Subject: Fwd: [AIDS-INDIA] Training in Telephone counselling for HIV/AIDS
Date: Fri, 05 Oct 2001 00:30:02 +0000
From: "latha jagannathan" <lathajagu@hotmail.com>
To: madhyamb@vsnl.com, samraksha@vsnl.net, knppius@vsnl.net, mamthasatish@vsnl.com, snehadaan@yahoo.com, vravi@nimhans.kar.nic.in, chandra@nimhans.kar.nic.in, j_ramakrishna@vsnl.com, pradeep@mahiti.org, sochara@vsnl.com, manohar@sangamaonline.org, bctbng@bgl.vsnl.net.in, lman@vsnl.com, svjrao@hotmail.com

>From: "Melita Vaz" <melita@vsnl.com>
>To: <aids-india@yahoogroups.com>
>Subject: [AIDS-INDIA] Training in Telephone counselling for HIV/AIDS
>Date: Thu, 4 Oct 2001 10:04:28 +0530
>
>Dear Friend
>
>I am forwarding the announcement of our next training programme on
>Telephone Counselling for HIV/AIDS. Unfortunately, due to the existing
>waiting list we have only 8 seats available now. So those who would like to
>attend, are requested to get in touch as soon as possible to avoid
>disappointment.
>
> "In the history of HIV community service development, hotlines are
>distinctive for the following reasons:
>1 usually they are among the first community initiatives to appear in the
>context of HIV community responses;
>2 usually they are organised initially by groups of the highest known
>sero-prevalence.;
>3 they usually endure and grow to the extent that the value of hotlines is
>now beyond any doubt in those communities where they have been
>established."
>
>Dr. David. Miller's comment in 1990 underlines the contemporary relevance
>of helplines and hotlines in providing much needed support to communities
>and People Living with HIV/AIDS. In addition, they offer confidentiality
>and 24-hour availability (sometimes). However, appropriate training is
>often lacking.
>
>The Cell for AIDS Research Action and Training (CARAT) is pleased to
>announce another hands-on training programme for counsellors who intend to
>take up telephone counselling.
>
>TELEPHONE COUNSELLING FOR HIV/AIDS
>DATES: October 31 (2.00 p.m.) to November 4, 2001 (4.00 p.m.)
>VENUE: Tata Institute of Social Sciences
>Sion-Trombay Road, Deonar,
>Mumbai 400 088
>
>COURSE FEES v: Rs. 225/-
>(includes shared accomodation & meals at Tata Institute)
>The workshop offers
>
>a. a working knowledge on HIV/AIDS-related issues like Basic Virology and
>Positive Living
>b. skills in telephonic counselling and handling inappropriate callers
>c. information on establishing a helpline, maintaining records, ethics of

lib AIDS resource file 5/10/01

TO: AT TN 5/X/01

>helplines
>d. a guided field visit to local helplines
>e. a complementary copy of the book "Telephone Counselling for HIV/AIDS: A
>Counsellor's Source Book" (second edition) Workshop faculty include
>helpline counsellors
>
>a. Individuals and organisations wishing to register for this workshop must
>send a draft for the full amount in the name of Tata Institute of Social
>Sciences to Ms Melita Vaz, Cell for AIDS Research Action and Training, Tata
>Institute of Social Sciences, Post Bag 8313, Deonar Mumbai, 400 088. Please
>indicate name of the participant, age and gender.
>
>Based on our experience of previous workshops, we are restricting numbers
>to 24 participants only. Please confirm your participation early to avoid
>disappointment. For further details, you may e-mail me at melita@tiss.edu
>
>Yours sincerely,
>
>Ms Melita Vaz
>Lecturer, Medical and Psychiatric Social Work Dept.
>E-mal:Melita Vaz" <melita@vsnl.com>
>
>

Essential medicines access - Doha WTO meeting

[AIDS-INDIA] Doha: Big Pharma outmaneuvered by activists

Subject: [AIDS-INDIA] Doha: Big Pharma outmaneuvered by activists
Date: Wed, 14 Nov 2001 11:47:55 -0500
From: Paul Davis <pdavis@critpath.org>
To: AIDS-INDIA@yahoogroups.com

WSJ November 14, 2001

Health: Deal Will Allow Poor Nations to Ignore
Patents to Meet Public-Health Needs
By GEOFF WINESTOCK and HELENE COOPER
Staff Reporters of THE WALL STREET JOURNAL

DOHA, Qatar -- The pharmaceutical industry is scrambling to limit the damage that might result from a deal hammered out by World Trade Organization negotiators this week that declares that poor countries can ignore drug-company patents and buy cheap generic drugs to meet public-health needs.

The drug industry has long argued that countries, even poor ones, must honor its patent rights or else the industry won't have an incentive to develop new drugs. Under intense political and public pressure, some companies have in the past year eased their position on patents for drugs to treat AIDS in poor countries. But the WTO deal goes further: Drug companies sought narrow language to encompass only health pandemics such as AIDS, but under the pact, illnesses from cancer to diabetes to asthma could qualify.

How the deal was struck shows how the industry was outmaneuvered by activists.

Just as WTO negotiations here reached a crisis on Monday morning, a fretful Alan Holmer, president of the Pharmaceutical Research and Manufacturers of America, fired off a letter to U.S. Trade Representative Robert Zoellick to warn against any compromise that might weaken drug patents.

Too late. Within hours, elated negotiators from poor countries were passing around a draft agreement that declares that public health trumps drug patents. "We agree that the [WTO] does not and should not prevent members from taking measures to protect public health," the agreement said. "We affirm that the agreement ... be interpreted and implemented in a manner ... to ensure access to medicines for all."

Mr. Holmer didn't return phone messages seeking comment.

Library - Access to medicines file 20/11

While U.S. trade negotiators here maintain they haven't weakened WTO legal protections for drug patents, the drug industry worries the agreement is bound to embolden poor countries to get cheap generics where they can.

AIDS activists, who showed up here in droves to battle drug-company lobbyists, were ecstatic. "It's like the WTO looked at the signs of the demonstrators on the street, and then put in a declaration and adopted it," said Jamie Love, director of Ralph Nader's Consumer Project on Technology.

Officials from Brazil -- where AIDS drugs are free and the fight for greater access to life-saving medicines is a cause célèbre -- were also elated. "Our expectations were fully met," said Paulo Teixeira, Brazil's top AIDS official. "Even six months ago, this was unthinkable." Brazil is the only country that sent both its top health and AIDS officials to

the meeting.

Tuesday, drug lobbyists at the meeting here were still struggling to figure out the pact's meaning. Vague language in the agreement, they fretted, could lead some countries, especially India, to continue to flout patents.

But their bosses back in the U.S. and Europe said they knew concessions were likely. "I wouldn't say that we're upset about this," said Nancy Pekarek, a spokeswoman for GlaxoSmithKline PLC. "The language [of the declaration] maintains the integrity of" WTO protections of patents.

Brian Ager, director general of the European Federation of the Pharmaceutical Industries and Associations, agreed. "It's still very much a political declaration," not a legal change to the WTO rules, he said.

Not everyone in the industry was so sanguine. "I am concerned," said Daniel Vasella, chairman and chief executive of Novartis AG. "It's important that the compromise express care for developing countries." But without patents, profits aren't possible, and research suffers, he said.

This needs to be addressed

Most trade envoys here said they assume the drug-patent agreement would take effect regardless of whether the WTO conducts and concludes a new round of trade-liberalization talks, but that isn't assured. "In the WTO, nothing is agreed until everything is agreed," one WTO official said.

>From the start, the drug-patents issue dominated talks here in Doha. Lobbyists from U.S., Swiss and European drug companies all descended on the meeting to protect their patents. But unlike in 1993, when intellectual-property protections were first negotiated as part of the initial WTO pact, this time the lobbyists were matched by AIDS activists who proved to be a well-coordinated group of opponents.

Even before negotiations started, AIDS activists were pressing delegates from poorer countries in Africa, Latin America and Asia to hold fast to their demands that the agreement allow them to override drug patents for a variety of ailments and not just pandemics such as AIDS. They also hounded the negotiators from the U.S., Europe and Switzerland, meeting with them again and again, to draft the agreement.

During a bus ride to one pre-conference meeting, the activists swarmed Finnish delegate Hannele Tikkanen. They demanded -- and received -- three meetings with U.S. negotiators, then passed the negotiators' cellphone numbers around.

Sometimes the battle between the drug lobbyists and the activists looked like a spy movie. "Shhh, that's Harvey Bale -- he'll hear us," one Oxfam America activist whispered after spotting the director general of the International Organization of Pharmaceutical Manufacturers on a late-night shuttle bus from the convention center. Oxfam is a charitable health organization.

At one point, the activists considered "outing" one drug lobbyist who sneaked into the WTO meeting using a press pass, but then thought better of it when they realized that about half of the activists themselves were also posing as reporters. The representative of the World Health Organization, which has close links to AIDS activists, was booted from one meeting of trade officials after the WTO complained he had no right to be there.

U.S. trade officials, once considered by activists to be allied with the

[AIDS-INDIA] Doha: Big Pharma outmaneuvered by activists

U.S. trade officials, once considered by activists to be allied with the devil himself on the patents issue, soon seemed almost angelic, especially when compared to the hard-line Europeans, particularly the Swiss. During a meeting Sunday at the Sheraton with the Swiss negotiators, Mr. Love of the Nader group listened for 45 minutes while the Swiss refused to move on the patents issue. The agreement should be limited to just AIDS, the Swiss envoys argued. What if African countries, they asked, used the pact to steal Novartis and other companies' patents on beauty products?

Mr. Love walked out of the meeting shaking his head.

But the Americans' traditional posture of defending patents suffered a severe blow several weeks ago, when Tommy Thompson, U.S. Secretary for Health and Human Services, threatened to seize Bayer AG's patent on Cipro, an antibiotic to fight anthrax, unless Bayer lowered its price. "We constantly reminded delegates of anthrax," said Mr. Teixeira of Brazil.

Since Brazil began producing local versions of expensive, foreign-made AIDS drugs, it has managed to bring down their prices by about 82%, according to the Brazil health ministry. As a result of widespread use of the drugs, the number of AIDS-related deaths and the infection rate in the country have both been cut in half in recent years. These statistics have made Brazil's AIDS program a model for the developing world.

Drug lobbyists did manage to win one point. The agreement fobs off to a committee the activists' demand that the WTO explicitly state that it's acceptable for countries that manufacture cheap generics -- such as Brazil and India -- to export those drugs to other countries.

-- Vanessa Fuhrmans in Frankfurt, Miriam Jordan in Sao Paulo and Gardiner Harris in Washington contributed to this article.

http://globalarchive.ft.com/globalarchive/article.html?id=□1112000760

Subject: [AIDS-INDIA] A request to the AIDS-INDIA eFORUM subscribers
Date: Sun, 18 Nov 2001 18:53:19 -0800 (PST)
From: AIDS INDIA eFORUM <indiaaids@yahoo.com>
Reply-To: aids-india@yahoo.com
To: AIDS-INDIA@yahoogroups.com

Dear AIDS-INDIA eFORUM subscribers,

Attached please find a brief blurb on AIDS-INDIA eFORUM.

It will be appreciated if you could post this on your notice board. Subsequently, if you have a publication or a news letter, please add a brief write up about the forum on your publication.

Thank you for your attention

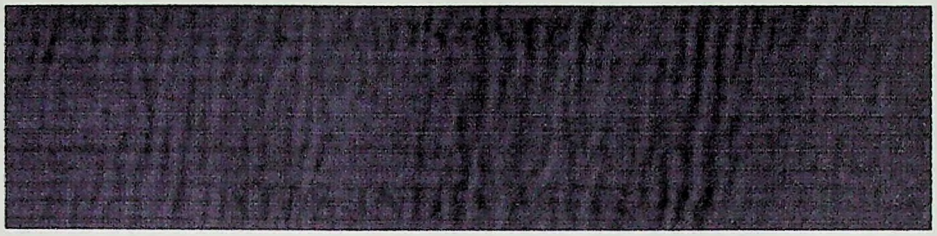
Yours sincerely

Joe Thomas
Moderator
AIDS-INDIA eFORUM
AIDS-INDIA@yahoogroups.com

AIDS forum ad.doc

Name: AIDS forum ad.doc
Type: Winword File (application/msword)
Encoding: base64
Description: AIDS forum ad.doc

lib
AIDS India - eforum file
21/11



An electronic forum to foster communication and collaboration among those of who are involved or interested in AIDS related issues in India.

- **Do you want to get daily (3-4) email messages about HIV/AIDS in India?**

- **Do you want to comment about HIV/AIDS issues in India?**

7500 members have already joined the forum.

INTERESTED?
To join this FREE e-forum please send a request message to:

AIDS-INDIA@yahoogroups.com

Or visit the Web page:
http://groups.yahoo.com/group/AIDS-INDIA

Subject: [AIDS-INDIA] Re: Asia will not be able to find its way forward if it uses the wrong M.A.P
Date: Sun, 18 Nov 2001 07:01:08 -0500
From: "George M. Carter" <gmc0@ix.netcom.com>
To: "AIDS India" <AIDS-INDIA@yahoogroups.com>

I think the best way to gather data on incidence and prevalence rates of HIV disease (as opposed to AIDS) is dependent on many factors.

Stigma and discrimination are horrible in India from all the reports I get. So maintaining confidentiality and anonymity are critical. How can that be achieved and still get good epi data?

The best solution--which may be technically challenging in some aspects--is a unique identifier system. If such a system can be put in place and run effectively in India, it could be a great stride forward for all nations facing the HIV pandemic.

What are other thoughts on the feasibility of such an approach?

George M. Carter
E-mail: <gmc0@ix.netcom.com>

Wh
AIDS India fb
21/11
TN
R
19/11

Subject: [AIDS-INDIA] Re: Doha: Big Pharma outmaneuvered by activists
Date: Sat, 17 Nov 2001 11:36:16 -0700
From: Rajan Gupta <rajan@lanl.gov>
Organization: Los Alamos National Laboratory
To: AIDS-INDIA@yahoogroups.com

We must all applaud and take lesson from the solidarity and purpose shown by the AIDS activists at Doha. Their successful heralding of a new era in the access and delivery of life saving medications for all, especially in the face of opposition by the big pharmaceutical companies, is exemplary. It constitutes a truly remarkable demonstration of the human spirit -- the very same people, who, in many countries are pariahs, have fought for the health and welfare of all.

We must strive to go further if we wish to see the transformation to a global civil society in the next decade. Basic health services, maternal and child care, protection from vaccine preventable diseases, clean drinking water, and sanitation must be guaranteed for all, as must education. Health care and education are the two most important pillars of modern society and any nation not providing these for its entire population will flounder.

Our path is laid out before us -- these two pillars cannot be built without good governance. Just like the AIDS activists built consensus in the public's mind that life saving drugs must be available to all -- that profits and patents are secondary to the universal value of human life -- so too must we build consensus that health care and education are more important than the posturing of politicians and bureaucrats, their obsession with power and pomp, and their taking refuge behind showcase development. We can no longer afford to allow them to hijack society.

If AIDS activistist can overcome social stigma, poor health, and daily preoccupation with death, then why can we not prevail and create good governance? The reason is simple -- the prospect of death unites the AIDS activists, the inability to carry out simple daily tasks makes health their number one priority, and asking for the ability to lead an honorable life cannot be denied by any religion, race or politics. The providing of health care and education for all is also an undeniable human right, however the healthy and the learned activists working on behalf of the marginalized have not been able to keep the same focus, drive, and clarity of purpose as the AIDS activists. And unfortunately, the marginalized are not able to speak for themselves.

We have the power, the purpose, and the reasons for demanding good governance. We, unfortunately, have lacked in creating unity through consensus. AIDS activists have shown us the way, so let us not continue to make excuses. The two billion people we purport to care about do not have decades to spare before they are allowed to enjoy what we call basic human rights. We must act with unity, unwavering purpose, and urgency to achieve what we believe in.

lib-AIDS-India file TN 11/21/01 R 19/11

Rajan Gupta
rajan@lanl.gov
http://t8web.lanl.gov/people/rajan/AIDS-india/

An acknowledgement would be appreciated
To Post a message: aids-india@eGroups.com
To Unsubscribe: aids-india-unsubscribe@eGroups.com
Web page: http://groups.yahoo.com/group/AIDS-INDIA

Your use of Yahoo! Groups is subject to http://docs.yahoo.com/info/terms/

Subject: [AIDS-INDIA] Indian Support Groups in US- Detroit
Date: Fri, 16 Nov 2001 08:42:52 -0500
From: "Anindita Choudhury" <t_anindita@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear Forum

I am a care coordinator working for an AIDS service organization in Detroit, Michigan. I recently came in contact with an Indian National who was looking for Indian support groups in the Metro detroit area. I was wondering if any of you could help me out and let me know if there are any organizations that I could refer this person to. The support groups/ organizations do not necessarily need to be HIV/AIDS related (although that would help) but should have an Indian bacground.

Please reply soon.

Anindita Rao
E-mail: t_anindita@hotmail.com

Lib
AIDS - India Force File
JN
21/11

TM
R
2011

Subject: [AIDS-INDIA] Re: Asia will not be able to find its way forward if it uses the wrong M.A.P

[AIDS-INDIA] Re: Asia will not be able ... way forward if it uses the wrong M.A.P

Subject: [AIDS-INDIA] Re: Asia will not be able to find its way forward if it uses the wrong M.A.P
Date: Fri, 16 Nov 2001 18:28:53 +0530
From: "tjjohn" <tjjohn@md4.vsnl.net.in>
To: "AIDS India" <AIDS-INDIA@yahoogroups.com>

Dear colleagues,

When people think or talk about an epidemic, there is something visible and striking. A large number of people suddenly getting hospitalised with typhoid fever, or a number of people developing cholera with some deaths or a dramatic increase in dengue hemorrhagic fever or Japanese encephalitis.

HIV infection is silent, no matter how many get infected. So it is misleading to use the same word epidemic for HIV infection because people will soon believe that it was a false alarm. Even AIDS (I prefer to call the illness HIV disease rather than AIDS) is not an epidemic in the usual sense as it has no sudden increase and a decline in real time -- as in all other epidemics. Technically the term epidemic is accurate, but the peak may be reached in decades rather than in weeks or months as in acute disease epidemics, nor will the decline be rapid and visible as in common epidemics in which the susceptibles are exhausted within a short period, weeks or months.

"Explosive outbreak or epidemic" is totally inappropriate since the epidemic is slowly progressing and not explosive.

Unless we have good disease surveillance system and HIV disease gets reported, all estimates of infection burden or illness prevalence will remain mere estimates with no accuracy. Most Asian countries do not have such a system, but Thailand has a reasonable one and Singapore has a good one. But I do not know if HIV diseases is on the reporting list.

The Indian system of "surveillance" (again misnomer, just surveys) or the current "sentinel surveillance" (again mere sentinel surveys) cannot give any incidence or prevalence figures with a reasonable degree of confidence. When Tuberculosis appeared in the old world, apparently a similar phenomenon occurred and it took some several hundred years for its epidemiology to settle into an endemic pattern that we see today. In the beginning the disease was more severe and with very high mortality rates. The same is the likely trajectory of HIV/HIV disease.

Still, some understanding of the magnitude is necessary in every country. In India the official figures put the total number infected at about 4 million. The error may be so huge that it may range to above 10 million, but how can any one prove it?

T Jacob John.
E-mail: <tjjohn@md4.vsnl.net.in>

[AIDS-INDIA] Vaccine to Prevent mother-to-child HIV transmission

Subject: [AIDS-INDIA] Vaccine to Prevent mother-to-child HIV transmission
Date: Fri, 16 Nov 2001 17:30:15 +0530
From: "tjjohn" <tjjohn@md4.vsnl.net.in>
To: AIDS-INDIA@yahoogroups.com

Vaccine to prevent mother-to-child HIV transmission to be put to test
****

AIDS vaccine researchers are preparing to test a vaccine aimed at protecting babies from contracting HIV through their mother's breastmilk.

Just over one in 10 babies who contract HIV through maternal transmission contract the virus through breastfeeding, but the use of formula feed remains problematic in the Third World, either because women cannot afford breastmilk substitutes or because they do not have access to clean water to mix the formula.

Now the International AIDS Vaccine Initiative has reported that a group of researchers at Makerere University in Uganda are preparing a trial protocol for approval to start a phase-one vaccine trial among newborn babies.

Only a limited number of patients are included in a phase-one trial, which tests the safety of a product. If the research protocol is approved, it will be the first time an HIV vaccine trial is conducted on babies outside North America.

The first HIV vaccine trials on babies were conducted in 1993, but the results of trials conducted so far have not been very promising. According to the initiative, the notion of a neonatal HIV vaccine might sound like a long shot, since there is still no effective adult vaccine, but the bar for protection in infants may be lower. Rather than long-term immunity, a neonatal vaccine need only protect for as long as babies are breastfed.

(Source: The Star, 2 November 2001)
http://news.hst.org.za/view.php3?id=20011108

TM
Lib - We need a new AIDS-INDIA FORUM resource file

Subject: [AIDS-INDIA] AIDS orphans in India
Date: Thu, 15 Nov 2001 06:39:26 -0800 (PST)
From: Rashna Ginwalla <arcturus4p@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Hello,
I am an Indian graduate student in the Master of Public Health program at the George Washington University in Washington, D.C. I am currently gathering information regarding HIV and AIDS in India that I hope to use as part of my thesis, and was wondering if anyone would have any suggestions on where to look and whom to speak with, especially on the following topic:

Having read UNDAIDS, NACO and Kasier Family Foundation literature on HIV and AIDS in India, it seems to me that the issue of AIDS orphans in India is not really being addressed. Obviously at this particular moment in time children orphaned as a result of AIDS is an issue of more immediate concern to countries in sub-Saharan Africa, but I would like to find out if there is any prophylactic/ preventive work being done in India prior to the emergence of such a cohort in our society, using the lessons learned from African countries.

I would appreciate any assistance you can give me.

Thanks,
Rashna Ginwalla

The George Washington University
School of Public Health and Health Sciences
Washington, D.C.

University of Southern California
Keck School of Medicine
Los Angeles, CA
E-mail: <arcturus4p@yahoo.com>

LeB
AIDS India folder
Ln
21/11

TO: NY TN
19/11/01

Subject: [AIDS-INDIA] introduction: The Rai Bahadur Gujarmal Modi Foundation
Date: Thu, 15 Nov 2001 18:17:17 +0530
From: "Juhi" <jsahai-modicare@modi.com>
To: <AIDS-INDIA@yahoogroups.com>

Dear Friends,
We have been reading and learning from your mails since 2 years now, without ever actively participating. No special reasons accept that we felt, that we were too new an organisation and didn't have much to share. However after much cajoling, its time to introduce to you all The RBGM Foundation, which has been set in 1996, with the primary objective of promoting HIV / AIDS awareness.

Since 1999, we chose 4 areas of work: Schools, Industries, sex workers/ clients & The RBGM Club (a volunteer s force).
Our focus is Delhi and this October we began work in Mumbai.

Do feel free to inquire more and keep in touch.

With Warm Regards,

Juhi Sahai.
Project Manager
The Rai Bahadur Gujarmal Modi Foundation
4, Community Centre
New Friends Colony
New Delhi - 65
Ph: 6321441-50; Ext -116.
E-mail:<jsahai-modicare@modi.com>

Lib
AIDS India file
No
21/11

To: NJ · TN
9/11/01

Subject: [AIDS-INDIA] World AIDS Day 2001 Resources
Date: Mon, 19 Nov 2001 10:12:38 -0800
From: "Sukontikar" <sukontikar@ahm.net>
To: AIDS-INDIA@yahoogroups.com

To help journalists and others interested in HIV/AIDS issues, the Kaiser Family Foundation has created a World AIDS Day web page (http://www.kff.org/worldaidsday). The Foundation is a leading resource for information about HIV/AIDS policy, public opinion and knowledge of the disease, and media-based sexual health campaigns. The special World AIDS Day web page will connect you to our latest research, analysis and innovative public health campaigns, as well as a wide range of other domestic and international World AIDS Day resources and activities.

In its first two decades, which are now coming to a close, AIDS has taken the lives of 22 million people worldwide, including 430,000 Americans. In the U.S., the poor, racial and ethnic minorities, and young people are increasingly at risk. This year AIDS became the leading cause of death in South Africa, and infection rates are on the rise in China, India, and elsewhere. At the same time, the development and availability of new treatments and the increasing sophistication of public health education campaigns hold real hope for the future.

If you would like more information about HIV/AIDS and the Foundation's work in this area, please contact Lauren Asher, Director of Communications, at 650-854-9400 or Jennifer Morales, Communications Officer, at 202-347-5270.
Thank you for your interest.

The Henry J. Kaiser Family Foundation

lib.- AIDS-India file
Jw
21/11

Subject: [AIDS-INDIA] Johns Hopkins Faults Researcher in Human Drug Trial in Kerala
Date: Fri, 16 Nov 2001 01:39:48 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

http://www.washingtonpost.com/wp-dyn/articles/A18596-2001Nov12.html.]

Johns Hopkins Faults Researcher in Human Drug Trial

By Shankar Vedantam
Washington Post Staff Writer
Tuesday, November 13, 2001; Page A06

A Johns Hopkins University researcher testing a cancer drug in India violated safety procedures, a university investigation has concluded.

As a result, the researcher has been barred from leading any medical studies involving human subjects in the future, officials announced yesterday in releasing the results of its investigation.

No one is known to have been harmed by the experiment, but it was conducted without the school's knowledge or permission and violated both school policies and federal requirements, school officials said.

In addition, the university had been lax in not launching an investigation before reports of irregularities appeared in the Indian media, the report found.

"The whole study was not up to the standard of Johns Hopkins University -- it fell far short," said Richard E. McCarty, dean of the university's Zanvyl Krieger School of Arts and Sciences.

The researcher failed to get approval from a university panel that must approve all research to ensure that it is safe, failed to get Food and Drug Administration approval to export the drug being tested, and had insufficiently tested the drug's safety by only experimenting in mice before trying it on people, McCarty and other officials said.

McCarty said that the school had not launched an investigation earlier because officials did not know the trial was underway.

The trial, which involved more than two dozen oral cancer patients, was intended to establish the safety of a medicine called tetramethyl NDGA.

The university did not name the researcher, but biologist Ru Chih Huang had acknowledged previously that she was the scientist involved. In a telephone interview last night, Huang defended her study and conduct and questioned the university's decision to punish her.

Huang said she had believed that only medical school researchers had to get approval from the university's Institutional Review Board to conduct a trial. As a scientist who was not directly in charge of patient care, she thought that approval from Indian authorities would suffice. She also said the university had been aware of the trial from the start and had even written two checks funding the trial -- one of which was sent to India the month before the trial began.

"It's authorized by the dean's office," she said. "He knew this before the trial started."

Library - Medical Ethics Resource File

TN 20/11

TN 20/11

In an earlier interview, Huang said that the experimental medicine had been thoroughly tested in dogs, rats, rabbits and mice before the human trial.

A report by the Indian Medical Association in the State of Kerala, where the trial was conducted, said that investigators had tracked down eight volunteers in the trial, none of whom had suffered adverse effects. The Indian doctors said that although some procedures had not been followed, there was no evidence that patients had been exploited, misled or placed at undue risk.

A statement by India's government in September said that contrary to early reports, the drug used in the trial had not been banned. Although there was no "violation of human rights," the statement said "a serious view" was being taken regarding certain regulatory and procedural lapses.

The university's report was also filed with two agencies at the Department of Health and Human Services, whose rules may have been violated: In addition to the FDA, the university also sent the report to the Office for Human Research Protections, which monitors patient safety in trials that use federal money.

A small amount of federal money might have been used in the trial, McCarty said. Huang said she had personally funded much of the trial by giving a gift to Johns Hopkins, which then wrote checks to the Indian institution running the trial. Johns Hopkins owns the patent on the experimental chemic

Vera Hassner Sharav, president of the patient advocacy group Alliance for Human Research Protections, said the university report ignored the institution's own role in permitting the research. She called for an independent investigation. "Internal self-investigation and self-regulation does not work," she said. "The public trust will not be restored with this k

Research at Johns Hopkins has been under heavy scrutiny since an asthma patient died during a drug trial in June. Federal regulators put all of the university's 2,200 trials on hold and ordered a review of each. University officials said yesterday that they had almost completed the reviews.

http://www.washingtonpost.com/wp-dyn/articles/A18596-2001Nov12.html.]

Subject: [AIDS-INDIA] School students get all they wanted to know about sex
Date: Mon, 26 Nov 2001 15:07:38 +0530
From: "Jagdish Harsh" <fxbjagdish@yahoo.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: <AIDS-INDIA@yahoogroups.com>

School students get all they wanted to know about sex

The Indian Express 25 November, 2001-New Delhi

PUJA BIRLA NEW DELHI NOVEMBER 24- If the number of questions asked by boisterous Class IX students at AIDS awareness programme is anything to go by, schools in the Capital have an uphill task.

With no sex education classes to clear their doubts, students are using AIDS awareness programmes, conducted by NGOs, as a guide to dispel myths about the birds and the bees.

Coordinators from the Rai Bahadur gujarmal Modi (RBGM) Foundation say that school students come up with the most pertinent of questions-a reflection of the prudish attitudes prevalent in homes and educational institutions. « I have to deal with questions ranging from how does one use a condom to where is GB Road, » says a coordinator from RBGM « They have no other source of correct information. Parents don"t talk about it and in the classroom, such topics are merely skimmed through. Even though the human reproductive system is there as a chapter in biology, most teachers will either skip it completely or barely glance at it. The situation is even more regressive in co-education schools, » he says. Thus coordinators become the only people who will provide correct information. « Information from friends is unbelievably skewed and fantastic. But no one wants to own up that he doesn"t know a particular thing," remarks another coordinator who has been involved in programmes conducted in private as well as government schools.

'There as an intersting difference in attitude that one encounters. Government school students usually come from traditional middle and lower-middle class families that keep a tight hold over 'values.' These kids feel that the reasons for contracting HIV through sexual contact doesn't hold true for them because they are brought up with traditional mores of celibacy and fidelity. They are more interested in knowing how to treat and behave with an HIV-infected person,' says the coordinator. On the other hand, the questions from public school students are mostly centred around sex and the ways of practising it safely. They are not very emphatic about celibacy and virginity and invariably most of the boys ask how they could prevent a girl from getting pregnant.

In all their workshops, a basic orientation is done starting from relationships, peer pressure, attractions and the need to prove that the students are mature adults. Gradually the concept of sexual attraction si introduced and from it the possibility of contracting the deadly virus. There is information on how it spreads and the tests that show conclusively whether a person is HIV positive or not. The most important part of the wordshops are the question and answer sessions, both for the coordinators as well as the students. Though there are sniggerings and smirks and nudges, the answers are carefully listened to. And sometimes even the coordinators are stumped by the queries of their young audience.

One of the RBGM coordinators remembers having to answer a question as to why a man could not have baby especially since a Hollywood movie discussed the possibility with none other than macho man Arnold Schwarzenegger playing the lead. 'We just had to tell the student that it was the way God decided and the rest was only make-believe,' said the coordinator.

****

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] Artists for AIDS -WAD activities In Calcutta
Date: Mon, 26 Nov 2001 13:02:39 +0530
From: "Jagdish Harsh" <fxbjagdish@yahoo.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: <AIDS-INDIA@yahoogroups.com>

Aritsts for AIDS
The Telegraph 25 November 2001, New Delhi

Responding to a state-sponsored programme seeking to sensitise people on AIDS, a number of Calcutta's renowned painters will put their brush to canvas on December 1, International AIDS Day. Painters Shanu Lahiri, Prakash Karmakar; Bijon chowdhury, Badhan Das and Robin Mondal, among others, are expected to assemble at Esplanade to participate in an art camp-AIDS through the eyes of painters'-in the morning.

****

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] Re: World AIDS Day Activities
Date: Mon, 26 Nov 2001 14:26:41 +0530
From: Kim Singh <kimsingh@juno.com>
To: AIDS-INDIA@yahoogroups.com

Asian AIDS Action will be engaged in organizing AIDS awareness programmers on December 1 World AIDS Day in Bombay, San Francisco, Bangkok and Hong Kong.

In Bombay AAA will be doing outreach along with several local AIDS NGOs at VT Station (Chhatrapati Shivaji Terminus) and at Churchgate Station from 8 AM - PM.

Local NGOs interested in participating please contact Asian AIDS Action Bombay office at 982 1180 665. NGOs are requested to bring along their NGOs banners, literature, condom and lube packages and fliers for distribution at the venues.

Thanking you

Kim Singh
Asian AIDS Action
E-mail: Kim Singh <kimsingh@juno.com>

Lib. Add to subject file
29/11 GM
27/11

Subject: [AIDS-INDIA] Re:3rd International Conference on AIDS India 2000
Date: Sun, 25 Nov 2001 22:29:51 -0800
From: rsvirknaco@youandaids.org
To: AIDS-INDIA@yahoogroups.com

Dear friends,

The first International Conference [Indo-US] on AIDS in India was held at AFMC, Pune during 1995.

rsvirknaco@youandaids.org

[Any details of the agenda of the The first International Conference [Indo-US] on AIDS in India, which was held at AFMC, Pune during 1995. Any follow up? Moderator]

[redacted]

Please file all

Subject: Fwd: [AIDS-INDIA] New member to the AIDS-INDIA eFORUM
Date: Sun, 21 Oct 2001 00:22:46 +0000
From: "latha jagannathan" <lathajagu@hotmail.com>
To: sochara@vsnl.com

Dr. Francis / Dr. Thelma,

I thought this may be of interest to the Task Force,

Latha

>From: Lalit Dandona
>Reply-To: joe_thomas123@yahoo.com.au
>To: AIDS-INDIA@yahoogroups.com
>Subject: [AIDS-INDIA] New member to the AIDS-INDIA eFORUM
>Date: Fri, 19 Oct 2001 10:58:40 +1000 (EST)
>
>[Dear forum mebers.now we have 701 subscribers to AIDS-INDIA eFOURM:
>Moderator]
>
>Hi
>
>I am a medical doctor and public health specialist.
>I have been involved in epidemiology studies and health system
>development in India. I have recently taken up the position of
>Director, Health Policy at the Administrative Staff College of India
>in Hyderabad.
>
>I look forward to participation in the AIDS debate in India.
>
>Best wishes,
>Lalit
>
>Lalit Dandona, MD, MPH
>Director, Health Policy
>Centre for Social Services
>Administrative Staff College of India
>Bella Vista, Raj Bhavan Road
>Hyderabad - 500 082
>India
>Email: dandona@asci.org.in,
>lalit_dandona@hotmail.com
>

Again — please join the AIDS-India eForum. TN

(done) & all (email sent)

Pl. note his address in email/electronic + manual address book.

Lib

22/X/01 TN 23/10

To: DD CMF/AO TN

22/X/01

Subject: [AIDS-INDIA] Re:AFFORDABLE MEDICINES AND TREATMENT CAMPAIGN
Date: Thu, 29 Nov 2001 10:09:07 +0530
From: "HIV Aids Unit" <aidslaw1@del2.vsnl.net.in>
To: <AIDS-INDIA@yahoogroups.com>

dear all,
a posting had been made about the Affordable Medicines and Treatment Campaign yesterday.
here are the details of the programs in delhi on world AIDS day.
Prices of Medicines are going to rise!

ACT NOW OR PAY LATER! The right to health is a basic fundamental right

- This includes the right to accessible and affordable medicines and treatment
- Prices of medicines, especially those for HIV/AIDS, are unaffordable for most people today.
- India has to change its Patent Law in accordance with the WTO TRIPs agreement by January 2005.
- This will make medicines even more expensive and totally unaffordable.

To demand the right to health for all, people living with HIV/AIDS, Activists, NGOs, Doctors and Lawyers have joined hands to initiate a campaign

JOIN US FOR THE DELHI LAUNCH OF THE NATIONWIDE
AFFORDABLE MEDICINES AND TREATMENT CAMPAIGN

On

World AIDS Day
December 1st 2001

The programme:

3.30 pm to 4.30 pm - PUBLIC MEETING AT DEPUTY SPEAKER'S HALL, CONSTITUTION CLUB, RAFI MARG, NEW DELHI

5.00 pm onwards - CANDLELIGHT VIGIL AT JANPATH, NEAR JEEVAN BHARTI BUILDING

For more details, contact: Sharan (Dr Bitra George) - 6868350, Delhi Network of Positive People (Naveen) - 6219147, Naz Foundation (Shaleen) - 6563929, Lawyers Collective HIV/AIDS Unit (Tripti/Akshay) 4321102/01

"HIV Aids Unit"
E-mail: <aidslaw1@del2.vsnl.net.in>

TN
30/11
Lib - Aids - India file
30/11

Subject: [AIDS-INDIA] sexual behaviour among school students in India
Date: Thu, 29 Nov 2001 05:59:51 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Hi all,

Just a short note to tell you that Volume 13, Number 6 of:
AIDS Care, a journal from Carfax Publishing contains the following article:

Study of perceived norms, beliefs and intended sexual behaviour
among higher secondary school students in India

M. S. Selvan, M. W. Ross, A. S. Kapadia, R. Mathai, S. Hira

[If the authors could post the findings of this study on the forum it will be appreciated.
Thannks. Modereator]

Subject: [AIDS-INDIA] TRIPS and Public Health
Date: Thu, 29 Nov 2001 12:28:53 +0530
From: "Jagdish Harsh" <fxbjagdish@yahoo.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

TRIPS and Public Health: the Doha Declaration
The Hindu 29th November 2001-New Delhi

CONTRARY TO many predictions, the Doha meeting of the World Trade Organisation did manage to put together a Declaration in TRIPS (Trade-related Intellectual Property Rights) and Public Health. This is one of the areas where the point of view of the developing countries has been conceded. There is an assurance that the restrictive clauses under the TRIPS agreement on drug patents will not overripe public health concerns. The Ministerial Declaration on TRIPS and Public Health was prompted by the recent criticisms on the high treatment costs with patented drugs for HIV/AIDS and Anthrax and the inability of governments and patients to access lower-priced generic versions because of the patent system. Essentially, the new declaration has very little new matter. Rather, it is a reiteration of the fundamental tenets already built in the 1994 Agreement on TRIPS. The Declaration has endorsed more emphatically the following points: Need for TRIPS to address the public health problems affecting the Developing Countries (DCs) and the Least Developed Countries (LDs) especially for HIV/AIDS, Tuberculosis, Malaria and other epidemics.

****

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] Indian teenagers sacrosanct about virginity
Date: Wed, 28 Nov 2001 10:42:56 +0530
From: "Jagdish Harsh" <fxbjagdish@yahoo.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Indian teenagers sacrosanct about virginity

The Indian Express 28 November, 2001-New Delhi

CHANNAI: Indian teen-agers tend to protect their virginity more than other nationals and the average age for a sexual experience in India is 20.3, according to a global survey. The Durex global sex survey carried out in 28 countries found that the average age for the first sex experience was 16.9 for Britishers and 16 for Americans. The survey conducted in the four metros found that 77 per cent of India's adults have had only one sexual partner, compared to 11 per cent in the case of Americans and 13 per cent in the case of Britishers. The findings of the survey were announced by T.T Raghunathan, executive vice-president, TTK LIG Limited, makers of Durex and other brands of condoms marketed in India and over 40 countries. Raghunathan said almost seven out of ten Indians were concerned about contracting the Human Immuno Virus (HIV) deficiency or other sexually transmitted diseases, but many were not protecting themselves. A quarter of Indians (27 per cent) were taking no steps to prevent the spread of HIV/AIDS by safe sex (use of condoms). Of those who do, just 15 per cent insist on using a condom for casual sex and only ten per cent ask their partner about their sexual history, the survey revealed.

****

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

AIDS India file
for 29/11
TM
29/11

Subject: [AIDS-INDIA] DARE TO CARE - HUMSAFAR ON WORLD AIDS DAY
Date: Wed, 28 Nov 2001 16:55:30 +0530
From: "Humsafar@vsnl.com" <humsafar@vsnl.com>
To: AIDS-INDIA@yahoogroups.com
CC: <avivekr@rediffmail.com>

DARE TO CARE

World Aids Day Commemoration on December 1st,2001

This year on the occasion of World Aids Day, The Humsafar Trust is putting up three stalls at different venues in Bombay and the slogan all over for the World Aids Day is DARE TO CARE.

The first stall is at the Kalina University Campus and will be attended by Humsafar Volunteers and Doctors from Sion Hospital. We will be providing basic information on HIV issues and the kind of help being provided by Humsafar to the MSM (Men having sex with Men)

The second stall is at Dadar Railway Station (Central) on the overbridge near the ticket booking counter. This stall will be attended by Humsafar Volunteers, Doctors and Counselors from Sion Hospital and much detailed information about HIV and STI's will be provided. We will be equipped with all sorts of IEC materials and any help needed on gay issues can also be discussed with the counselor present on the stall.

The stall will remain open to everyone from 10.00 am to 9.00 pm.

Finally the third stall will be put up at the Gateway of India where MDACS (Mumbai District Aids Control Society)
is holding a MELA on the World Aids Day where stalls by around 15 NGO's funded by them will be presenting their work over the last three years.

The Humsafar stall will be a high camp gay stall where the whole thing is being done up in Pink. Pink Cloth, Pink Paper materials and Pink Flower decorations will highlight the gay culture in it's full splendor. The stall will be attended by Humsafar Volunteers and Humsafar counselors and we will be open to the idea of discussing any and every gay issue under the sun.

We shall also be keeping IEC material imparting information about various STI's and HIV issues and emphasizing the need to use condoms.

The stall will remain open from 10.00 am to 8.00pm

We invite everyone to visit these stalls, especially at the Gateway of India as this is one more opportunity for gay men of the city to come out in the open and make their presence felt.

This is our chance to let the world know that WE DARE and WE CARE !!

Humsafar
E-mail: humsafar@vsnl.com

Subject: [AIDS-INDIA] Information on the AIDS Conference in Mumbai
Date: Wed, 28 Nov 2001 15:44:35 -0500
From: Avni Amin <aamin@genderhealth.org>
To: AIDS-INDIA@yahoogroups.com

Dear Forum Members:

Does anyone have information (location, registration etc) on the upcoming AIDS conference in Mumbai from Dec. 16th-19th? We seemed to have misplaced the information package the conference organizers sent us. I would be grateful if someone could send me the information on registration and location in Bombay where it is going to be held. Thanks.

With Kind Regards

Avni

Avni Amin, Ph.D.
Senior Program Associate
Center for Health and Gender Equity
6930 Carroll Avenue, Suite 910
Takoma Park, MD 20912
Tel: 301-270-1182
Fax: 301-270-2052
Website: www.genderhealth.org

AIDS - India file
29/11.

TN
29/11

Subject: [AIDS-INDIA] Comprehensive list of MTCT programs in India
Date: Tue, 27 Nov 2001 02:22:34 +0530
From: "thanuja choudary" <tanuja123@hotmail.com>
To: aids-india@yahoogroups.com

Dear Forum Members,

I am a Graduate student at Long Island University in New York and currently working on a paper reviewing the current services available for prevention of mother to child transmission in India.I will appreciate if you can refer me to a source where I can get a comprehensive list of MTCT programs(Government,Non Government and Private sector)in India.

Thank you for your assistance in advance
Tanuja
E-mail: <tanuja123@hotmail.com>

[Tanuja, If you managed to compile such a list, please feel free to post it on the forum. Thx. Moderator]

Subject: Cooking Oil--60 Brands Tested
Date: Fri, 09 Nov 2001 12:02:27 +0530
From: cerc@wilnetonline.net
To: Chhapte <chhapte@cal2.vsnl.net.in>, Darlena David <cd.cmai@vsnl.com>, Health Fact <mediconsumers@earthlink.net>, Kaushik Desai <ipacentr@bo1.net.in>, Madan Kataria <laugh@vsnl.com>, Mathew Nampudakam <vhai@vsnl.com>, "N. V. Ramamurthy" <nvramamurthy@express2.indexp.co.in>, Pharmabiz <ipharma@vsnl.com>, R Jha <ravisjha@hotmail.com>, Ravi Narayan <sochara@vsnl.com>, Strategic <hospital@strategicnewspapers.com>, Unnikrishnan <unnich@wilnetonline.net>, World Consumer <consint@entelchile.net>, Nina Shah <inika@icenet.net>

Press Release

INSIGHT - THE CONSUMER MAGAZINE

Cooking Oil--60 Brands Tested

The in-house comparative product testing laboratory of Consumer Education and Research Society (CERS), Ahmedabad, tested 60 brands of edible oil of eight different types and found quite a few of them adulterated. Some brands revealed less than the labelled weight, some did not meet the Agmark standards despite carrying the logo and still some others revealed rancidity. The detailed results have been published by CERS in the November-December 2001 issue of INSIGHT -- The Consumer Magazine, including the `best buy' for each type of cooking oil tested.

The eight types of cooking oil tested were : groundnut, mustard, sesame (til), sunflower, cottonseed, coconut, blended oil, and palmolein. Quite a few brands of mustard oil and groundnut oil, besides loose cottonseed oil, revealed adulteration. Some brands of groundnut, sunflower, palmolein and sesame oils showed rancidity too.

Although almost all the brands met the limits of the PFA Act for the 0.5 parts per million (ppm) limit on lead, a cumulative poison, two groundnut oil brands -- Dhara and Rajmoti -- could not meet the 0.1 ppm limit under Codex, the international standard.

Groundnut Oil : Amrut, Ankur, Appu, Bhoomi, Dhara, Dharti, Ginni, Kiran, Lion, Postman, Rajmoti, Safal, Sunsweet, and two loose samples were tested.

Oilseeds can get contaminated with fungus (mold), which produces aflatoxin, a poisonous material. Amrut, which claimed the Agmark, and Sunsweet did not comply with the Agmark limits for this parameter.

One loose sample of groundnut oil was adulterated with cottonseed oil. Amrut, Dharti and the two loose samples did not conform to the Bellier's Turbidity Test for adulteration. In the saponification value test for adulteration, Dharti and Rajmoti did not conform.

Amrut, Kiran and Rajmoti were found rancid.

All the packs of Appu, Ginni, Kiran, Postman, Safal and Sunsweet gave less than the labelled weight. On an average, Postman gave almost 9 grams less in every pack. But, Bhoomi, Dharti and Rajmoti gave more than the labelled weight.

Mustard Oil : Appu, Dhara, Double Hiran, Engine, Hafed, Kempro, Kolhu, Mastaan, P-Mark, Uday, and six loose samples were tested.

Consumer Issues file-?

Library →

RN 12/11

Dhara, Double Hiran, Engine, Hafed and Kempro did not comply with the Codex levels for lead.

Refractive Index indicates adulteration. Appu, Hafed, Kolhu, P-Mark and Mastaan did not conform to this parameter as per the PFA Act. In the specific gravity test for adulteration, Double Hiran, an Agmark brand, did not conform to the Agmark range. Another Agmark brand, P-Mark, did not meet the BIS and Agmark levels of the natural essential volatile oil - allyl isothiocyanate. Two loose samples did not pass the Bellier's Turbidity Test. Neem oil was found in another two loose samples.

Double Hiran and a loose sample were rancid. A high acid value indicates rancidity. Kempro, an Agmark brand, showed a higher acid value than the Agmark and BIS levels.

All 20 packs of Appu, Double Hiran, Kempro, Kolhu and Mastaan gave less than the labelled weight in every one of their packs. Engine and Uday gave more in every one of their packs.

Cottonseed oil : Amrut, Ankur, Fortune, Ginni, Maruti, Rishi, Tirupati and two loose samples were tested.

Amrut and Tirupati did not conform to the test for rancidity as per the PFA Act and the BIS. One loose sample did not conform to the tests for iodine value and refractive index. All packs of Amrut and Rishi gave less than the labelled weight.

Sesame oil : Idhayam, Kempro, Mahima, Pavithram, Raj, Swarnam, Tilola, Tilsona, Uday, and two loose samples were tested.

Kempro showed rancidity and a high acid value. Also, it did not conform to the BIS levels for the Baudoin Test, indicating poor quality.

Sunflower oil : Chaksun, Cooklite, Crystal, Dhara Health, Flora, Ginni Gold, Godrej, Kamani, Sundrop, Sunsleek and Sweekar were tested.

Crystal did not conform to the limits of lead as per the PFA Act. Checked against Codex, Cooklite, Dhara Health and Sunsleek did not conform.

Sunsleek did not conform to rancidity as per the PFA Act, the BIS and the Agmark. Also, Chaksun, Kamani and Sunsleek showed peroxide values well over the BIS levels, indicating rancidity.

Sundrop had a flash point below the minimum level fixed by the PFA Act, BIS and Agmark.

Coconut oil : A.O., Cococare, KPL Shudhi, Kera Popular, Nihar, Parachute, and two loose samples were tested.

Kera Popular did not clear the Codex levels for lead. One loose sample was found adulterated with cottonseed oil.

Palmolein : We tested Real Good, Ruchi Gold, Unique, and two samples from the public distribution system (PDS).

Ruchi Gold, Unique as well as the palmoleins bought from the PDS -- PDS-Maninagar and PDS-Naroda -- were rancid. Unique and PDS-Naroda showed double the peroxide levels prescribed by the BIS, indicating rancidity. A high iodine value indicates a tendency for the oil to turn rancid sooner. Ruchi Gold did not conform to the PFA Act for iodine value.

Blended oil: We tested Saffola

The blended oil, Saffola, with a mix of safflower oil and corn oil conformed to all our tests. But 17 out of 20 packs gave less than the labelled weight.

As a policy, we convey the test results to all the manufacturers. They receive only the results of their own products. Details of rating and ranking and communication with manufacturers is discussed in the magazine.

Manufacturers try to allure consumers with claims of healthy oils, zero cholesterol, triple filtered and so on. This issue of Insight - The Consumer Magazine discusses the genuineness or otherwise of all such claims and clears the confusion surrounding them. Choosing a healthy oil today seems to be a complicated task with much information or misinformation being disseminated about the benefits of particular brands and oil types and with conflicting versions on the different types of fatty acids. While some proclaim the benefits of polyunsaturated fatty acids, others approve of monounsaturated fats as the best cooking oil.Insight probes the pros and cons of the various types of oils and which oils are suitable for particular cooking, thus helping consumers to make an informed choice.

Date : 9/11/2001
Place : Ahmedabad

Pritee Shah
Editor, INSIGHT

CONSUMER EDUCATION AND RESEARCH SOCIETY
"Suraksha Sankool", Thaltej, Ahmedabad-Gandhinagar Highway, Ahmedabad- 380 054 (INDIA) Phone: 079-7489945-46, Fax: 079-7489947, E-mail: cerc@wilnetonline.net

---

Subject: [AIDS-INDIA] Ref: "TB -transmitted sexually" - NARI !!??
Date: Sun, 09 Dec 2001 12:45:39 +0000
From: "ramesh paranjape" <rameshparanjape@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear Forum Members,

<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

This is in response to the letter from Mr. Ashok Row Kavi.

1. It is unfortunate that I have been quoted wrongly by the Times of India. I would like to clarify that I had not made statement that TB is transmitted sexually. I had made statement on the transmission of Herpes and Hepatitis B based on the observations in our cohort.

2. Prevalence of HIV infection in newly diagnosed TB patients has been observed to the extent of 28% in clinic in Pimpri-Chinchwad area in Pune. However, I would like to make it clear that it is not MDR-TB.

NARI has been conducting research on various aspects of HIV/AIDS and the scientists from NARI have published a number of scientific papers in National and International peer reviewed Journals. We would keep up the tradition of good science.

Ramesh Paranjape

Officer-in-Charge, NARI

AIDS-India file-lib
10/12
TN

10/12

Subject: [AIDS-INDIA] Re: Migrants-a Health threat !
Date: Sat, 8 Dec 2001 20:55:39 EST
From: global325@aol.com
To: AIDS-INDIA@yahoogroups.com

Indigenous corrupt officials are a much greater health threat than migrants!

Ron Brinn
E-mail: global325@aol.com

AIDS Bodhi ft
for
12/12

TM

10/12

Subject: [AIDS-INDIA] NGO to court: Legalise homosexuality
Date: Sat, 8 Dec 2001 18:23:28 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

NGO to court: Legalise homosexuality

The Delhi Age 8th December, 2001 New Delhi

New Delhi, Dec.7: The Delhi high court on Friday issued a notice to the Centre among others over a writ petition seeking that homosexuality should be legalized and sex between consenting adults of the same gender should not be penalized. In its petition, Naz Foundation, an NGO, said that Section 377 of the Indian Penal Code was violative of Articles 14, 15, 19 (1) (A-D) and 21 of the Constitution (fundamental rights relating to equality and freedom.) It said that Section 377 was being misused to harass adults of the same sex who indulge in sexual activity by consent. Under Section 377 (Unnatural Offence Relating to Sexual Behaviour,) any police officer can arrest a person involved in such acts and the person can be punished with a life term if convicted. Calling the section unconstitutional, the petition said that Section 377 IPC, which equates homosexuality with sodomy and bestiality, has become a major impediment in the NGOs HIV/AIDS programs with the "men who have sex with men" community as it lead to harassment and extortion of NGO workers by the police. A division bench comprising justices Dewinder Gupta and S.K. Kaul issued notices to the ministry of social welfare, the Delhi government, commissioner of police and the national AIDS Control Organisation asking them why the petition should not be admitted.

The next date of the hearing has been fixed for January 28, Naz counsel Anand Grover on behalf his client submitted before the court that "the discriminatory attitudes exhibited by state agencies towards sexuality minorities including gay men, lesbians and transgender individuals has resulted in the denial of their fundamental rights." The counsel further added: "Unless the self respect and dignity of sexuality minorities is restored by doing away with discriminatory laws such laws as Section 377, it will not be able to promote HIV/AIDS prevention in the community.

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

TH AIDS India file 10/12

10/12

Subject: [AIDS-INDIA] Demystifying the 'taboo' word
Date: Sat, 8 Dec 2001 18:21:05 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Demystifying the 'taboo' word

NEW DELHI, Dec. 7. -The acronym AIDS has always raised eyebrows and has left people with unanswered questions, which one is unable to put it open either due to hesitation or lack of proper knowledge. Rai Bahadur Gujarmal Modi Foundation-an non-governmental organisation-is sensitising people, specially children for the past one year about this dreaded disease. The NGO organised "Peer Educator Workshop" today in the Capital with a group of children from different schools, for this purpose.

Huddled in a room with their teachers occupying one portion of the space and posters carrying AIDS messages on the wall, these children were initially reluctant to come out with the queries about the disease. So the first step towards success for Feisal Alkazi and Martha Farrell, the two "counselors", was to break the "ice" by putting up questions like "Do you know what is AIDS?" or "Have to met anyone who has AIDS? What was your reaction?" The idea behind putting these "simple questions" was to create atmosphere where the children could feel comfortable and not as "only" one "interested" in the disease. And when the ice finally broke, there were questions and more question from these children.

What came as a pleasant surprise to the counselors was that most of the children felt that it is the society which needs a "drastic change", when it comes to socialising with an AIDS patient. "We all know how the disease spreads, therefore, there is no point in alienating the person (suffering from AIDS) or ignoring their existence," said Mridul, a student of the Air Force School. After a point of time, there were open discussions between the students and teachers on whether or not an HIV infected person should marry or whether one should marry an HIV infected person. Then all sort of queries and solutions were given by the children pertaining to "safe sex" with an HIV infected person and what role should the spouse of an HIV infected person should play.

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

AIDS - India file - UB
TH
12/12
10/12

Subject: [AIDS-INDIA] Migrants-a Health threat !
Date: Fri, 7 Dec 2001 11:10:16 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Punjab Minister calls migrants a health threat

The Indian Express 4th December, 2001- New Delhi

If you ask State Health Minister Baldev Raj Chawla, migrants from other states are the biggest health threat for Punjab. Migrants have brought with them contagious diseases, Chawla said at an awareness Programme on AIDS and leprosy here. He held migrants responsible for the increasing AIDS cases in the state. "This deadly disease spreads among those who travel from one place to the other as they come across prostitutes or fall prey to drug addiction, the two major causes," he said. "Leprosy had been wiped out from the state but cases have now been detected due to immigration of the poor from other states, where the disease is still widespread," he said.

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

AIDS-India file-lib
for 10/12

TN

10/12

Subject: [AIDS-INDIA] Grown Up Govt lines up AIDS chat show
Date: Fri, 7 Dec 2001 11:09:13 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Grown-up govt lines up AIDS chat show
The Telegraph 5th December, 2001-New Delhi

New Delhi, December. 4 : For a government shy of including sex education in the school curriculum, hosting a chat show on AIDS on its channel-Doordarshan-is surely a step forward. To increase awareness on AIDS, the National AIDS Control Organisation (NACO)-an arm of the Union health ministry-has put together two chat shows in Hindi and English.

Neena Gupta and Mallika Sarabhai will anchor the shows. Khamoshi Kyon, presented by Gupta in Hindi, will begin this Wednesday at 10 pm on Doordarshan. Sarabhai's English show chat positive will begin on December 15 on Zee News at 2pm. 'These will be interactive sessions with an audience drawn from students, parents, young people. There will be an expert panel to discuss various dimensions of AIDS,' said J.V.R. Prasada Rao, NACO director, at a press conference today. Health minister C.P. Thakur was also present at the press meet.

The NACO representatives had reasons to feel pleased. First, the organisation had taken the lead to bread a social taboo. It also revealed its latest report on population behavioural surveillance, which showed awareness on AIDS at 76 per cent of the rural and urgban population even when the literacy rate stood at 62 per cent. The study revealed a significant rise in awareness about AIDS. However, awareness level was low in states like Bihar, Gujrat, Uttar Pradesh, Madhya Predesh and West Bengal. The report, largest ever of its kind, surveyed over 80,000 people. Since the study showed television to be the most popular medium with Doordarshan having the widest reach, the government's decision to host chat shows may help thaw the socialice on AIDS, which continues to be a taboo. Most people interviewed in the study were aware how AIDS was transmitted unlike in the past when people had little knowledge about the channels of infection.

Over 77 per cent males and 64 per cent women were aware that AIDS could be transmitted by sharing needles while over 54 per cent knew that the disease could be transmitted through breast-feeding. Mother-to-child transmission of AIDS is the largest source of HIV infection in children below 15 years of age.

The governent today approved a plan to extend the programme for prevention of mother-to-child transmission, which will come into effect from February next year. Over 50 per cent of respondents in the study knew that the risk of AIDS could be minimised by having one partner and a long-term relationship. Over 15 percent of males reported using condoms the last time they had sex with non-regular partner as against 39.8 per cent of women.

The government maintained that the number of HIV-infected people was not exaggerated. But it added that with increasing awarness, the spread of AIDS was getting under control. "Awareness has come to this level because of our efforts and now we are slowly reaching a plateau on AIDS,'' said health secretary Javed Chodhury.
****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

TN AIDS-India file - [illegible]
10/12 15/12

Subject: [AIDS-INDIA] AIDS counseling goes mobile
Date: Fri, 7 Dec 2001 11:04:19 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

AIDS counselling goes mobile
The Delhi Age 4th December, 2001-New Delhi

New Delhi, Dec. 3: Delhi health minister A. K. walia on Monday launched a unit of the "Rajiv Gandhi mobile AIDS counselling services" project, aimed at educating the general public, and not only high risk group, about the dreaded disease. The mobile unit, which is a joint venture of the Rajiv Gandhi Foundation and the Delhi state AIDS control society, would create awareness on HIV/AIDS, treat patients of sexually transmitted diseases, distribute condoms, inculcate safe behavioural patterns, help HIV positive persons to cope with the disease and its progression and provide regular counselling. The project has an integrated approach for the prevention, control and management of AIDS. The intervention package includes information, education and communication, counselling (pre-test, post-test and follow-up), networking with hospitals and nursing homes for testing, treating STDS, TB, managing people with HIV/AIDS and social marketing of condoms. This programme, the first of its kind, was planned and introduced in India by RGF in 1996. It is being successfully implemented in Delhi and Mumbai. Already 12 slums have been covered by the project in the city and the new unit would cover two areas - G. B. road and Rewla Khanpur - this year. The innovative experiment has succeeded not only in encouraging public to discuss and seek information, but also in providing adequate madical, social and psychological support services to persons with HIV/AIDS and high-risk behaviour. The model has generated a surge of voluntary efforts.

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

AIDS-India file-Lib
JH 10/12
TM
10/12

Subject: [AIDS-INDIA] "TB -transmitted sexually" - NARI !!??
Date: Fri, 7 Dec 2001 06:41:00 +0530
From: "Ashok Row Kavi" <arowkavi@vsnl.in>
To: <AIDS-INDIA@yahoogroups.com>

The Times of India carried an interview with the head of the National AIDS Research Institute (NARI), last Monday where he has made the unusual claim that "TB and some other diseases are transmitted sexually".

Is it at all possible that this claim has a modicum of truth in it? It appeared on Page 5 in the Bombay edition and I'm wondering how many people read it. It seems quite controversial as it claims India will be having an AIDS vaccine within two years.

I do know Prof Bob Bollinger and co from Harvard have been working very hard with NARI but I had no idea about claims of TB being sexually transmitted. Could he be talking of the proximity in sexual relations where an infected persons coughs or kisses an un-infected person?

I'm not sure what this is all about but it does seem alarming. The fact that 30 per cent of HIV positive persons do get MDR TB is one big problem but this claim seems a bit far fetched and could be cause for alarm.

Ashok Row Kavi
E-mail: <arowkavi@vsnl.in>

AIDS - India file Ab
1
12/12.

TH
10/12

Subject: [AIDS-INDIA] Training: Building Leadership for Mainstreaming Gender in RCH Programs",
Date: Mon, 19 Nov 2001 10:34:17 -0000
From: abrarkhan@vsnl.com
To: AIDS-INDIA@yahoogroups.com

Two week training course on "Building Leadership for Mainstreaming Gender in RCH Programs",

Goal: Develop leadership capacity of NGO networks to mainstream gender in reproductive and child health program design and delivery for increasing gender sensitive

Participant Profile: The training course has been designed expressly for organisational leaders, managers, board members and staff from SIFPSA and USAID partner agencies in India. Some seats are being offered to interested organizations and professionals working in the area of reproductive health, population, gender and development in Northern India.

For more details, please contact:

Mr. Abrar A. Khan
Senior Advisor Capacity Building CEDPA - India
Email: abrarkhan@vsnl.com

HNP - file - for women Health
JN
21/11

TM
B
29/11

Subject: [AIDS-INDIA] AIDS amoung South African Indians
Date: Mon, 10 Dec 2001 10:55:53 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

S. Africa row over 'fat, unsexy' Indian 'slobs'

The Asian Age, 8th December, 2001-New Delhi

Durban: Stereotyping of South Africa Indian women as "fat, unsexy slobs who dress badly" has angered them and kicked up a row in the country. The furore started when a newspaper, Sunday Tribune, quoted a few men who were asked why they had contracted AIDS. The report quoted the men as saying that their South Africa Indian wives failed to "turn (them) on" in bed. The report quoted them as saying that South Africa Indian women were "fat, dirty slobs" who dressed badly and wore "granny panties." The Tribune article generalized the issue to the extent that scores of South Africa Indian women have reacted over the past fortnight in many newspapers and radio programmes.

They claim the dignity of Indian women has been impaired, and that the men were using excuses to highlight further their failure to take responsibility for the increasing incidence of HIV/AIDS in the South Africa Indian community, which until recently was believed to have the lowest incidence of the disease because of cultural taboos on infidelity. South Africa has one of the highest HIV infection rates in the world, and Indians affected.

