to 8 million. The differing estimates also prompted the Indian government last week to ask United Nations agencies to accept its own estimate of 3.5 million as authentic and to stop issuing their own figures.

"Conflicting information can affect the credibility of the national effort towards prevention and control of HIV," Dr Chandreshwar Prasad Thakur, the Indian health minister, said. "[The National AIDS Control Organisation] is the only organisation collecting field data through sentinel surveys, and it would be advisable for UN agencies to adopt epidemiological data generated from these sentinel surveys," Dr Thakur said.

The National AIDS Control Organisation has objected to a suggestion by UNAIDS (the joint UN programme on HIV/AIDS) at the recent Durban AIDS conference that up to 300000 people may have died as a result of AIDS in India. The recorded figure in India is less than 12000. "There is no evidence yet for a spurt in tuberculosis or any other opportunistic infection from anywhere in India," said Mr Prasada Rao. Epidemiologists have long suspected that thousands of infected people may be dying of HIV related illnesses but are being missed by India's poor death recording system.

Rapid responses:

Read all Rapid responses

HIV Seroprevalence in India: Is it on the Rise?
Raviraj V Acharya, et al.
bmj.com, 11 Aug 2000 [Full text]

Re: Indian agency admits publishing "wrong" HIV figures
Anju Singh
bmj.com, 14 Aug 2000 [Full text]

HIV figures for India
J V R PrasadaRao
bmj.com, 15 Aug 2000 [Full text]

Not only Commissions But also omissions
Karri Rama Reddy
bmj.com, 17 Aug 2000 [Full text]

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INDIA AT A GLANCE

South and North East Asia at a Glance: Select Country

Documents related to India in Library

General Information
Indicators
Socio-Economic Background
HIV Situation
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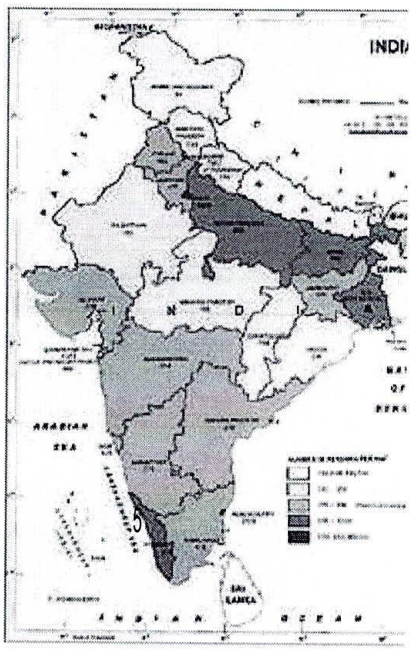
Support by Others

Capital: New Delhi

Currency: Indian Rupee

Independence: 15 August 1947 (from UK)



Source: Census of India - 2001, Govt
* *Disclaimer*

Click Here for a Larger Map

General Information

Location: South Asia, bordering the Arabian Sea and the Bay of Bengal, slightly more than one-third the siz Neighbouring countries are Bangladesh, Bhutan, Myanmar, China, Nepal and Pakistan

Government: Federal Republic

Languages: English is an important language for national, political, and commercial communication. Hin language and the mother tongue of 30% of the people. Twenty-four languages are spoken by at least on people. There are many regional languages like Bengali (official), Telugu (official), Marathi (official), Tan (official), Gujarati (official), Malayalam (official), Kannada (official), Oriya (official), Punjabi (official), Ass Kashmiri (official), Sindhi (official) and Sanskrit (official). There are many more languages and dialects

Administrative Divisions: 28 states and 7 union territories (UT). Andaman and Nicobar Islands (UT), Arunachal Pradesh, Assam, Bihar, Chandigarh (UT), Chhatisgarh, Dadra and Nagar Haveli (UT), Daman ar (UT), Goa, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Kerala, La Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Orissa, Pondicherry (UT), Pu Sikkim, Tamil Nadu, Tripura, Uttar Pradesh, Uttaranchal, West Bengal

Lib - HIV/AIDS in India file
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- Infections
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- Trafficking
- Voluntary Counselling and Testing

SERVICES

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- Care/Support (Hospital Based)
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- State AIDS Control Societies (India)
- STD Clinic
- Testing Centres

LIBRARY

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EXECUTIVE

Head of State President Kicheril Raman Narayanan (since 25 July 1997); Vice President Krisl 21 August 1997)

Head of Government Prime Minister Atal Behari Vajpayee (since 19 March 1998)

Cabinet Council of Ministers appointed by the president on the recommendation of the pri

LEGISLATURE

Bicameral Parliament or Sansad consists of the Council of States or Rajya consisting of not more than 250 members, up to 12 of which are appointed by tl remainder are chosen by the elected members of the state and territorial asser serve six-year terms) and the People's Assembly or Lok Sabha (545 seats; popular vote, 2 appointed by the president; members serve five-year terms)

JUDICIARY

Supreme Court and lower courts. Judges are appointed by the president and rem they reach the age of 65

SPECIAL FACTORS

- India is marked by a vast (one billion) and ethnically heterogeneous population, recognized regional languages and many hundreds of ethnic and linguistic grou the country.

- Liberalisation of economic policies in the recent past has led to a significant investment (from the West as well as the East), which in turn has st developments in the industrial and infrastructural sectors of the country.

- Due to the lack of balanced economic development throughout the counti population migrations - especially of young men in search of income - are comm

-Extensive cross-border trade with neighboring countries (especially Nep Myanmar, Sri Lanka and Pakistan) for commercial and other purposes is als Reportedly there are some well established sex work traffic routes between Nep Bangladesh and India. Refugee populations from Tibet, Sri Lanka and Afghanis concentrated in certain areas of the country.

- Social Sector Development (especially Health, Education and Social Welfar jurisdiction of the respective States and Union Territories. As a consequence, sector issues is seen as a matter for State Government, rather than Central Gov

- Issues of human sexuality are extremely sensitive, and attempts to broaden human sexuality matters are categorized by some as attempts to debase the l **traditions.**

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Indicators

Indicators	Estimate	Year	Source
Population (millions)	1027	2001	Census of India, 2001
Population growth (1991-2001)	21.34	2001	Census of India, 2001
Annual Population Growth (percent)	1.6	2000	U.S. Census Bureau
Population Density (per sq.km)	324	2001	Census of India, 2001
Sex Ratio (females per 1,000 males)	933	2001	Census of India, 2001
Crude Birth Rate (per 1000 population)	25	1999	UNPOP
Crude Death Rate	9	1999	UNPOP
Total Fertility Rate	3.3	1995 - 2000	Human Development
Infant Mortality (per 1000)	69	2000	Human Development
Maternal Mortality Rate	540	1999	Human Development
Human Development Index Ranking	124	2002	Human Development
Literacy (Total)	65.38	2001	Census of India, 2001
- Males	75.85	2001	Census of India, 2001
- Females	54.16	2001	Census of India, 2001
Increase in literacy	13.75	1991 - 2001	Census of India, 2001

People below poverty line (%)	35	2000	Human Development
Urban Population (%)	27.7	2000	Human Development
Growth of Urban population (annual)	2.2	1990 - 1998	World Bank
Life expectancy	63.3	2000	Human Development
Per capita GNP (US $)	440	1999	UNPOP
Population with access to proper sanitation (%)	31	2000	Human Development
Population with access to improved water sources (%)	88	2000	Human Development
Health Expenditure-Public (% of GDP)	--	--	--
Health Expenditure - Private (% of GDP)	4.2	1998	Human Development
Physicians per 100,000 population	48	1990 - 1999	Human Development
Population with Access to Essential Drugs (%)	0 - 49	1999	Human Development

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Socio-Economic Background

With more than a billion people, one of the fastest economic growth rates in the world since the 1980s and a Information Technology industry that is projected to earn about US $ 50 billion by 2008, India is a country of **contrasts.**

It has the highest concentration of poverty anywhere in the world with about 350 million people (1999 figures the poverty line. The country accounts for 40 per cent of the world's poor and its social indicators are still po measures of human development. At 9.6 per cent of GDP, its fiscal deficit is one of the highest in the world.

- More than half of all children under the age of four are malnourished and 30 percent of newborns ar underweight.
- India adds 16 million people every year to its population, just two million less than the entire popula
- Every day, it adds 42434 to the country's population.
- 60 per cent of the women are anaemic·
- More women than men die before the age of 35
- Maternal deaths in India account for almost 25 percent of the world's childbirth-related deaths.
- More than half of Indian women are illiterate though it has the second largest education system in th China.
- Maternal mortality rate in India is 100 times more than in the developed world.
- India has the largest remaining pool of polio transmission in the world.

But the poor indicators do not articulate India's achievements.

The general condition of India's population has improved since the 1970s. Average life expectancy at birth h from 50 years to 63 today, the infant mortality rate has fallen by half to about 70 per 1,000 live births, and th fallen by half to about thee children per woman.

India's national family welfare program has helped move the country about two-thirds of the way toward its g replacement- level fertility (2.1 births per woman.). However, population growth and the impending strain on environment, natural resources, and social services still pose a threat to India's development.

Malnutrition poses a continuing constraint to India's development. Despite improvements in health and well- malnutrition remains a silent emergency in India. The World Bank estimates that malnutrition costs India at billion annually in terms of lost productivity, illness, and death and is seriously retarding improvements in hu development.

Despite some improvement, India's women remain significantly more malnourished than men. Bias against is reflected in the demographic ratio of 933 females for every 1,000 males. The country's maternal mortality high, particularly in rural areas, ranging from 440 to 580 deaths per 100,000 live births.

Although declining, largely preventable diseases such as leprosy, tuberculosis, cataract blindness, and mala account for 50 percent of reported illness, and around 470 deaths per 100,000. Despite a decade of polio in India's immunization program, India accounted for more than two-thirds of polio cases reported worldwide in

India made modest increases in primary education enrollment rates in the 1990s. Today, it has 108 n aged 6 -10 attending primary school.

The rise in literacy rates over the last decade indicates India's progress in education. From 1991- 99, the ov

increased from 52 percent to 64 percent. Yet more than half of Indian women are still illiterate; about 40 mill school-age children are not in school (mostly girls and those from the poorest and socially-excluded househ about one-third of an age group completes the constitutionally prescribed eight years of education.

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HIV Situation

India's socio-economic status, traditional social ills, cultural myths on sex and sexuality and a huge populati marginalized people make it extremely vulnerable to the HIV/AIDS epidemic. In fact, the epidemic has beco serious public health problem faced by the country since Independence.

Since the first case was reported in Chennai, the capital of the South Indian State of Tamil Nadu, HIV has s from urban to rural areas and from high-risk groups to the general population. At the end of 1999, an estima people are living with HIV/AIDS in the country.

HIV/AIDS has been reported from almost all the states and union territories of the country. Currently the infe estimated to be 0.7 per cent in adult population (between 15 and 49 years of age).

The second decade of the epidemic is marked by visible heterogeneity. In fact, India's epidemic is made up epidemics and at some places, they occur within the same state.

The epidemic has become a major developmental challenge that goes beyond the realm of public health. TI complexity of the epidemic has made it an issue that touches all aspects of human life. And the perspective medical, human rights, ethical, legal, religious, cultural and political. The need to prevent the epidemic and p support to those infected and affected calls for an unprecedented response from all sections of society.

In the most affected state of Maharashtra, HIV has reached 60 per cent of Mumbai's sex workers, 14-16 pei STD clinics and over 2 per cent among women attending antenatal clinics (ANCs). The prevalence in wome antenatal clinics, an indicator for the prevalence in general population, has reached 6.5 in Namakkal in Tam per cent in Churachandpur in Manipur.

The epidemic is slowly moving beyond its initial focus among sex workers. Sub-epidemics are evolving with explosive spread among groups of injecting drug users (IDUs) and among Men having Sex with Men (MSM)

The last four years have seen a broadening of the epidemic across the southern and western states of India continued concentration of HIV among IDUs in the North Eastern states. The sharp increases in Andhra Pra Karnataka reveal that these two states have overtaken Tamil Nadu as states with the highest prevalence rat

In other parts of the country, the overall levels of HIV are still low with some areas reporting no cases at all. Sexually Transmitted Diseases (STDs), the presence of sexual networks and phenomena like migration anc point to a significant vulnerability.

The epidemic continues to shift towards women and young people with about 25 percent of all HIV infection women. This also adds to the Mother To Child Transmission (MTCT) and paediatric HIV. Adverse gender bi biological vulnerability of women.

The burden of AIDS cases is beginning to be felt in states affected early. Mumbai in Maharashtra and Manip East have recorded 20-40 per cent bed occupancy by HIV positive persons in certain referral hospitals.

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Estimates

HIV in India - A fast spreading Epidemic

- **1986:** First case of HIV detected in Chennai
- **1990:** HIV levels among High Risk Groups like Sex workers and STD clinic attendants in Maharash Injecting Drug Users in Manipur reaches over 5%.
- **1994:** HIV no longer restricted to high risk groups in Maharashtra, but spreading into the general pc also spreading to the states of Gujarat and Tamil Nadu where high risk groups have over 5% HIV p
- **1998:** Rapid HIV spread in the four large southern states, not only in highrisk groups but also in the population where it has reached over 1%. Infection rate among antenatal women reaches 3.3 in Na Nadu and 5.3 in Churachandpur in Manipur. Among IDUs in Churachandpur it crosses 76 percent a 64.4 per cent.
- **1999:** The infection rate in antenatal women in Namakkal rises to 6.5. About 60 per cent of the sex Mumbai sites are infected. Infection rates among STD patients reaches 30 per cent in Andhra Prad

per cent in Maharashtra. About 64.4 per cent IDUs at one of the sites in Mumbai and 68.4 per cent Chruachandpur are infected.

- **2001:** Infection crosses one per cent in six states. These states account for 75 per cent of the coun HIV cases. The Prime Minister addresses the Chief Ministers of high prevalence states and urges t prevention activities

HIV/AIDS Estimates

Estimated Number of People Living With HIV/AIDS : 3.97 million - 2001

Previous Years

Year	1998	1999	2000
No. of cases	3.5 million	3.7 million	3.86 million

Estimated Number of New Infections in 2001 : 0.16 Million

Previous Years

Year	1999	2000
No. of cases	0.2 million	0.16 million

Source : National Aids Control Orga

Figures	**Value**	**Year**	**Source**
Estimated Number of HIV cases (Adults and children)	3,970,000	2001	UNAIDS Global HIV/AII
Adults (15-49 years)	3,800,000	2001	UNAIDS Global HIV/AII
Women (15-49)	1,500,000	2001	UNAIDS Global HIV/AII
Children	170,000	2001	UNAIDS Global HIV/AII
Esimated number of deaths due to AIDS	--	--	--
Estimated Number of AIDS orphans	--	--	--

- Estimation of HIV/AIDS in India - 2001

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The National Response

India responded to the AIDS epidemic immediately after the first ever HIV/AIDS case was reported in the cc The country's National response encompassed the efforts of both the Government and civil society.

Recognising the seriousness of the situation, the Government constituted a high-power committee in 1986 t Ministry of Health and Family Welfare. Subsequently, a National AIDS Control Programme was launched in then, the National HIV Programme has moved through three phases.

1986-1992, Denial of the Threat of HIV: This was a period that saw the beginning of a largely research-ba Surveillance activities were launched in 55 cities in three states. The programme activities were left to the st strong central guidance.

1992-97, First Acceleration of the Programme: Backed by World Bank funding and strong WHO GPA (Gl on AIDS) support, this phase saw the creation of the National AIDS Control Organisation (NACO). Acheiver higher levels of awareness creation, establishment of state level structures for programme implmentation ar in blood safety. The launch of successful individual projects such as the innovative intervention in Sonagacl commercial sex workers and breakthroughs in reaching out to college youth through "University Talks AIDS amongst its achievements. The scope of these efforts remained however on a limited scale. Political accept and ownership of the programme by the states proved difficult to establish. Involvment of NGOs too was dif emphasis on blood-safety and strengthening of infrastructure yielded some gains, approach remained prima HIV seen largely as a health issue.

1998-2001, Focus on Targetted Intervention: Building on the experience of the first phase, there was a tw on coverage amongst high risk groups like sex workers, truck drivers and injecting drug users and to make t multisectoral.. It has resulted in a strongly decentralized programme with the responsibility of implementatio states. Flexible State AIDS Socieites were formed with stronger mechanisms for state level programme ma innovative approach for providing technical support to state programmes was launched by establishing a ne

Technical Resource Groups (TRGs), each covering different thematic areas of the epidemic. Each of them provide technical support to states. Surveillance has been expanded and strengthened and a new national been submitted to the Central Government. With a new round of resources mobilized from Government of I major bilateral donors and the UN system, the programme is moving into an important phase of implementa

The preparation of the new programme has given a fresh impetus to the national response. However, sever need to be addressed. These include building capacities to implement the strategies of prevention and build multi-sectoral response that is sustainable. It also involves mobilizing and coordinating a considerable range including the private sector.

National Programme Manager: Mr. J.V.R.Prasada Rao, Special Secretary and Project Director, New Delh

National AIDS Control Organisation (NACO):
In India, the National AIDS Control Organisation (NACO) carries out the country's National AIDS Programm formulation of policy and implmentation of prevention and control programmes. It was established in 1993 a running the second phase of the National AIDS Control Project (NACP-II). The first phase (**NACP-I**) ended i The duration of **NACP-II** is from December 1999 to March 2004.

In 1989, with the support of WHO, a medium term plan for HIV/AIDS control was developed. With a US $10 was implemented in five most affected states. The actual prevention activities gained momentum by 1992 a programme became more formalised with the establishment of NACO in 1993.

Besides NACO, the country also has a National AIDS Control Board, which is chaired by the Union Health S Board reviews NACO policies, expedites sanctions, approve procurement and undertake and award contrac agencies. The other major functions of the Board are approval of annual operational plan budget, reallocatic between programme components, formation of the programme managerial teams and appointment of senic staff.

Project Director, Mr.J.V.R.Prasada Rao, who is a Special Secretary to the Government of India, heads NAC

Objectives:

NACO has two key objectives

- To reduce the spread of HIV infection in India and
- To strengthen India's capacity to respond to HIV/AIDS on a long-term basis.

The overall vision of NACO is

- To lead and catalyse an expanded response to the HIV/AIDS epidemic in order to contain the spre
- Reduce people's vulnerability to HIV.
- Promote community and family based care to HIV/AIDS cases within an enabling environment with stigmatisation and discrimination and,
- To alleviate the epidemic's devastating social and economic impact

State AIDS Control Societies:

For the implementation and management of HIV/AIDS programmes in states, State AIDS Cells were create and UTs of the country. However over a period of time, it was realised that due to many cumbersome admir financial procedures, there was delay in release of funds sanctioned by the Government of India. This delay implementation of programmes at different levels. To remove the bottlenecks at the State level, Ministry of H Family Welfare advised the State Governments/Union Territories to constitute a registered society under the of the Secretary Health. The society is broad-based with members representing various ministries like Socia Education, Industry, Transport and Finance and NGOs. On an experimental basis, the Tamil Nadu State AII Society was created followed by a similar society in Pondicherry. Successful functioning of these societies l Government of India advising other states to follow this pattern for implementation of the National AIDS Cor

- Findings of Behaviour Sentinel Surveillance-2001
- National AIDS Prevention and Control Policy
- National Blood Policy

Source : National Aids Control Orgar

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UN Support

UN Support

- The UN system, through UNAIDS and its cosponsors, is committed to strengthening its support t coordination and technical collaboration. Each UN agency - cosponsors as well as UNIFEM and I lead in its specific strategic focus area. UNAIDS, besides facilitating and coordinating the UN (through the UN Theme Group(TG) and National Programme officers in several UN agencies), providing or brokering the provision of technical support to the National Programme.
- The latter include support for the Technical Resource Groups (TRGs), to state strategic planning building of NGOs and other service organizations.
- Through the Theme Group mechanism, UNAIDS is focusing the UN system's efforts on th according to the agencies' respective capacities and mandates.
- A collaborative framework and integrated work plan for 1999-20001 has thus been drawn u individual as well as collective UN strategies. Examples: UNFPA, UNICEF and WHO on re programmes; WHO on HIV/STD and behavioural surveillance; UNDCP and UNAIDS on drug use; ILO on interventions among Sex Workers; UNICEF, UNESCO and UNFPA on schools-based educ
- The World Bank has just pledged $191 million credits to support the response, including support programming, STI prevention and care and interventions targeting risk behaviours. This follows million credit to the National Programme.
- Besides the World bank IDA credits, there are several bilateral agreements for HIV/AIDS projects million AVERT project from USAID targeting Maharashtra, and a further $28 million from DFID whi projects in 4 selected states (WB, Orissa, Andhra P., Kerala) focusing on institutional capacity I interventions and BCC programmes.
- Other bilateral partners include CIDA and AusAID who intend to focus on capacity building at th partnerships with NGOs for targeted interventions and behaviour change programmes. And SIDA s the North East and elsewhere in the country.
- Extensive non-health sector involvement in National AIDS Committee.

Theme Group Chair: Dr.R.J.Kim Farley, WHO Representative to India, New Delhi.

Interim Country Programme Advisor, UNAIDS: Dr. Olavi Elo, New Delhi.

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Support by Other Ministries

- Ministry of Human Resource Development (Dept. of Youth & Sports) involved in implementatio Talk AIDS" Programme of the National Service Scheme covering 158 universities, 5000 colleges secondary schools.
- National Council of Education Research & Training (NCERT) involved in development of school cu for integration of HIV/AIDS into school education (extra-curricular activities).
- A national consultation on the integration of HIV/AIDS into school education has been organised ur of UNAIDS by UNESCO, UNFPA, and UNICEF with financial support from NACO and the active ir Department of Education and five key states where these activities have been implemented. Follo between NACO and the Department of Education with support from the UN System.
- Nehru Yuvak Kendra (NYK) involved in the implementation of non-formal educational apprc outreach programmes on HIV/AIDS through its national volunteer network in communities in the co
- The Ministry of Information & Broadcasting has been of assistance through its Directorate of Auc (DAVP), the Song & Drama Division, All India Radio and Doordarshan (national television service) and forums for the dissemination of public service programming and messages on HIV/AIDS preve
- Ministry of Railways undertook in 1994 a study of risk behaviors amongst its employees with UNDP. Survey results encouraged Ministry of Railways to design and approach NACO with proposal for response to HIV/AIDS in Railways sector; proposal currently under discussion with NA
- Ministry of Defense (Health Services) conducts IEC programmes and HIV screening within defense assistance from NACO.

World Bank Support

The Bank has provided two IDA credits to support India's National AIDS Control Program in collaboratio Health Organization, other donors and UNAIDS. Through its general health projects and dialogue with o countries, the Bank is focusing on HIV/AIDS as a major public health and development issue. In In supporting the country's ongoing program to reduce the growth of HIV infection and strengthen capacity epidemic through information awareness efforts, focused interventions promoting behavior change, volu counseling, and reducing transmission by blood transfusions and occupational **exposure**

Support by Industry

Industrial federations (West Bengal Chamber of Commerce & Industry, Confederation of Indian Indust Indian Chambers of Commerce & Industry) becoming involved in stimulating discussions on needs for response to HIV/AIDS. "AIDS & the Workplace" advocacy & IEC package developed by Confederation (CII) with assistance from WHO/UNAIDS/USAID for promotion of industry action on HIV/AIDS preventio

(CII) with assistance from WHO/UNAIDS/USAID for promotion of industry action on HIV/AIDS preventio policies. The Trucking Corporation of India (TCI) is actively participating in a national network of NGO being coordinated with support from ODA for the assurance of HIV/STD interventions for truck drivers.

Legislation and policies

- Goa Public Health Act Amendment of 1985 (Section 53.I.vii) allowed the public health authc discretion to isolate people with HIV/AIDS; repealed in 1996.
- Railway Board Administrative Notification of 1989 designating HIV/AIDS as "infectious disease" wh denial of passage; rescinded in 1996.
- Draft legislation in 1989 Session of National Parliament, which was evaluated as extremely prejudic PLWH/As withdrawn after intervention of WHO and national authorities.
- 1992 Administrative Notification from Minister of Health & Family Welfare (GOI) to all State Govern them to ensure non-discriminatory access to treatment and care for PLWH/As in all Central and St health care institutions.
- The Government has, by Administrative Order, required the screening for HIV of all units of blood t transfusion purposes.
- May 1997 Mumbai High Court Judgment held that employers cannot base employment decisions o employee

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Status

Country Status - 2001 by WHO

Country Profile: HIV/AIDS Surveillance Database, US Census Bureau (Pdf)

UN Offices

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UNICEF (United Nations Children Fund)

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Sources: UN Agencies, World bank, UNAIDS Epidemiological Fact Sheet - 2000, Census of India - 20 Responds to HIV/AIDS

* The map presented here is sourced from Census of India - 2001, Govt. of India. YouandAIDS is not liable other countries in the region or elsewhere in the world, organizations or individual might raise.

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DIS-2

Background Research on HIV/AID

for Dr TN

AB
25/3/03

Centres for CD4/CD8 Blood Tests

New Delhi:

1. AIIMS
2. Dr. RML Hospital
3. NICD
4. Safdarjung Hospital

Pune: BJ Medical College

Kolkata:

1. Calcutta Medical College

2. School of Tropical Medicine
Medical College, Kolkata

3. City Counselling Centre (Run by Durbar Mahila Samanwaya Committee)
8/1, Bawani Dutta Lane
Kolkata - 700 006

4. Bharuka Public Welfare Trust
\"Amaader Bari\"
63, Rafi Ahmed Kidwai Road
kolkata

5. Roy & Trivedi
Parkstreet (Beside Petrolpump near Park Street Thana)

6. Ranbaxy Speciality, Collection Centre
Divine Nursing Home
Beliaghata.

Indore: Choitram Hospital
Bhopal: Gandhi Medical College
Shimla: Govt; Medical College
Chennai: Institute of Thoracic Medicine, Tambaram
Mumbai: JJ Group of Hospitals, KEM Hospital
Imphal: JN Medical College

Lucknow:

1. KG Medical College
2. Department of Immunilogy, Sanjay Gandhi Post Graduate Institute of Medical Sciences, Raibareilly Road, Lucknow

Madurai: Madurai Medical College
Guwahati. Medical College

HIV/AIDS Indian fate

JN
19/2

Goa: Medical College, Panjim
Kerala: Tiruvanndapuram Medical College
Bangalore: NIMHANS
Hyderabad: Nizam's Institute of Medical Sciences
Chandigarh: Post Graduate Institute of Medical Education and Research
Jaipur: SMS Medical College
Ahmedabad: VJ Medical College

The Global Fund to fight AIDS, TB and Malaria

PURPOSE

What is the Global Fund to Fight AIDS, Tuberculosis and Malaria?