By it have only recently begun to come out of the closet about it. Families of victims have been hiding the fact for fear of isolation by community members. The controversy started after Julie Emmanuel-Bhagirithi of the Newlands West AIDS Support Group disclosed why Indian men are looking for pleasure elsewhere than in a long list of derogatory remarks allegedly made by men who had sought counselling with her service, Emmanuel-Bhagirithi said there was a desperate need" for sex education in the Indian community.

The comments allegedly made by the men refer to untidiness, sloppy dressing, poor personal hygiene and a lack of sex education. "My wife comes to bed with greasy, oily hair and bad breath and that is a direct turn-off. So it is not my fault when I am forced to visit prostitutes and call girls," one husband said. "I like to kiss a clean mouth. I like a good-smelling perfume. The magic is gone and she is there basically to cook for me, iron my clothes and take care of my children."

****

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

TM Lab AIDS India file 18/12 18/12

[AIDS-INDIA] AIDS amoung South African Indians

Subject: [AIDS-INDIA] Contact deatails of AIDS Bhed Bhav Virodhi Andolan (ABVA),
Date: Mon, 31 Dec 2001 08:10:49 -0500
From: "George M. Carter" <gmc0@ix.netcom.com>
To: "AIDS-INDIA-yahoogroups.com"@mx2.vsnl.com

Hi,

I have a friend who will be visiting Delhi in the near future and is interested in contacting this group: AIDS Bhed Bhav Virodhi Andolan (ABVA), and I have attached his request below. If anyone has information that could help him, please contact him directly at tstucker@bellatlantic.net.

Thanks.
George M. Carter
E-mail: <gmc0@ix.netcom.com>

Subject: [AIDS-INDIA] correct e-mail address for bitra george
Date: Tue, 25 Dec 2001 08:19:05 +1100
From: <jimmyd@vsnl.com>
To: <AIDS-INDIA@yahoogroups.com>, "Bitra George" <jimmyd@vsnl.com>

Dear Forum Members,

I would like to clarify that the email address jimmyd@vsnl.com belongs to me, Jimmy Dorabjee, and NOT Dr. Bitra George. Somehow this mistake has occured and I am receiving messages that are of no relevance to me. I am in Australia now and not in Delhi.

PLEASE NOTE THIS IN YOUR ADDRESS BOOKS.
Dr. George's correct email address is bitra_george@vsnl.net

Jimmy Dorabjee

Library - AIDS-India Forum
28/12.

TN
28/12

Subject: [AIDS-INDIA] File - Invitation- Please forward
Date: 1 Jan 2002 16:25:53 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Welcome to AIDS-INDIA eFORUM

AIDS-INDIA eFORUM is an electronic forum to foster communication and collaboration among those of who are involved or interested in AIDS related issues in India. Your e-mail id is on this list because you must have indicated your interest in AIDS related issues in India or some one else must have suggested your name as a person who may be interested in AIDS related issues in India.

This is a moderated forum. We would like to invite you to post messages, announcements, details of your AIDS related work in India. Confidentiality of the list members is assured. For more details of the forum please contact the moderator.

If you are already a member of AIDS-INDIA eFORUM please forward this message to your colleagues. Thank you for your attention.

Joe Thomas

Moderator
AIDS-INDIA eFORUM
aids-india@egroups.com
Web page: http://groups.yahoo.com/group/AIDS-INDIA

The views are of the authors. Please feel free to copy the messages.
An acknowledgement would be appreciated
To Post a message: aids-india@eGroups.com
To Unsubscribe: aids-india-unsubscribe@eGroups.com
Web page: http://groups.yahoo.com/group/AIDS-INDIA

Your use of Yahoo! Groups is subject to http://docs.yahoo.com/info/terms/

Leh. AIDS India file
TH
21/1/02
Jw 21/1

Subject: [AIDS-INDIA] Sexual Health in Kerala: Perspectives and Strategies"
Date: Mon, 3 Dec 2001 23:09:53 +0530
From: "Maitreya" <maitreya@asianetindia.com>
To: <sea-aids@healthdev.net>, <ISHIMA-subscribe@yahoogroups.com>, <firmkerala@yahoogroups.com>, <break-the-silence@hdnet.org>, "AIDS-INDIA" <AIDS-INDIA@yahoogroups.com>

From: Dr. Jos Chathukulam [mailto:crmrural@md4.vsnl.net.in]
Call for Papers: National on Seminar Sexual Health in Kerala: Perspectives and Strategies"

Ever since the first HIV case was detected in Kerala a number of initiatives to promote safe sexual practices have been undertaken in the state. Some are sponsored by donor agencies. Yet others have emerged as extensions of charity work already undertaken by some organisations with their own resources. Multiple perspective on sexual health exist in the state. There has not been a stock taking and comprehensive review of the efforts made so far. The seminar is intended to provide a forum for reviewing these efforts and also for crystallizing the different perspectives on sexual health. Whether an all-together different strategy is necessary given the socio-economic and political situation of Kerala also needs to be deliberated upon.

This is to notify in advance about the seminar so that you /your institution/ organisation/ department will be able to prepare a paper and contribute to the seminar. The seminar is proposed to be held in March 2002. The exact dates will be communicated in my next letter which you can expect within three weeks. The abstract of the paper may be sent before 31 January 2002. Deadline for the submission of the full paper is 27 February 2002. Papers will be peer reviewed and only the selected papers will be presented in the seminar. These papers will also be published in an edited volume brought out by a reputed publisher. The seminar is organised by the Centre for Rural Management in association with a few organisations including university departments. The paper contributors will be provided travel assistance and local hospitality.

Please circulate this letter among the scholars/staff of your organisation/ institution/ department for information. Early response to this letter from prospective authors will be highly appreciated.

Broad Indicative Areas

- Changing Modes of Sexuality in Kerala
- Profile of Risk Behaviour in Kerala : The Macro Situation
- Profile of Female (CSWs) and Male (MSMs) Sex Workers in Kerala
- Strategies for Mainstreaming STD/HIV Control into the Public Health Institutions
- Management of STD/ Syndromic Management
- Rehabilitation Measures
- Role of Local Governments and NGOs

[AIDS-INDIA] Sexual Health in Kerala: Perspectives and Strategies"

- Cases of Best Practices in Sexual Health Intervention
- Case Studies
- Issues Related to Counselling for CSWs and MSMs/ HIV/AIDS Counselling
- Condom Promotion Measures
- IEC, BCC Materials, Content, Effectiveness and Client -Friendliness
- Enabling Environment and Advocacy Building
- Ethical and Legal Issues
- The Rationale and Management of Drop In Centres for CSWs
- Other Organisational Aspects
- Gender Issues
- Evaluation of Sexual Health Programmes : Methodology and Process

Papers may be sent to Dr. M. Johnson Samuel who is the seminar coordinator.

Looking forward to your whole-hearted cooperation and with warm regards,

Yours sincerely,

Jos Chathukulam

Centre for Rural Management
Perumpaikadu P.O
Kottayam -686 029
Kerala
E-mail: crmrural@md4.vsnl.net.in

Subject: [AIDS-INDIA] Feed abck from the 5th international conference on home based care at Changmai held - 17-20 Dec 2001
Date: Thu, 3 Jan 2002 04:51:15 +0530
From: "Shyamala Ashok" <aabinand@satyam.net.in>
To: <AIDS-INDIA@yahoogroups.com>

Dear Friends

I had the privilege to be sponsored by FHI - India with many a thanks to attend the 5th international conference on home and community care for Persons living with HIV/AIDS from 17th Dec - 20th Dec 2001 in Changmai Bangkok. The following were the noted issues and possible solutions that were broadly discussed and expressed. It was clearly recognised that in the coming years home based care with community support is the only solution to HIV/AIDS management which of course should be integrated. The conference did give us insight especially to the NGOs who are running communioty based care programs from large countries like India wherein we face a lot of complexities with our existing programs.

Regards

shyamala ashok

Issues:

AIDS can be treated: HIV is a manageable chronic disease; Home care services helps us listen, care and support, the major obstacles to which are stigma & discrimination; Care & Support and Prevention should be integrated.

The reality of AIDS: Chronic ill health and stigma threatens humanity: AIDS has lead to friendships and to improve health we need medicines; fight to preserve human dignity, which includes a fight to drugs.

Barriers: Comprehensive needs assessment: Sex Workers and Micro credit; Commercial based research; Integrate counselling with home care; Quality of Life needs to get real; MTCT can now be narrowly focused; Long standing issue of integration; DOTS can also be applied to monitoring of ARV.

Improving access to Quality: Management of OI is primary; Prevention of OI helps in the long run; Simple medicines help the PLHA needs; Uncertainty of prophylaxis with clear information; ARV will become more available with CD4 monitoring; ARV are cheaper because of the greater involvement of PLWHA; Hospitals have chances to do better and improve their skills.

We still need Home Based Care: ARV progression causes conflicts; If treatment is to help prevention enrollment must be fair; ARV has not addressed stigma.

Home Care Continuum (HCC) is the key to reducing costs: Limit burden on hospitals; HCC necessasary for PLWHA needs; Small Scale Projects – Lessons learut; Volunteers and Cost Effectiveness.

Sustainability: Basic needs are not met; how could we sustain volunteers; Church programs are more successful; Incentives for volunteers.

How to achieve successful partnerships: GIPLWHA are cross cutting issues; misunderstanding between Govt. and PLWHA needs; Identity and different roles of the partners; Volunteers should have professional accountiability and improve quality; Volunteers with professionalism and supervision by peer leaders.

Stigma and Discrimination in the social context of care: Rights and violations of rights; heard repeated stories; experience is at a different stage; issues of self stigma, children neglected: need for community based programs to help both adult and children; Taboo in India; Cleanliness, adequate nutrition and health; disclosure by the burden of secrecy; interactive self help groups; making access to treatment and care a legal requirement; integrating AIDS care into existing programs; using church based

TH 7/1/02

[AIDS-INDIA] Feed abck from the 5th inter...ed care at Changmai held - 17-20 Dec 2001

volunteers more sustainable.

Rights of Doubly Discriminated persons: Immigrant women need respect for confidentiality; Rights in IDU and sex Workers received less importance; interactive self help groups.

Education and HIV infected child: AIDS having a devastating impact on children infected; involvement of teachers with more charges.

Coalition Efforts against Stigma and Discrimination: It is a major obstacle in partnership building; neutral organizations being a bridge to the Govt. Organizations; Bridge Organizations to sensitize the Governments and banish taboos with human touch.

Enabling Environment and Problem and Challenges: Strategically and financially scale up successful small scale projects; social support for PLWHA; capacity building of care providers in community that lacked funding for medicines; Disclosure of HIV status to adult children being problematic and not discussed sufficiently; needs of family care givers should be discussed in addition to their roles in homes; "Head in the Sand" are the levels of the private sectors who view HIV/AIDS very lightly; the challenges to strengthen partnerships Govt, NGO and Private Sectors; Family and members should be seen as individual human beings with problems and constraints; lack of discussion in community based to report to 1 million orphans; to reflect and synthesize greater contributions.

Possible Solutions:

Sustainability occurs only while you mainstream and integrate HCC with existing preventive programs; scaling up of Govt. and Private sectors with more pilot programs; Business can manage AIDS; Large networks of mass organizations are an effective tool to create an enabling environment; Information networks can be used as effective political advocacy to change views; Industrial networks to fulfill their objectives and contribute; human ability to accept to adapt and challenge situations but ultimately integrate HIV/AIDS into existing programs; voluntary counselling; Business / labor Policy / Program Development with sustainability; Enhanced partnership building; forceful advocacy and effective scale up.

Positive Living and obstacles: Stigma and Discrimination is still the riding factor; PLWHA should not hide their status and should come out openly and simultaneously people should accept; lack of education and knowledge which applies to the infected and affected; Disclosure and Confidentiality to be simultaneously observed; PLWHA are the best carers with good self care; Need for multi sectrol synergistic approach to support and care for PWHA.

Subject: [AIDS-INDIA] TB and HIV: An Online Course for Clinicians
Date: Thu, 22 Nov 2001 04:55:27 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

TB and HIV: An Online Course for Clinicians

About this Course

Course description
TB and HIV: An Online Course for Clinicians is the first in a series of online courses produced by the Francis J. Curry National Tuberculosis Center. The course offers text that describes the transmission, pathogenesis, epidemiology, screening, diagnosis, and treatment of TB and HIV-1 coinfection, including information on treatment of latent tuberculosis infection and treatment of active tuberculosis disease in the presence of protease inhibitors. A set of brief "review cases" and a full-length interactive "case study" challenge the user to apply the content they have learned in the text.

Target audience

Clinicians and other health professionals
Medical and nursing students

Prerequisites
None

Fee
None

Continuing Education Credits
Continuing education credits will be offered for a variety of professions, based on one (1) hour of instruction.

Course outline: [Summary] [Epidemiology] [Transmission and Pathogenesis] [Diagnosis] [Treatment of TB] [TB Treatment & Antiretroviral Treatment] [Screening] [Treatment of Latent TB Infection] [Bibliography]

WEB PAGE: http://www.nationaltbcenter.edu/tbhiv_course/index.html

---

Pl. show to James -(Soon. no. follow)

TN
23/11

Lib AIDS India file
26/11

[AIDS-INDIA] SC stays grant of Rs 1 lakh damages to AIDS victim

Subject: **[AIDS-INDIA] SC stays grant of Rs 1 lakh damages to AIDS victim**
Date: Tue, 20 Nov 2001 11:31:13 +0530
From: "Jagdish Harsh" <fxbjagdish@yahoo.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
To: <AIDS-INDIA@yahoogroups.com>

SC stays grant of Rs 1 lakh damages to AIDS victim
The Times of India 20, November- 2001

NEW DELHI- The Supreme Court on Monday stayed an Andhra Pradesh High Court order asking Singareni Collieries Company Ltd (SCCL) To pay Rs one lakh as compensation to a worker's wife who allegedly contracted AIDS during her treatment in the company-run hospital. A Bench comprising Justice B N Kirpal and Justice K G Balakrishnan also issued notice to respondents, including the claimant, and admitted the petition. SCCL challenged the HC's October 29 order, which had asked the state government to consider the "desirability of introducing a Bill granting sales tax exemption to imported medicines for treatment of AIDS."

The victim had alleged that his wife had contracted the disease due to the negligence of the hospital staff who did not screen the donated blood for HIV virus. The Bench directed that sufficient HIV test kits and other equipment be provided to all institutions and licensed blood banks be made to buy fool-proof equipment. All the government hospitals should compulsorily use disposable needles for injections, it had directed.

A five-judge Bench of the high court had treated a letter from the worker's wife as public interest litigation. It had also asked the state government to issue necessary circulars to public sector undertakings and other private sector companies "to see that the persons suffering from HIV-AIDS are identified and/or given proper treatment.

SCCL's counsel P P Rao and B Parthasarathi argued that the high court erred in treating the letter as PIL when the claim was of personal nature and not on behalf of the public.

Counsel said the high court also was not correct in recording a categorical finding that the victim had suffered on account of the negligence of the medical and paramedical staff and then leaving it open to parties to seek appropriate remedies before a civil court

---

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

JB
1. Pl. enter as part of Medical Ethics in our email address list — ~~write~~ pl return by 26/11

2. Lib - AIDS - India file

Subject: Fwd: [AIDS-INDIA] looking for guidance and a mentor for a study on disease perception
Date: Sun, 21 Oct 2001 00:30:05 +0000
From: "latha jagannathan" <lathajagu@hotmail.com>
To: madhyamb@vsnl.com, samraksha@vsnl.net, knpplus@vsnl.net, mamthasatish@vsnl.com, snehadaan@yahoo.com, vravi@nimhans.kar.nic.in, chandra@nimhans.kar.nic.in, j_ramakrishna@vsnl.com, pradeep@mahiti.org, sechara@vsnl.com, manohar@sangamaonline.org, betbng@bgl.vsnl.net.in, lman@vsnl.com, svjrao@hotmail.com
CC: deeptiprasad@netkracker.com

Hi all,

Does AFK / any member want to use Anoop's offer?

Please let me know.

Latha

>From: Anoopa Sharma

>Reply-To: aids-india@yahoo.com
>To: AIDS-INDIA@yahoogroups.com
>Subject: [AIDS-INDIA] looking for guidance and a mentor for a study on disease perception
>Date: Thu, 18 Oct 2001 18:24:58 -0700 (PDT)
>
>Hi
>
>I am a student from the US, almost finished with BS in Computer
>Science and Biology. I am applying for a Fulbright grant '
>which will allow me to go to India with full funding to do a
>study in disease perception in rural Indians and/or slum-dwellers.
>
>The bases behind my project is that international health organizations
>(such as WHO) need to have a basic understanding of Indian beliefs
>regarding disease before they can design adequate health interventions.
>
>Is this a relevant project? For example, I'm sure that WHO and other
>organizations do have locally-based partners from whom they get
>information about Indian culture and how it needs to be considered when
>designing a health program.
>
>While in India, I will need an organization which can provide me with
>some guidance and a mentor and with which I can work in affiliation
>while I am in India, but like I said I will have full funding.
>
>If you know of an organization that would be willing to work with me on
>this exploration of disease perception among rural Indians or lower caste Indians, please do contact me by replying to this email.
>
>I also welcome any suggestions or comments on my project idea.
>

To: DI TN 22/10/01

Subject: [AIDS-INDIA] fighting AIDS with laughter
Date: Tue, 8 Jan 2002 11:01:55 GMT
From: fxbkolkata@onlysmart.com
To: AIDS-INDIA@yahoogroups.com

Fighting AIDS with laughter
Hindusthan Times ,7th Jan.02

Imagine someone addressing a public meeting through a microphone covered with a condom. Don't be funny , you would say . But, that's what Dr.I.S. Gilada, Sunil Dutt's Public Health Secretary and HIV /AIDS consultant, did to urge people to use condoms. Infact he can do anything to drive home a point .Anything .Even wear condoms in the neck.

He hung a garland of condoms to urge people for safe sex. But why on earth did he cover microphone with condom? Says Dr. Gilada "for those who says that condom use reduses sexual pleasure".

"I told them if you can hear them properly , then you sure can enjoy sex wearing a condom". Speaking at Indian Science Congress On HIV Epidemic ;Dr. Gilada told that the best way to check HIV infection is awareness. The best way to convince people is to show them an example, he said adding, " of course I could not wear condoms where this should be worn".

He invoked Lord Narada and Ganesh to advice religious people,. "I was afraid hurting people's sentiment but in case of Ganesha and Naradmuni people tend allow some liberties". Dr. Gilada says "I said Lord Ganesha's prashad for children and condoms for adults". I also circulated cartoons (called them 'sextoons' if you will). showing Lord Ganesha telling Narad muni to ask people to have safe sex, and Naradmuni (who became Nirodhmuni running with a bag of condoms).In a lighter vein he asked people to change postures instead of partners.....

Dr. Gilada also used the platform to blast the Govt. specially NACO explianing why he left a cushy Govt. job. "I realized I was fighting two viruses : Govt. and HIV. I am a small man the diminutive campaigner said ,"I could not fight them both.

fxbkolkata@onlysmart.com

Subject: [AIDS-INDIA] Delete section 377 of IPC: NGO
Date: Tue, 08 Jan 2002 22:34:45
From: "kala rau" <kalarau@mantramail.com>
To: AIDS-INDIA@yahoogroups.com

Delete section 377 of IPC: NGO: DECCAN HERALD

Monday, January 7, 2002
BANGALORE, (DHNS. Mumbai-based Lawyers Collective HIV/AIDS unit and The Freedom Foundation with its head quarters in Bangalore has demanded the deletion of Section 377 of the Indian Penal Code which empowers the police to book people for indulging in unnatural sexual behaviour. Speaking to reporters here on Saturday, Mr. Anand Grover, Project Director, HIV/Aids unit, Lawyers Collective, accused Bangalore police of misusing the section against homosexuals, by rounding them up in parks. "As per the section, the guilty should be arrested only when found indulging in the sexual act and not when found cruising into parks", he said.

The IPC Section 377, under the unnatural offenses category reads thus, "Whoever voluntarily indulges in carnal intercourse against the order of nature with a man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years and shall also be liable to fine".

Lawyers Collective in association with Freedom Foundation, an NGO, launched an awareness drive about the rights of the HIV/AIDS affected in Bangalore on January 4 and 5, 2002. Mr. Ashok Rau Founder/Director of the Freedom Foundation, who is one of the India's most out spoken advocates and activist on HIV/AIDS and substance abuse, also spoke. " India needs to review and make some drastic changes in some of the existing statutes and laws, the existing ones are out dated and punitive" he said.

Justice Edwin Cameron, Supreme Court of Appeal, South Africa, and Justice Michael Kirby, High Court of Australia are in the city to promote the campaign. They have been interacting with different sections of society.

Justice Cameron who was also present at the press conference, said the issue was no more confined to only the medical or the social aspect but had assumed the form of an issue of rights. Justice Cameron said he was himself a gay and has been afflicted with the HIV virus since 1995 and is on anti retroviral medication. "If rights are given to the affected, the epidemic can be prevented from spreading", he added.

Lib

9/1 TM 9/1/02

Subject: [AIDS-INDIA] Free Booklet on issues involved in the care of AIDS affected children
Date: Fri, 04 Jan 2002 08:37:40 -0000
From: " Arabinda Pani" <arapani@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

HIV/AIDS increasingly threatens all of India's people, and more and more children are becoming victims. Some of these children are HIV positive, and many have been or soon will be orphaned by AIDS.

It is imperative that all types of social support be strengthened as the numbers of these children increase. We strongly believe these children can be integrated into existing child care programs in India.

While AIDS orphans who are not HIV positive do not pose any risk of transmission, the risk from positive children can be significantly reduced with the proper use of universal precautions. Nonetheless, many of these children are victims of unnecessary and unfounded stigma and discrimination, and left unable to access necessary services.

We have created Hand in Hand – a booklet describing issues involved in the care of AIDS affected children, as well as innovative initiatives child care programs throughout India have taken to address them. We hope organizations can learn from one another as well as network to enhance care for children.

We are sending this email to inquire whether you would like a free copy of this informative and useful booklet. Also, if you currently do serve these children or have plans to do so, we would love to hear about your successes and any suggestions you may have.

We look forward to receiving your reply with your mailing address.

Sincerely,
Arabinda K. Pani and Aarti Kumar
E-mail: arapani@yahoo.com

Lib
Sr
9/1

TH
9/1/02

Subject: [AIDS-INDIA] 5.18 % of HIV transmission in New Delhi is due to blood transfusion
Date: Fri, 4 Jan 2002 11:57:38 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Anti-AIDS drive in city in February

The Asian Age 4th January, 2001-New Delhi

New Delhi, Jan. 3: The Delhi government has decided to launch the 5th Family Health Awareness campaign against AIDS in the city in February. While talking to reporters, the Delhi health minister, Dr. A.K. Walia, said "as many as 646 cases of AIDS have been reported in the city so far. While 167 patients have died, there are over 22,000 HIV positive cases in Delhi." The health minister further said that of a total 646 AIDS cases, 557 were male, 89 female, 18 in the age group of 0 to 14 years 234 in 15-29 years, 282 in 30-49 years, 66 above 50 years and 46 have not specified their age. "The sentinel surveillance survey was conducted at seven sites in the city in 2000 which revealed that in general 25 per cent of the population were HIV positive, among STD patients, 3.73 per cent were infected and among drug users it was five per cent," said the minister.

The minister further said that about 73.58 per cent people had been infected due to unsafe sex, 5.18 per cent due to transfusion of infected blood, 4.08 per cent due to indictable drug use, 1.72 per cent due to prenatal transmission and 15.40 per cent due to other reasons.

Dr. Walia also said that number of factors like increase in migrant population, street children, commercial sex workers, and intravenous drug users contribute to the high risk of HIV transmission. Prevalence of STD-infected population also adds to the number of AIDS cases, he added. Health department of the Delhi government has evolved a multisectoral strategy by seeking help from public, private, various government departments and NGOs for effective implementation of this campaign. The Delhi government has also decided to create awareness among the masses through television, radio, video screening, advertisements, bus panels, hoarding at petrol pumps and colleges, kiosks on G.B. Road, stickers, message on electricity and water bills.

He said that the family welfare awareness campaign would be observed in Delhi from February 1 to 20 by setting up awareness camps.

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] TB and HIV: An Online Course for Clinicians
Date: Thu, 22 Nov 2001 04:55:27 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

TB and HIV: An Online Course for Clinicians

About this Course

Course description
TB and HIV: An Online Course for Clinicians is the first in a series of online courses produced by the Francis J. Curry National Tuberculosis Center. The course offers text that describes the transmission, pathogenesis, epidemiology, screening, diagnosis, and treatment of TB and HIV-1 coinfection, including information on treatment of latent tuberculosis infection and treatment of active tuberculosis disease in the presence of protease inhibitors. A set of brief "review cases" and a full-length interactive "case study" challenge the user to apply the content they have learned in the text.

Target audience

Clinicians and other health professionals
Medical and nursing students

Prerequisites
None

Fee
None

Continuing Education Credits
Continuing education credits will be offered for a variety of professions, based on one (1) hour of instruction.

Course outline: [Summary] [Epidemiology] [Transmission and Pathogenesis] [Diagnosis] [Treatment of TB] [TB Treatment & Antiretroviral Treatment] [Screening] [Treatment of Latent TB Infection] [Bibliography]

WEB PAGE: http://www.nationaltbcenter.edu/tbhiv_course/index.html

---

Pl. show Dr James -(soon. no. Follow)

TN
11/23/11

11/23/01 12:01 PM

Wb AIDS India file
TN
11/26/11

[AIDS-INDIA] SC stays grant of Rs 1 lakh damages to AIDS victim

Subject: **[AIDS-INDIA] SC stays grant of Rs 1 lakh damages to AIDS victim**
Date: Tue, 20 Nov 2001 11:31:13 +0530
From: "Jagdish Harsh" <fxbjagdish@yahoo.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
To: <AIDS-INDIA@yahoogroups.com>

SC stays grant of Rs 1 lakh damages to AIDS victim
The Times of India 20, November- 2001

NEW DELHI- The Supreme Court on Monday stayed an Andhra Pradesh High Court order asking Singareni Collieries Company Ltd (SCCL) To pay Rs one lakh as compensation to a worker's wife who allegedly contracted AIDS during her treatment in the company-run hospital. A Bench comprising Justice B N Kirpal and Justice K G Balakrishnan also issued notice to respondents, including the claimant, and admitted the petition. SCCL challenged the HC's October 29 order, which had asked the state government to consider the "desirability of introducing a Bill granting sales tax exemption to imported medicines for treatment of AIDS."

The victim had alleged that his wife had contracted the disease due to the negligence of the hospital staff who did not screen the donated blood for HIV virus. The Bench directed that sufficient HIV test kits and other equipment be provided to all institutions and licensed blood banks be made to buy fool-proof equipment. All the government hospitals should compulsorily use disposable needles for injections, it had directed.

A five-judge Bench of the high court had treated a letter from the worker's wife as public interest litigation. It had also asked the state government to issue necessary circulars to public sector undertakings and other private sector companies "to see that the persons suffering from HIV-AIDS are identified and/or given proper treatment.

SCCL's counsel P P Rao and B Parthasarathi argued that the high court erred in treating the letter as PIL when the claim was of personal nature and not on behalf of the public.

Counsel said the high court also was not correct in recording a categorical finding that the victim had suffered on account of the negligence of the medical and paramedical staff and then leaving it open to parties to seek appropriate remedies before a civil court

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

JB
Pl. enter as part of Medical Ethics in our email address. This — ~~write~~ pl return by 26/11

2. Lib. AIDS-India file

Subject: Fwd: [AIDS-INDIA] looking for guidance and a mentor for a study on disease perception
Date: Sun, 21 Oct 2001 00:30:05 +0000
From: "latha jagannathan" <lathajagu@hotmail.com>
To: madhyamb@vsnl.com, samraksha@vsnl.net, knpplus@vsnl.net, mamthasatish@vsnl.com, snehadaan@yahoo.com, vravi@nimhans.kar.nic.in, chandra@nimhans.kar.nic.in, j_ramakrishna@vsnl.com, pradeep@mahiti.org, sochara@vsnl.com, manohar@sangamaonline.org, betbng@bgl.vsnl.net.in, lman@vsnl.com, svjrao@hotmail.com
CC: deeptiprasad@netkracker.com

Hi all,

Does AFK / any member want to use Anoop's offer?

Please let me know.

Latha

>From: Anoopa Sharma

>Reply-To: aids-india@yahoo.com
>To: AIDS-INDIA@yahoogroups.com
>Subject: [AIDS-INDIA] looking for guidance and a mentor for a study on disease perception
>Date: Thu, 18 Oct 2001 18:24:58 -0700 (PDT)
>
>Hi
>
>I am a student from the US, almost finished with BS in Computer
>Science and Biology. I am applying for a Fulbright grant '
>which will allow me to go to India with full funding to do a
>study in disease perception in rural Indians and/or slum-dwellers.
>
>The bases behind my project is that international health organizations
>(such as WHO) need to have a basic understanding of indian beliefs
>regarding disease before they can design adequate health interventions.
>
>Is this a relevant project? For example, I'm sure that WHO and other
>organizations do have locally-based partners from whom they get
>information about Indian culture and how it needs to be considered when
>designing a health program.
>
>While in India, I will need an organization which can provide me with
>some guidance and a mentor and with which I can work in affiliation
>while I am in India, but like I said I will have full funding.
>
>If you know of an organization that would be willing to work with me on
>this exploration of disease perception among rural Indians or lower caste Indians, please do contact me by replying to this email.
>
>I also welcome any suggestions or comments on my project idea.
>

To: DR TN 22/1/01

Subject: [AIDS-INDIA] fighting AIDS with laughter
Date: Tue, 8 Jan 2002 11:01:55 GMT
From: fxbkolkata@onlysmart.com
To: AIDS-INDIA@yahoogroups.com

Fighting AIDS with laughter
Hindusthan Times ,7th Jan.02

Imagine someone addressing a public meeting through a microphone covered with a condom. Don't be funny , you would say . But, that's what Dr.I.S. Gilada, Sunil Dutt's Public Health Secretary and HIV /AIDS consultant, did to urge people to use condoms. Infact he can do anything to drive home a point .Anything .Even wear condoms in the neck.

He hung a garland of condoms to urge people for safe sex. But why on earth did he cover microphone with condom? Says Dr. Gilada "for those who says that condom use reduses sexual pleasure".

"I told them if you can hear them properly , then you sure can enjoy sex wearing a condom". Speaking at Indian Science Congress On HIV Epidemic ;Dr. Gilada told that the best way to check HIV infection is awareness. The best way to convince people is to show them an example, he said adding, " of course I could not wear condoms where this should be worn".

He invoked Lord Narada and Ganesh to advice religious people,. "I was afraid hurting people's sentiment but in case of Ganesha and Naradmuni people tend allow some liberties". Dr. Gilada says "I said Lord Ganesha's prashad for children and condoms for adults". I also circulated cartoons (called them 'sextoons' if you will). showing Lord Ganesha telling Narad muni to ask people to have safe sex, and Naradmuni (who became Nirodhmuni running with a bag of condoms).In a lighter vein he asked people to change postures instead of partners.....

Dr. Gilada also used the platform to blast the Govt. specially NACO explianing why he left a cushy Govt. job. "I realized I was fighting two viruses : Govt. and HIV. I am a small man the diminutive campaigner said ,"I could not fight them both.

fxbkolkata@onlysmart.com

Subject: [AIDS-INDIA] Delete section 377 of IPC: NGO
Date: Tue, 08 Jan 2002 22:34:45
From: "kala rau" <kalarau@mantramail.com>
To: AIDS-INDIA@yahoogroups.com

Delete section 377 of IPC: NGO: DECCAN HERALD

Monday, January 7, 2002
BANGALORE, (DHNS. Mumbai-based Lawyers Collective HIV/AIDS unit and The Freedom Foundation with its head quarters in Bangalore has demanded the deletion of Section 377 of the Indian Penal Code which empowers the police to book people for indulging in unnatural sexual behaviour. Speaking to reporters here on Saturday, Mr. Anand Grover, Project Director, HIV/Aids unit, Lawyers Collective, accused Bangalore police of misusing the section against homosexuals, by rounding them up in parks. "As per the section, the guilty should be arrested only when found indulging in the sexual act and not when found cruising into parks", he said.

The IPC Section 377, under the unnatural offenses category reads thus, "Whoever voluntarily indulges in carnal intercourse against the order of nature with a man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years and shall also be liable to fine".

Lawyers Collective in association with Freedom Foundation, an NGO, launched an awareness drive about the rights of the HIV/AIDS affected in Bangalore on January 4 and 5, 2002. Mr. Ashok Rau Founder/Director of the Freedom Foundation, who is one of the India's most out spoken advocates and activist on HIV/AIDS and substance abuse, also spoke. " India needs to review and make some drastic changes in some of the existing statutes and laws, the existing ones are out dated and punitive" he said.

Justice Edwin Cameron, Supreme Court of Appeal, South Africa, and Justice Michael Kirby, High Court of Australia are in the city to promote the campaign. They have been interacting with different sections of society.

Justice Cameron who was also present at the press conference, said the issue was no more confined to only the medical or the social aspect but had assumed the form of an issue of rights. Justice Cameron said he was himself a gay and has been afflicted with the HIV virus since 1995 and is on anti retroviral medication. "If rights are given to the affected, the epidemic can be prevented from spreading", he added.

Lib

9/1 9/1/02

Subject: [AIDS-INDIA] Free Booklet on issues involved in the care of AIDS affected children
Date: Fri, 04 Jan 2002 08:37:40 -0000
From: " Arabinda Pani" <arapani@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

HIV/AIDS increasingly threatens all of India's people, and more and more children are becoming victims. Some of these children are HIV positive, and many have been or soon will be orphaned by AIDS.

It is imperative that all types of social support be strengthened as the numbers of these children increase. We strongly believe these children can be integrated into existing child care programs in India.

While AIDS orphans who are not HIV positive do not pose any risk of transmission, the risk from positive children can be significantly reduced with the proper use of universal precautions. Nonetheless, many of these children are victims of unnecessary and unfounded stigma and discrimination, and left unable to access necessary services.

We have created Hand in Hand – a booklet describing issues involved in the care of AIDS affected children, as well as innovative initiatives child care programs throughout India have taken to address them. We hope organizations can learn from one another as well as network to enhance care for children.

We are sending this email to inquire whether you would like a free copy of this informative and useful booklet. Also, if you currently do serve these children or have plans to do so, we would love to hear about your successes and any suggestions you may have.

We look forward to receiving your reply with your mailing address.

Sincerely,
Arabinda K. Pani and Aarti Kumar
E-mail: arapani@yahoo.com

Lib
for
9/1

TH

1/1/02

Subject: [AIDS-INDIA] 5.18 % of HIV transmission in New Delhi is due to blood transfusion
Date: Fri, 4 Jan 2002 11:57:38 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Anti-AIDS drive in city in February

The Asian Age 4th January, 2001-New Delhi

New Delhi, Jan. 3: The Delhi government has decided to launch the 5th Family Health Awareness campaign against AIDS in the city in February. While talking to reporters, the Delhi health minister, Dr. A.K. Walia, said "as many as 646 cases of AIDS have been reported in the city so far. While 167 patients have died, there are over 22,000 HIV positive cases in Delhi." The health minister further said that of a total 646 AIDS cases, 557 were male, 89 female, 18 in the age group of 0 to 14 years 234 in 15-29 years, 282 in 30-49 years, 66 above 50 years and 46 have not specified their age. "The sentinel surveillance survey was conducted at seven sites in the city in 2000 which revealed that in general 25 per cent of the population were HIV positive, among STD patients, 3.73 per cent were infected and among drug users it was five per cent," said the minister.

The minister further said that about 73.58 per cent people had been infected due to unsafe sex, 5.18 per cent due to transfusion of infected blood, 4.08 per cent due to indictable drug use, 1.72 per cent due to prenatal transmission and 15.40 per cent due to other reasons.

Dr. Walia also said that number of factors like increase in migrant population, street children, commercial sex workers, and intravenous drug users contribute to the high risk of HIV transmission. Prevalence of STD-infected population also adds to the number of AIDS cases, he added. Health department of the Delhi government has evolved a multisectoral strategy by seeking help from public, private, various government departments and NGOs for effective implementation of this campaign. The Delhi government has also decided to create awareness among the masses through television, radio, video screening, advertisements, bus panels, hoarding at petrol pumps and colleges, kiosks on G.B. Road, stickers, message on electricity and water bills.

He said that the family welfare awareness campaign would be observed in Delhi from February 1 to 20 by setting up awareness camps.

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] AIDS Fund: Bureaucrats Betray People with AIDS in Poor Countries
Date: Fri, 23 Nov 2001 10:31:33 -0500
From: "George M. Carter" <gmc0@ix.netcom.com>
To: AIDS-INDIA-yahoogroups.com@mx2.vsnl.com

Forwarded message: FOR IMMEDIATE RELEASE 22 November 2001

Joint Press Release by NGOs from Belgium, Burundi, France, Ivory Coast, Morocco, Nigeria, South Africa, South Korea, UK, and US.

Global Fund for AIDS, TB and Malaria:

Bureaucrats Betray People with AIDS in Poor Countries
AIDS activists from around the world demand the Global Fund subsidize cheap AIDS Drugs

(Brussels) International AIDS activists and medical organizations confront the opening day of meetings of the Board for the Global Fund for AIDS, Tuberculosis and Malaria, in Brussels. Activists are concerned by the clear lack of commitment among Global Fund decision makers to financing AIDS treatment in poor countries.

Set to launch on December 15, 2001 the Global Fund is currently poised to finance treatment only for diseases cheaper to treat than HIV, despite public health evidence that AIDS treatment is cost effective and is a key aspect of an effective response to the AIDS pandemic. The activists insist that access to AIDS treatment is a fundamental human right that the Global Fund must help fulfill, as 30 million people with HIV are currently living with no access to affordable medication.

Activists from 10 countries have gathered in Brussels to meet with Global Fund Board members to demand funding for AIDS drugs, including antiretrovirals. The activists report that Global Fund decision-makers have already made clear that funding HIV treatment in poor countries will not be a priority for the Fund, despite the desperate worldwide need for AIDS drugs, and the tremendous gap in access to AIDS treatment that spurred the creation of the Global Fund by U.N. Secretary General Kofi Annan in April, 2001.

"The Global AIDS TB and Malaria Fund is turning into a slow, under-funded bureaucracy that will not be able to produce results. 27,000 people will die today because they lack access to affordable treatment for AIDS, tuberculosis and malaria," said Zackie Achmat of the Treatment Action Campaign in South Africa.

"What we're seeing here is a betrayal of what the Fund was invented for in the first place. Rich countries cannot be allowed to simply sentence 30 million people with HIV to death because they prefer to focus on cheaper diseases," said Evan Ruderman of the Health GAP Coalition. "There is no reason for the Fund to wait to deliver vital medicines and start turning the tide while global comprehensive plans guidelines are developed over the next year."

The proposals being debated by the Global Fund board members fail to address proposals for treatment programs, or for the procurement or distribution of medicines. A concrete proposal that NGOs are making is for the Fund to start saving lives now, by putting vital HIV drugs into the hands of qualified field organizations through procurement and delivery systems already housed within UN agencies.

"Hospitals, clinics and workplaces in the field can immediately scale up effective treatment and care if they are given the HIV/AIDS drugs they can not afford," said Joseph Essombo, an AIDS doctor with the Ivory Coast Bouake Health Network.

"The fund must prioritize programs that quickly put critical medicines into the hands of the suffering," said Pearl Nwashili of Stop AIDS in Nigeria.

TM
R
26/11

"But the donor countries seem perfectly content that the Global Fund will not finance programs to start saving lives now, when 10,000 people with AIDS die each day."

The Doha declaration on Public Health affirms the rights of poor countries to bypass patents and purchase generic HIV medicines. "Even the World Trade Organization recognizes that economics can not dictate double standards on world health" said Gaelle Krikrian of ACT UP Paris. "The experience of doctors in the field shows that HIV treatment is absolutely feasible in poor countries, and, since the advent of generic competition, entirely affordable".

The international group of NGOs will meet with Global Fund board members this week to demand:

* GF must commit to saving the lives of people infected with AIDS, tuberculosis and malaria by providing treatment. Treatment for AIDS must not be a lower priority than prevention, or treatment for TB or Malaria.

*GF must prioritize, encourage and fast-track financing for provisions for AIDS medications at best world prices through international bidding and bulk procurement.

* GF must agree that the Fund will quickly make funds for treatment available to any qualified care providers that can rapidly deliver treatment to people with AIDS tuberculosis and malaria.

* GF must support the use of best world price and not restrict the use of affordable generic medicines to fight HIV/AIDS, TB and malaria .

* GF must not use a shortage of resources to justify deadly ineffective measures such as HIV prevention in the absence of treatment. Donor countries must commit sufficient amounts to give the Global Fund, and make good on the promise made last June at the United Nations' Special General Assembly on AIDS to commit at least 10 billion USD a year to the global fight against aids.

Oxfam International
Health GAP Coalition
ACT UP New York
ACT UP Philadelphia
ACT UP Paris,
Treatment Action Campaign (South Africa)
WOFAK (Kenya)
People's Health Coalition (South Korea)
Stop AIDS (Nigeria)
Renaissance Sate Bouake (Cote D'Ivore)
Pharmacist's Association for Healthy Society (PAHS)
Intellectual Property Left (IPLeft)
People's Solidarity for Social Progress
Team of Drug Policy, Korean Association of Physician for Humanism
People's Health Coalition
-ends-

Subject: [AIDS-INDIA] The Sexuality and Rights Institute: Exploring Theory and Practice
Date: Fri, 23 Nov 2001 22:54:55 +0530 (IST)
From: crea@vsnl.net
To: AIDS-INDIA@yahoogroups.com

The Sexuality and Rights Institute. Pune, Maharashtra
March 15th to 30th, 2002.

This is with reference to the announcement for the Sexuality and Rights Institute that went out in early October. We have received repeated requests to postpone the last date for receipt of completed application forms over the last few weeks.

We would like to inform you that the last date for receipt of application forms has been extended to the 15th of December 2001.

Attached below are the details about the institute. Please write in to us at sexualityinstitute@vsnl.net if you have any queries.

The Sexuality and Rights Institute: Exploring Theory and Practice

The Sexuality and Rights Institute is an annual two week long residential course that focuses on a conceptual study of sexuality. It will examine the interface between sexuality and rights and its links with the related fields of gender and health.

Sexuality spans multiple disciplines and areas of work. Accordingly, the course content of the Sexuality and Rights Institute will draw from different social science disciplines. National and international faculty will teach the courses. They will employ different pedagogical methods including classroom instruction, group work, case studies, simulation exercises, fiction and films. The medium of instruction and discussion will be English. Participants will examine sexual and reproductive health programs as well as various legal and socio-cultural issues and will incorporate their learning into planning and working on programmes.

Course themes cover: Conceptual background; The Rights Framework and Sexuality; Sexuality and Gender; *Sexual and Reproductive Health and Rights; Victimhood and Agency; Representation of* Sexuality; Sexual diversities. The core faculty includes: Radhika Chandiramani, Dr. Lynn Freedman, Geetanjali Misra, Dr. Michael Tan, Dr. Jyoti Sanghera, and Dr. Carole Vance. Other national and international resource persons will also be part of the faculty.

Individuals working on issues of sexuality, rights, health or gender in India are eligible to apply. A maximum of twenty-five participants will be selected each year, based on their applications and personal interviews. Candidates must be fluent in English. Participants are required to stay for the whole duration of the course.

The Sexuality and Rights Institute will hold its first course in March 2002 in Pune, Maharashtra. Participants will stay on campus in twin-sharing accommodation. The Institute will cover costs of lodging and boarding for the 2002 course. Some travel scholarships will be available on a needs basis.

The Institute is a collaborative initiative of CREA (Creating Resources for Empowerment in Action) and TARSHI (Talking About Reproductive and Sexual Health Issues). Both CREA and TARSHI are registered non-profit organisations. Based on a vision of the right to sexual well-being for all people, TARSHI works towards expanding sexual and reproductive choices in people's lives. CREA aims at enhancing the capabilities of a new generation of women leaders using a rights based approach to address issues of reproductive and sexual health, violence against

For more information, and application form please contact The Sexuality and Rights Institute at the following address:

The Sexuality and Rights Institute
49, Golf Links, Second Floor
New Delhi 11003, India
Phone & Fax: 91-11-4610711 & 4654603
Email: sexualityinstitute@vsnl.net

Subject: [AIDS-INDIA] one day AIDS India conference in Boston
Date: Tue, 27 Nov 2001 14:17:00 -0800
From: "mverma" <mverma@dmv.com>
To: <AIDS-INDIA@yahoogroups.com>

I am a retired Delaware State Public Health Laboratory Director. I served the state for 24 years until 1996. during my tenure I engaged the services of the Association of State and Territorial Laboratory Directors now know as Association of Public Health Laboratorians with its HQ in Washington D.C.

I have served as chairman and facilitator of the Global Health Program Committee of APHL and have worked with the NACO, India since 1990. We have brought several Indian scientists and have trained them in the US in the diagnosis of HIV/AIDS and also have conducted many training sessions in Indian Medical Schools about laboratory aspects of HIV/AIDS.

More recently I have worked with the National Institute of Biologicals in India to establish QA/QC programs and with The University Research Corporation and WHO in the global eradication of Polio.

My interest in HIV/AIDS prevention and eradication in India remains my priority.

I am working with APHL and CDC as well as with The International Health Organization (IHO) based in Boston to establish HIV/AIDS diagnostic centers of excellence in India. APHL and CDC have begun this work in Tamburan Hospital in Chennai.

IHO is sponsoring a one day AIDS India conference "India, the next epicenter of the AIDS pandemic" on Friday, December 7, 2001 in Snyder Auditorium, Harvard School of Public Health, 677 Huntington Ave, Boston. Registration is now open (Call 617-254-5077 or Fax 617-254-2767)

Dave Verma
E-mail: <mverma@dmv.com>

TN
&
11/28/01

Subject: [AIDS-INDIA] FILM- "SAHELI: A FRIEND IN NEED" TO BE RELEASED ON 29th NOVEMBER
Date: Tue, 27 Nov 2001 10:46:38 +0530
From: "ihoaids" <ihoaids@vsnl.com>
To: "aids-india" <AIDS-INDIA@yahoogroups.com>,

FILM- "SAHELI: A FRIEND IN NEED" on TRIUMPH OF SEX WORKERS TO BE RELEASED ON 29th NOVEMBER:

A documentary film "SAHELI: A FRIEND IN NEED" directed by John Webster and produced by Oy Millennium Film Ltd., Finland on Struggle and Triumph of sex workers to be reckoned as a force for change through PHO's project Saheli will be released in India on 29th November as a prelude to the World AIDS Day- December 1. The aesthetically made film was honoured with a prestigious PRIX ITALIA award at a recently held Television Film festival in Italy.

John Webster is very positive that SAHELI documentary will be both informative and an important messenger via television to the world of that significant work done by Peoples Health Organisation (India) and Sahelies, peer leaders of sex workers. The film shows how the so-called most powerless and neglected people- 'sex workers' unite and changes the course of the HIV Epidemic, where in Mumbai notoriously termed as AIDS Capital of India has turned into 'AIDS Control Capital of India' by the positive outcome of the project. HIV infections are at standstill in Mumbai when they are rising elsewhere.

Oy Millennium Film Ltd. has granted a project to distribute 1000 copies of the film to Non-Government Organisations, Social work Schools, Universities and other relevant HIV/AIDS organisations in India and abroad. Another significant aspect of this film is that Sahelies were involved in all the stages of the film - from planning to production and now in distribution.

It may be recalled that Project Saheli, a brainchild of PHO was launched in 1991; which was the first of its kind intervention project in the field of HIV/AIDS in India and in 1993 it was recognised as a 'Bombay Model' at the 9th International AIDS Conference in Berlin, Germany. Currently this project is run without any grant or regular funding and is a 'low-cost, high out-put' project included in the UNAIDS best practices.

Saheli film will be released at the hand of PHO President Sunil Dutt, MP and Director, Max Mueller Bhavan Dr. Peter Schabert will preside over the occasion. The film will be screened for Sahelies, Media and NGOs at Max Mueller Bhawan, Kala Ghoda, Mumbai on 29th November at 3 pm. All the concerned persons are cordially invited. Sahelies will address the press after screening. Those interested in copy of this film should contact PHO, Municipal school Bldg., J.J.Hospital Compound, Mumbai-400008; E-mail: ihoaids@vsnl.com, with details like name and address of NGO/Institution, primary goal and how they wish to use it.

Dr.I.S.Gilada, Secretary General, PHO
Peoples Health Organisation (India) (Formerly IHO)
Municipal School Building, J.J. Hospital Compd, Mumbai-400008
Tel.3719020; Fax: 3864433; E-mail: ihoaids@vsnl.com

TH
R
28/11

Subject: [AIDS-INDIA] Re: Trafficking in women and children in India
Date: Tue, 27 Nov 2001 15:20:43 +0530
From: "T Jacob John " <tjjohn@md4.vsnl.net.in>
To: "AIDS India" <AIDS-INDIA@yahoogroups.com>

This is in response to the UNIFEM project on Violence Against Women, which focus on trafficking in women and children in India.

When we detected HIV infection first in India (Feb 1986), then we knew about trafficking of women. Stories are often heart rending. There seems to be no limit to human cruelty to humans, and mostly for money. Trafficking has been going on, unknown to us, for a very very long time. Interventions to prevent this inhuman trade is essential to reduce transmission -- not just for this, but trafficking is against all norms of ethics, decency, civil behaviour etc. We found that sometimes the extra money is a reason for complicity by the law keepers themselves. In the most recent Lancet, there is an article that police is a very important team of public health personnel. How true in this scenario too.

HIV never caused any epidemic. We do, by creating all sorts of channels for passing on the virus. I heard about a child getting infected in a Mumbai hospital very recently, through blood transfusion. Another child, thalassaemic, always got clean blood, many times, but visited the home town, away from Mumbai, got one transfusion and got infected. In 2001. When will we become civilised?

T Jacob John
E-mail: <tjjohn@md4.vsnl.net.in>

TM

28/11

Subject: [AIDS-INDIA] Woman with AIDS fights for son
Date: Sat, 24 Nov 2001 10:23:53 +0530
From: "Jagdish Harsh" <fxbjagdish@yahoo.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
To: <AIDS-INDIA@yahoogroups.com>

Woman with AIDS fights for son
The Delhi Age 24 November, 2001-New Delhi

Mumbai, Nov.23: A 40-year-old woman tested HIV positive has been fighting to gain custody of her one-and-a-half-year-old son, Sachin, from her niece, who acted as his custodian between February and March 2001, while the woman looked after her elder son who was recovering from a kidney ailment at St. George Hospital.

The mother, Jasu Jagdish solanki, who works as a sweeper in fort, resides with her elder son, five-year-old Dashrath, on a pavement in the neighboring alley.

Speaking to The Asian Age, Ms Solanki said: "Dasrath was suffering from a kidney ailment and he was admitted to St. George Hospital for treatment on February 19. I used to leave Sachin on the pavement but would always worry about him in the hospital, since he was alone and there was no one to look after him. Sachin's Aunt and my niece, Billu, offered to take care of him and she look him to her house. During Dashrath's treatment, Billu also took my thumb impression on a blank paper."

Ms Solanki said that when she went to fetch Sachin on March 20, after Dasharth was discharged from the hospital, Billu refused to part with him. Billu and her husband lured Ms Solanki into giving her son away by telling her that they would buy a house and a television set for her. On refusal, they did not even let her meet Sachin and asked her to go to her native place in Navsari. Ms Solanki has not approached the police. She said: "Billu's husband might bribe them and they may chase me off the pavement. Where will I go? My husband died of AIDS two years ago. Who will fall in the legal wrangle in his absence? Will i go to the course or fend for my family?"

Leslie Pereira, a social worker in the area, who is helping Ms Solanki to get custody of her son, said that Billu does not have a child and secondly, they have given neither her room nor the television. Instead, they are threatening her and asking her to leave town. Mr. Perrier said, "Billu told Ms Solanki that she had legally adoption. She got scared and now allows Ms Solanki to meet Sachin."

Sachin's elder brother Dashrath, who misses his younger sibling, said: "I miss him. I will take care of him and study. But please bring him here."

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

TH
R
26/11

Subject: [AIDS-INDIA] Twin-edged blade India at the WTO- Doha meeting
Date: Fri, 23 Nov 2001 10:49:33 +0530
From: "Jagdish Harsh" <fxbjagdish@yahoo.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
To: <AIDS-INDIA@yahoogroups.com>

Twin-edged blade

The Business Standard 23, November, 2001-New Delhi

The Indian negotiating team that went to the WTO Ministerial Conference in Doha is citing several trophies in support of its claim that it did rather well. One of these is the declaration on intellectual property protection and access to medicines and public health. The declaration has highlighted the provisions in the TRIPS agreement that give members the flexibility to take care of public health emergencies like HIV/AIDS, tuberculosis and malaria. But what is not emphasized before Indian audiences is that the declaration has simultaneously reiterated members' commitment to the TRIPS agreement. This underscores the belief that strong protection to intellectual property rights can coexist with addressing poor countries' medicine and public health.

How can this benefit India? In the first place, in seeking to make available affordable medicines to its AIDS victims, India and other developing countries-can ignore the rights of patent holders. They can buy these medicines from the likes of Cipla, which sell them at far cheaper rates. Perhaps, more importantly, many African and Latin American countries where there is an epidemic can import and distribute Cipla's products.

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] AFFORDABLE MEDICINES AND TREATMENT CAMPAIGN
Date: Wed, 28 Nov 2001 00:38:09 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

AFFORDABLE MEDICINES AND TREATMENT CAMPAIGN

Prices of New Medicines in India are going to rise!
YOU CAN PREVENT THIS..!!!!

Dear All,

Indian law will soon undergo change because India has signed the international agreement on Trade Related Intellectual Property (TRIPS). This change will have a huge impact on the Indian patent law, which protects the invention of new products. The 'process patent' system used in India so far will be replaced by a more restrictive 'product patent' system.

The impact of this change on new medicines is unimaginable! Foreign pharmaceutical companies will have sole rights to determine the production, distribution, pricing and, therefore, availability of new medicines. It is feared that such a situation will raise the prices of new medicines to amounts that are unaffordable to most Indians.

We wish to introduce you to a NATION WIDE CAMPAIGN ON AFFORDABLE MEDICINES AND TREATMENT for all. Many people in this country do not have access to medical treatment at present prices. The idea of prices of new medicines being several times more expensive is surely unthinkable.

This is an issue that will have a grave and far-reaching impact on the right to life and health of all Indians and requires immediate action by the Indian Government. Since the Indian Government has not responded to this urgent issue, we as citizens of India who have to face the eventual impact of TRIPS should ACT NOW!

This campaign plans to lay special emphasis on access to HIV/AIDS medicines for opportunistic infections (OIs) and Anti-Retroviral Therapy (ART). People with HIV/AIDS can prolong their lives with the help of these medicines, which are already very expensive (minimum Rs.1800 per month for ART). New medicines for the treatment of HIV/AIDS are going to be even more expensive. If we do not stand up against TRIPS now, many more lives will be lost to this epidemic.

We must create public awareness and mobilisation. This issue concerns all of us and must be confronted by a mass and unified effort. NGOs, doctors and HIV positive peoples groups across the country have joined hands to launch this campaign. It will focus on the accessibility of affordable medicines for all as a fundamental human right that is enshrined in the Indian Constitution under the right to life and health.

This campaign will be formally launched on World AIDS Day, December 1, 2001. Groups and organisations in Delhi are planning a public meeting and candle light vigil demanding Affordable Medicines and Treatment for all. Please find attached an invitation for this program. We would be grateful if you could display the same at prominent places and also extend the invitation to as many people and groups as you can.

In advancing this campaign we need to reach out to as many individuals and organisations as we can to create awareness on the issue. We invite you to participate in this joint initiative. It is very easy to join the campaign, all you have to do is write back to

us on this address for further information.

In order to create greater awareness on the campaign, a mission statement, a leaflet, a flyer and a signature campaign form have been prepared. these are being readied for dissemination. Please, find, however, the mission statement of the campaign attached.

The following individuals and organisations, who have come together in initiating this campaign, welcome and anticipate your support:

Delhi: Dr. Bitra George (Salaam Baalak Trust/Sharan), Shaleen Rakesh (Naz Foundation India), Delhi Network of Positive People (DNP+), Dr. V. J. Anand (Maulana Azad Medical College), Lawyers Collective HIV/AIDS Unit.

Manipur: Manipur Network of People Living with HIV/AIDS, Care Foundation.

Mumbai: Maharashtra Network of Positive People (MNP+), Swayam Siddha Sanghatana (SSS); Population Services International (PSI), Raghav Narsalay (Focus on Global South India), Dr. Nagesh Shirgoppikar (Forum Against Drugs), Tony Lewis (Salvation Army), Lawyers Collective HIV/AIDS Unit, Dr. Maninder Sethia, Denzil McDonald; James D.D.

Pune: Network of Maharashtra for Positive People (NMP+);

Goa: Positive People Goa.

Hyderabad: Rahul Luther (Freedom Foundation).

Bangalore: Ashok Rau (Freedom Foundation), Meera Levine (Alternative Law Forum), Karnataka Network of Positive People (KNP+); Sanghamitra Iyengar (Samrakasha).

Chennai: Indian Network of Positive People (INP+); Dr. Tokugha Yepthomi(YRG Care), Chitra Narayan, Advocate.

Trivandrum: Dr. Jaysree (Foundation for Integrated Research in Mental Health).

Thank You,

AFFORDABLE MEDICINES AND TREATMENT CAMPAIGN

Subject: [AIDS-INDIA] RED-RIBBON MARCH TO KICK-OFF AIDS AWARENESS WEEK ON NOVEMBER 30th
Date: Thu, 29 Nov 2001 22:45:19 +0530
From: "ihoaids" <ihoaids@vsnl.com>
To: <editor@expressindia.com>, <baghel@mid-day.com>, "The Statesman Limited" <thestatesman@vsnl.com>, "The Telegraph" <ttcal@cal.vsnl.net.in>, <editor@tribuneindia.com>, "Sudip Mazumdar" <sudipmazumdar@vsnl.com>, "Saira Menezes" <magnapub@vsnl.com>, <afpbom@vsnl.com>, <bigfight@ndtv.com>, "Community Research" <community-research@hivnet.ch>, "INTAIDS" <intaids@hivnet.ch>, "aids-india" <AIDS-INDIA@yahoogroups.com>, <apurvabhatt@yahoo.com>, "Alpana Sharma" <alpanasharma@hotmail.com>, "Metro News" <metronews@zeenetwork.com>

RED-RIBBON MARCH TO KICK-OFF AIDS AWARENESS WEEK ON NOVEMBER 30th

The Red Ribbon is an international symbol of AIDS awareness; a symbol of respect for those who have died of AIDS, of concern for those living with it, and reminder to us all of the constant need to keep up the fight against AIDS.

It is also a symbol of how great achievements begin with small actions. The Red Ribbon came into being in 1992 as the idea of a small HIV charity, Visual AIDS, in New York. Now, it is recognised world over as the symbol of AIDS awareness. However, that is only because the people who wear it show their support through speaking up and taking action on HIV and AIDS. Wearing the Red Ribbon is perceived as the first step in the fight against AIDS.

The World AIDS Week starting from the 14th World AIDS Day on December 1, the first AIDS Day of this millennium is unique in the sense, that the AIDS Awareness has now moved from highlighting the problem symbolising a monster, 'Bakasur', 'Narkasur', 'Anaconda' or Dinosaur, to care, as the theme of World AIDS Day 2001 is "I Care . Do You?"

>From a deadly disease during 1981 to 1995, HIV/AIDS has now become a chronic manageable disorder like diabetes and hypertension due to the discoveries of potent medicines for its management. Though the currently available anti-retroviral treatment (ART) does not cure the infection, it provides a lease of life for over 10 years. The cost of ART has come down from Rs. 40,000/- pm. in 1996 to Rs.1,500 to 8000/-pm depending on the combination of three different medicines.

PHO has organised host of activities starting with 'Red-Ribbon March' on 30th November, the eve the World AIDS Day, from its office in J.J.Hospital Compound. PHO President Sunil Dutt, cine-actress Kunika Lall and T.V. star (Tele-serial "Shagun" fame) Karan Sadanand will lead the march with host of other dignitaries. The Rotaract Club of Bombay Hills, National Cadet Corps (NCC) and several schools and colleges have joined PHO for the Red-Ribbon March and other programs during the week.

This is the twelfth consecutive year of the AIDS Awareness March organized by PHO so far. It will pass through crowded areas of Nagpada, Bombay Central, Lamington Road and Opera House before reaching Girgaum Chowpatty, where it will be on display till 8th December. On 8th December there will be an event for Lighting Candles at 'RED RIBBON' at 6 p.m. followed by VIGIL AGAINST AIDS - a Cultural Nite, Girgaon Chowpatty. PHO President Shri Sunil Dutt, M.P. Will preside over the function and several dignitaries will grace the program

PHO has organised several activities to observe the extended week in Mumbai and 19 cities of six states. PHO is holding two major Exhibitions: at Churchgate and Mumbai CST stations from Dec.1-7 in collaboration with the Western and Central Railways, besides collaborating with colleges, youth groups and NGOs. PHO appeals NGOs, religious bodies, colleges/schools and the entire community to observe this week to continue the spirit beyond to create much needed awareness. PHO will run a Coordination Hotline at Tel.: 3719020 and a Mobile HIV Counselling & Testing Service at several locations during the week.

Dr.I.S.Gilada, Secretary General, PHO

WORLD AIDS WEEK (Dec. 1-7)/ WORLD AIDS DAY: Dec.1

PEOPLES HEALTH ORGANISATION (INDIA)

MAIN PROGRAMS AT A GLANCE

Nov. 30: 2.30 pm: Star-studded 'RED RIBBON March' (an international symbol meaning- I care for HIV/AIDS) from PHO,J.J.Hospital to Girgaum Chawpatty via Nagpada, Bombay Central, Lamington Road, Opera House PHO President Shri Sunil Dutt, M.P. to lead the March

December 1:9-11 am: Human Chain for AIDS Awareness by Rotaract Club of Bombay Hills South and PHO, at Churchgate Junction

11 am: Inauguration of Mega-Exhibition on AIDS: Churchgate (Dec.1-8)

December 1: 1 pm: Inauguration of Mega-Exhibition on AIDS: Mumbai CST (Dec.1-8)

December 2: 10 am: Symposium on HIV Care for HIV-affected people

December 3: 10 am: HIV/AIDS in Workplace, Johnson & Johnson, Mulund Factory

December 4: 11 am: 'Two decades of HIV/AIDS', at Somaiya Medical College, Sion

2 pm: SEX WORKERS Educating Masses on AIDS & Free Condom

Distribution at Churchgate, CST, Bombay Central Stations

December 5: 11 am: HIV Awareness Programs for Western Railway: Bandra

December 6: 11 am: HIV Awareness Programs for Western Railway: Borivali

December 7: 11 am: HIV Awareness Programs for Western Railway: Churchgate

December 8: 6 pm: Lighting Candles at 'RED RIBBON' followed by VIGIL AGAINST AIDS - a Cultural Nite, Girgaon Chowpatty

PHO President Shri Sunil Dutt, M.P. to preside over

Several dignitaries will grace the program

Dr.I.S.Gilada, Hon. Secretary General, PHO

Rotaract Club of Bombay Hills, NCC, NSS and several colleges have joined PHO for the AIDS Awareness Week programs

---

Subject: [AIDS-INDIA] IHO's 3rd International Conference on 'AIDS-in-India' at Harvard University, December 7, 2001
Date: Fri, 30 Nov 2001 09:44:03 -0500
From: "Verma, Bikash (DPH)" <Bikash.Verma@state.ma.us>
To: "'aids-india@eGroups.com'" <AIDS-INDIA@yahoogroups.com>

IHO's 3rd. "AIDS-in-INDIA" CONFERENCE SCHEDULE
Friday, December 7, 2001
Snyder Auditorium, Harvard School of Public Health

MORNING SESSION

8:00- 8:30 REGISTRATION AND BREAKFAST

8:30- 8:45 Opening Remarks
Dean Dr. Barry Bloom, Harvard School of Public Health

8:45- 9:15 Welcome Address
Ms. Pramila Vivek, IHO

9:15- 9:30 Moderator, Introduction to AIDS-in-India
Dr. Bikash Verma, IHO

9:30-10:30 Keynote: 'Controlling HIV in India: Worldwide Evidence and Local Action
Dr. Prabhat Jha, World Health Organization (WHO)

10:30-11:15 'Role of World Bank: AIDS Programs Globally and in South Asia'
Dr. Salim Habayeb, The World Bank

11:15-12:00 'Overview of Government of India's AIDS Programs'
Dr. N.K. Ganguly, Director-General, Indian Council of Medical Res. (ICMR)
Advisor, National AIDS Control Organization (NACO), Government of India

12:00-12:15 Questions and Answers

12:15- 1:15 LUNCH

AFTERNOON SESSION:
Moderator Mr. Joseph D'Amour, Advisor, IHO

1:15- 1:40 'Linking US and India' - Role of USAID
Mr. Billy Pick, United States Agency for International Development (USAID)

1:40- 2:05 'Reproductive Health, HIV/AIDS and Human Rights'
Dr. Cliff Lenton, Management Sciences for Health (MSH)

2:05- 2:30 'FXB's Community-based AIDS programs in India'
Dr. Anil Purohit, Francois Xavier Bagnoud Foundation for Health and Human Rights

2:30- 2:45 COFFEE-BREAK

2:45- 3:10 "Sex, Lies and AIDS"
Mr. Siddarth Dube, Best-selling Author- "Sex, Lies and AIDS"

3:10-3:35 'Prevention, Care and Treatment for HIV/AIDS in Developing Countries'
Dr. Bruce Walker, Harvard Medical School/Massachusetts General Hospital

3:35- 4:00 'Catch them Young'- AIDS Education for Younger Population in India
Dr. Rajan Gupta, Los Almos National Laboratory/International

4:00- 4:25 'BOSTON TO BOMBAY' : Transferring Prevention Models from US to India'

Ms. Lina Sheth, MPH, Director, Massachusetts Asian AIDS Prevention Project

4:25- 4:35 Closing Remarks, Ms. Sharmeen Irani, IHO
4:35-4:45 Vote of Thanks, Mr. Atul Kamath, Harvard University

---

For more information, please call: Dr. Bikash Verma at: (617) 983 6565

"Verma, Bikash (DPH)"
E-mail: <Bikash.Verma@state.ma.us>

Subject: [AIDS-INDIA] Hello All friends and colleagues
Date: Fri, 30 Nov 2001 19:46:02 -0800 (PST)
From: Saxena Rishi <rishisaxena@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Hello All friends and colleagues

Today is World Aids Day, Lets observe a silence for a
minute in the memory of the people passed away.
Educate more and more people about HIV/AIDS

Saxena Rishi
E-mail:<rishisaxena@yahoo.com>

TN
3/12

Subject: [AIDS-INDIA] Sex on the kitchen table anyone?
Date: Fri, 30 Nov 2001 04:27:13 +0530
From: "Dr. E. Mohamed Rafique" <emrafi@md4.vsnl.net.in>
Organization: Tata Tea Ltd.,
To: <AIDS-INDIA@yahoogroups.com>

Sex on the kitchen table anyone?
Friday, November 30, 2001
Subhadip Sircar

For a nation that has done it right a billion times, sex is no laughing matter. And yet we revel in our contradictions when it comes to discussing sex. While sex has been a taboo topic, too sensitive for public discourse, we as a nation-state go into delirium every time Madhuri Dixit breaks into a dhak-dhak number.

But all that may be changing and for the good. If you are to go by the findings of a recent global sex survey released recently, Indians may finally be bringing their sexual fantasies and habits out of their closets.

Sample some of this. Indians not only love their bhaji on the beach, a third of Indians (32 per cent) would not mind a dalliance there, too. Seven per cent would, however, prefer a more domestic setting, notably the kitchen table! We have an average of three partners. And while 77 per cent have a single partner, 23 per cent of Indians have averaged a whopping 10 partners each. Talk of sexual reticence.

These are some of the more interesting finds of the sixth Durex Global Sex Survey, which studies the sexual behaviour and habits of people worldwide. The survey, carried out by Durex, the world's leading condom brand, reveals that people around the world are having sex an average 97 times a year. The Americans lead the way, making love around 124 times a year (around once in three days), followed by South Africans and Croatians (both 116) and New Zealanders (115).

Globally, it is also being witnessed that young people appear to be having sex for the first time at a significantly younger age than previous generations. While the over-45s had sex at around 18.7 years, those aged 16-20 tried physical intimacy for the first time at 16 years. However, almost a fifth admit that they had sex for the first time at 15 years or less.

Now for some good news. While we may feel threatened by the Chinese in everything from soft toys to motorcycles, when it comes to the bare basics, we beat them on all counts.

The Chinese have sex an average of 72 times a year, Indians clock a better average at 76. While Chinese have their first sexual encounter at an average age of 22, we Indians taste the forbidden fruit at an average age of 20.3 years.

Condom usage remains low in India. The Indian non-subsidised branded condom market is 280 million units, which manufacturers say is low for a nation of our size. And the growth rate at 5 per cent is not too encouraging. This is something in which our finance minister may find solace, considering his GDP growth estimates are not faring too much better.

On a more serious note, almost seven in 10 Indians (69 per cent) are concerned about contracting HIV/AIDS or other sexually transmitted infections, but many are not protecting themselves. Another area of concern is condom usage while having sex. Twenty-five per cent of Indians take this

protective measure while having regular sex, but when it comes to new or casual partners, condom usage stands low at 17 and 15 per cent, respectively.

Indians, however, do remain traditionalists on some counts. Indian teenagers tend to protect their virginity more than other nationalities and the average age for a first sexual experience is 20.3. This compares with the British 16.9 and the American 16.

When it comes to preferred information about sex, medical professionals and friends remain our preferred source. Interestingly, while a quarter of British adults prefer to seek sexual advice from their mothers, only 6 per cent of Indians would choose to do the same.

Finally, when it comes to the last word, the land that gave the world the Kama Sutra has finally got its act in place.

Subject: [AIDS-INDIA] Support to attend the Chiang Mai Conference..
Date: Sun, 2 Dec 2001 20:01:22 -0800 (PST)
From: Pinagapany Manorama <pmanorama@yahoo.com>
To: AIDS-INDIA@yahoogroups.com
CC: pmanorama@eth.net.in

Dear forum members,

I am Dr.Manoramaan and i head an organisation called CHES, which works for PLWH,children affected due to AIDS and also Women in Prostitution since 1994.

I sent in a paper to the 5th International Conference on Home and Community Care for Persons Living with HIV/AIDS to be held at Chiang Mai,Thailand from 17-20 Dec.2001, which has been accepted for poster presentation. But unfortunately, I did not get scholarship to attend the conference. My paper is about our experience working with PLWH/A on Home based Care since 1996.

I am writing this mail as a last option to try and get some help from the forum members. I will be very thankful if you all can provide me some details of agencies/organizations that maybe interested in sponsoring me to attend the Conference and present my paper.
With regards,
Dr.Manorama

TN
12/12

Subject: [AIDS-INDIA] My paper to the Chiang Mai Conference..
Date: 2 Dec 2001 12:45:32 -0000
From: "Pravesh Kumar" <kumarpravesh@rediffmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear forum members,

I am an individual associated with the field of Drug Abuse and HIV/AIDS from last
firstly as a counselor and then as a project coordinator. I sent in a paper to the
International Conference on Home and Community Care for Persons Living with HIV/AI
held at Chiang Mai, Thailand from 14-18 Dec.2001, which has been accepted for oral
presentation. But unfortunately, I did not get scholarship to attend the conferenc

I am writing this mail as a last option to try and get some help from the forum me
will be very thankful if you all can provide me some details of agencies/organi
that maybe interested in sponsoring me to attend the Conference and present my pap

My paper titled the Highway with Truckers□Eis about my five-years experience work
a most difficult and potentially high-risk target group i.e. Truckers on STD/HIV/A
strongly feel that my presentation would help and assist the international communi
well as the strategy makers to design effective intervention programmes among vari
high-risk groups.

With regards,

Pravesh Kumar
E-mail:<kumarpravesh@rediffmail.com>

TN

12/12

Subject: [AIDS-INDIA] World AIDS week Activites in Punjab
Date: Sat, 1 Dec 2001 20:44:41 +0530
From: "Ashok Goel" <drashokgoel1@rediffmail.com>
To: "aids-india" <AIDS-INDIA@yahoogroups.com>

(WORLD AIDS WEER DEC. 01-07, 2001)

The first AIDS DAY of 21st century is unique in the sense, that the AIDS Awareness has now moved from highlighting the problem symbolizing a monster, BAKASURA, NAKASURA or Dinosaur, to care as the theme of WORLD AIDS DAY 2001 is
' I Care... Do You?"

To commemorate World AIDS Day, Peoples Health Organisation, Punjab organised a rally of cars , scooters and pedestrians involving medical teachers, students and staff of Govt. Medical College, DAV College for Women, Hindu Sabha School and Hindu College.

The rally was flagged off from the Medical College by Sh. BR Banga, Commissioner, Municipal Corporation, Amritsar and Chief Patron of P.H.O Punjab. He was accompanied by Dr. OP Mahajan, Principal Medical College, Dr. AS Sandhu, Civil Surgeon, Dr. Renu Goel, Corporator and Patron, P.H.O, Punjab, Dr. SP Dewan, President, P.H.O, Punjab and Dr. Ashok Goel, Secretary General, P.H.O. Punjab. Another scooter rally was flagged off from Hindu College by Principal Mr. RC Verma. A rally was flagged off by Sh. Dharamvir Dhawan, Principal , Hindu Sabha School at 10.00 a.m today.

The 3 rallies reached the BBK DAV College for women where Principal Mrs. J.Kackaria received the rallyists.

Addressing the rally, Sh. BR Banga, Chief Patron said the AIDS AWARENESS DAY creates awareness amongst the masses throughout the world. This awareness must reach the grass root level especially amongst the slums, rural areas and ignorant and illiterate poor of this district, state and country. He appealed to the students to prepare "NUKKAR NATAKS", PLAYS AND SKITS relevant to Punjabi culture so that the message regarding HIV AND AIDS can be clearly given. He appealed to all sections of society in Amritsar to attend "LAMP LIGHTING" under "RED RIBBON", an International symbol of "I CARE FOR HIV/ AIDS" at Nehru Complex, Lawrence road Amritsar on 5th Dec. 2001 from 6 pm onwards. Individuals are requested to come and light a candle to show their concern and care for victims of HIV/AIDS.

Dr. OP Mahajan, Principal said that HIV/ AIDS is the largest public health problem and without the active involvement of society as a whole , nothing tangible can be achieved.

Dr. Ashok Goel and Dr. SP Dewan presented 200 complimentary copies of a book in Punjabi on HIV AND AIDS written by Dr. Ashok Goel and Dr. SS Deepti to Principal Mrs. J .Kackaria for staff and students .

Patron of Punjab , PHO Dr. Renu Goel said that the Red Ribbon is an International Symbol of AIDS Awareness , a symbol of respect for those who have died of AIDS of concern for those living with it , and reminder to us of the constant need to keep up the fight against AIDS. It is also a Symbol of how great achievements begin with small action . Red Ribbon was given to every rallyist by PHO. The rallyists were carrying placards of the theme of WORLD AIDS DAY i.e." I Care.Do You?" The red ribbon came into being in 1992 as the idea of small HIV charity in New York. It is a symbol of AIDS Awareness and people who wear it show their support through speaking up and taking action on HIV AND AIDS.

The girls of D.A.V College performed a skit on the theme of AIDS prevention. Dr. SP Dewan while addressing the rally appealed to the people to discuss HIV/ AIDS prevention with their friends and family members to create awareness. He further asked students to lead a pure marital life with single life partner or use condom for safety.

Secretary General PHO Punjab Dr. Ashok Goel demanded to create a new MINISTRY OF AIDS to save India from devastation as faced by Africa and western countries. He urged Govt. of Punjab to abolish sales tax on drugs , kits and equipment concerned with care of victims of HIV AND AIDS. Mrs. J. Kackaria , Dr. SK Malhotra, Dr. MD Gambhir and a student Miss Sakshi Parmar also spoke on Aids .

Dr. Ashok Goel
E-mail: <drashokgoel1@rediffmail.com>

Subject: [AIDS-INDIA] File - Invitation- Please forward
Date: 1 Dec 2001 13:42:52 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Welcome to AIDS-INDIA eFORUM

AIDS-INDIA eFORUM is an electronic forum to foster communication and collaboration among those of who are involved or interested in AIDS related issues in India. Your e-mail id is on this list because you must have indicated your interest in AIDS related issues in India or some one else must have suggested your name as a person who may be interested in AIDS related issues in India.

This is a moderated forum. We would like to invite you to post messages, announcements, details of your AIDS related work in India. Confidentiality of the list members is assured. For more details of the forum please contact the moderator.

If you are already a member of AIDS-INDIA eFORUM please forward this message to your colleagues. Thank you for your attention.

Joe Thomas

Moderator
AIDS-INDIA eFORUM
aids-india@egroups.com
Web page: http://groups.yahoo.com/group/AIDS-INDIA

The views are of the authors. Please feel free to copy the messages.
An acknowledgement would be appreciated
To Post a message: aids-india@eGroups.com
To Unsubscribe: aids-india-unsubscribe@eGroups.com
Web page: http://groups.yahoo.com/group/AIDS-INDIA

Your use of Yahoo! Groups is subject to http://docs.yahoo.com/info/terms/

TM

3/12

Subject: [AIDS-INDIA] Campaign for affordable medicines for AIDS
Date: Sat, 01 Dec 2001 23:12:11 +0500
From: ashok rau <freedom@bgl.vsnl.net.in>
To: AIDS-INDIA@yahoogroups.com

DECCAN HERALD : Saturday, December 1, 2001

Campaign for affordable medicines for Aids

By Michael Patrao
DH News Service
BANGALORE, Nov 30

On the occasion of World Aids Day on December 1, a group of individuals and organisations have come together to launch a nationwide campaign for making available affordable medicines and treatment for all. In Bangalore the campaign will be launched by Freedom Foundation and Samraksha, NGOs engaged in the field of Hiv/Aids, Alternative Law Forum and Karnataka Network of Positive People (KNP+), at Vidhana Soudha during a Aids rally at 3 pm.
This campaign plans to lay special emphasis on access to Hiv/Aids medicines for opportunistic infections (OIs) and Anti-Retroviral Therapy (ART). People with Hiv/Aids can prolong their lives with the help of these medicines, which are already very expensive (minimum of Rs 1,800 per month for ART). New medicines for the treatment of HIV/AIDS are going to be even more expensive.

According to Mr Ashok K Rau, co-founder of Freedom Foundation, Bangalore-based NGO engaged in the area of Hiv/Aids if we do not stand up against Trade Related Intellectual Property (Trips) now, many more lives will be lost to this epidemic.

Indian law will soon undergo change because India is a signatory to the international agreement on Trips. This change will have a huge impact on the Indian patent law, which protects the invention of new products. The 'process patent□Esystem used in India so far will be replaced by a more restrictive 'product patent□Esystem. Foreign pharmaceutical companies will have sole rights to determine the production, distribution and pricing and, therefore, availability of new medicines. It is feared that such a situation will raise the prices of new medicines to amounts that are unaffordable to most Indians, he said.

Mr Rau says that the campaign is launched since the Indian government has not responded to this urgent issue. More and more people are getting affected or a and the government has to take a pro-active stand, he adds.
Elsewhere in the country many individuals and organisations working in the areas of Hiv/Aids will campaign for affordable medicines.

They include Delhi Network of Positive People, Lawyers Collective Hiv/Aids unit (Delhi), Manipur Network of People Living with Hiv/Aids, Care Foundation (Manipur), Maharashtra Network of Positive People (MNP+), Mumbai, Network of Maharashtra for Positive People (Pune), Positive People Goa, Indian Network of Positive People (Chennai).

Mr Rau says that the prevention activity of the Government doesn't seem to make a major impact as more people are testing positive with a conservative official estimate of four million people in the country and nearly 10,000 reported cases in Karnataka. These figures, however, are a gross underestimate and the figure could be as high as eight to 10 million

-ctive people in the country, he adds.

He says in Karnataka, Udupi and Mangalore are emerging as centres were highest incidence of HIV positive cases are reported. Until recently Bellary, where Freedom Foundation has set up a centre, reported the highest incidence.

As many as 412 people have reported positive in Udupi and Mangalore area, but the actual figures could be as high as 1,000. The Foundation is planning to se Hiv/Aids treatment centre very soon.

Subject: [AIDS-INDIA] Discussion on National Health Policy
Date: Sat, 01 Dec 2001 11:36:19 -0700
From: Rajan Gupta <rajan@lanl.gov>
Organization: Los Alamos National Laboratory
To: AIDS-INDIA@yahoogroups.com

To the moderator,

I had posted my comments on India's National Helath Policy 2001 about 8 weeks back. There was call for a discussion to be held on this policy on this forum.

In the last few days I have received a number of e-mail, I presume,s responding to my comments the National Health Policy 2001. These files had a virus and our fire wall eliminates them (so it is not even clear to me what the files contained, I am just guessing at the contents from the subject header). My replies to the e-mail addresses from where the comments came from bounced with user unknown! So I cannot get in touch with the senders.

I am enclosing my comments again in case the original message somehow got corrupted with a virus. Perhaps you can repost my note and send out another call for comments? I feel it is very important to initiate a debate about the NHP 2001 -- if the policy it self is so lacking, how can we expect any credible intervention.

Best
rajan
==========

The Ministry of Health & F. A. is in the process of formulating a new Health Policy. The Draft National Health Policy has been put together as part of a consultative process involving Civil Society, Specialists in various disciplines, Various Govt departments, the Private Sector and others.

It has been suggested that The New Draft Document be put up on the web site of the Ministry for a further consultative process. Those interested can access the same on their site http://mohfw.nic.in/np2001.htm you can also give in your valuable input to Ms. Urvashi Sadhwani (Addl.Eco. Adviser) at email: aeabop@nb.nic.in

==========

COMMENTS ON THE National Health Policy 2001
BY RAJAN GUPTA (rajan@lanl.gov)

The National Health Policy 2001 aims to be a comprehensive document that sets out to provide a new policy framework for accelerated achievements of Public Health goals. On reading the draft I find the following deficiencies.

1) The document provides no information on the budget for various categories of health services of the central government or of the states. I feel that t is essential that a table showing past and anticipated future budgets for all states and center be provided. Without such information it is not possible to judge the feasibility of proposed goals.

2) The document provides no information on the number of primary, secondary, and tertiary medical centers in both the public and private sector. We request data for each state and UT.

3) The document speaks about opening more medical colleges in areas that are under-represented. Unfortunately, it does not discuss adequately the reality that more and more of even the established medical colleges are failing -- loosing their best faculty members, are teaching outdated procedures, do not have adequate funds for practical training, and

granting degrees. In such an environment, it would serve the nation more to upgrade the existing institutions rather than create more mediocre or failing ones.

4) The NHP-2001 does not establish clear priority for a vaccination program for all citizens. The minimal acceptable is vaccination against MMR, DPT, polio, and Hepatitis B using quality vaccines.

5) The document mentions HIV/AIDS in passing, while it has a separate section on providing medical facilities to users from overseas. This shows the clear misunderstanding of priorities for public financed health. This jumbling of priorities suggests that the government, in spite of its rhetoric, does not appreciate the threat posed by HIV/AIDS. My interactions with many thousands of people show that proper knowledge of HIV/AIDS is highly lacking even amongst the literate and denial is very common. Furthermore, even those who have some information, they have not understood how to use this information to change behavior -- due to lack of money, empowerment, or simply fatalism. Also, along with HIV/AIDS the growing threat of TB and especially MDR Tuberculosis has to be addressed.

6) While HIV/AIDS is mentioned a couple of times, the document completely ignores Hepatitis B and C crises. Current estimates suggest 4 million cases of HIV/AIDS, 15-20 million of Hepatitis C, and 60-80 million of Hepatitis B. Today many hospitals are seeing as many cases of failing/failed livers in people in their late thirties and forties as they are of HIV patients. The tragedy is that, except for select private blood banks, the national blood supply in public institutions is still not being tested for Hepatitis C. The NHP-2001 is completely silent on this issue.

7) The document mentions better monitoring of private health centers. It fails to specify how it intends to monitor them since its record of monitoring public hospitals, roadside clinics, alternate medicine centers, and pharmacists is abysmally poor.

8) The document attributes most of the blame for failing PHC on the lack of a steady supply of drugs. The reality is that a large fraction of PHC have failed because doctors assigned to them do not show up or have set up private practices sometimes right next to the PHC. Also, the nursing staff and doctors are profiting from the sale of drugs on the black market and thus creating an artificial shortage. Furthermore, they are also involved in kick-backs from pharmaceutical companies, and in schemes where drugs are not delivered even though money is paid. Thus, without effective monitoring and accountability in the system, creating more PHC will just enlarge the problem.

9) The government should, over time, consolidate their bloated PHC staff into the functioning PHCs (Even though many states have prepared lists of PHC that function and those that do not, they still keep pouring money into the failed ones, i.e., into the pockets of the corrupt). Turning over the failed PHC to NGOs and philanthropic institutions, along with the funds earmarked for these PHCs, will lead to better services. If outright handing over of the PHCs is not acceptable, then at least the running and monitoring of the PHCs should be handed over to NGOs and philanthropic institutions.

10) The document completely ignores the existing huge problem of alcohol and drug addiction. Recognizing that de-addiction is a very costly, lengthy, and failure ridden process, the NHP-2001 should have a very clear plan on how to address this issue. The present policy of the government -- of implicitly encouraging alcohol use in order to collect taxes -- is shameful and will lead to a dis-functional labor force in the near future. The growing menace of an already huge drug abuse problem is being ignored. The silence of the NHP-2001 on this issue is consistent with reports that those in power are often involved (directly or indirectly) in the trafficking of drugs.

11) The need for mental health care is enormous. It is estimated that there are 7 million people with severe psychiatric disability and 22 million more that need psychiatric care. To take care of these, India has only 3500 mental health professionals! When one adds the burden of alcohol and drug abusers to the psychiatric patients, the scale of the problem becomes obvious. Little wonder that the government turns a blind eye to the atrocities committed against the mentally ill (including burning inmates chained to trees in Erwadi, TN, a so called progressive state).

12) There is no mention of the growing epidemic of abortions as the leading method of birth control because of the refusal of the government to discuss safe methods of contraception in schools and colleges, and making these methods (pills, IUDs, condoms) available. This is presumably the responsibility of the non-existent Public Health system. NHP-2001 needs to address this issue.

13) Lack of education on male and female reproductive health and sexually transmitted diseases in schools and colleges has made containment of HIV/AIDS, Hepatitis B and C, and other STDs difficult. The NHP-2001 does not adequately address this issue nor does it recommend the appropriate size of funds required to implement this.

14) The division of responsibility between the state and central governments is being used as a cover to deny responsibility by both. The original intent was that such a division would provide better coverage by making people closer to particular conditions in charge. The reality is a non-existing system in many states. The NHP-2001 does not adequately address this problem.

15) THE NHP-2001 is completely silent on the issue of emotional, physical and sexual abuse of children. Given the magnitude of the problem, the devastation it causes to the victims, and its connections to addictions and risky behavior (leading to HIV and Hepatitis infections), this issue has to be addressed.

CONCLUSION:
==========

It is with much sorrow that I conclude that NHP-2001 is an attempt at writing an eloquent but empty paper document that fails to address many issues that should be priorities. It reads like a "business as usual" plan whereas the nation is faced by many simultaneous pandemics and is totally lacking a publich health system. It does not address the magnitude of the problem nor does it underscore the urgency for massive intervention. In fact it essntially ignores the crisies -- HIV/AIDS and the growth in MDR TB, Hepatitis B and C, addictions to alcohol and drugs, and mental health.

NHP2001 assumes that a system that has not delivered over the last 50 years will suddenly start working by miracle, nor does it provide any believable implementation plans to counter the known failures. For example, it is hard for me to believe that if potable water and sanitation is not available to a significant fraction of the population, one will be able to eradicate Malaria and other vector and water borne diseases by 2010 -- one needs only to look at any slum in any part of India to see the obvious lack of planning or facilities for water and sanitation.

So, while NHP-2001 recognizes that India today has a failed public health care system resulting in a health crisis and is faced with many simultaneous unchecked pandemics, the new policy does not give any confidence that health is finally a priority with the national planners and leaders. The proposed public funding is too small, and there are no new ideas that address the widespread corruption and inefficiency -- the core reasons for inefficient utilization of

Rajan Gupta
E-mail: <rajan@lanl.gov>

Subject: [AIDS-INDIA] SAATHII website
Date: Sat, 01 Dec 2001 21:14:12 -0000
From: anilph7@yahoo.com
To: AIDS-INDIA@yahoogroups.com

Hi,

Today, on World AIDS day, SAATHII has started a new initiative. A website will be developed to provide networking between the government and non-government organizations in India. Among the major goals for this initiative will be to provide referrals in India and an information clearing house for health care providers and the clinicians. Besides these, there will be a repository of resources and materials on HIV/AIDS, information on all the relevant events in India and outside, information on HIV and other services provided by all the organizations that become a part of this initiative and research/training/funding information.

The initial steps of registration of domain name, creating a home page and hosting that home page have all been completed. Please take some time to look at the home page at www.saathii.org. Since this home page is still under construction, any advice/comments will be welcome. All the tags on the home page currently display a page notifying that it is under construction.

At this time, we estimate to have a working website with lots of relevant content in the net four to six weeks. We will notify you when the website is launched.

Subha Raghavan/Anil Hingorani/Vinod Chandanani
E-mail: anilph7@yahoo.com

TM
3/12

Subject: [AIDS-INDIA] HIV/AIDS-INDIA:Who is Responsible?
Date: Sun, 02 Dec 2001 22:11:21
From: "kala rau" <kalarau@mantramail.com>
To: AIDS-INDIA@yahoogroups.com

HIV/AIDS: Who is Responsible?

Bangalore, November 29, 2001: In 1981, the human immunodeficiency virus (HIV) and the fatal disease it causes, acquired immune deficiency syndrome (AIDS), emerged in what then appeared to be a series of discrete epidemics among certain populations in specific parts of the world. Today, the virus continues to spread through much of the world at a pace that outstrips efforts to control it. The HIV/AIDS pandemic now affects men, women and children in nearly every populated region on earth. A disease that began as a public health crisis affecting millions of people has now evolved into a force that threatens the social, economic and political development and stability of entire nations.

The World Health Organization (WHO) began organizing a response to HIV/AIDS in 1986 and launched a global strategy to fight the disease a year later. Since then, the world health community, governments and other international agencies have contributed significant technical and financial resources to support the battle against HIV/AIDS, but these resources have not been sufficient to meet the continuing global challenge. Everyday, the number of HIV infections increases and the pool of resources available to fight the disease diminishes.

In 1991, WHO reported twelve million HIV infections worldwide; today the total has increased to 36 million. Ninety percent of these infections will have been sexually transmitted, most as a result of heterosexual intercourse. Specific behaviors, common in all parts of the world speed the spread of HIV. However, the vast majority of infections has and will continue to occur among people in developing countries least able to mount the programs needed to prevent and control the disease.

HIV/AIDS has attacked the developing world at a time when decades of investment in social and economic development is beginning to yield results. In India, precious gains have been made in child survival rates and adults are living longer and healthier lives. In other areas, a better-educated work force has increased the potential for foreign investment and the expansion of manufacturing and services sector industries. HIV/AIDS threatens to halt or reverse many of these gains; in fact it already has in some areas. According to the latest report to Congress on the USAIDS Program, AIDS has become the leading killer of children in some developing countries. The disease has already severely impacted the work force in many countries and has led to the withdrawal of planned foreign investment in others.

In India, economy is fragile, technical resources are limited and governmental infrastructure, policy positions and service systems are weak or unstable. We already know, for example, that no health care system currently existing in India or the developing world will be able to manage or provide care for the continually increasing number of people infected with HIV or suffering with AIDS.

HIV/AIDS also battens the supporting social structures of a nation. Extended families are common in India and individuals are dependent upon these families for many aspects of their well being. Although such communities have a long tradition of caring for the ill, the enormous financial burden and too-frequent stigmatisation associated with caring for people with AIDS have ripped families and communities apart. Those families, who do not turn over the care, of the ill to strangers face increased poverty as they lose the income of both the patient and the person who cares for them.

Fear, lack of knowledge, limited resources and weak institutional capabilities have combined to facilitate the spread of HIV in the developing world. Although the world may have been slow to understand and respond to this disease and its future implications, much important work has been done and many successful disease interventions have been tested. The world health community has recognised the need to temper fear with knowledge, defined

interventions to prevent the spread of HIV. However, currently available resources fall far short of what is needed to apply what has been learned on a large enough scale to effectively impact the pandemic.

Cooperative efforts are needed. No nation or international organization can successfully shoulder the burden alone. The resource gap must be filled through the collective efforts of the public and private sectors at local, national and international levels. Government, private enterprise, religious institutions, private voluntary organizations, international service organizations, community-based groups and private philanthropy must assume the responsibilities of leadership and seize this opportunity to improve the human condition.

Ashok K. Rau
The Freedom Foundation-India
Bangalore, Bellary, Mangalore, Udipi and Hyderabad

Source: www.youandaids.org

Mr. Ashok K. Rau could be contacted at freedom@bgl.vsnl.net.in or ashokrau@hotmail.com)

Subject: [AIDS-INDIA] TOGETHER WE BUILT A BETTER COMMUNITY ! - Who is Responsible?
Date: Mon, 3 Dec 2001 12:32:13 +0530
From: "Avnish Jolly" <avnish@ch.sps.org.in>
To: "Love And AIDS Group" <loveandaids@yahoogroups.com>

TOGETHER WE BUILT A BETTER COMMUNITY ! - Who is Responsible?

The FIRST AIDS DAY of 21st century is unique in the sense, that the AIDS Awareness has now moved from highlighting the problem symbolizing a monster, to care as the theme of FOURTEENTH WORLD AIDS DAY 2001 is

' I Care... Do You?

AIDS knows no favourites and it kills males, females, rich or old and children of all races and communities. It kills without conscience and without remorse. December 1 is the World's AIDS (Acquired Immuno Deficiency Syndrome) Day. According to a UN report: "Asia faces the threat of 'major, generalised epidemic' of AIDS, driven by unsafe sex, intravenous drugs and tainted blood."

The ignorance of people make them shun AIDS victims. People have to learn that touching, kissing, eating, sharing the same toilet seat with AIDS patient will not infect to them. Similarly, children with AIDS will not infect their classmates. By now every one knows that those who indulge themselves in unsafe sex and frequent changing of sex partners, use unsterilised needles and get infected blood acquire AIDS. The main role of the community is to counsel people. The one who is HIV positive has to learn his responsibilities.

In 1981,HIV and the fatal disease it causes, AIDS, emerged in what then appeared to be a series of discrete epidemics among certain populations in specific parts of the world. Today, the virus continues to spread through much of the world at a pace that outstrips efforts to control it. The HIV/AIDS pandemic now affects men, women and children in nearly every populated region on earth. A disease that began as a public health crisis affecting millions of people has now evolved into a force that threatens the social, economic, political and religious development and stability of the World.

The World Health Organization began organizing a response to HIV/AIDS in 1986 and launched a global strategy to fight the disease a year later. Since then, the world health community, governments,NGOs and other international agencies have contributed significant Moral, motivational, technical and financial resources to support the battle against HIV/AIDS, but these resources have not been sufficient to meet the continuing global challenge. Everyday, the number of HIV infections increases and the pool of resources available to fight the disease diminishes.

In 1991, WHO reported twelve million HIV infections worldwide; today the total has increased to 36 million. Ninety percent of these infections will have been sexually transmitted, most as a result of heterosexual intercourse. Specific behaviours, common in all parts of the world speed the spread of HIV. However, the vast majority of infections has and will continue to occur among people in developing countries least able to mount the programs needed to prevent and control this developing disaster.

HIV/AIDS has attacked the developing world at a time when decades of investment in personal, social and economic development is beginning to yield results. In India, precious gains have been made in child survival rates and adults are living longer and healthier lives. In other areas, a better-educated work force has increased the potential for foreign investment and the expansion of manufacturing and services sector industries. HIV/AIDS threatens to halt or reverse many of these gains; in fact it already has in some areas. According to the latest report to Congress on the USAIDS Program, AIDS has become the leading killer of children in some developing countries. The disease has already severely

impacted the work force in many countries and has led to the withdrawal of planned foreign investment in others.

In India, economy is fragile, technical resources are limited and governmental infrastructure, policy positions and service systems are weak or unstable. We already know, for example, that no health care system currently existing in India or the developing world will be able to manage or provide care for the continually increasing number of people infected with HIV or suffering with AIDS. Community must join hands and support the existing resources and create tolerance.

HIV/AIDS also batters the supporting social structures of a world. Extended families are common in India and individuals are dependent upon these families for many aspects of their well being. Although such communities have a long tradition of caring for the ill, the enormous financial burden and too-frequent stigmatisation associated with caring for people with AIDS have ripped families and communities apart. Those families, who do not turn over the care, of the ill to strangers face increased poverty as they lose the income of both the patient and the person who cares for them.

Fear, lack of knowledge, limited resources and weak corporate capabilities have combined to facilitate the spread of HIV in the developing world. Although the world may have been slow to understand and respond to this disease and its future implications, much important work has been done and many successful disease interventions have been tested. The world community has recognised the need to temper fear with knowledge, defined the resources needed to impact the epidemic in specific countries and developed interventions to prevent the spread of HIV. However, currently available resources fall far short of what is needed to apply what has been learned on a large enough scale to effectively impact the pandemic.

Cooperative efforts are needed. No nation or international organization can successfully shoulder the burden alone. The resource gap must be filled through the collective efforts of the public and private sectors at local, national and international levels. Government, private enterprise, religious institutions, private voluntary organizations, international service organizations, community-based groups and private philanthropy must assume the responsibilities of leadership and seize this opportunity to improve the human condition.

Although there has been mounting pressure on school education system for the introduction of sex related matters in the curriculum, there is a lot of variation in the conceptualisation of this educational area. Different concepts like sex education, family life education, reproductive health education and poverty education have been used to describe the nature of this area. And even these concepts have been defined differently.

I believes in GLOBAL Healthy Relationship, in fact anything that you want to make a point
about at International level for the betterment and benefit of the Society at Universal Level for
Holistic Development.

I am thank full to you for becoming a part of this movement. Let us Come forward and work
together and share our experiences. I request to my fellow friend, to motivate like minded friends who are interested and willing to serve the community at holistic level.

I am always here to share my experiences with you and for my orientation also. I shall also be grateful to you if you could motivate the community to work for Rehabilitation of People Living With HIV/AIDS.

With great hopes from the GLOBAL COMMUNITY,

I remain your comrade in arms against this menace of AIDS.
Dr. Avnish Jolly

Subject: [AIDS-INDIA] AIDS will bring down GNP
Date: Tue, 04 Dec 2001 06:03:08 -0000
From: drrajashekarpalleti@usa.net
To: AIDS-INDIA@yahoogroups.com

==========
AIDS will bring down GNP
==========

October 23, 2001:
The winner of this year's Commonwealth Award for comprehensive care of HIV patients, Ashok Rau of the Freedom Foundation, India, says AIDS is not just a health problem but a development issue.

The foundation is among the 12 winners from 52 Commonwealth countries for action on AIDS. The 72 entrants for the prestigious award were from countries like Kenya, Malawi, Namibia, South Africa, Trinidad and Tobago, Uganda and United Kingdom.

Freedom Foundation set up in 1992 has helped 5,000 AIDS patients so far, out of which 146 patients have died peacefully. "Since the prevention aspect does not have tangibility, we focus on care and support," says Ashok, the founder of the organization, who received the award in Melbourne on October 4.

He cites cases of heads of companies, college students, children and groups of people from families testing HIV positive in recent days at the Bangalore centre. "AIDS will bring down the GNP in 2005-2010 by 15 per cent, so we should understand the enormity of the epidemic in India," he says.

Ashok likes to describe Freedom Foundation as the Shoppers' Stop for AIDS patients, "with all facilities including legal under one roof." The legal and structural shifts initiated by the foundation include changes to property-ownership laws that discriminate against women and the mainstreaming of AIDS in the health sector.

The foundation is considered a replicable, low-cost, community-centered model for meeting the needs of people infected and affected by HIV.

Dr Neal Blewett, the former Australian Minister for Health announced at the Melbourne awards ceremony: ``nearly 60 per cent of HIV positive people live in the Commonwealth countries, and half of all AIDS deaths have been in Commonwealth member countries." Ashok adds that according to reliable statistics the number of AIDS patients in India is four million today.

The New Delhi-based Naz foundation was also one of the award winners for prevention of AIDS, this year.

##

Subject: [AIDS-INDIA] Quality of blood screening
Date: Thu, 6 Dec 2001 08:53:44 +0100
From: "John Nivard" <jnivard@multiweb.nl>
To: <AIDS-INDIA@yahoogroups.com>

Dear forum members,

I am in the process of contacting the responsible person's for the "national external quality assurance program in the bloodscreening laboratories" within the National AIDS Control Organisation Ministry of Health & Family Welfare, Candralok Building. 9th floor, 36-janpath, New Delhi - 110001 INDIA.

I need this information to speed up our AIDS prevention project in bloodscreening laboratories. Can some one help me to get in contact with the appropriate people. I did send the following letter but no response until now.

Copy of the letter

Dear Sir,

From the SEAWP I see INDIA is launching a national external quality assurance program in the bloodscreening laboratories. I am verry pleased to hear of this project and I am convinced that our service can help you with your project. I am offering my help and our service to facilitate your project. To addapt our service to your standards we would like to have a copy of the technical manuals you prepared for the HIV testing laboratories. A greate help will be a e-mail list of the participating laboratories.

Introduction

First of all I would like to introduce myself to you. My name is John Nivard a independent expert in the field of information processing in bloodbanking. I made my carrier as a information Technology and Communication expert in the field of medical information processing. If have designed, build and managed large scale information systems, operation systems and database systems. I have worked as a IT manager of the Central Laboratory of the Blood transfusion Services of the Dutch Red Cross and became a expert in automation and data processing in the field of blood banking and blood transfusion
medical trials and laboratory information systems. I was for a long period member of the ISBT Working Party on Automation and Data Processing and several national organizations. Currently I am a independent consultant adviser

I have developed a internet service named "www.GlobalQualityServices.com" specially geared to the quality control and quality assurance of bloodscreening laboratories (see the detailed description below). From the start the service is designed and build with the state of the art products and the internet in mined. The complete internet based service can be of interest by setting up a regional or national reference laboratory for the quality assurance of bloodscreening laboratories in the developing countries.
The service is direct available for use for every bloodbank or transfusion service with a access to internet.
Access to the internet is preferably ones a day. The service supplies a information service only. A group of bloodbanks, a National or regional reference laboratory, a research group or a supplier of reagents can use the service to set up a proficiency program or use the service for monitoring the outcome of runcontrols of a group of bloodscreening laboratories. Because the economy of scale your costs are reduced to a minimum, no IT staff and infrastructure is involved, no additional software is required, no investments in money and IT projects. The only requirements are a internet connection and a standard web brouwser. You can deploy the application in a national or international context direct from the start.

Currently we are active in setting up a project in INDIA involving several bloodbanks (see the description blow). The project named AIDSINDIA is in the starting up phase and is using the service (see project description below)

The goal of the project is to monitoring the quality of the bloodscreening by plotting the outcome of the runcontro's from the blood screening markers in a classical "Shewart Control Chart" and "Cumulative distribution" format. Because the multicenter setting you are able to observe the observations of the participants while maintaining the anonymity and the source of the data. Global Quality Services maintains a international accessible database for bloodscreening laboratories. By the law of large numbers (Chebyshev's inequality) the period between the start of the deviation and the
moment of detecting and signalling a deviation will decrees. GQS has added data entry screens for nearly suppliers of reagents. We will make the service availlable in other developing countries free of any charges and we are in the process of applying for external funds and other support.

I hope you or your staff member will contact my

Waiting for your reply,

J Nivard
VisionFactory
Slimdijk 1 1631 DB
Oudendijk NH
The Netherlands
jnivard@multiweb.nl

1-Project description AIDS INDIA project

1.1 Goal:

Monitoring the quality of the bloodscreening by plotting the outcome of the runcontrols from the screening markers in a classical "Shewart Control Chart" and "Cumulative distribution" format. Because the multicenter setting you are able to observe the observations of the participants while maintaining the anonymity and the source of the data. Global Quality Services maintains a international accessible database for bloodscreening laboratories. GQS has added data entry screens for nearly all suppliers of reagents.

1.2 Methods:

QC samples from the manufacturer or prepared by the laboratories are included in every run. Results obtained from the QC samples including lotnumbers are entered in a international accessible database and plotted in the classical Stewart control chart on a daily basis. Plotting the QC data allows to observe trends towards a change in performance of the assay alerting them to potential problems.

1.3 Results

By a daily monitoring of all the runcontrols of all the assays of the routine screening of donors the laboratories are able to detect a deviations in a early stage. For example a field upgrade of a laboratory instrument, the introduction of a new lot of reagents etc. can effect the results. By the law of large numbers a change will be detected in a early stage. By a systematic comparison of the bias and variation in the assay results of the participating laboratories the organisation is able to detect the source of the bias and or variability in relationship with method used, instrument, reagent and procedure while maintaining the anonymity and the source of the data. Sharing of the information with a direct feedback including charts will stimulate the awareness of quality

1.4 Discussion

To develop a own information service for this purpose is very difficult. While lack of understanding is one reason, there is also the question of resourcing of funds, training and staffing. A internet based service for Quality Control my overcome the basic problems and the availability of the results can stimulate the quality of the bloodscreening processes and funding of improvement programs. Implementation or development of a national or regional reference laboratory can be stimulated. Because the economy of scale your costs are reduced to a minimum, no IT staff and infrastructure is involved with the exception of internet connection, no investments in money and IT projects. You can deploy the application in a national or international context direct from the start. If nessasery the service can be implemented as a complete in-house application. Because it is a multicenter set up you can see your observations between the observations of the other laboratories while maintaining the anonymity and the source of the data. You are able to study the outcome of the runcontrol in relationship with reagents-lotnumbers, runcontrol-lotnumer and or/instruments. By the law of large numbers (Chebyshev's inequality) the period between the start of the deviation and the moment of detecting and signalling a deviation will decrees. You are able to start your own quality control circle. At membership processing you are able to define a new group or you request a membership of a existing group. A proficiency test provider or National Reference or regional reference laboratory can start his own group and can use the service to collect the data from the participating bloodscreening laboratories. In addition he can using GlobalQualityServices to automate his complete business process starting with the invitation to his custommers to participate in a proficiency program to the online statistical analysis and billing. The statistical request are direct executed and the Shewart Control Chart and performance chart are online direct available.

1.5 Assumptions:

-Global Quality Services is only in the role of information service provider and facilitator of the process
-Participants are the organisers and carry out the process and are getting other participants involved

1.6 Organisation

-Laboratory involved in blood screening for transfusion are organised in quality circles.
-Participants are active seeking contacts to get others involved

1.7 Runcontrols

QC samples from the manufacturer or prepared by the laboratories are included in every run. Results obtained from the QC samples including lotnumbers are entered in a international accessible database. On request of the participant a "Control Chart" and/or "performance chart" is generated. A quick start is the use of the runcontrol of the manufacturer of the test assay or the material of a national reference organisation.

1.8 Data entry templates

Data entry templates are available for : Abbott, Avicenna, Boehringer, Fujirebio, Innogenetics, Murex, Organon Teknik, Ortho, Sanofi Pasteur Monolisa, BAG, Biomerieux, Biotest AG, etc. For a complete list of 200 data entry templates access our product catalogue. On request we ill add new templates to cover all suppliers of reagents.

1.9 The role of the participants

Participants are active seeking contacts to get others laboratories involved. Participants are organised in regional quality circles Each circle is responsible for the distribution of the runcontrol/reference material. The use of the runcontrol of the supplier of the reagent or the use of the reference material of a national organisation is a option. You can start using the service in-house

1.10 Costs involved

The information service for this project is free a off any charges. In the long term we will seek funds from the EU or other organizations for the cost recovery. As a starting point you can use the service for your own local blood bank. In this case there are no out of pocket costs involved with the exception of the costs you already made for the reference sample you prepared by yourself or received from the manufacturer of the reagents. External reference material is also (commercial) available from National reference laboratories or commercial organisations. In case you start a quality circle you have to take in account some out of pocket costs for the distribution of the reference sample. The distribution costs involve: transportation and packing material. In case you use external (commercial) reference samples you have to take those cost into account

1.11 Logistical details

The optaining, production, administration and distribution of reference samples are the responsibility of the members of the quality circle. Starting with a single bloodbank and scaling up to two or more will give time to build a distribution network. GlobalQualityServices contains the procedures and product catalogue for the ordering of the reference material from national or commercial organisations.

1.12 Statistical details "Shewart Control Chart"

The control chart is a simple graphical device which is useful in keeping track of production quality. "Control" implies that some static condition exist. If the quality does improve or change significantly we say we have no longer control. and we depend upon our control chart to detect the change. On the vertical axis we have a scale for observed values of the variable. On the horizontal axis we have a scale for days, or time at which the sample was taken. A solid horizontal line is drawn through the expected (assumed) value, and two parallel lines are drawn, one above and one below the solid line. We plot the observed value of the sample and plot it in the chart. If the point is between the parallel lines we say that the process is in control and take no further action. If the point is above the upper or below the lower line we say that the procedure is out of statistical control, and we attempt to find the factor which is causing the extreme observation. We wish the chance of asserting lack of control to be very small when the static condition still exists. We control this chance by the distance between the parallel lines, the so called Upper Control Limit and Lower Control Limit. In practice it is customary to use 3*Sigma / square (N) as control lines. For a normal distribution these control lines give a 0,27% chance of deciding erroneously that there is a lack of control. The statistical method's applied have as a goal to detect systematic deviations from deviations witch occur by chance. The control value's are calculated from the sample in the case that they are not supplied by the user. Besides the statistical upper and lower control limits you can specify a technical control limits. The technical control limits are determined based on technical or economical criteria and must be supplied by the user.

1.13 Performance chart

The performance chart is a cumulative distribution chart of all observations. Your observations are plotted against all other observations. The percentile score of the average value of your observations is marked.

1.14 Current status

Until now we have 8 reactions out of INDIA for our bloodscreening project (see project description). This is a very good start for a long term blood screening quality project. Until now we have questions about the following aspects: -costs involved, -logistical details,-statistical details.

1. 15 Invitation to participate

In case you are involved in the bloodscreening for transfusion you are invited to start using this services free of any charges. To start using this service register at http://www.GlobalQualityServices.com and within 24 hours you can order a data entry template out of the online product catalogue (free of any charges). You are able to start using the service for your own bloodbank and in addition you can use the service with more added value in a regional or national context. The service is available in nearly all countries. We have now 8 members and 3 users starting to build the AIDS INDIA bloodscreening database. In case you are active involved in the screening of blood donations in a developing countrie please register free of any charges at http://www.GlobalQualityServices.com. You will recieve a username and password and access to the database. To get used to the service, access to a demo version is supplied to.

2 Description of the service www.GlobalQualityServices.com

A complete new internet enabled application for the proficiency test provider, monitoring of runcontrols (external) variables and/or collecting data for research is available on the internet as a standard service:

-Portal infrastructure, a dynamic personalized website tailored to the need of the user
-Workflow processing, the complete business process of the provider captured in workflow steps
-Data entry, users can order a catalogue item including the data entry template's he/she needs
-Publications, after the publication date users can query the data base including charts

Using this service you are able to collect data rapidly over the internet and distribute and publish the results on line in a statistical chart and/report. Do you need a national or regional monitoring system for your indicators in the field of healthcare, here it is easy to use and no complicated IT project involved. Do you need a data collection system for your research project or routine monitoring of runcontrols, her it is easy to use and you can design your own data entry template direct for use.

2.1 The functions of the service include for example:

-user registration / ballot committee
-order processing (sample material, run controls, reagents and data entry templates and keys)
processing of order/invoice
-workflow management (inluding standard letters and workflow, e-mail lists and e-mail response)
-production of labels for manual mail, material distribution and workorders
-data entry and validation and personalization
-log of the input to the database
-data collecting (upload from your lims)
-distribution (download a selection formatted for your own application)
-on line statistical analysis and reports including charts (summary,control charts, cum control chart, distribution, performance etc)
-processing of extreme cases and outliners
-early warning alerts
-publishing of inclosures
-discussion forum
-on-line form design
-integration with your own website

2.2 Requirements

The only requirements are a PC and a standard web brouwser. No additional software at the client site is

necessary. The services is designed for a 17" monitor resolution 1024 by 768 and tested with internet explorer version 4 and netscape navigator version 3 and higher the only thing you need is a internet connection and a 28 kb modem or higher. The extreme low requirements of using this service makes it possible to use this service in the developing countries to. We deliver this service to the bloodbanking community free of any charges.

2.3 Demonostration database

The service as available now contains all the functions necessary for (national) proficiency testing, monitoring of runcontrols (external) variables, research studies, calibration and qc of equipment and reagents and technical support in the field. As a provider you are able to offer this service to your custommers integrated with your own website. Try it out now by ordering a data entry template and use it in the demonstration database named NRL. The demonstration database is a example in the field of bloodscreening laboratories and contains predefined data entry templates for all suppliers of reagens. Using the demo database you are able to enter data and add data poibts and to generate realtime a sheward control schart and performance chart.

Register at the website : www.GlobalQualityServices.com or use our demo database by following the steps 1 and 2 below:

step 1 go to the home page at: WWW.GlobalQualityServices.Com and click Orders. Log in using the user name "Lab1 NRL" and the password "Lab1NRL". Select the item from the catalogue and purchase the template free form any charges.

step 2 The template will be deliverd to you about 24 hours later and you are able to start to monitor the variable of your chose

step 3 Use the "help getting started" and folow the lessons 1-7 to get used to the service

2.4 Management summary

Global Quality Services is a high quality cross industry services in the field of benchmarking /quality assurance, quality control. You are able to benchmark a product, service or organization in a national or international context. Global Quality Services is consolidating the measurable quantitative aspects of quality knowledge in your organization and makes the knowledge available to all the participants. The service is direct available for use. You can deploy the application in a national or international context direct from the start. There is no need for additional software at the client site. A standard up to date web brouwser will do the job. The cost of ownership for you and your customers is reduced to a minimum. Global Quality Services is a cross industry solution. Global Quality Services is active in the different fields or industry sectors like food, pharmaceuticals, manufacturing, blood banking, transfusion, medicine, agricultural, mineral and petrol , management and hospitals. This combined knowledge is to your advantage. The standard service is global available. The service is based on the knowledge collected in different sectors and industries. Using this information service you are able to speed up your quality assurence and control projects in the field of bloodscreening laboratories. In combination with the availablity of commercial available reference samples from several sources you are able to set up a national qc program. Global Quality Services supplies only a information services. Using the model of Application Service Provider the service is direct available for use. Because the economy of scale your costs are reduced to a minimum, no IT staff and infrastructure is involved, no investments in time, money and IT projects. You can deploy the application in a national or international context direct from the start. Global Quality Services as a specialized internet portal can compete with the generic statistical products available to day. VisionFactory develops and implement complete innovative e-business solutions based on Lotus Domino, the Lotus smartsuite and IBM WebSphere and if nesssery is working

with respected partners.

Waiting for your reply.

Kind regards,

J Nivard
VisionFactory
Slimdijk 1 1631 DB
Oudendijk NH
The Netherlands
jnivard@multiweb.nl

Subject: [AIDS-INDIA] International migrants day
Date: Mon, 10 Dec 2001 09:54:13 +0000
From: "Rakhi Nair" <Rakhinair@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear friends;

18th December 2001 is International Migrants Day. It is estimated that some 130 million people live outside their countries of origin.

Rakhi Nair
Director-Special Programmes
FXB-Rajasthan Society
Sumerpur
email: rakhinair@hotmail.com

Lib. AIDS-India file
TM
14/12

Subject: [AIDS-INDIA] Social mobilisation trainers Manual
Date: Fri, 7 Dec 2001 18:45:32 +0530
From: "Maheshs" <maheshs@mail.com.np>
To: <AIDS-INDIA@yahoogroups.com>

Dear forum members

We are in the process of developing a Trainers Manual on Social Mobilisation for HIV/AIDS. This manual is aimed to mid level programme managers or field programme managers. We would appreciate any materials, experiences related to this is shared with us or guide us where to look at for relevant information.

Best regards
Mahesh Sharma and team
maheshs@mail.com.np

Dear Sri Mahesh + team,
Dr Ravi Narayan + others have ~~had~~ brought out a guide to Social Mobilization for Malaria for the WHO-SEARO region. While HIV/AIDS has certain specifics, this may be useful. Do write to him if you are interested or his email address

Bookmarked
In D/R.

TM
10/12

Sent
14/12

PN
13/12

Lib

Subject: [AIDS-INDIA] The AIDS aid dilemma
Date: 12 Dec 2001 13:38:40 IST
From: palleti rajashekar <drrajashekarpalleti@usa.net>
To: AIDS-INDIA@yahoogroups.com

The Aids aid dilemma The UN's global fund for HIV/Aids, TB and Malaria has $1.5bn to spend. But does prevention or treatment have the greater claim? An opinion piece from the UK newspaper, The Guardian. By Sarah Boseley, the Guardian's health editor and Liz McGregor, deputy comment editor. Early next year, a group of people - exactly who they will be is still being fought out - will decide how to distribute the $1.5bn so far collected in the name of UN Secretary General Kofi Annan's global fund for HIV/Aids, TB and malaria. When the fund was launched, in the wake of the public uproar at the spectacle of 39 pharmaceutical giants suing the South African government to prevent it importing cheap medicines, Aids activists were ecstatic. There was a general assumption the fund would buy the antiretroviral drugs (ARVs) that keep people with HIV alive in the west and without which HIV in Africa is a death sentence. Since then, expectations, along with the contributions from rich nations to the fund, have slumped. Kofi Annan said that $10bn a year was needed. In around nine months $1.5bn has been raised. And the word from donor government quarters is that Aids drugs are definitely not the priority. Clare Short, the UK's international development secretary, is one of the most influential world leaders in this area. Privately, she does not believe the fund should ever have been launched - her view is that existing bilateral aid programmes can best tackle the problem. But since it exists, she is clear that it must focus equally on three diseases, not one - TB and malaria as well as HIV/Aids. And she firmly believes that the best way to tackle HIV/Aids is through prevention. She wants to see the fund paying for condoms and microbicides, not expensive drugs. In many ways, her position is logical. Most of the world's 40m people with HIV/Aids do not live in the rich west. It is not conceivable that the fund could raise enough to pay for drugs for all, even at the rock-bottom price of $300 a patient a year which the generic companies are asking for their copycat drugs (the patented versions cost $10,000 a year). There is no cure for Aids, the argument runs, so the best bet is to stop people developing it. The HIV virus, which causes Aids, is now spread mostly through heterosexual sex, which can be prevented by the use of a condom. If people understand this and act on it, the epidemic can be halted. But, as the latest figures show, prevention does not appear to be working. Undoubtedly more money spent on education and condoms would help but the primary obstacle appears to be cultural. Of the 5m infected with HIV in 2001, 3.5m live in sub-Saharan Africa which, by and large, is constituted of patriarchal societies where women have little control over their sexuality. The high incidence of rape, frequently exacerbated by war; polygamy; the cultural pressure on women to bear children early and often; their relative powerlessness in relation to men which makes it difficult for them to insist on condoms - all conspire to allow the virus to run unchecked. Cultural change, the empowerment of women to say no, is the idealistic answer, but it takes decades, if not centuries. Some 3m people are dying a year, leaving orphans in the streets, uneducated, unprotected, unfed and heading for a life of crime if not one day anger and terrorism. There is an urgent humanitarian need to stop the deaths and to change attitudes, and there are those who say that offering treatment will do it. Most of the 40m people living with HIV do not know they carry the virus. The stigma of Aids, coupled with the knowledge that it is a death sentence means most would rather not know. NGOs such as Médecins sans Frontières argue that treatment produces a change in behaviour. If people know that they will have access to drugs if they are infected, they are much more likely to come forward for testing. Pre- and post-test counselling provides the first steps towards changing behaviour. Another compelling argument is economic: the drugs can, hopefully, provide another five to 10 years of healthy life: HIV positive parents can nurture children to adulthood in that time; employees can remain economically active. Teachers, health workers and other key professionals will be able to stay in their posts longer. And hospitals will not be overwhelmed by repeated admissions for opportunistic infections by HIV positive patients. And then there are the human rights of the 40m already infected. How can it be ethical to write them off? The biggest obstacle - apart from funds - to treating people with HIV/Aids in poor countries is the lack of health care facilities. Many cities have more than adequate hospitals where they could start using ARVs tomorrow, yet in some rural areas there is barely a basic clinic, a doctor and a nurse. But a project in Haiti started by Harvard scientists found it was possible to disseminate ARVs in the same way as TB drugs - a low key approach in which community health workers make an assessment of people's need for treatment without complicated blood tests, counsel them and ensure they take their drugs within the necessary time frame. Gradually the obstacles to ARVs for Africa's poor are being surmounted, but it will take courage and imagination for the global fund to hand out money for poor countries to spend on drugs. Politics is a further obstacle. The US,

TM
13/12

Private and European nations are vulnerable to pressure from the pharmaceutical lobby. Following the prevention route bypasses clashes of interests. Most donor country politicians would rather leave the

minority of sufferers - as they are now doing. But the genie will not go back in the bottle. Now that the drug companies are offering Aids drugs at discount, albeit too expensive, prices, there will be demands from activists and unrest from those with HIV. The task for those who will sit on the global fund panel, judging the bids for the money, is going to be tough. Info: Aids: the figures Living with HIV/Aids Children under 15 - 2.7m Women - 17.0m Adults - 37.2m Total - 40m Newly infected, 2001 Children under 15 - 0.8m Women - 1.8m Adults - 4.3m Total - 5m Aids deaths, 2001 Children under 15 - 0.58m Women - 1.1m Adults - 2.4m Total - 3m Source: UNAIDS

==========

==========Source: MSF

==========

Subject: [AIDS-INDIA] AIDS WAR: WHO IS ON THE RIGHT TRACK?
Date: Tue, 11 Dec 2001 12:25:32 +0530
From: "annajoy" <pulickal@hotmail.com>
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Friends,
This is an article appeared in Mumbai Times (Times of India), which many may want to respond. Joy.
****

AIDS WAR: ARE NGOs ON THE RIGHT TRACK
Sharmistha Chatterjee
Times News Network

(Mumbai Times, Times of India, December 1, 2001)

Maharashtra has over 1,000 non governmental oranizations (NGOs) battling Acquired Immune Deficiency Syndrome (AIDS). Their presence, however, seems to have done little good as the state continues to have high numbers of HIV-positive patients. Although NGOs receive over Rs.10 billion in funding, from overseas (30 percent) and the Central Government (70 percent), barely 10-20 percent of the money is used. Gross misappropriation has prompted the social wing of the National AIDS Control Organization (NACO) to set up guidelines for running of NGOs and to increase surveillance.

Even though 2.5 percent of Mumbai's population suffers from AIDS, experts feel the figures the figures are grossly under-reported due to absence of a recording system. Actual figures could be double the projected figures, say experts. The large number of AIDS cases has prompted the mushrooming of NGOs in Mumbai already. Two years ago there were only about 50.

Says Dr.J.K.Maniar of Grant Medical College, "The existence of so many NGOs doesn't means they are doing a lot of work. Only 20 percent are doing constructive work. Most of the funds are used for other purposes." This view is echoed by a top NACO officer.

Considered fashionable thing to do, people are very quick to associate themselves with NGOs fighting the disease. "Te battle against AIDS has attained a glamorous status and it means big money," says Dr.Aravind J Shah, senior medical officer, STD Clinic (Asha project). "Most NGOs confine themselves to seminars and dinners restricted to an elite circle."

Besides, it is extremely easy to get registered as an AIDS NGO with NACO, which ensures easy availability of funds. Various societies are set up like the Maharashtra AIDS Society and Mumbai Districts AIDS Soceity, to facilitate raising of funds. In addition, the lack of monitoring encourages fly-by-night operators. Says Dr.Jairaj G.Thanekar, director of the successful BMC-run Asha Project, "How many NGOs would actually work for the poor if funds were not easily available? We face severe shortage of funds, yet we carry on."

With people shunning tertiary health care centers due to the stigma attached with HIV, NGOs can play a pivotal role in the battle against AIDS. This would require a collaborative and focused approach. Says Thanekar, "Together with the public health care system, NGOs should work towards bringing about a positive behavioral change in people and providing comprehensive health package. Both aspects are being completely overlooked."

The benefits of this approach have already been witnessed. But these positive contributions have been tarnished by other NGOs. According to

TH
14/12

Shilpa Mechant, of Population Services International, "it could be true that some NGOs don't do their job. But it's wrong to point fingers at all NGOs as some provide excellent services which go unrecognized." This view is shared by Dr.Maninder Setia, of Lokmanya Tilak Hospital: "NGOs have proved very useful, especially when it comes to counseling patients. This compliments the public health care system. Public hospitals are some times unable to provide basic amenities."

Subject: [AIDS-INDIA] Manipur to close AIDS Projects !
Date: Thu, 13 Dec 2001 11:02:15 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Firefight against Aids wrapped in red tape

The Statesman 12th December, 2001 New Delhi

Manipur observed World Aids Day on 1December with fanfare but ground action to combat Aids is in jeopardy. According to data collected till August, Aids-related deaths stand at 186 and confirmed cases at 997 with 1,2000 people testing HIV positive in the state.

The first Aids case was reported in Manipur in 1986. The authorities, however, are yet to evolve a system free from bureaucratic and political interference to combat the dreaded virus. Funds are not being released by the Manipur Aids Control Society (MACS), the state apex body to combat Aids. This has affected the functioning of NGOs, which run hospitals for Aids patients, organise rapid intervention and other programmes.

Funds were frozen after a blanket ban that followed a Union home ministry report which alleged: "Funds have been siphoned off to underground elements through NGOs." This death a blow to about 100 NGOs empanelled with MANS. According to a report, the National AIDS Control Organization (NACO), the nodal Aids-fighting agency in India, had approved Rs 681.53 lakh for 2001-2002 for MACS under its action plan for Manipur where the disease is spreading fast because of its proximity to the "Golden Triangle".