The Global Fund is an independent, public-private partnership designed to attract, manage, and disburse new resources to fight the global crises of AIDS, tuberculosis, and malaria. The Fund's objectives are to: finance effective programmes, balancing the needs for prevention, treatment, care, and support, in order to alleviate suffering, save lives, and help end these diseases dramatically increase the global resources dedicated to fighting these diseases.

Why was the Fund created?

The Fund was created to fight the global HIV/AIDS, TB, and malaria epidemics by sharing resources and expertise across national boundaries, and between the private and public sectors.
The concept for an international funding mechanism to fight HIV/AIDS, TB, and malaria began at the Okinawa G8 Summit in July 2000. At the urging of UN Secretary General Kofi
Annan and many national leaders, the concept of the Fund was unanimously endorsed in June 2001 at the first UN General Assembly Special Session to focus on HIV/AIDS. In July 2001 at its meeting in Genoa, G8 leaders committed US $1.3 billion to the Fund.

Why address these three diseases?

The need for more rapid, sustained and concerted action on AIDS, TB, and malaria is overwhelming. Together, these diseases have a devastating global impact, killing nearly 6 million people each year and causing major social and economic upheaval. While effective interventions now exist to help prevent and treat these diseases, they remain out of reach for most people in the developing world. A dramatic increase in resources to fight HIV, TB, and malaria is urgently needed to help reduce the suffering and death caused by these diseases.

How is the Fund different from previous efforts to address HIV/AIDS, TB, and malaria?

The Fund is a unique global public-private partnership that includes donor and recipient country governments, multilateral agencies, NGOs, private sector representatives, and representatives from the communities affected by the three diseases. The full involvement of all these stakeholders reflects an unprecedented level of shared commitment to roll back these global health and development challenges. The Fund is a novel approach that emphasizes the achievement of results, independent technical validation of proposals, and efficient processes for utilizing resources.

Does the Fund replace current funding mechanisms for HIV/AIDS, TB, or malaria?

The Fund is meant to supplement, not to replace, current funding mechanisms for HIV/AIDS, TB, and malaria. In fact, support for current efforts to fight these diseases should also be increased.

How will the Fund ensure that it doesn't duplicate or compete with the work of others in the field?

The Fund is not an implementing agency, so it will in no way compete with development or international agencies on the ground. Instead, the Fund is a mechanism to raise new funds to fight HIV/AIDS, TB, and Malaria and to direct these resources quickly and efficiently where they are most needed, to programs and interventions that are not adequately funded now. The
Fund is committed to coordinating with and working through existing international, regional, and national mechanisms wherever possible.

Will the Fund address the root causes of these diseases, including poverty, gender disparity, lack of education, and poor nutrition and sanitation?

Effectively addressing HIV/AIDS, TB, and malaria in developing countries will require action from a broad developmental perspective. The Fund will favour programmes that build on and coordinate with efforts to address factors that can be root causes of these diseases, including poverty, gender disparities, lack of education, lack of access to healthcare, and inadequate nutrition and sanitation.

HOW TO SUBMIT PROPOSAL APPLICATIONS

What is a Coordinated Country Proposal (CCP)?

The Coordinated Country Proposal (CCP) is the single coordinated proposal to be submitted to the Global Fund through the Country Coordinating Mechanism (CCM). A CCP must address one or more of the three diseases (HIV/AIDS, tuberculosis or malaria) and may also address system-wide/cross-cutting aspects of these diseases in ways that will contribute to strengthening health systems, depending on country realities and readiness.

Who can submit a CCP?

The Global Fund accepts proposals from a Country Coordinating Mechanism (CCM). There should be only one CCM per country, except where a sub-national CCM exists. In certain circumstances such as the case of very large countries, a sub-national CCM, based on principles of inclusiveness and partnership, may be formed to submit a proposal. Such a proposal should be consistent with nationally formulated policies, and there should be either evidence of a legal framework stating the autonomy of the sub-national entity or endorsement by the national-level CCM (or, if no national CCM exists, through other relevant national authority) for the application. Non-CCM proposals can only be accepted under very specific conditions described below (see question 8).

COUNTRY COORDINATION MECHANISMS (CCM)

What is a CCM?

The CCM functions as a "national consensus group" that coordinates proposal submission from its national partners. The CCM should facilitate the proposal development process, including the translation of national strategies into concrete implementation plans with clear responsibilities, timing of activities, budgets and expected outcomes; approve and endorse the final version of a single coordinated country proposal (CCP); and play a mayor role in monitoring and follow up on the implementation of proposed activities. The CCM is a body that functions as a forum to promote true partnership development and multi-sectoral programmatic approaches. At the very least, in-country partners must come together regularly to discuss plans, share information and communicate on Global Fund issues. The CCM should engage in substantive discussions and, therefore, its membership should reflect the ability to maintain such a dialogue, with a representative number of members and an active chair.
The CCM is an overall guiding body responsible for the use of Global Fund resources. The CCM will need to manage relations with the Global Fund.
The CCM should ensure that all relevant actors are involved in the process; and that all views are taken into account. As such, it is responsible for ensuring that information relating to the Global Fund, such as the Call for Proposals is disseminated widely to all

interested parties in the country. Interested parties in the country may include the following: government agencies, NGOs, community / based organizations, private sector institutions and bilateral and multilateral agencies, as well as other organizations, such as country or regionally based academic institutions or faith based organizations, that can facilitate and support the programs. The CCM is expected to be responsive and supportive of NGOs and other civil society actors wishing to be included in the Country Coordinated Proposal.

What is the recommended composition of a CCM?

A CCM should be as inclusive as possible and seek representation of the highest possible level from various sectors such as:
Government
NGO/ community based organizations
Private Sector
People living with HIV/AIDS, TB and /or Malaria
Religious/Faith Based Groups
Academic/Educational Sector
United Nations/Multilateral/Bilateral Agencies
However, CCMs should remain of a manageable size (between 15 and 30) in order to work and discharge responsibility effectively.

What kind of proposals will have the best chance of being funded?

Successful proposals must clearly demonstrate the added value and impact that additional resources would have on the epidemics in country. Successful proposals will focus on measurable results.
Successful proposals will in general be based on:
Technical soundness of approach
Country partnerships
Feasibility with respect to implementation plan and management
Potential for programmatic and financial sustainability
Recent country situation analysis
Monitoring & Evaluation
In addition, successful proposals will include a focus on institutional and absorptive capacity.

Does the Fund support basic research projects?

No. However, the Fund supports operational research projects as part of a broader scope.

How will eligibility to receive funding from the Global Fund be assessed?

In assessing the conditions for support, the following parameters will be taken into account:

Disease burden for HIV/AIDS, TB and/or malaria – based on accepted international standards for assessing disease prevalence, incidence and magnitude.

Potential for rapid increase of disease – based on accepted international indicators such as recent disease trends, size of population at risk, prevalence of risk factors, extent of cross-border and internal migration, conflict or natural disaster.

Economic and poverty situation - based on relevant indicators such as GNP per capita, UN Human Development Index (HDI), poverty indices, or other information on resource availability.

In addition to the above criteria based on epidemiological and socio-economic profile, proposals will also be evaluated on the basis of the following critical dimensions.

Political commitment by the country submitting the proposal at the highest possible level. Indicators of such commitment may include: government contribution to the financing of programmes covered in the proposal; per capita health expenditure; existence of supportive national policies and multiyear strategic plans; appropriate legislation; and recent political pronouncements.

Complementarity and additionality to existing programmes by demonstrating how the resources sought from the Global Fund would complement, add to and be consistent with country level frameworks (such as National Plans, Poverty Reduction Strategies and Sector-wide Approaches, etc.) by building on or scaling up existing efforts and filling existing gaps in national budgets and funding from international donors. The funds from the Global Fund should not replace existing national and international resources.

Absorptive capacity by demonstrating how additional resources from the Global Fund could be effectively absorbed and used. Particularly in cases where applicants plan to greatly increase the amount of financial resources, evidence should be provided to show that programme and human resource capacity exists to absorb the additional funding within the given period.

Soundness of approach by explaining the mechanisms and work plan it will use to achieve its goals. It should clearly explain how the funds requested will be used, justify the amount requested and indicate how those funds will supplement resources from other sources.

The proposal should demonstrate a clear logical structure. In particular, each component should have an overall goal. The overall goal should translate into specific objectives. In turn, each specific objective should translate into a set of main activities to achieve these objectives. The expected results for each of these levels of strategy should be clearly formulated.

For each level of strategy (overall goal, specific objectives, broad activities), indicators must be provided to measure expected results of the proposal and/or broader country programmes to which the proposal is linked.

For each main activity, the proposal should also identify the implementation arrangements including roles and responsibilities of implementing partners.

What are the specific areas of focus of the Fund?

The Global Fund supports comprehensive programmes based on multi-sectoral approaches and widely inclusive partnerships with a particular emphasis on scaling up proven approaches.
Resources from the Global Fund may be used to support activities which must include on or more of the following:
Prevention, treatment, care and support of those directly affected
Increased access to health services; recruitment and training of personnel and community health workers;
Behaviour change and outreach; and community-based programmes, including care for the sick and orphans;
Provision of critical health products (including drugs) to prevent and treat the three diseases, and for the strengthening of comprehensive commodity management systems at country level; and
Operational research in the context of programme implementation:
Basic research will not be covered by the Global Fund grants.
For activities involving the use of essential drugs, there should be a description of the products and treatment protocols as well as resources (human and systems, etc.) in place to ensure rational use and maximizing adherence and monitoring of resistance.

What are the Fund's priorities for funding?

The highest priority will be given to proposals from countries and regions with the greatest need, based on highest burden of disease and the least ability to bring the required additional financial resources to address these health problems.

Does the Fund support the purchase of ARV treatment?

Provision of antiretroviral treatment is currently included in the Fund's scope as an example of the types of activities that could be supported. The Board of the Fund will balance the available resources against the priorities that countries themselves identify within the context of comprehensive health system strategies and plans.

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HIV spread by violence against women

ADVERTISEMENT

Forty-Seventh Session of the
Commission on the Status of Women
Statement by Bertil Lindblad, Deputy Director UNAIDS New York Office

Violence against women fuels the spread of HIV, according to a statement by UNAIDS to the 47th session of the Commission on the Status of Women. "The fear of intimidation prevents the risk of contracting HIV from being discussed and worse, results in HIV infection," said UNAIDS. "In a number of countries, HIV-positive women were found to be 10 times more likely to have experienced male violence than those that are HIV-negative." The elimination of all forms of violence against women and girls is a main theme of the 47th session, being held in New York from 3-14 March.
5 March 2003

Mr. Chairman,

At the heart of the global AIDS epidemic lies gender inequality. At the end of 2002, women for the first time comprised 50 percent of the 42 million people living with AIDS worldwide. In sub-Saharan Africa, there are 17 million women living with HIV, 58 percent of the total. Women bear the main burden of care; women are the last in the queue for treatment; women and girls are denied information and education and women are denied the power to negotiate their sexual safety because they do not have control over income and property.

Women and girls often lack information about HIV/AIDS. A recent UNICEF survey found that up to 50 percent of young women in high prevalence countries did not know basic facts about AIDS. Girls do not sleep with older men because they think it is safe. They may do so to be able to pay their school fees. Sex workers do not agree to sex without condoms because they do not know their benefits. They do so because they get paid up to five times as much money. Women do not breastfeed their babies because they are unaware of the risks. They do so because they do not know their HIV status and they are afraid of condemnation or they cannot afford to use breast milk substitutes safely. The point is that women need more than advice. They need resources, education, jobs - real options to live safely and productively in a world with AIDS.

The interplay between gender inequality and AIDS is therefore central to the world's pledges to do better. It is a key component of the action plans in follow up to the World Conference on Women and the

International Conference on Population and Development. Likewise, a pervasive theme throughout the 2001 Declaration of Commitment on HIV/AIDS, adopted at the UN General Assembly Special Session on AIDS in June 2001, is the importance of gender equality and women's empowerment as a core long-term strategy to reduce the vulnerability of women to HIV/AIDS.

Women's empowerment - the full realisation of women's human rights - reduces their vulnerability to HIV/AIDS. This year's theme of the Commission - women's human rights and the elimination of all forms of violence against women and girls - is particularly important in defeating the epidemic. Strategies to protect women from sexual aggression and violence are not only important in their own right, but will markedly increase women's protection against HIV infection. The varied forms of violence against women, and the economic dependence which makes violent situations harder to escape from, fuel the spread of HIV. Between 10 and 50 per cent of women worldwide report physical abuse by their partners. The fear of intimidation prevents the risk of contracting HIV from being discussed and worse, results in HIV infection In a number of countries, HIV-positive women were found to be 10 times more likely to have experienced male violence than those that are HIV-negative.

At the same time, HIV positive women have in many cases not sought care or treatment for the same fears of physical violence, stigma, discrimination and ostracism. This despite the fact that for millions of women worldwide, their only 'risk factor' for HIV has been sex with their spouse. Findings of recent research have shown that in many cases, the majority of HIV positive women were infected by their husbands. For example, in a city in Asia, more than 90 percent of women being treated for sexually transmitted diseases admitted to having only one sex partner in their whole life - their husband, and 14 percent of the women had been infected with HIV.

Mr. Chairman,

Conflict situations greatly increase the vulnerability of women and girls and the risk of contracting HIV. The breakdown of social systems, lack of access to care and education services, and increased levels of sexual violence all contribute to this risk. UNAIDS is working closely with the UN Department of Peacekeeping Operations to ensure that wherever they are deployed, UN peacekeepers are also warriors against HIV. Similarly, special HIV/AIDS gender advisers have been attached to peacekeeping operations to work with both uniformed personnel and affected civilian populations to try to break the link between conflict and HIV transmission.

The UNAIDS partnership comprising the eight Cosponsoring organizations and the Secretariat is giving particular attention to the gender dimensions of the epidemic across their full mandate. So, for example, ensuring that the goals of Education for All are met by ensuring that girls are not pulled out of school when a crisis

strikes, is a fundamental action to protect against HIV. Likewise, the UNAIDS' partnership with UNIFEM is raising awareness of the centrality of the realisation of women's human rights to the HIV/AIDS epidemic.

Overcoming the gender inequality that drives the global AIDS epidemic therefore requires targeted action on many fronts:

Attacking stigma and discrimination;
Enacting and strengthening legislation to give women economic rights and access to credit
Expanding access to prevention services, including prevention of mother to child transmission, as well as access to antenatal care and real options available to HIV-infected women in choosing not to breastfeed;
Training uniformed services and health personnel;
Protecting orphans, particularly girl orphans.
Women's empowerment, gender equality and reversing the spread of the HIV/AIDS epidemic are inextricably linked. As the Secretary General's Special Envoy for Humanitarian Needs in Southern Africa, Mr. James Morris, concluded in September 2002: "An immediate, strongly led and broadly implemented joint United Nations drive to take action on gender and HIV/AIDS -involving all UN partners, actively engaging governments and substantially increasing support to civil society organizations - must be initiated without delay".

Substantial though the task may be, it is not hopeless. To take one example of action under way, in Southern Africa, where girls are infected with HIV at four times the rate of boys, UNAIDS is supporting a youth AIDS initiative with a special emphasis on adolescent girls. Working with eight different countries, community-based interventions are expanding reproductive health services, training peer educators, extending micro-credit and health insurance, and supporting training and employment.

There are hopeful signs emerging across the world, and often, it is young women who have been the harbingers of hope. HIV rates among young women have fallen -- in parts of Zambia, among young South Africans, in Addis Ababa, in Malawi, in Cambodia and elsewhere.

This message of hope needs to be central in the deliberations of the Commission. The link between violence against women and the spread of HIV can be broken if and when concerted action is taken against these twin evils.

I thank you.

India has had a sharp increase in the estimated number of HIV infections, from a few thousand in the early 1990s to a working estimate of about 3.8 million children

and adults living with HIV/AIDS in 2001. With a population of one billion, the HIV epidemics in India will have a major impact on the overall spread of HIV in Asia and the Pacific and indeed worldwide. Most of the Indian states have a population greater than a majority of the countries in Africa.
The spread of HIV within the country is as diverse as the societal patterns between its different regions, states and metropolitan areas. In fact, India's epidemic is made up of a number of epidemics, and in some places they occur within the same state. The epidemics vary from states with mainly heterosexual transmission of HIV, to some states where injecting drug use is the main route of HIV transmission. Both tracking the epidemic and implementing effective programs poses a serious challenge to the authorities and communities in India.

When the first case of HIV was discovered in Chennai in 1986, the Indian Government responded to the HIV epidemic immediately. Recognising the seriousness of the situation, the Government constituted a high powered committee under the Ministry of Health and Welfare. Subsequently, a National AIDS Control Programme was launched in 1987. The program activities covered surveillance, screening blood and blood products and health education.
In 1990, HIV levels were high amongst high-risk groups such as sex workers and STD attendants in Maharashtra and injecting drug users in Manipur; infection rates reached over 5%. This period saw the beginning of a largely research-based national programme. Surveillance activities were launched in 55 cities in three states. The programme activities were left to the states and did not have strong central guidance.
The National AIDS Control Organization (NACO) was established in 1992. NACO carries out India's National AIDS Programme, which includes the formulation of policy, prevention and control programmes. The same year that NACO was established, the Government launched a Five -Year Strategic Plan for HIV/AIDS prevention under the National AIDS Control Project. The Project established the administrative and technical basis for programme management and also set up State AIDS bodies in 25 states and 7 union territories. The Project was able to make a number of important improvements in HIV prevention such as improving blood safety. To strengthen surveillance the Government established 140 centres and 180 sentinel sites across the country, to monitor HIV trends and the geographical spread of HIV among the general population at-risk groups.

When surveillance systems in the Indian state of Tamil Nadu, home to some 60 million people, showed that HIV infection rates among pregnant women were rising, tripling to 1.25% between 1995 and 1997, the State Government acted decisively. It set up an AIDS society, which worked closely with non-governmental organizations (NGOs) and other partners to develop an active AIDS prevention campaign. This included hiring a leading international advertising agency to

promote condom use for risky sex in a humorous way, without offending the many people who do not engage in risky behaviour. The campaign also attacked the ignorance and stigma associated with HIV infection, encouraging compassion for those affected. The bold safe-sex campaign was a hit with its target market of young sexually active men. Regular behaviour surveillance shows that the number of visits to sex workers and sex with other irregular partners has fallen, and condom use during risky sexual encounters has rise dramatically.

Although HIV prevalence rate is low (0.7%), the overall number of people with HIV infection is high according to estimates by UNAIDS. The official Indian figures do not reveal such a scale of infection, but weaknesses in the serosurveillance system, bias in targeting groups for testing, and the lack of availability of testing services in several parts of the country suggest a significant element of underreporting. Given India's large population, a mere 0.1 percent increase in the prevalence rate would increase the number of adults living with HIV/AIDS by over half a million people. HIV infection in India is currently concentrated among poor, marginalized groups, including commercial sex workers, truck drivers, and migrant labourers, men who have sex with men and injecting drug users. Transmission of HIV within and from these groups drives the epidemic, but the infection is spreading rapidly to the general community. The epidemic continues to shift towards women and young people with about 25 % of all HIV infections occurring in women. This also adds to mother to child HIV transmission and paediatric HIV.

About 90% of the total reported AIDS cases occur in the sexually active and economically productive 15 to 44 age group. Men account for 79% of HIV infections in India. The predominant mode of HIV transmission is through heterosexual contact, the second most common mode being injecting drug use. Previously blood transfusion and blood product transfusion were also major causes, but blood safety measures are now in place to prevent such transmission.

In 2001, the HIV infection rate went above one per cent in six states, and the Prime Minister urged the Chief Ministers to intensify prevention activities. Three states, (Maharashtra, Tamil Nadu and Manipur), account for 75% of the country's estimated HIV cases. The burden of AIDS cases is beginning to be felt in states affected early. Mumbai and Manipur have recorded 20 to 49 per cent bed occupancy by HIV positive people in certain hospitals.

In the most affected state of Maharashtra, HIV has reached 60% in Mumbai's (Bombay) sex workers, 14-16% in sentinel STD clinics, and over 2% among women attending anti-natal clinics. The prevalence rate in women attending antenatal clinics can be treated as an indicator for the prevalence in general population. This prevalence rate has reached 6.5% in Namakkal in Tamil Nadu and 5.3% in Churachandpur in Manipur.

The last four years have seen a broadening of the epidemic across the southern and western states of India, as well a concentration of HIV among the injecting drug users in the North Eastern states. The sharp increases in Andhra Pradesh and

Karnataka reveal that these two states have overtaken Tamil Nadu as states with the highest prevalence rates. In other parts of the country, the overall levels are still low with some areas reporting no cases at all.
The AIDS epidemic in India consists of a number of local epidemics. Around 70% of India's population lives in rural areas, once though to be relatively immune to the epidemic. Some recent studies, however, suggest that HIV has begun to spread in several rural areas. The epidemic is now moving beyond its initial focus among sex workers and injecting drug users and is shifting towards the general population; making women and young people the most vulnerable for HIV infection.
In India, as elsewhere, AIDS is perceived as a disease of "others" - of people living on the margins of society, whose lifestyles are considered 'perverted' and 'sinful'. Discrimination, stigmatisation and denial (DSD) are the expected outcomes of such values, affecting life in families, communities, workplaces, schools and health care settings. Because of HIV/AIDS related DSD, appropriate policies and models of good practice remain underdeveloped. People living with HIV and AIDS continue to be burdened by poor care and inadequate services, whilst those with the power to help do little to make the situation better.
In a recent study by UNAIDS different levels of discrimination and stigmatisation were found among people living with HIV/AIDS in India. UNAIDS found that there was uncertainty among health care staff about basic HIV-transmission information and about the need for and purpose of universal precautions. Also, the study revealed a depressing picture of widespread labelling and stereotyping and a lack of care throughout the health sector, with the possible exception of a small number of hospitals where good practice and policies have been established.
UNAIDS also found that HIV/AIDS related DSD in India is in some respects a gendered phenomena. Women are often blamed by their parents and in-laws for infecting their husbands, or for not controlling their partners urges to have sex with other women. Children of HIV-positive parents, whether positive or negative themselves, are often denied the right to go to school or are separated from other children. People in marginalized groups (female sex workers, hijras (transgendered) and gay men) are often stigmatised in India on the grounds of not only HIV status but also being members of socially excluded group.

For India to respond effectively to infection trends and limit the costly social and economic impact of HIV and AIDS, its efforts need to be accelerated, intensified and expanded while the country remains at a low prevalence of HIV and there is still time to slow the spread of the epidemic. With HIV prevalence doubling every one to two years in certain groups, there is still a narrow window of opportunity over the next few years in which to prevent the HIV epidemic from becoming generalised and much harder to control.

India's socio-economic status, traditional social ills, cultural myths on sex and sexuality and a huge population of marginalized people make it extremely vulnerable to the HIV/AIDS epidemic. In fact, the epidemic has become the most serious public health problem faced by the country since the Independence.
The Indian Government and individual state Governments have launched prevention programmes to reduce high-risk sex and, there is evidence that in some states these programmes are resulting in safer behaviour. There are some success

stories for effective prevention and control of HIV infection. An intervention programme among commercial sex workers in Sonagachi, Calcutta has been able to increase condom use from 0% in 1992 to more than 70% in 1992-1994 and sustained this at over 70% until 1998. If current prevention efforts can be scaled up and sustained, India may be able to bring down the rates of HIV infection in particularly exposed groups and avert a widespread heterosexual epidemic.

India

THE UNAIDS report on the global impact of HIV/AIDS presented at the XI International Conference on AIDS stated that there are an estimated 2-5 million people infected with HIV in India today. 50,000 to 100,00 cases of AIDS may have already occurred in this country with a population of over 900 million. The most rapid and well-documented spread of infection has occurred in Bombay and the State of Tamil Nadu. In Bombay, HIV prevalence has reached 50% in sex workers, 36% in STD patients, and 2.5% in women seen in antenatal clinics. The infection affects both urban and rural areas. In Bombay, seroprevalence rose from 2-3% in patients seen in STD clinics in 1990 to 36% in 1994 and in rural areas 3-4% of some populations have an STD. Source: The Status and Trends of the Global HIV/AIDS Pandemic Official Satellite Symposium presented at the XI International Conference on AIDS in Vancouver, July 5-6, 1996)

IV drug users (IDUs) present a major problem in the State of Manipur which comprises part of the Golden Triangle, the source of the world's supply of pure grown heroin, 55% of the users are HIV-infected. HIV infection among IDUs jumped from zero to nearly 70% in 1992, according to the U.S. Census Bureau.

In India, there are an estimated 1-2 million cases of tuberculosis every year. TB is the most prevalent form of POI (opportunistic infection) in over 60% of AIDS cases. In Bombay alone, 10% of the patients with TB are HIV-positive.

Tibet

The Central Administration of the Tibetan government in exile, under the leadership of His Holiness, the Dalai Lama, is located in Dharmasala, India. A Department of Health was established in 1981 to serve the needs of of all Tibetan refugees in India and Nepal and has set up 67 health centers, 8 hospitals and employs 255 field staff, most of whom are Community Health workers. Because of the HIV/AIDS situation in the host countries of India and Nepal, the Department declared 1997 as Tibetan AIDS Awareness Year. The year began with a public speech by the health minister and a series of workshops on AIDS prevention were held at various refugee settlements. The Department is now in the process of producing a short video on AIDS in Tibetan to be distributed to all of the health centers, hospital, and schools.

Kalsang Norbu, the Training and Reproductive Health Officer of the Department of Health is the coordinator of a training program for nurses and health workers which addresses the topics of HIV/AIDS and STDs. He said that there are no statistics available on AIDS on the Tibetan refugee population in India and Nepal and attributes this to a lack of available facilities such as testing materials, counselors, and lack of a policy concerning PWAs. Mr. Norbu also pointed out that there are also no statistics available on the HIV/AIDS situation in Tibet.

India has a population of one billion, around half of whom are adults in the sexually active age group, with a large number below this age group. The first AIDS case in India was detected in 1986, and since then, HIV infection has been reported in all States and Union Territories. The spread of HIV in India has been diverse, with much of India having a low rate of infection and the epidemic being most extreme in the southern States. 96% of the total number of nationally reported AIDS cases were found in 10 of the 28 States and 7 Union Territories, the worst being Maharashtra in the west, Tamil Nadu and Pondicherry in the south, and Manipur in the north-east. In Maharashtra and Tamil Nadu the infections are mostly due to

heterosexual contact, while infections are mainly found amongst injecting drug users (IDU) and their sexual partners in Manipur

Estimated numbers of adults and children living with HIV/AIDS, end 2001

Adults	3970000
Women	1500000
Children	170000
Adult HIV prevalence estimate	0.7%

These estimates above are based on previously published estimates for 1997 and 1999 and on recent trends in HIV/AIDS surveillance in various populations. Adults are defined as men and women aged 15 to 49. These estimates include all those with HIV infection, whether or not they have developed symptoms of AIDS.

AIDS data on December, 2002

AIDS cases in India	Cumulative
Males	32161
Females	10786
Total	42947

The statistics for AIDS cases may be a poor guide to the severity of the epidemic, as in many situations a patient will die without HIV having been diagnosed, and the cause of death attributed to an opportunistic infection, such as tuberculosis or PCP.

Transmission Categories	Number of cases	%
Sexual	36201	84.29
Perinatal	1119	2.61
Blood and blood products	1282	2.99
Injecting drug users	1232	2.87
Not known	3113	7.25
Total	42947	100

Age group	Male	Female	Total
0 - 14	1018	624	1642
15 - 29	10427	5011	15438
30-44	18132	4507	22639
=>45	2584	644	3228
Total	32161	10786	42947

State/Union Territory	AIDS cases
Andhra Pradesh	2350
Assam	149
Arunachal Pradesh	0
A & N Islands	24
Bihar	146
Chandigarh (UT)	650
Delhi	720
Daman & Diu	1
Dadra & Nagar Haveli	0

Goa	124
Gujarat	2029
Haryana	247
Himachal & Kashmir	2
Karnataka	1575
Kerala	267
Lakshadweep	0
Madhya Pradesh	941
Maharashtra	9106
Orissa	82
Nagaland	298
Manipur	1238
Mizoram	34
Meghalaya	8
Pondicherry	157
Punjab	227
Rajasthan	616
Sikkim	6
Tamil Nadu	18276
Tripura	5
Uttar Pradesh	804
West Bengal	930
Ahemdabad M C	267
Mumbai MC	1563

HIV estimates, 2001

The prevalence rates below are taken from data collected during screening of women attending antenatal clinics, meaning that these prevalence rates are only relevant to sexually active women.

State/Union Territory	HIV Prevalence (%)
Andhra Pardesh	1.50
Assam	0
Arunachal Pradesh	0
A & N Islands	0.16
Bihar	0.13
Chandigarh (UT)	0
Delhi	0.13
Daman & Diu	0.25
Dadra & Nagar Haveli	0.25
Goa	0.50
Gujarat	0.50
Haryana	0.51
Himachal Pradesh	0.13
Jammu & Kashmir	0.25
Jharkhand	0.08

Karnataka	1.13
Kerala	0.08
Lakshadweep	-
Madhya Pradesh	0.25
Maharashtra & Mumbai	1.75
Orissa	0.25
Nagaland	1.25
Manipur	1.75
Mizoram	0.33
Meghalaya	0
Pondicherry	0.25
Punjab	0.40
Rajasthan	0
Sikkim	0
Tamil nadu	1.13
Tripura	0.25
Uttar Pradesh	0
Uttaranchal	0
West Bengal	0.13

Some areas report an HIV prevalence rate of 0 in antenatal clinics. This does not necessarily mean that there is no HIV in the area, as some of them report the presence of the virus at STD clinics and amongst injecting drug users.

Sources:

UNAIDS Epidemiological factsheet, 2002 Update.

NACO HIV and AIDS Surveillance in India, 31/12/2002

D15-2Q.

27th March 2003

Attn:

Dr. Ravi Narayan
Coordinator
PHM Secretariat (Global)
Community Health Cell
Bangalore

Dear Dr. Ravi Narayan,

Sub: Study on Assessment of Mobility, Migration and HIV/AIDS Risk in India

Mobile and migrant groups are being increasingly recognized, as a vulnerable group in the context of HIV/AIDS infection. However, very little is known about their vulnerability and factors that contribute to their vulnerable status. Heterogeneity of the groups that migrate, variation in types of mobility and migration, and lack of appropriate definitions of migrant groups in the context of HIV/AIDS vulnerability further restricts the understanding of these groups.

The Social and Environmental Research Division (SERD) of Blackstone Market Facts is currently carrying out an Assessment of Mobility, Migration and HIV/AIDS risk in India. The study is supported by NACO, FHI and USAID. It aims to understand the various types and patterns of mobility and migration in India as well as the associated HIV/AIDS risk/vulnerability.

The first stage of the study is a desk research involving identifying and reviewing available information in the form of books, articles, reports of research studies and unpublished documents on Mobility, Migration, HIV/AIDS vulnerability and related topics in India. The objectives of this exercise are to understand existing pattern of mobility and migration (intra- and inter-district, and inter-state), identify sites (source, transit and destination to which people migrate), and estimate the volume of migration and mobility in Karnataka.

We are also in the process of organizing nine regional consultations across the country with local stakeholders and experts (government departments, research institutions, academic institutes, and NGOs, etc.). These meetings will give an opportunity to share information about the study with the local stakeholders and experts and learn from their experience, and consequently, provide specific information on typology of mobility and migration and establish HIV/AIDS of these vulnerable groups. The first regional consultation workshop was held on March 15 at Kolkata for West Bengal and Orissa. A similar regional consultation is planned to be held in Hyderabad for Karnataka and Andhra Pradesh, tentatively in the second week of April.

As a team member of this study and in charge of the Karnataka region, I have been in the process of collecting literature as well as information from various institutions and NGOs. I would be very

D18-20

Main Identity

From: "Geoff Heaviside" <gheaviside@rediffmail.com>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Saturday, May 31, 2003 1:02 AM
Subject: [AIDS-INDIA] Re: Response from the office of Karnataka Chief Minister

Dear Chief Minister,

In the 21st Century the wonders of electronic mail means that human rights issues become known to local, national and international members instantaneously.

Many lives have been saved when an email alert has activated messages to senior politicians or bureaucrats some of whom were not even aware that a problem was playing out in their country or ministerial area of responsibility.

The down side of such capability is that it is never clear just how many people will both read and respond on behalf of their brothers and sisters in trouble.

It is therefore unavoidable that target chief officers will find out very quickly when the cat is amongst the canaries. While this process will generate a significant once only hit, of hopefully enormous proportions depending on the seriousness of the alert, it usually is a once only email and doesn't go on and on from the same people.

The comfort that you can take from the deluge of single mails that arrived in your in-box would seem to me to indicate that Karntaka and the welfare of all of its people is very important to the local, interstate and wider global family.

That same support of course would be available to you and your government if you were to raise an alert concerning something that affected your government's capacity to care so please don't see it as an immature response. The facts were very clear. The correspondence from the Chief Medical Officer who, as a medical doctor presumably, was in fact issued to the agency and he or she like so many other doctors in India really need to attend some in-service training so they will not fan hysteria where there is no need for an hysteric reaction to occur.

I have to say that I was not one of the people who contacted your office but I have great pleasure in writing to you now from Melbourne, Australia but hopefully soon again in India and of course for some time, in Karntaka again.
It would be very empowering and encouraging if you could try to plan an official visit to the project in the OMBR layout. Your presence will bless the residents whose lives will probably end there and it will also dispel some of the fears of the people who live nearby.

Apart from forest dwelling brigands and pickpockets who work tourists over on the State Rail network Bangalore in particular was a highlight of my recent visit and I look forward to returning again quite soon.

Geoff Heaviside
SUNSHINE 3020 Victoria Australia
E-mail: <gheaviside@rediffmail.com>

Lib. AIDS India file

grateful if you could provide me with relevant information on this subject (in the form of data, reports – published/unpublished, articles, working papers, list or NGOs/organization working on migration and health, etc.) which would help us in identifying mobile and migrant groups and mobile and migration 'hotspots' in the state.

I would also be grateful if you could give me a time of your convenience for a meeting so that we could share more information on this aspect.

Thanking you,

With Regards

Dr. Meena Nair
Research Coordinator
Social and Environmental Research Division

Our address:
Blackstone Market Facts
No.25, II Floor, II Main, 7th Cross,
I Stage, Indira Nagar,
Bangalore – 560 038.
Tel: 5286452 / 5214898 / 5214899
Fax: 5286453
Mail id: meena@blackstonemarketfacts.com

Confirmation copy of email

715-2Q

Bella Mody

From: Bella Mody [mody@pilot.msu.edu]
Sent: Tuesday, June 24, 2003 12:42 PM
To: 'sochara@vsnl.com'
Subject: Gates Foundation Call for Proposals

Hullo Thelma: It is a long time since we met. You very kindly attended a meeting in April 2001 to educate me on what you and others in Bangalore were doing on HIV media campaigns when I was on sabbatical with Unicef in Delhi, I still have the posters you brought to show me what was happening.

I remember that I was a little more candid about NACO and Neelam Kapoor than was appropriate in front of Ashok Rau: my heart went into my stomach when you told me afterwards that my comments would go straight to Delhi through him. I noticed that he has been honored and rewarded amply by the GOI, and I suspect his org DOES do good stuff: yes?

I returned to Michigan and told an old family friend about you: Margaret Bansod and her husband Madhav/Michael worked with you and your husband at St John's Med College, she told me.

Is your Community Health Cell still active? Have you seen the Gates Foundation's call for letters of intent? Would you be interested in collaborating in some way: with my univ? with me? My web site address with publications etc. is below my address.

I am attaching a copy of the Call from their web site. The deadline for a brief Letter of Intent is end-July. I will be with my mother in Whitefield mid July to early August if we wanted to discuss a draft letter and meet to work out details.

I do hope we can work together. My best wishes.

Bella

Bella Mody, Ph.D.
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470
8/7 LB

6/26/2003

India AIDS Initiative

Background

With a population of over 1 billion, India has the second largest number of HIV positive persons in the world, currently estimated at around 4 million cases. Although HIV prevalence nationwide is relatively low (0.8%), given the size of the population and widespread poverty, India could face a much bigger epidemic. India has a very small window of opportunity within which to control the HIV/AIDS epidemic. A significant increase in prevalence will overwhelm India and it is therefore critically important to act promptly to keep the epidemic under control.

The epidemic in India is spread over vast and varied geographies and is being driven by small and highly mobile risk groups. The current response is fragmented and insufficient in scale. Public awareness is limited and there is a lack of resources for large HIV/AIDS programs. In addition, considerable stigma and discrimination present a real challenge to the fight against HIV/AIDS.

Initiative Description

The overall goal of the India AIDS Initiative (IAI) is to decrease HIV prevalence in high-risk groups and stabilize it in general population by 2008. The IAI pursues two objectives:

1. Reduction in HIV and Sexually Transmitted Infection (STI) transmission in select core populations in areas characterized by population mobility; and
2. Increased leadership and improved enabling and learning environment for effective HIV/STI prevention and care.

The initiative focuses on core transmitters, mobile populations and their partners. Prevention of HIV among mobile populations and their core-transmitter partners will have a highly efficient "multiplier" effect. Reduction in HIV/STI transmission in core populations will prevent a chain of HIV infection in other geographic areas nationwide. Because of denial, stigma and apathy, advocacy efforts will be critical at all levels (national, state, district) to build a supportive environment for IAI interventions.

The strategy consists of two core strategies and four inter-related and synergistic supporting strategies. Each strategy targets specific groups, and has a set of major activities, indicators and expected outcomes.

Core strategies:

District Focus, State impact (SI1)
Interventions will be implemented in approximately 100 districts of 6 high prevalence states (Andhra Pradesh, Tamil Nadu, Karnataka, Maharashtra, Manipur, and Nagaland) for female and male sex workers, their clients, injecting drug users, and bridge populations in high and potentially high prevalent districts. Interventions include implementation of a comprehensive integrated package of

services. Core interventions will consist of STI treatment, Behavior Change Communication (BCC), condom promotion, harm reduction. Additional interventions include Voluntary Counseling and Testing (VCT) services, care and support.

Protected Passages (SI2)
Interventions will be implemented along 7,000 kilometers of the major highways in India (NH1-9, North-South and East-West corridors). Target groups include inter-state truckers/helpers and highway-based commercial sex workers/partners. Core interventions include STI treatment, BCC, condom promotion, and VCT. Additional interventions consist of harm reduction, care and support.

Supporting strategies:

Integrated communication (SI3)
Design and implementation of a comprehensive communication strategy that will give individuals the knowledge, skills and motivation needed to reduce the risk of HIV/STI transmission.

Essential advocacy (SI4)
Design and implementation of advocacy strategies at all levels to support changes related to HIV/STI programming in policies, attitudes among key political, governmental, private sector, and societal leaders.

Knowledge building and impact monitoring (SI5)
Design and implementation of a research agenda for HIV/STI programming.

Raising capacity (SI6)
Design and implementation of a strategy to increase the quality and the quantity of organizations and individuals working in the field of HIV/AIDS through fellowships and other training programs.

Funding Opportunities

The foundation is currently seeking letters of inquiry (LOI) from outstanding international and Indian organizations interested in contributing to the India AIDS Initiative.

Read more ▶

India AIDS Initiative - Letter of Inquiry

Please follow these instructions carefully when submitting an LOI for the India AIDS Initiative. All organizations must submit an LOI using the form provided below. This includes organizations applying to the foundation for the first time, *as well as* those who are current or previous foundation grantees.

Prior to requesting funding, carefully review the description of the **India AIDS Initiative** to determine whether the proposed project falls within the initiative's scope and strategy.

Letter of Inquiry Guidelines

Only letters of inquiry will be reviewed in response to this solicitation. **Please do not submit a grant proposal in lieu of an LOI.**

For the current phase of the program, the foundation is requesting LOIs from organizations interested in implementing interventions for the District Focus, State Impact Initiative (SI 1) in the states of Tamil Nadu, Maharashtra, Manipur, and Nagaland. LOIs are also being solicited for the four supporting strategies: integrated communication; essential advocacy; knowledge building and impact monitoring; and capacity building.

Eligibility criteria

The foundation invites organizations that are **501(c)(3) public charities** or organizations registered with the **Indian Central Government under the Foreign Contribution (Regulation) Act (FCRA) 1976** to submit Letters of Inquiry (please see definitions below). These organizations should have prior experience in implementing large scale HIV prevention programs, have the capacity to provide technical support to local NGOs/CBOs and be able to demonstrate prior funding support from international donors. Organizations that are awarded grants as a result of this announcement will partner with local non-governmental organizations (NGO's) and community-based organizations (CBO's) through a separate process.

- **501(c)(3) Public Charity:** Your organization has a determination letter from the United States Internal Revenue Service that designates the organization as exempt from federal income tax under section 501(c)(3). The organization is further defined as a publicly supported organization under section 509(a)(1), 509(a)(2), or 509(a)(3).
- **FCRA:** Your organization is registered with the Indian Central Government in terms of section 6 of the Foreign Contribution (Regulation) Act 1976.

LOI Format

Please use the **LOI form** when submitting your LOI. Due to tax, legal, and reporting issues, we

require that all LOIs be submitted in English.
Download File

Submitting your LOI Form

Please submit your LOI electronically in the format provided. It is **not** necessary to mail a duplicate hard copy. Please do not send any additional attachments or information (videos, books, program materials, etc.)

Please submit LOIs to the India AIDS Initiative (**IAI@gatesfoundation.org**) no later than 5:00pm International Standard Time (IST) on **July 31, 2003**.

Review Process

The foundation will send an acknowledgement after receiving your LOI. Your LOI will be reviewed and a decision will be communicated to you in approximately six to eight weeks. If your LOI is accepted, you will be notified and invited by the program staff to submit a grant proposal. **A request for a proposal does not guarantee funding.**

If your LOI is declined, the reason will be shared in the response letter. Due to the extremely high volume of LOIs, it is not possible for staff to discuss declination reasons.

Review Criteria

Foundation staff will review all Letters of Inquiry. The LOI will serve as the basis for requesting a detailed grant proposal. Letters of Inquiry and grant proposals will be evaluated using the following criteria:

Significance: Does this project fit within the IAI's overall strategic framework and priority areas? If the aims of the project are achieved, what impact will the proposed work have on the HIV/AIDS situation in India? How will scientific or program implementation knowledge be advanced in India, as well as globally? What will the effect of this project be on the concepts or methods that drive this particular field?

Strategy: How does the project align with the priorities of the Bill & Melinda Gates Foundation's Global Health program, and specifically, the objectives of the India AIDS Initiative?

Approach: Are the project/research design, conceptual framework, methods, and analyses adequately developed and appropriate to the aims of the project? Do you acknowledge potential problem areas or issues that could hamper the success of the project?

Innovation: Does the project employ novel concepts, approaches, or methods? Are the aims original and innovative? Does the project challenge existing paradigms or develop new methodologies or technologies?

Potential for Affecting Change: Does the scope, scale and design of the project attempt to answer a critical question outlined in the India AIDS Initiative; offer stepwise improvements or a solution to a

problem; develop tools or knowledge that drive toward resolution of HIV/AIDS in India?

Budget: Is the budget narrative clear and complete? Are costs reasonable for the work described? Are salaries in line with other comparable positions in the field? Are indirect costs within foundation guidelines?

Organizational Strengths: What is your organization's comparative advantage in conducting the proposed work? What is organization's track record in managing large-scale programs, particularly in India?

Appropriateness for Independent Sector Funding: Can the funding for the proposed work be accessed through other public or private sector resources?

Bill & Melinda Gates Foundation
India AIDS Initiative
Date Submitted: mm/dd/2003

Letter of Inquiry – Summary Information

Project Name: _____

IAI Strategy Addressed: _____

Organization Name: _____

Primary Contact for LOI:

Prefix _____ *First Name* _____ *Surname* _____ *Suffix* _____
Title _____ *Telephone* _____
Address _____ *Fax* _____

_____

E-mail _____
Web site _____

Amount Requested (U.S. dollars): _____ **Project Duration (months):** _____

Does your project involve clinical trials with human subjects? _____

U.S. and India Tax Status *(Refer to Tax Status Definitions)*: _____

Geographic Location(s) of Project: _____

Charitable Purpose: *Please include the following components: disease or health condition; strategic approach; if appropriate, location of activity and limit to 255 characters.*

Example: to demonstrate an effective and transferable program model for the control of X-disease in Y-location.

Project Description *(describe how the funds would be used to meet the charitable purpose, limit to 150 words)*:

If relevant, please briefly describe any previous contact with the foundation:

Letter of Inquiry - Narrative

Please follow the outline below, limiting your narrative to **three pages or less**. Please use 12-point font and one-inch margins; include your organization's name and the page number in the footer; and include the submission date in the header.

- E-mail your completed document to IAI@gatesfoundation.org with IAI-LOI indicated in the subject line.
- Please delete all instructions before submitting your LOI.

I. Background and Rationale

Clearly articulate which strategy your project addresses. The IAI is currently seeking LOIs for all strategies, *except* for the Protected Passages.

Describe your approach to the problem. Describe how the proposed project relates to the broader context of the IAI, and discuss how the proposed solution will impact HIV/AIDS in India (i.e., cost, appropriateness, improvement of current technologies, etc.). Describe your sense of the limitations of the current programs. Provide a brief review of the antecedents to your project.

II. Goal and Objectives

Please describe the goal and expected health outcome(s) of the project. Describe the measurable objectives to be accomplished during the project period and explain how they will contribute to the overall achievement of the IAI's goal and expected health outcomes.

III. Project Design and Implementation Plan

Please describe the research/program design and major activities required to achieve the stated objectives. Specify the scope for the project (target groups), the geographic area(s) where the project will take place, and the time period within which it will be completed. Describe factors that could inhibit the success of the proposed activities and how these could be overcome. Explain how these activities will be sustained or transitioned to other sources of support at the end of the proposed project period.

IV. Monitoring and Evaluation

Comment on your plans for monitoring and identifying the specific outcomes and indicators that will be used to define progress and success during your project period. Describe evaluation plans clearly outlining baselines and targets for indicators.

V. Organizational Capacity

Please provide a brief description of the organization's history, mission, structure, and activities in developing countries, particularly in India. Describe the comparative advantage your organization brings to accomplishing these activities.

VI. Budget

Please provide a preliminary project budget by major activities and year. If appropriate, please indicate whether support (in-kind or financial) is being provided for this project by other organizations. Please provide all financial figures in U.S. dollars

DIS-2-Q.

News Update

[Under embargo until November 30th, 2002]

"When the history of our time is written, it will record the collective efforts of societies responding to a threat that has put in balance the future of whole generations." - Nelson Mandela, World Economic Forum, Davos, 1997.

Come December 1st and once again, we will observe World AIDS Day. Another year in a 20 years history of the epidemic that has spread like wildfire around the world. The day provides us with an opportunity to remind ourselves of the promises we've made promises to halt the epidemic and prevent new infections and care for those already affected it is a time to reflect on what we've managed to achieve, share our learning, rethink and rebuild out strategies to move forward with greater urgency and effectiveness.

Worldwide currently, there are an estimated 40 million people who are HIV positive. Five million were newly infected with HIV and three million people dies of AIDS this year alone. HIV/AIDS is among the top four killer diseases in the world today.

Developing countries have been the most vulnerable to this ranging epidemic. As per 2001 figures from the National AIDS Control Organisation (NACO) India alone has an estimated 3.97 million infected with HIV. With infections having doubled since 1997, the country is predicted to soon have the highest number of people with HIV anywhere in the world.

Due to a number of factors, most of the infections continue to remain undetected and unreported. In fact, HIV/AIDS initially thought to affect only "high - risk" population such as sex workers and truck drivers, has long since permeated the general population, with rapid increases in infection among young married women who have no risk factor other than, very simple being married.

The factors intensifying the country's vulnerability to HIV/AIDS are many; poverty, illiteracy and ignorance; the low status of women; the burgeoning numbers of sexually active youth in the 15 - 24 age group. We continue to be confronted by an overburdened, inadequate health system struggling to provide adequate care. Underlying all this is the social climate; social norms that discourage open, healthy discussion of sex and instead drive sexual activity into subterranean spaces characterized by misinformation or lack of information and risky, unsafe sex. Women and youth are especially vulnerable, given their limited access to health information and services and inability to negotiate safe sex to protect themselves.

TOP

The Karnataka Scenario

Within the country, Karnataka is one of the six "high-prevalence" generalized epidemic states together with Maharashtra, Tamil Nadu, Andhra Pradesh, Manipur and Nagaland. It is estimated that about 1.35 percent of the state's adult population or 400,000 people are HIV positive. The number reported are just the tip of the iceberg.

Lib - Karnataka AIDS file for 5/9

Risk Transmission Categories	India		Karnataka	
	No. of Cases	Percentage	No. of Cases	Percentage
Sexual	34323	84.32	1377	86.49
Perinatal Transmission	1052	2.58	56	3.52
Blood and Blood Products	1233	3.3	13	0.82
Injectable Drug Users	1217	2.99	14	0.88
History not available	2883	7.08	132	8.29
Total	40708	100	1592	100

Source : NACO website, KSAPS data, as on September 2002

A Detailed analysis of sentinel surveillance data in the year 2001 also reveals that ;

- Less than half the state's districts are covered by sentinel surveillance.
- There are geographic inconsistencies in HIV prevalence: some northern districts have high prevalence, others lower.
- High prevalence is seen in both rural and urban areas.
- HIV prevalence is higher among people who are
- Illiterate
- Migrants.
- HIV prevalence is higher among young pregnant rural women attending antenatal clinics than their urban counterparts.
- There is a higher prevalence among women whose husbands are in agricultural or unskilled occupations.
- Between 11-24 percent of STI patients (almost one is every four) are already infected with HIV

TOP

KSAPS : An Overview of Efforts

Under Phase 1 of the National AIDS Control Programme (1992 - 1998), a State AIDS Cell was formed under the Directorate of Health and Family Welfare in 1992. In 1997, this was established as the Karnataka State AIDS Prevention Society **(KSAPS).**

The Society's initial efforts, in line with the national mandate, focused more on general awareness to the community, establishing information systems for surveillance, blood safety, STI and condom programming apart from establishing system for program management.

However, in the second phase, the focus areas for the Society are:

- Targeted Interventions for high -risk groups through condom promotion, NGO participation and service for management of Sexually Transmitted Infections.
- Preventive Interventions for general population such as increasing awareness through information, education and communication (IEC), school AIDS education, Voluntary Counselling and Testing Centres and ensuring Blood Safety.
- Provision of low-cost HIV/AIDS care.
- Institutional strengthening through training, sentinel surveillance and computerized monitoring information systems.
- Intersectoral Collaboration.

A significant development has been the recent establishment of the India-Canada Collaborative HIV/AIDS Project (ICHAP) funded by the Canadian International Development Agency (CIDA). The Project, which is being implemented in Karnataka and Rajasthan, has been established to provide technical assistance at the national and state level to key areas of emphasis by the government such as:

- Communication including Media Advocacy and Communication to promote behaviour change.
- Management of Sexually Transmitted Infections.
- Focussed Interventions through NGOs for vulnerable populations.
- Voluntary Counseling and Testing.
- Care and Support.

In all of these areas, building the capacity of key stakeholders to implement HIV/AIDS prevention and care programs is a critical need, especially given that this is an issue with complex social, economic, medical ethical dimensions.

TOP

Some of our key achievements in the last one year included :

- Successful implementation of the Prevention of Material to Child Transmission (PMTCT) feasibility study. Vani Vilas Hospital has been selected as one of the 11 sites in the country of the PMTCT project. The project involves administration of AZT to pregnant positive women to reduce the risk of transmission to their unborn children.
- Completion of a community - based STI survey.
- Completion of a mapping study of high risk populations and geographical areas and development of strategic interventions based on this evidence.
- Launching a Legislators Forum by the Chief Minister to ensure that legislators are sensitized and advocate for HIV/AIDS prevention efforts.
- Upscaling of Voluntary Counseling and Testing Centres from 6 to 31, ensuring in the process that every district in the state now has a functioning VCTC with necessary infrastructure, testing kit and trained male and female counselors in place. What's equally noteworthy is that Karnataka is now probably the first state in the country to establish VCTC as the taluka level. Figures within the first month of inaugurating the centers in Mudhol and Jamkhandi (Bagalkot district, Northern Karnataka) indicate that almost 50 percent of the clients who were tested were diagnosed to be HIV positive - a grim reminder of the task that lies ahead.

TOP

Other significant activities planned for the immediate future are :

- Expanding sentinel surveillance for HIV (ANC) from 10 districts to 27 districts. This is part of our efforts to ensure strategic, evidence - based planning of programs.
- Instituting Press Fellowships for improving and increasing media coverage of HIV/ AIDS.
- Establishing PMTCT services at every **district.**

Much has been achieved - but a lot more needs to be done. For this, the government's efforts alone with not suffice. HIV/AIDS is not only a health problem but a wide - ranging development and social issue.