The amount approved initially was Rs 480.53 lakh but was increased on MACS' request. Of the allocation, Rs 240 lakh is in MACS' kitty. MACS' executive committee and governing body had approved the action plan and the funds had been disbursed. However, after the imposition of Central rule in Manipur in June, funds were frozen on instruction from the Union home ministry vide GoI letter no 8/17/200-ME-dated 6/12/2000 which sought the blanket ban. Earlier, the state government continued to disburse continued to disburse funds in violation of the order on the premise that MACS was an autonomous body and directly monitored by NACO. Usage of funds were approved by its governing and executive bodies of which the chief minister was the chairman and commissioner (Health) was president, respectively.

But after the imposition of Central rule, the Governor-in-Council, with the Governor as its head, took over the task. The council felt the ministry's clearance was needed before releasing funds.

According to MACS, nearly Rs 100 lakh of the Rs 240 lakh released as first installment had been used up - before the restriction came into effect - under the NACO representative's supervision. MACS project director, Khomdon Lisam, said: "We have written to NACO and the Union home ministry for direction. We have apprised them of the situation and critical nature of the work. A public interest litigation has been filed by a journalist. "The joint secretary of the Union home ministry, Surinder Kumar, told us over telephone to get clearance for all NGOs working with MACS from the district commissioner before disbursing funds. We have written to the DC for clearance certificates for all NGOs working with us." The Commissioner (Health), Henry K Henny, had written to NACO on 30 October that the matter was "toppriority" Mr. Henny had highlighted that all activities" of MACS had been grounded in the past three months. The government drew media criticism. "We cannot treat this at par with other issues as the situation is critical and lives are at stake," said Dr Khomdon. "We understand the Union home ministry's concern but HIV/AIDS is an epidemic and should be treated as such," he said. This cannot be put on hold. "People are dying. The virus is spreading rapidly and the least we can do is to continue with the fire fighting. All NGOs must not be made to suffer for the handiwork of some," Dr. Khomdon said. "If there is information on specific NGOs having a nexus with insurgents, these must be blacklisted so that we can get on with the work," The Governor's adviser, Mr. Kinpgin, who handles the health portfolio, said the funds were blocked after an official memorandum from the home ministry. MACS had been blacklisted in January. In March, senior officials of NACO were asked

any discrepancy. So the funds had been disbursed to it. "We have also found out that the allegation that MACS had a nexus with underground organizations is not true. Dr. Khomdon will be sent to New Delhi soon," Mr. Kipgen said. Mr. Kumar has been asked to conduct a probe into the NGOs activities in Manipur.

"The present instruction is that funds to existing NGOs be disbursed after verification by senior officers of the department concerned at the Centre and any new NGOs seeking funds need to be cleared." But the problem is that officials concerned are unwilling to visit Manipur, he said. A senior official, who did not want to be named, said the blanket ban should be extended to all insurgency-prone areas like Assam and Nagaland and not be restricted to Manipur. On the blanck list are names of NGOs, which have not received any funds. Aids/HIV statistics are shocting, thought. Of the 3,456 blood samples tested up to September, at least 948 were found HIV positive, while 249 were confirmed Aids cases.

Manipur has recorded 1,010 HIV positive cases since 1986 from blood samples of 54,232. The unofficial figure is much higher. Many Aids-related deaths are not reported because of the stigma attached to the disease. The good news is that there is a decline in the HIV seroprevalence rate from 80.7 per cent in 1997 to 60 per cent in 2001. The bad news is that the rate among pregnant women is no the rise. The latest epidemiological analysis of HIV/AIDS in Manipur conducted by MACS estimated there are about 1,000 afflicted children in Manipur. The trend is shifting from intravenous drug users to sexual transmission, according to field workers. After Maharashtra and Tamil Nadu, Manipur is the third-highest HIV/AIDS infected state in India.

****

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] Partners conference 2001 - invitation for participation
Date: Thu, 13 Dec 2001 01:37:35 -0800 (PST)
From: satheesh r <somasatheesh@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear Friends,

Partners' conference 2001: Organised by PFK, Kerala State AIDS Control Society and SMA

Partners forum Kerala (PFK) is a professional networking body of NGOs in Kerala, started in 1997. It aims to bring changes in the functioning of partnering organisations by adopting a professional and system oriented approach. Fifty three NGOs working in the area of development are members of the forum. Among the members 43 organisations are implementing the PSH (Partners in sexual health - HIV/AIDS prevention programme) programme in different districts of Kerala. The main objective of the organisation is to identify areas of development concern, mobilise and channelise resources and build up capacities of partners to address the issues.

Every year PFK organise annual meet in collaboration with Kerala State AIDS Control Society and State Management Agency. This year we plan to hold the meet on 21st and 22nd of December 2001. The theme for the meet is "Opportunities for working together - Government, Bilateral, Multilateral and NGOs". We expect participation from Central and state Government, Bilateral agencies, Multilateral agencies and NGOs.

Since it is a unique event and get-together of individuals and organisations working in the field of development, we expect participation of all the people in the field.

The programme is planned for two days. On the first day after the inaugural function it is introduction of partner organisation teams and the sharing of partner experiences. On the second day a scientific session on the theme will be held followed by the valedictory session.

The detailed programme will be send to you by 17th of this month. The venue of the programme is Cochin, Kerala.

For further communication and information please contact:

Satheesh Chandran
President, PFK
UR- 9, Uppalam Road, Statue, Trivandrum - 695 001,
Kerala, India. Tel: 0471 - 475650, Fax: 0471 - 464181,

Email: somasatheesh@yahoo.com

TN
Lib - AIDS-India file
Jw
14/12

Subject: [AIDS-INDIA] Partners conference 2001 - invitation for participation
Date: Thu, 13 Dec 2001 01:37:35 -0800 (PST)
From: satheesh r <somasatheesh@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear Friends,

Partners' conference 2001: Organised by PFK, Kerala State AIDS Control Society and SMA

Partners forum Kerala (PFK) is a professional networking body of NGOs in Kerala, started in 1997. It aims to bring changes in the functioning of partnering organisations by adopting a professional and system oriented approach. Fifty three NGOs working in the area of development are members of the forum. Among the members 43 organisations are implementing the PSH (Partners in sexual health - HIV/AIDS prevention programme) programme in different districts of Kerala. The main objective of the organisation is to identify areas of development concern, mobilise and channelise resources and build up capacities of partners to address the issues.

Every year PFK organise annual meet in collaboration with Kerala State AIDS Control Society and State Management Agency. This year we plan to hold the meet on 21st and 22nd of December 2001. The theme for the meet is "Opportunities for working together - Government, Bilateral, Multilateral and NGOs". We expect participation from Central and state Government, Bilateral agencies, Multilateral agencies and NGOs.

Since it is a unique event and get-together of individuals and organisations working in the field of development, we expect participation of all the people in the field.

The programme is planned for two days. On the first day after the inaugural function it is introduction of partner organisation teams and the sharing of partner experiences. On the second day a scientific session on the theme will be held followed by the valedictory session.

The detailed programme will be send to you by 17th of this month. The venue of the programme is Cochin, Kerala.

For further communication and information please contact:

Satheesh Chandran
President, PFK
9, Uppalam Road, Statue, Trivandrum - 695 001,
Kerala, India. Tel: 0471 - 475650, Fax: 0471 - 464181,

Email: somasatheesn@yahoo.com

TN
Lib - AIDS-India file
12/12

Subject: Fwd: [AIDS-INDIA] NSAHIVNET Fiscal Sponsorship Application
Date: Thu, 13 Dec 2001 00:25:36 +0000
From: "latha jagannathan" <lathajagu@hotmail.com>
To: madhyamb@vsnl.com, samraksha@vsnl.net, knpplus@vsnl.net, mamthasatish@vsnl.com, snehadaan@yahoo.com, vravi@nimhans.kar.nic.in, chandra@nimhans.kar.nic.in, j_ramakrishna@vsnl.com, pradeep@mahiti.org, sochara@vsnl.com, manohar@sangamaonline.org, bctbng@bgl.vsnl.net.in, lman@vsnl.com, svjrao@hotmail.com
CC: deeptiprasad@netkracker.com

Sent 13/12/01
TIS - draft please
13/12/01

Should AFK apply?

Latha

Dear Lata,
Subj – NSAHIVNET

(a) It may be worth exploring this possibility for AFK. We need to find out more about the group – both from directly + from friends who may know, such as Dr Jacob John.

(b) Nirupama Sarma had visited yesterday, + I am just wondering whether AFK could use her health communications skills – in terms of assessing community needs, studying how information has been disseminated + interpreted by "target groups", are the methods she use getting the right messages across. Do any of the projects AFK has ep with ASAPS allow for some payment – it could fit into our financial + ethical parameters. Professionalism in health communications is essential – + Jaya Shree (Ramakrishna) has been doing a lot in this regard. We could try out Nirupama + check how she performs. You could also look at her previous work. You would be the best person as you know her.
Best regards
Sabine

>From. "Abhijit Ghosh"
>To: sapha@yahoogroups.com. AIDS-INDIA@yahoogroups.com
>Subject: [AIDS INDIA] NSAHIVNET Fiscal Sponsorship Application
>Date: Tue, 11 Dec 2001 18:11:39 -0500
>
>Please find attached an application for all interested parties to be
>considered for fiscal sponsorship of the National South Asian HIV/AIDS
>Network (NSAHIVNET). NSAHIVNET emerged from a August 2001 conference
>aimed at improving community access to HIV/AIDS preventive services for
>people living in the United States with family origins in South Asian
>and disaporic countries. The network convenes a multidisciplinary group
>of community leaders and service providers reflecting the diversity of
>South Asian communities throughout the nation.
>
>The deadline for completed applications is January 8, 2002. We anticipate
>selecting an agency to fill this important role by February 2002. Feel
>free to direct any questions to NSAHIVNET's Fiscal Sponsorship Committee
>(contact information given below). Thank you for interest in this important
>endeavor.
>
>Sincerely,
>NSAHIVNET Fiscal Sponsorship Committee
>Melindah Sharma, melindahs@yahoo.com, phone (401) 952-6953
>Neelam Gupta, neelamg@onebox.com, phone (310) 754-6226
>
>
>
>Chat with friends online, try MSN Messenger: http://messenger.msn.com

NSAHIVNET_fiscal_sponsorship_application.doc	**Name:** NSAHIVNET_fiscal_sponsorship_application.doc **Type:** Winword File (application/msword) **Encoding:** base64

TM
13/12
Leo

National South Asian HIV/AIDS Network (NSAHIVNET)

Fiscal Sponsorship Application Form

Completed forms must be returned no later than January 8, 2002

First Name:_____ Last Name:_____

Agency:_____ Title:_____

Address:_____

City_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____ Email:_____

Vision/Mission Statement:_____

_____

_____

_____

Year Founded:_____ Annual Budget:_____ Number of Staff:_____

Does you agency perform an annual audit?

❑ Yes ❑ No

Population(s) served by your agency (check all that apply and list any collaborators):

❑ South Asian (please specify) _____

❑ Asian/Pacific Islander (please specify) _____

❑ Other (please specify) _____

What charges would be associated with fiscal sponsorship (a percentage of funds, etc.)?

What services would be included (financial, insurance, human resources, administrative, etc.)?

What would your expectations of NSAHIVNET be as their fiscal sponsor?

Please indicate any additional information you would like to have about NSAHIVNET.

Please return completed form by January 8, 2001 to:

NSAHIVNET Fiscal Sponsorship Committee

Melindah Sharma, email: melindah@unionrelay.com, phone: 401-952-6953

Neelam Gupta, email: neelamg@onebox.com; phone: 310-754-6226

Subject: [AIDS-INDIA] Pill factory to the world -India's drug industry
Date: Thu, 13 Dec 2001 08:05:54 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Pill factory to the world
Andrew Tanzer, Forbes Global, 12.10.01

India's drug industry is growing beyond cheap knockoffs of Western innovation.

It's better to be a pirate than a killer," says Amar Lulla, the comanaging director of Cipla in Bombay. Lulla's outfit is the type of pharmaceutical manufacturer most associated with India: It ignores patents. Cipla's copy of Bayer's anthrax-fighting Cipro, fabricated by more than 100 Indian drug manufacturers, retails for 12 cents a pill in India, versus $5.50 in Manhattan. With reverse engineering, Cipla, whose revenue in fiscal 2001 was $226 million, makes and sells more than 400 of the world's 500 top branded drugs.

Now meet the face of a new Indian pharmaceutical industry: K. Anji Reddy, 58, the soft spoken founder and chairman of Dr. Reddy's Laboratories, whose headquarters are in Hyderabad. Reddy is lobbying the Indian government to adopt and enforce the international drug-patent regime, something that New Delhi under a World Trade Organization agreement has promised to do by 2005. Reddy aspires to build his enterprise into a research-based drug major. "We [in India] have brilliant people who are as good as or even better than anyone anywhere else in the world," he insists. "We're ready for 2005."

India, with its flowering of English-speaking, scientifically literate people, just might rise above the business of making generic drugs and ripping off patents. It could become an innovator and a respecter of intellectual property.

Dr. Reddy's invests 6.5% of its $276 million sales in research, a habit that it began in 1994. The results are impressive; the company has discovered three molecules it has licensed for diabetes drugs, two to Novo Nordisk, one to Novartis. Anji Reddy says that he's negotiating licenses for several more cholesterol, diabetes and cancer drug molecules discovered in his laboratory. For the three diabetes licenses, Dr. Reddy's should gross $72 million during the drug-development stage. After commercialization, Reddy's will earn royalties on overseas sales and hold comarketing rights in India, where 70 million diabetics live.

Even this research-rich company gets a chunk of revenue from generics. Dr. Reddy's generics, though, are increasingly of the sanctioned variety--copies of drugs whose patents have expired. In August, U.S. drug regulators awarded Dr. Reddy's a so-called 180-day exclusive period for the 40-milligram generic version of Eli Lilly's Prozac, which had just come off patent. Merrill Lynch says that Reddy's took an 80% share of the 40-milligram market within eight weeks and estimates that it will net an amazing $45 million on $65 million sales of the generic capsule this year. Merrill forecasts that Reddy's will earn $69 million, 25% of aftertax revenue; that's a better profit margin than Merck's 15%.

In April, Reddy's listed on the New York Stock Exchange and, with help from Merrill, raised $133 million. The share price has since more than doubled, to $21, and is this year's best performing ADR. At that, it is only 23 times current fiscal-year earnings and 20 times next year's projections, versus averages of 42 and 27 in the U.S. pharmaceutical

TN 12/13/01

The company symbolizes enormous national potential. India missed the industrial revolution, but it is bursting with entrepreneurs and intellectual capital. "Our chemistry skills are among the best in the world," says G.V. Prasad, Reddy's CEO (and Anji Reddy's son in law). In India a chemist with a Ph.D. can be hired for $15,000, versus $100,000 in the U.S.

But you need patent protection to keep that talent from voting with its feet. "Since patents weren't recognized in India, the best brains went abroad," explains Satish Reddy, the company's chief operating officer; educated at Purdue University in the U.S., he is Anji Reddy's son. Ajit V. Dangi, the director general of the Organisation of Pharmaceutical Producers of India, estimates that 15% of the drug scientists in U.S. laboratories are Indian immigrants. But he foresees a "revolution" in the Indian industry, including an influx of foreign investment in research and clinical testing--if the Indian government implements the patent law.

Will it? In a 1970 law the government stopped recognizing product patents on drugs. This permitted Indian drug companies to reverse-engineer Western pharmaceuticals without paying licensing fees. Foreigners' share of the Indian market collapsed from 75% in 1970 to 30% last year.

In a poor nation with scant medical insurance and with serious public health problems, the patent abrogation made eminent political sense. It may also, at least transitionally, have spurred industrial competitiveness (rare for India). Today drugs in India typically sell for just 3% to 15% of their U.S. price. V. Thyagarajan, managing director for India of GlaxoSmithKline, the national market leader, estimates that India accounts for 35% to 40% of the drug giant's global sales by volume but only 1% by value.

Anji Reddy, who founded Dr. Reddy's in 1984 with $40,000 in cash and a $120,000 bank loan, makes no apologies for his country's history. "We [Dr. Reddy's Labs] are products of that [1970 law]. But for that, we wouldn't be here. It was good for the people of India, and it was good for this company." The Reddy family's 26% stake in the Bombay-listed company is worth $430 million.

In fighting AIDS, Brazil's generics makers have gotten much ink. But according to data from IMS Health Global Services, India's active pharmaceutical sales by volume are about triple Brazil's. India gets efficiencies from huge volume. Quality is high; more than 25 of the country's drug plants have been inspected and approved by the U.S. Food & Drug Administration (FDA). The country's chemists are innovative.

http://www.forbes.com/global/2001/1210/026.html

Cross posting from Ip-health mailing list
Ip-health@lists.essential.org
http://lists.essential.org/mailman/listinfo/ip-health

HIV drugs - patents

Subject: [AIDS-INDIA] Cipla gearing up for AIDS-related drugs
Date: Thu, 13 Dec 2001 10:48:56 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Cipla gearing up for AIDS-related drugs

The Business Line 13th December, 2001 New Delhi

CIPLA Ltd. the supplier of cheap drugs to a large Nigerian AIDS Wednesday it now planned to supply affordable drugs to treat opportunistic diseases resulting from AIDS. Cipla is supplying anti-AIDS drugs to a programme to treat 10,000 Nigerian patients at a concessional price of less than $1 a day, a thirtieth of the price of the drugs in the United States. "In addition to the anti-AIDS drugs, we have started the supply of small quantities of fluconazole, a treatment for fungal infections in AIDS patients, to the charity Medecins Sans Frontieres," Cipla's Chairman, Mr. Y.K Hamied, told Reuters. The Nigerian programme, the biggest in Africa, was scheduled to start on Monday, but has been delayed.

The Mumbai-headquartered Cipla, India's second-ranked drugmaker by market share, shook the global drugs market when it made its offer of cheap anti-AIDS drugs in February, and prompted a series of price cuts by large drug multinationals. It is now offering 200 mg tablets of fluconazole, a generic copy of Pfizer's price. "If we're approached, we can also supply drugs to treat cancer, pneumonia and tuberculosis in AIDS patients at a fraction of international prices," Mr. Hamied said. GlaxoSmithKline controls the patents on lamivudine, one of the drugs in a three-drug anti-AIDS cocktail Cipla is offering.

Bristol-Myers Squibb controls the patent on stavudine, the second drug in the melange, and Germany's Boehringer Ingelheim that on nevirapine. More AIDS initiatives Mr. Hemied said Cipla wanted to broaden its initiatives in AIDS treatment. It has offered to conduct largescale clinical trials in India of an anti-AIDS vaccine being developed in the US. "We plan to launch a home AIDS detection kit and supply it cheap to poor AIDS sufferers all over the world," he said. Cipla's plans to supply anti-AIDS drugs could get a boost with the visit of a United Nations inspection team in November, he said. "We had our facilities inspected by the United Nations Children's Fund, and we're likely to be an approved supplier through them of anti-AIDS drugs to countries where patents don't apply or where they've expired," he said. As many as 25 countries have started importing Cipla's cheap anti-AIDS drugs, and some countries were interested in the process technology, which Cipla would offer free, he said. The company has also offered to supply South African mining giant, Anglo American Plc, drugs to treat its workers once Cipla's anti-AIDS products are registered in South Africa.

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

f3 12/13/01 2:23 PM

2 12/13/01 2:27 PM

Subject: [AIDS-INDIA] 60 test HIV positive in Kerala this year
Date: Tue, 18 Dec 2001 10:17:08 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

60 test HIV positive in Kerala this year

Thursday November 29, 2001

THIRUVANANTHAPURAM: As many as 60 people were tested HIV positive in Kerala this year, Health Minister P. Sankaran informed the assembly on Thursday. Replying to questions, the minister said the state AIDS Control Society, which is coordinating various AIDS awareness activities, had tested 1,270 blood samples this year.

According to official sources, an estimated 70,000 to 100,000 people in the state were infected with HIV. This estimate was worked out on the basis of periodic surveys conducted among pregnant women in the state. There were 869 reported AIDS patients in the state, but the actual number would be much higher, the sources added.(PTI)

<http://timesofindia.indiatimes.com/articleshow.asp?catkey=878156304&art_id=44169371&sType=1>

TH
19/12

Subject: [AIDS-INDIA] AIDS in Udupi
Date: Tue, 18 Dec 2001 10:23:59 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

AIDS Udupi, DK come right behind Bangalore Urban

By STANLEY G PINTO

BANGALORE: The combined HIV-positive cases in Dakshina Kannada and Udupi districts stand at 1,331, full blown AIDS cases 187 and deaths due to AIDS 21.

These figures from 1987 to June 2001, available at the Karnataka State AIDS Prevention Society make grim reading. Last year there were 1,180 HIV-positive cases reported, 136 full blown cases and 19 deaths due to AIDS. The gateway to the state is also turning into the gateway for AIDS.

Little wonder then that the combined figures of the two districts make them rank two in Karnataka after Bangalore Urban, with the largest number of HIV-positive cases and AIDS deaths. It is reported that there are 3,130 HIV cases in Bangalore (Urban) district.

The situation in the two districts offers no comfort. There are 765 cases of HIV-positive in DK and 566 in Udupi, which makes DK third in the state and Udupi fourth. The second spot for HIV-positive cases goes to Bellary (847). Udupi stands third with 169 AIDS cases, after Dharwad (256).

The first HIV-positive case was isolated in DK in 1987, thanks to the testing facilities at the Kasturba Medical College (KMC) here. Dr Ramachandra Shastry, AIDS Nodal Officer, told The Times of Indiathe figures were definitely cause for concern. He admitted the HIV-positive cases may be more as the affected feared ostracism by society and hence did not come forward for testing until they reached a full-blown stage.

Other doctors point out, ''at a time when even leprosy still attracts social stigma, HIV-positive people are afraid to come clean''. Dr Shastry notes only awareness can bring about change in attitude towards the disease and those infected.

On high prevalence of AIDS in the district, Dr V.K. Venkatesh, district health and family welfare Officer, said the strategic location of the district on National Highway 17 and migration of a large number of people to Mumbai for employment was primarily responsible for the present state.

NGOs said attempts to educate truck drivers had not elicited good response. It is estimated that India has about 3.86 million HIV-positive cases. And in Karnataka the figures stand this way till June 2001: 8,627 HIV positive cases; 1,040 full blown AIDS cases and 109 deaths.

Till a few years ago, the state had only three AIDS detecting

Lib - AIDS-India file
SN 19/12
GN 19/12

centres -- two in Bangalore and one at Mangalore. Now there are eight. Dr Shastry reasons, setting up testing centres was primary for detection.

Many districts in the state still don't have AIDS detection centres. For the people of Dakshina Kannada and Udupi alarm bells are ringing. If they do not wake up to the danger of AIDS now, many more will fall victim to the virus.

<http://timesofindia.indiatimes.com/articleshow.asp?catkey=-2128833038&art_id=147765463U&sType=1>

Subject: [AIDS-INDIA] please check your computer for this virus
Date: Wed, 26 Dec 2001 11:33:11 +0700
From: "afppd" <afppd@inet.co.th>
To: <Undisclosed-Recipient:@mozart.inet.co.th;>

Dear all,

Please read this email.

I just received an email that said I might have virus that is spread from address book to address book. It is apparently undetectable by Norton or McAfee. It remains dormant for about 14 days and then activates and wipes out hard drive data. When I checked my hard drive I did find the virus and successfully deleted it.

Since I have you in my address book I want to share this message in case you, too, picked it up. The directions for removing it are quite easy to follow.

1. Go to "start" - then to "find or search" (depending on your computer)

2. In the "search of files or folders" type in "sulfnbk.exe". This is the virus.

3. In the "Look in" make sure you are in drive C.

4. Hit "search" button (or find).

5. If this file shows up (it's an ugly blackish icon that will have the name "sulfnbk.exe") do not open it.

6. Right click on the file - go down to "delete" and left click.

7. It will ask if you want to send it to the recycle bin. Say Yes.

8. Go to your desktop where all your icons are, and double click on the recycle bin.

9. Right click on sulfnbk.exe and delete again - or empty the bin.

If you find it, send this email to all in your address book, because that is how it is transferred.

Sorry for the bad news. Hopefully you won't find it or at least will find it in time to avoid the problems with your hard drive.

Sincerely,

Lilibelle Austriaco
Programme Associate

TM 27/12

Name: 13th SAFRW- Pgme.doc
13th SAFRW- Pgme.doc Type: Winword File (application/msword)
Encoding: base64

Subject: [AIDS INDIA] MAJEED AT LAST, FACES MUSIC
Date: Mon, 24 Dec 2001 08:29:08 +0530
From: "meena" <meena@pn3.vsnl.net.in>
To: "AIDS-INDIA" <AIDS-INDIA@yahoogroups.com>, "Maitreya" <maitreya@asianctindia.com>

1 of 2

Great news maitreya! so somethings move at last.
I have in the last few years started feeling that our's is a hopeless situation, but this gives me hope. In sangli district alone we have hundreds of persons who have taken this wonder cure and have really suffered for it.
the problem is the wide spread feeling that `AIDS has no cure'.

Doctors who practice allopathy refuse to touch, much less treat PLWHA and those that do treat opportunistic infections do so from a distance. as long as they do not have to touch the patient they are willing to give medication. The fact that it has become a `govt problem' is very evident. Even second degree dehydration is not treated with intraveneous fluids. the doctors are trying to save their skin!! It is this fact that leads ordinary people to fall prey to the majids of this world. we need effective campaigns to deal with this issue urgently.

In solidarity, meena SANGRAM/VAMP.

TM
26/12

Subject: [AIDS-INDIA] Feedback from 5th International Conference on Home & Community based Care at Changmai
Date: Sun, 23 Dec 2001 23:40:15 +0530
From: Bitra George <jimmyd@vsnl.com>
To: AIDS-INDIA@yahoogroups.com
CC: SAATHI <SAATHI@yahoogroups.com>

Dear All,

This is to share with all of you my feedback on the International Conference on Home & Community based Care at Changmai, Thailand from 17th to 20th December, 2001. The theme of the conference was "Power of humanity"

(1) Importance of Home & Community Care in the era of Antiretrovirals:

Dr Eric Van Praag, Director of Care at Family Health International set the tone with an excellent plenary talk on the importance of Home & Community Care in resource rich & resource poor settings. He lamented that home care issues is 'losing ground' to the campaign for universal access to anti-retrovirals. Even in wealthy countries, home care is still needed for PLHAs to ensure adherence to antretrovirals, to provide psychological & emotional support, tackle stigma issues and providing palliative care. It was important to understand that there is no 'magic bullets' for HIV/AIDS and there needs to be a multi-faceted approach to tackle the growing epidemic. Dr van Praag was adamant that home & community based care complements the use of anti-retrovirals.

There were a number of presentations (both oral & posters) which looked at various successful models for providing home & community based care for PLHAs in Thailand, Cambodia, Uganda & Kenya. There was much more clarity on the basic concepts and definition of Home & Community based Care. There were various presentations that looked at
(a) Role of family, community, religious institutions, NGOs & Govt as well as social networks in providing care & support for PLHAs
(b) Potentialities and coping ability of family and community in handling problems and their role as caregivers
(c) Determinants of the chosen strategies/approaches (economic, social, cultural, local beliefs & values)
(d) Mechanisms contributing to success or failure of the development and implementation of home & community based care)
(e) Mobilising resources for Care & Support programs for PLHAs

There were a number of skills building workshops which looked at the continuum of care, role of family members as caregivers, improving access to HIV related treatment, home-based care, alternative care, care for children affected by AIDS, care for IDUs etc.

(2) Positive living & PLHAs:

There were some strong presentations on what 'positive living' means to PLHAs. Ms Lynde Francis from ICW, Zimbabwe made a fervent appeal for PLHAs to empower themselves with the latest information on how the virus affects the body and to fight the disease within themselves - not with drugs but with healthly living, exercise, meditation and balanced dietary habits. Different people living with HIV/AIDS from different countries talked about their experiences including stigma faced by PLHAs, the role of support groups in helping PLHAs to cope and the role of PLHAs as counsellors and care givers. There was also an Positive lives exhibition and various skill building workshops on the same issues.

There was also a strong representation of PLHAs from India who made some

[AIDS-INDIA] Feedback from 5th Internatio...n Home & Community based Care at Changmai

there was also a UNDP & Sahara sponsored symposium on Greater Involvement of PLHAs which presented the results of a number of capacity building activities identified and carried out by PLHA groups in Bangladesh, India, Nepal, Pakistan and Srilanka.

(3) Incorporating care component in Community & Prevention programs:

Presentations & posters were also made on how to incorporate care & support programs in community and HIV prevention projects in Thailand & India.

(4) Tackling stigma & discrimination in the context of care for PLHAs:

There were presentations which looked at PLHA community mobilisation and attempts to destigmatise AIDS in rural communities in India, Indonesia, Zimbabwe etc.

General points:

* Overall, the conference was well organised with topics reflecting the selected themes
* The whole concept of Home & Community based care was brought well into focus
* Officials from NACO & Ministry of Health and doctors from institutions were missing from the conference. Is it because of the low priority given to Care & Support programs in India?
* India is far behind other countries in the region (Thailand, Cambodia, Vietnam) in the area of Home & Community based care except for few hospice and community care initiatives.

Dr Bitra George
Sharan/ Salaam Baalak Trust
New Delhi

Subject: [AIDS-INDIA] Report on Skill building workshop on CAA in Changmai
Date: Sun, 23 Dec 2001 23:39:27 +0530
From: Bitra George <jimmyd@vsnl.com>
To: AIDS-INDIA@yahoogroups.com
CC: sea-aids@healthdev.net

Dear All.

The skills building workshop on programs for Children affected by AIDS was held on 19th Dec,2001 during the 5th International Home & Community Care Conference at Changmai, Thailand.

Report on the Skills building workshop on Care for Children affected by AIDS by communities

Preparatory meeting:

A meeting in preparation for the skill building workshop was facilitated by Dr Bitra on 18th December in the lobby of Changmai Orchid hotel. 5 CAA project representatives from Delhi, one CAA representative from Cambodia & FHI representatives from Zambia & Cambodia were present at the meeting. The format for conducted the skills building workshop was discussed. The participants decided that the it would be best to list seven main challenges facing CAA programs in India & Cambodia and use them for group work. The presentations would be kept to the bare minimum, but time would be given to two presentations from Cambodia. The seven issues were identified and the program details were finalized. Coffee, tea & cold drinks were served to the participants.

Workshop details:

Date: 19/12/2001

Time: 1.30 pm – 5.00 pm

Venue: Room no: 2/1, Changmai Orchid hotel

Sponsored by: FHI/Asia

Facilitator: Dr Bitra George (Salaam Baalak Trust/India)
Co-facilitator: Mr Daphneton Siame (International HIV/AIDS Alliance/Zambia)

Rappateurs: Ms Napatorn & Ms Priti Patkar

Total number of registered participants: 71

(1) Welcome & Introductions:

Bitra welcomed all the participants to the skills-building workshop. He later introduced the co-facilitator for the session.

(2) Workshop overview & Objectives:

Daphneton gave an overview of the workshop. In addition, he also stated the objective of the workshop. The broad objective of the workshop was to illustrate key program components & strategies that are required to set up support system at the community in connection to a larger system for caring of children affected by HIV/AIDS. Daphneton also clarified that the definition of Children Affected by HIV/AIDS (CAA) for the present skills building workshop includes children of sex workers, street children, infected & affected children and AIDS orphans

[AIDS-INDIA] Report on Skill building workshop on CAA in Changmai

(3) Outline of the group work:

Bitra outlined the seven issues to be discussed in different groups. He gave a brief summary of the preparatory meeting and the reason for choosing the issues. He stated that all the participants would be broken into 7 different groups through drawing of chits of paper and each group would be handed one issue for discussion. The participants were asked to locate fellow members of the group with the same name of a colour and were asked to sit in small circles.

The seven issues for the groups to discuss included –

GROUP NO	ISSUE TO BE DISCUSSED	GROUP COLOUR
1	Psychosocial support for CAA	PINK
2	Caring for caregivers of CAA	RED
3	Stigma and discrimination against CAA	BLUE
4	Life skills for CAA	BLACK
5	Repatriation and Reintegration of CAA	YELLOW & WHITE
6	Resource mobilization for communities to deal with CAA	ORANGE
7	Criminal networks and legal issues deal with CAA	GREEN

All the groups were asked to brainstorm on each issue under the following heads –

(a) What are the underlying issues or situations?
(b) How can the underlying issues be addressed?
(c) Who are the key players who can be of help?

All the groups were provided with chart papers and were asked to choose a rapporteur for the group. Forty-five minutes were allocated for the group work.

(4) Reporting back to the larger group:

After the completion of discussion and group work, the participants were asked to name one important thing that they learned during the group work. Some of the responses included –

'I have realized that inspite of the language barrier, we could communicate with each other without too much difficulty'

' I realized during the group work that there is a need for providing care to the caregivers'

' The problems with Children affected by AIDS are similar despite variation in terms of geography, culture & traditions'

'The participants from various countries felt a common bond unifying them and felt that the most important need of the hour was to care for the next generation'

After the tea & snacks break, each of the groups were provided 5 minutes for presentation after which there was a

discussion on the issue in the larger group.

Group 1: Stigma and discrimination against CAA

Underlying Issues	How to address the issue	Who are the key players
CAA were excluded out of children groups	· Provide knowledge on HIV/AIDS to the community and caretakers	Social worker· Health workers· Home-based care worker· NGO and government
CAA were excluded out of school	· Provide HIV/AIDS awareness to teachers and school program · Motivate teachers and students to be compassionated	Collaboration between the Ministry of Health and Ministry of Education and religious institution
Loss of business & source of income	· Micro credit program · Vocational training · Marketing Raising awareness on HIV/AIDS to the community	· NGO health worker · Church · Government Ministry of Health
Abandoned by relatives and community	· Raising awareness in community & relatives · Orphanage/ shelter homes	As the abovePagodaAnd other department

Points of Discussion:

1. Within schools, teachers and principles need to be sensitized.
2. Perceived self stigma among infected/affected children need to be addressed.
3. The role of the social workers is also important as they are key players to speak to other people in the community and help in creating awareness
4. Sensitization & Advocacy is carried out at different levels by different key players
5. Community needs to be identified as key player.
6. What about children themselves as key player (peers)?
7. Information and knowledge needs to be provided at different levels for prevention as well as addressing their own stigma

Group 2. Psychosocial support for CAA

Situation	Underlying Issues	How can it be addressed	Key players
· Vulnerable (street children & children of sex workers) · Affected (Parents are living) Crisis (parents have died) · Infected · Grandparents as caregivers	· Insecurity · Fear · Grief Depression · Self discrimination · Education · Social Interaction	· Support from extended family · Adoption or foster care · Refer to other service providers (orphanage) · Skills training · Group support · Counseling for both parents and children · Recreation	· Older siblings · Parents · Relatives · Neighbors · Community leaders · Religious leaders · School teachers · Counselors · Outreach workers

Points of discussion:

How do we reveal a test result to the child? How do we break the news of parents being infected and parents die?

There was discussion on this issue but the consensus was that

- Child needs to know and the best people to inform the child are the parents themselves. It is been seen that caregivers and especially parents think that the child need not know but it is important to understand that children are intelligent and will find out from other sources. Parents should be encouraged to talk to their children and not leave it to the last minute.
- Specialist in child counseling could be involved in the process and the process of disclosure could be slow and gradual. There is a need at the community level to create awareness that children understand therefore tell the children. Hiding HIV test status from the children will make them feel more traumatized and therefore the damage would be even more.
- Kenya example-Children don't undergo volunteer testing unless they are sexually active or married so there is no question of revealing their own or parent's HIV test status.
- In various cultural contexts like India, people don't like to talk about death. The participants stated that children should be prepared about the parent's illness and their death.
- Lessons from Uganda have shown how memory books could be used to record happy moments in the parent's lives for their children in the future.

What would happen if the child came to know that their parents have got HIV through an immoral act?

The consensus was that it was important that the child is told about the virus and not how the parents got the infection. It is also important to help the child understand and cope with the situation. Counseling of parents and family members how to break the news to the child need to be encouraged.

Group 3. Caring for caregivers affected by AIDS

Underlying issues	How can it be addressed	Key players
· Poverty (child employment, orphans) · Education · Social environment: drug addiction, sex worker, rejection · Illness/Medical care · Early marriage · Lack of guidance · Lack of shelter · Nutrition · Effects on the caregivers A: Overwhelmed by the issue, the stress & psychological problems B: the lack information if they work in isolation C. lack of resources, lack of training D: Strained relationship with the children E: Stigmatization F: Risk of infections	· Advocacy · Improve education and training to the care-givers · Resource mobilization, lobby and income generating activity · Provide psychosocial support · Legislation / policy improvements (eg. Early marriage) · Improve access to healthcare · Provide daycare center · Improve the agriculture	· Care-givers (Grandparents, Parents, Widows/Widowers, Relatives and extended family, Elder or younger siblings, Social workers, Foster parents, Health workers, Volunteers, Teachers) · PLWA · Religious organization, NGOs, UN agencies · Government to take the lead · Healthcare workers & health care centers · Institutions

Points of discussion:

There was a discussion on the need for relief for caregivers. Some practical methods of providing respite include –

(a) Buying rations/grocery for the household

(b) Being at the bedside for sometime so that the care giver can have some time to sleep & relief.

(c) Paying for their bills.
(d) Chatting with the caregiver in person to allow ventilation of feeling & emotions.

Stress management program & training of caregivers to help in coping with the situation

Group 4. Life Skills for CAA

Underlying Issues/situations	How can it be addressed	Key players
· Care-giving (children as caregivers) · Access to education · Dealing with empowerment-economic, social, psychological, political · Decision making-sexual life/drug · Vocational skill for livelihood · Dealing with emotional effect of care-giving and all other issues (grief and loss) · Social life – friends, play · Health · Access to good nutrition · Dealing with cultural context (Taboos), maintaining cultural, religious, spiritual life · Self esteem, Self actualization, and Mental Health	· Education and training · Daycare center · Lobby the government, NGOs role, church group, community and other programs · Children involvement at every stage as planners/managers etc · Get understanding of knowledge and attitudes · Education through dramas, games, plays, story telling-assertiveness · Technical training, train as health educator · Harm reduction and counseling · Group therapy · Monitor and get access to referral system, health training in school and health monitoring by students volunteers and health camp · Nutrition skills, cooking, growing food · Support groups (peers activities-painting, music, physical activities, sports clubs, group activities, teachers	· Children · Teachers · Remaining family members · Friends/peers · Health personnel · Community (leaders) · NGOs · Government local, state, national · Religious leaders · International community · Donor agencies

Points of discussion:

What is life skill education?

Skills needed for people/children to handle/cope with every situation in life. Should we insist for formal education or should be explore incorporating life skills in non-formal education program also.

How can we conduct sex education, as it is a taboo in many countries?

Sex education can be termed family life education or value education for acceptance. One needs to be careful about how it is presented and how it is packaged and what are the basic messages.

Who should be teaching life skill education?

We don't have to rely on professional all the times – different trainers and different organizations can accomplish the same task.

Group 5. Resource Mobilization for Communities to deal with CAA

Issues	How can it be addressed	Key players
· **Home based care:** Stigmatised healthcare setting/ workers, lack of acceptance, lack of skill, obstacles, traffic jam, difficult in accessing, needs of children & women ignored most often	· Structure/system within the community · Strengthen and empower PLHA within community · Community Education and awareness (media, peers health, representation of common group/committee, fund generator, fund raising)	· Training of volunteers · Volunteers should be PLWA/Family extended · Develops power within PLWA-define their own need objectives and roles
· **Education:** Facility for children to study at home (non formal education)	Study groups, NSS, other students, Peer support, Big Brothers/Sisters, teacher-empower them	
· **Home visits:** Stigma attached during disclosure	Educate healthcare workers	
· **Health:** Accessibility/ Non affordability, orphan care and fear	· Rotary club/Health camps · Community health center · Referral system	
· Collaboration, integration, linkages	· Holistic approach · Availability in community · Who takes initiative · No competition · Do not duplicate · Better coordination · Build networks · Open mindedness	
· Nutrition & Poverty	· Mother education on nutrition · Teaching family to grow their own food · Participation of children themselves	

Points of discussion:

(a) We need to contact other and explore the services that exist to avoid replication.
(b) Resources doesn't mean only financial. It could be services, time and personnel.
(c) We need to compliment each other.
(d) There is a need to map resources within the community, Need to do community assessment.
(e) Need for capacity building of family.
(f) Resource mobilization with an emphasis on prevention more than curative.

Group 6. Repatriation and Reintegration of CAA

Issues	Address	Key Players
· Abandoned children	· Identify an extended family	· Social worker and community
· No family (orphan)	· Adoptions (Processes orphanages)	· Social worker, volunteers institution, NGOs
· Street children	· Temporary shelter	· NGOs/Gos, social workers
· Abuse children: sexually, physically, and psychologically	· Temporary shelter · Counseling session · Peer support	· NGOs/Gos · Psychologists · Social workers · Medical personnel · Peers
· Dysfunctional family	· Responsible parenthood · Initial assistance · Case management	· NGO/Gos · Social workers
· Temporary/transitional family problems · Dead, sickness · Parents troubles	· Temporary shelter · Extended family support	· Social workers · Community workers · Health peers · 2nd/3rd degree relatives
· Disintegrated family	· Extended family · Community support	· Social workers · Community workers · Health peers · 2nd/3rd degree relatives
· Child Labor	· Employers must be given information against child labor · Awareness	· Government · Legal issue
· Sick children (infected)	· Hospitalization · Follow up · Information to mother · Nutrition · Counseling · Education	· Parents · Teachers · Peers · Health workers · Social workers · Religious organizations
· Trafficking of children	· Counseling · Shelter · Education · Vocational training · Networking	· Government · Police · Social workers · Community workers

Points of discussion:

1. Repatriation is a difficult process and a very challenging one.
2. There are some situations where repatriation will not help and should be avoided.
3. One needs to understand the family situation before repatriating the child.

Group 7. Criminal networks and legal issues deal with CAA

Issues	Address	Key Players
· Child prostitution/Pornography · Child labor - domestic, industries. Errand boys/girls · Child soldiers · Child sacrifice · Domestic sexual abuse/ physical abuse · Children involved in drug trafficking · Illegal adoption · Inheritance rights · Child headed families are vulnerable to being inducted into criminal activity	· Policy guidelines by-state that considers children. · Laws protecting the child (children's rights to education, security, etc) · Law enforcement (has to be prompt) · Study and sensitise children and the community and law enforcement machinery · Advocacy for support networks-help line, children welfare society and active juvenile courts	1. Children 2. Government – Ministry of Labor, Ministry of Public Health, Judiciary, Police, and Social Welfare 3. Immediate family, community (neighborhood) and the general society 4. NGOs 5. Schools/educational systems 6. Religions leaders 7. International Communities like UNICEF, Save the Children, USAID, FHI, UNESCO, World Vision etc. 8. Local Leader

Points of discussion:

Policies usually present but there is poor implementation by legal authorities, no political will, corruption.

(5) Presentations by CAA projects of Cambodia:

After the group work, there were presentations by 2 CAA projects of Cambodia.

(a) How to create Kien Kes volunteer network by Venerable Khut Ung
(b) Social support to Children affected by AIDS and families by Sok Sophal

The presentations brought into focus the human face of the issue of Children Affected by AIDS and the difficulties faced by them.

(6) Concluding remarks:

Bitra summarized the various issues discussed at the skill- building workshop. He thanked all the participants and hoped that it was useful. The participants were asked to collect all handouts (Report on CAA projects in India, leaflets on various CAA projects in India & Cambodia) along with limited copies of the facilitator's guide " Teaching life skills & reproductive health to vulnerable children".

Dr Bitra George
Salaam Baalak Trust
New Delhi, India

Subject: [AIDS-INDIA] MAJEED AT LAST, FACES MUSIC
Date: Sat, 22 Dec 2001 09:29:22 +0530
From: "Maitreya" <maitreya@asianetindia.com>
To: "AIDS-INDIA" <AIDS-INDIA@yahoogroups.com>

Dear Forum Members,

T A Majeed, proprietor of Fair Pharma, was today restrained by a Division Bench of the Kerala High Court from manufacturing, marketing, selling and advertising (including to hold a website) by any mode the drug he claims to have developed for curing AIDS, mental retardation and cholesterol, which requires license. The State unit of People's Union for Civil Liberties (PUCL) filed a public interest litigation, a month back, against Majeed in the High Court of Kerala. They sought to stop Majeed from manufacturing, marketing and selling any drug claiming to cure all the above mentioned diseases.

They asked the court to give a direction that the so called 'magic cure' should be clinically tested by expert bodies like National Institute of Communicable Diseases, National Institute of Virology and Centre for Advanced Research in Virology before being marketed. The court complied. Majeed was selling his drug under the Drugs and Cosmetics Act.

After incessant requests from activists it was cancelled by the Drug Controller of India. But Majeed got a stay order from a single bench judge of Kerala High Court and was going on doing brisk business. The High Court today through its order cancelled the stay. So that is the beginning of the end of Majeed and his magic medicine, I hope.

Please communicate this information with the public at large through all means of communication so that they may not be swindled in future. Majeed may still find means to circumvent this order, so it is our duty as health activists to defend this order and propagate this information.

Love
Maitreya
maitreya@asianetindia.com

TH
26/12

Subject: [AIDS-INDIA] Fw: Bihar: AIDS fund goes unutilised
Date: Fri, 21 Dec 2001 09:30:18 +0530
From: "ihoaids" <ihoaids@vsnl.com>
To: <AIDS-INDIA@yahoogroups.com>

Dear all,
This news about the underutilisation of NACO funds in Bihar will now set the hectic parleys to utilise the remaining 65% funds amounting to 1.3 crore Rs. in what is termed as '31st March Syndromme' - utilise the allocated budget before the end of finanancial year!

NACO and several of its constituent bodies - State AIDS Control Societies and their funded NGOs, like other government departments, are known for such spendings during last couple of years. Such spending are mere wastage and amounts to large-scale corruption/ siphoning of public funds, hence should be avoided. If there is no concrete program at hand, better freez that money and spend for next financial year.

Dr.I.S.Gilada
inoaids@vsnl.com

TM
26/12

Subject:
[AIDS-INDIA] Bihar. AIDS fund goes unutilised
Date:
Fri, 21 Dec 2001 01:34:53 -0000
From:
AIDS-INDIA@yahoogroups.com
To:
AIDS-INDIA@yahoogroups.com

AIDS fund goes unutilised

SACHCHIDANAND JHA

TIMES NEWS NETWORK

PATNA: Of the Rs 2 crore released by the National AIDS Control Organisation (NACO) to it last year to launch an AIDS awareness campaign across the state under information, education and communication (IEC) programme, the Bihar State AIDS Control Society (BSACS) has so far spent only Rs 70 lakh.

In fact, slow spending of the Central fund has considerably affected implementation of the AIDS control programme in the state. The BSACS, in all, has received Rs 7.5 crore from the Naco. Of this sum, it has been able to spend only Rs 3.05 crore. Of the 846 blood samples tested since April this year at the voluntary counselling and testing centre located in Rajendra Memorial Research Institute of Medical Sciences, Agamkuan, Patna, 170 had tested HIV positive.

While the BSACS has put up an AIDS Clock near the income tax roundabout here displaying the monthly figure of HIV/AIDS in the country and Bihar, the same is yet to be put up at other district headquarters and in remote areas. Then,against a target of distribution of 10 lakh condoms free of cost, only 50,000 condoms have been distributed.

The distribution of condoms at line hotels and other transit points considered to be high risk zones has not been done, while AIDS literature and pamphlets are yet to reach people in the remote areas.

The fortnight-long Yauvan Mangal Mela organised at the block headquarters in June this year proved to be a damp squib as far as IEC programme is concerned. The AIDS control officials are now wary of even talking about it. A senior BSACS functionary said feedback received about the Mela was not very encouraging. Now, there is a plan to organise similar Mela, under the name Family Health Youth Mela, next February hoping for a better result.

The accountant general, in its inspection report sent to the state health department, had taken strong exception to the tardy implementation of the AIDS control programme in Bihar.

BSACS project director C K Anil said AIDS Clock is yet to be put up at 37 district headquarters, while 300-square-feet hoardings carrying information about the disease had been put up at the district headquarters. Besides, AIDS message had been written on walls of all the primary health centres and referral hospitals of the state, he added.

Anil said to prevent the transfusion of infected blood to people, Elisa Reader had already been installed in the micro-biology departments of five of the six medical college hospitals, Regional Blood Bank, Patna, and Indira Gandhi Institute of Medical Sciences. The sadar and sub-divisional hospitals, however, were yet to get Elisa Reader.

---

http://timesofindia.indiatimes.com/articleshow.asp?catkey=-2128817995&art_id=479035566&sType=1

TH
21/12

Subject: [AIDS-INDIA] PHO DECRIES FALSE AIDS ALARM:
Date: Thu, 20 Dec 2001 11:35:52 +0530
From: "ihoaids" <ihoaids@vsnl.com>
To: "AIDS -INDIA" <AIDS-INDIA@yahoogroups.com>

PHO DECRIES FALSE AIDS ALARM:

People's Health Organisation (India) feels that, the news 'Alarming rise in HIV among city's Married Women' published in a section of press as a false alarm with motives of scare-mongering and unfair intentions, when HIV is actually levelling off here.

The study was supposedly done by National AIDS Control Organisation (NACO), National AIDS Research Institute (NARI) (Indian Council for Medical Research-ICMR) and AIDS Research Control Centre(ARCON). The HIV prevalence of pregnant women has been shown as 3.5% based on a sample population of 8000 women attending JJ, Nair and KEM Hospital during last 18 months and a sample of 400 women attending Municipal and private clinics during August-October, 2001.

PHO challenges this study and its generalisation to the entire Mumbai's population; which is 1/8th of the state's population, on following counts:

1) All the three hospitals used in study- JJ, Nair and KEM, are tertiary referral hospitals, where complicated cases are referred for special management from periphery of the state if not rest of India. Referrals also include women with HIV/AIDS, detected elsewhere. Just 1% referrals can increase HIV prevalence by 1% of the entire study sample.

2) JJ and Nair Hospitals are in close proximity to the country's largest redlight areas. HIV prevalence among Mumbai sex workers is between 50-70% in different areas. Even a small presence of upto 2% of sex workers among pregnant women can increase HIV prevalence of the entire study population by 1%.

3) When one says, there is an alarming rise of HIV in a particular population; it has to be based on a 'baseline' figure in the same population; which is lacking in the current study.

4) The current HIV prevalence among pregnant women at Wadia Hospital, next door to KEM Hospital in PHO-Wadia project; which has Asia's largest such study to its credit having screened 110,000 women in 9 years, is below 2% and is almost static for 5 years.

5) HIV prevalence in donors (mainly adult male population) of all the city blood banks is less than 2%. Hence, HIV rates in female gender of same population cannot be higher; unless and until extra-marital sex among married women is more common than in men.

The negative fall-out of such false alarm is that all pregnant women will be seen with suspicion of HIV; women will be scared to go to these hospitals for fear of being detected HIV carrier; city women will face discrimination elsewhere in country at treatment points and matrimonial problem for city girls.

PHO demands thorough investigations in this study and an immediate clarification from NACO and ICMR.

Dr.I.S.Gilada, Secretary General, PHO

Peoples Health Organisation (India)
Municipal School Building, J.J. Hospital Compd, Mumbai-400008
Tel.3719020; Fax: 3064433; E-mail: ihoaids@vsnl.com

Subject: [AIDS-INDIA] AIDS Prevention for Indian armed forces
Date: Tue, 18 Dec 2001 10:18:32 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Dear Forum members,

[The following statemnet " Pregnant women, if found to be infected by their spouses, are administered with limobledin, which minimises the chances of transmitting the infection to the new-born" is interesting. Moderator]

Prevention better than cure for the armed forces

Friday November 30, 2001

PUNE: Are you interested in joining the country's defence forces? Then get an Acquired Immuno Deficiency Syndrome (AIDS) test done at the earliest or face the consequences of being thrown out from the services, if later caught to be harbouring the killer virus and consequently declared medically unfit.

To make a beginning, this message is being clearly spelled out to all personnel of the armed forces. And the reason given by Lt. Gen. M.A. Tutakne, commandant, Armed Forces Medical College, is the alarming increase in the number of human immuno virus (HIV) cases across the country.

"A person is taken in the defence forces to save the nation. And if that person is found incapable of delivering the goods, there is no reason why he should be allowed to hang on," the commandant reasoned, adding, "We don't want to take any chances."

Admitting that the number of HIV cases detected within the defence forces have increased in recent years, Lt. Gen. Tutakne said that a specialised health education programme has been recently inducted in the course curriculum of the cadres at all levels. "I cannot reveal the figures as it will not only send out the wrong message but it will also violate the supreme court order in this regard," he added.

Lt. Gen. Tutakne said a separate AIDS control organisation has been set up in the AFMC. The unit works in collaboration with the National Aids Control Organisation (NACO). "These two organisations are working in tandem on issues related to HIV cases in the defence forces," he said, adding that NACO is also providing funds to fight the disease.

The commandant, however, favoured a proper AIDS screening mechanism at the beginning of the training. "Maybe the situation is still considered to be not so alarming as to make it mandatory for such a test," he said, adding that there were also the human rights violations to think of.

Speaking on the steps taken by the AFMC in this regard, he said cadets found to be carrying the virus are made to undergo a post-exposure prophylyxis. This is the stage when medicines fail to react and the affected persons are asked to take personal preventive measures. Pregnant women, if found to be infected by their spouses, are administered with limobledin, which minimises the chances of transmitting the infection to the new-born.

To spread awareness about AIDS and observe World AIDS Day on December 1, the AFMC has planned a motorcycle rally and an exhibition on the campus.

Lib - AIDS - India file

Subject: [AIDS-INDIA] 'GAURAV SAMMAN 2001 AWARD' TO Dr.GILADA
Date: Mon, 31 Dec 2001 12:03:05 +0530
From: "ihoaids" <ihoaids@vsnl.com>
To: <editor@expressindia.com>, <meenal@mid-day.com>,
"The Statesman Limited" <thestatesman@vsnl.com>, "The Telegraph" <ttcal@cal.vsnl.net.in>,
<editor@tribuneindia.com>, "Sudip Mazumdar" <sudipmazumdar@vsnl.com>,
"Saira Menezes" <magnapub@vsnl.com>, <afpbom@vsnl.com>,
"aids-india" <AIDS-INDIA@yahoogroups.com>, <apurvabhatt@yahoo.com>,
"Metro News" <metronews@zeenetwork.com>

December 31, 2001

'GAURAV SAMMAN 2001 AWARD' TO Dr.GILADA FOR HIS WORK IN AIDS FIELD:

The well-known AIDS Expert of India and Secretary General of the People's Health Organisation (India), Dr.Ishwar S. Gilada, who has been tirelessly spearheading the fight against AIDS since 1985, has given prestigious award "Gaurav Samman -2001" by the Uttarpradeshiya Mahasangh. Captain Yogesh Dube, Chairman of the Mahasangh and Chief organisor of the National Convention of the Uttarpradeshiya Mahasangh said "We feel a great pride of Dr.Gilada being an expert of AIDS Awareness, his work and name is a prestige for India and is appreciated internationally, why not us?" Members of the Parliament Smt. Prabha Rau and Shri Subil Dutt presented the award at the glittering ceremony held at General Wadya Maidan in Borivali in North Mumbai and attended by over 25000 people of Uttar Pradesh origin and the friends of UP.

Other recipients of the awards for their yeomen services in the respective field of work were- Film Director Mahesh Manjarekar, Lyricist Naushad, Cardiologist Dr. Lekha Pathak, Critical Care expert of Hinduja Hospital Dr.Sanjoy Bhuiyan, Philanthropist-Businessma Shrikant Jalmian. The eminent personalities like President of Maharashtra Congress Committee Shri Govindrao Adik,Cine stars Arun Govil, Mukesh Khanna, Anjan Srivastav were present.

This recognition to Dr.Gilada comes at a time when India in general and UP in particular is passing through difficult time as regards to HIV/AIDS. He is known for his spirit of creative innovation that accounts for his unusual success. He conducts a tremendous number of activities with a very limited resource base. He is responsible for starting and running the People's Health Organisation (India) (formerly Indian Health Organisation) since 1982, which is the first and the single largest NGO in the world in AIDS awareness. He has several firsts to his credit: India's first AIDS Awareness campaign, first AIDS Clinic, first Mobile AIDS Clinic, first successful AIDS intervention project 'Saheli' for Sex Workers, first AIDS Counseling Centre, first AIDS Hotline, first Anonymous HIV testing centre and first Coprehensive HIV Management Clinic.

Born in a large orthodox family in Latur and brought up with lots of hardship, Dr. Gilada has come a long way in bringing Mumbai on AIDS control map of the world, carrying out social reforms through medical profession in tackling sensitive issues like prostitution and AIDS. He had travelled to more than 30 countries, presented 170 research papers at several international meetings, addressed over 4000 public meetings and training programs in India covering 16 states. He has more than 55 awards to his credit, including the Annemarie Maqisan International AIDS Award-1999, endowed with Rs.250,000/- in Germany in recognition of his work for AIDS-patients in India describing him as 'the Indian Machinegun against AIDS'. He had organised several national and global meets including the World Congress on AIDS in Mumbai in 1990.

GH Lib AIDS-India file
1/1 Jw

In response, Dr. Gilada thanked the Governing Board of Uttarpradeshiya Mahasangh for the honour accepted it with utmost humility. He said, such encouragements and recognitions would go a long way in furthering my aims and objectives in the service of humanity through the PHO. He said, I regard this award more than the International Award, as this is the recognition in my Karma bhoomi; where I have spent over 20 years of public life.

Dr. Ghanshyam Bhimani, Associate Secretary- PHO

Subject: [AIDS-INDIA] New Year Greetings and Personal Thanks
Date: Sun, 30 Dec 2001 13:06:47 +0530
From: "subha raghavan" <subharaghavan@aol.com>
To: "subha" <ssr12@columbia.edu>

Dear SAATHII advisers, members and well wishers,
Wish you all a Merry Christmas and Happy New Year. I hope 2002 will bring us all little bit more closer and together in fight against HIV in India. I would like to take this opportunity to thank you very much for your advice, participation and input in our activities in India or for Indians. Many of you lend us your time, your name and your resources, which made many of our activities possible and successful. Many of you have spent countless hours advising me and encouraging us to move ahead with our activities, despite our lack of experiences or major financial resources. I am truly grateful for every minute of your time.

Each of you play crucial and varied roles in tackling HIV epidemic in India. Our role is to bring all of you to the table for continued discussions and debates. Many times it is very difficult (next to impossible) as all of us have various platforms or opinions or different bureaucratic affiliations in fight against HIV. We at SAATHII strive to be a neutral body, with an understanding that any less contribution from each of you will be a major loss towards prevention, care, treatment and advocacy.

Thus it will be our responsibility and continued commitment to bring all us of together from time to time, despite our disagreements. I am sure all of us agree that we are working towards only two goals ''to protect one billion from being infected'' and ''caring for 5 million who are infected''. We hope to see you at the India-Satellite meeting in Barcelona. Everybody who attended Durban satellite went away with positive spirit and we would like to replicate that spirit with much more focused agenda in Barcelona.

Please continue to send your suggestions, criticism and good wishes.

In solidarity

Subha for SAATHII

SAATHII 2001 Update:

INFORMATION DISSEMINATION has been our number one focus in last two years. Many have come up to us personally at various conferences to inform us that the information (research, funding and training) we disseminate via SAATHII (saathii@yahoogroups.com) list serve is very useful for those with limited electronic resources and time. We will try to improve our technology and services as resources become available for us to do so. We are currently serving 1050 individuals via this list serve.

We also would like to thank AIDS INDIA forum (AIDS_INDIA@yahoogroups.com) for their collaboration with SAATHII in information dissemination. We hope to co-ordinate our list serves better in future to avoid duplication.

Lib - AIDS - India file

[AIDS-INDIA] New Year Greetings and Personal Thanks

AIDS-INDIA electronic forum fosters daily discussions and sharing of information about HIV issues in India among 850 groups or individuals working in or for India.

SAATHII Website (www.saathii.org or www.hivindia.org) dedicated to providing India specific HIV information is getting constructed and will be able to provide valuable information some time very soon. If you would like to assist us any way to speed up the process please let us know.

SETTING UP AN INFORMATION RESOURCE CENTERS FOR/IN INDIA: We are trying to set up a resource center in India to disseminate information for those with no access to Internet and also to disseminate information that can't be transmitted via e-mail (e.g books, CD ROM, UNAIDS/WHO documents). Organizations with similar interests and have funding, please do e-mail us so that we can move ahead with this endeavor soon. We would like this resource center to be lead by PWA organizations, hoping that this center can be used for support groups and training of PWAs and small NGOs.

ORGANIZING SATELLITE MEETINGS AND ADVOCAY EVENTS has been our number two focus. We had conducted several satellite meetings, facilitated several discussions, and organized advocacy events with specific emphasis on India/ASIA. All these meetings were possible only due to your valuable presence and input. THANK YOU VERY MUCH FOR PARTICIPATING AND CONTRIBUTING TOWARDS THESE EVENTS. Your intellectual and moral support (and where ever feasible financial support) keeps us moving ahead in a positive direction.

We are very excited about our upcoming India Satellite at the World AIDS Conference in Barcelona. You will be receiving a preliminary announcement about this very soon. Those who are interested to co sponsor, collaborate or assist us in any way please do write to us. We would like to make this a valuable meeting for sharing ideas, networking, and setting priorities. I hope we all can work together to have one meeting rather than two to three competing meetings.

NETWORKING various individuals and organizations has been and will be a mantra for SAATHII. It was gratifying to note that at the recent meeting with the Health Minister at UNGASS, many NGO expressed their interest in making SAATHII as a central mechanism for communication related to HIV issues for the whole country. It is an ambitious project, however, we will be able to make this happen by end of 2003 with the assistance of a small grant we received from the John Lloyd Foundation. We thank JOHN LLOYD FOUNDATION for their interest in SAATHII.

This grant will enable us to map the services in India and network various organizations either by state or issue. Of course we will need lot of help from you to make this happen. We will request specific information about your programs some time very soon. If you would like to collaborate with us on mapping the HIV services in India, please send us an e mail. SAHAYA (www.sahaya.org) is serving as a fiscal sponsor and collaborator for this project, as SAATHII is not yet 501c approved for receiving funds. We thank SAHAYA profusely for their assistance.

Sai Subhasree Raghavan, Ph.D. ,

Subject: [AIDS-INDIA] Organisers expand scope of 2002 AIDS meeting
Date: Sat, 05 Jan 2002 04:18:21 -0000
From: "Joe Thomas" <joe_thomas123@yahoo.com.au>
To: AIDS-INDIA@yahoogroups.com

Organisers expand scope of 2002 AIDS meeting

In an effort to close what they feel is a serious gap between AIDS scientists and people working on the ground in the fight against the worldwide HIV epidemic, organisers of this summer's XIV International AIDS Conference have reformatted the meeting to give greater prominence to prevention, implementation, and policy. The biannual conferences have become perhaps the most influential meetings in the area, and the July 7-12 meeting, which will be held in Barcelona, Spain, is expected to draw more than 15 000 scientists, clinicians, activists, and journalists from around the world.

Past conferences have placed a heavy emphasis on biomedical research, while prevention and field-based programmes have tended to receive much less attention, says Jordi Casabona, director of the Centre for Epidemiological HIV/AIDS Studies (Catalan Health Department, Barcelona) who with Jose Maria Gatell of the Infectious Disease Unit, Hospital Clínic de Barcelona, will co-chair the Barcelona conference.

This was understandable, Casabona says, because at the time AIDS was a new disease and little was known about the causal virus. But as the epidemic has grown and evolved, it has become increasingly clear that a purely "biomedical" approach will not be enough. "In Western countries, for example, the focus of AIDS research has been primarily on drug treatments", he says. "We now have an idea of what drugs can achieve--that they can dramatically alter the course of the disease and prolong life--but we also know they will not end the epidemic." To do this will require effective policies and programmes that promote science-based prevention and provide affordable access to effective treatments, he says.

The challenge is to translate what we know into effective action, he says, for good science is of little use without good programmes and policies. "Often there is a disconnect between what we know works and policy", he notes. "Laws that prevent needle exchange programmes are a good example of this. Needle exchange is restricted because of cultural and political concerns, despite the scientific evidence that it works." Thus, to try to forge closer ties between scientists and the community, the conference organisers have created the "Barcelona framework", which organises the conference programme around two main components: one, dedicated to "science" and one dedicated to "action" with bridging sessions where scientists and those working in programmes and policy can meet and discuss the issues.

Casabona says the goal of the framework is to maintain the scientific quality of the meeting, which will continue to have tracks featuring presentations of new work by the world's top researchers in the basic, clinical, and public-health sciences, but also to provide a high-profile venue where programme and policy issues can be presented and discussed.

In addition to the new format, the conference will have three new tracks: "Prevention Science", "Interventions and Program Implementation", and "Advocacy and Policy". The prevention science track will be added to the science component. In past meetings, the conferences had no special venue for prevention research, Casabona says, and, as a result, good papers on prevention were often

TH
7/1/02

scattered throughout the meeting diluting their effect. There was also a feeling that prevention research was less scientific than clinical studies. This perception is untrue, Casabona says, pointing to a growing body of prevention research that has been conducted as rigorously as are clinical trials of drugs.

The prevention science track will bring together researchers in all areas of the field, from scientists working on new vaccines and microbicides to field workers conducting behavioural work in the community. "You can't separate biological and non-biological interventions, because they must be used together", Casabona says. "To prevent mother-to-child HIV transmission, for example, you need to give antiretrovirals to infected pregnant women, but you also need to increase testing coverage and primary prevention among young women."

The interventions and programme implementation track, which will be part of the second "action" component of the conference, will focus on how to take research findings and put them into practice, says the track's co-chair Ron Valdiserri, deputy director of the National Centre for HIV, STD, and TB Prevention at the US Centers for Disease Control (CDC) and Prevention. "For example, how do you take a successful study that involved a few hundred people and translate its findings into a programme involving thousands, even tens of thousands of people", Valdiserri says. The track's sessions will include a mix of presentations of peer-reviewed abstracts, talks by invited speakers, as well as debates and group discussions. The focus will be on how to design, implement, and sustain effective programmes.

The last new track, advocacy and policy, will focus on how to create a political, social, and cultural climate that will help people fighting HIV/AIDS succeed. The sessions will address such issues as the mobilisation of community resources, priority setting and resource allocation, trade and intellectual property rights, and how to empower marginalised groups such as sex workers, sexual minorities, and refugees. "In my mind, policy and advocacy underlies everything that has happened, is happening, and will happen in response to HIV/AIDS, but we have never addressed it before in a coherent way", says track co-chair Margaret Duckett.

The goal of bridging sessions will be to bring people from all the tracks together to discuss common concerns. "My own personal view is that the real challenge for the Barcelona conference is the bridging sessions", says Luis Guerra Romero, a technical adviser to the Secretary of the Spanish National Plan on AIDS and an advocacy and policy track co-chair. One such session might be entitled "Vertical transmission: from molecules to programmes", he says, and would include presentations on the biology and epidemiology of mother-to-child HIV transmission, the efficacy and effectiveness of drug treatment, and community support and advocacy for HIV testing, counselling, and treatment in pregnancy.

The strength of the Barcelona meeting will be its scientific rigour and its multisectorial approach says Casabona. "As a public health problem, the fight against AIDS needs both of them." (More information is available at www.aids2002.com. The deadline is Jan 14 for abstracts on paper or disk, Jan 21 for online submissions, and June 1 for late-breaking reports.)

Michael McCarthy
http://www.thelancet.com/journal/journal.isa

Subject: [AIDS-INDIA] Consultation Meeting on Male Sexual Health in Nepal
Date: Sat, 05 Jan 2002 02:28:58 -0000
From: "cspsb" <cspsb@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear Forum members,

Blue Diamond Society Nepal is organising a consultation meeting on Male reproductive and sexual health in Kathmandu on 11th- 13th January 2002. For more information contact:

Sunil Babu Pant
GPO Box:8975, EPC No: 5119
Kathmandu Nepal. Ph:+977 1 427608

Email:cspsb@yahoo.com

FN
7/1/02

Dear Arabinda Pani & Aarti Kumar
I write from the Community Health Cell, a professional resource group in public health/community health in response to your AIDS-India email. We would like to have a copy of your booklet 'Hand in Hand' for our library/information centre, which is used by several groups/individuals.
Thanking you and with best wishes, Yours sincerely, TN 4/1/01

Sent 4/1/02

Subject: [AIDS-INDIA] Hand in Hand
Date: Thu, 3 Jan 2002 11:32:59 +0530
From: "Hand in Hand" <handinhand_india@yahoo.com>
To: <AIDS-INDIA@yahoogroups.com>

Dear Forum Members,

HIV/AIDS increasingly threatens all of India's people, and more and more children are becoming victims. Some of these children are HIV positive, and many have been or soon will be orphaned by AIDS.

It is imperative that all types of social support be strengthened as the numbers of these children increase. We strongly believe these children can be integrated into existing child care programs in India.

While AIDS orphans who are not HIV positive do not pose any risk of transmission, the risk from positive children can be significantly reduced with the proper use of universal precautions. Nonetheless, many of these children are victims of unnecessary and unfounded stigma and discrimination, and left unable to access necessary services.

We have created Hand in Hand – a booklet describing issues involved in the care of AIDS affected children, as well as innovative initiatives child care programs throughout India have taken to address them. We hope organizations can learn from one another as well as network to enhance care for children.

We are sending this email to inquire whether you would like a free copy of this informative and useful booklet. Also, if you currently do serve these children or have plans to do so, we would love to hear about your successes and any suggestions you may have.

We look forward to receiving your reply with your mailing address.

Sincerely,
Arabinda K. Pani and Aarti Kumar

Feb-

TN 4/1/02

Subject: [AIDS-INDIA] Training in US and England
Date: Wed, 02 Jan 2002 14:38:49 -0600
From: "Jack Weatherford" <planetaide@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear Forum Members, PlanetAide wishes to announce that it is accepting inquiiries for the arrangement of 3-month rotations with volunteering AIDS-experienced doctors in the United States and Great Britian. Visiting doctors are expected to pay their own airfares. Volunteers provide housing and food. Please send inquiries to the address below. Jack Weatherfordm Director, PlanetAide, Box 176, 3010 Hennepin Avenue South Minneapolis, Minnesota 55408 USA, telephone: 612-333-6003 email:jack.weatherford@planetaide.org"

Library - AIDS - India

Subject: [AIDS-INDIA] Condoms and Lube in India
Date: Tue, 01 Jan 2002 16:59:34 -0500
From: "George M. Carter" <gmc0@ix.netcom.com>
To: "AIDS-INDIA-yahoogroups.com" <AIDS-INDIA@yahoogroups.com>

Dear Forum Members,

I need help in securing some few thousand condoms in either India or Nepal, if possible. Also a similar amount of lube in individual packets. These are to be shipped to Kathmandu. What reputable companies exist that make good and popular products? I've been checking out http://www.pashupatiseohung.com/ as a possible source.

Please respond to me directly.

And a happy, safe new year to all!

George M. Carter
"George M. Carter" <gmc0@ix.netcom.com>

Library - AIDS India file
for 4/1
TM
4/1/02

Subject: [AIDS-INDIA] Human Rights Meeting in Thiruvananthapuram
Date: Tue, 1 Jan 2002 15:50:13 +0530
From: "Maitreya" <maitreya@asianetindia.com>
To: "AIDS-INDIA" <AIDS-INDIA@yahoogroups.com>

Dear Forum Members,

Public Meeting with Justice Michael Kirby and Justice Edwin Cameron on 7th January, 2002 on "HIV/AIDS and Human Rights"

AIDS is not just another disease but it is an epidemic, which brought with it or made to surface so many ethical, social, moral, human rights and economic issues. As the world is shrinking at a fast pace we could not deal these issues by a piecemeal approach. So networking and interaction at the International level is the need of the hour. As part of the Lawyers Collective HIV/AIDS Unit's work in providing free legal aid, advice and allied services for people affected with HIV/AIDS and conducting an extensive advocacy programme on HIV/AIDS, Law and Human Rights, two of the foremost international jurists on HIV/AIDS Law are visiting Thiruvananthapuram to interact with NGOs, lawyers, healthcare professionals and students. In collaboration with Department of Futures Studies, University of Kerala and Foundation for Integrated Research in Mental Health (FIRM), Thiruvananthapuram, the Unit is organising a Public Meeting on 'HIV/AIDS and Human Rights'. The details of the meeting are:

Date: 7th January 2002
Time: 2pm - 4 pm
Venue: University Senate Chamber,
Thiruvananthapuram

PROGRAMME

2.00 - 2.10 pm Welcome & Introduction - Dr. Jayasree A.K., Chairperson, Foundation for Integrated Research in Mental Health (FIRM), Thiruvananthapuram
2.10 - 2.25 pm Introduction to the meeting - Anand Grover, Lawyers Collective HIV/AIDS Unit

2.25 - 2.55 pm Address by Justice Michael Kirby, High Court of Australia

2.55 - 3.25 pm Address by Justice Edwin Cameron, High Court of South Africa

3.25 - 3.50 pm Discussion and Q&A with audience

3.50-4.00 pm Closing Remarks & Vote of Thanks - T. S. Arunkumar, Research Scholar
Department of Futures Studies, University of Kerala, Thiruvananthapuram

As someone concerned with the issue of HIV/AIDS and its grave impact in India, we take this opportunity to invite you for the meeting and look forward to your fruitful participation. Please find bio-data of Justice Michael Kirby and Justice Edwin Cameron on the other side of this invitation. Kindly confirm your participation by calling Department of Futures Studies, Tel: 305321, Thrani, Tel: 300334, FIRM, Tel: 470896.

Jan — Library AIDS India file

Honorable Justice Edwin Cameron

Edwin Cameron is a Judge of the High Court, and a Judge of Appeal of the Labour Courts of South Africa. He is currently an acting Justice in South Africa's highest Court, the Constitutional Court.

Edwin Cameron was educated at Stellenbosch University and then at Oxford, where he was a Rhodes Scholar and obtained two degrees with first class honours and the Vinerian Scholarship.

Before his appointment as a Judge in 1994, he was a human rights lawyer in practice at the Johannesburg Bar, and a Professor of Law at the Centre for Applied Legal Studies, University of Witwatersrand. Apart from initiating litigation on HIV/AIDS issues, Edwin Cameron helped found the national AIDS Consortium in 1992, and the AIDS Law Project in 1993, and was a member of the team that drafted the South African National AIDS Plan in 1993/94. He co-drafted the Charter of Rights on HIV/AIDS.

Currently he a patron or trustee of a number of AIDS service and community organisations, and chairs the South Africa Law Commission's Project Committee on HIV/AIDS. Since 1996 this Committee has produced four reports recommending law reform measures, including a ban on pre-employment testing for HIV, which was passed into law in November 1998.

Honorable Justice Michael Kirby

In February 1996 he was appointed one of the seven Justices of the High Court of Australia, Australia's Federal Supreme Court. He holds the degrees BA, LLM, BEc from Sydney University. The degree of LLM was conferred on him with First Class Honours. In 1997 the National Law School University of India conferred the honorary degree of Doctor of Laws on him.

He has chaired two committees of the OECD on Privacy and Data Security. He served as a Member of the Global Commission on AIDS of the WHO. In November 1993, he was appointed the Special Representative of the Secretary General of the United Nations on Human Rights in Cambodia- a position he held until April 1996. In March 1994, he was appointed by the Director General of UNESCO to be a member of the International Jury for the UNESCO prize for the teaching of human rights.

In 1995 he was appointed to the Ethical, Legal and Social Issues Committee of the Human Genome Organisation now based in London, monitoring the largest cooperative scientific project in history. He was also appointed in 1996 to the International Advisory Group on Advocacy Training of the Inns of Court School of Law in London and International Council for Conflict Prevention of International Alert, London. In 1997, he took part in the preparation of a Judicial Training Manual on Human Rights being prepared by the UN Centre for Human Rights. In 1995 he was elected the President of International Commission of Jurists.

In 1991 he was awarded the Australian Human Rights Medal. In 1998 he was named Laureate of the UNESCO Prize for Human Rights Education, award biennially.

Subject: [AIDS-INDIA] India Government Cracks Down on Biomed Researchers
Date: Mon, 07 Jan 2002 10:56:31 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

India Government Cracks Down on Biomed Researchers
By Subhadra Menon, PhD. Friday January 4 5:16 PM ET

NEW DELHI (Reuters Health) - India's Ministry of Health and Family Welfare has ordered that all clinical trials at the Regional Cancer Center (RCC) in Trivandrum, Kerala be suspended for 6 months.

This action is in response to the RCC cancer drug trial controversy that erupted some months ago. The RCC had been conducting unauthorized trials of the drugs M4N and G4N on unsuspecting cancer patients, in collaboration with a scientist from Johns Hopkins University in Baltimore, Maryland.

India's Union Health Minister Dr. C. P. Thakur has also officially announced that his government will censure the scientists involved in the trials. If the government finds any future violations of Indian Council for Medical Research (ICMR) ethical guidelines, he said, it will place a lifetime ban on the concerned scientist and the institution.

Meanwhile, the government is also planning to conduct a nationwide review of all ongoing research involving clinical trials.

These announcements come even as the results of the central and Kerala state government inquiry reports into the trials are yet to be revealed.

After the 6-month ban at the RCC is over, all clinical trials at the institute will be reviewed and permission will be granted only for trials cleared by the Drugs Controller General of India and the health ministry's screening committee.

Dr. Sri Ram Khanna, honorary managing trustee of the Delhi-based Voluntary Organization in Interest of Consumer Education (VOICE), which works to spread awareness about consumer rights, called the government's move a ``knee-jerk'' reaction. Without a larger effort to create regulation and transparency, Khanna said, the government's action is of little use.

Meanwhile, the government has also advised the RCC to reconstitute its Ethics Committee by co-opting a representative from the ICMR.

These most recent measures, according to the health minister, are meant as a clear indication of India's policy on biomedical research. The government has said, in its official press note on the subject, that while biomedical research is to be encouraged, the government will not tolerate any violations.

Thakur also believes these measures will send signals to the research community both within and outside the country that Indians cannot be

treated as guinea pigs.

But more extensive reform is needed, according to Khanna. ''The government should be working towards creating a transparent, strictly regulated system, whereby all companies and institutions are governed by the same set of mandatory rules when it comes to testing new drugs,'' he said.

He added that VOICE believes the Ministry of Health and Family Welfare should be able to quickly put in place such a rigorous system of regulation, as far as drug trials on humans are concerned

http://dailynews.yahoo.com/h/nm/20020104/hl/research_1.html

Subject: [AIDS-INDIA] Deadline Reminder - Barcelona 2002
Date: Tue, 08 Jan 2002 01:31:31 -0000
From: "Karen Bennett" <KBennett@aids2002.com>
To: AIDS-INDIA@yahoogroups.com

Dear Forum members,

Remember the following upcoming deadlines for the XIV International AIDS Conference (Barcelona, Spain, 7-12 July 2002):

14 January 2002: Abstract Submission in paper format or on diskette

21 January 2002: Abstract Submission on-line (www.aids2002.com)

1 February 2002: Scholarship Applications

Please visit our web site www.aids2002.com for application forms and more information.

"Karen Bennett" <KBennett@aids2002.com>

---

lib
Sv
TM
8/1/02

Subject: [AIDS-INDIA] CPM Leader Biman Bose on AIDS
Date: Mon, 07 Jan 2002 08:52:17 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Biman Bose readies for speech on AIDS

KOLKATA: Left Front chairman Biman Bose is busy rehearsing his speech. But it is not on POTO, POCA, Marxism or even Vidyasagar. He is scheduled to speak on AIDS at the Vidyasagar Mela on December 24.

Bose — executive president of the Vidyasagar Mela committee — will moderate a discussion on AIDS. Other speakers are Dr Manish Chakraborty, Dr Shekhar Chakraborty and Dr Asish Bhoumik.

When asked to explain why he had chosen to speak on AIDS despite being a political man, Bose explained that the situation was alarming and that he wanted to be the role model in making people aware of the danger. "I believe it is my duty to speak on this subject.

We should make people aware to prevent the spread of AIDS," said Bose, adding that he had been reading up several books on it since he was not an expert.

"In India, Manipur is a state recording the highest number of AIDS patients. We are yet to know the exact picture of West Bengal regarding the hidden spread of the disease," he said. Bose advocated that a comparative study on the status of AIDS in the country should be done in the international perspective immediately.

TIMES NEWS NETWORK [SATURDAY, DECEMBER 22, 2001 12:09:47 AM]

http://www.timesofindia.com/articleshow.asp?catkey==-
212883082l&art_id=u9055066&sType==1

TM
8/1/02

Subject: [AIDS-INDIA] consultants database
Date: Thu, 10 Jan 2002 15:52:44 +0530
From: kpradeep@youandaids.org
To: AIDS-INDIA@yahoogroups.com

Dear all

UNAIDS India is developing a database of experts in different fields who can be called upon for short term assignments as and when there is a demand for such inputs in different parts of the country.

In this regard, please find attached a format for consultants. Could you please pass this on to anyone who you think migth be available and or interested in providing short term on call inputs in their areas of expertise.

Please note that the database once developed will be available in the public domain and will be used by different agencies as appropriate.

Thanks again for your support and do look forward to hearing from you.

Sincerely

K.Pradeep
E-mail: kpradeep@youandaids.org

Consultant format.rtf	**Name:** Consultant format.rtf **Type:** Winword File (application/rtf) **Encoding:** base64

Consultants

Kindly fill in all the columns

Name:	
Organization:	Designation:
Phone Office: Residence:	Fax Office: Residence:
Mobile	
Email1:	Email2:
Web URL:	
Languages (Hindi/English/Others):	
Education:	
Experience (briefly mention the areas of work starting from your current job)	
Expertise (please identify 3 areas of expertise based on your experience)	
Your availability for short-term assignment (The database will be widely circulated to different agencies working in the area of HIV/AIDS. Indicate how many days in a month you will be available for consultancy work)	
Your fees (What will be the fees that you charge per day for short term assignments) Rs.	
Any other information that you would like to share with us	
Please attach a copy of your CV for reference. Please note that this information is being sought for developing a database of consultants in India and is **NOT** in anyway intended as an offer of consultancy/recruitment.	

Subject: [AIDS-INDIA] ICRW India Fellows Program 2001-2002
Date: Thu, 10 Jan 2002 06:36:51 -0000
From: "ICRW" <fellowsapp@icrw.org>
To: AIDS-INDIA@yahoogroups.com

ICRW India Fellows Program 2001-2002

The International Center for Research on Women (ICRW), Washington, DC, with funding from Ford Foundation, India is pleased to announce a fellowship program for Indian development and human rights specialists,activists, lawyers, economists, and academics. The program provides six fellows with three month sabbaticals at ICRW Washington to explore conceptual and programmatic issues related to the following question:

How can a rights-based approach to development build upon the links between economic, political, and social rights to improve the economic condition and promote the full human development of women who are poor and/or belong to marginalized castes, religious, or ethnic groups?

Fellows may choose to examine this questions in one of several ways - through research, documentation of success stories, design of programs or strategies, or in other ways that they deem important. It is envisioned that while the Fellows' work will represent the extension of their work within their home institutions, the collection of studies and findings generated through the Fellows program will also contribute to a deeper understanding of the relationship between human rights and development and the means to operationalize that relationship. Based on their work done at ICRW, fellows will present two in-house seminars and prepare a summary report to be presented at an end of program conference held in India in 2003.

Fellowship applications must include a completed application form, a resume or curriculum vitae, two letters of recommendation from professional colleagues or professors, and a short sample of recent written work that illustrates the candidate's research interests and abilities.

For further information and application forms please see a detailed fellowship announcement at www.icrw.org or email fellowsapp@icrw.org.

Applications must be submitted by February 10, 2002 via e-mail, fax, mail, or online submission
to:
Project Director, Fellows Program
1717 Massachusetts Avenue, NW
Suite 302
Washington, DC 20036
FAX: 202-797-0020
e-mail: fellowsapp@icrw.org
online submission: www.icrw.org/fellowfrm.htm

The International Center for Research on Women (ICRW) is an independent non-profit organization established in 1977 with the mission to improve the lives of women in poverty, advance women's equality and human rights, and contribute to broader economic and

[AIDS-INDIA] ICRW India Fellows Program 2001-2002

ICRW accomplishes this, in partnership with others, through research, capacity building and advocacy on issues affecting women's economic, health and social status in low and middle income countries. We concentrate on the following strategic areas: poverty reduction and economic growth; HIV/AIDS and development; social change, norms and institutions; reproductive health and nutrition; and adolescence. ICRW has offices in Washington, DC, USA and New Delhi, India.

Subject: [AIDS-INDIA] Any info on Aloe Vera
Date: Fri, 21 Dec 2001 02:38:10 +0530
From: "Melita Vaz" <melita@vsnl.com>
To: AIDS-INDIA@yahoogroups.com
CC: <aidsforum_mumbai@yahoogroups.com>

Hi All

I was at a public gathering yesterday where there were some salespersons who were drooling over aloe vera. Their literature mentioned:

Curtailing HIV infection An extract of manose, one of the sugars in aloe can inhibit HIV-1 (the virus associated with AIDS). Aloe slowed virus reproduction by as much as 30% reduced viral load suppressed the spread of the virus from infected cells and increased the viability (chance of survival) of infected cells.

Has anyone heard of this before? Please let me know the source of the literature.

Thanks
Melita Vaz (Mumbai)
E mail: <melita@vsnl.com>

Aids-AIDS Archives
Jn
24/12

TM
24/12

Subject: [AIDS-INDIA] Skill building workshop on children affected by AIDS at Changmai
Date: Thu, 13 Dec 2001 08:17:23 +0530
From: Bitra George <jimmyd@vsnl.com>
To: AIDS-INDIA@yahoogroups.com
CC: SAATHI@yahoogroups.com

Dear All,

There will be a special skill building workshop on " Interventions to address vulnerabilities of Children affected by AIDS" at the International Home & Community based care conference at Changmai on 19th December, 2001 between 1.30 to 5.00 pm. This session is sponsored by FHI and there will be presenters from India, Cambodia, Uganda to share their experiences. In addition, there will be discussion on various important issues affecting children including -

(a) Meeting basic needs of children (shelter, food, clothing, 'safe space', medical help, counselling)

(b) Interesting methods for providing information to children on health, hygiene, HIV/AIDS, sex & sexuality, STIs & substance use

(c) Addressing issues including poor self esteem & lack of self awareness, tackling peer pressure

(d) Addressing stigma & discrimination issues and Institutional care versus Community care

(e) Coping with death & dying issues & caring for siblings

Regards,
Dr Bitra George
E-mail: jimmyd@vsnl.com>

Lib. AIDS-India file
Jo, 13/12/01
TM
13/12

Subject: [AIDS-INDIA] Teens Turn to Web for Health Info
Date: Tue, 11 Dec 2001 22:52:48 -0800 (PST)
From: Saxena Rishi <rishisaxena@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Tuesday December 11 1:45 PM ET
Survey Finds Teens Turn to Web for Health Info
By Reshma Kapadia

NEW YORK (Reuters) - Teens and young adults are flocking to the Web for health-related information as much as they are downloading music and playing games online, and more often than shopping online, according to a national survey from the Kaiser Family Foundation released Tuesday.

A survey conducted by the foundation found that one in four people 15 to 24 years old say that they get ``a lot'' of health information online and a significant proportion of youth are acting on what they find.

``We had no idea that so many young people were going online to get health information. A lot of us assumed that they were going online just to download the latest Red Hot Chili Peppers song so that was a surprise. It is even more so than adults,'' said Victoria Rideout, vice president and director of the program for the Study of Entertainment Media and Health at the foundation.

Nearly 40% of those surveyed said they have changed their own behavior because of information they found on the Web.

The survey, Generation Rx.com, includes findings on how young people use the Internet as a health resource, their concerns about confidentiality, their opinions on filtering technology and online pornography, and new data on where and how often teens and young adults are going online.

Half of all online youths have searched the Web for information on specific diseases such as cancer or diabetes. Sensitive, youth-oriented topics such as HIV (news - web sites)/AIDS (news - web sites), birth control and sexually transmitted diseases are also popular.

About one in four of those surveyed have looked up information on weight issues, mental health, drugs and alcohol and violence.

``Confidentiality is so important and at this point most young people have faith that the Internet offers them that confidentiality,'' Rideout said.

The majority of youth who have surfed the Web for health information do so just a few times a year, but nearly four in 10 do so at least once a month, the survey found.

Among those surveyed 90% have gone online and three

TN 13/12 Lib. AIDS India file 13/12

out of four have Internet access from their home.

About 17% of young people said they would trust health information found on the Web ``a lot'' while 40% said they would trust it at least ``somewhat.''

Rideout said the study, one of the first to look at this age group's interest in health issues on the Web, raises a series of questions, including the quality of the information available and targeted at this age group.

Among 15- to 17-year-olds who were looking for health information online, nearly half said they have been blocked from sites that they said were non-pornographic due to filtering, the survey found.

The views are of the authors. Please feel free to copy the messages.
An acknowledgement would be appreciated
To Post a message: aids-india@eGroups.com
Unsubscribe: aids-india-unsubscribe@eGroups.com
Web page: http://groups.yahoo.com/group/AIDS-INDIA

Subject: [AIDS-INDIA] HIV Disease instead of AIDS
Date: Mon, 10 Dec 2001 08:21:13 +0530
From: "tjjohn" <tjjohn@md4.vsnl.net.in>
To: "AIDS India" <AIDS-INDIA@yahoogroups.com>

Even today a lot of people use the term AIDS for HIV infection. This is not acceptable.

The Medical University at Chennai had a workshop a few years ago in which a consensus arose, to use the term HIV Disease instead of AIDS, in all situations except in scientific papers. This will create better distinction between HIV infection and HIV Disease.

Just be conscious the next time you say AIDS.

T Jacob John.
E-mail: <tjjohn@md4.vsnl.net.in>

LA AIDS-India file
SN 13/12

TN
13/12

Subject: [AIDS-INDIA] Cipla responds to Glaxo's CEO on its price cuts
Date: Wed, 16 Jan 2002 00:59:29 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Cipla responds to Glaxo's CEO on its price cuts
Amar Lulla, Director of Cipla, writes:

Hopefully Sir Richard Sykes lashing out emanates from ignorance.
I am sure he means well.

Sir Richard Sykes perhaps has not been informed of the developments in India, both on the availability of AIDS drugs and their pricing. Zidovudine was launched in India as early as 1993. Since then the price has been consistently reduced and now stand at around one third. Similarly, other molecules such as Stavudine, Lamivudine, Nevirapine, Efavirenz have been launched and their prices have been slashed from time to time. Cipla donated Nevirapine to the Governments of India, Kenya, Sudan, Zambia and Cameroon for prevention of MTCT. We would be very happy to share the facts with Sir Richard Sykes in case he cares to look at them.

Sir Richard Sykes also has perhaps overlooked the fact that Cipla's "rhetoric and publicity" offer of supply of cheap AIDS drugs lead to supply of these drugs to Algeria, Bahamas, Cambodia, Cameroon, Central African Republic, Chad, Colombia, Ethiopia, Guatemala, Iran, Ivory Coast, Jamaica, Kenya, Liberia, Macao, Malawi, Mauritius, Mozambique, Myanmar, Nigeria, Peru, Sudan, Swaziland, Tanzania, Uganda, Vietnam and Zambia.

Sir Richard Sykes also perhaps has missed out reading in the international press that his company in June 2001 offered cheap AIDS drugs to 63 countries. Would his company have done this without Cipla's "rhetoric and publicity" offer? Did he also miss out Mercks offer to slash AIDS drugs prices in March 2001? Did he also miss out Pfizer's offer of free AIDS drugs to poorer nations in June 2001 and did he miss out BMS offer to sell AIDS drugs in Africa at below cost in March 2001? WERE ALL THESE OFFERS ALSO "RHETORIC AND PUBLICITY"?

Let Sir Richard Sykes do his bit and let the Indian companies do theirs in making available AIDS drugs to dying millions.

With kind regards,

Yours sincerely,
Amar Lulla
Director Cipla

Cross posting from<aidsact@CritPath.Org>

Subject: [AIDS-INDIA] Govt must protect AIDS patients' rights: Sorabjee
Date: Tue, 15 Jan 2002 13:02:36 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Govt must protect AIDS patients' rights: Sorabjee

PTI [THURSDAY, JANUARY 10, 2002 11:18:41 PM]
NEW DELHI: Emphasising that the Constitution imposes an obligation on the government to adopt measures to protect the rights of an HIV infected person, Attorney General Soli Sorabjee on Thursday said the Apex Court should take a proactive stand on this issue and give directions.

"If some PIL comes up on this issue, I will support it. Article 21 of the Constitution imposes an obligation on the state to adopt positive measures to protect their (HIV infected persons) rights," Sorabjee said at the "Colloquim on HIV/AIDS: The Law and Ethics".

Lamenting the lack of a comprehensive legislation on National Public Health which penalises discrimination of HIV infected persons, he said "waiting for it is of no use. The Supreme Court should take a proactive stand on this issue and give directions."

Pointing out that India has over 3.9 million HIV positive people, the second largest in the world, Supreme Court Judge Justice Kirpal urged doctors, lawyers and the media to educate the people about the AIDS.

Justice Michael Kirby of the High Court of Australia criticised the attitude of the society towards the HIV positive and said the governments should make efforts in sensitising the society and must allocate more money to tackle the disease.

http://timesofindia.indiatimes.com/articleshow.asp?catkey=-2128936835&art_id=1356429206&sType=1

Subject: [AIDS-INDIA] Community REACH grants available for Africa, Asia
Date: Wed, 16 Jan 2002 20:12:44 -0800 (PST)
From: Sukontikar Jinapengkas <sukontikarj@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Community REACH grants available for Africa, Asia, Americas and Eastern Europe?
AIDS Channel By Julian Meldrum - January 11, 2001

A US-government backed grants programme called Community REACH (Rapid and Effective Action Combating HIV/AIDS) was launched on 7 January with a Request For Applications to support work on HIV and AIDS in selected countries and regions around the world. The definitive list of eligible countries was not, however, released until 14 January; this report has been updated to reflect that list.

This is the start of an initial five-year, 40 million US dollar programme funded by the US government and administered by the organisation Pact, in partnership with the Futures Group International, which may be extended and expanded later. The aim is to speed up funding and make it more flexible to give better support to communities responding to HIV/AIDS.

To distribute funds, Pact will issue approximately two to three solicitations for proposals a year. Grants will be awarded in amounts starting at $100,000 for periods of up to three years, depending on fund availability, with unlimited potential for cost sharing (see below) from other sources.

The first round of grants will be restricted to countries and regions categorised by USAID as "Rapid Scale Up" or "Intensive Focus", based on the scale of their HIV epidemic and their ability to make use of international resources in responding to it.

These countries are now (from 14 January 2002): Brazil, Cambodia, Dominican Republic, Ethiopia, Ghana, Haiti, Honduras, India, Indonesia, Kenya, Malawi, Mozambique, Nepal, Nigeria, Russia, Rwanda, Senegal, South Africa, Tanzania, Uganda, Ukraine, Zambia, Zimbabwe.

A longer list of countries is in line to benefit from future rounds (subject to negotiation and discussion between USAID and Pact).

US and other international "Private and Voluntary Organisations" (PVOs) can apply for these grants, but must have either a current presence in the country for which they are applying to conduct a project or partner with a local non-governmental organisation (NGO) in that country. Regional and local NGOs, universities, and faith-based organizations engaged in HIV/AIDS activities that meet USAID's criteria are also eligible. All applications must also be supported by the relevant USAID mission in the country or region.

There is an expectation that organisations will raise some part of the cost of the programme from other sources ("cost share"). "Community REACH expects applications of $100,000 to $300,000 to include a minimum cost-share of 10%. Applications above $300,000 should include a minimum cost-share of 25%."

Grants can be awarded in all areas of activity that USAID supports, broadly divided into three categories:

Primary HIV/AIDS prevention strategies including behavior change communication, condom promotion and availability, prevention of mother-to-child transmission, blood safety, harm

Neb
18/1/02

reduction for intravenous drug users and stigma reduction.

Voluntary counseling and testing focusing on provision of high quality services, introduction of rapid testing and training of health personnel.

Care and support for those living with and affected by HIV/AIDS (see below for more details; this is the focus of the first grants round).

Grants will be directed to those activities that have a direct impact on these areas. Funded activities will be consistent with USAID's goals of "increased use of improved, effective and sustainable responses to reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic."

For the current round of funding, the focus is on care and support. This means:

Referrals for prophylaxis, treatment of opportunistic infection, and palliative care
Referrals for out of hospital to competent, home-based care and ambulatory care
Care for orphans and vulnerable children
Food and nutrition component for HIV/AIDS infected/affected.

Applications for the first round will be accepted until 8 March 2002. For additional information, contact the Community REACH team at reachgrants@pacthq.org. Information will also be available at USAID Missions, Pact and the Futures Group International field offices (as well as through the web links given at the beginning of this article).

http://www.aidschannel.org

Subject: [AIDS-INDIA] Manual - Guidelines for Reproductive and Sexual Health Projects
Date: Wed, 16 Jun 2002 10:24:07 -0700
From: "Sohgaph Kolkata" <subidita@loxinfo.co.th>
To: <AIDS-INDIA@yahoogroups.com>

Dear colleagues,

The much awaited manual ' Guidelines for Reproductive and Sexual Health Projects in Developing Countries' (For Facilitators and Health workers at the Grass Root Level)is finally out in January 2002.

If you had contributed to this manual (and your contribution had been accepted)

you will shortly recieve a free copy. Thought provoking discussions on the needs for change in attitudes and new innovative approaches to change the health scenario would be useful for researchers and students in addition to project directors and managers.

Additional attractions are -
a. Workshop on basic healthcare for PHA (People with HIV/AIDS), care givers and other non health personnel by MSF and Access(Thailand).
b. Life skills training modules for training of trainers as well as adolescents themselves
c. Training modules for traditional birth attendents.
d. Pictorial representation of in depth medical knowledge for non-medical managers / health workers ,could be copied and converted into Flip charts or cloth posters for IEC work.
e. A short e-group training discussion on Reproductive Health will be available free of charge to the buyers of this manual.

Please check the website http://www.geocities.com/sohgaph_1993/manual.html for further information. Publisher- School of Human Genetics and Population Health, Kolkata,India. Please book you copies early.

The International price is US$25 and the Indian price is Rs.500/- (plus postage charges). Order for 5 or more copies will entitle you to a discount of 15% Order for 10 or more copiesw will entitle you to a discount of 25%

Any further queries or questions about the contents of this manual may be addressed to the lead author Dr. Subidita Chatterjee at subidita@loxinfo.co.th

Please contact us for booking at
Manager Manual,
School of Human Genetics and Population Health ,Kolkata, India
sohgaph_1993@hotmail.com
or
sohgaph_org93@hotmail.com

Leb
15/7/02

Subject: PHA-Exchange> Fwd: Commission on Macro-economics and Health
Date: Wed, 16 Jan 2002 00:35:21 +0000
From: pamzinkin <pamzinkin@gn.apc.org>
To: IPHCWORLDWIDE@yahoogroups.com, PHA-Exchange@kabissa.org, health-fin@lists.vicnet.net.au, PHA2001@yahoogroups.com, PHA-Europe@egroups.com, PHA-Europe@yahoogroups.com,
CC: ckchan@usm.my, sphdgl@pop.latrobe.edu.au, beiras@nodo50.org, benos@med.auth.gr, mikerowson@yahoo.org, chetley.a@healthlink.org.uk

Dear Friends
David Legge's response is excellent. Just before Christmas Bruntland and Jeffrey Sachs gave a short information session for a few people at DFID. Mike and I plus Regina Keith of SCF were there. I notified Qasem about Mike instigating a circle on macroeconomics and health. It seems that David and Mike are going along the same lines so perhaps they can link up. Mike will actually be in Australia soon so can we try to link them? I need David Legge's phone number and I will try to send this to Mike There is also a brief report on the Bruntlands meeting on the healthlink web site.

>Date: Tue, 15 Jan 2002 09:59:11 -0500
>From: "mikerowson" <mikerowson@medact.org>
>Reply-To: <mikerowson@medact.org>
>To: <pamzinkin@gn.apc.org>
>Subject: Commission on Macro-economics and Health
>X-Mailer: <IMail v7.05>
>
>Dear Friends
>
>Medact's response to the Report of the Commission on Macro-economics and
>Health is on the Medact website www.medact.org. Follow the links from the
>home page.
>
>If anyone is interested in helping us form a PHM circle on macro-economics
>and health, then please e mail me at mikerowson@medact.org
>
>Best wishes
>Mike Rowson

Pam Zinkin tel:44 (0)20 7609 1005
pamzinkin@gn.apc.org fax:44 (0)20 7700 2699
45 Anson Road
London N7 0AR
UK

LEB
18/1/02

Subject: [AIDS-INDIA] Doctors Should Prescribe ARVs for rape survivors
Date: Thu, 17 Jan 2002 08:26:45 -0000
From: asia@critpath.org
To: AIDS-INDIA@yahoogroups.com

SAMA calls for ARVs for rape survivors

Doctors Should Prescribe Anti-Retrovirals, say Medical Association

South African Press Association (Johannesburg)
January 15, 2002: [Posted to the web January 16, 2002. Pretoria]

The SA Medical Association (SAMA) on Tuesday came out in support of its member doctors who prescribed anti-retroviral drugs to rape victims in contravention of government policy.

"Doctors are obliged to act in the best interests of their patients," said SAMA human rights, law, and ethics committee chairman Dr Anant Chetty.

"Government policy does not determine medical ethics."

In terms of official policy, public hospitals and clinics are not allowed to give anti-retroviral drugs to rape victims, as the government maintains there is no evidence they are effective.

SAMA, however, was of the opinion that the drugs were beneficial, Chetty said. "There is evidence that this is a worthwhile exercise."

It would therefore be unethical of a doctor not to at least inform a patient of the benefits of anti-retroviral drugs.

SAMA, the only representative body of South African doctors, reiterated its support for the right of medical practitioners to clinical independence and autonomy.

This included the right to treat patients without undue influence, pressure or victimisation from employers or government institutions.

"The SAMA also supports the rights of patients to receive necessary treatment, always with their informed consent," the organisation said in a statement.

"This includes the rights of pregnant women who are HIV-positive to receive the best available treatment that has been proven to reduce mother-to-child transmission. This principle should apply to rape survivors."

Chetty said the body would support any of its members who got into trouble for prescribing anti-retrovirals.

SAMA represents some 17000 doctors, two-thirds of which are employed in the public sector.

Last week, opposition politicians expressed disgust at the Northern

Heb 18/1/02

Cape government's response to a doctor's decision to give anti-retroviral drugs to an 11-month-old gang-rape victim.

Northern Cape Health MEC Dipuo Peters reportedly lambasted the Kimberley provincial hospital after media reports revealed the child had been given the anti-retroviral drug AZT.

The hospital subsequently issued a circular reminding doctors they were barred from administering the drug to rape patients.

It was claimed the hospital had a policy of administering the drugs, but had to change it when the government intervened.

The Northern Cape baby was raped and indecently assaulted by six men in Louisvale in November when she was nine months old.

The girl, named "Tshepang" (have hope) to hide her identity, has since been transferred to the Red Cross children's hospital in Cape Town, where she is expected to undergo reconstructive surgery.

The government is also involved in litigation against the Greater Nelspruit Rape Intervention Project, which hands out anti-retroviral drugs to rape victims at six hospitals in the greater Nelspruit area.

The case is pending.

Asia Russell
asia@critpath.org
ACT UP Philadelphia
Health GAP Coalition

Subject: Press Release from CERC, Ahmedabad
Date: Thu, 17 Jan 2002 14:46:46 +0530
From: cerc@wilnetonline.net
To: Darlena David <cd.cmai@vsnl.com>, Madan Kataria <laugh@vsnl.com>, Mathew Nampudakam <vhai@vsnl.com>, Naresh Agarwal <saveraindia@rediffmail.com>, Nina Shah <inika@icenet.net>, Phalgun Patel <sandesh@ad1.vsnl.net.in>, Praviena Sharma <pravi_s@yahoo.com>, Ravi Narayan <sochara@vsnl.com>, World Consumer <consint@entelchile.net>

Ref:E&R/04//Projects/EH/2002

New Energy Efficiency Testing Lab
to be Opened in City

A new laboratory for comparative testing of energy efficiency of electrical appliances will be opened at the Consumer Education and Research Centre (CERC) complex on Saturday 19 January.

The Rs.1.38-crore lab section, funded by USAID, fulfills a long-felt need for testing energy consumption and efficiency of air-conditioners, fridges, air-coolers, fans, tubelights, etc. The test results will be published and publicized through INSIGHT - The Consumer Magazine as well as the regional and national media.

Mr. Richard L. Edwards, Director, Office of Environment, Energy & Enterprise-USAID, will declare the laboratory open. Hon'ble Mr. B.M. Oza, member, Gujarat Electricity Regulatory Commission, will preside over the function. Mr. A.T. Kusre, General Manager-ICICI, Mumbai, will be guest speakers and Prof. Manubhai Shah, Managing Trustee, CERC, will deliver the welcome address.

The setting up of the laboratory under Clean Technology Initiative and its test findings will help and encourage consumers to go for energy-efficient appliances, rather than spend their money on gadgets and appliances consuming heavy electricity. This will also help the Indian industry in adopting clean technology and certified environment management systems and encourage them to manufacture energy-efficient products.

CERC is the only consumer organisation in India and Asia which is equipped with an independent, in-house laboratory complex devoted to the comparative testing, evaluation and ranking of consumer products. The products now tested come under food, pharmaceuticals and domestic electrical appliances.

Based on our test results and technical studies on electrical appliances -- the test findings are published in INSIGHT - The Consumer Magazine and the national media -- we suggest several amendments to the BIS for upgrading the existing standards. The BIS has revised the standards for electric irons, plugs, immersion water heaters, etc.

CERC is also advocating with the BIS the inclusion of energy efficiency parameters in the Indian Standards for all high energy-

Feb
18/1/02

consuming products . CERC is represented on various BIS technical committees on electrical appliances and helps the latter in the formulation and revision of standards.

The Indian Soaps and Toiletries Makers Association (ISTMA) has donated Rs 51 lakh to set up a laboratory for testing personal-care products like cosmetics, soaps, shampoos, toothpastes, etc., which will open shortly.

****

Editors/Chief Reporters: the following FOR FAVOUR OF PUBLICATION

in your newspaper in the "ENGAGEMENT/CITY DAIRY /EVENTS" COLUMN

dated 19 January 2002. Thanks.

INAUGURATION OF ENERGY EFFICIENCY TESTING LAB: Mr. Richard L. Edwards, Director, Office of Environment, Energy & Enterprise-USAID, to inaugurate the new addition to the in-house laboratory at Consumer Education and Research Centre (CERC) Premises, Gandhinagar-Thaltej Highway; 5.30 p.m. Hon'ble Mr. B. M. Oza, Member, Gujarat Electricity Regulatory Commission, to preside; Prof. Manubhai Shah, Managing Trustee, CERC and Mr. A.T. Kurse, General Manager ICICI, Mumbai to speak.

Date : 17 January 2002
Place: Ahmedabad

Lalita Meduri
Consumer Relations Officer

Opinions, test results and research findings issued through this Press Release cannot be used in any form directly or indirectly for advertising, promotional or commercial purpose.

CONSUMER EDUCATION AND RESEARCH CENTRE
"Suraksha Sankool", Thaltej, Ahmedabad-Gandhinagar Highway, Ahmedabad- 380 054 (INDIA) Phone: 079-7489945-46, Fax: 079-7489947, E-mail: cerc@wilnetonline.net

---

Subject: [AIDS-INDIA] Indian Paradox: Condoms may be a crime
Date: Thu, 17 Jan 2002 03:21:36 -0800 (PST)
From: Jagdish Harsh <jamworld@vsnl.com>
Reply-To: jharsh@afxb.org
To: AIDS-INDIA@yahoogroups.com

Paradox: Condoms may be a crime

New Delhi, Jan 14: Sodomy does take place inside Tihar jail, a top police official admitted on Monday but said the jail could not become a party to the crime by supplying condoms.

Speaking at a press conference, director-general (prisons) Ajay Agrawal admitted that sodomy exists. "I don't deny that these kinds of activities take place inside the jail complex. But that happens everywhere in the world. What do you do about it? When such a case comes to light, we take action against the person and a proper criminal cash is registered by the local police. Despite this the jail administration does not allow condoms in Tihar.

"By supplying condoms we do not want to be a party to the crime. The police cannot be seen aiding this practice. We do not want to legalise it by supplying condoms," he said.

The director-general denied that the crime was "prevalent" in the jail. "Just a few cases have come to light. Over crowding of jails has discouraged this," said the director - general.

According to him, overcrowding of the jail barracks, where at an average 150 people sleep together, had helped, to an extent, prevent sodomy as if anybody indulged in such an act there are hundreds who are watching them.

The puritanical attitude of the jail administration exposes Tihar inmates to a risk of contracting HIV infection and sexually transmitted diseases. In the year 2001, 12 inmates at the Tihar jail were suffering from AIDS. At present, nine inmates had AIDS.

Mr. Agrawal said the problem faced by the jail authorities stars when an inmate having AIDS refuses to leave the jail premises.

Citing a case of an inmate infected with the disease, Mr Agrawal said the inmate approached the Delhi High Court and sought intervention in this regard.

The reason behind the inmates move, according to Mr Agrawal was that free medicines were available in the

feb 18/1/02

jail complex for victims.

However, even after getting the medicines, the inmate had refused to leave as he was getting free medical facilities inside the jail complex which were very expensive outside the jail.

Jagdish Harsh (jharsh@afxb.org)
Director of Administration
François-Xavier Bagnoud (INDIA)(www.fxb.org)

Subject: [AIDS-INDIA] Re : Govt must protect AIDS patients
Date: Thu, Jan 17, 2002 at 10:46:24 IST (GMT+0530)
From: <srimaddur@vsnl.net>
To: AIDS-INDIA@yahoogroups.com

Dear All,

This kind of initiative was most necessary and expected for a long time. Its nice to hear that somethings are happening, the key to successful antidiscriminatory and destigmatising situations is offcourse constitutional sanctions and effective policies. Strong voices such as the Attorney General Soli Sorabjee needs to be heard for a consensus and action, if we have the stem the growth of HIV/AIDS in India.

Srinath M Maddur
ICHAP
BangaloreE-mail:<srimaddur@vsnl.net>

Leb
18/1/02

Subject: PHA-Exchange> The WHO Civil Society Initiative: Important you respond
Date: Fri, 18 Jan 2002 20:51:10 +0700
From: "Aviva" <aviva@netnam.vn>
To: <pha-exchange@kabissa.org>

> The newly established WHO Civil Society Initiative herewith extends an
> invitation to your Organization to participate in an informal electronic
> consultation on the attached document "WHO Civil Society Initiative - work
> in progress."
>
> The document is the first outline of a possible WHO policy framework on
> relations with civil society. It describes current plans for and thoughts
> about WHO interaction and collaboration with civil society organizations
> (CSOs), and proposes areas of work and activities that can lead to
improved
> mutually beneficial relations. We want to stress the draft character of
the
> document since many key partners are still to be consulted before
finalizing
> the framework. Our plans are to develop a final version of the policy
> framework by September 2002.
>
> As part of the this process we have now chosen to consult with you and
other
> selected international CSO partners electronically. It is important that
> the policy framework reflects the views not only of WHO, but also of a
broad
> range of different types of CSOs with whom WHO works and interacts. Thus,
> we are very interested in your comments on the document and on the
process.
>
> In order to facilitate your comments a form is attached for your
electronic
> usage. We look forward to hearing from you and would be pleased to receive
> your responses by 8 February 2002.
>
> Please return the form to Margareta Skold, CSI, email: skoldm@who.int.
> Yours sincerely
>
> Eva Wallstam
> Director, Civil Society Initiative
> External Relations and Governing Bodies
> World Health Organisation

> CIVIL SOCIETY INITIATIVE
> Informal Consultation Document
> (work in progress)
> 19 December 2001
>
> 1. Why this paper?
> This paper is one of several tools in the development of a renewed WHO
> policy on interaction with civil society. Its purpose is to inform
> stakeholders about the current stage of the WHO Civil Society Initiative
> (CSI), as a basis for consultations with and inputs from CSOs and other

1 of 8

22/1/02

1/22/02 11:25 AM

> interested partners. The paper is a "work in progress", and will be
further
> developed on the basis of further consultations during the next 6 months.
>
> 2. What has CSI done so far?
> The CSI was launched by Dr Brundtland at WHA 2001, to review official and
> informal working relations between WHO and CSOs and to guide the policy
> discussion on how to further strengthen mutually beneficial relationships.
> This mandate was later broadened to include the involvement of civil
society
> in health and government/CSO relations. The objective is to develop a WHO
> policy framework for more effective collaboration, information exchange
and
> dialogue with CSOs, and to strengthen WHO's support to Member States in
> their work with CSOs in global and national health.
>
> Initial investigations have included consultations with a range of
> stakeholders at all levels within WHO, and with partners outside WHO,
> including CSOs. It has included:
> · mapping WHO experiences and relations with CSOs both at HQ and at the
> Regions offices;
> · identifying current forms of interaction between CSOs and WHO, and the
> opportunities and concerns to which they give rise;
> · exploring current thinking about civil society and CSO involvement in
> health;
> · gaining insights from other UN entities, donors and financial
institutions
> on their policies and processes for interaction with civil society;
> · listening to the expectations of CSOs and initiating dialogue with them;
> and
> · identifying specific areas of concern and issues that WHO needs to
> address.
>
> To date, about 50 WHO HQ staff have been interviewed, and this process
will
> continue with staff at WHO Regional and country offices.
>
> 3. Working definitions
> WHO has traditionally worked with health-specific non-governmental
> organizations and utilized the term "NGO", but the terminology of "civil
> society" and "civil society organizations" is increasingly preferred. This
> reflects the growing recognition by WHO of the importance of collaborating
> with and reaching out to a broad range of actors. The term 'Civil society
> organisations' (CSOs) generally refers to non state, voluntary
> organisations, not formed for purposes of making profit. These networks
and
> associations draw from community, neighbourhood, workplace, social and
other
> connections, and include formal and informal voluntary organisations, non
> government organisations, professional associations, social movements,
> community groups and so on. WHO works CSOs that are health related,
whose
> interests are consistent with WHO values. Foundations, academia and media
> are not dealt with by CSI, as they are covered by other WHO units.
>
> WHO's primary interest is in working with CSOs which share its values and

> offer the greatest opportunities and synergies for improving health
> outcomes. As in relations with the private-for-profit sector, there are
> potential conflict of interest for the WHO. Relations with the for-profit
> and non-profit actors are therefore developed in parallel to ensure
> consistency.
> 4. WHO's past and current relations with CSOs
> Collaboration with NGOs is not new for WHO, and interaction, consultation
> and co-operation with them are clearly encouraged by its Constitution. The
> first World Health Assembly, in 1948, adopted a set of working principles
> governing admission of NGOs into Official Relations , which were amended
and
> expanded by later WHAs. The current principles have been in place since
1987
> . Collaboration with NGOs is a standing agenda item at both the EB and
WHA.
> It was the theme of Technical Discussions 1995, and was highlighted in the
> Executive Board's 1997 and 1998 discussions and the consultations on the
> revised Health for All process 1997 . As such, the governing bodies of WHO
> have shown long-standing support and encouragement for strengthened WHO
> relations with NGOs, including those whose main area of competence lies
> outside the health field.
>
> WHO interactions with CSOs can be formal (official relations) or informal.
>
> There are now:
> - more than 190 NGOs in formal, official, relations with WHO. They have
> responsibilities and privileges that are outlined in the Principles
> governing relations between the World Health Organization and Non
> governmental organizations; and
>
> - an even larger number of CSOs/NGOs that have working relations or other
> interactions with WHO at different levels (at HQ, regions and countries),
> but are not in official relations.
>
> Both type of relations can include different types of activities such as:
>
> · joint action and research in service provision, programme and community
> outreach, technical and resource inputs in specific areas, and
co-ordinated
> fundraising and financial contributions;
> · advocacy and information sharing, building wider alliances for health
> goals and sharing information through existing networks; and
> · policy dialogue and development through round table discussions, issue
> management groups for policy development, policy strategy advisory
> committees, public hearings, commissions and consultations.
> 5. Issues and Challenges
> The CSI investigations have resulted in many findings of importance for a
> future WHO policy framework. The following issues and challenges are some
> examples of these findings, but do not represent an exhaustive list.
> 5.1 At global level
> During the last 20 years, there has been a dramatic growth of civil
society
> organizations (CSOs) and an increase in the political influence of civil
> society. Global political, economic and social changes have had a
profound
> influence on the role of the nation state, notably in health, pressuring

> governments to align national policies with global and regional agreements
> within a more demanding and constraining environment. This has raised the
> profile and increased the participation of non-state actors in health
> service provision, both non-profit and for-profit.
>
> In addition, increasing CSO concern about the effects of globalization and
> global policies on health has led to a greater involvement in public
policy
> debates, eg on globalization, trade, development co-operation and health.
In
> this role, civil society can enhance the accountability and performance of
> national governments and global governance systems, adding a political
> dimension to civil society involvement in health.
>
> 5.2 At national level
> CSOs have become critical elements in the health domain at the national
> level. They contribute resources and skills to service outreach;
development
> aid is increasingly channelled through them; and global initiatives such
as
> Roll Back Malaria, the Global Fund to Fight HIV, Tuberculosis and Malaria
> and the Tobacco Free Initiative, are involving CSOs as major actors at
> country level. New development processes such as PRSPs and SWAPs also
> require CSO participation. This situation has in some cases increased
> tensions between governments and NGOs regarding the handling of external
> funds to the health sector; and many Ministries of Health are reluctant or
> uncertain about how to handle the processes. Another area of interest is
> the governments contracting out health services to CSOs. Member States
will
> increasingly look to WHO for guidance and support in handling these
> relations.
>
> 5.3 At UN level
> ECOSOC revised its policy on CSO relations in 1996 (Resolution 1996/31).
In
> July 1999, a report to the Council by the Secretary General (Renewing The
> United Nations: A Programme For Reform) stressed the need to reach out to
> civil society in activities such as research and information outreach,
> policy dialogue and advocacy as well as fund-raising and programme
delivery,
> and to facilitate the emergence of CSOs in developing countries. Lack of
> financial means and inadequate access to relevant information have
prevented
> Southern NGOs from contributing as much as Northern NGOs in the policy
> dialogue conducted in UN forums.
>
> The Millennium Summit Declaration in September 2000 similarly reflected
the
> need for the United Nations to work in different types of partnerships
with
> civil society, including finding ways for UN leaders to hear the voices
and
> advice of CSOs.
>
> Collaboration with CSOs takes many forms. Most UN entities have a system
of

> official status establishing admission criteria, obligations and
privileges.
> With the notable exception of ECOSOC, the number of CSOs in official
status
> is typically limited to a few hundred at the most. However, there is
> informal collaboration on a wide range of activities with other CSOs,
often
> based on registers or rosters.
>
> The increased importance attached to the role of development CSOs by the
UN
> has led to reviews of existing policies and strategies and the
introduction
> of new forms of communication and collaboration. A number of UN entities
> have "up-graded" headquarters units dealing with CSO issues and designated
> liaison officers at departmental level. Mechanisms are being established
at
> senior management level for involvement of CSOs, with and without official
> status, in policy making, such as "CSO Liaison Committees" and "Civil
> Society Advisory Committees".
>
> 5.4 At development partner level
> Among bilateral and multilateral donors the emphasis on enhancing
relations
> with CSOs is perhaps even stronger, work with CSOs being seen as closely
> linked to the overall aim of poverty reduction which features prominently
in
> donors' development programmes.
>
> Strategies aim to support Northern as well as Southern CSOs, support to
the
> latter often being channelled through the former. All the donors studied
> have specific funding instruments for which Northern CSOs can apply, some
> also funding Southern CSOs directly. Service delivery and capacity
> development are important components of CSO programmes, and there are
> various mechanisms to enable CSOs to participate in and influence policy
> formulation, programme development, etc, and to support CSO networking and
> strengthen their capacity.
>
> 5.5 At WHO level
> WHO's corporate strategy clearly outlines strategic directions that build
on
> contributions from a broad range of other partners including CSOs. It is
> recognised that the global changes described above and WHO's outreach to
new
> actors call for a review and renewal of the way the Organization itself
> interacts with civil society. There are many issues that need to be
> addressed.
>
> Technical departments' desire to work with CSOs is strong, and there is
> added value. However, there are also some perceived risks involved,
arising
> from the North-South imbalance in current CSO relations; limited
> representativeness, unclear legitimacy of some CSOs; and possible
conflicts
> of interest associated with governance and financing arrangements. While

> many CSOs voice increasing concerns about the growing partnerships between
> WHO and the for-profit sector, others participate directly in such
> partnerships.
>
> Differences in current approaches to interaction with CSOs, between clusters
> and between regional offices, cause some confusion to CSOs. Both within and
> outside WHO, the present system of official relations is seen as being in
> need of revision and updating.
>
> One issue raised, at regional level, was the possibility of decentralising
> authority to Regional directors for the establishment of official relations
> with national NGOs.
>
> There is a recognised need for improved knowledge, attitudes and practices
> relating to interactions with civil society among WHO staff at all levels,
> and particularly at the country level. An internal institutional forum or
> network between HQ and ROs, for discussion on CSO relations, has been
> requested. Policies and guidelines are in urgent demand.
>
> 6. Tentative workplan for CSI in the next biennium.
> The above developments form the basis for CSI's work-plan for the next
> biennium, which will evolve as a result of continuing consultation. CSI has
> set four main objectives for its first phase:
>
> · Coherence in WHO policy on CSO relations, to maximise synergies and
> opportunities for joint work towards WHO goals, while managing the risk of
> conflicts of interest.
>
> The planned activities aim at:
> - a renewed system of relations with CSOs that appropriately recognizes the
> contribution of CSOs to the work of WHO and clearly outlines their
> privileges and responsibilities, based on a review and evaluation of the
> current official (formal) relations system and an assessment of other
> informal working relations; and
>
> development of appropriate tools for screening, selecting and assessing
> prospective CSO partners (including identification and management of
> possible conflicts of interest), based on the experience of the official
> relations system and lessons learned.
>
> · A knowledge bank on civil society actors and issues, to inform WHO
> effectively on civil society involvement in public health.
>
> The planned activities aim at:
> - a knowledge base that covers policy analyses on civil society and health,
> a research agenda and reports, practical and technical information on areas
> of civil society contributions to health, tools, guidelines, briefings to
> support WHO work with civil society and regularly updated inventory of WHO/

> CSO relations.
>
> - collaborative projects between CSI and technical departments to develop
> knowledge relevant to civil society activities in health at the country
> level.
>
> · Improved communications and policy dialogue based on better informed
links
> within WHO and between WHO and CSOs.
>
> The planned activities aim at:
> - a communication strategy, using tools and mechanisms such as a CSI
website
> and information materials on WHO policies, and the knowledge base on CSOs
> and health.
>
> · Strengthened WHO capacity to support and facilitate mutually beneficial
> Government/CSO relations at the country level.
>
> The planned activities aim at:
> - WHO staff training and support in the form of tools, guidelines and
> seminars.
>
>
> Consultation form for CIVIL SOCIETY ORGANISATIONS
> on the document entitled "WHO Civil Society Initiative-work in progress"
> dated 19 December 2001
>
> 1. Name of CSO:
> Primary function:
> HQ address:
> Website:
>
> Name of Respondent:
> Position:
> Address:
> Email:
>
> 2. Does the document cover your concerns about WHO relations with Civil
> Society? YES/NO
> If no, are there gaps in the paper or other issues that could be included?
> Do you have specific comments on the workplan of CSI?
>
>
> 3. Do you think the current system for WHO relations with NGOs/CSOs is
> adequate? YES/NO
> If no, in what ways, if any, could the relations between CSOs and WHO be
> improved?
> How should the formal (official relations) system for CSO relations be
> changed?
>
>
> 4. Do you currently collaborate with WHO in any area of your work?
> YES/NO
> If yes, what has been the most constructive way of collaborating with WHO?
> What have been some of the constraints or drawbacks?

> 5. Do you think the communication between WHO and CSOs is satisfactory?
> YES/NO
> If no, what information would you like to receive from WHO?
> What could CSI provide or do to strengthen communication between WHO and
> CSOs?
>
> 6. Do you produce and make publicly available any of the following in the
> area of
> civil society and health?
> If YES, please include a list of these documents.
>
> - research reports YES/NO - technical guidelines YES/NO
> - training materials YES/NO - policy papers YES/NO
>
> 7. Any other comments?
>
> Please return this form to: Margareta Sköld, CSI, email : skoldm@who.int

---

Subject: [AIDS-INDIA] Vacancy notice: Obstetric - Gynecologist (3)
Date: Fri, 18 Jan 2002 09:06:39 -0000
From: tini.unfpa@undp.org
To: AIDS-INDIA@yahoogroups.com

Job Title Obstetric - Gynecologist (3)

Organisation United Nations Population Fund (http://www.unfpa.org)
Job Location East Timor (Dili and Oecussi Districts)

Closing date 20 Jan 2002
Job Description and qualifications:

Ministry of Health of East Timor Public Administration, in collaboration with United Nations Population Fund (UNFPA), is seeking candidates for the following position:

Position: Obstetric - Gynecologist (3 posts) Duty Station: East Timor in the districts of Dili (2 posts) and Oecussi (1 post)Duration: 12 months (3 months probation period) Start date: Immediately or 1 February 2002 at the latest

Duties and responsibilities:

Under the direction of Director of the respective hospitals, the Obstetric - Gynecologist, is expected to undertake the following major responsibilities:

Provide specialist OB-GYN services within the country.
Provide continuing education for health workers as required, especially in Reproductive Health related matters.

Qualifications:

1. An OB-GYN specialist with 2 years of working experience as a specialist in developing countries.

2. A membership of OB-GYN professional association. International membership is an asset.

3. Initiative, sound judgment and ability to work in harmony with staff from different cultural backgrounds;

4. Fluency in English and Bahasa/Malay is an advantage, knowledge in Tetun and/or Portugese is a plus.

Payment and benefits:

In line with the salary scale for international staff in the Ministry, the salary is offered at US$ 3000/month (nett). In addition, the incumbent will receive leave entitlement, accomodation, and one return air-ticket (including authorized travel-related expenses).

Candidates should submit a cover letter and recent curriculum vitae to UNFPA-Dili (tini.unfpa@undp.org) or fax number: 670-390-312-618.