It is not possible to bring about requirement behaviour change without encouraging and facilitating a healthy discussion on sex and sexuality, condom promotion, and sex education for adolescents who constitute a significant proportion of the population. Continued silence on these issues will only bring us closer to some of the African countries where the life expectancy has decreased considerably due to HIV/AIDS

An expanded multisectoral response is critical if we are to stem the tide of the epidemic. This calls for a response within every sector : education, industry, media, women's rights/welfare, to name a few.

Corporates and industry must ensure HIV/AIDS education in the workplace, provision of necessary health services to employees, and prevent stigmatization and discrimination of infected employees. TV and film producers need to integrate HIV/AIDS issues into entertainment formats to change social norms and values that are fuelling the epidemic. The media will also have to debate issue relating to HIV/AIDS prevention and care and support to the infected and affected.

All Government departments and organizations in the private and NGO sector will have to integrate the HIV/AIDS education and awareness activities into their mandate until the State and the country is able to have some control over the epidemic. This epidemic demands the active and collective effort of all sections of the society.

We may yet be able to halt the epidemic and alter the course of history. We must act now.

Statement from the Project Director, KSAPS

December 1, 2002.

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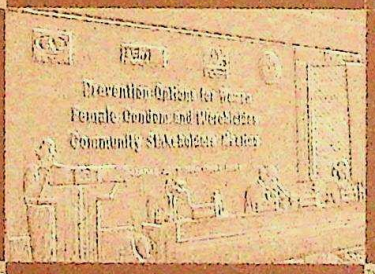
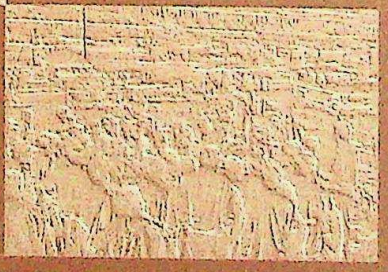
ISRCDE

Activity
2002 - 2003





GUJARAT AIDS AWARENESS AND PREVENTION UNIT Of ISRCDE

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Prologue

Greetings from GAP.

It has been an exhilarating, demanding and in somewhere depressing year.

Exhilarating, as because GAP has been exposed to external evaluation b officially and unofficially- but results are equally exciting. Mr. Aloysius James, appointed by CORDAID to carryout the external evaluation and his repo utterly inspiring.

Highlights has been the visits of two extraordinary connoisseurs of the subj Dr. Arvind Shinghal, who is a global expert on communication strategies on AI visited the centre and appreciated the IEC materials produced by GAP. indeed a great achievement of GAP. The second visitor of the year Dr. Anthony Klouda of Care International and working in the field since beginning of the epidemic. Dr. Anthony Klouda also conducted a worksho GAP and was extremely satisfied with the team work, understanding and cl about the issues and the diligence with which the group works.

GAP's experience as working partner with rural NGOs is unique and gave opportunity to understand the insight of the problem and found its role as Trai Institute. GAP endeavours to create and sustain partnership that lea development and better future for all.

As usual during the year lot of events happened but by far the most eventful e ,when GAP and Trained School Teachers together launched the advoc programme on the need of adolescents reproductive and sexual health educa in schools on 14th April,2002.

2002,Gujarat visualized one of its horrendous moment during the commu violence. This has shaken all of us and gave us the opportunity to question ab our responsibility towards society. As the premier institute in the field of HIV/AI we all understand that the problem of HIV should not be seen in isolation. It developmental problem and interrelated to social-cultural and economic sphe as well. Hence time has come now, to learn to respect and tolerate. GAP's fu plan of action incorporated the issues around communal harmony and toleran

We look forward to continue our work with you.

In unity,

Dr. Ms. Radium D Bhattacharya
Director
GAP-ISRCDE
May 2003

What GAP is and What GAP does:

GUJARAT AIDS AWARENESS & PREVENTION : (GAP), unit of International Society for Research on Civilization Diseases and on Environment, (ISRCDE). GAP - ISRCDE is a non governmental organization registered under Public Trust Act 1950 & Societies Registration Act 1860 F 1429, Ahmedabad

Our Mission

GAP is the lead non governmental organization for the people and other organizations in the field of HIV/AIDS and sexual health. It works to raise the information level and awareness of HIV/AIDS and sexual health, influence on attitude, opinion, policy, prevention and professional practices. It is a resource center for advise, information, advocacy and expertise. Collaborating with other organizations of India and abroad, GAP aims to create an understanding towards all those affected by HIV/AIDS.

Activities

GAP is Gujarat's first information dissemination center for the people who are concerned about the spread of HIV and AIDS and also those who are affected by HIV/AIDS. The center was opened in May 1989. It has been a basic tenet in all the UNIT's work that we aim for a holistic model of working in which strategy development, community work, material production, training and development and counselling and care are the major thrust areas.

Work is undertaken with a wide range of statutory agencies and voluntary and community groups in the city and outside city and GAP has links with many relevant organizations regionally, nationally and internationally.

GAP's interventions to mitigate HIV/AIDS are focused in the following directions:

- Focused intervention for behavioural change
- Preventing and treating Sexually Transmitted Diseases
- Providing an enabling environment and access to condom
- Strengthening the capacity of NGOs/CBOs
- Expanding care and support for People Living with HIV/AIDS
- Providing voluntary counselling and Testing
- Support to HIV positive pregnant woman and preventing transmission from mother to child
- Designing culturally acceptable and appropriate intervention materials (IEC)
- Networking & linking
- Advocacy
- Campaign
- Mass awareness Programme

Future Direction and Strategic planning

Dr. Anthony Klouda, Consultant, CARE International was invited to condu workshop for GAP to help in developing the strategic planning for future direc This was a four day workshop. Dr. Klouda highlighted the impact of HIV/A awareness programmes all over the world. He talked about what has b achieved and what is the degree of the achievement . Special attention drawn to the Ugandan results. Most important emerging issues from workshop were:

There is a definite behavioural pattern of the people in general, the spectru people - who would like to take risk in life and who will never take risk in life.

The importance of a support system existing within the community, who can in averting the adverse situation and help in supporting weaker people in fin the right ways in life

The workshop helped GAP in realizing the dynamics of HIV/AIDS and nece of revising the strategic planning accordingly.

GAP's achievement on production of IEC materials

Dr. Arvind Singhal and Everett M Rogers, are the joint writers of the b 'Combating AIDS : Communication strategies in Action.'. Both the authors h immense experience on communication strategies put into operation by diffe countries, NGOs and agencies. It was a moment of pride for GAP to rec Dr.Arvind Singhal, Ph.D. from the College of Communication - Ohio Universi the GAP office, thanks to The American Centre, Mumbai. Dr Sin appreciated the IEC materials produced by GAP and, also, its approach tow intervention programmes. It was tremendous pride for GAP to be appreciate Dr.Arvind Singhal.

Visit of Deputy Director, The American Centre (MUMBAI)

GAP received Ms. Anne E. Grimes, Deputy Director, The American Centre, also praised the work done by GAP and assured GAP that her office wi always there to help GAP carry out its very important work in the field of HIV/A

Social Marketing Condom

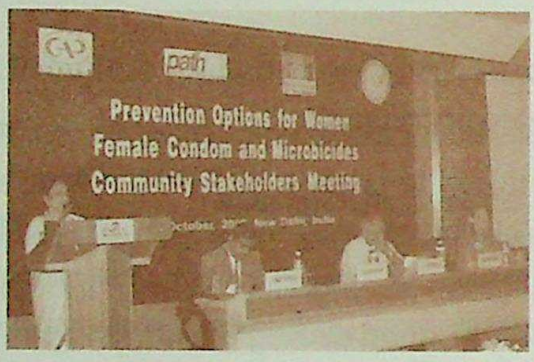
Mr. Andrew Piller, Director DKT India, visited GAP office and discussed the fu plan of action in respect to Social Marketing of condom in Gujarat. GAP has b identified as one of the partners in the social marketing of condom programm Gujarat

Reproductive and sexual health education *

Honorable Minister Smt. AnandibenPatel addressing the meeting

On 14th April 2002, a meeting was held to advocate the issues of sexual and reproductive health education for adolescents. The meeting was organized by GAP and was attended by more than 200 teachers trained by GAP, parents, students and academicians. Honourable Minister for Education, Smt. Anandiben Patel inaugurated the meeting and Commissioner of Education delivered the valedictory address. A joint recommendation was handed over to Ministry of Education.

Advocacy on Dual Protection for women *



Prevention Option for Women Female Condom and Microbicides

An advocacy meeting, at a national level, was jointly organized by GAP, Indian Network of NGOs on HIV/AIDS (INN)-Path India and Global Microbicides campaign in New Delhi- which was attended by eminent activists NGOs/CBOs, researchers on microbicides, female condom companies and international agencies. The meeting was addressed by Dr. Minakshi Dutta Ghosh, Project Director - NACO, Mr. J V R Prasada Rao, Secretary Health and Family Welfare, Government of India, Dr.David Miller, India Country Representative UNAIDS.

GAP's response to communal violence : a visit by Kolkata based media team

Youth response of communal riot in Gujarat : Intervention with Kolkata Media

GAP organized a meeting on the request of Kolkata based journalists and community leaders with the adolescence and youth of riot affected areas of Ahmedabad. The objective of the meeting was to understand the impact of violence on youth, both socially and emotionally and their perception for the future relationship amongst different communities they live with. The most shocking experience from the meeting shows, that, there is a drift in the relationship between the different members of the community and this might have a long term effect on the relationship. This meeting surely influenced GAP to include the issue of social cohesion and communal harmony in all future project planning.

External Evaluation by Cordaid

GAP evaluation Workshop Conducted by Mr. Aloysius James of Partners Andhra Pradesh

Mr Aloysius James of Partners, Andh Pradesh, carried out the extern evaluation for GAP. His conclusiv remarks are, "The evaluation proces throws a lot of challenges to GA However to GAP's advantage, it has committed and skilled team, who cou adapt and change its activities ar approach based on the emerging situation and need. The skills and expertis available in GAP can make a lot of difference to the lives of HIV/AIDS infected ar affected people."

Positive dynamics in PWHA Life style and GAP's Contribution

Care and Lifestyle workshop

Care and Life Style Workshop

Facilitators : Mr. Eldred Tellis, Sankal Mumbai and Mr. Luke Sampson, Shara New Delhi

Participants : GAP field officer counsellors and PWHA volunteers ar peer educators

The objective of the workshop was to equip the participants to understand th philosophy of Continuum of care and to preparing a module for GAP in th direction. The workshop included the different components of care, continuum care, home remedies, including nutritional needs and positive life style. Durin the workshop it has been realized that GAP has already enormous resources o Home Remedies and the facilitators requested GAP to compile these resource and come out with a book. GAP is working on the same.

Workshop on Bereavement and Multiple Loss

Facilitator: Ms. Anna Demetrakopolis, Ontario Bereavement Foundatio Canada

The entire GAP team participated in the workshop including the PLWH volunteers and peer educators.

The objective of the workshop was to look at the need for providing support those who are facing multiple loss and death and are facing stress and a burn o situation.

Workshop on Bereavement and Multiple Loss

Though the workshop was very heavy with its content, the methodology adopted by the facilitator made things easy and supportive to learn. The content of the workshop was

(1) Sociometric (2) Theoretical grief cone (3) Grief journey (4) Sustaining grief (5) Coping styles and startegies.

The workshop has been very important for GAP staff to prepare themselves to face multiple loss in their working field.

PLWHA monthly club

Participant of the PLWHA in house Skills Development Training Workshop

During the year, 14 meetings were held where 94 PWHA participated. There were 29 male members, 50 female members and 15 children, who came with their parents. The main objective of such meetings is to expose the people to their peers, prepare an enabling environment to open up and discuss the problems and needs, and finally to take the decision to live positively and change the life style. These meetings have a very profound impact on the participants. They go back with a positive approach towards life.

Face to Face: Video documentation *

Face to Face

The monthly meetings prepare the participants to appear in front of people and talk about their life's experience so that others can understand their situation. Un-edited video versions of dialogue with the PWHA are available with GAP, which can be used for advocacy and educational programmes to bring awareness amongst the people and remove stigma and discrimination.

Medical consultation camps

Specialist in the field of HIV/AIDS treatment, are visiting GAP center every month and extend consultancy service to the patients. GAP organizes such visits of the patients who can get consultation free of cost. During the year 10 such camps were organized and a total of 51 new patients took the advantage, of getting free consultation.

Clinical Tests, ELISA Test and CD4 count

Through a liaison with pathology laboratories, established by GAP, tests a done at concessional rates for the patients who cannot afford to pay the amou The CD4 cell counts are mostly recommended by the visiting consulta physician who desires to prescribe ARV after the checking the count result.

School Fees

GAP pays the school fees for three affected children who have lost their father.

Early detection gives quality life

Advocacy & campaign

GAP continuesis its advocacy and campaign with the general practitioner blood banks d pathology laboratories of Ahmedabad city. The objective is to brin the current information on HIV/AIDS, understanding the HIV/AIDS prevale situation in different city areas and advocating the medical fraternity to accept th services available to GAP for their patients. During the year 488 medic practitioners are being contacted by outreach social workers, 7 new patholo laboratories reached and 12 blood banks have been visited.

Voluntary Counselling and Testing (VCT)

Voluntary counselling and testing is one of the most important components prevention and care.GAP launched this service in response to the growi awareness and a subsequent need was perceived.

During the year, 24 VCT camps have been organized in the GAP Clinic. 1 volunteers visited the camps and each one of them had been given pre and po test counselling.

Focused Intervention for Behavioural change

In the Focused Intervention (FI) programme, the components taken up are:-

(1) Dissemination of information on STD / HIV / AIDS

(2) Syndromic detection of STIs / STDs and their treatment

(3) Partner counselling

(4) Condom distribution

(5) Establishing an enabling environment and reaching to the outreach through Peer educators (P.E.)

Men's Responsibility on prevention and control of HIV/AIDS

Men's Responsibility on prevention and control of HIV / AIDS

Through this programme, GAP tried to reach to male population of the city. The major thrust is on Highway No.8. The area covered is around 20 kms. During the year GAP reached 5484 men. Through an enabling environment and with 35 peer educators, 203120 condoms have been distributed.

Intervention with migrant ad unorganized worker

Mass Awerness Programme: Street Corner Meeting

GAP is working with unorganised labour group in different areas in Ahmedabad city. During the year GAP outreach workers contacted 2594 workers, distributed 3792 reading materials and 2648 condoms.

Window of Hope

Inculcate responsible behaviour in adolescents

Adolescent Participation in Reproductive & Sexual Health Education

Class room intervention to inculcate responsible behaviour amongst adolescent boys and girls, is one of GAP's most important programme. During the year, GAP completed the intervention in 8 Ahmedabad district schools. The number of students reached in these schools are 925. The schools covered during this year are from low socioeconomic strata and 90% parents are daily wagers. The details about the classroom intervention programme can be obtained from GAP office.

Mile Stone

1989

Safer blood supply to the communityThis is the project stared by GAP in 1989 and the focused group was Commercial Blood Donors (CBD) who use to sell their blood for livelihood. Today, in Ahmedabad, this trade is almost non-existing, thus increasing the participation of voluntary blood donors of the city for safer blood supply to the community.

Mile Stone

1990

GAP was formed as a special wing of International Society for Research on Civilization Diseases and on Environment to tackle the just emerged AIDS problem.

Mile Stone

1992

Psychosocial support: Core group of trained counsellors developed and counselling remains as one of the most important element in the prevention and control of HIV/AIDS.

Mile Stone

1993

Focused Intervention: Several programmes were launched with focused attention on groups like Truck drivers, Migrant labour, Unorganised labour, CSW and Jail Inhabitants.

Mile Stone

1994

Anamika Drop -in centre: This is the counselling centre where confidentiality is the key word. The center works for those who would like to have counselling without disclosing their name and address PLWHA groups formed.

Outside school system

Red Ribbon Campaign Participation of Adolescent

GAP concentrated its work with the scho dropouts, during the year 2002-2003, different slum areas of Ahmedabad. A extensive survey had been carried out understand the actual situation in the slu areas in respect to the lifestyle of youth, th number of dropouts, their knowledge abo HIV/AIDS and STDs. The main observatio recorded show that, level of education among girls is very poor and a gende based approach is very much predominant, girls are also employed in sm business and sexual exploitation is quite high. Attitude of parents towar education for girls is quite negative and early marriage is common. Scho dropout boys are loitering in the community, engaged in gambling, are not mu interested in learning something new or to apply themselves. Boys surely g more privileges than their siblings - which manifests strong gender biases in t community. These are some very common observations from different slu areas covered in this study.

Gujarat Villages are awakening : GAP's programme through 24 partner NGOs in 8 districts covering 256 villages

Reaching to village folk-from the temple courtyard with HIV / AIDS prevention messages

GAP worked with 24 different NGOs from districts of Gujarat to bring the awarene programme and focused interventions in ru Gujarat. The NGOs were selected by adopti criteria for selection and then facilitated wi capacity building work shops. In partnersh with GAP, these NGOs have carried o awareness programmes with different target audience.

The intervention components were
(1) Information dissemination (2) Syndromic detection of STIs/STDs, treatme and counselling (3) Condom promotion (4) Selection and training of pe educators.

e Stone
1994
Network of working on GAP took vee to launch brought the ewent in the control and counselling olf HIV/AIDS

Mile Stone
1995
Youth and Adolescents: To inculcate responsible behaviour amongst the future generation, the project was launched within the school system, with school drop-outs in urban slum areas.

Mile Stone
1997
Gay men's programme and MSM programme: To reach the outreach through the peers and peer educators.

Mile Stone
1999
Reaching to village population through Capacity building: Thousands of villages of Gujarat have been reached with the awareness programme through the partner NGOs of GAP whose capacity building to tackle HIV/AIDS programme was facilitated by GAP.

Mile Stone
2000 Advocacy
Millennium turn: Strengthening movements towards advocacy on Access to ARV-Human Rights-Reproductive and sexual health-Dual Protection for women-legal and ethical issues around HIV/AIDS

Mile Sto
2003
Building on the learned throu years and forward fo directio approaches.....

Women participation

Focused Intervention: Diamond Polishing Factory

The work had been carried out with Diamond Polishers, Fishermen, Mahila Mandals

The impact of the programme on village community are as follows:

- There is greater awareness among the target group, specially the young men and women
- Increased demand of Condom
- Openness developed through enabling environment and clear confession about the risk habit
- Earlier people were reluctant to take medical treatment for STDs. Now the medical practitioners and the NGOs admit that many of them are approaching for medical advice and treatment, and this is obviously a very positive development
- Many youth approach the peer educators and health workers for advice and counseling - which is an indication of their motivation as well as being conscious towards health issues.
- In the villages people started demanding disposable syringes and needles at the government hospitals and new blades at the barbers shop.
- Many HIV/AIDS cases have been identified.
- The outreach groups formed their own forum.

Review meeting with Partner NGOs: Future need and Responsibilities

The final review meeting with the partner NGOs held in Ahmedabad. The objective of the meeting was to understand the attitude and need of the Partner NGOs in respect to the programme carried out at 8 different districts of Gujarat with varied target audiences. The meeting started with the presentation of Dr. Singhal, the eminent global communication expert on his global experience of HIV/AIDS. He emphasized that if you want to achieve something, you have to SHOUT for it, only by making noise, your purpose will not be served. And, only when the NGOs get together, they will be able to make the SHOUT audible.

The following important points emerged from the review meeting and the needs felt were:

(1) It is necessary to expand the intervention work from district to village leve

(2) Government should show a more pro-active attitude towards NGOs.

(3) Extensive training programmes should be launched

(4) Research is needed to understand the local situation

(5) Availability and accessibility to condom and STD treatment should b enhanced.

Capacity Building of Organizations and Institutes: Training Programmes

Communication skills development programme for NGOs / CBOs

After extending training to 32 NGOs of rural Gujarat and successfu implementation of the project by 24 NGOs, there is a great demand from th NGOs to impart training for their social workers, on communication skills an information dissemination skills on HIV/AIDS. In response to the demand, GA invited 20 participants from 18 NGOs for a 4 day workshop. The NGOs got fu benefit of the workshop and the evaluation reveals that 100% recognized tha condom is for the prevention of HIV and STDs. An attitudinal change was see where 94% said that PLWHA should not be isolated. It was also recognized b NGO representatives that young people should know about HIV/AIDS and STDs

Training workshop for All Gujarat Jail staff at Sabarmati Jail

During the year's period, GAP has conducted 4 workshops to enrich the jail sta with the information and knowledge on HIV/AIDS, their role and attitude toward the prisoners. 87 staff members from all the jails of Gujarat took part in thes workshop.

Capacity building on counselling skills for B.M.Institute students

B.M.Institute is one of the prestigious institutes where special training has bee extended on different counselling skills. For last 3 years, GAP has been identifie to extend Counselling skills development training to the students of B.M.Institut on HIV/AIDS. This year 7 students attended a 4 day workshop.

Basic Counselling skills development training for Partner NGOs

While working in the field the partner NGOs of GAP realized the importance c counselling and the need for skill development for counseling, as they hav started encountering the HIV infected and affected people in their geographica area.

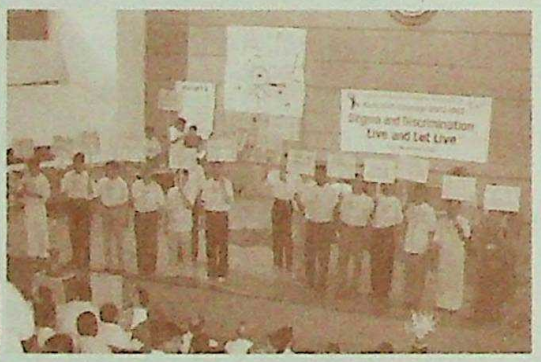
The workshop helped them in developing self confidence to cope up with the situation for the moment, though they realized that further training is needed and this is the need of the day.

World AIDS Day : 2002

World AIDS Day 2002
Live and Let Live

Stigma and Discrimination, under the slogan LIVE & LET LIVE, has been chosen as the theme for the World AIDS Day Campaign in 2002-2003 by UNAIDS.

GAP and its 24 NGO partners, school partners jointly observed World AIDS Day on 30th November 2002 in Ahmedabad. Dr. R. B. Deshmukh, Project Director, GSACS presided over the programme. A healthy and peace loving society can be established by balancing equity and harmony. The presence of leaders from different communities, Muslim, Christian, Brahamakumari and Swaminarayan sects, set the tune for a harmonious society and to demonstrate respect for each other.



World AIDS Day 2002
Live and Let Live

20 people living with HIV/AIDS, men, women and children marched on the stage, bringing out very clearly the theme LIVE and LET LIVE, with slogans giving messages to do away with discrimination, emphasizing the need for respecting their rights for care and dignity in the society. 3 posters prepared by GAP on the theme on WAD campaign were released on this occasion.

Stigma and Discrimination: All religion Participation

Stigma and discrimination can be eliminated from society only through a successful awareness programme which was demonstrated by children of the community through different skills, drama, puppet show and by using various other communication media.

Participation in International / National and Local conferences, workshops:

- Window of Hope The need for reproductive and sexual health education for adolescents *Seminar, Mahatma Gandhi Labour Institute, Ahmedabad, April 2002*

- Advocacy for Microbicides and female condom: Facilitation at skill building workshops *Microbicides 2002, Antwerp, Belgium, XIV International AIDS Conference, Barcelona, July 2002*
- Mobilizing the Community Based Organization in Rural Gujarat and their Capacity Building, *XIV International AIDS Conference, Barcelona, July 2002*
- Community Managed Organization (CMO) and Sustainability of the Project, *XIV International AIDS Conference, Barcelona, July 2002*
- Introduction to GAP's activities : Sabarkantha District Medical Association, *Shyamalaji, October 2002*

Dr. Radium D. Bhattachrya, HIV/AIDS Education and Implications for Policy Advocacy *National Workshop on Policy Advocacy,* at *Goa*

- 'Working with Teenagers' Workshop attended organized by *Sangath Reach, Goa, October 2002*
- Prevention options for women: Female condom and Microbicides, *India Habitat Centre, New Delhi, October 2002*
- Organizational Working and the Role of Networking, *Indian Institute of Health Management & Research (IIHMR), Jaipur, October 2002*
- Strategic Planning for Social Marketing of Condom in Gujarat state, Meeting organized by DKT India, November 2002
- HIV/AIDS Education and Implications for Policy Advocacy *National Workshop on Policy Advocacy, Goa, February 2003*
- Presidential Address at the *VII National Convention of Indian Network of NGOs on HIV/AIDS (INN), Madurai, February 2003*
- Advocacy for Access to Treatment and ART *VII National Convention of Indian Network of NGOs on HIV / AIDS (INN), Madurai, February 2003*
- The INN Booth Experiences at the NGO Exhibition Centre- XIV International AIDS Conference, Barcelona A Report - *VII National Convention of Indian Network of NGOs on HIV/AIDS (INN), Madurai, February 2003.*

Exhibition - Melas etc

Tarnetar Mela, 2002

XIV International AIDS Conference, Barcelona, NGO booth at Exhibition Centre, Barcelona, July, 2002

Tarnetar Fair (South Gujarat) September, 2002

Rupal (District -Gandhinagar) religious festival. "Rupal Palli" Mela, October 2003

GAP takes part in Exhibitions & Fairs to reach more people with knowledge & Information

Exhibition organized by The American Centre, - Prince of Wales Museum, Mumbai December 1st and 2nd, 2002

Exhibtion and Awareness program : NSS Camp for students of Mahila Grambharti Vidyapith, Nardipur at Shankarpura, Dist Mehsana, January, 2003

Publications : 2002

This years publications includes

(1) A set of 3 Posters and one calendar on the theme Live and Let Live

(2) Video Interviews of PWHA : Face to Face available in CD

(3) GAP's response to HIV/AIDS 1989-2002, compilation of work done by GAP. (Available both in print and on CD)

(4) A compilation of 2000 articles on behavioural science and HIV/AIDS/STDs on CD. This is a work of Dr. Anthony Klouda, CARE International, USA. GAP has been given the authority to distribute the CD.