22/1/02

Subject: [AIDS-INDIA] Re: Goa to make HIV- test must before marriage
Date: Sun, 20 Jan 2002 13:56:31 -0530
From: "Dr. K. Kishore Kumar" <kumarkishore@satyam.net.in>
To: <AIDS-INDIA@yahoogroups.com>

Dear Friends,

The labs there will be making a lot of money. I feel that the couples must get reports from at least two labs a few hundred miles apart. Recheck every six months must made statutory.
Jai Hind. Yours sincerely,

Kishore

Mailing address:
Dr. K. Kishore Kumar,
Ashoka Bhavan,
Near MSM College,
Kayamkulam 690502
India
Email ID: kumarkishore@satyam.net.in

Subject: PHA-Exchange> The International Human Right to Health
Date: Sun, 20 Jan 2002 11:07:41 +0700
From: "Aviva" <aviva@netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>

The International Human Right to Health: What Does it Mean for the World?
>
> *Kinney, Eleanor D*
> *34 Indiana Law Review 1457 (2001).*
>
> *An abstract for the article is posted on the SSRN web page:*
> *http://papers.ssrn.com/sol3/papers.cfm?abstract_id=296394*
> <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=296394>
>
> *The article itself is located at:*
> *http://indylaw.indiana.edu/programs/CLH/kinneyihrh.pdf*
> <http://indylaw.indiana.edu/programs/CLH/kinneyihrh.pdf> .
>
> *".....The article suggests three approaches to the implementation of*
the
> *international human right to health:*
(1) define universal outcome measures that measure compliance with the core
state obligations of the human right to health;
(2) establish systematic reporting to responsible international bodies to
monitor progress on implementation and compliance with international human
rights obligations, and
(3) highlight civil rights violations, such as discrimination against
protected groups, that inhibit access to health care services.
>
> *These three approaches are realistic given the economic, social and*
cultural
> *differences among the nations of the world. While these approaches are not*
> *comprehensive, they can do much to advance recognition and implementation*
of
> *the international human right to health throughout the world.*

> *Eleanor D. Kinney, JD, MPH*
> *Samuel R. Rosen Professor of Law & Co-Director, The Center for Law and*
> *Health http://www.iulaw.indy.indiana.edu/Programs/CLH/law_health.htm*
> <http://www.iulaw.indy.indiana.edu/Programs/CLH/law_health.htm>
> *Indianapolis.*

PHA Exchange is hosted on Kabissa Space for change in Africa
To post, write to: PHA-Exchange@kabissa.org
Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

Nob
22/1/02

Subject: [AIDS-INDIA] 89 nations to fight sex trade
Date: Sun, 20 Jan 2002 14:59:37 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

89 nations to fight sex trade

The Statesman 20th January, 2001-New Delhi

New Delhi Jan.19-- Eighty nine countries have signed optional protocol to work against the sale of children, child prostitution and child pornography, stated a Press release issued by the United Nations International Children Education Funds.

There are over roughly one million children - mostly girls- who enter the multi billion commercial sex trade around the world annually.

According to recent studies, teenage girls are forced into prostitution due to the mistaken belief that younger girls are unlikely to be infected with the HIV/AIDS virus.

Jagdish Harsh (jharsh@afxb.org)
Francois-Xavier Bagnoud (INDIA) (www.fxb.org)

Feb
22/1/02

Subject: [AIDS-INDIA] NGOs challenge UNAIDS India AIDS estimates
Date: Sat, 19 Jan 2002 18:03:26 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

NGOs punch holes into UN agency's AIDS estimates

The Indian Express 19th January, 2002-New Delhi

A Group of NGOs and independent activists today claimed that the India figures of HIV/AIDS cases put out by UNAIDS, the United Nations' nodal agency for AIDS, contain several contradictions, and "cover-ups"

"They have released the same 199 9 HIV/AIDS data on four different occasions, and in their latest report, called the 2000 'Revised' update, all the data was suddenly removed," alleged Purushottaman of the NGO Joint Action Council Kannur (JACK).

According to the epidemiological factsheet (India) of the UNAIDS' AIDS Epidemic Update, which is brought out twice a year, there were 3.10 lakh AIDS deaths in India in 1999. The same figure was quoted in the updates of June 2000, December 2000 and June 2001. All the data Are available on the UNAIDS website.

"On what ground have they removed the figures from the latest report?" asked Purushottaman. A UNAIDS official said: "Our figures are accurate." He refused to comment on the alleged "disappearance" of the figures in the 'revised 2000 update.

The activists also questioned the use of the word "epidemic" which is used by the international community to describe the AIDS situation in India. As per the latest UNAIDS/NACO figures, there are 3.86 million people living with HIV/AIDS in India.

"The actual incidence of HIV/AIDS is substantially lower than the projections made by UNAIDS," said Smitu Kothari of the NGO Likayan. According to UNAIDS figures, the HIV prevalence rate in Manipur -- one of the country's earliest entry points due to rampant intravenous drug use --- rose from "hardly detectable" in 1988 to 71 per cent in four years. "Given that the period for HIV to progress to AIDS has been fixed at 4-5 years for India, there should have been visible signs of an epidemic in these areas," said Purushottaman.

Since cost projections, as well as donations and international aid for HIV/AIDS are derived from UNAIDS figures, Kothari Pointed out that incorrect figures may result in gross overestimates of money needed for treatment and healthcare costs.

****

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

22/1/02

Subject: [AIDS-INDIA] Eastern states still low on AIDS awareness: NACO
Date: Sat, 19 Jan 2002 00:56:50 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Eastern states still low on AIDS awareness: Report

The Indian Express 16th January, 2002-New Delhi
TEN YEARS after the country launched the ambitious National AIDS Control Programme, the level of awareness about the killer disease is still pretty low, especially in the eastern states.This has been admitted by none other than National AIDS Control Organisation (NACO), an autonomous body under the Ministry of Health and Family Welfare.

While 76.1 per cent of the population is believed to have ever heard of HIV and AIDS, the percentage is lower in the eastern states, with Bihar figuring at the bottom of the list with just 40.3 per cent awareness.

Equally bad is Uttar Pradesh (50.6 per cent) and Gujarat (55.7) while West Bengal too is much below the national average with just 58.2 per cent aware of diseases known as AIDS.

When it comes to various means of preventing the disease, the eastern states are again on the wrong side, with only 29.5 per cent of the respondent in Bihar saying they know AIDS could be prevented by use of condoms.

West Bengal too figures poorly in this aspect with only 31.1 per cent of the respondents in a nationwide survey admitting they were aware that consistent condom use could prevent AIDS.

Also poor is Orissa's status with just 37 per cent saying so, while Assam too figured poorly with just 49.9 per cent saying yes to condom. Incidentally, though 76.1 per cent of respondent's nation-wide said they heard of AIDS, only 58.9 per cent of them at the national level said they thought condom use could prevent AIDS.

Also poor is Orissa's status with just 37 per cent saying so, while Assam too figured poorly with just 49.9 per cent saying yes to condom. Incidentally, though 76.1 per cent of respondents nation-wide said they had heard of AIDS, only 58.9 per cent of them at the national level said they thought condoms could prevent AIDS. Similar is the awareness level as far as needle sharing as a mode of transmitting AIDS is concerned, with Bihar and West Bengal figuring last in the all-India list of awareness. While only 37.6 per cent of the Bihar respondents knew needle sharing could transmit AIDS, the level of awareness in West Bengal stood at 49.1 against the all-India awareness of 71.2 per cent.

When asked whether they knew AIDS could be prevented by having one faithful uninfected sex partner, only 30.2 per cent of respondents in Bihar said yes. In West Bengal, it was 31.1, while Orissa came a close third from the bottom with 38.2 per cent. Even in the northeastern states, where the alarm bells have already started ringing over the high rates of infection, the awareness level was only 41.2, with the sole exception of Manipur.

In what is one of the worst AIDS-affected states, 71.4 per cent of the respondents said they were aware of safe sex, against the national average of 57 per cent.

****

Jagdish Harsh (jharsh@afxb.org)

Leb
22/1/02

Subject: [AIDS-INDIA] Re: Goa to make HIV- test must before marriage
Date: Sat, 19 Jan 2002 08:26:57
From: "pramod kumar" <pramodsarang@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear Forum members,

This is in response to the news item Goa may make HIV-test must before marriage. very intersting report. Delicate balance between protection of women's vulnerability and the rights of the infected and affected.

However, potential tool for misuse. It will be interesting to see how do we react to this ? Is anything similar in practice anywhere else in the world? The informed may please come forward.

Pramod

Pramod Kumar
E-mail: pramodsarang@hotmail.com

rib
22/1/02

Subject: [AIDS-INDIA] Goa to make HIV- test must before marriage
Date: Sat, 19 Jan 2002 01:01:02 -0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Goa may make HIV-test must before marriage

The Indian Express 18th January, 2002-New Delhi

The Goa government will consider making HIV test compulsory for couples before registration of marriages, the state Assembly was informed today.

The suggestion to make HIV test compulsory before marriage, came from Speaker Partap Singh Rane, during discussion on a question of Victoria Fernandes (Cong) about the number of HIV sero positive people in Goa.

Chief Minister Manohar Parrikar welcomed the suggestion. In tervening during the discussion, Rane pointed out that there was a law in Goa to ensure that all couples were vaccinated against small pox, before marriages. Now small pox is eradicated and similar law could be framed for mandatory HIV test before marriage, he added.

Under the Common Civil Code, which is in force in the state, registration of marriages is compulsory for all the communities residing in Goa. Cutting across party lines, the legislators pointed out that all 11 talukas in the state have the problem of HIV infection and also expressed serious concern over the spread of disease.

Nirmala Sawant, Francisco Sardinha, Jitendra Deshprabhu, Mauvin Cudinho (all Cong), and former chief minister Dr. Wilfred D'Souza urged the state to improve the facilities in government hospitals for detection and treatment of HIV sero-positive people. Victoria Fernandes (Cong) urged the government to consider subsidising AIDS-control drugs at least for people belonging to low-in-come group.

In his reply, Health Minister Dr. Suresh Amonkar said HIV sero-positive people were detected in all the 11 talukas and nearly 801 people have tested positive in the testes conducted by the Goa Medical College Hospital in 2001.

****

Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Feb 22/1/02

[AIDS-INDIA] Goa to make HIV- test must before marriage

Subject: [AIDS-INDIA] Greetings from Manipur
Date: Fri, 18 Jan 2002 07:38:53 +0000 (GMT)
From: "Anand Singh" <chanand43@yahoo.co.in>
To: AIDS-INDIA@yahoogroups.com

Dear All,

I'm a new member in the group and I'm certainly happy to be in the group.

I'm from Manipur working with IVDs for the last 10 years. Working with IVDs in Manipur itself covers HIV/AIDS issues. Many have died and many are in need of care and support. There is no doubt that Prevention plays a key role in the fight against Drugs and HIV/AIDS. But,what about those unfortunate victims !

As the Attrony General of India Soli Sorabjee has strongly come up for this victims,it is high time that doners/funding agencies also start dealing the CARE AND SUPPORT component as one of their top priorities.

As fall out of this illness,more number of widows, orphans are on the increase. OI management itself is becoming a big burden to many of the affected/afflicted due to their state of economy with least concern for the anti-retroviral therapies available now.

I would also request the group to keep me informed about TRAINING/WORKSHOP/ETC. So that myself and my staffs may get the chance to get to know more about how the world is fighting the issues.

If any member/s wants to know more about the problem of IVDs in Manipur,please feel free to ask me.I represent KRIPA FOUNDATION (a national level NGO working in the field of ALCOHOLISM/ADDICTION AND HIV/AIDS) in the state of Manipur.

With regards,

Anand
Kripa Foundation.
"Anand Singh" <chanand43@yahoo.co.in>

Subject: PHA-Exchange> WB Private Sector Dev Threatens Basic Services
Date: Sun, 20 Jan 2002 11:09:16 -0700
From: "Aviva" <aviva@netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>
CC: "hlthpol" <hlth.policy@hn.vnn.vn>, "afro-nets" <afro-nets@usa.healthnet.org>

The action alert below concerns the new WB Private Sector Development strategy that would enhance support for private providers of basic health services. This would encourage further privatisation and undermine country decision making. Background information and critical analysis can be found at www.challengeglobalization.org.
The strategy will be discussed by the Bank's Board soon, but there still is time to share
concerns with Board members. A strong and broad civil society response is important.
Ellen Verheul, WEMOS.

ACTION ALERT
THE THREAT TO BASIC SERVICES (WATER, HEALTH AND EDUCATION):
THE WORLD BANK GROUP'S PRIVATE SECTOR DEVELOPMENT (PSD)
STRATEGY

This Action Alert contains an overview of the PSD Strategy, plus key messages to send to decision-makers, especially the World Bank's Board of Executive Directors. We urge you to communicate with Board members before January 25, 2002 to influence their final decisions on the PSD Strategy.

A LIST OF BOARD MEMBERS CAN BE ACCESSED AT
http://www.challengeglobalization.org/html/ta_menu6.shtml

ANALYSIS OF THE PSD STRATEGY can be found in the Winter 2002 issue of "News & Notices for IMF and World Bank Watchers" at
http://www.CHALLENGEGLOBALIZATION.ORG/html/news_notices/winter2002/Winter02N&N.pdf

A formated copy of this Action Alert along with the The Overview and Conclusion of this issue appear below.

I. OVERVIEW OF THE PSD STRATEGY. The PSD Strategy would expand four types of operations financed by the World Bank Group: structural adjustment, privatization of infrastructure and services, social funds, and microfinance.

Two arms of the World Bank Group would partner to privatize infrastructure and service provision, especially in low-income countries: the World Bank's private sector affiliate, the International Finance Corporation (IFC) and the World Bank's soft loan arm, the International Development Association (IDA). The IFC will increasingly take the lead in expanding private provision of services, while IDA will work with governments to design subsidies and other schemes to offset the costs of private provision to low-income consumers.

In the past several months, the Bank's Board of Executive Directors considered, debated, and rejected successive drafts of the PSD Strategy.

LCB 22/1/02

Some officials said that they had never seen the U.S. -- the main proponent of the Strategy -- in such an isolated position. The Board has postponed decisions on the PSD Strategy for several weeks. In a related decision, the IDA Deputies also postponed action on a U.S. proposal to convert half of IDA's resources from loans to grants.

The three prongs of the PSD Strategy would:

A. Launch a new and expanded generation of structural adjustment programs (SAPs) with policy conditions intended to induce borrowers to adopt "minimum investment standards." The launch of this investment initiative comes just after the announcement by the World Trade Organization in November of a new round of negotiations on investment rules (which will revive the Multilateral Agreement on Investment). Bank promotion of output-based aid (see "B," below) depends, among other things, upon easier private sector entry into markets of low-income countries.

B. Accelerate the privatization of infrastructure and basic services (e.g., health, education, water) on a commercial basis- that is, with cost-recovery user fees. The International Finance Corporation (IFC) would help spearhead this process by, among other things, urging governments to employ more output-based aid (OBA) schemes. OBA schemes delegate basic service
provision to private firms (and NGOs) under contracts that tie provision of financial support to the outputs or services delivered. These schemes can be risky, especially in poorly regulated environments.
Also, because OBA schemes provide back-loaded finance, they often favor international actors with "deep pockets" rather than domestic enterprises.
The U.S. is pressuring the shareholders of the World Bank to convert IDA resources from loans to grants so that, among other things, grant financing can subsidize private provision of services, including OBA schemes.

C. Launch more aggressive efforts to expand the reach of markets by supporting small and medium-sized enterprises, mainly through expanded business development services and microfinance schemes.
The Bank plans to revise its operational policies to ensure that finance is provided on unsubsidized terms. Some loan operations contain microfinance schemes to enable low-income consumers to borrow at market rates in order to purchase basic services,
such as water.

II. Key Messages

1. Undermining Democratic Processes. The World Bank and other creditors and donors should not use pressure tactics to induce recipient governments to privatise basic services. Examples of pressure tactics include: failing to involve the public and
affected unions in privatization decisions, failing to publicly disclose information about privatization plans; withholding aid until recipient governments agree to privatize; running "public information" campaigns to persuade publics to privatize; and supporting
biased cost benefit analyses of policy options. Important political decisions about modes of service delivery should be made by domestic groups, including poor and vulnerable groups, without outside interference.

2. Privatizing Social Services. The World Bank Group poses as a "knowledge bank," but the PSD Strategy states that there has been no evaluation of operations that privatize social services. Yet, new loans show expanded support for such privatization!

3. Imposing User Fees. People may be deprived of basic services because (a) exemptions and subsidizes for private primary education and basic health care may fail to reach the people who need them;
(b) low-income groups may not be able to afford fees, especially for non-compulsory levels of education and secondary/tertiary health care; and (c) the PSD Strategy practically overlooks the necessity for regulation of social sectors.

4. Privatizing into Poorly Regulated Environments. The World Bank Group is "harmonizing" regulatory standards with those of other development institutions. In this process, World Bank safeguard (and other) policies are being weakened with adverse
implications for poor and vulnerable groups and the environment.
(Ultimately, this process may be guided by the WTO's ambiguous emphasis on "least burdensome" regulation.)

5. Sidelining Domestic Actors. Output-based aid (OBA) schemes compensate service providers AFTER services have been delivered. Back-loaded finance will favor international actors with "deep pockets" over domestic service providers. Domestic actors should not be sidelined, especially in service sectors.

6. Providing Grants rather than Loans. The Bank has not disclosed the uses to which grants might be put and, in particular, whether grants would subsidize OBA schemes. Many groups feel that grants are inappropriate in certain circumstances. (For instance, according to Bank publications ("Note on IDA13 and PSD," November 2001), the Bank envisions subsidizing corporations that have not recouped costs through tariffs.)

7. Increasing Fiscal Burdens. The PSD Strategy overlooks off-budget fiscal risks implicit in privatization schemes (e.g., the failed Enron project in Maharastra). Acknowledgement of risks would undermine claims that the PSD Strategy would shift performance risk to private actors and Northern taxpayers

8. Deepening World Bank – WTO Collaboration. The World Bank Group has not disclosed the ways in which the PSD Strategy will pave the way for a new WTO agreements on investment and services, which are currently in the works.

9. Expanding Ineffective Operations. The World Bank's own evaluators have demonstrated the ineffectiveness of PSD operations in low-income countries. The Bank should not expand ineffective operations.

For further information, see "News & Notices for IMF and World Bank Watchers," Winter 2002. The entire issue can be viewed at:
http://www.CHALLENGEGLOBALIZATION.ORG/html/news_notices/winter2002/Winter02N&N.pdf (Please note that this is in PDF format and you need the Adobe Acrobat
Reader from http://www.adobe.com)
Contact: ncalexander@igc.org

Subject: PHA-Exchange> Athough for Africa, has global importance
Date: Sun, 20 Jan 2002 11:58:18 +0700
From: "Aviva" <aviva@netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>

AID AND REFORM IN AFRICA:

LESSONS FROM TEN CASE STUDIES, FINAL REPORT

World Bank, Aid Effectiveness Research, Development Research Group (released March 27, 2001).

[www.worldbank.org/research/aid/africa/release/aid.htm]

Welcome to a post-mortem of and a critical look at Structural Adjustment Programs (SAPs) in Africa together with a proposed new recipe to make them better, avoiding their (sometimes now judged clumsy) pitfalls.

The Report reviews aid and policy reform in ten African countries spanning from the eighties to the nineties. The countries are arbitrarily divided into four categories:

-Successful Reformers (Ghana and Uganda –and, interestingly, Vietnam added),

-Post-socialist Reformers (Ethiopia, Mali and Tanzania),

-Mixed Reformers (Ivory Coast, Kenya and Zambia), and

-Non-reformers (Zaire and Nigeria).

All of them received large amounts of aid and all of them had SAPs.

Overall, I see the Report as an apology for market-based reforms, because the authors truly believe them to be the best option. In doing the latter, the Report tacitly calls on Western donors and on the private foreign investors to rethink their strategies and to support countries that adopt WB-sponsored macroeconomic policies.

Without having any qualms about the brilliance of this Report, the first monumental problem *I* have with it is that it represents a typical cold economists' account and analysis of an indeed complex matter.

The warm analysis of the social consequences and costs of these reforms is nowhere to be seen!! It is skipped as if it does not exist, as if it doesn't count, as if it is unimportant. Passing-by, casual mentions of poverty reduction on pages 4, 31 and 34 add to mere mockery. This shortcoming seriously detracts from the Report's ultimate moral authority.

The second problems I have with this Report relates to the authors' definition of what constitutes "good policies". In an astonishing leap of faith, they arrogantly tell us: "we know enough about development policies to make a fair assessment of the quality of policies across countries and over time... the notion that we are doing

PHA-Exchange> Athough for Africa, has global importance

a reasonable job of measuring policy across countries is supported by the fact that our broad measure of policy predicts fairly well the GDP growth rates of the four categories of countries in our study". Absence of high inflation, functioning foreign exchange and financial markets, openness to foreign trade, effective rule of law and delivery of key services, plus tax and sectoral policies that create good incentives for 'accumulation', and the public sector providing services complementary to private initiatives are given as key elements of "good policy". (pp.2-3) For the Report's analyses, this is then all blended into a 0-4 scale or index in a way that remains unexplained in the main text (trust us: "we know enough about development...").

In short, "good policy" here clearly fits (and serves) the ideological outlook of the World Bank. That, to me, detracts on the Report's objectivity.

The Report (controversially) concludes that aid is not a primary determinant of policy, i.e. that variables under donor control do not consistently influence the success or failure of reform; that aid does not buy good reform. We are further told that policy is truly independent of aid and that the effect of aid will increase with the quality of policies. Aid, in the authors' eyes, did play a significant and positive role in the 'success' of the two sustained reformers (Uganda and Ghana). (pp.4-6)

The Report then goes on to regret that donors tend to concentrate their assistance in countries with mediocre policies with the expectation that aid can spur policy reform. But we are told that policy formation is primarily driven by the domestic political economy where vested interests can (and do) perpetuate poor policies. Therefore, no relationship between formal democratic institutions and good economic policy could be found. Actually, large amounts of aid to countries with bad policies sustain those poor policies allowing the delay of reform, we read. Funds can (and do) actually sustain corrupt and incompetent governments. Attaching conditions to the aid (conditionality) has, in the Report's view, not led to successful policy change. It has often been wasteful and even harmful. If countries perceive donors want to set policy, ministries become passive without disagreeing with the donors since this will only serve to delay the arrival of the much-needed resources.

Further, donors coordinate their work in a remarkably poor way and actually do not discriminated effectively among different countries: they tend to provide the same package of assistance everywhere and at all times; they also give less aid per capita to populous countries. All this is explained by the fact that aid in too many cases is a foreign policy tool rather than a tool for economic development. It is often dictated by colonial relationships and or voting patterns in the United Nations and often ends up financing non-viable or even non-development schemes. Alternatively, aid provides governments with the breathing space they require to contain domestic opposition to market reforms, or it fills the shelves of supermarkets to provide a psychological impression of better things to come. Donors should definitely not provide aid before governments are serious about reform. (pp.5, 6,12,21,26,27-29)

In the early stages of serious reform, we learn that leaders and technocrats (self-servingly meaning those sympathetic to WB policy advice) actually welcome conditionality to 'bind' the process of change. Later, once the reform movement is well in place, conditionality becomes less useful and should be withdrawn, because it limits participation and it disguises the ownership of reforms. But the case studies show that, in a mistake, this has not happened and conditions have become tighter, more numerous and their acceptance more important for lending to be approved. (p.6,30-32) (In an oxymoron, on page 31, we read that to be useful, conditionality must reflect measures that the government wants to carry out... then why the conditionality?, I ask)

The composition of aid is important, we read.

In the pre-reform period, Technical Assistance (TA) and Policy Dialogue are most supportive.

During rapid reform Financing and Conditional Loans are most important.

At a later stage of reform, sustained Finance remains crucial. (p.6)

Rapid reform leading to "good policy" occurs when all of the important macroeconomic reforms have been completed, we are told. (Note the total absence of any mention of the social realm). Then, countries are said to need to move into "second generation reforms"; and which are these?.... privatization , civil service reform, judicial reform, and budget reforms. (p.23)

One cannot avoid but asking: and what about structural reforms leading to poverty alleviation, greater equity and the provision of services for the poor...?

The Report repeatedly speaks about "poor policy" periods, always assuming those to mean periods when World Bank-prescribed policies were not (yet) followed. Confirming the political nature of aid, it goes on to say that governments were estranged from the West during their "poor policy" periods.

In the Report's context, policy dialogue -eufemistically called "low-key assistance" or "dialogue with foreign experts"- seems to be associated with the license Bretton Woods IFIs and donors took to put high pressure ('leverage', the Report says) on governments to adopt macroeconomic reforms, i.e. **replacing state controls by market mechanisms, the latter gratuitiously assumed to be superior.** "When governments are sufficiently desperate... the promise of support induces them to come to agreement relatively quickly on far reaching reform programs". (p.24,26-35)

...so much for the conclusion above that aid is not a primary determinant of policy.

The Report self-servingly claims that policy dialogue with the IMF and WB played a critical role in the early years of "good policy" reform involving small groups of dedicated technocrats and politicians and that TA (absorbing up to 13-18% of all financial aid!) was later most helpful in pushing the early reform agendas. It then recognizes that TA was sometimes ineffective , because it was supply-driven from the donors side. (pp.15,16,20-35).

With hindsight I ask myself, is that what you call 'buying yourself a reform package'?

In procuring technical assistance, the report warns us that many of the consultants "parachute in" giving mediocre advice even as countries complain they need freedom to buy expertise as they see fit. TA, it is confessed further on, is designed to provide ammunition to reformist technocrats: in that sense, policy choices are driven by donor funding rather than the domestically formulated policies: a nice contradiction here again with what is said earlier. (pp.20-21)

Historically, there does not seem to be a systematic relationship between structural adjustment programs and the extent to which African countries reformed, we read. It seems countries embraced serious reform only after they exhausted all other options, and the last option for most often meant adopting IMF SAP packages.

Most interestingly, reforms tended to occur following a crisis. ("Necessary but unpopular decisions had to be made quick before opposition to the reforms could be mobilized"). This highlights the role of leadership, technocrats, ideology, and institutions during such crises and, in order to lead to a "good" reform process, TA has to have done its job. (pp.6, 7,8 -12)

PHA-Exchange> Although for Africa, has global importance

From the case studies, it is clear that countries often slide back following rapid reform. Examples of reasons given for this slippage include wage increases that had to be given to civil servants and political opposition.

To me, these seem quite genuine reactions to growing misery brought about by acute macroeconomic reforms. Donors react to slippage with cut backs particularly when they perceive 'inability' of the government to privatize. (p.9)

Any reform program has losers, we are further told. Because of that, we need objective decision-makers to minimize negative impacts. 'Disinterested' economists then have an edge, because they can 'sell' the program both to winners and potential losers.(pp.10+11)

I find it hard to accept that there is genuine disinterest here. Good reformers do need consultative processes:.period: even in the absence of formal democratic structures.

I further find it objectionable that the Report trivializes the role of external economic shocks and pressures in bringing about and perpetuating economic hardship in African countries. In a put-down way, it is said that President Nyerere "believed" that to be the case. (p.11)

Negating the negative effect of these external factors on national economies is borderline part of a dishonest analysis, I contend

The Report concludes that donors have three basic instruments that they can use to encourage the adoption of "good economic policies" in developing countries: money, conditionality and technical assistance policy dialogue.

It contends each of these made positive contributions in the 10 case studies. But donors used these instruments fairly indiscriminately and later, in the 1990s, did not provide appropriate debt relief. Using the wrong instrument at the wrong time proved wasteful and retarded reform. This, in concluding we are told, calls for "a better calibration of aid and reform".

Giving aid to countries with "poor " policies will not stimulate reform, will maintain the status-quo and will not be reflected in poverty reduction (!)

Finally, donors need to be more selective of the recipient countries they choose and the instruments they use and when. They should operate "on a small scale" with governments with poor economic policies, perhaps providing support to groups outside of government. Conversely, they should maintain high levels of finance in countries with sustained "good policies".

Money can help improve policies, but the key is to disburse it when actual policy improvements have already been achieved.

Surprisingly, and despite all the suffering they have caused, the Report regrets the fact that SAP loans became discredited as instruments: "they could have been useful"....if what is said in this Report would have been heeded ... (pp 33,34-35)

I find that I always learn from reading documents I do not agree with 100%. In this and other cases, I think it will be the same for you.

Subject: PHA-Exchange> New: INASP Health Links
Date: Sun, 20 Jan 2002 12:12:03 -0700
From: "Aviva" <aviva@netnam.vn>
To: "jamie" <jamie@netnam.vn>
CC: <nnbich@yahoo.com>, "pha-exch" <pha-exchange@kabissa.org>

> *New: INASP Health Links*
> *----------------------*
>
> *http://www.inasp.info/links/health/*
>
> *LAUNCHES TODAY!*
>
> *'INASP Health Links' is a new Gateway to selected Web sites of special interest to health professionals, medical library communities, publishers, and NGOs in developing and transitional countries. Please have a look and let us know what you think of the site and, especially, how we might improve it.*
>
> *INASP Health Links consists of three sections:*
>
> *1. GENERAL RESOURCES*
> *(search engines, gateways - global and regional, bibliographic databases, abstracts, clinical trials databases, research networks, dictionaries, glossaries, disease classifications, evidence-based medicine, full-text E-books, image collections, journals, newsletters, medical education resources, news, e-mail lists, and WHO sites).*
>
> *2. SUBJECT INDEX*
> *(e.g. Anaesthesiology, Basic Sciences, Dermatology, HIV/AIDS etc.)*
>
> *3. LIBRARY AND PUBLISHING SUPPORT, AND USE OF ICTs*
> *(Information for Development, Internet Skills, Medical Informatics/Telehealth, Publishing Tools)*
>
> *Each section consists of several pages of hyperlinks, arranged alphabetically, and each hyperlink carries a brief description of the site concerned.*
>
> *FOCUS ON DEVELOPING COUNTRIES*
> *It is estimated that there are at least 30,000 health-related sites on the Internet - but the vast majority are targeted at users in North America and Europe. INASP Health Links contains links to 448 selected sites, of which 160 are specifically focused on health information in developing countries. New links will be added on a regular basis. Sites with a specific focus on users in developing countries are clearly marked with a symbol.*
>
> *Although INASP Health Links does not claim to be comprehensive, our impression is that the many and varied needs of developing-country health professionals (from specialist researchers to village health workers) and health information providers (librarians, publishers and others) are, overall, poorly addressed by existing Web resources. There are some excellent individual resources, but they are few and far between and there are large gaps in coverage. We hope that INASP*

Feb 23/1/02

PHA-Exchange> New: INASP Health Links
[AIDS-INDIA] job opportunities in Bangalore

> Health Links will help others to identify these gaps and encourage
> the development of new resources to address unmet needs.
>
> A TEMPLATE FOR CUSTOMIZATION BY OTHERS
> INASP Health Links is offered freely for use as a template by others
> (e.g. medical school libraries, ministries of health, publishers, li-
> braries, NGOs) to develop customized gateways on their own websites.
> This approach should reduce the risk of duplication of effort while
> maximizing the usefulness of the gateway for specific target groups.
>
> IMPORTANT NOTE
> INASP Health Links is seen to be a "short-term" contribution to help
> address the increasing demand in developing and transitional coun-
> tries for easy access to relevant, reliable health information on the
> Internet. INASP Health Links has been produced with minimal resources
> and is not intended to be definitive nor comprehensive. Moreover, us-
> ers should note that there has been "no formal quality assessment" of
> content. It is hoped the site will encourage the collaborative devel-
> opment of more comprehensive sites by others.
>
> In the long term, health professionals in developing and transitional
> countries require an international collaborative effort to deliver
> comprehensive and quality-controlled gateway services, in consulta-
> tion with end-users. Such vital initiatives are currently being
> planned by a range of international organizations, including the WHO-
> led Health InterNetwork and Interactive Health Network. Ideally,
> every site in such a gateway should be evaluated for quality and
> relevance of content, as occurs with gateway services such as the Or-
> ganizing Medical Networked Information (OMNI), which focuses on the
> information needs of UK health professionals.
>
> HEALTH INFORMATION FORUM, London, 21 May 2002
> INASP encourages international cooperation among existing and planned
> initiatives, so that long-term solutions can be identified, imple-
> mented, evaluated, and improved. To this end, INASP is organizing a
> Health Information Forum meeting at the British Medical Association,
> London on 21 May 2002. The theme of the meeting is: 'INTERNET PORTALS
> AND GATEWAYS TO PRACTICAL INFORMATION FOR FRONTLINE HEALTHCARE
> WORKERS IN DEVELOPING COUNTRIES'. Admission is free thanks to BMJ
> sponsorship but we regret that there is no funding available for
> travel expenses etc. For further details, or to reserve your place,
> please contact Neil Pakenham-Walsh at <health@inasp.info> .
>
> Note:
> Health Information Forum meetings are now formally recognized by the
> Royal Colleges for accreditation for continued professional develop-
> ment (credits are awarded on a meeting-by-meeting basis).
>
> ACKNOWLEDGEMENTS
> INASP Health Links is adapted for international use from the original
> gateway provided by the University of Zambia School of Medicine Li-
> brary (UNZA). The UNZA gateway was developed by UNZA staff in con-
> junction with Lenny Rhine, Librarian at the University of Florida
> Health Science Center Libraries.
>
> INASP Health Links is compiled by Lenny Rhine and Neil Pakenham-

> Walsh. INASP Health Links acknowledges the support and contributions
> of Exchange, INASP, University of Florida Health Science Center Li-
> braries, and University of Zambia School of Medicine Library. INASP-
> Health activities are also supported by the British Medical Journal,
> CDSI (International Council for Science), and the World Health Or-
> ganization.
>
> PRINT COPIES
> Print copies of INASP Health Links are available on request for 45 US
> dollars (25 pounds sterling) [including postage and packing], and
> free of charge to libraries in developing countries.
>
> Dr Neil Pakenham-Walsh
> Programme Manager, INASP-Health
> International Network for the Availability of Scientific Publications
> mailto:health@inasp.info
> http://www.inasp.info

PHA-Exchange is hosted on Kabissa - Space for change in Africa
To post, write to: PHA-Exchange@kabissa.org
Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

Subject: PHA-Exchange> Women's Rights - World Report 2002
Date: Fri, 25 Jan 2002 11:55:56 -0700
From: "Aviva" <aviva@netnam.vn>
To: "pha-exch" <pha-exchange@kabissa.org>
CC: "jamie" <jamie@netnam.vn>

> *Women's Rights - World Report 2002*
>
> Available online at: http://www.hrw.org/wr2k2/women.html
> <http://www.hrw.org/wr2k2/women.html>
>
> *"..... The international women's rights community moved forward,*
> *pressing to protect women's bodily integrity and right to sexual autonomy,*
> *to examine the ways that race or ethnicity and gender intersect to deny*
> *women human rights, and to protect women from gender-specific violations*
of the laws of war....."

> Content:
> *Human Rights Developments*
> *Women's Status In The Family*
> *Labor Rights*
> *Trafficking*
> *Women in Conflict and Refugees*
> *Violence Against Women*
> *The Role of the International Community*
> *United Nations*
> *United States*
> *European Union*
> *Council of Europe*
> *Organization for Security and Cooperation in Europe (OSCE)*
> *Relevant Human Rights Watch Reports*

> *Human Rights Watch World Report 2002*
> *January, 2002*
>
> *Sections of the report have been posted as PDF file at:*
> *http://www.hrw.org/wr2k2/download.html*
> <http://www.hrw.org/wr2k2/download.html>
> *in English, Spanish, Portuguese and French*
>
> *".....The 670-pages Human Rights Watch World Report 2002 includes*
summaries of human rights events in 2001 in 66 countries, as well as
analyses of
U.S. and European foreign policy, refugee issues, international justice,
> *corporate social responsibility, and the weapons trade....."*

PHA-Exchange is hosted on Kabissa - Space for change in Africa
To post, write to: PHA-Exchange@kabissa.org
Website: http://www.lists.kabissa.org/mailman/listinfo/pha-exchange

Leb
29/1/02

Subject: [AIDS-INDIA] Goa: What is happenings are appaling! What is NACO doing??
Date: Thu, 24 Jan 2002 01:08:38 -0800 (PST)
From: Aditya Bondyopadhyay <adit_bond@yahoo.com>
To: AIDS-INDIA/@yahoogroups.com

Hi everybody,

I have been following what has been happening in Goa Legislative assembly with increasing dread. Has NACO taken any initiative to educate the members of the consent and confidentiality issues involved in testing and the problems of mandatory testing under any circumstance. More importantly has NACO, or the state AIDS cell taken any initiative to enlighten the rather misinformed members about the latest status of AIDS Vaccinations. We seem to have the real threat of making Goa the gunea pig state for international vacination trials with the active but foolish collusion of the people's representatives themselves.

Given their zest to be seen to be doing something, as also their record of the past [ref: lucy D'souza case], I am afraid the respected legislators may land us with another misguided and misinformed initiative like the Supreme Court judgement suspending the rights of HIV Positive people to marry. All their talk reeks of bad science and of an utter lack of understanding of the human rights perspective involved. I hope NACO acts now when there is time rather than try damage control later. That way maybe NACO can avoid being targeted again with criticism of the kind thay were subjected to in Melbourne with regards to the Lucknow case.

Extremely worriedly yours

Aditya Bondyopadhyay
e-Mail: <adit_bond@yahoo.com>

Lib
28/1/02

Subject: [AIDS-INDIA] Goa: Compulsory AIDS vaccination mooted
Date: Wed, 23 Jan 2002 08:34:35 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Compulsory AIDS vaccination for couples mooted

TIMES NEWS NETWORK [THURSDAY, JANUARY 17, 2002 11:31:03 PM]

PANAJI: Intervening a debate during the question hour in the Goa assembly on Thursday, Speaker Pratapsingh Rane suggested to the government to examine a proposal to see if it could make it mandatory for all couples who are getting married to go in for anti-AIDS vaccination.

The question originally tabled by Victoria Fernandes on HIV seropositive patients drew the attention of the whole House when Health Minister Dr Suresh Amonkar told them that between 1998 and 2001, the Goa Medical College Hospital at Bambolim detected 2,960 positive HIV cases while the number of AIDS cases stood at 90.

Rane held the view that couples earlier used to get vaccinated for cholera before marriage. Since AIDS was causing tension in society, why was the state government not asking couples to go in for a mandatory check for AIDS before the marriage is registered, he questioned.

Former Chief Minister Churchil Alemao expressed concern over the rising number of cases in Salcete taluk covering his Benaulim constituency in south Goa while Cong MLA Mauvin Godinho said, several cases die a silent death for fear of getting exposed before the society or they all choose to go out of the state for medical treatment.

Replying to a supplementary tabled by the mover of the question Fernandes, the Health Minister told the House, he would ask the Finance Minister to consider a suggestion to scrap sales and octroi tax imposed on medicines brought in Goa for curing this disease.

Fernandes argued that medicines prescribed for AIDS were very costly and not all lower income group people could afford to buy them.

When the government pointed out that there were 40 AIDS cases detected in 2001 alone, a couple of Legislators suggested that the administration should be more vigilant and aggresive in case of commercial sex workers in the suburbs of Vasco town.

When the opposition leader remarked that there was a decline in AIDS cases during the tenure of former Chief Minister Pratapsingh Rane (now Speaker), Rane observed that it was true but one MLA from that area lost his seat then.

When it was revealed that in Satari and Canacona, covered under the Western Ghats as well, Goa had detected five and nine cases in 2001, the House was shocked.

Apart from the Goa government, the health minister said, non-governmental organisations were working towards prevention and control of HIV/AIDS. The government, he said, had strengthened STD clinics

http://www.timesofindia.com/articleshow.asp?

LEB 28/1/02

Subject: [AIDS-INDIA] HIV testing centres to be set at PHCs
Date: Wed, 23 Jan 2002 08:39:57 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

HIV testing centres to be set at PHCs

TIMES NEWS NETWORK [THURSDAY, DECEMBER 27, 2001 12:34:17 AM]

HYDERABAD:The state government proposes to set up HIV testing centres at the primary health centres and anti-natal counselling centres in all the assembly constituencies, according to Chief Minister N Chandrababu Naidu.

Intervening in a discussion under Rule 304 on AIDS, Naidu urged the MLAs and religious leaders to extend a helping hand to the government in containing the "menace".

He said the government has decided to further streamline the blood banks and sensitise local bodies to pay special attention to create awareness among the villagers. Government would also introduce sex education in the curriculum at the Intermediate level, he added.

Naidu appealed to the religious and political leaders to speak about the need to control AIDS at the end of every programme they participate in.

http://www.timesofindia.com/articleshow.asp?catkey=-2128916011&art_id=-822484165&sType=1

Lab
25/1/02

Subject: [AIDS-INDIA] Bihar: Move to make policemen aware of AIDS
Date: Wed, 23 Jan 2002 08:43:22 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Move to make policemen aware of AIDS

TIMES NEWS NETWORK [THURSDAY, JANUARY 17, 2002 3:02:48 AM]

PATNA: The Bihar State Aids Control Society (BSACS) has sought co-operation from director general of police (DGP) R R Prasad for launching an Aids awareness campaign among policemen in districts.

This follows the reported death of 40 policemen in Maharashtra allegedly due to Aids.

BSACS project director C K Anil has also sent to the DGP a newspaper clipping carrying the report on the death of 40 Maharashtra policemen due to the dreaded disease. The report says incidence of Aids/HIV among policemen is on the rise in Maharashtra with 202 of them getting infected with it.

Anil, in a communication to Prasad on January 10, said that the BSACS held Aids/HIV awareness camps at the headquarters of different battalions of the Bihar military police (BMP) between August and December, including those at Patna, Gaya and Dehri-on-Sone.

Anil urged Prasad to direct all the SPs to co-operate with the BSACS in this endeavour.

The BSACS has also decided to launch a programme for sex workers and transport workers operating on national highways in the state besides starting counselling through telephone. It has invited applications from voluntary organisations in this regard and will hold a high-level meeting with them between February 12 and 14.

Anil said sex workers have to be motivated to put pressure on their clients to use condoms for safe sex. Sex workers fear that the number of their clients would come down if they start putting pressure on them to use condoms, he added.

The state government, following a directive from the Union health ministry, has formed an umbrella society in all the 30 districts to implement various national health programmes for control of Aids, kala-azar, polio, malaria etc instead of having separate district-level societies for implementation of different health programmes. All the district-level societies have been merged into one, Anil said.

BSACS sources said so far 107 Aids cases have been detected in Bihar.

The BSACS is, however, unlikely to achieve the target for distribution of free condoms among people, particularly those in high-risk groups, during the current financial year. Against the target of 10 lakh, the BSACS has so far distributed only 1.5 lakh condoms. Anil said condoms are being rushed to all the primary health centres for free distribution during the fortnight-long family health awareness campaign beginning from February 14.

The BSACS recently received Rs 1 crore from the National Aids Control Organisation for implementing Aids/HIV control schemes in the state. Last year, it had received more than Rs 7 crore of which it has spent only Rs 3.5 crore so far.

Leb 25/1/02

Subject: [AIDS-INDIA] Alcohol and sexual behavior
Date: Wed, 23 Jan 2002 04:06:42 -0800 (PST)
From: Dr.BM Tripathi <bmt_54@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear Colleagues,
I am interested in collecting information on alcohol use and sexual behaviors in Indian culture(s). I realise much of the work from developing countries is not reflected in the available databases. If you have published and unpublished research documents, reports, articles, assessment instruments, references etc. related to the topic please forward it to me. Your contribution will be duly acknowledged. I will be thankful for your help and cooperation.
Thanks,

=====

Dr. BM Tripathi
Additional Professor
Department of Psychiatry
AIIMS, New Delhi-110029, INDIA
email:bmt_54@yahoo.com
Ph:(Res)00-91-11-6519719,
Ph:(Hosp)00-91-11-659 4410

Lib
25/1/02

Subject: PHA-Exchange> WHO CSI request
Date: Tue, 22 Jan 2002 03:52:45 +0600
From: Dr Qasem Chowdhury <gksavar@citechco.net>
To: "pha-exchange-kabissa.org" <pha-exchange@kabissa.org>

Claudio posted the letter from Eva Wallstam of CSI with Informal Consultation Document on CSI and a consultation form few days back. CSI invited People's Health Movement (PHM) for the consultation. In the meantime PHM formed an ad hoc working circle on WHO/WHA/CSI to deal with the ensuing WHA and CSI request and entrusted Ravi Narayan and Zafrullah Chowdhury to initiate the circle. Ravi will coordinate circle. In our new structure document it is suggested that PHA should have a common and collective response on different international issues.

Those who wants to respond to the CSI documents, please send your suggestions, comments to Ravi who will collate all the information and will make final
documented to circulate among the members before forwarding it to CSI. Kindly send
your response to Ravi by 31st of January 2002.

With all the best to all of you.

Qasem

4-6
23/1/02

Subject: [AIDS-INDIA] PMTCT launch in India
Date: Tue, 22 Jan 2002 22:37:15 +0530
From: "Dr. Bitra George" <bitra_george@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear All,

I have reviewed all the reactions to my comments on the launch of PMTCT program in India and I respect them. I am glad that Mr Prasada Rao, Project Director, NACO provided clarifications on some of the issues raised. Let me reinforce some points again.

(1) I am indeed proud that India is launching this program whereas other countries including South Africa are still struggling with this issue. I am also aware that it was necessary to conduct a feasibility pilot study before implementing a program of this magnitude.

(2) The points that I have raised is not to criticise the efforts made by the Government but to flag important issues that need to be kept in mind while implementing this program. I am sure that Mr Rao along with Dr P.L.Joshi and rest of his dedicated team will tackle these issues.

Mr Rao, I will definitely take up your offer to place some more constructive suggestions before you for your consideration.

Regards,
Dr Bitra George
E-mail: bitra_george@hotmail.com

Lib
23/1/02

Subject: [AIDS-INDIA] Re: Personal reaction to the launch of PMTCT in India
Date: Mon, 21 Jan 2002 19:58:39 +0530
From: "T Jacob John" <vlr_tjjohn@sancharnet.in>
To: "AIDS India" <AIDS-INDIA@yahoogroups.com>

Dear friends,

All those interested in PMTCT are invited to read the following:

1. Merchant RH et al. Strategy for preventing vertical transmission of HIV. Bombay experience. Indian Pediatrics 2001; 38: 132 - 138.

2. John TJ. Mother-to child transmission of HIV must be prevented. Indian Pediatrics 2001; 38:680 - 682.

3. John TJ. Frequency of mother-to-infant transmission of HIV. Indian Pediatrics 2000; 37: 1027 1029

Any local pediatrician will be getting Indian Pediatrics regularly and you can access the journal locally.

T Jacob John.
E-mail:<vlr_tjjohn@sancharnet.in>

Ltr
22/1/02

Subject: [AIDS-INDIA] Message from a new member
Date: Mon, 21 Jan 2002 13:10:36 -0000
From: "Pramod Kumar" <pramodsarang@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear Moderator,

Thanks for including me in the AIDS-INDIA Forum. Though I have not been visible in the electronic discussion forums, I have been watching the proceedings from the wings. I follow most of the discussion groups where debates are serious.

As some of the members of the forum may know, I have been a journalist working from Chennai for the HINDU and my areas of specialisations have been public health, information communication
technologies and issues related to social deprivation.

I have been writing and reporting on HIV/AIDS for more than a decade now. I have been away from Chennai for nearly a year doing a consultancy with UNAIDS ICT in Delhi. I will be back to work after this sabbatical by March 15. YOu can see my reports again from March.

Here are my contact details.

G.Pramod Kumar
Special Correspondent, THE HINDU, 859, Anna Salai, Chennai.
Ph. 91-44-8413344 (o) and 91-44-8211666 (h)
Till March 15, I may be contacted in Delhi at 9810203670.
Thanks, Regards

Pramod
E-mail: pramodsarang@hotmail.com

Lib
22/1/02

Subject: [AIDS-INDIA] Re: NGOs challenge UNAIDS India AIDS estimates
Date: Wed, 21 Jan 2002 10:57:09 -0500
From: "Dr.A.K.Agarwal" <crsei@giascl01.vsnl.net.in>
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

Dear Forum members,

[This is in reference to the news item Purushottaman of the NGO Joint Action Council Kannur (JACK)]

I cannot comment on the confusion about the figures. But, it would be improper to say, HIV is not visible in the country. In Manipur, you go ask anybody whether you have seen anybody suffering or dying of AIDS, he would tell you "yes" in all probabilities. This is also the case in many other parts of the country. Well, we do not expect HIV to occur like common cold or influenza and only then call it an epidemic. By definition, epidemic is occurrence of any disease in a frequency significantly higher than in the past. Even a prevalence of 1% of HIV, in places where it was zero in the past, is a significant variation. Hope this clears, a few doubts.

Dr.A.K.Agarwal, MBBS, MD
South Asia, Regional Technical Advisor - HIV/AIDS
Catholic Relief Services

E-mail: "<crsei@giascl01.vsnl.net.in>

Leb
22/1/02

1/22/02 10:30 AM

Subject: [AIDS-INDIA] Write-up on HIV/AIDS in India in British Medical Journal
Date: Fri, 25 Jan 2002 09:51:03 -0600
From: "Lalit Dandona" <dandona@asci.org.in>
To: AIDS-INDIA@yahoogroups.com

http://bmj.com/cgi/content/full/324/7331/192

BMJ 2002;324:182-183 (26 January)

Editorials

Can India avoid being devastated by HIV?
Yes, by scaling up local prevention efforts targeted at the most vulnerable groups

HIV has reached epidemic proportions in India. Many predict that this nation of one billion people will soon see infection rates soar if current prevention programmes are not scaled up.1 India may be next in line after sub-Saharan Africa to be devastated by the virus.

The Indian government estimates that in 2000 3.95 million Indians were infected with HIV, the second largest number of infected people after South Africa.2 Although the prevalence of HIV in India may seem relatively low0.7% of the general adult population compared with rates of 20% and over in South Africa, Zimbabwe, and Botswanathe infection has now been detected in all states and union territories. It is no longer confined to vulnerable groups, such as sex workers and transport workers, or to urban areas.

If effective prevention efforts are not implemented immediately, and sustained long term, the World Bank warns that India could have 37 million people infected with HIV by the year 2005.3 This is roughly equal to the total number of HIV infections in the world today. Rising HIV rates are also likely to fuel India's epidemic of tuberculosis. Tuberculosis was already a major cause of death in India before the HIV epidemic, and it is the most common opportunistic infection in Indian patients with AIDS. 4 5 In an analysis of deaths between 1987 and 1997 in Mumbai in people aged 25-44 years, tuberculosis related mortality increased by 140%probably related to Mumbai's worsening HIV epidemic.

The focus of prevention efforts in India must be on preventing unprotected heterosexual intercourse with an infected partner, the predominant mode of HIV transmission, accounting for nearly 88% of the total.7 India is particularly vulnerable to an explosive growth in HIV infection because of the many obstacles to HIV prevention campaigns, including widespread poverty and illiteracy and social inequalities based on caste and gender. Sex is a taboo subject. There has been a lack of strong political commitment to deal with HIV and a persistent denial and disbelief among many policy makers, public health specialists, care providers, and the general public about the size of the HIV epidemic.

Evidence from successful AIDS control projects around the world shows that targeted intervention programmes by peer educators among the groups most vulnerable to HIV are the most effective way to contain the rapid spread of HIV infection. Interventions should focus on vulnerable "core transmitter" groups, such as sex workers, rather than on widely dispersed groups, such as male clients of sex workers. This approach has been central to every successful prevention effort in India. For example, the STD-HIV intervention project in Kolkata targets women sex workers based in brothels. Peer volunteers, themselves sex workers, counsel the women about HIV prevention, and the women receive treatment for

29/1/02

sexually transmitted diseases and education about using condoms and in negotiating skills.

The HIV prevalence rate among these sex workers has remained below 10%.9 In contrast, in Mumbai, where there have been no similar interventions, HIV prevalence among sex workers rose rapidly from below 10% in the early 1990s to over 50% by 2000.

The targeted approach has also been used successfully at state level. Tamil Nadu was once considered an epidemic "hot spot." Since the mid-1990s, however, the state has raised public awareness of HIV and has identified the vulnerable core transmitter groups, who received the same interventions as those received by the women in the Kolkata project. These groups have shown substantial changes in their behaviour,10 a prerequisite for the epidemic to slow down. Indeed, the latest round of surveillance in antenatal clinics suggests that the epidemic in Tamil Nadu may be slowing down.10

There are some promising signs that India could find the political will to control its HIV epidemic. For example, the prime minister, Atal Bihari Vajpayee, has spoken publicly of the need for HIV control, has met infected people, and has urged the corporate sector to respect the rights of infected employees. The success story in Tamil Nadu was partly due to successive chief ministers actively supporting HIV control. But a few success stories are not enough to reverse or even slow India's HIV epidemic. For this, at least 80% of vulnerable core transmitter groups need to be reached.11 They must be mapped, identified, and enrolled into peer based interventions. Such mapping will require a reliable database, drawing from different kinds of surveys and surveillance systems.

Better planning and funding at the national level and by the states with the highest HIV prevalence are needed to establish this database. States must show a stronger commitment to direct and fund HIV control programmes: they should look to countries like Thailand, where HIV was controlled through surveillance and targeted interventions.12

S Ramasundaram, joint secretary.
Department of Commerce, &
Government of India, Udyog Bhavan,
New Delhi 110011, India (ramasundaram@vsnl.com)

Footnotes

The opinions expressed here are not necessarily those of the Indian government.

1. Ratnathicam A. AIDS in India: incidence, prevalence, and prevention. AIDS Patient Care STDS 2001; 15: 255-261[Medline].
2. National AIDS Control Organisation. Country scenario:1999-2000. New Delhi: Ministry of Health and Family Welfare, 2000.
3. World Bank. Project appraisal document on a proposed credit in the amount of SDR 140.82 million to India for a second national HIV/AIDS control project. Washington, DC: World Bank, 1999.
4. Hira SK, Dupont HL, Lanjewar DN, Dholkia YN. Severe weight loss: the predominant clinical presentation of tuberculosis in patients with HIV infection in India. Nat Med J India 1999; 11: 256-258[Medline].
5. Lanjewar DN, Anand BS, Geeta R, Maheshwari MB, Ansari MA, Hira SK, et al. Major differences in the spectrum of gastrointestinal infections associated with AIDS in India versus the west: an autopsy study. Clin Infect Dis 1996; 23: 482-485[Medline].
6. Hira SK, Srinivasa ASR, Thanekar J. Evidence of AIDS related mortality in Mumbai, India. Lancet 1999; 354: 1175[Medline].
7. Jha P, Nagelkerke JD, Nyugi EN, Prasada Rao JV, Willbond B, Moses S, et

al. Reducing HIV transmission in developing countries. Science 2001; 292: 224-225[Full Text].
9. Dana S, Bandyopadhyay N, Mukherjee S, Dutta N, Basu I, Saha A. STD/HIV intervention with sex workers in West Bengal, India. AIDS 1998; 12 (suppl B): S101-S108.
9. Salunke SR, Shaukat M, Mira SK, Jagtap MR. HIV/AIDS in India: a country responds to a challenge. AIDS 1998; 12 (suppl B): S27-S31.
10. Ramasundaram S, Allaudin K, Charles B, Gopal K, Krishnamurthy P, Poornalingam R, Warren D. HIV/AIDS control in Indialessons learned from Tamil Nadu. Geneva: Commission for Macroeconomics and Health, World Health Organization, 2001. www.cmhealth.org/docs/wg5_paper25.pdf (accessed 21 Nov 2001).
11. Jha P, Vaz LME, Nagelkerke N, Plummer F, Willbond B, Ngugi EN, et al. The evidence base for interventions to prevent HIV infection in low and middle-income countries. Geneva: Commission for Macroeconomics and Health, World Health Organization, 2001. www.cmhealth.org/docs/wg5_paper2.pdf (accessed 26 Nov 2001).
12. Nelson KE, Celentano DD, Eiumtrakol S, Hoover DR, Beyrer C, Suprasert S, et al. Changes in sexual behaviour and a decline in HIV infection among young men in Thailand. N Engl J Med 1996; 335: 297-303[Abstract/Full Text].

Lalit Dandona, MD, MPH
Director, Health Policy
Centre for Social Services
Administrative Staff College of India
Bella Vista, Raj Bhavan Road
Hyderabad - 500 082
India
Email: dandona@asci.org.in, lalit_dandona@hotmail.com
Tel: (+91 40) 331 0952, ext 295
Fax: (+91 40) 331 2054
http://www.asci.org.in

Subject: Request for organizational endorsement: money for global AIDS fight
Date: Fri, 25 Jan 2002 12:35:19 -0500
From: Paul Davis <pdavis@crnpath.org>
To: healthgap <healthgap@crnpath.org>

Organizational sign-on's needed:

Call for urgent action by President Bush and U.S. Congress to fund the fight against AIDS

The request for $2.5 billion from the US government is for next year's contribution to the Global Fund to fight AIDS TB and Malaria, and for bilateral AIDS programs.

If your organization supports greater contributions towards the Global Fund, please sign on to the short statement below. If yes, please send an email to pzeitz@globalaidsalliance.org;

Please provide the name of your organization and its location (state and country);

2. Please pass this email on to your listserve, consider posting on Your website, and encourage as many organizations as possible to sign on to this statement;

3. This statement will be used by U.S. advocacy groups who are meeting members of Congress in their Districts and in Washington Offices. It will also be sent to the President and all key Administration officials. The statement is designed to demonstrate the broad-based coalition that is supporting increased US government funding to stop global AIDS;

4. Updated lists of signers for this "Call for Action" will be posted at www.globalaidsalliance.org

---

CALL FOR URGENT ACTION TO STOP GLOBAL AIDS

(Update as of 25 January 2002)
Our organizations are humanitarian, religious, and other groups committed to a full-scale effort to stop the global AIDS pandemic and its related causes, particularly in the impoverished regions of the world, which have been the hardest hit by the AIDS crisis. Because of the unprecedented impact of the crisis, we call on President George W. Bush and the US Congress to provide $2.5 billion in FY 2003 resources to the Global Fund to Fight AIDS, TB, and Malaria and to bilateral AIDS programs.

Without bold investment now, projections are that 100 million people will become infected by 2007. The AIDS pandemic and its related causes in Africa, Asia and elsewhere threaten to destabilize nations and undermine global security. We believe taking immediate action to ensure adequate resources to combat AIDS, TB, and Malaria is one of the best ways the US can exert leadership in a troubled world.

Respectfully,

US-based Organizations
ACT UP/Cleveland
ACT UP/East Bay
ACT UP/Philadelphia
Africa Faith & Justice Network
African Services Committee
AIDS Healthcare Foundation
Allard K. Lowenstein International Human Rights Clinic, Yale Law School
American Jewish World Service

Lib - HIV Studie fiche
IN
25/1

IN
25/1

Artists Against AIDS Worldwide
Artists for a New South Africa
Berkeley Gray Panthers
Bishop's Task-Force on AIDS -- Greek Orthodox Diocese of Chicago
Blue
Boston Global Action Network Africa AIDS Project
Central Conference of American Rabbis
Detroit Catholic Pastoral Alliance
Disciples Advocacy Washington Network
Doctors of the World, USA
Elders for Survival
Episcopal Church, USA
Equal Partners in Faith
Federation of Temple Sisterhoods
Foundation for Hospices in Sub-Saharan Africa
Global AIDS Action Network
Global AIDS Alliance
Global Immunity
Global Partnerships for Excellence in Education, Research, and Service
Greek Orthodox Archdiocese of America
Harvard AIDS Coalition
Health and Human Rights Interest Group, Univ of Mass Medical School
Health GAP Coalition
Hope for African Children Initiative
Hospice Alliance of Colorado
The Hunger Project
Management Sciences for Health
Marin Interfaith Task Force on Central America
Medical Mission Sisters: Alliance for Justice
Mennonite Central Committee U.S. Washington Office
Middle East Children's Alliance
Missionary Oblates of Mary Immacuate
MIT United Trauma Relief
National Association of Black Social Workers
NETWORK, A National Catholic Social Justice Lobby
North Coast HIV/AIDS Coalition
Northwest Coalition for AIDS Treatment in Africa
NYC AIDS Housing Network
OneDiaspora Project
Orphans and Vulnerable Children's Task Force
Pan-African Charismatic Evangelical Congress
Partners in Health
Pearl S Buck International
Pendulum Project
Physicians for Human Rights
Presbyterian Church (USA), Washington Office
Project Concern International
RESULTS
Search for a Cure
Society of Missionaries of Africa
Student Global AIDS Campaign-Tulane Medical School Chapter
Students for Global Public Health
The Futures Group International
TransAfrica Forum
Union of American Hebrew Congregations
Unitarian Universalist Association
U.S. Doctors for Africa
Washington Office on Africa
Washington State Africa Network
Women of Reform Judaism
World Conference for Religion and Peace
Wyoming: Positives For Positives
Yale AIDS Network
Youth Against AIDS

International Organizations
ACT UP/Paris
Association of People With AIDS in Kenya
CARE Thailand / Raks thai foundation

quest for organizational endorsement: money for global AIDS fight

Chisomo Children's Club, Malawi
Development Aid from People to People, Zambia
Hospice Africa, Uganda
Jerusalem AIDS Project, Israel
Kenya AIDS Intervention/Prevention Project Group, Kenya
Liberal Association for the Movement of People, India
Lilongwe Diocese - Catholic Church, Malawi
No Limit for Women Project, Cameroon
Organization of Development Program for the Underprivileged, Bangladesh
Population Concern, United Kingdom
Rabeya Hai Welfare Trust, Bangladesh
Selian Lutheran Hospital, Tanzania
Society For The Advancement of Women, Malawi
The Grail, South Africa
Youth Net and Counseling, Malawi

Paul Davis
pdavis@critpath.org
Health GAP Coalition
ACT UP Philadelphia

+1.215.833.4102 mobile
+1.215.474.6886 tel.
+1.215.474.4793 fax

Subject: [AIDS-INDIA] A Treatment Activist Proposal for tiered pricing system
Date: Fri, 25 Jan 2002 09:51:34 -0500
From: "George M. Carter" <gmc0@ix.netcom.com>
To: <AIDS-INDIA@yahoogroups.com>

I had held some dim hope that as activists we could support some form of tiered pricing system that would allow industry to obtain somewhat higher prices from wealthy nations while developing countries could move forward with unfettered access to generically-priced AIDS drugs.

Several issues have arisen that take that negotiating point off the table.

First is the UNAIDS pharmaceutical slush fund. The recent conference in Ouagadougou made no mention of parallel imports or compulsory licenses. It would appear that this erstwhile noble concept, aside from being brutally underfunded, is going to be little more than a shifting of cash from nations and organizations into the coffers of pharma.

Second is the recent increase in the cost of AIDS drugs as much as 5-10% in the midst of a recession and serious budget cuts being faced by many state governments. The effect on ADAP and Medicaid state formularies is NOT going to be a boon to the health of people with AIDS. In addition, such squeezing of funds will assure that access to other interventions, such as dietary supplements like carnitine, acetylcarnitine, protein powders, coenzyme Q10 and so forth, will be eclipsed. These types of interventions have data supporting their use in offsetting the hideous and potentially fatal side effects of ARV use.

Clearly, despite agreements made between industry and the Fair Pricing Coalition, their word is not to be trusted. This is consistent with past behavior. Even the first hard-won drop in the price of AZT years ago from the then Burroughs Wellcome was offset by an increase in the price of acyclovir. The industry has displayed a consistent pattern of deceit and shady business practices, resulting in massive increases in prices to which Americans hitherto have had little recourse (short of costly trips to Canada or Mexico).

Clearly, they have little regard for the mere voices of AIDS activism. And little shame in their activities. They have had no compunction about threatening nations' right to seek compulsory licenses with sanctions--and sweet talking others with bribes. Yet still, 8,000 people die every single day, in large measure because of their greed.