Staff Members

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Senior Project Coordinator
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Project Coordinators
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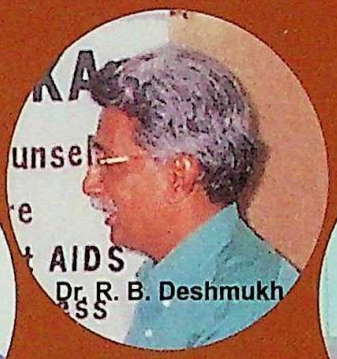
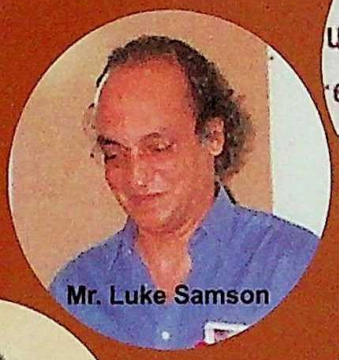
- Department of International Funding (DFID -UK), India
- British Deputy High Commission Office, Mumbai
- Dr. Steve Kerkez Foundation, United Kingdom
- UNICEF, Gandhinagar
- Swiss Youth Fund, Switzerland
- Health and Environment Public Charitable Trust, India
- Shri Mahesh Bhogilal Memorial Charitable Trust, India
- Shri Gijubhai Shukla Charitable Trust, India
- Government of Gujarat

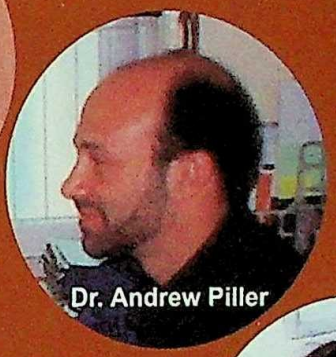
and many individuals from India and abroad

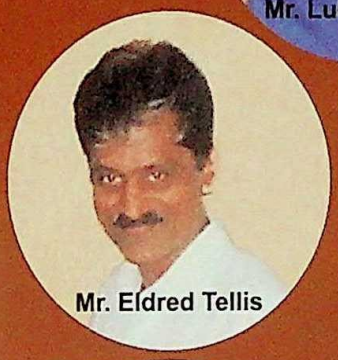
The asterik(*) marked project reports in print copy / CDs are available on request

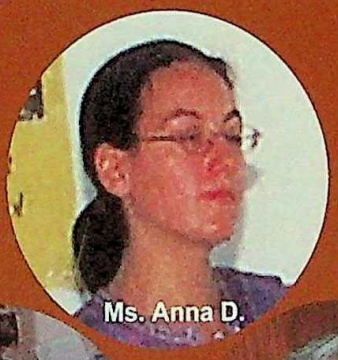
Our visitors in 2002


Dr. R. B. Deshmukh


Mr. Luke Samson


Dr. Andrew Piller


Mr. Eldred Tellis


Ms. Anna D.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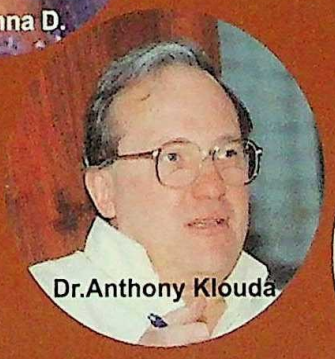
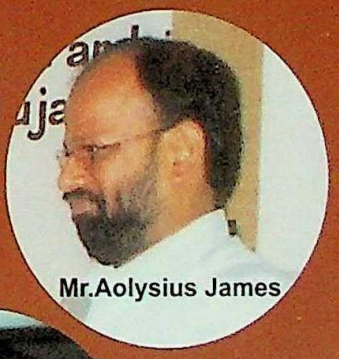
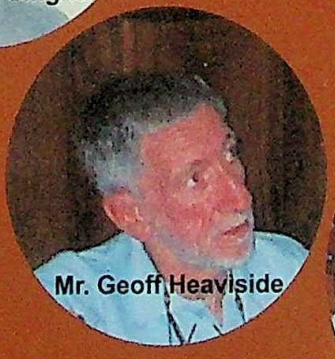
Mr. Arvind Singhal


Ms. Arundhati Char


Dr.Anthony Klouda


Mr.Aolysius James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DIS-2Q.

Community Health Cell

From: "tnvha" <tnvha@eth.net>
To: "tnvha@md2" <tnvha@md2.vsnl.net.in>
Sent: Wednesday, June 09, 2004 5:29 PM
Subject: NACO AIDS Statistics

TAMIL NADU VOLUNTARY HEALTH ASSOCIATION

18, Appadurai Main Street, Ayanavaram, Chennai - 600 023
Ph : 044-26450462 / 26479585 Fax : 044-26601829
Eamil : tnvha@eth.net / tnvha@md2.vsnl.net.in
Website : www.tnvha.org

Health Through People

DM
10/6

Surveillance for AIDS Cases in India

(as reported to NACO as on 30th April 2004)

AIDS CASES IN INDIA	Cumulative	This Month
MALES	50900	558
FEMALES	18659	192
Total	**69559**	**750**

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RISK/TRANSMISSION CATEGORIES		
	No. of cases	Percentage
Sexual	60006	86.27
Perinatal transmission	1964	2.82
Blood and blood products	1687	2.43
injectabie Drug Users	1389	2.00
5History not available	4511	6.49
Total:	**69559**	**100.00**

Age group	Male	Female	Total
0 - 14 yrs	1619	1025	2644
15 - 29 yrs.	15178	8485	23663
30 - 44 yrs	30234	8186	38420
> 45 yrs.	3869	963	4832
Total	**50900**	**18659**	**69559**

S. No.	State/UT	AIDS Cases
1	Andhra Pradesh	7198
2	Assam	171
3	Arunachal Pradesh	0
4	A & N Islands	33
5	Bihar	155
6	Chandigarh (UT)	861
7	Delhi	894
8	Daman & Diu	1
9	Dadra & Nagar Haveli	0

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11	Gujarat	4233
12	Haryana	350
13	Himachal Pradesh	149
14	Jammu & Kashmir	2
15	Karnataka	1945
16	Kerala	267
17	Lakshadweep	0
18	Madhya Pradesh	1131
19	Maharashtra	11726
20	Orissa	128
21	Nagaland	417
22	Manipur	1238
23	Mizoram	52
24	Meghalaya	8
25	Pondicherry	302
26	Punjab	261
27	Rajasthan	978
28	Sikkim	8
29	Tamilnadu	29782
30	Tripura	5
31	Uttar Pradesh	1307
32	West Bengal	930
33	A.bad Mun.Corp.	267
34	Mumbai M.C	4342
	Total:	**69559**

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6/10/04

DIS-28

AMTC Response on Programme Implementation Guidelines for a Phased Scale up of Access to Antiretroviral Therapy (ART) for People Living with HIV/AIDS (PLHA)

The Affordable Medicines and Treatment Campaign (AMTC) is a national campaign launched on World AIDS Day 2001 in different parts of India, with the following mission statement: ***The right to life and health is a fundamental right guaranteed to every person living in India and is non-negotiable. This campaign aims to demand and create an environment that will ensure sustained accessibility and affordability of medicines and treatment for every individual in India, including access to affordable Anti-Retroviral Therapy for persons living with HIV/AIDS. This campaign shall be democratic and participatory. It will seek the mobilization of communities and civil society to make state, national and international agencies and industry accountable for securing health for all.***

A recent development of significance has been the announcement made by Sushma Swaraj on the eve of World AIDS Day last year, of the government's intention to finally provide ART through the national AIDS control program from 1st April 2004. We are happy that through this plan, the Government and NACO have positively responded to [and accepted] one of the long-standing demands of networks of people living with HIV/AIDS, a range of activist voices, of advocacy efforts by a range of groups and campaigns such as the AMTC. This is the recognition that the HIV/AIDS epidemic has indeed impacted a large number of people in India, many of whom are in urgent need of treatment that they cannot afford. It is also a recognition that such treatment can actually be provided. Further, it is a recognition that India has a relative advantage, having a vibrant generic drug industry, an advantage that has not thus far been used to its full potential. Most significantly, it is an attempt to re-constitute HIV as a treatable condition and thus, to reduce the stigma and fear that surround it, to encourage more voluntary testing and thus to bring about the normalisation of HIV/AIDS.

The document titled "Programme Implementation Guidelines for a Phased Scale up of Access to Antiretroviral Therapy (ART) for People Living with HIV/AIDS (PLHA)"shows a paradigm shift from a prevention focus to an approach where the synergies between care/support and prevention are be put in action. While we eagerly await the realization of the objectives of the program, we have some concerns related to the manner in which the program is envisaged and suggestions to improve the concept and implementation of the ART rollout.

The mass provision of ART is a complex process, which can backfire seriously if not carried out properly. Sustainability and context sensitivity of such a program is of prime importance. The risk of resistance to the drugs is high and, as has been seen with the experience of the development of MDR TB, a careless program could lead to a more complicated epidemic. Similarly, the high level of toxicity and experiences of severe side effects make it necessary that the mass provision of ART be a part of a more comprehensive program for the provision of care and support. Further, the impending changes to patent laws could soon drastically reduce the government's ability to actually procure these drugs [and new line regimens] at affordable rates. As such, the program itself needs to be one that is based on the experiences in and of the public health system.

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the experiences of people providing and receiving ART in the Indian context, and retaining as the base, a human rights approach to public health strategy.

Although feedback from civil society, on the rollout plan, has not yet been solicited by the government, the AMTC is here presenting a preliminary response to it. The following points have been articulated by members of the campaign and other friends, over email and through brief discussions. As stated earlier these comments are intended to be taken in the spirit of constructive suggestions.

Main points of concern:

Strategy to bring about an enabling environment – The inherent logic of the program is that the provision of treatment will contribute towards the creation of an enabling environment, whereby people have an incentive to voluntarily access testing facilities and health care services. This establishes the relationship between care/support and prevention. While such recognition is positive, there remains some ambiguity in the document, where it refers to the 'identification' and 'tracking' of people who may test positive. There is no doubt that in order to receive treatment, people must first recognize themselves as needing it. This implies large increases in testing and access to healthcare services. The question here is, how is this increased testing envisaged? In this regard, the plan identifies certain 'entry points' for ART, including STD clinics, PPTCT centers, Blood Banks, TB DOTS centers and government hospitals. The ambiguity in the document lends space for mandatory screening of all those who access these services. This may have the undesired impact of actually decreasing access to these services, despite the promise of treatment for those who need it. The present minimal amount of voluntary testing is indeed more complicated – stigma around HIV/AIDS, in other words, is brought about by more factors than the inaccessibility of treatment.

The document needs to clearly recognize the difference between creating an enabling environment where people are encouraged to use the services of VCCTCs and tracking down people for the purposes of providing treatment. The NACP identifies itself as being based on a 'human rights approach'. This should include addressing concerns such as the need for informed consent, confidentiality and non-discrimination. The commitment to these principles needs to be clearly stated. At the outset, it needs to be made clear that a promise of treatment does not amount to a justification for doing away with adherence to human rights.

Maintaining confidentiality – scaling up of ART requires a careful consideration of how confidentiality will be maintained. This is more so when considering the mandate of enabling adherence to the treatment. While the document does contain a minimal reference to the need for maintaining confidentiality, there is no clear conceptualization of protocols and systems through which confidentiality will be ensured. However, the document talks about providing identity card to persons on ART. This again, would impact the efficacy of the program. Hence, we feel that confidentiality norm shoul not be compromised at any stage of the treatment.

Funding and Sustainability - ART is not a one-off treatment but is meant to continue for life. Interruption of the therapy has been seen to significantly raise the risk of resistance to the drugs and a drastic decline in health. In this context, sustainability of the treatment

program is of central importance. As of now, there is no reference in the plan to the budget which has been allocated for purchase of ARVs, the estimated price of purchase, how much money has been set aside, from what source, to buy medications at what price, and from whom. Without this information what we basically have is a training manual for ARV scaling up without an assurance of sustainability.

Some estimates place the expected cost for the treatment plan as Rs 500 Crore per annum. Of the GFATM commitment of USD 140 million (Rs 700 Crore), *spread over a period of 5 years*, only USD 100.08 million (Rs 500.40 Crore) is for HIV/AIDS. Additionally, this commitment is geared towards ART programs being run by NGOs. It is not clear whether the government plan is dependent on resources from the GFATM. At the same time, the government does not seem to have moved the Planning Commission or included the cost of the program in its interim budget. As such, there is no hint of where the resources for the program are expected to come from.

The document recognizes that India has an established 'domestic drug manufacturing base' but fails to recognise that this relative advantage may not survive much longer if strategies such as pushing for a TRIPS review, and building the capacity of public sector industry to provide drugs are not simultaneously considered.

Procurement – there is no clarity on the plan for procurement of drugs, facilities and services that have been mentioned in the plan. The only mention is that the procurement will be done by NACO based on estimates provided by SACS. The constant reference to 'public – private partnerships', seen in conjunction with the impending amendments to the Indian Patent Act, which will seriously harm the generic drug industry implies that the government may soon be in a position where it will be held at ransom by the multinational pharmaceutical industry and have to depend on charity of the drug industry. Further, there is no mention of mechanisms to ensure transparency of the process of procurement, a concern that needs to be addressed at the inception of the program itself.

Who will get the treatment? The plan document does not specify how many people will be given treatment when. It refers to providing treatment for 100,000 "starting on April 1st, 2004". The actual extent to which the rollout plan will address treatment needs in the epidemic right now is ambiguous. It is interesting to note here that the evaluation of number of people who need ART is to be carried out by SACS, and that the deadline is very short.

At present the government plan limits the coverage of the program by identifying certain categories of people as beneficiaries. At present, the only beneficiaries identified are (i) sero-positive mothers who have participated in the PPTCT programme; (ii) seropositive children below the age of 15 years; and (iii) people with AIDS who seek treatment in government hospitals. It is important to know, but to difficult to estimate, how many individuals such a scheme would cover. We estimated that the number of pregnant women who would be covered with this new scheme. Assumptions were drawn from National Sample Survey (NSS) 52nd round, National Family Health Survey 2 and NACO on the following parameters: estimated number of women in age group 15-49 percent that seek antenatal care, percent that visit government facilitates and estimate of HIV prevalence among ANC attendees (assumed 1 percent prevalence). Based on these assumptions, it was estimated that about 55, 000 pregnant mothers who were HIV

positive would seek care in government facilities. Of these about 8,000 pregnant HIV positive women would be ART eligible in a year, and the target for the new policy. NSS and other statistics indicates that a much lower percent of all those who seek care about 18 percent seek care in public facilities for their illnesses. If we take the population who are ART eligible (7,50,000) then about 1,35,000 individuals would be accessing public health facilities. This of course includes the pregnant mothers as well. Even if we add all the pregnant mothers here, we get 143000 individuals who will be covered by the new programme. Adding 13, 000 who are already being covered currently, we arrive at 1, 56, 000 individuals who are going to be covered by ART. This still leaves a gap of about 600000 individuals who are not covered by ART.

Further, a miniscule number of women living with HIV/AIDS have access to the PPTCT program, many may not participate for a range of complex reasons, and of those who do participate, not all are in need of ART. Similarly, there is no explanation why only those who seek treatment in government hospitals will be provided treatment, considering the high rates of discrimination and refusal of treatment in the public sector in many parts of the country. The problematic presumption here is that the public health care system is already a functional site for treatment of PLWHA, one which is repeatedly disproved by real life experiences. Third, the document does link up with the indicators for ART as identified in the (draft) guidelines on ART published recently by NACO. These guidelines lay out in detail the government's own prescription for when and in what conditions ART is to be started. In the presence of these guidelines, the reasons for using other indicators, such as participating in PPTCT programs, or of qualifying as an 'AIDS patient' are unclear. It is one thing to identify certain sites where ART will be provided and quite another to limit the benefits of the program to certain sections of the population.

The experience of refusal of treatment and of discriminatory behaviour in health care is magnified for marginalized populations. It was the lack of MSM friendly services, for example, that justified focused 'targeted interventions'. Basing the treatment plan in government hospitals is thus a tacit exclusion of these populations from the treatment program. There is no justification provided for such exclusion. The government plan thus emerges as a moralistic framework of 'treat the victim', one that sits well with the moralistic tone that seems to have seeped into AIDS control policy in India in the last few years.

Role of PLHA Net Work, Civil Society Organisations and NGOs: Over the years many NGOs are providing ARV treatment and developed expertise in the area. However, the plan covers only government hospitals and gives only minimal role to NGOs and civil society organisations such as home visits follow up of cases etc. The plan should make use of the experience of these organisations. This is important because studies show that the majority people do not depend on government hospitals for health care.

How and where will the treatment be provided? The document identifies three phases of the rollout program. The first phase involves preparing 15 centres in the six 'high prevalence states' to provide treatment, the second extends this to all government hospitals with medical colleges and the third to all district level hospitals in these states. To this end, health care workers at these various sites will be trained over a period of five days on a range of issues relating to the provision of ART. Two main concerns need to be emphasised here. First, the reasons for a focus on high prevalence states are unclear,

especially where the provision of care and support is being seen as related to a prevention strategy. Second, systemic and infrastructural issues of preparedness are not addressed by the program, which presumes that five days of 'training' will be sufficient to enable an effective system of ART provision.

Finally, almost all the centers where the treatment will be provided are located in cities, with a concentration in Chennai and Mumbai. It needs to be emphasized here that if access to treatment is to be a reality, rather than simply a populist measure, the centers must be closer to those who need the treatment, must be PLWHA friendly, and must match patterns of health seeking behaviour in the populations.

Nutrition – the rollout plan recognizes that nutrition is a requirement that needs to be provided for alongside the rollout program. Unfortunately, it does so in terms of provision of anabolic steroids, which by themselves are controversial hormonal drugs that are to be used in very particular circumstances. The provision of everyday low cost nutritious food in different settings is not addressed.

Gaps in training of care providers – the plan has a detailed description of the training workshops that will go towards building the capacity of the centers to provide ART. Almost all the sessions are medical in nature, as though the complex socio-economic and political issues that need to be considered in the provision of ART have already been addressed. In a context where discrimination in healthcare continues to be a widespread experience, creating 'preparedness' will involve a more serious engagement with these issues as well. Whereas there is a half-hour slot for discussion of 'legal and ethical issues', there is no scope for a focus on human rights issues and protocols, in terms of attitude or actual systems through which confidentiality and informed consent will be ensured. Further, there is minimal scope for learning from people's experiences at the field level.

Testing facilities not addressed – the provision of ART requires not merely ARVs, but requires as well accessible and affordable CD4 and Viral load testing facilities. These again, are not addressed by the rollout plan, although the NACO –WHO workshop on 28th-29th January 2004 did have presentations by private corporations on their capacity to provide such testing facilities. Again the growing dependence on private corporations needs to be accepted with caution. With respect to such testing facilities in particular, the field level experience in some parts of the country seems to be that governmental facilities, however limited, are more reliable than those provided by private companies. NACO should make efforts to establish at least one CD4 testing labs in every districts and at least one PCR labs in every state.

Regimens being offered – the framework of the rollout plan envisages a standardisation of drug regimens, based on WHO recommendation on a 'public health approach'. Unfortunately, this goes against experiences in clinical practice. As such, the standardisaiton of regimens is an aspect that still needs to be debated and cannot be taken for granted as the desirable strategy. How the specific requirements of specific individuals are to be addressed is not envisaged in the document. Further, there seem to be some problems with the regimens prescribed in certain circumstances – for example, whereas it is recognised that women receiving NVP as part of PPTCT programs may have developed resistance to it, and thus, that the recommended first line regimen of

d4T/3TC/NVP may not be effective, the only alternative that is provided to them is replacement of NVP with EVP. EVP as well, unfortunately, is not indicated in pregnant women. In this context there other options available in western markets that have not been suggested.

NVP was adopted as the strategy for PPTCT despite its rejection in healthcare systems in Europe and the US due to the high risk of resistance, which could impact on treatment options in the future. It is the effect of this decision that we are now faced with where a certain segment of the population that needs ART will not have effective options. This is an articulation of the implications of the politics of health. The rollout plan does not recognize or address this.

Language and presumptions - Finally, a note needs to be made of the largely insensitive language of the document, and the continuing use of phrases that fuel stigma and discrimination against people living with HIV/AIDS. Terms such as 'HIV infected' and 'indulging in "disinhibition"' are scattered through the document. If this document is to be the basis for training in the public health system where stigma is a definite problem to be addressed, then a certain degree of sensitivity needs to be incorporated into it. Second, the identification of beneficial and adverse affects of ART have been made in a manner as to already place the blame of any failure of the program on people living with HIV/AIDS, for example, through the emphasis on the phenomenon of 'disinhibition', which thus far has only been identified in specific *western contexts*. Similarly, concerns with respect to adherence in the document seem to be an exercise of the political construction of the 'third world patient'. The fact that evidence that forms the basis of these concerns comes from particular western experiences needs to be clearly stated.

Since the document says " the document will be reviewed frequently so that it keeps up with new regimes .....also reflects the backward and forward linkages between programmes for treatment and interventions for prevention of HIV/AIDS and care and support of people living with HIV?AIDS". We hope that the above suggestions would be incorporated in the coming days.

[it is clear that this has been due to the sustained advocacy efforts and impact by several individuals and organisations including networks of people living with HIV/AIDS, NGOs working on HIV/AIDS and campaigns like the AMTC, which many of these networks and NGOs have created and are a part of.]

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PIS-2Q

HIV+ve Children Kottiyoor

Kottiyoor is a small village situated in the eastern part of Kannur district in Kerala. The nearest railway station is Thalasery which is 64 kms away. Hills, forests and a noisy river that flows through it makes one feel that this is indeed God's Own Country. The annual festival of the Shiva Temple draws pilgrims from all over Kerala. After the festival which last for about twenty seven days the village settles back into it quiet peaceful routine fro another year. However the year 2003 witnessed something different. People from all over Kerala and even the neighboring states started to come to this village. Soon Kottiyoor became well known both in Kerala as well as outside the state. All this was happening even after the festival had come to an end. The reason was far removed from the shiva temple or popular religiosity. In fact Kottiyoor was now becoming famous on account of the discrimination that was being meted out to two children who had turned out to be Hiv positive.

The story of Rema Akshara and Anathakrishnan:

Shaji and Rema belong to a lower middle class family. They had three children Athira who is eleven years old, Akshara who is eight years old and Ananthu who is six years old. Shaji Kumar, the father of Akshara and Anantakrishnan was a motor mechanic who worked in Mumbai and Goa. Shaji returned to his native village Kottiyoor after having fallen ill a few years back. When he was taken to Pariyaram Medical College, Kannur for a check up, it was found out that he was HIV+ve. The doctor who was treating Shaji informed him and Rema his wife about this and asked them whether this should be informed to anyone else. However even before they reached Kottiyoor after being discharged from Pariyaram Medical College, the news that Shaji was HIV+ve spread like wildfire. When they returned people did not ask them directly about this but there was a visible change in their behaviour. Some of them would prevent their children from coming to their house. Soon Shaji began to loose weight (the opportunistic infection in his case was tuberculosis) and people began to ask Rema if it was true that he was HIV+ve. To this Rema replied in the negative and told them that he had T.B. not HIV. Meanwhile Shaji was taken to a hospital at Peravoor where he was treated for opportunistic infections.

Shaji's family then arranged for him to be transferred to Pratyasha Bhavan, Kannur. However this was done without the knowledge or consent of either Shaji or Rema and as a means of reducing the embarrassment that they were facing on account of the social stigma. Only on reaching Pratyasha Bhavan did they realize that they were brought there to be admitted. Since he did not want to stay there and at the same time not quarrel with his relatives, Shaji requested Rema to come back after a week and take him home. Later on when Rema tried to take him home, Shaji's brother and family opposed it saying that the villagers would not allow Shaji to enter Kottiyoor. In spite of this Rema got Shaji discharged from the

Recd from Sunil George
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hospital and took him home as per his wishes. By then Shaji had become quite weak than when he was admitted and Rema was confident that she could take care of him at their home in a better way. Shaji passed away on 9-06-2003. Very few people turned up for his funeral on account of fear of contracting HIV. It is interesting to note here that Shaji is not the first person to die from HIV in Kottiyoor. When the first death occurred the doctor who was involved in treating the person told the family to buy two quintals of powdered (slaked) lime and bury him in that! This was verified with various people in Kottiyoor and found to be true. Seeing and hearing about this created a fear psychosis about HIV/AIDS among the villagers. When Shaji died the local health department workers who handled his body not only sprinkled powdered slaked lime but also warned those who were present not to touch the body or come near it! The question that people ask today is. "If HIV is easily destroyed as you say then why all this fear even among the health department and doctors" After Shaji's death a few institutions notably St.Camillus sisters had offered to take Rema and her children to a Care Home for HIV+ve people in Bangalore as well as at a few other places. However, since Rema desired to stay in Kottiyoor she declined these offers. Rema's contention was she had a house in Kottiyoor and both she and her children were healthy. Hence why should they go and live in a care home? The locals who stood by Rema also contented that if every one who is sick is being taken to Bangalore or another place soon that place would be full of HIV+ve people! They decided to settle this issue at Kottiyoor itself .

On account of the death of her father and the situation at home Akshara did not attend school for sometime. Meanwhile some members from the school management/SNDP unit approached Rema and asked her not to send her to school, till the issue settled down a bit. Meanwhile Ananthakrishnan continued to go to the local anganwadi and as a reaction to his presence the parents pulled out their children from the anganwadi. Soon Ananthakrishnan found himself out of the anganwadi as well!! Athira was required to produce a certificate concerning her HIV status and once that was done, she was allow to continue her studies in the nearby Upper Primary school. Initially there were rumours among the parents of the school that she was also sick but the teachers have been clear that she was HIV-ve and hence the question of her leaving the school doesn't arise.

Having neither a job as well as facing social alienation Rema and her children (Athira, Akshara and Ananthakrishnan) had to depend on the charity of a few locals and at times Shaji's family as well. Around this time, Navajyothi a local NGO came to know of the situation and stepped in to help them. They have given Rema employment in their office as a positive speaker and have been involved in the struggle to obtain educational facilities for her children, Akshara and Ananthakrishnan.

With the intention of getting the children back to school Navajyothi approached the Education Department (offices of the AEO and DEO). An official order was also issued by the District Collector to

ensure their readmission to the school. When approached, the school authorities pointed out that they could not readmit Akshara since she was absent for a very long time without giving any proper reason. Taking into account the prevailing social situation at that time, Navajyothi decided not to press the matter further that year. The next year (i.e., 2004), they started to get in touch with the school from February onwards. In the month of March, a written request was sent to the school asking them that a decision be taken with regard to admitting both the children and if this was not possible to specify it (that) in writing. A clear answer was however not coming and the school authorities pointed out that they could reply only after a meeting of the PTA, which would discuss this issue.