As a result, I propose that we begin a grassroots campaign to lobby ADAP and Medicaid officials to seek parallel imports or compulsory licenses as a point of leverage and out of economic necessity to obtain the lowest possible price for ARV medications.

I look forward to lively discussion. Although, having raised this on the CST list, I fear that many of the upper echelon of activists have been compromised by the conflicts of interest that are faced by their respective organization's heavy reliance upon pharm industry funding and thus will remain either silent or find reason to oppose this campaign.

Comments?

George M. Carter
E-mail: <gmc0@ix.netcom.com>

Drug pricing

Lib - AIDS India file

TN 28/1

TN 28/1

Subject: [AIDS-INDIA] information on HIV pandemic and its spread to rural areas
Date: Sat, 26 Jan 2002 20:29:20 +0530
From: "Vijay Rai" <vijayrai@bol.net.in>
To: <AIDS-INDIA@yahoogroups.com>

Formerly believed to be mainly an urban phenomenon, HIV/AIDS now threatens the lives and livelihoods of millions of rural dwellers throughout the developing world. "Rural HIV often remains silent and invisible" because of poor health infrastructure, restricted access to health facilities and inadequate surveillance, according to the report.

Africa, with its predominantly rural population, remains the global epicenter of the HIV/AIDS pandemic, with 83 percent of all deaths to date and 8 out of 10 new infections. In nine countries in sub-Saharan Africa, adult HIV/AIDS prevalence rates exceed 10 percent and in Botswana, Namibia, Swaziland and Zimbabwe in Southern Africa, between 20 percent and 26 percent of the population aged 15 to 49 is living with HIV or AIDS.

However, India - with four million people affected by HIV/AIDS - is the single country with the largest number of infected people. There, where 73 percent of the population is rural, recent studies have shown that HIV is spreading faster in some rural areas than in urban ones.

And in Latin America and the Caribbean, several Caribbean countries have among the highest incidence of the disease in the world, although the spread of the epidemic in Latin America has been slower than in other regions.

Besides the human suffering, HIV/AIDS threatens sustainable agriculture and rural development. At the household level this translates into loss of adult farm labor, as adults fall sick and die, resulting in a decline in productivity, loss of assets and income, increase in household expenditures to meet medical bills and funeral expenses, and a rise in the number of dependents relying on a smaller number of productive family members.

HIV/AIDS incidence also results in the forced disposal of productive assets, the loss of indigenous farming methods, and may require a switch to less labor-intensive crop production - often leading in turn to declining levels of nutrition.

In Zimbabwe for example, agricultural output of small farmers could have been slashed in the past five years by as much as 50 percent, mainly because of the effect of HIV/AIDS. Sickness and death of an adult family member can result in the inability of a household to cultivate the land. In addition, AIDS widows may not have legal rights to land and property after their husbands' death. Many women must leave their homes and face severe poverty, the report says.

Two types of rural areas are particularly vulnerable to HIV/AIDS - those situated along truck routes and those that are sources of migrant labor to urban areas. The spread of HIV/AIDS along trade routes is well-established, whereas traditional subsistence regions have been perceived to be less vulnerable to HIV/AIDS. However, the fact that many subsistence agricultural regions are also sources of migrant labor in the agricultural lean season may make them similarly vulnerable.

Many people infected with HIV/AIDS return to their villages when they become ill, the report notes. Rural families then provide most of the care for HIV/AIDS patients and bear the costs for food, medicine and funeral expenses.

Poverty makes people increasingly vulnerable to HIV/AIDS by increasing migrant labor, family breakup, landlessness, overcrowding and homelessness. In the absence of traditional family and social ties, people are more likely to engage in risky sexual behavior. The poor are also less likely to take seriously an infection that is fatal in years to come, if they are struggling with daily survival. The incubation period of HIV/AIDS is likely to be shortened by poor standards of nutrition and repeated infections, while access to medical care is lowest among the poor.

Poverty also makes HIV/AIDS education difficult, as there are high levels of illiteracy and little access to mass media, health and education services, particularly in rural areas. Poor women are especially vulnerable as they are not likely to be able to protect themselves from infected husbands. They tend to be ill informed on health matters and have little power to control any aspect of sexual relations.

Sub-AIDS-India file

JN 28/1

JN 28/1

According to a report by UNAIDS which concludes that governments should make agricultural and rural development decisions with the consequences of HIV/AIDS in mind. Ministries that deal with agriculture should be sensitized about HIV/AIDS education and advocacy. Households affected by the pandemic should have better access to and control over resources such as extension, credit and land.

Vijay Rai
E-mail: <vijayrai@bol.net.in>

Subject: [AIDS-INDIA] Re: HIV in Rural India: Many challenges ahead of us
Date: Mon, 28 Jan 2002 03:19:33 -0000
From: "Dr. Sai Subhasree Raghavan " <subharaghavan@aol.com>
To: AIDS-INDIA@yahoogroups.com

Dear Forum Members,

This is in response to the spread of HIV in rural areas in India and a need for an immediate intervention:

I am glad to see a discussion on HIV spread in rural areas. I do hope some of you may elaborate on these issues.

Let me add some of my observations. I come from a small village in East Godhavari District in Andhra Pradesh, which is a prosperous village, due to the availability of water for irrigation. It is by the most beautiful river, Godhavari and flushed with greenery and beauty. In our village ignorance and innocence with regard to sexual issues are equated with good behavior.

Literacy levels are low especially among the lower economic strata, and economical independence by women is often unheard of or unaccepted in the village system.

I am already hearing many stories about the number of people my village and surrounding villages lost to AIDS and this spread worries me. Yes it is a development issue for our village and other villages, as many of these villagers work on the farm for their living, and agriculture is main staple of our income. With regards to to HIV in rural areas are:

1) Use of any barrier methods either in lower or higher income stratum, by educated and uneducated individuals is very low (insignificant). Many women are not simply aware of barrier methods. Those who are aware simply have no power in negotiating or they don't seem themselves at risk for acquiring infection.

2) There is tremendous amount of sex trade at many levels in the villages, may be much more than at urban level. Farmwomen trade unsafe sex with farmer/land lord for a bag of rice to feed her family, for a small loan to get her daughter married or for a palm leaf to cover her hut or for lack of power over the landlord. Many of these men from all social economic levels (and castes) also frequent small towns near by and cities (Kakinada, Peddapuram and Rajamundry etc) to visit commercial sex workers. [For those who are interested data on these networks, you can get them from APSACS office, as they have already mapped these sexual networks]

3) Wives of these men may be aware of their husband's sexual practices, however, they continue not to question as they accept it as a normal practice or left with no economic options in case they would fight against it.

4) It is an empowerment issue, it is a negotiation issues, it is a poverty issues, it is an issue of education, it is an issues of

gender inequality and finally it is an issue of misuse of power by men.

5) Until we bring about massive changes in education, economic situation and empowerment issues among these women (which I am afraid will take few decades), women-specific barriers methods are the only immediate option we have in fight against HIV in India.

6) enhancing access to FHC with specific HIV related services is emerging as an urgent need.

If we succeed in empowering these women, where will we house them when they are thrown out for their homes for wanting to negotiate barriers methods with their partners or husbands?

Dr. Sai Subhasree Raghavan
Columbia University
New York
E-mail: subharaghavan@aol.com

Subject: [AIDS-INDIA] Re: Goa: Compulsory AIDS vaccination mooted
Date: Mon, 28 Jan 2002 12:06:20 +0530
From: "Dr.A.K.Agarwal" <crsei@giascl01.vsnl.net.in
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

FORUM Subscribers,

"Goa assembly Speaker Pratapsingh Rane suggested to the government to examine a proposal to see if it could make it mandatory for all couples who are getting married to go in for anti-AIDS vaccination""

But, what is this anti-AIDS vaccine ? Has such vaccine already developed ? I do not have report of any such development. There are a number of vaccines under trial. But, so far there has been no recommendation for out of research use.

Dr.A.K.Agarwal, MBBS, MD
South Asia, Regional Technical Advisor - HIV/AIDS
Catholic Relief Services
E-mail: <crsei@giascl01.vsnl.net.in

Leb
29/1/02

Subject: [AIDS-INDIA] Re: Personal reaction to the launch of PMTCT in India
Date: Mon, 28 Jan 2002 08:26:20 +0530
From: "T Jacob John" <vlr_tjjohn@sancharnet.in>
To: "AIDS India" <AIDS-INDIA@yahoogroups.com>

Reply to Dinesh Agarwal's concerns.

[Dr.Dinesh Agarwal (dinesh.agarwal@unfpa.org.in) wrote, [snip]Considering the fact that a substantial number of deliveries are taking place in pvt nursing homes/ clinics especially in high prevalence states, it will be crucial that pvt sector is also to be on board for any such intervention to achieve its objectives. Also considering gender dimension, what about treatment to mothers?]

Each point is valid.

But, any journey must begin from where you are.
The short course treatment does no good for mother, true, but no harm either. But we can reduce MTCT from about 30% now to less than 5 % in those who actually get treated.

The principle and policy are the beginning points. From there, increasing proportions of mothers will get the benefit in coming years. More deliveries must take place under supervision, for the sake of the safety of mother and newborn and the new policy will be one more reason to encourage this.
Let the Govt first accept its responsibility to formulate policies and then other steps will follow.

Private sector has already begun some action. But it is in a policy vacuum.

T Jacob John.
E-mail: <vlr_tjjohn@sancharnet.in>

Leb 29/1/02

Subject: [AIDS-INDIA] Courts cannot solve AIDS issue, says SC
Date: Sun, 27 Jan 2002 15:08:38 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Courts cannot solve AIDS issue, says SC

RAKESH BHATNAGAR
TIMES NEWS NETWORK [FRIDAY, JANUARY 25, 2002 11:24:55 PM]

NEW DELHI: The Supreme Court has said that it cannot decide the controversy whether HIV virus causes AIDS. ``The controversy is not capable of judicial determination nor is judicially manageable'', the court said while dismissing a public interest petition seeking certain directions to the Union government including an end to administering of toxic drugs to HIV positive suspected patients.

Petitioner Joint Action Council (Kannur) said even the scientist who discovered HIV was unable to isolate the virus. Unless and until it was isolated and there was evidence to show that a person suffered from AIDS, the government should not put the individual on such medicines or drugs or injections, which were confirmed to be ``lethal and toxic,'' worse than the disease itself, petitioner's counsel Kamlesh Jain said.

Later, Union government told the court that it was a global problem. A global strategy was being devised to fight an epidemic which is spread over the world.

A Bench comprising Justice R C Lahoti and Justice Brijesh Kumar, while rejecting the petition, said,``UNO is also involved in devising the strategy and making the funds available for fighting the epidemic''.

The court hoped that the Central government may consider the representation made by the petitioner .``We have no reason to assume why the government may not take into consideration and keep them in view while devising any policy'' on AIDS.

http://timesofindia.indiatimes.com/articleshow.asp?catkey=-2128936835&art_id=2068758090&sType=1

Lib
28/1/02

Subject: [AIDS-INDIA] Kaushalya's one-woman fight against AIDS
Date: Sun, 27 Jan 2002 15:09:56 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Kaushalya's one-woman fight against AIDS

HARNEET SINGH
TIMES NEWS NETWORK [THURSDAY, JANUARY 24, 2002 3:05:11 AM]
CHANDIGARH: Confident, unassuming and shy are the adjectives that best describe 27-year-old Kaushalya. But beneath this veneer is a steel- hard and unbreakable spirit. This gutsy lady from Namakal in Chennai is a true survivor.

An HIV positive patient, she has the guts to say this to death: "You do what you have to. I am going to live." Kaushalya has not only come out in the open about her condition, she's also heading a support group for women so that they are aware of their rights and know all about AIDS.

President of Positive Women Network in Chennai that she started in 1998 with 18 women, Kaushalya is now working with 90 women, no mean achievement this... what with the stigma attached to the ailment.

Providing belief to the popular adage, 'still waters run deep' Kaushalya narrates her own story, "It was in 1995 that I came to know that I was suffering from HIV/AIDS. I got the virus through my husband who died within three months of our marriage. I didn't know then that he had AIDS and thus my initial reaction was of denial and anger." It took her time to come out of her denial and when she did, she decided to fight at her own level so that women like her who usually get the virus unknowingly can become aware of the disease, "Once I decided to fight, I made a conscious decision that my fight would not remain restricted to only me but would include all the women so that we can voice issues as a united force not just as an individual.

That's how I started the Positive Women Network" adds Kaushalya. The courage to go public with her illness came from within her and from the support of her maternal uncle "When I was first diagnosed with AIDS I just knew that it was a killer disease. That's all. Even if my friends used to express their support and solidarity with me, I used to shun them believing that the virus was contagious.

It was my maternal uncle who educated me about the disease after which I decided to discard all my inhibitions and started giving my story in local papers and television." Ironically although she decided to shift base from Namakal near Salem to Chennai believing that the acceptance of the disease would be more in the urban city, Kaushalya found the reality to be just the opposite, "The acceptance level in Namakal was much more than Chennai.

Although people were not much aware of AIDS, they were indeed more concerned about it whereas in Chennai, a HIV positive woman was burnt alive."

This happening proved to be a major set back for Kaushalya who also went underground only to resurface a year later because of that steely resolve of hers. Currently on combination drugs, Kaushalya is fighting the disease valiantly even though her doctors had lost all hope for her survival.

A year-and-a-half back when they had as good as declared her gone, she bounced back courtesy her mental make-up, "Mental treatment is the best treatment and I am alive for my movement and I have decided to really live till I don't die," says Kaushalya. Amen!

28/1/02

Subject: [AIDS-INDIA] Youth ambassadors for Positive Living
Date: Sun, 27 Jan 2002 15:11:28 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Against a dangerous enemy
HARNEET SINGH

TIMES NEWS NETWORK [THURSDAY, JANUARY 24, 2002 3:07:53 AM]
CHANDIGARH: They're all here -Participants from Bangladesh, India, Maldives and Sri Lanka attending a three-day sub-regional workshop for youth ambassadors for Positive Living organised by the Commonwealth Youth Programme (CYP) Asia Centre, Chandigarh, at its premises.

The first day of the training programme was inaugurated by Dr. David Miller, Country Programme Adviser, UNAIDS (India). In addition to an expert panel of resource persons, the workshop also included presentations by international organisations such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations International Children's Emergency Funds (UNICEF). Speaking on the occasion, Raka Rashid, regional director, CYP Asia Centre, said, "Youth ambassadors for the Positive Living Programme, which was officially launched in January 2001, is an adopted version of Youth Ambassadors of Positive Living Programme of CYP Africa region which recruited HIV-positive people to send out the message of positive living to young people whereas at CYP Asia Centre, youth ambassadors, irrespective of their HIV status are recruited to spread the message."

Dr David Miller, a native of New Zealand, a pioneer in HIV/AIDS psychosocial management since 1983 and working on HIV/AIDS in developing countries since 1986, who is also a member of the WHO Global Programme on AIDS from 1989-1990, presented a staggering account of the AIDS epidemic in the country. In his one-hour presentation, he said, "Although k n o w l e d g e about the disease has come a long way since 1982 when the first patient of AIDS was diagnosed, our capacities as a species to battle AIDS has not shown much mobility.

" Blaming the mindset of the people, Dr Miller said, "The stigma attached with AIDS kills just as effectively as the virus, thus the first step is to fight the stigma at all levels." He presented some shocking figures that served as big eye openers, "In 2001 there were 40 million people with AIDS out of which six million were from Southern Asia.

In the world, 3-million cumulative number of deaths have occurred due to the AIDS infection during 2000. India is also the second most populated country in the world with regards to AIDS where 11,000 new infections are reported in a week and where 21.1 percent of AIDS patients are women." Another astounding fact that Dr Miller presented was that, "90 percent of women with HIV-in India have had only one sexual partner who in most cases is the husband.

" Also present at the occasion was Dr Ajit Sarcha, Deputy Director, State AIDS Control Society, Chandigarh, who said "In Chandigarh there were 262 reported cases of AIDS in 2000 which turned into 475 in 2001 but still the city is a low prevalent state as regards the AIDS epidemic."

http://timesofindia.indiatimes.com/articleshow.asp?
catkey=54640994&art_id=351237912&sType=1

Leb
28/1/02

Jegadish Haran (jharan@fxb.org)
Francois-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] Re: HIV in Rural India- Microbicide is the priority !
Date: Thu, 31 Jan 2002 08:27:11 +0700
From: "Peter Godwin" <peterg@bigpond.com.kh>
To: <AIDS-INDIA@yahoogroups.com>

What Maitreya says about condoms and women's status is very true, especially in India. I don't think that female condoms will make much difference, however, the evidence seems to suggest that they require just about as much negotiation as male condoms, and are far more clumsy to use.

But what about microbicides? They are so much more suitable for women's use and empowerment - why is there not much more pressure being generated to make the development of a good microbicide a top priority? They usually seem to be tacked on as almost an afterthought to discussion or programmes for vaccines. With its great bio-medical research base, and the kind of really pressing need Maitreya demonstrates, why is India not in the forefront of microbicide development?

Peter Godwin
Phnom Penh
E-mail:<peterg@bigpond.com.kh>

Subject: [AIDS-INDIA] Re:HIV in Rural India: Can family ties save us?
Date: Thu, 31 Jan 2002 10:00:44 +0530
From: "Dr. Ashok Kumar Agarwal" <crsei@giascl01.vsnl.net.in
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

Dear Avni Jain,
Good to see so many people reacting to my mail. I am aware of all the studies you are quoting. I have always preached HIV should not be only associated with CSWs but the intervention should also address the so called "low risk" general population and that is what I was doing while looking after projects in Manipur and West Bengal between 1993 to 2001.

I have stayed and worked in the remotest part of the country, seen and faced the systems in villages which are skewed against women. But, still I find "the strong Indian family ties" could be worked to an advantage.

Female condoms for housewives could always be tried on a pilot basis in a project. Lot of things need to be studied before making a generalized strategy: do you think a rural/urban deprived women would be able to afford a female condom, or insert it properly, how many times she is going to use it, how is going to clean it / with what, or is there any organization which would give a free adequate supply to these women. You would agree even the free male condom supply frequently goes out of stock.

I would say, the best means of empowering a women is financial freedom and access to information / education. All other things follow suit. But, then these things take a long time. So we need to have a multipronged approach.

Dr. Ashok Kumar Agarwal, MBBS, MD
South Asia, Regional Technical Advisor- HIV/AIDS
Catholic Relief Services
52/2 Orient Row, Kolkata - 700 017
India
Tel. No. 91-33-2287 6033/1969
Fax No. 91-33-2280 9652
E mail : crsei@giascl01.vsnl.net.in(aagarwal)

Ref
6/2/02

Subject: [AIDS-INDIA] Re: Indian representation at the Global Fund (GFATM) Board !
Date: Thu, 31 Jan 2002 10:11:05 +0530
From: "ihoaids" <ihoaids@vsnl.com>
To: <AIDS-INDIA@yahoogroups.com>

[Readers are invited to propose specific actions to be taken by Indian AIDS NGOs, NACO and the Government. Moderator]

Dear Forum members,

It is nice to note that someone has raised the voice, at last.

We Indians and largely almost all Asians are used to the attitude of submissiveness and patience. Asia inhabitates 60% of the world population and nearly 25% of HIV infections (my estimate of HIV in India; which has been deliberately downplayed to 4 million or less for variety of reasons since 1997, is 10 million if not more).

Most important is the incidence (rate of new infections) of HIV in Asia is much more than that of African countries, though the prevalence (rate of cumulative infections) is much more in Africa.

At the time of selection for NGO representatives for GFATM, there were several congratulatory messages for those selected and raising the issue of Asians or Indians would have been seen out of place.

However, now as the dust is settled down, we must raise the issue equivocally from the region.

The second anomaly in the NGO selection was that two of the three were given to HIV+ve people, while only one seat was reserved for HIV+ person out of the three NGOs.

No doubt that the importance of HIV+ person on the board is much more pertinent, but then an additional seat for NGO can be created on the board.

The other possible issue regarding why Indian or Asian NGO representative is not selected is, the the indifference of GFATM and the donor countries of the board.

India, Thailand and China being the front runner countries in the world in providing cheaper ART and diagnostics circumventing patents, certainly irks the powerfull multi-national pharma lobby which pulls the strings / calls the shots of the board.

Ironically, India is not listed as a priority country in receiving subsidised ART drugs either in UNAIDS list or the GFATM.

Till date GFATM as well as UNAIDS has not taken a decisive

Subject: [AIDS-INDIA] Instruments for the assessment of sexual risk behaviors
Date: Thu, 31 Jan 2002 05:11:52 -0800 (PST)
From: bm tripathi <bmt_54@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear Colleagues,
I am looking for the instrument(s) for assessment of sexual behaviours among HIV infected persons, population of risk, general population. There is paucity of such instruments in the published literature from India. If you are using a schedule/questionnaire for assessment of sexual behaviours in your clinical/research work, please forward it to me.
Thanks

Dr. BM Tripathi
Additional Professor
Department of Psychiatry
AIIMS, New Delhi-110029,INDIA
email:bmt_54@yahoo.com
Ph:(Res)00-91-11-6519719,
Ph:(Hosp)00-91-11-659 4410

Subject: [AIDS-INDIA] Bhubaneswar: HIV tested blood cost 2 times more
Date: Thu, 31 Jan 2002 20:07:03 -0000
From: "Subash Mohapatra" <scmours@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

HIV tested blood bottles cost 2 times more

Bhubaneswar: The price of 200mg RBC blood bottles that earlier used to cost around Rs.140 has soared as high as Rs.290. This sudden rise in the price of blood bottles has created resentment among the people, who are unable to afford blood bottles at the time of emergency. The Blood Bank authorities have explained that the rise in cost is due to the HIV testing of blood.

As per the directives of the Centre, supply of blood without HIV testing has been prohibited. For the HIV testing of the blood, National AIDS Control Organization (NACO) used to provide AIDS kit for HIV testing. But these kits are out of stock for the last 2 weeks. Though the AIDS cell of the state govt. has been informed about the matter, no steps have been taken so far. As a result, the chemicals required for the testing is being purchased from the open market. Hence, Rs.160 extra is being charged on a single bottle, says Dr Debasis Mishra of Blood Bank. He has assured that as soon as the kits will be provided by NACO, the bottles will be available at the original price of Rs.140.

When asked about the irregularities in the supply of AIDS kits, joint director of State AIDS Cell (SAC) Dr TN Swamy assured that things would again come back to normalcy. He informed that the kits are being provided by NACO basing on the demands of the previous year.

But since, in certain Blood Banks, the demands went up suddenly, the kits became out of stock before the deadline. Swamy said, if NACO delays in supplying the kits, SAC would chalk out other alternatives. According to him, the ELISA kits supplied by NACO is being misutilized. With the help of this kit, 96 blood samples can be tested at a time. But in most of the blood banks, ELISA kits are being used to test only 5 6 blood samples. Once opened, the utility of the kit is reduced to a great extent. So, keeping this in view, the SAC has asked NACO to provide RAPID kits through which, only one blood sample can be tested at a time.

dharitri:oriya daily dated on 31 jan,2002
---
s. c. mohapatra
E-mail: <scmours@yahoo.com>

Subject: [AIDS-INDIA] Re: HIV in Rural India: Many challenges ahead of us
Date: Wed, 30 Jan 2002 16:50:43 -0500
From: Avni Amin <aamin@genderhealth.org>
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

Dear Dr. Agarwal:

Current UNAIDS and NACO figures for HIV infection in India show that the epidemic is moving steadily beyond its initial focus on sex workers to the general population, especially women (25% of infections are in women). In Maharashtra data show that wives of men attending STD clinics who have only had sex with their husbands are increasingly becoming infected (14% in Pune), and the proportion of women attending Antenatal Clinics who are infected is also steadily increasing (2% in Maharashtra which indicates that the epidemic has spread to the "general" populations). What this tells us is that the epidemic in India is no longer just about "sex workers". Women in primary partnerships (i.e. housewives) in India are not only at risk, and becoming infected, but as much as sex workers are unable to convince their partners to use the male condom. Therefore, advocating the female condom only for sex workers, and not for housewives is not only contrary to the hard evidence provided by the NACO figures, but also does not take into account the realities of women's situation in our society.

We have enough studies conducted in India that clearly show the vulnerability of Indian women in their family context with respect to not being able to talk about fertility, sex, STIs, and contraception including condom use with their partners, and experiencing violence especially if they dare to question them about their sexual behaviors (refer to study by Martin et al., in UP, Annie George's study on sexual communication and negotiation in urban areas of Mumbai - Tata Institute of Social Sciences, Bang and Bang study in Gadchiroli on high levels of RTI in rural Maharashtra and many others). These studies clearly tell us that the our notion of the famous "Indian family ties" really rests on denying women their right to information that will protect themselves and their families from STI and HIV, and denying their right and the necessary means to act upon that information by negotiating safe sex with their partners. While I agree with you that men need to be an integral part of the solution (as they are more than a part of the problem), negotiating safe sex with men will remain a distant dream for all women (housewives and sex workers) in India unless we start thinking of empowering them with concrete strategies like the female condom.

Furthermore, efficacy studies conducted on the female condom in other countries (both developed and developing - US, UK, Thailand, South Africa, Brazil) show that the female condom not only protects against HIV, but also also against STIs, RTIs and unwanted pregnancy. Even if you feel that the HIV epidemic is really a problem of sex workers (which itself is debatable), surely you would agree that other STIs, RTIs and of course fertility (and we have enough evidence for this) are a huge problem for all women in our country. So the female condom, controlled by women themselves might be worthwhile advocating for all women, not just for sex workers.

I hope this has provided enough hard evidence from numerous studies conducted in India and published that test the notion of "Indian family ties", and demonstrate the need for concrete strategies to protect Indian

Subject: [AIDS-INDIA] Indan represeatation at the Global Fund Board !
Date: Wed, 30 Jan 2002 19:54:23 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Dear Forum subscribers,

Some of you may be interested in the povisional list of Global Fund Board Members. China, Pakistan, Thailand and Japan from Asia are voting members. Neither Indian NGOs nor the Government is represented on the Board.

Moderator
AIDS-INDIA e FORUM

Global Fund Board Members: PROVISIONAL LIST

Voting Members

BRAZIL (Latin America & Caribbean)
Dr. Paolo Teixeira
Director National AIDS programme
Ministry of Health Brazil

CHINA (Western Pacific Region)
Dr. Huang Jiefu Vice-Minister
Ministry of Health

EUROPEAN COMMISSION
Dr. Lieve Fransen
Acting Head of Unit
Human and Social Development Directorate General for Development

FRANCE
To be determined

GATES FOUNDATION
Dr. Helene Gayle
Director of HIV/AIDS Program
Bill and Melinda Gates Foundation

NGO REPRESENTATIVE FOR DEVELOPED COUNTRIES
Dr. Christoph Benn
Germany
German Institute for Medical Mission

NGO REPRESENTATIVE FOR DEVELOPING COUNTRIES
Mrs. Milly Katana
Uganda
Health Rights Action Group

ITALY
Mr. Giandomenico Magliano
Minister Plenipotentiary
Director-General Development for Cooperation

3

3/1/02

1/31/02 10:08 AM

Ministry of Foreign Affairs

JAPAN
Mr. Seiji Morimoto
Deputy Director-General of the Multilateral Cooperation
Dept. Ministry of Foreign Affairs

PAKISTAN (Eastern Mediterranean Region)
Mr. Ajaz Rahim
Federal Secretary
Health Government of Pakistan

PRIVATE SECTOR
Mr. Gavan Lingani
Deputy Chairman
Anglo American plc

SWEDEN
Mr. Lennarth Hjelmåker
Director Department for Global Development
Ministry of Foreign Affairs

THAILAND (South East Asia)
Dr. Suwit Wibulpolprasert
Deputy Permanent
Secretary Ministry of Public Health

UGANDA (Eastern & Southern Africa)
Dr. Chrispus Kiyonga
Minister without Portfolio
Government of Uganda

UKRAINE (CIS region)
Dr. Vitalii Moskalenko
Minister of Health

UNITED KINGDOM
Mrs. Clare Short
Minister for International Development

USA
Dr. Tommy Thompson
Secretary of Health and Human Services

[redacted] & Central Africa
Awaiting confirmation of Board seat and representative

Ex Officio Members without voting rights
NGO Representative of the community of people living with HIV/AIDS or from a community living with TB or malaria

Ms. Philippa Lawson
Sr. Program Manager.
International HIV/AIDS Team Leader
Academy for Educational Development
Center for Community-Based Health Strategies

1/31/02 10:08 AM

Subject: [AIDS-INDIA] Re: HIV in Rural India: Many challenges ahead of us
Date: Wed, 30 Jan 2002 11:25:14 -0500
From: Mary Shepherd <mshepher@jhsph.edu>
To: AIDS-INDIA@yahoogroups.com

Dear Dr. Ashok Kumar Agarwal,

I would respectfully suggest that you read the UNAIDS report by Dr. Shalini Bharat on HIV/AIDS discrimination and stigmatization -- especially with respect to women.

She has documented how (in urban settings) the experience of the epidemic is intensified for women due to the family ties of which you speak. Women tend to carry a disproportionate share of the blame for infecting their husbands with HIV, and the burden of caring for those infected. The responsibility accorded to women for the epidemic is disproportionate to the control they have over their risk.

"...it is the content of relationships that sets apart women's experiences from those of the men. Women are wives, mothers, daughters and daughters-in-law before they are HIV-positive women... to the extent that familial and social relationships are dictated by societal and sexual norms, the impact of HIV/AIDS for men gets blunted and shared; for women it gets sharper and more focussed in her. ...

Daughters, wives, and daughters-in-law experienced greater discrimination in comparison to sons, husbands, and sons-in-law."

[Bharat S (1999). HIV/AIDS related discrimination, stigmatization and denial in India. Mumbai, India, UNAIDS and Tata Institute of Social Sciences]

With kind regards,

Mary Shepherd
PhD Candidate, School of Hygiene & Public Health
Johns Hopkins University
[illegible] N. Wolfe St., Rm W4510
Baltimore MD 21205

Feb 31/1/02

Subject: [AIDS-INDIA] Research Ethics Fellowship Program
Date: Wed, 30 Jan 2002 05:05:41 -0000
From: "Joe Thomas" <joe_thomas123@yahoo.com.au>
To: AIDS-INDIA@yahoogroups.com

Announcing: 2002-2003 Research Ethics Fellowship Program at the Harvard School of Public Health This two-year, non-degree fellowship is being offered by the Program on Ethical Issues in International Health Research in the Department of Population and International Health. The program will support four fellows and is funded by an International Bioethics Education and Career Development grant from the Fogarty International Center of the National Institutes of Health.

Please note that this program is specifically geared toward individuals from Asia

The Research Ethics Fellowship has two phases:

Phase I: During the first phase (September 2002-June 2003), fellows will take courses at the Harvard School of Public Health and other Harvard schools, attend institutional review board meetings, and participate in a field visit to the Department of Clinical Bioethics of the Warren Grant Magnuson Clinical Center at the National Institutes of Health. Fellows will also develop workshop curricula and a research project to be completed in their home country during the second year.

Phase II: During this 12-month period (July 2003-June 2004), fellows will return to their home institutions to carry out the research projects and short-courses that have been developed in Phase I. Following the completion of Phase II, fellows will attend a four-day regional meeting for the purpose of sharing the results of their research and planning future collaborations.

The fellowship will include: program-related travel expenses, room, board, tuition, and health insurance for the 10-month Phase I period. In addition, funding will be provided for a research project and program-related travel expenses in the Phase II period.

This fellowship is intended for individuals involved in all areas of international health research, including medicine, anthropology, epidemiology, education, journalism, political science, and law; government, foundation, and industry officials with funding responsibilities; and members of institutional and governmental review boards.

Applications are due on March 1, 2002.

To download an application packet, please visit our website (http://www.hsph.harvard.edu/bioethics) or contact:

Tracy Rabin
Program on Ethical Issues in International Health Research
Building 1 1106 B

Leb
1/31/02

Subject: [AIDS-INDIA] HIV in rural India
Date: Wed, 30 Jan 2002 10:03:14 -0530
From: "Vijay" <vrai-rhgm@modi.com>
To: <AIDS-INDIA@yahoogroups.com>

With reference to the continuing debate on the spread of IW/AIDS in Rural India.
I would like to highlight the issue of the dearth of information among the comman people about the pandemic and the precautions to be used while coping with the pandemic.

I would like to quote an incident where in a pregnant woman was not allowed to stay in her home when she was found to be positive.

Also to quote a news report in the Times Of India where in a team of Health workers were distributing condoms in rural areas of East India. the villagers asked the workers whether it (the condoms) should be taken with cold water or hot water. highlighting the bare lack of information and the state of working of the Govt. media in such situations.

vijay Rai
E-mail:<vrai-rhgm@modi.com>

Lo6
31/1/02

Subject: [AIDS-INDIA] Re: HIV in Rural India: Many challenges ahead of us
Date: Wed, 30 Jan 2002 12:36:03 +0530
From: "Dr. Ashok Kumar Agarwal" <crsei@giascl01.vsnl.net.in>
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

Dear Ms Jayasree,
Thanks for the comments. I never denied the risk of "women being thrown out" if she starts negotiating with her male partner. My intention was only to make the issue light and address both the female and male. Do you know of any study or report saying, large number of women being thrown out as they started negotiating on sex ? Strategies are not made on rare events. There may be many other social reasons for the woman being thrown out. I agree, we need to react fast and adequately for curbing the HIV epidemic. That is why, I said, we should not hold back the empowering interventions for women and also include men in the program.
Introduction of female condoms may be applicable for sex workers but I am not sure of them being recommended for housewives. Please let me know of any study you know of.
The issue of strong family ties is a debatable one. Over the years, my view has changed. I agree, the ties may also work towards disadvantages but then I find there are more advantages. During my twenties, I used to feel, the ties are more of a disadvantage. Now in thirties, I feel, they are more of advantage.
Hope I have been able to clarify myself to some extent.

Dr. Ashok Kumar Agarwal, MBBS, MD
South Asia, Regional Technical Advisor- HIV/AIDS
Catholic Relief Services, 4/2 Orient Row, Kolkata - 700 017
India. Tel. No. 91-33-247 6433/1969. Fax No. 91-33-240 8652
E-mail : crsei@giascl01.vsnl.net.in(aagarwal)

31/1/02

Subject: [AIDS-INDIA] Re: Goa: Compulsory AIDS vaccination mooted
Date: Tue, 29 Jan 2002 13:25:52 +0530
From: "Rajesh" <buddhadev@iqara.net>
To: <AIDS-INDIA@yahoogroups.com>

Dear FORUM Subscribers

This is in reference to GOA developments.
is anybody knows which Anti AIDS vaccine they are trying to implement ?
Till date to my knowledge there is no such vaccine available except
Researchers are trying hard for it.

Political agencies & NACO -are you aware of the facts which is happening in
GOA ?

Dr.Rajesh Buddhadev MD
NISARG AIDS CARE
buddhadev@worldgatein.com

Dr.Rajesh Maganlal Buddhadev <nisarg@bom6.vsnl.net.in>
M.D.
Nisarg Skin & Aids Clinic
Dermatology & HIV Medicine

Lib
30/1/02

Subject: [AIDS-INDIA] Re: HIV in Rural India: Many challenges ahead of us
Date: Tue, 29 Jan 2002 09:34:10 -0530
From: Dr.Ashok Kumar Agarwal <crsei@giascl01.vsnl.net.in>
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

Dear Dr.Sai Subhasree Raghavan,

I appreciate your analysis on the continuing rapid spread of HIV in India and the plight of women. I would not be scared of a situation where woman may be thrown out of their homes for wanting to negotiate use of safety device. Our strategy should address both women and men folk right from the beginning. The incidents of women thrown out from house would be very minimal. Indian family ties are still very strong.

Dr. Ashok Kumar Agarwal, MBBS, MD
South Asia, Regional Technical Advisor- HIV/AIDS
Catholic Relief Services
4/2 Orient Row, Kolkata - 700 017
E-mail : crsei@giascl01.vsnl.net.in(aagarwal)

Lib
30/1/02

Subject: [AIDS-INDIA] Master's in Clinical Research Training Program
Date: Tue, 29 Jan 2002 10:54:38 -0500
From: "Vinayaka R. Prasad" <prasad@aecom.yu.edu>
To: AIDS-INDIA@yahoogroups.com

Master's Degree in Clinical Research Training Program (CRTP)
sponsored by the AITRP at AECOM

There is an increasing need for clinical research on AIDS in India. This is both due to the highly needed epidemiological and other AIDS studies as well as to many anti-HIV drug and vaccine trials currently being planned for India. Therefore, we, the AIDS International Training and Research Program (AITRP) at the Albert Einstein College of Medicine (AECOM) wish to help promote clinical training in this critical area. The admission to the CRTP at Albert Einstein is competitive, but if the candidate that the AITRP will sponsor is successful in obtaining admission, up to two candidates each year will be funded by the AIDS International Training Research Program (AITRP) of the Albert Einstein College of Medicine (AECOM).

We invite highly qualified candidates in India who may be interested in applying for admission to the Master's degree in Clinical Research Training Program (CRTP) of the Albert Einstein College of Medicine.

Eligibility requirements:

1. A basic medical degree. MBBS or equivalent.
2. A strong aptitude for Clinical AIDS Research documented by attendance in conferences, workshops or other relevant training.
3. Prior AIDS research experience as evidenced by publications in Clinical AIDS Research.
4. The candidate should demonstrate strong desire to return to India. Ideal candidates are those who hold positions in an organization that is currently performing or is involved in AIDS clinical research. Situations where the candidate does not currently have such a position, but is likely to be appointed to such a position will also be acceptable - provided documented evidence is provided.
5. Epidemiological studies in which the data was or will be collected in India, but the analysis is done during the 2-year CRTP course here are ideally suited for this program. However, projects involving bench research are not excluded.
6. If you meet these requirements, click the following link to read about the AECOM-AITRP's policy and then click on the link to read the requirements laid by the Albert Einstein College Of Medicine. After reading the eligibility requirements, if you wish to apply, contact Dr. Vinayaka R. Prasad (prasad@aecom.yu.edu) before submitting the application.

http://www.aecom.yu.edu/aitrp/training/Master%27s_in_Clinical_Research.htm

--
Vinayaka R. Prasad, Ph. D.
Professor, Department of Microbiology and Immunology
Director, AIDS International Training and Research Program
Albert Einstein College of Medicine

 Lib
30/1/02

Subject: [AIDS-INDIA] What is an HIV Microbicide?
Date: Fri, 01 Feb 2002 21:39:58 -0000
From: "Joe Thomas" <joe_thomas123@yahoo.com.au>
To: AIDS-INDIA@yahoogroups.com

Microbicides to Prevent Heterosexual Transmission of HIV: Ten Years Down the Road" AIDScience (01.28.02) Vol. 2; No.1

(AIDScience.org/articles/aidscience015.asp)::Janneke van de Wijgert; Christiana Coggins

The development of topical microbicides for HIV prevention originated in response to the deepening spread of HIV despite the availability of an effective HIV prevention tool (condoms). Without an HIV vaccine, condoms or microbicides are the most feasible method of HIV prevention. However, consistent condom use remains difficult to achieve due to resistance to condom use in some settings. Women often have limited ability to get their male partners to use condoms due to social, cultural and economic gender inequalities. The female condom has increased the options of some women but their long-term acceptability is questioned, and female condoms cannot be used without the cooperation of men.

A microbicide is a product applied topically inside the vagina or rectum to prevent infection with HIV and potentially a number of bacterial and viral STDs. These may take the form of a gel, cream or suppository and may or may not be spermicidal (have a contraceptive effect). There are some indications that some microbicides may be used to prevent transmission of HIV from women to their male partners and they may be versatile for use in the rectum for anal sex.

The identification of novel microbicidal compounds is a rapidly expanding area of HIV prevention research. An estimated total of 56 products are currently in the pipeline: 34 are in pre-clinical stages; 15 are in phase I safety trials, four are in Phase II expanded safety and preliminary effectiveness trials (Savvy cream, Emmelle gel, Lactobacillus crispatus suppository, and Praneem Polyherbal suppository), and three are about to enter Phase II/III trials (BufferGel and Pro-2000 gel), or Phase III trials (Carraguard gel) effectiveness trials.

The candidates fall into four categories or combination of categories:

1)
Products that kill or inactivate infectious pathogens - these include detergents (like nonoxynol-9, Savvy), peroxides, lipids, plant extracts (Praneem, gossypol), antimicrobial peptides, monoclonal antibodies and acidic buffers. Early hopes were pinned on over-the-counter spermicides containing nonoxynol-9 as potential microbicides. Recent studies have shown the nonoxynol-9 products are ineffective against HIV and most STDs and increase the risk of genital ulceration.

2)
Products that block fusion, i.e. prevent attachment to the mucosal surface of target cells - these include those that specifically target HIV surface proteins or HIV receptors and non-specific blockers that are active against multiple organisms (Carraguard, Emmelle, Pro-2000 and Usercell).

3)
Products that inhibit post-fusion activity by interrupting HIV life cycle after the virus has infected the cell - these included nucleoside/tide RT inhibitors; non-nucleoside/tide RT inhibitors; protease inhibitors; and post-binding fusion

inhibitors.

4)
Products that enhance naturally occurring vaginal defense mechanisms. The natural vaginal flora of healthy women is dominated by lactobacilli, which produce a number of compounds that inhibit pathogenic microorganisms. These compounds also maintain a low, acidic pH in the vagina. Other important defenses are naturally occurring antimicrobial peptides and antibodies in the vagina. A few newly developed microbicides aim to enhance these natural defenses. They may be of particular relevance to those countries in sub-Saharan Africa where almost half the women of childbearing age have bacterial vaginosis, characterized by a lack of vaginal lactobacilli. (Products include Lactobacillus crispatus suppository, BufferGel, Acidform gel, Protegrins, Plantibodies [monoclonal antibodies]).

About 35 of the products currently in research are contraceptives as well as microbicidal.

Much progress has been made on microbicides but many challenges remain. Badly needed is a significant increase in investment from both the public and private sectors. To date, no major pharmaceutical company has made a significant investment in this research and development. Innovative public-private partnerships, similar to the International AIDS Vaccine Initiative, are being explored.

Microbicides, once proven effective, need to be available and accessible to all women who need them. Developers should aim for over-the-counter availability and international agencies and governments should begin early to explore distribution networks, pricing, local manufacturing, education, regulatory processes and increased awareness.

Subject: [AIDS-INDIA] File - Invitation- Please forward
Date: 1 Feb 2002 10:16:15 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Welcome to AIDS-INDIA eFORUM

AIDS-INDIA eFORUM is an electronic forum to foster communication and collaboration among those of who are involved or interested in AIDS related issues in India. Your e-mail id is on this list because you must have indicated your interest in AIDS related issues in India or some one else must have suggested your name as a person who may be interested in AIDS related issues in India.

This is a moderated forum. We would like to invite you to post messages, announcements, details of your AIDS related work in India. Confidentiality of the list members is assured. For more details of the forum please contact the moderator.

If you are already a member of AIDS-INDIA eFORUM please forward this message to your colleagues. Thank you for your attention.

Joe Thomas

Moderator
AIDS-INDIA eFORUM
aids-india@egroups.com
Web page: http://groups.yahoo.com/group/AIDS-INDIA

Subject: [AIDS-INDIA] Seaweed as Microbicide: Clinical trials begins.
Date: Fri, 1 Feb 2002 13:53:30 +0530
From: "Rajesh" <buddhadev@iqara.net>
To: <AIDS-INDIA@yahoogroups.com>

A red seaweed used as a thickening agent in ice cream, toothpaste and baby formula may be the next great hope for millions of poor women seeking to protect themselves against HIV. Human clinical trials of Carraguard, a gel made from seaweed that grows along the coasts of Novia Scotia, are scheduled to begin in South Africa and Botswana later this year. The gel was developed by the nonprofit Population Council. The Bill & Melinda Gates Foundation plans to announce this weekend a multimillion-dollar grant to help fund the studies, which will involve 6,000 women.

The trials will test a promising theory: that women who use Carraguard up to an hour before intercourse can block HIV and possibly prevent other STDs. "This would allow women to take prevention into their own hands," says Dr. Helene Gayle, the former chief of AIDS prevention at the CDC and a senior advisor on HIV/AIDS at the Gates Foundation. "It is very difficult for women in the world to negotiate safe sex and insist on their partner using condoms. And the reason HIV is spreading is not primarily because of women's risky behavior. It's due to risky behavior by their male partners."

In the 1990s, Dr. David Phillips, a senior scientist at the Population Council's Center for Biomedical Research, found that carageenan, a seaweed-derived compound that contains large negatively charged molecules, isn't absorbed in the body. Researchers still aren't sure exactly how the process works. However, it is believed that carageenan binds to the virus or to target cells, coating them much like a layer of thick paint.

In earlier animal trials, Carraguard was found to be effective in blocking sexually transmitted viruses such as herpes simplex virus type 2 and human papillomavirus, as well as the bacterial infection gonorrhea, Phillips said. Janneke va de Wigjert, the Population Council's principal investigator on the trials, said the next round of studies, which are expected to cost $50 million and will require U.S. Food and Drug Administration approval, will follow HIV-negative women for two years. At least three other microbicide products are going into trials this year, according to Henry Gabelnick, director of the Global Microbicide Project.

"Trials Will Test if Seaweed Gel Can Block HIV"
Wall Street Journal (01.31.02)::Rachel Zimmerman

Dr.Rajesh Buddhadev. MD
buddhadev@worldgatein.com
NISARG AIDS CARE CENTRE
Surat-395009, Gujarat

Subject: [AIDS-INDIA] HIV in rural areas. FAO documents
Date: Fri, 01 Feb 2002 22:55:48 -0000
From: "Joe Thomas" <joe_thomas123@yahoo.com.au>
To: AIDS-INDIA@yahoogroups.com

The Implications of HIV/AIDS for Rural Development Policy and Programming: Focus on Sub-Saharan Africa: by Daphne Topouzis Consultant. Sustainable Development Department, FAO HIV and Development Programme, UNDP

June 1998 This page presents the Table of contents and Executive summary of the paper. The full paper is also available for downloading via FTP (MS-Word 6, zipped, 74K)

Executive Summary
This paper examines the implications of the HIV epidemic for rural development policies and programmes in sub-Saharan Africa and, in particular: the inter-relationships between rural development and HIV/AIDS; and the broad policy and programming challenges that the epidemic poses for rural institutions. The proposed conceptual framework for the identification of key policy and programming issues for rural development raised by HIV is intended to provide guidance for the design and conduct of a set of four case studies to be carried out in Southern and Eastern Africa. The main objective of the case studies will be to help formal and informal rural institutions

areas of land tenure, agricultural research, training and extension, appropriate technology, credit, etc.) in each of the four countries.

The relationships between rural institutions and HIV/AIDS are bi-directional:

1. the epidemic may have an effect on rural institutions. The effects of HIV/AIDS on formal rural institutions may: i) impoverish directly affected clients; ii) erode the capacity of rural institutions through losses in human resources; and iii) disrupt the smooth operation of rural institutions by severing key linkages in the organisational and/or production chain. The effects of HIV/AIDS on informal rural institutions may create a crisis of unprecedented proportions particularly among the extended family and kinship systems, with implications not only for the spread of HIV but also for the viability of rural institutions and of traditional social safety mechanisms (widow inheritance, child fostorage, etc).

2. the policies and programmes of rural institutions may have a positive or negative effect on the HIV epidemic (i.e. by enhancing mobility and strengthening urban-rural linkages, they may inadvertently facilitate HIV transmission; by improving support and social services, they may contain the spread and impact of the epidemic).

The following key points cross-cut the proposed conceptual framework on the implications of HIV/AIDS for rural development policy and programming:

1. The causes and consequences of the HIV epidemic are closely associated with wider challenges to development, such as poverty, food and livelihood insecurity, gender inequality. In effect, HIV/AIDS tends to exacerbate existing development problems through its catalytic effects and systemic impact.

2. In areas heavily affected by HIV/AIDS, the catalytic effects and systemic impact of the epidemic on rural development may:
   * amplify existing development problems to such an extent as to trigger structural changes (i.e. in adult and infant mortality); and/or
   * create new problems and challenges for rural development (child-headed households, the breakdown of informal rural institutions and thus of certain vital social safety net mechanisms).

3. Given that many problems arising from the epidemic are not specific to HIV/AIDS, policy and programme responses need not be HIV/AIDS-specific but must address the root causes and consequences of the wider challenges to rural development. In other words, a developmental rather than an AIDS-specific focus is critical to tackling the multi-sectoral complexity of the epidemic and its systemic impact and to ensuring the sustainability of both HIV/AIDS responses and rural development efforts.

4. The policy environment plays a key role in defining the parameters of susceptibility/vulnerability to HIV/AIDS and of the impact of the epidemic.

5. Gender, age and marital/family status play as decisive a role in determining susceptibility/vulnerability to HIV/AIDS and the potential impact of the epidemic as economic and cultural conditions. For this reason, the interplay between these factors needs to be considered at each stage of policy and programme development.

6. The policy and strategy recommendations put forth by the World Conference on Agrarian Reform and Rural Development and by the World Food Summit in particular provide a springboard from which to

mainstream HIV/AIDS in rural development policies and programmes. In particular, WCARRD's focus on poverty alleviation and participation by rural people in the institutions that govern their lives as a basic human right, and the World Food Summit emphasis on food security and sustainable human development are not only prerequisites for the revitalisation of the rural economy, but also for effective responses to HIV/AIDS.

7. Rural development policies and programmes in support of poverty alleviation, food and livelihood security, the empowerment of rural women, etc. are, in effect, also HIV prevention and AIDS mitigation measures and vice versa.

8. While rural development programmes can be integrated with HIV/AIDS prevention and mitigation programmes, HIV/AIDS-specific policies and programmes have an important complementary role to play.

The proposed conceptual framework focuses on selected rural development focus areas, and in particular on:

Poverty alleviation
This section examines the broad inter-relationships between poverty and HIV, identifying gaps in knowledge (i.e. on household coping strategies), critical issues that are not currently being addressed (such as the consequences of HIV-related inter-generational poverty and of the increasing asset/land concentration and marginalisation of the poor) and alternative targeting criteria (such as adult death and/or household dependency ratios) for poverty alleviation programmes.

Food security and sustainable livelihoods
The dynamics of labour mobility/ migration and food security/sustainable livelihoods are critical dimensions of HIV transmission and impact. This section raises the issue of the sustainability of labour-intensive food production strategies, upon which food security policies and programmes are often based, given labour shortages arising from HIV/AIDS, drought, migration and other factors. The issues of labour shortage and livelihood insecurity and of food/livelihood security coping mechanisms of informal rural institutions to HIV/AIDS impact are also examined.

Empowerment of rural women
Gender inequality facilitates the spread of HIV and exacerbates its impact. This section examines: a) the gender-specific impact of young adult mortality; the gender (and age/marital status) differentiated effects of HIV on household income and expenditures; and c) the interface between formal and informal rural institutions, gender and HIV/AIDS as manifested in traditional social safety net mechanisms for women, such as widow inheritance, and the implications of the adverse effects of such practices for women.

Labour
The heterogeneity of labour is highlighted as a critical factor in the analysis of the impact of the epidemic. Human rights, production and productivity issues, employment and labour market issues resulting from the impact of HIV/AIDS are examined in terms of their policy and programme development implications. More specifically: the role of the workplace in HIV prevention; lost skills and experience; the substitutability of labour; losses in production and rising payroll costs are analysed in the context of HIV/AIDS.

Infrastructure
The implications of construction, maintenance and operation of rural infrastructure are examined in terms of their potential positive or negative contribution to the spread and impact of the epidemic. The

conditions, is also examined.

Participatory, gender-sensitive and multi-sectoral rural development policies and programmes are essential elements of any response to HIV/AIDS. The need to develop capacity-building strategies to improve the planning capabilities of agricultural and rural development institutions and to help them cope with the loss in human resources and other effects of the epidemic is underscored. Rural institutional strengthening and capacity-building activities that will also assist the case studies to generate policy and programme responses may include one or several of the following components of the menu of options proposed below:

1. Rural development sector/sub-sector susceptibility/vulnerability assessment (Why and how is a sector/sub-sector vulnerable to HIV/AIDS? Which population/employee groups are most susceptible/ vulnerable? How do labour conditions facilitate HIV transmission? etc.)

2. Human resource needs/capacity assessment of public and private rural development institutions, to evaluate the degree to which their policies and programmes are aligned with the effects of the epidemic and with the implications of human resource losses.

3. Participatory training for rural institutions and their clients/target groups in: bottom-up, cross-sectoral, gender-sensitive planning; the implications of HIV/AIDS for rural development; and mechanisms that move field-based information on the bi-directional relationships between HIV and rural development up the planning ladder so as to influence how planners and policy-makers think, how they plan responses and set policies.

4. Policy/programme review (national and district level rural development policies and plans, etc) to take into account the dynamics and impact of the epidemic; to enhance multi-sectoral collaboration among rural development programmes; and to integrate rural development programmes with HIV/AIDS prevention and mitigation programmes.

5. Creating a mandate on HIV/AIDS and generating political commitment at the highest level for HIV/AIDS. Setting up a Management Information System on HIV/AIDS in rural areas.

* Download full document Implications of HIV/AIDS for rural development policy and programming: Focus on Sub-Saharan Africa (MS-Word 6, zipped, 74K) http://www.fao.org/sd/wpdirect/wpre0074.htm

Subject: [AIDS-INDIA] NEW DELHI: AIDS awareness campaign launched
Date: Sat, 2 Feb 2002 18:28:12 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

AIDS awareness campaign launched

The Statesman 2 February 2002 New Delhi
NEW DELHI, Feb. 1. - Distribution of over 32,000 condoms and 18 lakh contact cards along-with setting up of 807 camps are the highlights of the "Family Health Awareness Campaign" launched today by the Delhi chief minister, Mrs. Sheila Dikshit.

The 20-day awareness campaign, being organised by the Delhi State AIDS Control Organisation, will crate awareness about the epidemic through nukkad natak, magic and film shows, community gathering and discussions.

About 3000 banners and 80,000 posters have been put up at dispensaries, hospitals, basti vikas kendras and slums clusters.

Mrs. Dikshit, who asked for bigger participation from voluntary groups, said free medical check-ups and drugs will be given to patients at the camps.

Over 800 non-governmental organisations have been taking part in the campaign. Prayas' Institute of Juvenile Justice, a voluntary group, will target street and working children.

****
Jagdish Harsh (jharsh@afxb.org)
François-Xavier Bagnoud (INDIA) (www.fxb.org)
_____

Subject: [AIDS-INDIA] Positive Womens' National Consultation
Date: Sat, 02 Feb 2002 18:15:01 -0000
From: "Positive Women of South India" <poswonet@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Positive Womens' National Consultation.

POSITIVE FACES AND VOICES OF WOMEN FROM INDIA

We the Positive Women of South India are organizing a National women's Consultation & workshop "Positive faces and voices of women from India" from the 8th to the 11th of March 2002, at Chennai.

The first two days would have only women living with HIV as participants. On the third and fourth days the sessions are open for women activists, NGOs, and the Government representatives.

The number of participants has been limited to 75, of which 35 are Women living with HIV and 15 are women activities. There are 5 men living with HIV, 10 steering committee members and 10 support staff/ volunteers also will be participating in the consultation and workshop.

Please note only women activists, and women living with HIV, can participate. Therefore, whoever is interested in such issues, may contact us with their details by the 6th of February.

Kousalya

POSITIVE WOMEN NETWORK OF SOUTH INDIA
23, BRINDAVAN STREET, WEST MAMBALAM, CHENNAI-33. INDIA
Ph. 3711176, 4717363.
E-mail: poswonet@hotmail.com

Outline of the consultation and the workshop

TITLE: `POSITIVE FACES AND VOICES OF WOMEN FROM INDIA'

ORGANISING ENTITY: THE STEERING COMMITTEE OF THE NATIONAL CONSULTATION FOR HIV POSITIVE WOMEN (consisting of women representatives from INP+, PWN+, DNP+, PAN, MNP+ (Manipur), MNP+ (Maharashtra, ICW, Positive Life, Sahara)

ELECTED CORE GROUP: INP+, ICW, PAN, PWN+

ELECTED EXECUTING AGENCY: POSITIVE WOMEN NETWORK OF SOUTH INDIA 23, BRINDAVAN STREET, WEST MAMBALAM, CHENNAI-33
Ph. 3711176, 4717363. Email: poswonet@hotmail.com

SUPPORT AGENCY: INDIAN NETWORK FOR PEOPLE LIVING WITH HIV/AIDS (INP+)

INTRODUCTION
Women representatives of the agencies referred to above established in April 2001 a Steering Committee to plan and process the work towards increased attention and response to the issues related to women and HIV/AIDS in India. Two Steering Committee meetings have already been held in New Delhi (hosted jointly by UNAIDS and UNIFEM). The deliberations of the Steering Committee resulted in the decision to jointly gather the HIV positive women known to the Steering Committee from all over India to a national consultation. In order to manage this task, the Steering Committee agreed to form a core group of 4 members to take the lead. It was also agreed that PWN+ and INP+ collaborate in organising the consultation. PWN+ would take the lead on the contents and be co-ordinating and handling the funds, while INP+ would support logistically.

Positive women network of south India (PWN+)

PWN+ is a self-help organisation of women living with HIV, registered under the Tamil Nadu state society's registration act in October 1998. The organisation functions as an information centre, and its activities include Networking, Advocacy of issues of women living with HIV, Counselling, Training, Initiation of self-help groups of women living with HIV, organising workshops and sensitising groups on positive living and issues of women living with HIV/AIDS.

Background:
The HIV/AIDS epidemic has brought about a drastic global change far more extensive than what was predicted. HIV, which was originally considered only as a serious health problem has now clearly emerged as a development crisis, shaking the very roots of a nation. There are about 36.1 million people living with HIV worldwide, out of which 5.8 million are from South and South East Asia, with India, having 3.86 million people living with HIV (NACO, 2001). Women and children account for about 1.46 million among the total population of people living with HIV in India and HIV/AIDS continues to emerge as one of India's most complex epidemics; a challenge that extends beyond public health, raising fundamental issues of human rights and drastically affecting development.

The need to prevent the epidemic and at the same time, provide care and support, calls for an unprecedented response from all sections of the society. But with new infections increasing everyday, it has become clearly apparent that the Government should take stock of its initiative in working to control the epidemic. The Government has till date concentrated more on prevention strategies than on providing care and support to people living with HIV, and in involving them in their efforts, which is one of the major factors involved in the lack of control of HIV/AIDS in India.

The impact of HIV/AIDS on women and children is very drastic and acute. In many developing nations, women are already economically, culturally and socially disadvantaged, and lack equal access to treatment, financial support and education. Here, women are often perceived as the main transmitters of sexually transmitted infections, leading to further stigmatisation. Some of the issues of women include physical ill-health, compounded due to more concentration on husband and children's health and needs, lack of availability of proper medication, and inability to afford those that are available; discrimination and non-availability of treatment for even opportunistic infections at health care centres; sudden role reversal as a sole breadwinner of family for some women; and lack of resources and support systems available to women and children living with HIV.

Objectives:

a) To facilitate experience sharing among women living with HIV, and identifying critical issues.
b) To develop concrete advocacy strategies for Government and women's organisations.
c) To elicit a strong commitment from Government agencies towards HIV/AIDS related women's issues.
d) To establish definite follow-up activities in care and support, and income generation for women living with HIV.

Expected outcomes:

The workshop would lead to the following:

a) Increased awareness among the participants of access to information about services on all aspects related to HIV
b) List of recommendations to government officials and women's groups on responding to the needs of HIV positive women and women's vulnerabilities to HIV/AIDS
c) Increased understanding of HIV/AIDS related issues among government and women's groups
d) Developed concrete follow-up plan/initiatives in the field of capacity

Subject: [AIDS-INDIA] Workplace HIV/AIDS Intervention
Date: Mon, 4 Feb 2002 10:46:54 +0530
From: "Vijay" <vrai-rbgm@modi.com>
To: <AIDS-INDIA@yahoogroups.com>

Dear forum members

I would like to introduce the HIV/AIDS Workplace intervention program being implemented by Modicare RBGM Foundation.

As you are aware that HIV / AIDS continues to affect the lives of millions of people around us and even as we have entered the 21st century, there is still no cure for this most devastating disease the world has ever known. Until a vaccine or a cure is found, our greatest weapon against HIV/AIDS is knowledge. There is an urgent need to educate our immediate communities about the epidemic, which is where we look forward to you to carry the message

India has a workforce of over three hundred and six million workers. thirty seven percent of India's total population is workers. this section of society is being addressed with the purpose of promoting AIDS awareness with in the business agenda.

objective

a. Increase awareness among Industrial workers on HIV/AIDS/STI
b. to address psychosocial problems of Industrial workers
c. Improve health seeking behavior of Target group
d. to promote condom usage
e. to remove stigma about HIV/AIDs prevalent in community target group

A. industrial workers and their families

The foundation will work with the following commitments: -

a. The foundation provides awareness sessions for all the employees.
b. Foundation conducts sessions of thirty to sixty minutes duration.
c. The session will include all the information an individual must know about HIV/AIDS pandemic.
d. The questions of the participants are also answered.
e. The workshop for the peer's educators (maximum 10/ Industry) will be of one-day duration.
f. The one-day workshop aims at preparing peers to continue the awareness programs in the unit and reinforcing the information with the co-workers.

The foundation also provides referral services to the workers.

I request all the members to please circulate this program to contact persons in Industries and those working with Industries

looking forward to hear from all the members

Thanks

with best wishes

Ms. Juhi Sahai / Vijay
□-community center, New friends colony
New Delhi. # 6321□□1-50 extn- 116,106
E-mail: <vrai-rbgm@modi.com>

Log
6/2/02

Subject: [AIDS-INDIA] Re: Manipur: HIV/AIDS has become an election issue
Date: Tue, 5 Feb 2002 0□:55:06 +0530
From: "Dr. Ashok □umar Agarwal" <crsei@giascl01.vsnl.net.in
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

This is real good development. I would hope the pledge in the manifesto gets converted into action later on. The epidemic can only be curbed by efforts at all levels. The political leaders enjoy a unique position in the community. The position may not be very praiseworthy but is always seen with some amount of power. But, then the politicians should also be well oriented to the subject. They should consult professionals on the subject before making public statements.

Dr. Ashok Kumar Agarwal, MBBS, MD
South Asia, Regional Technical Advisor- HIV/AIDS
Catholic Relief Services
□/2 Orient Row, Kolkata - 700 017
India
Tel. No. 91-33-2□7 6□33/1969
Fax No. 91-33-2□0 9652
E-mail : crsei@giascl01.vsnl.net.in(aagarwal)

Lob
6/2/02

Subject: [AIDS-INDIA] Microbicides Trials in India
Date: Tue, 5 Feb 2002 06:15:54 +0700
From: " □eter □odwin" <peterg@bigpond.com.kh>
Reply-To: <sea-aids@healthdev.net>
To: <AIDS-INDIA@yahoogroups.com>

Forwarded by Peter Godwin, Phnom Penh

Microbicides: Communities Ready and Trials Moving Forward
Third International Conference on AIDS in India
2 - 5 December 2001, Chennai, India
Special Report - Bobby Ramakant

At the recent AIDS India 2001 conference, an exclusive satellite session on Microbicides was held in the main conference auditorium. It was attended by many delegates and got an impressive response from researchers, microbiologists, policy makers, and many from the NGO sector in India.