With the school refusing to admit Akshara and Anantakrishnan and no proper reply coming forth, Rema decided to go on a strike along with her two HIV−ve children in front of the Secretariat in Thiruvananthapuram. This was resorted to after all local possibilities of reaching an amicable solution were exhausted. The Chief Minister who saw the two kids on a dharna outside the legislature inquired about the issue and requested them to come to his office. He immediately passed an order that the children be admitted back to the school and also gave them a financial assistance of Rs. 25, 000/-. Along with Rema and her children, a Deputy Director of Education Mr.Sashidharan was sent to see that the order was implemented. On reaching Kannur, the Headmistress and the school Manager were summoned by the D.D.E to the collectorate and asked to make the necessary arrangements in order to admit the children by 2.00 pm. At 2.00 pm, the D.D.E, D.E.O., A.E.O. and the children arrived at the school. The Headmistress was however absent. The manager of the school said that it was not possible to admit the children due to the prevailing social situation. Around 100 parents had meanwhile arrived with the intention of physically preventing the children from entering the school. Meanwhile the D.D.E. decided to wait for the Headmistress who arrived by 4.00 pm. She once again refused to admit the children citing the same reason- opposition from the parents of the other children. She was asked to give this in writing and placed under suspension.

Soon after this incident the manager of the school filed a writ petition against the order of the Chief Minister at the Ernakulam High Court. IN this he stated that since children having communicable diseases cannot be admitted in a school and since Hiv can be spread through saliva and blood, hence a communicable disease, the children can't be admitted. The judge who quashed the writ petition in his order stated,

> "Ignorance appears to be the root cause for the misplaced apprehensions raised in the writ petition."

He also issued order that awareness classes be conducted in Kottiyoor in order to remedy the situation. Having lost their case in court, the manager, the PTA president as well as the panchayat president president

approached the CM's office requesting the order be modified. In the meantime the PTA had met and placed nine demands if the children were to be educated at SNLP School. A procession was also organized by the PTA in which the other children studying in the school carried placards saying, "We do not want AIDS children in our school."

Some of the demands were

1. The children should be taught in a separate classroom that is located 500 meters from the school.
2. There should be no interaction whatsoever between Akshara and Ananthakrishnan and the school or the other children studying there.
3. None of the teachers in the school will teach these children.

The request to have a classroom 500 metres away was turned down and instead a separate classroom within the school compound was mooted as a compromise. Since none of the teachers were willing to teach them, the Department of Public Instruction was on the look out for a teacher who would volunteer to teach these children. Mr.Vinod Kumar who was teaching at Mulakunu U.P. School volunteered and was transferred to SNLP School Kottiyoor as a special teacher. Mr. Mohandass one of the locals who has been involved in getting Akshara and Ananthakrishnan back to school and his brother in law decided to send their children to study along with Akshara and Ananthakrishnan. While this was supposed to be a temporary solution leading to complete integration of the children, this is becoming a more or less permanent solution in the eyes of those concerned.

Current Situation

Are the children receiving proper education at SNLP school? The answer is both yes and no. While a special teacher has been appointed and even other teachers are taking classes for these four children, it is a very artificial arrangement. These children long for the company of the other kids. Even if they get a five-minute break, they go and sit on the staircase overlooking one of the regular classrooms and observe what is happening there. Occasionally a few kids come and talk to them. While a few months back Akshara and Ananthakrishnan were not allowed to even mingle with others, today children have broken this barrier. The great myth that playing together can spread the virus is being broken day after day as some kids play along with Akshara and Ananthakrishnan.

But this is an uneasy calm. Rumours that Akshara and Anathakrishnan are moving around with syringes and blades in order to infect other children are very common in Kottiyoor. A teacher told me that one day a parent came and produced a syringe saying that it was brought by Akshara and given to her child! On investigating the incident this teacher found out that there was no connection between the

syringe and either Akshara or Ananthakrishnan! Another child had brought the syringe in question to school. When I was present, there was an incident of other kids taunting Akshara "HIV, HIV"
Rema's latest CD4 count is 298 whereas Akshara and Ananthu have a CD4 count of 860 and 839 respectively.

Many who are involved in this issue would like other s to believe that everything is fine at Kottiyoor. However this is far from the truth. When I asked Rema about this she told me the following,
"*I do not want to forcibly get my children to sit in a regular class. When the people realize that HIV will not be spread by my kids sitting along their children and ask me to send them to a regular class, only then will I send them. Till then let them study in a special class*"

Bensy and Benson

The first case of discrimination against children in schools based on their HIV status that came into the limelight was of Bensy and Benson. Two years of struggle that included a hunger strike as well as the intervention of the President of India has got them back into school. However even today their grandfather Mr. Geevarghese John is not sure of what will happen to them after his death. In fact he told me that their lives would also come to a standstill once he passes away. Before I visited their home there were reports that their grandfather is making money by using these two children. It was also reported that he had misused the money that he had received from various quarters since he had an alcohol problem. While it may or may not be true what I was able to understand from the half a day that I spent with them was that he loved these children a lot. A fact confirmed by Bro. Joseph Charuplackal who did a detailed study of the situation in Benson and Bensy's case. When their HIV+ve status was known, Bensy and Benson had to discontinue their studies as the school where they were studying was not willing to let them continue there. At present they are studying in the local government school. From being asked to leave the school to being asked to migrate to some other state by the then local representative, Mr. Geevarghese John and these children have faced several forms of discrimination. Today with the children becoming celebrities, everyone from political bigwigs, officials as well as other would like to be photographed with them and promote their cause. Mr John brought an album that was nearly empty and showed it to me. "It was full of photographs of these children and their parents but the people who came took them away and have never returned it." All that remains in that album is a picture of his daughter and her husband. Bensy needs to get admission in the U.P school next year in order to continue her studies. Mr. Geeevarghese John has fears whether they would manage to secure admission for her or if the whole cycle would repeat itself!

A report done by Bro Joseph Charuplackal into this issue throws some interesting parallels between the case of Benson and Bensy and Akshara and Ananthu.

In both their cases over exposure has been a factor that aggravated the problem. According the report by Bro Charuplackal, one Fr.Johnney Thottam who was involved on behalf of these kids went to the school along with media personnel and demanded that the two kids should be taught in the school no matter what the cost. If anyone had any objections they could remove their children from that school. However he also demanded that every child who left the school for this reason should be subjected to a HIV test to know his/her status. How can anyone make such a stupid, insensitive remark? Is it a surprise that the other parents would react as they did when the so-called protectors of the most abandoned hurt their sensitivities in such a crude manner? In one such meeting that was held to find a solution there were foreign media personnel veering the whole issue. Was their presence required? Did they contribute to vitiating the already tense atmosphere? It seems that their presence did more bad than good for Bensy When I went to meet Bensy and Benson, their grandfather told me that one of those who exploited them was this person called Fr.Johnney Thottam. My efforts to contact him personally did not yield any success and hence his opinion on this issue could not be obtained. But when an independent report as well as the caretakers themselves level accusations at him one wonders why Fr.Johnny got involved in this in the first place. Was it for the welfare of the children or his personal gain?

The locals interviewed by Bro Charu have said the following,

"The children were first sent out of a school run by their own community. Why can't they come forward and take care of these children. In that school the parents pay fees for their children's education and when they don't want them there is no problem. This school where they are studying is a govt. school where children of poor people like us study. We have no other option than sending our children to this government school. What about those who sent them away from their first school? They are considered good people, while we have become inhuman!"

Mrs. Deepa Suresh the P.T.A president has said in the report that when they went to meet the District Collectors office to find an amicable solution to the problem, they were told that even if all the other kids left the school it will function for the sake of Bensy and Benson. Such a reply infuriated the other parents who had gone to meet the officials. Further conflicting opinions from doctors abut the facts of HIV had confused the parents. Moreover the report even says that few doctors told the parents that even though they knew the facts about HIV/AIDS, they would never permit their children to sit with HIV+ve children in their schools. If doctors themselves say such a thing then why portray simple people like us as being inhuman? She asks.

Sandhya and her children

Sandhya (name changed) is a young widow about twenty seven years. She stays in a village very close to the border of Kerala and Tamilnadu. I first met Sandhya at the office of an NGO in Thiruvananthapuram. Her husband had passed away three years ago. When it was discovered that they were positive, her husband suggested to her that they commit suicide. However keeping her children in mind, she refused to listen to him. One day he left the house under the pretext of going to meet his friends and later people discovered that he had consumed poison. He died while being rushed to the hospital. While she and her first child Anjali (name changed) are both Hiv +ve, the other two children are HIV-ve. According to her while the locals know of her status as a HIV+ve person they are not very sure about it. Anjali was very sick and bedridden when she was very young. Today with Anti Retroviral therapy she is much better but wants to know when her medicines will stop. Her mouth is full of blisters as a result of oral candidiasis but she longs to go to school and play with her classmates. When Sandhya's husband passed away she had to change the school where Anjali studied on account of opposition from some of her relatives who threatened to withdraw their children if anjali came to the school. A member of the management even told her that sending anjali to school would be one of the greatest harm that they would be doing to society! Anjali was sent to another school where the management was very positive and decided to admit her while keeping her status as HIV+ve confidential. Today while Anjali doesn't go to school on account of her poor health she still looks forward to the day when she can attend her classes! Sandhya's case is not an isolated one in her village there are reportedly nine families who were HIV +ve according to the volunteer who accompanied me.

Global Scenario

In 2003, an estimated 4.8 million people (range: 4.2–6.3 million) became newly infected with HIV. This is more than in any one year before. Today, some 37.8 million people (range: 34.6–42.3 million) are living with HIV, which killed 2.9 million (range: 2.6–3.3 million) in 2003, and over 20 million since the first cases of AIDS were identified in 1981.

Asian Scenario

An estimated 7.4 million people (range: 5.0–10.5 million) in Asia are living with HIV. Around half a million (range: 330 000–740 000) are believed to have died of AIDS in 2003, and about twice as many—1.1 million—(range: 610 000–2.2 million) are thought to have become newly infected with HIV. Among young people 15–24 years of age, 0.3% of women (range: 0.2–0.3%) and 0.4% of men (range: 0.3–0.5%) were living with HIV by the end of 2003.

DIS-2P.

An evolving response to the HIV-AIDS epidemic in Karnataka State, India

This relatively new health and social problem was recognised in India in 1986 and in Karnataka in 1988. The first AIDS Surveillance Centre was set up in Bangalore Medical College in 1987 with technical guidance from the Indian Council of Medical Research. During 1989-94 the Blood Safety Programme, assisted by Government of India, initiated the modernization of the blood banking system in Karnataka. The State AIDS Cell was established in 1992. From 1992-1998, Phase I of the National AIDS Control Programme (NACP) was implemented with World Bank assistance through, NACO (National Aids Control Organisation), Government of India. Under this programme 10 zonal blood testing centres were established and 51 blood banks (37 government, 15 private) were modernized. Sectoral Surveillance was carried out through 7 STD clinics and one antenatal clinic. Three Voluntary Blood Testing Centres (VTCs) were set up. Training of doctors and paramedical workers was conducted. Health education and IEC programmes reached out to communities using a variety of media. STD clinics have been strengthened. The Karnataka State AIDS Prevention Society (KSAPS) was registered . Phase II of the AIDS Control Project was launched in December 1999 for a 5 year period till 2004, with World Bank Assistance. It aims to reduce the spread or transmission of HIV infection in the State and to strengthen capacity to respond to HIV/AIDS on a long-term basis.

NGOs have been active, particularly in Bangalore. Three NGO's provide care and support to People Living With AIDS (PLWA's) in Bangalore (one also has a home based care programme), one for women in Chickmangalur while another is being established in February, 2001 in Mangalore. A well women clinic is run by an NGO in Bangalore; two other NGOs work with CSWs in Bangalore and Belgaum. Other NGOs work with preventive education in schools and industries in and around Bangalore; and with truckers in Raichur, Bangalore and Mangalore. Two networks namely the AIDS Forum Karnataka (AFK) and the Karnataka Network for People Living with HIV/AIDS (KNP+) have been formed. Another NGO network, CHAIKA has undertaken sensitization and training programmes for its member institutions (over 300) working in different districts. A few mission and private hospitals provide testing and inpatient facilities for HIV positive patients who need medical care. Training of counsellors for HIV-AIDS is also carried out. Other NGO's include

HIV/AIDS work as part of their overall health work. For instance HIV/AIDS awareness is part of womens health empowerment training programme. The National Law School University of India takes an active part in legal and ethical aspects of HIV/AIDS.

Thus over the years a slow but sure response to the HIV epidemic has evolved in Karnataka. Efforts are however inadequate and slow in respect of the rapidly increasing trends in infection rates, the spread of the infection into the general community and evidence regarding growing vertical mother to child transmission.

There is need for

a. diagnostic facilities in each of the 27 districts to run as Voluntary Testing Centres with counsellors and social workers.
b. provision of facilities for care of AIDS patients who may not be able to live with their families.
c. treatment for opportunistic infections, particularly TB. This should be integrated with general health care services.
d. provision of antiretroviral therapy at low cost. The state / country could use provisions under WTO for indigenous production which would lower costs Prevention Therapy to protect against mother to child transmission needs to be more widely available.
e. management and Prevention of sexually transmitted diseases
f. training of networking for home based care, including use of herbal medicine and other systems of healing with back-up support from referral hospitals.
g. promotion of healthy lifestyles among positive persons
h. preventive education among different groups, children, adolescents, womens groups.

DIS - 2p.

Lawyers Collective HIV / AIDS Unit

Adv/Letter/128/p/05

25 July 2005

Dear Colleagues,

Enclosed is the Lawyers Collective HIV/AIDS Unit Comment on the proposed HIV/AIDS Bill. We have submitted this note to the Law Minister of Karnataka today. Please do not hesitate to call us if you want clarifications on any aspects of the Karnataka proposed bill.

Warm regards,

Priti Radhakrishnan
Senior Project Officer
Lawyers Collective HIV/AIDS Unit - Bangalore

Encl:(1) Lawyers Collective HIV/AIDS Unit Comment on the proposed HIV/AIDS Bill
(2) Letter to the Chief Minister of Karnataka.

HIV/AIDS resource file

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17/8/05

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A Comment on the Proposed Karnataka HIV/AIDS Bill

Lawyers Collective HIV/AIDS Unit

The *Human Immuno Deficiency Virus Affected And Acquired Immuno Deficiency Syndrome Persons (Protection of Rights And Prevention Of Infection) Bill, 2005* is the initiative by the Karnataka state government. The Karnataka state government has recognized the needs of Persons Living With HIV/AIDS and is making a commendable attempt in trying to legislate to protect rights and prevent the spread of HIV/AIDS.

It should be noted that if the State Assembly passes this bill in its present form, it may result in harmful consequences. This bill, though a praiseworthy attempt, is ridden with ambiguities. There is also an absence of key provisions that are essential to a comprehensive statutory response to HIV/AIDS.

In this document, we set out in **Part I** a **"Broad Analysis"**, offering overarching comments with respect to areas of concern in the legislation. In **Part II,** we undertake a **"Specific Analysis"**, offering comments on selected chapters/provisions.

PART I: BROAD ANALYSIS:

Pending Bill in the Centre: There is a national HIV/AIDS legislation on the anvil that is expected to be tabled with the Parliament this year. This national legislation contains a comprehensive set of provisions of law. In the eventuality of such a bill becoming a statute or an enactment, in case of repugnancy the Central Legislation will prevail over the state statute or legislation as provided under the Constitution. *It is advisable that the state government consults the central government before proceeding forward with this piece of legislation.*

Overlapping sections: There are sections in this bill which overlap with provisions in existing legislations. In cases where provisions of this bill conflict with any provision in central legislations, the central legislations will prevail over the state legislation. For the bill to override the already existing provisions, there should exist a non-obstante clause, which is absent in the present bill. (e.g. "Notwithstanding anything contained in any law for the time being in force"....).

Inconsistency in the Statement of Objects and Reasons: The objects and reasons of any bill form the core statement of the topic that is being legislated, as the purpose and the rationale behind the bill is explained. There should exist no contradictions in the body of the bill when it is read with the statement of objects and reasons. In the present bill contradictions do exist. The substantive clauses have not covered all the areas articulated in the statement of objects and reasons, such as information and education to heighten awareness.

Ambiguities and absences in the definitions: The definitions are not precise and are incomplete. Definitions form the crux of any legislation: in the event of the Hon'ble Courts interpreting the meaning of a term, the judicial determination will depend heavily on the definitions. In case the definitions are ambiguous, the Hon'ble Courts will depend on other statutes; this may be inappropriate for an HIV/AIDS response as each statute is legislated for a different purpose and will ascribe meanings to words that may not conform to the HIV/AIDS context.

Furthermore, in the proposed bill, there is an absence of critical terms such as "person", "consent", "confidentiality", "discrimination", etc.

Absence of special provisions protecting rights of women and children: The disease burden of HIV/AIDS in India falls disproportionately on women and children. In this bill, specific sections do not exist to address this reality. (e.g. matrimonial rights, domestic violence, custody, sexual assault, breach of confidentiality, the concept of discrimination within family and children, age of consent, or the issue of informed consent).

Key issues are absent: The bill fails to adequately address concepts such as discrimination, confidentiality and consent, which form the core areas requiring

legislation for HIV/AIDS. Furthermore, the bill does not address many other areas, which are central to an HIV/AIDS legislation, such as risk reduction for vulnerable communities, Information/Education/Communication (IEC), implementation mechanisms, a safe working environment, and access to antiretroviral and related treatment to prolong healthy lives of HIV-positive persons.

Lack of evidentiary or scientific basis. Any statutory response to HIV/AIDS should base itself on strategies that have worked in India and abroad. In this respect, there is a crucial lacuna in the bill, as it is based on hypothetical assumptions and not on evidence and science.

Uncertainty in the bill's legislative scope/reach: The legislative scope of the bill is unclear: will it be applicable to the private sector, public sector or both? In some of the provisions, the bill suggests that the private sector would fall within the parameters of the bill, and in some other provisions it suggests that it would not.

Additionally, the sections cover only the rights of Persons Living With HIV/AIDS, but do not set out rights for persons who are affected by HIV/AIDS [e.g. orphans, family members, etc] or those perceived to be HIV- positive [e.g. those perceived to be "at-risk"].

Confusion on the identity of the State Authority: The bill provides for a Board or an Authority that is to be formed, but it remains unclear if the bill is replacing the present Karnataka State Aids Prevention Society ("KSAPS"), or if the bill envisages the creation of a new body. If the structure is the same as KSAPS and is merely statutorising the body, it is dramatically decreasing the functions of the body. This will have a severe impact on health outcomes as programmes focused on targeted interventions, IEC, blood, and others will cease to exist. Moreover, there will have to be a structure to take over the present KSAPS, which is quite a cumbersome structure in any bill: indeed, in the national legislation, the structure takes 20 pages. On the other hand, if the bill is creating a new body, it is unclear why it would do so and it is duplicating work.

In either case, the bill implies a change in the structure and functioning of the present KSAPS. This will change only in Karnataka as no other state has a bill with similar provisions to date. Furthermore, in case the Board under the bill does become a statutory body, it will have different powers and responsibilities and may not be able to work under the National AIDS Control Organisation. This may have negative consequences for HIV/AIDS programming and health outcomes in Karnataka: a national, coordinated response is integral to tackling the spread of the epidemic.

Lack of provision on expedited procedures for relief: The bill does not create any provision to expedite the procedures to obtain judicial reliefs. In our experience litigating on behalf of HIV-positive persons in Karnataka, justice may be delayed for years. A provision that mandates faster procedures is essential.

Dearth of adequate remedies: The bill does not provide for remedies in a systematic or definite manner. The remedies provided in the bill are inadequate and insufficient.

Incorrect usage of terms: The provision uses the word "rehabilitation" in the context of HIV-positive persons. This raises a concern as to how HIV/AIDS is viewed in our society: Persons Living With HIV/AIDS do not require "rehabilitation". Rather, some may require life-saving treatment, and perhaps the word "treatment" is more appropriate here rather than "rehabilitation".

Certain sections contain the term "HIV/AIDS patient", which we believe to be paternalistic and inaccurate. As HIV is a condition/infection, a person can be HIV positive and stay asymptomatic for years. They may not be patients at all, but healthy individuals capable of leading productive lives for many years.

Arbitrary powers given to the officials: The "good faith" clause provides immunity to the board members without making them responsible for any acts which they may have done that violated rights. Due to the fact that a comprehensive set of rights is not set out, if an official acts to prevent HIV/AIDS in a manner that violates rights, but does so in good faith, the victim may not have legal recourse. To illustrate, if there is no right provided against discrimination or isolation, and if HIV-positive persons are isolated in good faith to prevent the spread of the infection, they would not be able to redress the wrong. This clause gives sweeping powers for the directors and other board members and places too high a burden on the Person Living with HIV/AIDS.

Problematic Nature of Board/Authority: The proposed structure raises several concerns pertaining to the composition of the Board and appointing of the members. The Board lacks representation of Persons Living with HIV/AIDS. The proposed bill does not indicate how the Board members and other officials will be sensitised to issues of HIV/AIDS, or mention the duration of tenure for ex-officio members. There is a lack of recognition of vulnerable populations in the programme as they are among those affected, and their rights need to be protected in order for prevention of the infection to be possible.

PART II SPECIFIC ANALYSIS

Chapter II: Rights Of the HIV/AIDS Infected

Every person and citizen is entitled to some fundamental rights that are provided in the Indian Constitution. One of the greatest lessons that the HIV pandemic has taught public health experts is that the spread of the HIV infection can be prevented, from HIV-positive persons to others, if the rights of people infected or affected with HIV/AIDS are protected. By creating an enabling environment, Persons Living With HIV/AIDS will access health services, allowing interventions to prevent the epidemic from spreading.

This lesson has been shown in our country in Sonagachi, Kolkata. Using the rights-based approach for sex workers, condom usage was scaled-up from 2.7% in 1992 to 90.5% in 1998. As a result, the number of persons testing VDRL dropped in the same period from 25.4% to 11.5%. In the same period the number of new persons testing for HIV from 442 to 506 and the number of persons who tested HIV negative rose from 0.15-2.11% CI to 3.54-7.52% CI. Thus when people know that they are entitled to certain rights which protect their status, they will be encouraged to exercise such rights, e.g. get themselves tested, disclose their HIV status voluntarily and engage in safer behaviour. This lesson has to be incorporated in any law on HIV that is enacted.

In the context of the present bill, it is an important step that the Karnataka government seeks to vest rights in Persons Living With HIV/AIDS. It is important to note, however, that the bill also takes away rights of confidentiality, informed consent and freedom to procreate. Such provisions will only discourage people from accessing health services and preventing the spread of transmission. Therefore, it is the paramount duty of the state government to legislate a bill keeping the rights-based approach in mind.

Furthermore, the bill reemphasizes the following existing rights under the Indian Constitution:

Provisions in Karnataka Proposed Bill	Provisions in Constitution of India
Section 3(a)(b)	Article-15 (2)(a)(b)
Section-3(c)	Article-19(1)(g)
Section-4	Article-14 and Article-16
Section-6 and Section-7	Article 21

The bill is therefore duplicating existing constitutional rights and is not expanding the area of its applicability. The rights guaranteed under the Indian Constitution are applicable only to the public sector, and are enforceable only against such authorities that are public sector enterprises or are working under them. The bill does not explicitly set out whether these existing rights are applicable to the private sector or private individuals.

3. Rights against enforcement of social disabilities: *No person shall on the ground of HIV/AIDS infection enforce against any person any disability with regard to:*

a. *access to any shop, public restaurant, hotel or place of public entertainment; or*

b. *the use of any utensils, and other articles kept in any public restaurant, hotel, or public place for the use of the general public.*

c. *the practice of any profession or the carrying on of any occupation, trade or business.*

d. *the use of or access to any river, stream, spring well, tank cistern water tap or other watering space, or any bathing ghat, burial, or cremation ground, any sanitary convenience, or any other place of public resort which other members of the public have a right to use or have access to; or*

e. *the use of or access to any public* ***conveyance.***

Comment: Section 3 seeks to remove any kind of discrimination against HIV-positive persons. However, it uses the phrase "social disability", which is not an accurate term to use, unless it is defined. Since there is no definition for "disability" in Chapter I, it will be difficult to enforce the rights provided in this section.

This section reemphasizes the right already guaranteed under the Indian Constitution but it is not clear whether such right is vested in a person and can be enforced against a private person or private body, as the reading of the section implies that only public places are covered.

4. Right to equality in matters relating to employment: *No person shall be subjected to a discriminatory treatment on the ground that he is HIV-positive, nor shall he/she be removed from service.*

Comment: The subheading refers to equality, whereas the substantive section is about non-discrimination. There is a significant legal distinction between the two which is not addressed.

The section provides for the right against discrimination in the context of employment. However discrimination is not defined. This is a serious flaw in the bill. Also, there is a wealth of judgments on this point, which need to be incorporated.

The section provides that any person because of his HIV status should not be removed from service and should not be subjected to discriminatory treatment. In order that an HIV positive person should be able to exercise rights guaranteed under this section, specific acts must be included, e.g. demotion, ill treatment, non-payment of bonus separation, unnecessary transfers, etc. This should be done within the definition of discrimination.

***5. Right against pre-employment HIV test**: All pre-employment HIV tests are banned. No employer shall prescribe a pre-employment HIV test.*

Comment: This section is in accord with the National Testing Policy. The overall coverage of the section would include the private sector. There is no basis for testing for HIV in the pre-employment setting.

***6. Right to treatment:** Every HIV/AIDS patient shall have a right to medical treatment in all the Government Hospital/Primary Health Centres*

Comment: This section provides for all HIV-positive people to be treated in all government hospitals and primary health centres. Other institutions run by the government are absent, e.g. community health centres, government specialty hospitals, etc. Therefore, the section limits the availability of medical treatment. Moreover, treatment is not defined. The aspect of finance is not looked at, as unless the central government agrees to this provision it will not be realised, since all HIV work is funded by the central government.

***8. Right to marry:** Every HIV/AIDS patient shall have a right to marry a person who has freely and voluntarily consented to that marriage being conscious of the fact that the person is HIV positive. However, this right shall be subject to the provisions of Chapter-IV.*

Comment: The section is a step in the right direction in that it actualises the right of HIV-positive persons to marry. However, it requires any HIV-positive person who seeks to get married to disclose his/her status to the prospective spouse and only if the prospective spouse accepts such a condition, can the marriage take place. The problem is that this right is subject to the rights in Chapter IV. Read together with that, the section implies disclosure of one's status but does not provide any safeguards for the same, such as maintaining confidentiality to make sure that the other person does not disclose one's status to the world without his consent. The section also does not envisage a situation where an HIV-positive person might not know his HIV status.

In a country like India where marriages are usually arranged, this is not a feasible provision to implement, especially for women. This is particularly so in Karnataka where 46% of marriages are child marriages. Women, who usually do not have a choice to choose their life partner, may not be in a position to ask for an HIV test from their prospective spouses. Therefore, unless other provisions are put in place to empower women and girl children, this section may be used against women by stigmatising and blaming them.

***9. Punishment for violation of rights:** Any person violating the above rights shall be punished with an imprisonment for a term which may extend to one year and also with a fine of up to twenty five thousand rupees.*

Comment: This section is a penalty clause for violation of the rights provided for under Chapter-II. The Section does not expressly mention what rights are referred to. Assuming all the rights in this chapter are covered, it is not clear which court will try the offence and whether it is cognisable and/or bailable or **not.**

***10. Right to information**: Every Medical practitioner who knows that he has HIV/AIDS infection shall before performing any en vivo medical procedure on a person shall inform him of the said infection.*

Comment: This is a specific section applicable only to medical practitioners. It is now universally accepted that an ordinary doctor performing day to day to medical procedures does not pose a significant risk to the patient. Even in the realm of surgeries, only major invasive surgeries are considered to pose a significant risk. The risk reduces further with the use of universal precautions. In any event, it is the duty of the employer to ensure that the surgeon is free from HIV. This would require reporting the HIV status to the employer, not to every patient.

Chapter-III: Prohibition of Certain Acts

This chapter prohibits acts that hinder the rights of HIV positive and negative persons. The sections in this chapter are not in a purposeful sequence or grouping.

11. Intentional Transmission of HIV:
(a) No person who knows or in all reasonable probability would have known that he has HIV infection shall intentionally or knowingly engage in any practice or behaviour or do or abstain from doing any act, which places or has a tendency to place any other person at risk to HIV infection.

Comment: Section 11(a) includes provisions that are similar to those already existing in the Indian Penal Code, sections 269 and 270. Section 269 and 270 make acts that may transmit disease dangerous to life punishable. These provisions, which cover HIV transmission, are sufficient in scope. *Therefore, a new criminal provision is not necessary.*

The primary reason for rejecting such a provision is on grounds of public health; enacting such a provision:

- Serves as a disincentive to testing because of the criminal liability and because safeguards for confidentiality will not exist;
- Obstructs access to counselling and related services;
- Enhances HIV/AIDS related stigma, discrimination and isolation;
- Spreads incorrect information about HIV/AIDS;
- Punishes persons who, given the lack of education and counselling that exists in society today, know their HIV status but are not aware of its implications, e.g. transmission.

Such consequences will serve to drive HIV-positive persons underground, and away from crucial health information and services, which will inevitably promote the spread of the epidemic. Furthermore, HIV specific criminal legislation contradicts the more effective message that it is the behaviour of each individual, whether infected or not, which determines the course of the epidemic and whether individuals contract HIV.

In other parts of the world, similar attempts to introduce HIV-specific criminal laws were rejected. In South Africa, such a provision was considered largely because women and girls were being infected. The South African Law Commission rejected the provisions in part because (1) a change in the law would be based on "urban legends" and not scientific/empirical evidence that HIV-positive persons were wilfully/negligently placing people at risk, (2) problems would ensue e.g. burden of proof and constitutional issues, (3) limited prosecutions under existing provisions indicate that few will utilize an HIV-specific statutory offence. Similarly, Canada, the United States and Namibia abandoned similar statutory provisions.

(b) Whoever contravenes sub section (a) shall, regardless of whether such practice or behaviour or act has actually transmitted the infection to such other person or not, shall be punished with imprisonment for a term of not less than five years and which may extend to ten years and with fine, which shall not be less than two lakh rupees and which may extend to twenty five lakh rupees.

Comment: This section punishes a person regardless of whether the infection was actually transmitted or not. Indian Penal Code section 269 and 270 provides punishment for similar acts. There is no need to have a special section for HIV as Penal Code sections 269/270 deal with the situation adequately. It is important to note that such a huge fine will only work against the poor, particularly against the sex **workers.**

(c) Any court sentencing a person to fine under sub section (b) may award such fine or any part thereof as compensation to the person placed at risk of HIV infection.
(d) The compensation awarded under sub section (c) shall be in addition to and not in derogation of any compensation to which such person is entitled, if any, under any other law for the time being in force.

Comment: This section provides for compensation to the victim, and the accused is required to pay a fine in addition to the imprisonment. The victim is further entitled to claim damages under any other statute, which simply means that the accused will have to not only pay compensation under this bill, but also damages.

12. Prohibition of misleading advertisements: *All misleading advertisements about cure to HIV/AIDS in print, electronic and other media are prohibited. All persons responsible for issuing and publishing such advertisements shall be punished with an imprisonment for a term which may extend to one year and with a fine which may extend to twenty five thousand rupees.*

Comment: This section punishes any person providing misleading information about a cure for HIV/AIDS. The term "misleading" itself is a subjective term. As one person might find an advertisement misleading and another might not, "misleading'' therefore needs to be defined clearly. The bill replicates an existing provision under the Drugs and Cosmetics Act. The difference is that the section under this bill provides a penalty for violation of this provision. It is not clear whether the offence is cognisable and bailable and which court will entertain the case. This provision will not work if there is no authority to take proactive action against persons who issue the advertisements. Moreover, it is not only advertisements which need to be tackled. There are many who claim, through word of mouth and/or practice, that there is a cure for HIV/AIDS.

13. Prohibition of mass tubectomy, etc.: *Mass tubectomy, circumcision, and any other such mass camps without involving qualified medical practitioners shall be prohibited. Any person organising such camps in contravention of this provision shall be punished with an imprisonment which may extend to six months and with a fine which may extend to ten thousand rupees*

Comment: This section prohibits mass tubectomy and circumcision where qualified medical practitioners are not present. By implication, this provision allows for situations wherein qualified medical practitioners are present. There is no rationale for this section, as no data supports the contention that these camps promote the spread of the infection.

14. Prohibition of disclosure of HIV test results: *Subject to the provisions of this Act, the fact that a person has tested positive to HIV test shall remain confidential.*

Comment: This section prohibits disclosure of one's HIV status without providing any exceptions and situations. There is no indication as to when disclosure is permissible, e.g. cases of sexual assault, cases where there is an identifiable partner who is at significant risk, by an order of the court, etc.

Chapter –IV: Regulation of Matrimonial Relations and Procreation

The title of Chapter IV reflects an intent to permit the state to interfere with the individual's private rights, e.g. the right to know one's HIV status, the right to privacy and the right to procreate. On the other hand, the State does have the authority to legislate on the lives of individuals, provided such authority is not violating basic fundamental rights. In this chapter, fundamental rights are violated.

This chapter also impedes effective HIV strategies by using marriage as the normative construct, thereby excluding other relationships. Given that HIV infection is spreading in Karnataka through sexual and needle-sharing relationships outside of marital relationships, this chapter does not reflect the realities existing in the State.

This chapter is also flawed as implementation of the provisions appears impossible.

15. Pre Marital HIV Test: *If one of the contracting parties to the marriage insists on the test to check the HIV status of the other person, the other person shall undergo such test to the satisfaction of the person concerned.*

Comment: This provision does not create an enforceable right beyond what ordinary persons are free to do in the absence of a statute: request an HIV test from a prospective spouse before marriage.

If the intent of the provision is to give prospective spouses the right to know their partner's HIV status before marriage, it may not achieve its objective. At the time of the test, there is a possibility that a person may test negative, even if they are infected with HIV. This time period is known as the "window period". The common way in which the test for HIV is conducted is an antibody test. Even if the person is infected with HIV, the antibody test result will still show a negative result if the antibodies are not developed. Hence, a single antibody test for HIV does not serve the purpose of identifying people with the virus, and preventing he /she from getting infected.

If the intent of the provision is to protect women who are likely to be infected by their husbands, the question is raised: will the prospective spouse ask the question if there is a law? Will the law really empower women? This is doubtful given the cultural traditions that exist in India where the girl child is not empowered. The real challenge is to empower the girl child and educate her about sex. This will empower women not only before marriage but also during marriage, which will help her in case her husband contracts the infection after marriage which is very often the case. Absent such empowerment, the law can only be a paper tiger.

This provision also has a number of weaknesses: it will encourage unscrupulous doctors to give false negative certificates, there will be deleterious consequences for persons who obtain "false positive" results (which is very high in India), and it does not prevent the spread of the infection to sexual partners outside of marriage or needle-sharing partners.

Even if this provision becomes law, it does not address the crucial issue of what will happen to the persons if they are found HIV-positive. Once the community knows a person's HIV status, the stigma and discrimination the person will face are not addressed and adequate safeguards are not provided. Safeguards to protect confidentiality must be **included.**

The provision also raises two other concerns: (1) the phrase "to the satisfaction of the person concerned" is not set out clearly, and does not explain what would meet the standard of satisfaction, which is a subjective criteria; (2) the phrase "contracting parties" raises an issue as to whether Hindu couples would fall within the provision, as the Hindu Marriage Act does not recognise marriage as a contract.

Lastly, it is important to note that this provision is alarmingly close to a provision mandating pre-marital HIV testing. Pre-marital mandatory testing has been considered

and rejected in India and abroad as an appropriate public health strategy, and such a provision would lie in direct contravention of NAPCP. This is due to a number of factors, including the faulty assumption that unsafe practices and subsequent HIV-infection do not occur after marriage. Furthermore, experiences in different contexts have proven to be a failure in terms of reducing HIV transmission. In the United States, the strategy failed and statutes were repealed. In the province of Johor in Malaysia, mandatory testing was introduced and is a failure. The percentage of persons testing HIV-positive was extremely low, persons married regardless of status, and many couples were married in neighbouring states to avoid getting tested. The pitfalls of pre-marital mandatory testing are well-documented and should be thoughtfully considered before such a provision is included.

16. It shall be the duty of the concerned authorities in all cases to disclose the results of HIV tests to the spouse or the sexual partners of the person subjected to test with proper counselling. Otherwise, the results of HIV tests shall remain confidential.

Comment: This Section imposes a mandatory duty on the concerned authority to disclose the results of one's HIV tests to the spouse or the sexual partners. No authority should be vested with such wide and arbitrary powers, as it is an individual decision to disclose information regarding one's health and related aspects. Furthermore, the term "concerned authorities" is not defined, leaving open the question as to who has a duty to disclose. If this provision refers to doctors or counsellors it needs to be specified. It is also unclear under this section whether the aggrieved can sue the authorities, in the event that the authorities do not disclose the status of the individual to the spouse or sexual partner.

This section takes away discretion from the doctor. It also does not promote the doctor to encourage his/her patient to voluntarily disclose his/her status. There is a wealth of practical experience and case law on this: the doctor should encourage voluntary disclosure through counselling in case she/he comes to the conclusion that the patient is engaging in high risk practices, and warn the patient that if she/he does not do so, she/he will disclose to the spouse or the partner.

The impact on women has not been taken into account in this provision. In case such disclosure does happen to the spouse (husband), a woman may face domestic violence or be thrown out of the house. Our experience in Karnataka demonstrates that women are often blamed for transmitting the virus to their spouses, despite being infected by the spouse.

The section implies that the disclosure is permissible only to the spouse and the sexual partner, but in all other cases, no such disclosure should happen. The provision does not set out other circumstances where disclosure is possible. Additionally, the section does not take into account that the spouse may be separated, not engaging in risky behaviour. Given the highly stigmatised nature of HIV/AIDS, such powers must be specifically narrowed down.

In case this section is implemented, people may not want to get themselves tested as test results may be disclosed to their spouses and sexual partners. Out of fear that individuals will be known as HIV-positive, they may stop accessing medical services. In turn, they will not get essential information about safe sexual and needle-sharing practices, and the disease may spread further. By protecting the rights of one person we can protect the rights of the whole society.

17. If the husband is HIV positive and wife is HIV negative, they shall not procreate children through wedlock.

Comment: This section may violate Article 21 of the Indian Constitution, which sets out a right to privacy. The right of procreation has been read into this right. This provision allows the state to intervene in the choice of two individuals without offering a rationale for the same. Courts have found that HIV-positive people may get married. If there is consent between two persons, the State cannot intervene. Similarly, it may be argued that the State may not intervene in a decision to procreate arrived at between two consenting adults. It may also be argued that a woman has the right to procreate and have complete autonomy over her own body, among other rights.

The section is probably based on a misconception that married couples only engage in sex for procreation. This is obviously not true as people engage in sex for pleasure. Furthermore, it should be noted that implementation of this section will be nearly impossible.

Lastly, the intent behind the section is unclear. No explanation has been offered as to why HIV-positive husbands and HIV-negative wives may not procreate through wedlock, whereas HIV-negative husbands and HIV-positive wives may procreate through wedlock. In this respect the section would be unconstitutional and is liable to be struck down.

18. All pregnant women shall be tested for HIV during the 3rd month, 6th month and before delivery. Those found positive shall be compulsorily counselled and treated to prevent transmission of HIV infection to the child.

Comment: This provision adopts mandatory testing as a public health strategy. The provision dispenses with the need for pre-test counselling and written, informed consent, both of which are acknowledged by leading public health authorities as essential for prevention of HIV transmission. It has not been proven that mandatory HIV testing of pregnant women is the most effective approach for reducing prenatal transmission. Leading public health authorities recommend voluntary counseling and testing as the optimal strategy for prevention of HIV transmission.

The data in India and Karnataka, demonstrating that mandatory testing is unnecessary, is ignored in this provision. India has rightly followed the protocol of voluntary counseling and testing in the antenatal clinic setting. There exists criticism that it is not "really" a voluntary counseling and testing situation, as the counseling is lacking. However, even if there is only information given to the mother about the benefits of testing, then the results

are evident: at the national level, of the women who were counseled in the ANC setting or given basic information, 97% opted for testing. Thus, there is no need to make testing or treatment mandatory.

The consequences of mandatory testing are well-documented; persons often avoid accessing medical services and information, fueling the spread of the epidemic. These consequences are equally applicable in the context of pregnant women. This provision presumably restricts the woman's rights in the best interest of the unborn child, seeking to prevent children from being born HIV-positive. Experiences in Karnataka indicate that when women are offered HIV information in a pre-natal setting, by and large they seek testing and treatment to prevent transmission to their unborn child. Experiences also demonstrate that pregnant women who are HIV-positive often shun medical help because they fear they might be stigmatized or discriminated against. By offering these women crucial health information and a choice to get tested, the chances may be increased that women will obtain counselling, testing and treatment.

Mandatory testing in any situation creates fear and fuels stigma and discrimination against people infected or affected by HIV/AIDS. Women already suffer from discrimination as a result of social, political, cultural and legal factors in our society. Subjecting pregnant women to compulsory HIV testing not only violates women's rights but also places them at heightened risk for being blamed for infecting the spouse, domestic violence, being thrown out of their homes, losing custody of the children, etc. This is particularly true under a provision such as Section 18, which does not provide for confidentiality, and when read with Section 16, mandates disclosure to the spouse or sexual partners.

Furthermore, it may be argued that mandatory HIV testing and treatment violates rights to bodily integrity and privacy.

Factually a large number of pregnant woman do not access health services until the last day of pregnancy. Therefore the access of public health services for women has to improve tremendously. This requires empowering the girl child so that when she is pregnant she knows she has to access health services for a safe delivery.

It should also be noted that implementation of this provision will require a tremendous investment of financial and human resources. Most importantly, no provision has been made for the continued treatment of the woman after transmission to the child has been prevented.

Furthermore, the treatment referred to in the provision, to prevent transmission to the child, is problematic under the current scenario in India. Emerging problems include drug resistance, unavailability of alternatives, and contraindicated medications (for opportunistic infections) being offered in the absence of alternatives.

Lawyers Collective HIV / AIDS Unit

Adv/Letter/121/p/05

12 June 2005

Hon'ble Chief Minister
Shri Dharam Singh
Room 323, Vidhana Soudha
Bangalore-560001
Karnataka

Dear Sir,

This is in respect to the proposed bill to protect the rights and prevent the infection of persons with HIV/AIDS, currently being considered by the Karnataka State government.

We appreciate the efforts of the concerned persons to enact a statute that will attempt to protect the rights of persons living with HIV/AIDS and prevent the spread of the infection. The protection of rights has been recognised by various countries including India as the optimal strategy for preventing the spread of the infection. Such a public health strategy is referred to as the "AIDS Paradox": by protecting the rights of those infected or at-risk, these persons will not be fearful to access life-saving health information and services, including prevention information. Thus, by protecting the rights of individuals, transmission of the infection is prevented and the community as a whole is protected. It is a praiseworthy step that Karnataka is contemplating a law on HIV/AIDS that recognises public health strategies based on such realities.

However, we would like to bring to your attention a few key concerns regarding the proposed bill:

1. Foremost among these is the fact that the Central government, through the Advisory Working Group ("AWG"), commissioned the drafting of a **national legislation on HIV/AIDS**. The legislation is being presented this week to Dr. Anbumani Ramadoss, the Health Minister, Ministry of Health, Government of India, and is to be tabled in Parliament this year. We would like to bring to your attention that in the event that there are provisions that are absent or contradictory in the state law, the national law would, under the Constitution, ***override the state law*** in the same field.

2. Recognising the pressing need for an HIV/AIDS law in Karnataka, and further taking into consideration the unique cultural, economic, social, and other factors

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present in Karnataka, we acknowledge that Karnataka may require a contextually appropriate legal response. However, it is imperative to emphasise the following point: the nature of the epidemic in India is cross-border and not state-specific. Karnataka, with its central location and high rates of **inter and intra state mobility**, demands a legislative response that necessarily takes these realities into account. An isolated state response that is not coordinated with other states, particularly those bordering it, will be ineffective. Therefore, we believe that only a national response is appropriate for the needs of Karnataka, and any state response must be fashioned in the context of the national response.

3. Furthermore, we are deeply concerned that the Karnataka proposed bill, unlike the national draft law, was not created in a ***consultative*** and participatory manner, obtaining inputs from those infected, affected and working for HIV/AIDS. We believe that a democratic, participatory process, ensuring that people's voices are heard, is integral not only to drafting any HIV/AIDS law but also to ensure its successful **implementation**.

   We sincerely believe that in order to create an appropriate legal response that best fits the Indian legal and social context vis-a-vis HIV/AIDS, extensive research must be undertaken of global approaches attempted and lessons learned, rigorous scrutiny must be performed of these laws and policies and programmes, and a detailed examination must occur of the application to the Indian legal and social context. For the national draft law, research was first undertaken of laws in other parts of the world that culminated in a background book, "***Legislating an Epidemic: HIV/AIDS in India***". We enclose a copy of the book herewith for your examination.

   This was followed by extensive consultations around the country. Consultations were held with various stakeholders, including: Persons Living With HIV/AIDS, marginalized populations (e.g. sex workers, men who have sex with men, injecting drug users), health care workers, employers/employees, NGOs working with HIV/AIDS, women and children. Each consultation lasted two full days, and was conducted with thorough involvement from various State AIDS Control Societies ("SACS"). This process enabled an understanding of realities occurring at the local level, incorporating a broad cross-section of perspectives and experiences into the draft law.

   What emerged from these consultations was a reaffirmation of our belief that understanding the experiences and needs of affected persons necessarily entails taking cognizance of unique regional differences and perspectives, such as HIV prevalence rates, and social, economic, political, infrastructural, educational and cultural factors. A regional consultation was held in *Bangalore*, Karnataka, in March 2004, with stakeholders from across Karnataka providing critical inputs.

   Above all, it was realized that the law on HIV should be evidence and rights-based and not premised on hypothetical notions of what "should be". The national

law does not base itself on any ideological precepts. It strongly bases itself on evidence of successful strategies in India and around the world. It is also rooted on protection and promotion of the rights of those infected and affected. The understanding of the HIV paradox is crucial to understanding the battle against HIV.

We continue to believe that any statutory approach to the HIV/AIDS epidemic must be informed by these realities, and believe that the national law will therefore most effectively protect persons and communities significantly affected.

4. The national legislation covers a vast array of topics and is ***holistic*** and ***comprehensive***. The proposed Karnataka bill is neither. There are crucial features which are absent or not dealt with adequately in the proposed Karnataka bill that any HIV/AIDS law should provide for, viz. consent, confidentiality and rights against discrimination, special understanding of vulnerable communities and provisions on risk reduction, Information/Education/Communication ("IEC"), implementation mechanisms, a safe working environment, access to anti-retroviral and related treatment to prolong healthy lives of HIV-positive persons, special promotions of rights of women and **children.**

Given the devastatingly high number of people living with HIV/AIDS who are desperately requiring treatment in Karnataka, it is a glaring gap that there is no sufficient provision for access to medicines and treatment, an essential component of a comprehensive response to the epidemic.

5. We would like to highlight a few of the most troubling sections of the bill, that compromise the rights of women, and of persons living with HIV/AIDS, and which we do not believe will prevent the spread of HIV/AIDS in Karnataka:

- A mention of pre-marital HIV tests that does not provide for enforceable rights, and borders on the dangerous mandate of pre-marital mandatory testing;
- A provision on a mandatory duty to disclose that violates the right to confidentiality and does not provide essential safeguards for Persons Living With HIV/AIDS;
- A provision that proscribes procreation between consenting adults, violating fundamental rights;
- A provision requiring the mandatory testing, counselling and treatment of pregnant women, violating fundamental rights and placing the women of Karnataka at heightened risk of negative health effects, domestic violence, and other deleterious consequences.

These provisions are liable to be challenged and held unconstitutional by courts of law, on account of the violation of fundamental rights. In fact, data from around the country maintained by NACO and SACS demonstrates that of the pregnant women who are reportedly counselled, 97% undergo testing voluntarily.

Therefore, there is no need to test any women mandatorily. This indicates that the law is not based on ground realities or on any evidence, but is premised on hypothetical assumptions that are disastrous in the long run.

6. We would like to note that any statute seeking to prevent the HIV/AIDS infection, and protect rights, must be thoughtfully and precisely drafted. Unfortunately in the proposed bill, terms are not well-defined, sections exist that overlap with existing law, there is no clarity as to which sections are applicable to the public or private sector, proscriptions are recited without judicial avenues named, and remedies or penalties are not clearly set out, to name a few of the problems. Furthermore, the functions of the state board and officials are not explained in relation to the existing national and state bodies and programmes that already exist. Such ambiguity will only result, we believe, in justice denied to those who desperately need it and alienate Persons Living With HIV/AIDS from the rest of society.

We have attached an **in-depth legal analysis** of the proposed bill that highlights its poor draftmanship, which we believe will impede its effective implementation and could potentially worsen the current situation.

7. In conclusion, we request you not to pass this proposed legislation that could have a negative impact on public health and on individuals. We request you to re-examine the law and strategies that can be employed that will empower the citizens of Karnataka, particularly persons living with HIV/AIDS, so that they in turn will effectively prevent the spread of the HIV infection in Karnataka. We respectfully request you to adopt/wait for the national comprehensive HIV/AIDS legislation to be enacted, which we believe is the optimal legal and public health response for **Karnataka**.

Thank you,

for Anand Grover
Project Director
Lawyers Collective HIV/AIDS Unit – Bangalore

Cc: Dr. Anbumani Ramadoss, Hon'ble Health Minister, Ministry of Health
Dr. Quraishi, Director General, National AIDS Control Organisation
Mr. Patil, Hon'ble Law Minister, Karnataka
Mrs. Mukthamba, Project Director, Karnataka State AIDS Prevention Society

Enclosed:

1. A comment on the proposed Karnataka bill by the Lawyers Collective HIV/AIDS Unit
2. "Legislating an Epidemic: HIV/AIDS in India", a publication of the Lawyers Collective HIV/AIDS Unit

HIV/AIDS White Papers

Winning the Battle Against HIV:
How Homeopathic Growth Factors Can Strengthen The Immune System To Kill The Virus

It's August in Johannesburg, South Africa, and the informal settlement of Finetown fails miserably to live up to its name

The informal settlement of Finetown, South Africa fails miserably to live up to its name. The clinic set up in the Sancta Maria/Don Bosco School is filled with the intense smell of illness but offers hope to the small children who seek health care within its walls. The children, particularly those with pediatric HIV infection, are scarred from sores, plagued by hard, dry coughs and exhaustion. Their little bodies have never known what it is to feel well. They have been orphaned by AIDS, and they're now fighting for their own lives.

The country's number of HIV-infected orphans, while tragic, is not surprising. With a total of 4.2 million infected people, South Africa has the largest number of people living with HIV/AIDS in the world. Up to 40 percent of women of child-bearing age are infected, and the average lifespan has decreased from 94 to 56 years.

South Africans don't receive antiretroviral therapy (ART), the standard of care in the U.S. for HIV/AIDS, until they have full blown AIDS. In addition, these patients have inadequate access to properly trained doctors who understand the complexities of antiretroviral therapies (ARTs), rotations of medications and toxic side effects. The South African epidemic, like any in poverty-stricken locations, demands a therapeutic solution that is effective, inexpensive and free of side effects.

Fortunately, a proven, affordable treatment to curb the advance of HIV to AIDS has been discovered.

The Hypothesis

The seeds of this tremendous breakthrough were planted a decade ago. While Barbara Brewitt, a researcher with a PhD from the University of Washington's School of Medicine in Biological Structure, was conducting post-doctoral research on growth factor effects on gene regulation at the National Institute of Health (NIH), she had a vision – to develop a safe and affordable treatment for HIV and AIDS. Up to that point, conventional medical wisdom had largely avoided the immune system in its quest for HIV treatments, focusing on ways to inhibit viral replication. Yet Dr. Brewett suspected that the key to treating immune system diseases like AIDS was to bolster the patient's immune system. By strengthening the body's own defenses, she hypothesized, the body may be best able to defend

itself.

In the mid-1980s, researchers learned how to make cell signaling proteins, which the human body would recognize and accept just as if it had produced them. Dr. Brewitt developed oral growth factor medicines as active cell signaling proteins. Growth factors regulate and coordinate immune, nervous and endocrine communication in order to effectively and efficiently coordinate optimal functioning and defenses within the body. Because growth factors are so important to immune function, including immunosuppression of various sorts, Dr. Brewitt theorized that homeopathic doses of growth factors may provide therapeutic benefits to people with HIV infection. She recognized that growth factors used the same signaling pathways and DNA regulatory mechanisms within the cell as HIV does; therefore, presenting a possibility of growth factor signaling competition to HIV replication and an affordable, safe, survival approach for people across the globe.

During her research at the NIH, Dr. Brewitt was also studying at the National Center for Homeopathy. A system of healing the whole person, homeopathy uses extremely small doses of highly diluted organs, tissues, metabolic factors, recombinant materials, plants, animals and minerals to stimulate the body's own immune system. Homeopathy has a history of success in the treatment of infectious disease, including many of the most serious and potentially fatal infectious diseases known to humankind. In the 1800s, death rates in homeopathic hospitals from cholera, typhoid, yellow fever, scarlet fever and pneumonia were commonly one half to as little as one eighth of those in conventional medical hospitals.

While pharmacologic doses of growth factors that were tested on people with AIDS in the early 1990s caused many side effects, Dr. Brewitt believed that growth factors that were prepared homeopathically (HoGFs) would eliminate side effects while achieving measurable results.

The Studies

In 1994, Dr. Brewitt first put her hypothesis to the test. Collaborating with the Director of Research at Bastyr University in Seattle, Leanna Standish, N.D., Ph.D, Dr. Brewitt began a clinical study using homeopathic doses of a combination of four growth factors: insulin-like growth factor-1, platelet-derived growth factor BB, transforming growth factor β-1 and granulocyte-macrophage colony stimulating factors. This 12-week, double-blinded placebo-controlled clinical study (DBPCS) involved 21 adults with HIV and AIDS who were using natural therapies and no ART. Patients were given 10 drops of these homeopathically prepared medicines three times per day from each of four bottles or the **placebo**.

The patients receiving the combination of HoGFs experienced:

- reduced HIV viral load
- increased CD4 T-cells
- appropriate weight gain averaging 10 pounds, with maintenance of lean body mass
- stopped inflammation and opportunistic infection in the body
- experienced no adverse side effects
- improved metabolism without abnormal fat deposition
- improved blood mineral status
- healthier levels of liver enzymes
- improved quality of life

Dr. Brewitt then conducted an open label study for nine months with

the same 21 adults, plus six additional subjects. Again, the results were the same.

With two successful studies completed, Dr. Brewett sought to answer her critics who claimed her results were, at least in part, attributable to her involvement. In 1996, she found seven independent urban clinics to conduct DBPCS in Los Angeles, San Francisco, San Diego, Portland, Kona, New York City and Tucson. The 55 subjects, none of them using ARTs, experienced the same benefits from the treatment as discovered in the original Seattle studies.

Two and half years after the second Seattle study, she conducted a year-and-a-half-long follow-up study with those same subjects. In this study there were three sub-groups: 1) those taking HoGFs with other natural therapies of their choice; 2) those taking natural therapies of their choice; and 3) those on ARTs that were also taking HoGFs. Once again, the results were consistent with the prior studies. In addition, those with HIV/AIDS given HoGFs experienced no hospitalizations or new opportunistic infections during the 2.5-year follow-up versus 25% and 40% hospitalizations and opportunistic infections in those with AIDS taking ARTs or using only natural medicines, respectively. The studies show that HoGFs alone increased a greater diversity of cells in the immune system without any toxic side effects, which is fundamental to preventing infections and defending the body against pathogens. The data from these studies implied that HoGFs alone stimulated a more diverse population of immune cells without any toxic side effects.

Global Significance

The clinical data from the first four studies were presented at peer-reviewed international AIDS conferences in six different countries and were translated into five languages. The studies were published in medical textbook about complementary and alternative therapies for AIDS (Churchill Livingstone 2002). Additionally, editors from the Journal of Alternative and Complementary Medicine and an author in public health, Dana Ullman, have published third-party reviews about this work that were read worldwide.

Studying South Africa's Orphans

One such online viewer was a student embarking on her doctoral thesis for her homeopathy degree from the University of Johannesburg in South Africa. Monica Da Silva contacted Dr. Brewitt requesting to test HoGFs on children with HIV and AIDS. Dr. Brewitt knew this was a critical step to filling South Africa's desperate need for an affordable, effective treatment. The study protocol was presented to three levels of safety and scientific review through the University of Johannesburg prior to its start. Ms. Da Silva and her research supervisor, Dr. Radmilla Razlog, designed and began the study in April of this year with 24 children in Finetown, ages one to 12, who have spent their lives sick, undernourished and small for their ages, as is typical of pediatric HIV sufferers.

These orphans received the HoGF for 12 weeks after two weeks of pre-treatment. The results not only confirmed the prior findings, but proved exceptionally promising for this population. While the disease usually stunts growth, these children experienced "catch-up" growth with significant increases in height averaging 6-7 centimeters, head circumference and lean body mass. The children's CD4 T-cells increased by five percent, and they enjoyed an improved quality of life and required no **hospitalizations.**

The Future of HIV/AIDS Therapy

The effect of this new treatment could have astounding results, not only for the children of Finetown, but for the entire country of South Africa and those stricken by this pandemic around the globe. These HoGFs represent a new class of medicines, combining today's advanced biotechnologies, modern molecular biology and basic homeopathic principles formed two centuries ago.

Presently, the standard treatment for HIV/AIDS is the use of multiple ARTs through a highly active antiretroviral treatment (HAART). While these drug cocktails led to the first real medical progress in the treatment of the disease, HAART has not effectively stopped viral replication. A study published in the Journal of the American Medical Association found that 78 percent of people taking HAART are resistant to one form or another of these drugs, and 27 percent are resistant to all HAART drugs. Another 40 percent of people on HAART suffer from unwanted side effects such as insulin resistance and hyperglycemia. For underdeveloped countries or populations lacking economic resources, HAART therapy is out of reach and risks unwanted, potentially dangerous side effects.

In fact, researchers from the NIH report that even the most sophisticated of today's ARTs may never completely cure HIV-infected individuals. After more than 15 years of research into the cause and potential cure for AIDS, the message remains the same: a human immune system must destroy HIV.

Without effective, expanded prevention, treatment and care efforts, the AIDS death toll in South Africa, and the rest of Sub-Saharan Africa, is expected to continue rising before peaking around the end of this decade.Treating and caring for the millions of Africans living with HIV/AIDS poses an inescapable challenge to the continent and the world at large. HoGFs provide an affordable option without side effects for people around the world. All five studies demonstrate that HoGFs strengthen the immune system and immune diversity, improve the nervous system and increase lean body mass and quality of life. And because these homeopathic medicines are highly diluted, HoGFs reduce costs up to 80 to 90 percent of conventional medicines. This breakthrough is not only a potential solution to South Africa's AIDS epidemic; HoGFs can also be used prophylatically around the globe to stem the spread of HIV.

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ALTERNATIVE THERAPIES FOR HIV TREATMENT

Traditional Chinese Medicine	Homeopathy	Acupuncture
Siddha Medicine	Unani Medicine	Diet Therapies
Bodywork & Massage	Yoga	Mind-Body Therapies
Herbal Medicine	Ayurveda	

Alternative medicine has been variously called natural, complementary, 'holistic' and numerous other terms, which refer to elements of a particular modality or tradition. The traditional ethnomedicinal systems are by nature holistic, meaning that they aim to treat the whole individual, rather than a specific disease or symptom, and that they address not only the physical aspect of the patient but also the mind and the spirit. It is assumed that each individual possesses an innate healing capacity (the "immune system" in the broadest sense), and the goal generally is to reinforce this capacity and restore strength and balance to weakened systems using a variety of natural modalities: body work, detoxification, foods, herbs and other botanicals, tailored as much as to the individual's specific constitution and condition. The use of alternative therapies for AIDS grew out of this same eclectic mix.

At the beginning of the epidemic, little or no treatment was available for people with HIV possible/AIDS. Although as yet there is no cure, over the last decade researchers have identified a number of drugs that slow progression of the virus as well as therapies to treat the many opportunistic infections that attack people with HIV disease. The key to effective treatment is early detection and intervention. Some early treatments aim to strengthen the immune system, help patients reduce stress, and maintain good nutritional practices and appropriate exercise regimens. Many of the gettingalternative therapies described below place significant emphasis on these lifestyle issues. Taking an active role in any disease is an important adjunct to treatment. Consideration of alternative therapies in conjunction with conventional medicine may offer additional opportunities for persons living with HIV/AIDS to be proactively involved in their treatment.

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How to Approach Alternative Therapies
Here are a few suggestions to follow before involved in any alternative therapy:

- Obtain objective information about the therapy. Besides talking with the person promoting the approach, speak with people who have gone through the treatment—preferably those who were treated recently and those treated in the past. Ask about the advantages and disadvantages, risks, side effects, costs, results they experienced, and over what time span results can be expected.

- Inquire about the training and expertise of the person administering the treatment (i.e., certification). If any uncertainty remains, verify the information.

- Consider the costs. Alternative treatments may not currently be reimbursable by health insurance.

• Discuss all treatments with your primary care provider, who needs this information in order to have a complete picture of your treatment plan.

People with HIV/AIDS in the United States use many kinds of alternative approaches to treatment. Some of the most common are briefly described below.

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The use of acupuncture and Chinese herbal medications has become one of the most commonly used alternative therapies for AIDS. Its use has become so widely accepted that two Chinese Medicine Clinics in San Francisco have been awarded contracts through the SF Health Department's AIDS Office to provide Chinese Medical treatment to people with HIV. The contracts are funded by Ryan White CARE Act allocations. Most people with HIV who use acupuncture and Chinese herbs do so in conjunction with western medicine. There are, however, some who use it as their principal form of medical treatment. It is strongly suggested that it be used under the supervision of a licensed practitioner.

The systematic practice of Chinese Medicine dates back over two thousand years, making it the oldest medical system in the world. Where western medicine is derived solely from scientific method as a means of treating disease, Chinese medicine is intertwined with a philosophy of life, and is based on a holistic view of supporting the mind-body's innate ability to maintain health and to heal itself should illness occur. This approach is the result of many thousands of years of accumulated experience. Rather than dealing with mechanistic components of the human organism, as western science advocates, the TCM approach is one of aligning the functions of the organs and systems as a whole, promoting the dynamic balance of energy polarities which maintains health and well-being.

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Central to the philosophy of Chinese Medicine is the concept of ch'i, or qi, which can loosely be defined as the vital energy of the universe, of which all things are made. Ch'i patterns fluctuate between the polarities of what are called yin and yang, the active and passive sides of the life force. Illnesses can crudely be viewed as either excesses or deficiencies in either the yin or yang components of ch'i. Ch'i is believed to vitalize the body by its movements along the pathways which are known as meridians. The "meridian theory" of Chinese Medicine is not accepted in western medicine, because they have never been objectively identified anatomically. The circumstantial evidence of their existence, however, is undeniable to Chinese doctors, since points along the meridians have been used successfully as the sites for acupuncture needling for thousands of years.

In San Francisco, where Chinese medical treatment has been funded for three years by the Ryan White CARE Act, the American College of Traditional Chinese Medicine has treated over 300 symptomatic HIV-positive patients in long-term care. A study of the medical records of these patients, and of quarterly health surveys, has identified seven HIV-related conditions which appear to be most responsive to Chinese medicine. These seven conditions are: weight loss; diarrhea/loose stools; abdominal pain; nausea; headaches; enlarged lymph nodes; and neuropathy.

Chinese medicine was first popularized as a treatment for AIDS in San Francisco by Misha Cohen, a Doctor of Oriental Medicine, in 1984. A good deal of western type research on certain aspects of Chinese Medicine has since been conducted. Many of the herbs have been found to inhibit HIV and other viruses in laboratory experiments. Other herbs have been shown to act as biological response modifiers, enhancing certain immune responses. In addition, a small, strictly controlled study using acupuncture to treat HIV infected individuals was conducted at Lincoln Hospital in Bronx, NY, a few years back. It was reported that individuals receiving correctly applied acupuncture needling had notable increases in their CD4 counts after only a brief course of therapy. This pilot study certainly demonstrated the need for further research.

Some human efficacy studies of Chinese medicine for HIV disease are currently underway. Chinese herbs may be a rich source of therapeutic agents for AIDS and its related illnesses. It is essential that people with HIV have all the information they need to select the treatment options most suited to their own needs and dispositions. Chinese Medicine is a promising option which is safe, appears to be somewhat effective, and is affordable to most.

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Prior to the emergence of AIDS, few people were familiar with or cared about the immune system. Now, more than ever, the general public is interested in

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exploring ways to bolster immune response to prevent the progression of AIDS, as well as to reduce the number and intensity of opportunistic infections and to improve the overall state of their health. By strengthening a person's own defenses, the body is best enabled to defend itself.

Homeopathy is one way to do this. Although no therapy can or will help every HIV+ person or everyone with AIDS, homeopathy is beginning to develop a reputation for helping people at varying stages of this disease. To understand what homeopathy has to offer, it is necessary to learn something about a different approach to infectious disease than simply attacking a pathogen.

As increasing numbers of physicians learn about homeopathic medicine, they will be exposed to viable alternative treatments which can play an integral role in the care and treatment of people with HIV and AIDS.

Homeopathic medicines, which include minerals, vitamins, and animal products, are natural substances given in very low doses. Homeopathy is based on the principle that "like cures like", that is, substances that in large doses would cause adverse symptoms will, in small doses, treat those same symptoms. Homeopathy is highly individualized to a patient's symptoms.

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The treatment of people with HIV or AIDS requires professional health care, even when their ailments are seemingly minor. Ideally, they should receive treatment from a homeopath who is an M.D. or a D.O., but otherwise the best care is one that integrates homeopathic treatment with appropriate medical diagnosis and, in emergency situations, with appropriate medical treatment.

One of the advantages of using homeopathy in treating people with AIDS is that they tend to get various unusual symptoms, diseases, and syndromes which evade immediate diagnosis. A homeopath, however, can prescribe a remedy before a definitive conventional diagnosis is made. Because homeopathic medicines are prescribed on the basis of a person's unique pattern of symptoms, a conventional diagnosis is not necessary for a curative remedy to be prescribed. Preliminary results of a study initiated by the Central Council for Research in Homeopathy (CCRH) in 1989 testify to immunostimulatory role of homeopathic medicines in HIV **infection.**

A randomized placebo-controlled study during 1995-1997 to ascertain the treatment efficacy involved 39 people prescribed homeopathic medicines—Amyle Nitricum-30CH and Azadirachta indica-6X—taken as medicated globules. The individuals also underwent physical and breathing exercises, besides half ounce of honey and 30 grams to 50 grams of *moong dal* (green gram) sprouts in their daily regimen. At the end of each month, the individuals tested remained asymptomatic.

Despite the seemingly positive results that homeopathic medicines provide for people who are HIV positive, for those with early onset of AIDS, and for those with nonextreme cases of AIDS, most homeopaths do not observe significant improvement in treating people who have advanced stages of AIDS. But there are exceptions to this general rule, and numerous homeopaths find that select patients with advanced stages of AIDS experience dramatic improvement in their quality of life.

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Dr. Issac Mathai, a homeopath based in Bangalore, India, recounts: "I have handled around 20 AIDS cases since 1987 with positive changes. The treatment, which improves our immune system by stimulating it to fight this immunity related disease, includes homeopathic medicines, herbal supplements and vitamins. This helps in AIDS cases as the condition itself is related to immunity. Besides, dietary or lifestyle changes make a lot of difference in the patient's general health."

Dr. Mathai mentions a 38-year-old, diagnosed HIV positive in 1985 along with his partner, who was asymptomatic after the treatment: "During the treatment his general health was good. Occasionally, he suffered from colds, coughs and stomach upsets, which were treated appropriately with acute homeopathic medicines. During this time his partner passed away. Yet he survived with maintenance medicines, which keep his immune system in good condition."

Concludes Dr. Mathai: "Since homeopathic treatment is customized to a patient's requirement, it could vary from person to person."

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Mumbai-based homeopath Dr. Mukesh Batra also treats HIV/AIDS. Says Batra: "We have treated about half-a-dozen AIDS cases in the three years. The treatment works on building up the immune system. Our success rate has been almost 100 per cent in treatments that relieve symptoms of AIDS patients such as repeated cold, cough, weight loss, diarrhea. A patient with AIDS was treated at

our clinic in Mauritius a couple of years ago. He tested HIV positive. He was losing weight and had repeated attacks of cold, cough and pneumonia. With homeopathic treatment for about a year and a half he began to put on weight and his tests returned to normal."

The history of homeopathy's successes in treating infectious disease epidemics, the research that suggests the immunomodulatory effects of homeopathic medicines, and the clinical research on HIV+ and AIDS patients that indicates beneficial response to homeopathic medicines should command attention by physicians, scientists, and public health officials. Despite this body of work, it is both surprising and depressing that homeopathic medicine has been consistently ignored as a viable part of a comprehensive program in treating HIV positive and AIDS patients.

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Acupuncture involves the relatively painless insertion of extremely thin needles into the skin at specific points to help balance the body's flow of energy, referred to as qi ("chee"). When needles are inserted into the appropriate points, it is thought that energy is unblocked, and symptoms can be relieved. Variations of acupuncture include acupressure and shiatsu (pressure and massage of acupuncture points). Acupuncture is sometimes used to relieve some HIV-related symptoms such as neuropathy, fatigue, and pain. It is also used in an attempt to strengthen the immune system.

Acupuncture is based on the understanding that just as energy can be disrupted or depleted, so also can it be rechanneled and replenished. Thus, the acupuncture needles may stimulate the body's own energy reserves or they may transmit energy from the environment into the body. Because each individual will have a unique interplay of energies, organs, and elements, as well as a unique character, the treatment is, theoretically, individualized.

It is important to find a licensed acupuncturist who is experienced in treating people with HIV. Local AIDS hotlines and community-based organizations may be helpful in offering referrals. After finding a qualified acupuncturist, the first step in treatment is accurate diagnosis. The practitioner uses several traditional diagnostic techniques to determine whether treatment should be aimed at stimulating or dispersing energy. Needles are then inserted at specific points along the appropriate meridian.

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Initially, practitioners used acupuncture to provide symptom-relief for persons with AIDS. Michael Smith, MD, D.Ac., of Lincoln Hospital in the Bronx has noted that after the first four or five treatments, most patients begin to experience a decrease in abnormal sweating, diarrhea, and skin rashes. Patients have also reported higher energy levels and many have gained substantial amounts of weight.

Patients on chemotherapy have noted a reduction in side effects such as nausea, fatigue, and weakness. "Acupuncture helps the body help itself," claims Dr. Smith, who emphasizes that the affects of the treatment on the overall health of a person is the key to understanding acupuncture. The Somerville Acupuncture Center in Boston, The AIDS Alternative Health Project in Chicago, and Quan Yin herbal support program in San Francisco have reported similar symptomatic relief and overall improvement.

Recently, at a local conference on AIDS, Dr. Merrill, M.D., presented a compelling view regarding acupuncture and HIV-infected individuals. Dr. Merrill stated that he would not recommend alternative therapies as a sole treatment for HIV, but that acupuncture may add significantly to an overall improvement in the sense of well being of HIV-infected patients. Additionally, while Merrill believes acupuncture may not cure infections or increase T4 cells, it does provide subtle enhancing properties, like increasing endorphins and possibly reducing stress and pain. Merrill also stated that acupuncture might be helpful in reducing spasms in gastrointestinal conditions, common drug-induced nausea, and some neurologic problems.

The validity of acupuncture and Traditional Chinese Medicine remains controversial in the Western culture. There is no claim that acupuncture has direct antiviral effect on HIV. But many professionals trained in both Western and Chinese medicine, have found that acupuncture offers many benefits to the overall health of a person with HIV. In fact, more and more people with HIV are using acupuncture to reduce stress, pain, and tension, among other conditions.

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The Tamil *Siddhars* are 18 enlightened men and women who wrote down the causes of 4,448 different diseases and prescribed medicines. AIDS was called '*Vettai Noi*'. AIDS syndrome was already known to the Siddha system of medicine. It was further classified into 21 types, most of which are caused due to wrong diet, excessive sex causing depletion of *prana* (meaningless sex depletes a person emotionally, physical and spiritually according to the Siddhars). The chief cause of *Vettai Noi* is the defects in the three humors—*Tridohas*.

The 18 *Siddhars* of the Siddha traditional have classified 4,448 diseases and prescribed medicines in the form of herb, roots, salts, metals and mineral compounds. AIDS was classified as *Vettai Noi* as early as a few thousands of years ago in the cradle of the ancient prehistoric civilization in Tamil Nadu, Southern India.

Siddha system is based on hypothetical and biological laws of nature. The *Siddhars* were pioneers to the world in the field of minerals, metals, and medicinal herbs. They found out the methods of processing metals, minerals, herbs and natural raw materials to make *churnams, chenthurams and leyhams* (Churnam is powdered formulation, leyhams is thick batter like formulation).

Vettai Noi, was further classified into 21 types, most of which are caused by depletion of the *Prana* and/or *Ojas* through excess indulgence and abuse of the body, rendering the immune system weak and susceptible to pathogens.

The chief cause of *Vettai Noi* is due to the three humors, *Tridoshas* and mainly due to *Azhal Kurtrum* (*Pittam* or bile, acidic nature) exhibited in the blood stream.

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The following herbs are recommended for the effective treatment of *Vettai Noi*.
1. *Aragumpul* (Cynodon Dactylon Pers)
2. *Karisalinkanni* (Eclipta Alba Hassk)
3. *Musu Musukkai* (Mukai Scavrillia)
4. *Thoodhovali* (Solanum Trilobatum Linn)
5. *Jeeragam* (Luminum Cyminum)

Other Siddha medicines that could be prescribed under medical supervision and administered for AIDS as supportive therapy are as follows:

1. For purification of blood: *Kanthaga Rasayanam, Paranki Pattai churam, Palakaria Parpam.*

2. For reducing fever: *Linga chenduram, Gowri Chinthamani, Thirikadugu Churnam, Rama Banam, Vadha, Piththa, Kaba Sura Kudineer.*

3. For persistent diarrhea: *Thair Sundi churnam, Kavika churnam, Amaiodu Parpam.*

4. Revitalizers and rejuvenators to the disabled immune system of the body: *Orilai Thamarai karpam, Serankottai Eagam, Thertran Kottai leyham, Amukkara.*

5. Antiviral drugs: *Rasagandhi, Mezhugu, Murukkanvithtu, Masikai, Edi Vallathathy mezhugu.*

6. Restoration of the disturbed mind: *Vallarai.*

The medications *rasagandhi mezhugu, amukkara chooranam* and *nellikkai lehyam* are effective for HIV/AIDS patients who do not have overt neural HIV.

Drugs that control opportunistic infections complement these. Since 1992 all the three formulations are said to have been tested on over 35,000 patients at the Government Hospital of Thoracic Medicine, Tambaram Sanatorium, Chennai, India, and are apparently without side effects. They are said to reduce viral load, boost counts of CD8 and CD4 cells, control symptoms and increase body weight. Although prolonged viral suppression has occurred in a few patients, these drugs are as yet unable to cure AIDS.

(Reference: Dr. V . Kalidoss, Siddha System of Medicines for Treatment of AIDS)

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The Treatment for AIDS Prospects in Siddha Medicine

The body's immunity gets heavily depleted by excess indulgence as stated by the *Siddhars*. *Siddhars* have evaluated that *Azhal thathu* is responsible for the defense of the body. Disease takes place with the deterioration of the *Vindhu thathu*. Such deterioration leads to diseases such as pain, skin lesions, formation of nodes, malignancy, fistula, abscess, cervical adenitis, inquinal adentitis (adentitis is inflammation of the glands), ulcers in the loin, eczematous eruptions, pustules, constipation, TB, diarrhea, chronic dysentery, anemia, jaundice and upper respiratory infections. Siddha medicines are formulated in such a way as to have a total rejuvenating effect on the body and not only effective against a

particular disorder.

The special feature of the Siddha medicine is that most of the preparations are in compound formulation, and because of its synergistic action, toxicity is diminished, thereby increasing bioavailability through the cells of the body. The pharmacodynamics of this system is entirely different from other systems of medicines.

Drugs that could be prepared for AIDS may be classified as follows:
1. Herbal preparations
Serankottai Nei (herbal ghee), *Mahavallathy leyham*, *Parangi rasayanam*.

2. Herbo mineral preparations
Gandhak Parpam, Gandhaka rasayanam.

3. Herbo mercuric preparations
Idivallathy mezhugu, Poona Chandrodayam.

4. Herbo-mercuric-arsenal preparations
Rasagandhi mezhugu, Nandhi Mezhugu, Sivandar Amirtham, Kshayakulanthan Chenduram.

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Homeopathy in HIV infection: a trial report of double-blind placebo controlled study.

Rastogi DP, **Singh VP**, **Singh V**, **Dey SK**, **Rao K**.

Central Council for Research in Homoeopathy, JNBCHA, Janakpuri, New Delhi, India.

OBJECTIVE: This study was aimed to evaluate the immuno-modulator role of homeopathic remedies in Human Immunodeficiency Virus (HIV) infection. METHODOLOGY: A randomised double blind clinical trial was conducted to compare the effect of homeopathic remedies with placebo, on CD4+ve T-lymphocytes in HIV infected individuals, conforming to Centres for Disease Control (CDC) stage II & III. 100 HIV+ve individuals between 18-50 y (71% males) were included in the study. 50 cases conformed to CDC stage II--Asymptomatic HIV infection, and 50 cases to CDC stage III--Persistent Generalised Lymphadenopathy (PGL). Cases were stratified according to their clinical status and CD4+ve lymphocyte counts. The randomisation charts were prepared much before the start of the trial by randomly assigning placebo and verum codes to registration numbers from 1 to 50. A single individualised homeopathic remedy was prescribed in each case and was followed up at intervals of 15 d to one month. A six months study was performed for each registered case. Assessment of progress was made by evaluation of CD+ve lymphocyte counts, which was the prospectively-defined main outcome measure of the study; the results were compared with the base line immune status. RESULTS: In PGL, a statistically significant difference was observed in CD+ve T-lymphocyte counts between pre and post trial levels in verum group ($P < 0.01$). In the placebo group a similar comparison yielded non-significant results. ($P = 0.91$). Analysis of change in the pre and post trial counts of CD4+ve cells between groups was also statistically significant ($P = 0.04$). In asymptomatic HIV infection, differences in absolute CD4+ve lymphocyte counts between pre and post trial levels were not significant. Analysis of changes in pre and post trial CD4 levels of placebo and verum groups for combined strata of asymptomatic and PGL groups was also not significant. CONCLUSION: The

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study suggests a possible role of homeopathic treatment in HIV infection in symptomatic phase, as evidenced by a statistically significant elevation of base line immune status in persistent generalised lymphadenopathy.

Publication Types:

- Clinical Trial
- Randomized Controlled Trial

PMID: 10335412 [PubMed - indexed for MEDLINE]