Dr. Alan Stone, from the UK Medical Research Council and Dr Gita Ramjee, from the South African Medical Research Council in Durban, co-chaired the session, with Dr. N. M. Samuel, Head of Indian Experimental Medicine and AIDS Resource Centre from Dr. MGR Medical University, Chennai, as the moderator. Below are three reports based on panel presentations.

- - -

"Namakkal, is primed for microbicide research and acceptability study"
Dr. Samuel remarked that as "Microbicides is a new area for India," it is important to give it a focus at the congress. He explained that this was the prime reason to select two experts (Dr. Stone and Dr. Ramjee) one each from a developed and a developing country - to have a better understanding of the complexities of the issue and the relevance of Microbicides in Indian context.

Dr. Samuel's presentation was titled "Do Women need Microbicides?" he began by discussing, starkly, the vulnerability and risk Indian women face in contracting sexually transmitted infections (STIs) including HIV.

Twenty million births occur in India every year, with 1-□ % of all pregnant women found to be HIV seropositive. He quoted a study in which pregnant positive women who received AZT had one HIV-positive baby in 12 births, and without AZT had three HIV-positive infants in 12 births.

Only 59% of tested women return for their HIV test results; drug affordability and accessibility continue to be obstacles to care; and □3% of women give birth at home in India with trained or untrained midwives.

Discussing results from a recent study conducted by Dr. MGR Medical University at an antenatal clinic in Namakkal, a small district □00 km from Chennai, Dr. Samuel said that of 92.5% of study participants responded "no" to a survey question that asked: "Will your husband discuss the use of condom with you?" However 91% women responded "yes" when asked if they would use a protective cream if given, to prevent STIs/HIV and and pregnancies.

Dr. Samuel said that this is an important indicator to community preparedness in India to products like microbicides.

6/2/02

The Namakkal experience has several learning lessons including: the need for primary prevention of infection and behavioural modification of men and women; challenges in seeking informed consent (such as female autonomy, role of the husband); and also the role of the community, local authority, health ministry and big pharmaceuticals. Pricing microbicides may be another area of high concern in India, but that bridge will be crossed when we get to it.

"Namakkal, is primed for microbicide research and acceptability study", he concluded

- - -

"First Microbicides may hit the market by 2006-2007"

Dr. Alan Stone, from the UK Medical Research Council, spoke on "Microbicides and their role in HIV Prevention" at the special satellite session on Microbicides.

"WHO has stated that there are no safe and effective microbicides yet on the market," he began, and then re-framed the issue adding, "but we already have developed several highly promising product leads (half a dozen formulations), all of which have tested non-toxic too".

Speaking to the vulnerability of women, Dr. Stone said that of the 5.3 million new HIV infections in 2000, half of them were in women.

Pointing to India, he added that STD clinics in Mumbai and Delhi noticed sharp rise in their cases in past decade (by 6□ %).

"But why do we need microbicides when effective options like male condoms are there?" he asked rhetorically. Condoms, he said, are a male-controlled option and provide good protection against a broad range of STIs/HIV. However the use of the male condom is inconsistent as: men complain that they reduce sexual pleasure; they reduce spontaneity; they question the level of trust between partners; they challenge the accepted power relationships when a woman asks a man to put a condom; and in couples attempting to conceive a child - they prevent child-bearing.

Microbicides, on the contrary, are: female controlled prevention options; requiring less or no negotiation with partners; are not a physical barrier to sexual pleasure; do not interrupt the natural course of events during sex (as microbicides are applied before-hand); broaden the range of safer sex choices; and are not necessarily contraceptive.

He commended the formation of International Working Group on Microbicides, which encompassed key players from WHO to local agencies like AIDS Resource Centre at Dr.MGR Medical University in Chennai.

Commenting on the need to have microbicides that do not damage the natural defence system of vagina, Dr Stone said that the internal vaginal wall is an excellent natural barrier to STIs and HIV.

Dr. Stone marked the 'obligatory requirements' of having a safe and effective microbicides. A microbicide, he said, should be highly active against free and cell associated HIV. It should be active against a range of HIV strains and sub-types. Microbicides, he added, must have a low cyto-toxicity in vitro, must be non-mutagenic and stable in standard tests, and effective in semen as well. Their compatibility with latex

is also mandatory. And above all, microbicide product leads must be non-toxic in vitro too.

Enumerating preferable characteristics, Dr. Stone remarked that microbicide product leads should: not have any activity against lacto-bacilli; not be systemically absorbed; not have an offensive colour, odour or taste; have an effectiveness that spans a broad spectrum of STIs including HIV; and must be affordable and available in different formulations.

Referring to Nonoxynol 9 (N-9) as a possible microbicidal agent, Dr Stone quoted the UNAIDS 2000 report that stated that "N-9 actually increased HIV acquisition in a study," by irritating the inner vaginal walls, the lesions made the study participants more vulnerable to HIV transmission.

These trials, he said, were disappointing because they were largely held in sex workers' community (where frequency of sexual intercourse is higher) and lesions once formed inside vagina, may take up to 2-3 days to heal.

However N-9 no longer remains the lead product and, since then, microbicide research has come up with several promising leads (more than a dozen) with different mechanisms of action like antiretrovirals, surfactants, sulphonated polymers, natural extracts, etc.

No side effects are reported in these current product leads however clinical trials are still on-going. Microbicide research is following two parallel tracks - one is with currently available product leads, and the second is in basic research laboratories where new understanding of HIV transmission and acquisition is opening up new vistas of second and third generation product leads for microbicide research and development.

Dr. Alan Stone concluded optimistically, "The First Microbicide may hit the market by 2006 2007 which will be a low cost, broad spectrum, self-administered, female controlled option to prevent transmission of STIs including HIV. And this will be no magic bullet, rather it will widen the range of existing options to prevent HIV transmission".

- - -

"Three Microbicide - product leads to enter Phase III trials soon"

Dr. Gita Ramjee, from the Medical Research Council in Durban, South Africa, spoke on "Vaginal Microbicides - Clinical Trials, Ethics, and Acceptability" at the satellite session.

She explained in detail the various Phases - I, IIa and IIb, IIIa and IIIb, and IV - in clinical trials. In Phase I are initial safety trials of the product in question, Phase IIa is a pilot clinical trial to evaluate efficacy and safety, Phase IIb is a pivotal trial that must adhere to a rigorous demonstration of efficacy, Phase IIIa is conducted in the target population, and Phase IIIb deals with quality of life and marketing issues. Phase IV focuses on issues that arise once the product is marketed and is based on observation or experience of the target population.

Currently, there are 10 microbicide product leads in the pre-clinical phase. Six product leads have completed Phase I trials - Cellulose sulphate, PMPA, PSS, CSIG, Acidiform, and DS. And three products have completed Phase II trials - Carraguard, Lactobacillus crispatus, and PRO 2000- with Phase III trials planned to begin soon. Only two products have undergone phase III before - both N-9 based products (conceptrol and advantage 24) - that have been discontinued as N-9 has been shown to

trials, however, have more hopes pinned on them.

The ethics of microbicide research and development, as in other trials, are often tricky and controversial. Dr. Ramjee commented that in the 'Vaginal Microbicide - COL 1L92' multi-site study, several potent ethical concerns came to the forefront including - the exclusion of some HIV-positive women from the study, lack of care and support available to HIV seroconverters, and the process of obtaining informed consent.

The COL 1L92 study was conducted with L77 sex workers, where 20% of them were illiterate. Maintaining confidentiality was critical, and HIV positive women were separately counselled and trained to provide convincing reasons when asked by their community members why they had not participated in the study.

In Durban, women who seroconverted during the trials were provided routine standard of care and treatment - but no ARVs. And in Abidjan, ARVs were provided with the routine standard of care.

Commenting on "informed consent", Dr Ramjee said that in Durban, 70% of women had a very poor understanding of study objectives and 98% of women had a poor understanding of potential effects and risks involved. To address this finding, condom counselling was increased and study objectives reiterated at every follow-up. In Cotonou, L5 % of women in the trials had a very poor understanding of gel + condom use, and 75% women had no understanding of the 'placebo' arm.

Dr. Ramjee categorically stated that "informed consent" is an ongoing process, and there is a pressing need for repeated verification, monitoring (by outside agency), and reiteration at every available opportunity.

Sensitivity to cultural and moral values and building of mutually respectful relationships between the research community and women undergoing trials emerged as significant concerns during the COL 1L92 study.

However, there were many positive outcomes of this study including individual development of trial participants contrary to those who did not participate in the trials, and a noticeable increase of self-esteem in these women. Dr. Ramjee remarked that visible 'altruism' was also an important indicator in most participants as they were not disappointed by the research outcome of this study and were willing to participate in future trials for an effective female controlled prevention option.

She expressed strongly, the need to prepare for adverse trial outcomes before the trial begins.

Continuing, Dr. Ramjee said acceptability studies must go alongside research and development. Acceptability studies have shown that a potential microbicide must address issues related to following product features: lubrication, types of formulation, insertion and aesthetic appeal. It should also address social issues such as the impact on condom usage, and the role of men.

Wrapping up her elaborate presentation, Dr.Gita Ramjee said that there is no doubt about the compelling need for female controlled HIV prevention intervention. She repeated that complex ethical issues can only be

resolved if developing countries come up with their own guidelines, and researchers, community, and service providers work together - and not in isolation.

Bobby Ramakant
HDN Key Correspondent, India
E-mail bobbyramakant@yahoo.com
E-mail: correspondents@hdnet.org
A cross posting from SEA-AIDS sea-aids@healthdev.net

Subject: [AIDS-INDIA] Manipur manifesto:HIV/AIDS has become an election issue
Date: Mon, 4 Feb 2002 23:27:08 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Manipur manifestos with a difference

The Statesman 4th Feb, 2002-New Delhi

Feb. 3.' -- Manifestos of various state parties for the forthcoming Assembly elections have laid considerable stress on dealing with AIDS.

For the first time in the country, perhaps, HIV/AIDS has become an election issue. With the number of HIV positive cases in the state being 12,817, parties can no longer neglect the problem. Never in the past 20 years had any political party taken up such issues as drug addiction and AIDS for elections in the state.

Former minister and president of Manipur People's Party Mr. O Joy Singh feels the issue should be above party politics. Mr. Chandramani, president of Federal Party of Manipur, feels the same. Mr. Singh has mooted an idea of forming cells within the party structure to spread awareness of the disease among people. He said other parties should also open such cells.

Former chief minister Mr. RB Koijam of Samata Party said his party is concerned about the growing number of HIV positive cases and has included the issue in their election manifesto.

"We would take up whatever strong measures required to tackle the scourge." He said tactical understanding with Myanmar at the national level should be made to stop drug trafficking.

Congress (I) has put AIDS on its top priority list and so has Democratic People's party. The BJP in its manifesto has called for restructuring of the state AIDS and drug programmes to make them more effective.

This kind of initiative to combat the disease on political level could have come sooner, said the Manipur State AIDS Control Society Project director, Dr. Khomdon.

"The bad news is today HIV has moved to general population and the rate of infection among children and women is at 2 pre cent. In Africa, AIDS infection among children and women grew form 2 per cent to nearly 80 per cent in a span of 5 years. If we don't take proactive action now, in 5 years we will be no better. we must learn from the African experience."

****

Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
Francois-Xavier Bagnoud (INDIA) (www.fxb.org)
161,Satya Niketan Moti Bagh-II
New Delhi-110021
Phone: +91 11 6111793 94
Fax: +91-11-4107381

Lib - AIDS - Zeitschrift
JN

Subject: [AIDS-INDIA] Need information on funding agencies
Date: Fri, 08 Feb 2002 06:51:17
From: "supreeta sampath" <supreetas88@hotmail.com>
To: aids-india@yahoogroups.com

Hi,

I'm from a a group called "Dream A Dream", in Bangalore and we do integrative and awareness work with children. I was wondering if you could give me information on funding agencies, that would be interested in HIV awareness and integrative programmes in schools and colleges.

Regards,

Supreeta
E-mail: <supreetas88@hotmail.com>

Dream a Dream and the rest shall follow:)

Lob
11/2/02

Subject: [AIDS-INDIA] 6th National Convention of INN
Date: Wed, 6 Feb 2002 22:29:18 +0530
From: "gap" <gapad1@sancharnet.in>
To: <AIDS-INDIA@yahoogroups.com>

Dear friends,
Thank you very much for your response to the mail on 6th National Convention of INN to be held at Bhubhanesnwar, Orissa from the 26th to 28th February 2002 .The draft programme for the 6th National Convention is attached with this mail. Unfortunately due to an overwhelming response, we are unable to accept any registrations at this moment. We welcome you to attend the 7th National Convention of INN in 2003.

We also welcome all interested to become a member of the Indian Network of NGOs on HIV/AIDS (INN) as per the membership guidelines :-

1) Institutional Membership @ Rs. 100/- per annum
2) Associate Membership @ Rs. 20/- per annum
3) Individual Membership @ Rs. 20/- per annum
4) Life Membership @ Rs. 1000/-

Admission fee (one time) of Rs. 25/- to be added.

Please fill and send to:
The Secretary
Indian Network of NGO's on HIV/AIDS (INN)
B-01, Siddhachakra Apts.,
Pritamnagar 1st Slope,
Ellisbridge, Ahmedabad-380006
Phone: 079-6575292, Fax: 079-6575962
E-mail: gapad1@sancharnet.in

Best wishes !
Dr.(Ms) Radium D. Bhattacharya
President, INN

6th NATIONAL CONVENTION OF INDIAN NETWORK OF NGOs ON HIV/AIDS (INN)
26th, 27th, 28th February 2002 - Bhubhanesnwar, ORISSA

Draft Programme

Inaugural Session - With participation of Mr. G.V.K.Prasada Rao, Project Director NACO, representation from UNAIDS -New Delhi, Orissa AIDS Control Society, Representation from the Ministry of Health & Family Welfare Orissa, WHO, CARE, OVHAI etc.

Session 1- Reporting the 2001 experience of INN, Access to treatment, Partnership with the Global Campaign for microbicides and preventive options for women, White Paper on HIV/AIDS

Session 2 - Participating NGOs share field experiences in opportunities and barriers for effective HIV/AIDS awareness and control programmes.

Session 3 - Discussion on reports and experiences : Directions suggested by Sessions 1 & 2 - Presentations and discussion

Session 1 Technical Paper I: AIDS Vaccine Development -

Discussion

11/2/02

from the social, political and legal perspective in India.
* Migration trends and their impact on HIV/AIDS awareness and control.

Session 3 Technical Paper II: Prevention of mother-to-child transmission of HIV.
Discussion

Annual General Meeting

Session 1 : Parallel Workshops - (3)

i) Advocacy and how to use media campaign
ii) Adolescent sexual health education
iii) Livelihood options for HIV infected and affected

Session 2 : The Orissa Situation
Exploration : Local needs in Orissa : HIV/AIDS prevention/control/care/ counseling and treatment availability

Session 3 : White Paper on the status of HIV/AIDS awareness and control in India : :
Discussion on the draft paper.

Concluding Remarks and Comprehensive Recommendations
Press Meet

Subject: [AIDS-INDIA] Re:Manipur Election &AIDS. Questions to the Politicians
Date: Sat, 9 Feb 2002 15:05:02 +0530
From: "John O. Lall" <jol@softhome.net>
To: AIDS-INDIA@yahoogroups.com

Dear Forum members:
Much is being said about the Issue of HIV/AIDS being raised during this Election in Manipur. But the reality is that nothing is seen done here at the Ground. It is indeed an encouragement to see that the political parties brought up the issue of HIV/AIDS after a long slumber as part of their Manifestos. Well, wht discourages me is that they have been only talkin about it. Doing nothing!! Not even a single poster or a phamplet is being published by the various political parties to spread awareness among the people in Manipur. Posters of various parties are being printed in Thousands!!! Cant see a line of HIV/AIDS messages on it.. amazing.. !!! How can we know that they will do something after they are elected..when they are not doing anything visible at the moment. Nothing is being said and done about the Provision of Health Care to people living with HIV/AIDS in Manipur. I guess it will be good if the political parties are really interested to work towards stoping the spread of HIV and AIDS in Manipur and else where.. they got to stop talking too much and rather Start DOING something.

I would like to ask those politicians whether they have done something about the situation. Have they have budgeted some amount from their election budget to be given for AIDS CARE, Awareness, Opportunistic infection management? Have you planned what the parties will do even if u were not elected? If the answers to the above questions were YES!!, We will know that we would see work being done in the ground. Show us the work and we will give the Vote!! Think that should be the slogan

The people of Manipur who are affected and infected with HIV dont need preacher politicians. Someone who cares is wht they need. What they need is some one who can plan for 50years.. not 5 years and not implement it... someone who has a vision to help fellow citizens and see that things planned are being implemented. Total commitment and dedication to the work of HIV/AIDS is a must in the present situation in Manipur.

We seem to be sleeping still!! and just keepin quite floating with the politicians.
Regards,

John
E-mail: <jol@softnome.net>

Feb 12/2/02

Subject: [AIDS-INDIA] Re: Manipur elections and the " Politics of AIDS"
Date: Fri, 8 Feb 2002 11:01:18 -0530
From: "Mona Mishra, Positive Life" <plife@vsnl.com>
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

Dear Forum subscribers,

[This is in response to Dr Roy'posting on the politics of AIDS in Manipur. Moderator]

Dr Roy, that was indeed an insightful posting. You are right, political endorsement of AIDS (pre-poll) does seem to have an underbelly. And someone like you will have a keen sense for that. Thank you for flagging the issues that you have. Things are interconnected and part of the work of AIDS workers is to able to see that.Thanks!

The only reason I feel optimistic (don't know what Dr Agarwal has to say on this) is that while motives for getting AIDS on the election agenda can be suspect, the fact that it has got there in the first place, can set a trend, fill a gap. Of course, citizens like you will make sure it is absolutely on the right track.

The question however is the following: Despite suspect motives for getting AIDS on the election manifesto, is there something that the people of Manipur (or people elsewhere in india) stand to gain, in terms of AIDS information, demystification of the virus, and giving AIDS its rightful place in the process of governance? What do they lose in the process? How can the losses be minimised?? etc

Whatever the answer maybe...we need to study the current Manipur process carefully - learn about it from people like you, Dr Roy - and generate a discussion among people who work in the area of AIDS...

Wondering what you are thinking about all this...

Best Regards
Mona

"Mona Mishra, Positive Life" <plife@vsnl.com>

Feb 11/2/02

Subject: [AIDS-INDIA] Re-HIV/AIDS in Manipur Election
Date: Fri, 8 Feb 2002 12:37:05 -0000 (GMT)
From: "Anand Singh" <chanand43@yahoo.co.in>
To: AIDS-INDIA@yahoogroups.com

Dear Members,
It must be a good news for many who are from outside the state of Manipur that the Politicians in the state seems to have utimately opened their eyes which had remained closed for so many years despite the problem of addiction and HIV/AIDS prevailing in their own houses and relatives.But this is just going to be one of the noises which politicians are expert in making during election time.This election is going to be an interesting one for the state of Manipur.Since all the major political parties has no new agenda to take to the people apart from the same old rhyme of rooting out corruption,safe-guarding the territorial integrity of the state,employment,infrastructure development,blah..blah....Therefore,they will only be trying to con people with the agenda on HIV/AIDS for their votes only,nothing else to expect from them. The primary focus for this people is to recover the amount they have spend on the election and get ready for the next.

Many things are beautiful on papers but they are useless until and unless it is put into practice.I would be the first person to tell this people "get lost" since I'm sure that they will forget this issues once they are elected.Commitment and dedication is the key in the fight against this twin problem.The state needs politicians with such qualities.But,it is too late that they are trying to fool the people with the HIV/AIDS issues.

with regards,
Anand.
chanand43@yahoo.co.in

Feb 14/2/02

Subject: [AIDS-INDIA] Mother to child HIV transmission rates come down to 2% in AP
Date: Sun, 10 Feb 2002 06:42:47 -0000
From: "SHEETAL VYAS" <sheetal.vyas@timesgroup.com
To: AIDS-INDIA@yahoogroups.com

Mother to child HIV transmission rates come down to 2% in AP

SHEETAL VYAS
TIMES NEWS NETWORK [THURSDAY, JANUARY 31, 2002 11:37:22 PM]

AIDS. Taboo word. Dreaded disease. But with 38 lakh children and adults living with the disease, it's not something we can ignore any longer.

Even after seven years of government sponsored programmes and millions in aid dollars, HIV continues pose one of the biggest challenges to health workers. The prevention of transmission from mother to child has been identified as one of the ways to stem the spread of the virus.

A baby born to an HIV-positive mother has a 25 to 35 per cent chance of becoming infected during childbirth or through breastfeeding. More than 540,000 children world over were infected in this way in the year 2000 alone. But there's good news. According to a pilot study conducted by National AIDS Control Organisation, New Delhi, the rates of transmission have come down drastically - from 36 per cent to 10 in the span of a year.

This feasibility study was carried out across 11 hospitals all over the country, including Nayapul Hospital in Hydorabad. According to the NACO MTCT report, the transmission rates for the state lower than the national average and stand at two per cent. Says K Damyanti, project director, APSACS, "It varies from district to district but averages out to 2.02 per cent in the state.

Which means that of 16 lakh pregnant mothers every year, 32,000 children will be born with HIV." How does the MTCT intervention work? Dr Subhash Hira, Director, Aids Research and Control Organisation (ARCON) Mumbai, explains, "It involves administering a drug called AZT during the last month of pregnancy and a few doses during delivery as well."

And the study is soon going to be implemented in a big way in Andhra Pradesh. "The initial training is being conducted by the Nayapul Hospital at 10 hospitals that are attached to medical colleges in the city. And they will start work in April. The district hospitals will be trained in May and June and they should be operational by July. So within a few months, we should see the results of this study implemented."

The programme also has the additional advantage of bringing families into the awareness programme. Says Hira, "Initially during AIDS awareness, we talked mostly to men and sex workers. Now we have a great opportunity to reach families through women as well. It gives us a wider base."

sheetal.vyas@timesgroup.com

Leb 12/2/02

Subject: [AIDS-INDIA] Jobs: District Medical Officers
Date: Sun, 17 Feb 2002 08:19:27 -0000
From: terrikaitlin@hotmail.com
To: AIDS-INDIA@yahoogroups.com

Job Title District Medical Officers
Organisation East Timor Ministry of Health

Job Location East Timor
Closing date 22 Feb 2002

Job Description and qualifications:

District Medical Officers will be located in the Districts of East Timor and will provide medical services to the population of the district and provide capacity Building.

More specifically the consultant will assist in the following tasks:

Outpatient consultation (including treatment and observation) at the Community Health Centre (CHC), usually the main centre of a district
Periodic visits to Sub-district Community Health Centres for medical consultation of cases identified by the health staff as required a medical officer's opinion

Technical advice to sub district CHCs and health posts from the district base through radio communication

In some districts, care of inpatients admitted to the small IPD. In these cases, medical support to the district will be reinforced by at least one other medical professional.

Applications for this position should be sent to:

Terri Kaitlin
HR Specialist
MoH, East Timor

E-mail: terrikaitlin@hotmail.com

---

lib
18/2/02

Subject: [AIDS-INDIA] HIV test for Rs 10 only (20 US Cents!)
Date: Fri, 15 Feb 2002 14:15:07 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: François-Xavier Bagnoud (INDIA)
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

HIV test for Rs 10 only

The Times of India 15th February, 2002-New Delhi
Hyderabad: Rupees 10 is all it costs to get a three Elisa test done in Andhra Pradesh for a confirmation of HIV positivity or negativity at the 26 Voluntary Counselling and Testing Centres (VCTC) set up by the AP State AIDS Control Society. The three Elisa test confirms HIV positivity upto 99 per cent. Private hospitals and diagnostic clinics in the state however, charge between Rs 400 and Rs 600 for the same.

The VCTCs are located in the 10 government medical colleges and the district hospitals where no government medical college is present, APSCAS additional project director NSR Brahmachary said.

All the 23 districts in the state are covered by the VCTCs, Brahmachary said. He said, many people are not continue going to private hospitals and diagnostic centres.
****
Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Lib
18/2/02

Subject: [AIDS-INDIA] Important "NGO and Private Programs working on PMTCT in India
Date: Fri, 15 Feb 2002 16:03:11 -0800 (PST)
From: ngoprivatepmtct@yahoo.com
To: saathi@yahoogroups.com, aids-india@yahoogroups.com

Important Regarding NGO-Private programs interested in Prevention of Mother to Child Transmission in India:

A consortium of NGO and Private sector programs in India are working together to apply for funding from Global fund to reduce Mother to Child Transmission in India. This consortium was formed in January 2002 and dedicated towards providing technical and administrative assistance for NGO and Private sector interested in expanding PMTCT services in India.

This is a collaborative effort, and interested in assisting as many groups as we can.

If you are an NGO and Private Hospital/clinic with ACCESS TO LARGE NUMBER OF PREGNANT WOMEN and interested in EXPANDING/ STARTING, PMTCT services and interested to join our efforts, please contact us immediately.

This is an opportunity for the whole NGO/Private sector to come together and also it is an opportunity to involve the private sector in PMTCT care. More than 50% of the institutional deliveries take place in private settings in India

Following are some ideas:

1. NGOs working on HIV issues can contact large private/corporate hospitals near you to initiate collaborative efforts. Please contact us only after you made these efforts.

2. We certainly need more initiatives in the North, North East, East and West India. We have identified many programs in the South and West.

3. BEFORE YOU CONTACT US, THIS IS WHAT YOU NEED TO DO:

** Willingness to work with HIV Positive Individuals or deliver HIV positive women

** Have access to large number of pregnant women

** Should have an Ob-Gyn and a Pediatrician Interested in assisting you with your efforts

4. In addition to these groups, we also need assistance of positive women networks, federation of Ob-gyn (to assist us with training), and Indian association of Pediatrics (to assist us with). if you are interested please contact us.

Looking forward to hearing from you.
Consortium of NGO/Private Sector PMTCT Programs in India.

Feb
18/2/02

Subject: [AIDS-INDIA] AIDS & Valentine Day
Date: Fri, 15 Feb 2002 00:49:22 +0530
From: "ihoaids" <ihoaids@vsnl.com>
To: AIDS-INDIA@yahoogroups.com

ON VALENTINE DAY KEEP HIV AT BAY!

At a 'Chat Show' in one of our AIDS awareness programmes, we were baffled with a question- why do we celebrate Children Day on 14th November? The right answer in that crowd was 'because it comes exactly 9 months after Valentine's day!' (not due to Jawaharlal Nehru's birthday). Looking at the polarised views and turmoil generated out of the Valentine's Day, we find the need to talk science-based rationale or practical things. In the era of MTV and Chalie Movie we need to have open channel of communication with our youth, who usually have an attitude of rebellion, when you talk about 'our rich cultural heritage or orthodox society'. If you wish them to refrain from certain things, they would tend to do excesses.

The AIDS scenario has assumed dangerous proportions, affecting mainly youth, however the nightmarish problem can be effectively countered by confronting the reality on war-footing, using all possible avenues, including the mega-events like the Valentine's Day. The denial of such a trend, complacency and inaction has made India top the world in HIV/AIDS. PHO has coined a slogan: During Valentine Celebration; Resist Temptation,To avoid HIV Infection!

After some awareness about the fallouts of Navaratri (disco-Dandiya), some studies established that the rate of abortions were very high after the festivity, attributing to heightened sexual promiscuity. In similar scientific spirit, we must study the consequences of Valentine's Day. AIDS threat has done a great job! The focus in casual sex has now shifted from sexual intercourse to non-penetrative sex, mainly kissing. PHO hotline gets hundreds of calls to inquire about what amounts to safer sex and is kissing safe to prevent HIV transmission? Let us use occasions like Valentine's Day, Navaratri, Rose Day to educate youth on how to observe or celebrate these occasions without getting trapped into unhealthy consequences. You cannot prevent the celebrations like these, but can certainly prevent HIV/AIDS, unwanted pregnancies.

Even almighty god has created human being in such a way that sex organs are positioned inferior to heart, but brain is positioned superior to it. The youth needs to be impressed upon that - it is better to postpone choosing a Valentine till academic/financial achievements are done and while choosing one, use brain more than heart. Stability in relationship will not only benefit them, but also will shape up a better society with less of crimes and diseases.

PHO has initiated a program 'Healthy Youth, Healthy India' with the support of Dept. of Youth Affairs, Govt. of Maharashtra, which aims at creating resistance to save the youth from the clutches of Hazards of un-healthy sexuality, Tobacco, Alcohol and other recreational drugs and to provide them education on HIV/AIDS and Human sexuality; Importance of Exercises and Yoga; Constructive revolution; Brain-storming for National Development; Role of Youth in crisis management etc. Around 25% of India's population (250 million) is aged between 11 and 20. While exploring sex, they not only face the risks of pregnancy & Sexually Transmitted Diseases (STD) as did their parents, but also a new risk of current times- 'HIV/AIDS'. The need for educating Teens is enormous, as they are more likely to experiment and take risks. It is easier to prevent the changing behavior pattern than to modify after it becomes habit. Bureaucratic delay or double standards in preventive efforts may prove detrimental, when youth are marrying later and becoming sexually active earlier. Wide gap between puberty and marriage, urbanization and lax sexual mores, it is more likely that unmarried teenagers would be sexually active. Youth can contact PHO AIDSline: 3719020 and Unison: 3061616 for guidance.

Leb
15/02/02

Subject: [AIDS-INDIA] Campaign for a Civil Law on Domestic Violence
Date: Thu, 14 Feb 2002 19:06:48 +0530
From: "women rights initiative" <wri@vsnl.net>
To: AIDS-INDIA@yahoogroups.com

Subject: Campaign for a Civil Law on Domestic Violence

Dear Friends,
As you are aware NGOs, activists and women's organizations have been campaigning for a civil law on domestic violence for the last couple of years. Pursuant to extensive consultations, in depth academic research, grass roots action and experience working for victims of domestic violence, we had drafted the civil law on domestic violence and shared the same with the Government of India at various forums. The women's movement was unanimous in the provisions in the draft law submitted to the Government for consideration.

ATTACHED PLEASE FIND THE UPDATE AND BRIEFING DOCUMENT, THE LAWYERS COLLECTIVE DRFAT BILL AND ALSO THE GOVERNMENT BILL ON DOMESTIC VIOLENCE.

While we welcome the bold step of the Government in recognizing the necessity of legislation on the subject and the need to protect women against this increasing evil by law, the Bill as proposed by the Government leaves much to be desired. Even while it does not take into account most of the recommendations put forward by us, it falls far short of our expectations and indeed what is required to be done. We are of the opinion that this bill in its present form will actually turn out to be dangerous in its implications for women who are victims of domestic violence.

We strongly oppose the law in its present form for the following reasons:

1 Defines domestic violence in a manner that fails to capture women's experience of abuse and daily violence at home. The definition in fact hides rather than reveals the true dimensions of domestic violence. In modern law, we cannot leave the interpretation of law to the subjective views of judges. Definitions are meant to set objective standards and define the content of the wrong complained of. It is left then to judges to decide whether a particular act complained of amounts to domestic violence as defined. An inclusive understanding of the subject of the Bill is necessary, otherwise women's rights cannot be protected nor promoted. The definition of domestic violence must be in line with that contained in International Conventions to which India is a party and in consonance with the UN Model Code on domestic violence;

1 Fails to declare that women have the right to reside in the "shared household" which is the most important right for women and victims of domestic violence, without which the present law will have no meaning for them;

1 Excludes unsuspecting victims of bigamous marriages by the usage of the word "relatives". Women who are led to believe that a marriage has taken place are later told that the same was not legal as it did not com ply with essential formalities must be protected. It is therefore necessary to include women who have been living in relationships akin to marriage and in marriages considered invalid by the law;

1 Fails to empower judges to grant residence orders, orders restraining dispossession and mandatory repossession of the matrimonial home, which is perhaps the most important reason for having a new law on domestic violence;

1 Does not provide for emergency monetary relief, custody orders for her children that need to be provided to any victim of violence on a emergency footing;

1 Lacks any mandate of monitoring and effective implementation of the law so that the

Leb 15/2/02

functioning of the law envisioned. It ignores the need for a Coordinator for the prevention of domestic violence;

1. Is silent on periodic training of protection officers and law enforcement machineries and does not spell out any mechanism for dissemination of information on the rights of the victims or duty of the state;

1 Provides for mandatory counseling of the victim of domestic violence, which may not be in the interest of the victims. Mandatory counseling is intended to correct the behavior of the abuser and not meant for the abused person;

1 Vests jurisdiction in the Magistrates Court instead of the civil court to exclusively deal with domestic violence cases, which in our opinion is not at all advisable as domestic violence issues are often connected with long term matrimonial disputes which are decided by civil courts. It is therefore advisable to vest jurisdiction in civil court rather than criminal courts as the women can deal with one court rather than two or more courts for all her needs. The person aggrieved should also have the option to seek relief in existing proceedings, civil or criminal. Otherwise it would lead multiple litigation, which is an onerous burden to impose on the person aggrieved.

In short, the Bill requires substantial review. The issues raised above need serious consideration, as we believe that a law that does not carefully and adequately address all the aspects of domestic violence against women can work to their disadvantage.

We are hopeful that we can together address these issues of concern and confront domestic violence in a purposeful way. We are sending this letter to all ministers concerned with the subject and to all members of parliament, as also the Chairperson of the Standing Committee on Empowerment of Women. We request you to send similar letters to all of them and also to disseminate information on this issue as widely as you can. Meetings, Discussions, Consultations on the same are welcome and we offer our relentless services to achieve our targets in a united manner. Please feel to get in touch with us anytime on anything.

Looking forward to hearing from all of you;

Thanks and warm regards,

INDIRA JAISING
Director
Lawyers Collective
Email<wri@vsnl.net>

Subject: [AIDS-INDIA] Epidemiology/ Medical Anthropology courses in India
Date: Tue, 12 Feb 2002 00:12:44 -0500 (EST)
From: "D. Anoopa Sharma" <das19@duke.edu>
To: AIDS-INDIA@yahoogroups.com

Hello!

Some of you have heard from me before...I am a student from the US, almost finished with my BS in Computer Science and Biology. I have applied for a Fulbright grant which will allow me to go to India with full funding to do a study in disease perception in rural North Indians. My proposal is now in the second (and final) stage of selection, with good chances of being accepted. The idea behind my research is that it is crucial to have a basic understanding of Indian beliefs regarding disease (arising from religion and culture) before adequate health interventions can be designed. This cultural exposure will also help me in my future career as an Epidemiologist.

While in India, I would like to take courses on Medical Anthropology or Epidemiology. I thought JNU would be able to provide me with these courses, however I am having a hard time contacting faculty at JNU's Centre of Social Medicine and Community Health. I will also need a mentor (a faculty member at an Indian University) with whom I can discuss my project and to whom I can ask questions about methodology while I am in Delhi. From there, I am hoping to conduct my research in affiliation with RLEK (Rural Litigation and Entitlement Kendra) in Dehra Dun after my coursework.

I was wondering if anyone could provide me advice on how I can contact JNU faculty (email addresses listed on the JNU website do not function). Or, if anyone on this list is a professor of Epidemiology or Public Health and could serve as my mentor while I am in India (if I receive the grant of course), or if you know of other faculty who would be able to assist me. I prefer to stay in North India because I speak some Hindi, however this is not a necessity.

Please let me know if you would like to read my proposal or would like any further information.

Thanks!

Very Sincerely,
Anoopa Sharma
E-mail:<das19@duke.edu>

Lib
12/2/02

Subject: [AIDS-INDIA] Feasibility study on HIV care and support activities
Date: Tue, 12 Feb 2002 08:58:15 -0800 (PST)
From: Samarendra Misra <misranaco@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear all,
This is in regard to a feasibility study, I plan to do in the near future on Care and support activities in relation to HIV/AIDS in developing countries, especially India. Though, most of us are aware that provision of antiretroviral drugs is the main stumbling block towards comprehensive care, I would appreciate if there is some feedback on other ground issues towards better individual care, and management of care programs in general.

I would also like to mention that this is my individual effort and not part of any organisational study or activity.

I would very much appreciate your suggestions.

regards.
S. N. Misra
misranaco@yahoo.com

Lib
13/2/02

Subject: [AIDS-INDIA] Forays into the twilight zone
Date: Tue, 12 Feb 2002 18:30:10 -0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: François-Xavier Bagnoud (INDIA)
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Forays into the twilight zone
The Statesman 12th February, 2002-New Delhi

Most People acknowledge that teenagers are a confused lot. They are entitled to their blues and need space to stretch their wings. But what about the young adults of today? How much do they know of their bodies and of their worlds? Have they resolved their conflicts and settled down into mature adulthood? Are they responsible citizens?

An analysis of the telephone calls received by a city-based counselling centre for teenagers and young adults reveals that the largest group of 18-25 years. The pattern of calls indicate that the youth of today are confused and clueless about their body and mind, about balancing the expectations of society with their own desires, responding to emotions and what exercising responsibility means.

Is Ignorance bliss? Ignorance about reproductive health and sexual behaviour is very common among today's youth. This can be traced to the usual exclusion of such lessons from the school curriculum and embarrassment on the part of parents to talk about delicate issues. Says Anish, a 19-year old: "Young people are generally very curious to know how their body functions sexually and what its implications are. But since sex education is denied to them most of the time during adolescence, they step into adulthood with a desire to try out sex as a new sport or develop a peculiar obsessive sexual curiosity.

The dangers of casual sex or sex with multiple partners are many. But most young men and women don't have a clue as to how indiscriminate sexual activity can lead to HIV and other STDs. Apart from ignorance, many harbour bizarre and totally baseless preconceptions. One caller at Askline was convinced that his habitual sexual thoughts had infected him with sexually transmitted diseases.

Most young people know of pregnancy but not the physical and mental trauma that abortion entails. One instance of people treating sex as a fun game and courting trouble is that of a girl who called up the helpline minutes after having sex, giggling and totally unaware of the implications of her boy-friend having used a plastic packet as a condom.

Curiosity killed the cat, or did it? The almost universal guilt surrounding masturbation can perhaps be traced to its strong condemnation by powerful social and religious institutions. Callers report having been forbidden to masturbate by fathers, uncles, headmasters, religious gurus and even doctors, because it supposedly leads to sexual impotency, affects eyesight, causes STDs and what not! Why is such a simple and safe practice viewed as something totally dark, negative and unhealthy? Additionally, people growing up with this guilt complex later experience anxiety of performance in their marital lives and also perpetuate this distorted vision in their marital lives and also perpetuate this distorted vision in their younger generations. At the extreme, obsessive curiosity about sex can take the form of addiction to pornography, compulsive fantasising and masturbation, leading to a total breakdown of a sense of balance in life.

Responsibility and basic instinct Another controversial issue which needs to be addressed is that can young adults engaging in sexual relations after being "seduced" by older and more experienced people, be considered as "consenting" adults? Or is it more a case of abuse? For instance, a 19-year-old male called up the helpline, saying that an older female tuition teacher was trying to seduce him and was it okay to have sex with her?

106

13/2/02

person, hovering on the brink of two worlds, was caught in a serious moral trial, and was carrying about a heavy emotional weight. Had he been counselled about sex at a proper age, he might have been aware of the risks and taken the right decision.

Society needs to recognise that sex being an intrinsic part of human nature, must be given the recognition and respect it deserves. If not, young people grow up without a basic part of themselves being acknowledged, which leaves them with a deep insecurity regarding their sexual identities. From there they go on to assert themselves sexually in thoroughly unwholesome ways. Most young people agree that sex-education should be imparted from 16 years or so, preferably in school by external and objective counsellors. A young person confided that apart from satisfying curiosity and teaching responsibility, sex-education is important to win the acceptance of peers, who otherwise scoff at you and treat you with condescension. Rajat, a 21-year old, feels that knowing about sex does not necessarily push one to consider having sex, as most parents would have it. Instead, being aware gives one the power to say "no".

Thoughtshop Foundation, a city-based NGO, has been running Askline, a helpline for young adults for the last two years. So if you have any confusion regarding relationships, any queries about sex or HIV/AIDS, ring up 4176120 on weekdays between 1 and 6 p.m. and speak to the counsellor. What is new about Askline is that it has recently started peer-counselling sessions. A few enthusiastic young people have been trained to help their friends become more aware, responsible and safe.

Peer counsellors at Askline are very enthusiastic about the whole project. Himalini Verma of Thoughtshop says, "Helping people out needs a certain amount of maturity and a balanced head. We select these young people only after determining whether they have the necessary aptitude and gauging their maturity levels." Sreya, one such young woman who has come forward to help out her peer-group, adds: "There will always be people who call up just for fun and irritate you with inane questions. But at the end of the day, the feeling of having helped out a few really gives me a high."

****

Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
François Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] AIDS : Stigma the core issue !
Date: Tue, 12 Feb 2002 18:26:20 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: François-Xavier Bagnoud (INDIA)
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Aid in the time of epidemic
The Economic Times 12th February, 2002-New Delhi

Government organisation and NGOs are trying to break down the stigma associated with AIDS but that is only the tip of the iceberg, write Sudhir Mulji and Rosaleen Multi

This month, the Delhi State AIDS Control Society is organising a family health awareness campaign. Medical advice and check-ups are being provided free in nine different health centres. The government, NGOs and many international organisations have, from time to time, published reports on AIDS awareness, yet far too few people have really comprehended the horror of what could actually happen and what is already happening in India as a result of the HIV virus. Since the epidemic is at a nascent stage, the thoroughness of these reports tends to have the effect of lulling us into the feeling that things are under control, that wise measures are being taken and that there is no need to panic.

Those who think in terms of money are particularly prone to this attitude for the total amount that has been allocated to deal with the problem is indeed impressive. But we should pause and consider whether all this is having the desired effect.

For starters, let us look beyond the paper the reports and recommendations are written on. We should listen to those who are actually involved, to the patients themselves and their families, and to the doctors who are treating them to those who know the real story because they are living with it. We should perhaps contrast what is being done here with AIDS awareness campaigns in other countries like, for instance, the open and direct approach that has been so effective in controlling the spread of the virus in Thailand. Or, for that matter, what is happening in Africa where families and communities are being decimated and livelihoods destroyed. Some people feel it is different here in India since the central government is giving directives and governments of states like Tamil Nadu and Maharshtra are reportedly taking serious measures. But are the right measures being taken?

In most Africa countries, people are facing up to what is happening. The epidemic cannot be ignored. Yet many communities, or what is left of them, are rallying round in a remarkable way to make the best of what remains. The catastrophe of AIDS has actually brought communities together to help victims and to spread information about how to combat it.

In India, HIV is "taboo" and when talked about at all it tends to be either in a sexually jocular way or in hushed tones. Since relatively few people of the total population have had their blood tested, the estimates of the numbers of those infected with HIV can be little more than guesses, and projections into the future are even more suspect.

To what extent should we rely on the experience which international organisations have gathered from other countries? Or again, how much planning should be left to NGOs and to the doctors and nurses who must do their best whatever decisions are come up with?

It may well be best for these questions to remain unanswered, as what proves successful is often a combination of different approaches. Besides we have become all too aware here of the pitfalls central planning can fall into.

This epidemic is like an iceberg with only its tip showing. We cannot tell what lies below

Kob
13/2/02

During that time there is no way of telling whether a person has been infected unless he or she decides to have a special blood test. Meanwhile there is the great danger of the virus being passed on to other individuals.

Another reason why so much of the epidemic lies hidden is the stigma it carries. People are even more scared of it than of leprosy because they associate AIDS with promiscuity or homosexual behaviour. Families as well as individuals conceal the illness as long as they can out of a combination of fear and shame. It is essential to break down this stigma, because of its consequences for public health and the population as whole. With AIDS it is sadly not a question of allocating resources between prevention and cure, for there is no cure. All medicines longer. And, for this, sympathetic care is quite as important as any thing to happen to somebody who has contracted HIV. Health workers must shoulder much of the burden of caring for AIDS patients and see to it that they get on with their lives for as long as possible.

It is up to them to prevent mothers passing on the virus when they give birth and through breast feeding, so they have to make sure that suitable milk is available and can be afforded. CIPLA's achievement in making cheaper drugs available is to be welcomed but at the same time it is essential for doctors to be made aware of the dangers of using them unwisely and causing the virus which is very liable to mutate to take new forms. Family health awareness campaigns are important but they are a tentative approach to a problem that must be squarely faced. It is largely a matter of communication, of making sure that as many people as possible are informed about the danger and the precautions they should take to protect themselves, their families and anybody they are intimate with.

This is a big ask simply because it concerns people not only all over the country but also with different levels of education and different customs and mindsets. It includes schoolchildren, adolescents who are forming their ideas about sexual norms, as well as their parents who may have prejudices. It is not enough to concentrate on so-called "at-risk groups" such as exploited sex workers and truck drivers.

The problem of HIV/AIDS is best not seen in isolation. Learning about the infection should be part of health education as a whole. It is one thing to ensure that condoms become the norm and are readily available everywhere but people also need to understand why they are necessary.

Most NGOs have realised that AIDS awareness is best approached as part of general health through women's groups. It is here that most of the progress is being made, but it takes time for customs to change. Unfortunately the virus will not wait. At the same time, there is always another slice of the population reaching the age when they need to learn how to take necessary precautions to prevent contracting AIDS.

The AIDS crisis is also an opportunity for improving health care standards throughout India. The resources that have become available will surely be of help in other areas.

****

Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] CCDT: Trust empowers communities through education
Date: Sun, 10 Feb 2002 11:40:29 -0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Trust empowers communities through education

The Delhi Age 9th February, 2002-New Delhi

I have a passion for children, so every project I undertake involves children. Of course, there is no point working with children alone, and so we work with their families and their environment," Says Ms Sara D'Mello, a former schoolteacher, who started the committed community development trust to empower marginalised communities through health, social education and community development.

It all started around 1987, when Ms D'Mello visited the leprosy colony at Borivali. "I realised the injustice of it all. Leprosy is curable but most people don't know this and are, thus, scared of those suffering from it because of physical deformities. Like AIDS, this is due to lack of awareness," she said. She began to work with the people there, doing what she could to help and in 1990, realising the need for a larger team, the Committed Community Development Trust was registered.

The state government gave CCDT the opportunity of start a leprosy control programme called Good Bye Leprosy in 1993 for slum communities in Borivali and Dahisar. In addition, a primary health centre and pre-school education programme run by women of the colony was started. These programs were so successful that they are being phased out. "We are only catalysts. Ultimately people take charge of their own lives. We cannot supplant the government but we can help people access government services," points out Ms D'Mello.

Today, 180 tribal children from Sanjay Gandhi National Park are enrolled in school and CCDT has begun to work with migrant labourer community in Dahisar, holding classes from women and children. Another of their programmes in Dahisar is the "Help a mother, save a child", where a follow up is done for 30 months with pregnant women to prevent infant mortality.

In the mid-90s, CCDT began working in red light areas and Project Ankur was started in Kamathipura, Worli and Bhandup for the children of women in prostitution. Ms D'Mello explains: "We need to get these children into the mainstream. We placed them in municipal schools, provided day-care centres and girls. It was difficult at first but we tried to build bridges. What is important is to strengthen the mother-child bond."

Project CHILD was initiated in 1995 for the children of HIV positive women, especially women in prostitution. She adds: "We found many women who were ill and not responding to treatment. It was discovered they were HIV positive. When they began to show symptoms and became too ill, they were thrown out of the brothels and left to die in the streets."

For the children infected or affected by HIV, Ashray, a residential centre was started in Bandra where a home environment is created. Later these children are placed in schools. The BMC helped them in accessing centres for the HIV positive women in prostitution.

Today, CCDT is working with those families affected by HIV and has begun training other groups in spreading AIDS education and awareness. It promotes family-based care as an alternative to institutionalisation. CCDT is always looking for volunteers whether it is architects to help repairing their centres or artists to help with play therapy for the kids. Recently, Shiamak Davar volunteer to conduct dance classes for them.

Ms D'Mello says: "We have a long way to go, but we have made a breakthrough since people have begun coming to us. Today we work with 200 families and 300 children affected by HIV. We try to provide them with alternatives, how to cope and take control of their lives."

****

Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Leb 12/2/02

Subject: [AIDS-INDIA] DD1& Zee; Dispelling myths about AIDS
Date: Sun, 10 Feb 2002 11:55:11 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: FXB INDIA
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Dispelling myths about AIDS

The Business Line 9th February, 2002-New Delhi

Are you sitting comfortably in front of your TV? Digging, perhaps, into a steaming plate of chicken biryani, attention riveted on the latest twists in a soap drama, or the ODI face-off between England and India or even smirking at the inanities of opinion and talk shows. Good. Now turn to DD on Wednesday nights or Zee News on Saturday afternoons for bit of a jolt.

For the past month, these two channels have, every week, been airing a talk show on AIDS. Khamoshi kyon on DD-1 anchored by Neena Gupta and Talk positive on Zee News anchored by malika Sarabhai. For the first time in Indian television history, a public broadcaster and a private channel have come together to dispel shibboleths about this disease a panel of experts to reply to uneasy questions.

Of course, this is not as altruistic as it sounds because the programmes have been sponsored and therefore paid for by NACO (National AIDS Control Organisation).

Although open discussions on AIDS have been running for years on Vividh Bharati and TM channels, getting TV channels to air an issue which even in 2002 is considered taboo has not been easy. NACO's first choice was high visibility entertainment channels like Star Plus, Sony and Zee who politely refused despite the possibility of increased income.

Also unsuccessful were attempts to get popular production houses to include a character suffering from AIDS into their storyboard. Perhaps with the start of two new hospital-based series, Sanjivani and Dhadkan, this task will be made easier.

At last, after too many years of superficial yet sympathetic coverage of AIDS, the ghastly predictions, the appalling descriptions, incomprehensible inertia of the establishment, these two shows have pushed the issue at a more basic level. Celebrity activists Sarabhai and Gupta, far removed from their respectibe roles as a glossy host for CNN's Style South Asia or the weepy second wife in Saans and Shaanji, are effective rapporteurs: concerned, smart, yet not hopelessly sappy.

With 3.86 million established cases of HIV in India (there's a heated controversy over knows AIDS cases and the figure sweeps from 15,000 to 50,0000), the programmes are a brave and necessary attempt at stripping the public face of the disease.

The approach of each of the two programmes varies. In Hindi, Khamoshi kyon kicks of with a small drama explaining the issue of the day, dealing with topics like the importance of sex education or protection, whereas Talk Positive, probably anticipating a more educated viewership, plunges right into audience questions, some of which are quite explicit.

The panelists include health workers, doctors, educators and inevitably HIV patients unraveling their experiences. In between there are snippets on AIDS, immunity, the probability of cross-infection and the dangers of selling blood.

So far I have only seen a few episodes but it world be interesting to see whether any of

Feb 12/2/02

efficacy of expensive drug treatment.

BBC finally aired Commando, the new reality, fly-on-the wall series on 26 January. Produced by Miditech Productions, the series Zeroes in on the commando-training course at Belgaum, Karnataka.

Dr.Jagdish Harsh (jharsh@atxb.org)
Director of Administration and Operations
Francois-Xavier Bagnoud (INDIA) (www.fxb.org)
161,Satya Niketan Moti Bagh II
New Delhi-110021
Phone: +91-11-6111793-94
Fax: +91-11-4107381

Subject: [AIDS-INDIA] Politics, Mainsteaming, AIDS and Sexual minorities in India
Date: Sat, 16 Feb 2002 12:22:15 +0000 (GMT)
From: "Aditya Bondyopadhyay" <adit_bond_2@yahoo.co.in>
To: AIDS-INDAI@yahoogroups.com

Hi,

The past week has been a watershed of sorts for myself as various events tumbled out over the week and I wish to share it with you all on all the various lists. What happened has portents for sexual minority politics, sexual minority in mainstream politics, and for HIV/AIDS.

Like all story let me begin at the begining. Last saturday People for the rights of Indian Sexual Minorities [PRISM], a Delhi based group of individuls working for the rights of sexual minorities in India but also having faith in building alliances with other groups of opressed people like the women's movement, slum dwellers, et al, was given space to have a stall in the most happening place in Delhi, namely 'Delhi Haat'. A board was put up at one prominent junction of the Haat where an impromptu opinion poll was taken. The statement put out was "being homosexual is normal". Small chits were given out to whosoever wanted to jot their opinion and the responses were pinned up either to the left of the board if the response was "I Agree", or to the right if it was "Disagree".

Response was overwhelming and the age range of respondents were from school kids to grandmothers. Daddies and sons wrote out and stuck their opinion chits togeher on the board. And by the end of the day, the agree side of the board had spilled over well into the space reserved for the disagree side of the board. By more than 25 to one the average haat going middle class persons of Delhi had found no abnormality with homosexuality.

But semantics of polls aside, what was more important was that there was that there was an activist with a poster stuck on his back exclaiming in LOUD letters "GAY & PROUD". He did not even raise eyebrows. No body gave a fig as to him being gay. A real life substantiation of the fact that the poosters were not just polling politically correctly, they really found nothing awkward in being gay.

PRISM tied up with a street theater group, who enacted a play on homosexuality, homosexual love, and the kind of problems that homosexuals face. By the end of the day there were 3 encore performances. The public came, saw, and enjoyed....with fathers, daughters, moms, sons, friends, all gathered around and no elder trying to hustle away a child from such "bad things". Leafet given were read and not thrown away, but tucked into purses and pockets, queries being made on how prism or similar groups can be contacted should some one they know need help. I could not help thinking that most people know of some one or the other who is homosexual, and this information was being kept to aid them should they need so.

On to sunday last, at the NDTV studios in Delhi. It was shooting time for Bharkha Dutts people's talk show "We the People". They were to discuss the laws on homosexuality. What brought it on was the petition filed by Naz India challenging the vires of 377 in the Delhi High Court. In the crowd of 100 were various LGBT activists including myself, the historian Saleem Kidwai [co-author of the meticulously researched 'same sex love in India - readings from literature and history'], one Additional Solicitor General, the token IPS guy Uday Sahai, the token Psychiatrist, and the BJP MP VK Singhal. The opening shot was given by the hon'ble MP about the need to criminalise as homosexuals were in every which way appaling to India, Indians, Culture and what have you. Along the way Mr. Sahai did his out of turn and out of context pitch on Lucknow, doling out a story that is probably the n-zillioneth version of the lie coming from the police camp, and quiet coincidentally much in varience of the report that the police themselves have filed in the courts. The learned ASG threw in his hat for the need to criminalise and the good psychiatrists went against the grain of world psychiatric opinion on homosexuality, hee-hawed, and tied himself up in knots. But all these people were what we call the establishment. The drivers for the powers that be. Their attitude was important because suddenly in the midst of all this I realised why NACO had not defended its policies in public when the police in Lucknow were so effectively shredding and rubbshing it. They could not because they are part of the same establishment. They are not courageous fighters for the truth, the just, or what

Lib
18/2/02

they themselves say they belive in. They are driven by these drivers and therefore by these attitudes. No wonder I also felt the fear of what it means for the AIDS containtion movement in India.

Talking of AIDS, because the debate from the inception hinged on the morality and 'indianness' of homosexuality, Criminalisation and how it impacts HIV intervention could not become a main theme of the debate. But what is heartening is that other than the establishment the rest of the "People" came out strongly on the side of the "Oppressors", and some of their simple logic quite literally floored the establishment-wallas. It was quiet amusing to see their attemts at establishing the validity of their hatred by dogma, convoluted logic on culture, and plain simple Joseph Goebblesisms.

Again I could see that the common person does not have the greater homophobia that we apprehend. The average mother, the average brother, the average friend, does not judge by sexual orientation. They judge by what one means when sexual orientation is kept aside. The fact that this has happened is what I feel is the positive in the political struggle of sexual minorities. The real fight is with the establishment wallas and their attituted. It is they who would not hesitate to give cultural, indianness, or any other twist, if they see any king of political mileage being gained by having another punching bag around. It is them that we have to deal with by using the best arsenals we have- truth, good science, honesty, justice, and our human rights to be who we are.

[Note: This programme is scheduled to be telecast at 8PM IST on the star news Channel on the 17th February 2002.]

Then I came over to Lucknow on work. Here one of the political heavyweight has a challenger who is a eunuch. Lalji Tandon of the BJP has been having quiet a fight from this gutsy person, namely Payal, a candidate for the Rashtriya Communist Party. She held a meeting yesterday and in her campaign, quiet a few members of the sexual minority population from all over joined in. A public coming out of the closet of sorts after the Kristellnacth days last July in Lucknow. And today the press has gone to town about hows gays have come to the aid of Payal. There are big articles in the 'Indian Express", "Times of India", "Asian Age", and most of the Hindi Newspapers. Of course the political camps of Mr. Tandon has given the necesary spin about how the participation of gays is either a conspiracy of the rebel BJP/RSS persons who do not love Tandonji, or how it is their handiwork to spoil Tandonji's chances at the hustings.

But I am more pleased with the fact that the candidate and her party have courted gay men/homosexuals with open arms and have publicly stated that their rights to be needs to be respected. I hear from reports tat there are eunuch candidates being fielded in these elections by quiet a few parties including the congress. I would be interested in knowing if they as parties share this same opinion and if so what they propose to do about it. Thus far there are no answers. But what is clear is that collectively sexual minorities of all hues are becoming a political force and not very far from today, I feel, the establishment wallas can no more hide behing their hatred and homophobia and ignore the fact that sexual minorities are human beings with human rights that cannot be denied them just to abet their own personal bigotry. With these elections I see that the silence has finally been broken.

If rights are at the root of effective intervention for HIV/AIDS, then this can only mean a better future, homophobia of the estblishment wallas aside.

When Shabnam mausi became a legislator, or when the other eunuchs were elected in the past, there were e-mail traffic on the net asking if they were able to help in any way in furthering the cause of sexual minority rights. After what happened at Payal's campaign, I feel that sexual minority activists [myself included] in the past have erred in not reaching out to these elected representatioves or by not providing support in their candidacy days. That I feel shall not be a mistake repeated by us in the future. We cannot come to the reaping to toil, and yet expect a share of the harvest.

The piticizing of sexual minority in the mainstream of politics has begun, I fingers crossed, I hope only for the better.

Love and regards

Subject: [AIDS-INDIA] Govt announces new pharma policy
Date: Tue, 19 Feb 2002 13:12:23 -0000
From: "Dr Dwijen Rangnekar" <d.rangnekar@ucl.ac.uk>
To: AIDS-INDIA@yahoogroups.com

Govt announces new pharma policy

The government, on Friday, announced the pharmaceutical policy 2002 reducing price control substantially and exempting a drug with turnover of less than Rs 100million from the control regime.

Laying down a two-tier criterion for regulation of prices the policy spells out measures for boosting research and development by exempting drugs developed indigenously. Moving towards decontrol regime of drugs, the exemption limit has been raised to Rs 100million from the earlier Rs 40million. A bulk drug will come under price control if its total moving annual turnover (MAT) is more than Rs 250million and market share of manufacturer is 50 per cent or more.

According to the second condition, a drug would come under control, if the total MAT value is less than Rs 250million but more than Rs 100million and market share of any of the formulators is 90 per cent or more.

As per the policy, which was approved by the Cabinet on February 5, new drug patented under Indian Patent Act 1970, developed through indigenous research and not produced elsewhere will be exempt from price control for a period of 15 years from the date of commencement of its commercial production.

Similarly, a formulation involving a new delivery system, will be eligible for exemption from price control in favor of patent holder formulator from the date of the commencement of its commercial production till expiry of patent.

It has, however, retained the same maximum allowable post-manufacturing expenses (MAPE) at 100 per cent for indigenously manufactured formulations.

PTI, February 15, 2002

Dr Dwijen Rangnekar
Senior Research Fellow
School of Public Policy
University College London
29/30 Tavistock Place
LONDON WC1H 9QU, UK
E-mail: d.rangnekar@ucl.ac.uk

Feb 20/2/02

Subject: [AIDS-INDIA] Mandatory Pre-marriage AIDS test In Mumbai ?
Date: Tue, 19 Feb 2002 13:35:39 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Pre-marriage AIDS test likely in Goa, should city follow?

SHARMISTHA CHATTERJEE

TIMES NEWS NETWORK [SATURDAY, FEBRUARY 16, 2002 9:29:38 PM]

In Goa, the government is seriously considering making HIV testing mandatory before marriage. With citizens strongly endorsing it, experts feel there is a strong possibility that pre-nuptial AIDS tests for couples will soon become a reality in the tourist hot spot. Mumbai, however, experts treat the idea with skepticism despite the megapolis' large AIDS population.

State Health Minister Dr Digvijay Khanvilkar says mandatory HIV testing is an encroachment of human rights. "You can't compel people to get themselves tested. You can't make a success of anything by forcing it down people's necks, that too in a city like Mumbai," he says. Adds a government hospital doctor, "By making the tests compulsory, you are assuming that everyone's sexually promiscuous. This is a gross violation of human rights. Besides, who will work as the watchdog?"

In Uganda, in the early '80s, a public appeal for HIV testing was made after 40 per cent of the population was found to be HIV-positive. Though more and more people between 25 to 35 years of age are being identified as AIDS victims, experts feel mandatory testing may prove counterproductive. "A fear psychosis may develop and sexual patterns will change," says Dr Subhash Mira, director, AIDS Research and Control Organisation (ARCON). "Only voluntary compliance can prove effective."

With a window of six to seven years between infection and detection, chances are the virus may not show up even in a pre-nuptial test. Says Dr Shanta Shankar Narayan, joint director, Mumbai District Aids Control Society, "Besides, how do you ensure that an individual will not indulge in high-risk behaviour after marriage?"

Most settle on counselling and awareness building as the solutoin. Says Dr J K Maniar, Grant Medical College, "You can't force anything on people. Explaining the implications of one's behaviour is what one can do." Agrees Sudesh Agarkar (name changed), who tested himself seven times before marriage to ensure he is not HIV-positive, "I got it done, not because I was asked to, but because I realised that wife-to-be's life was also at stake."

http://www1.timesofindia.com/articleshow.asp?art_id=1089558&sType=1

Feb 20/2/02

Subject: [AIDS-INDIA] HIV: Talk before you test
Date: Tue, 19 Feb 2002 13:38:09 -0000
From: geetanjalipatole@indiatimes.com
To: AIDS-INDIA@yahoogroups.com

HIV: Talk before you test

GEETANJALI PATOLE

TIMES NEWS NETWORK [SUNDAY, FEBRUARY 17, 2002 11:37:50 PM]

ackling the threat that HIV, and subsequently AIDS, poses for a developing country like India is proving to be a varied challenge.

Besides the enormity of awareness programmes that are required to make sure the prevent-HIV message gets out to the masses, the population of our cities, including Pune, is forcing doctors and social workers to neglect a very crucial aspect while preventing the HIV juggernaut from rolling on.

Even though the Indian Medical Association (IMA), has guidelines that make it mandatory for anybody taking an HIV test to receive pre-test counselling, this is not happening in Pune.

While on the face of it, pre-test counselling may seem an expendable process, it is often what can make all the difference between life and death for the person taking the HIV test.

Which is why pre test counselling is de rigeur in medical facilities the world over and admitted to, as a necessity, even by HIV experts in the city. Most hospitals in the city this reporter visited were not equipped with counselling cells to provide any such facilities.

A standard pre test counselling procedure assesses the patient's risk factor through a series of queries and prepares him/her to accept the test result confidently.

Dr Sanjay Mehendale, deputy director of the National Aids Research Institute (NARI), said that pre-test counselling was perhaps one of the most important aspects of any HIV/Aids awareness programme.

"Testing for HIV can put the patient through enormous stress and trauma, since a lot of fear, stigma and dread is attached to the disease. Whether the result is positive or negative, it is essential for the patient to go through a thorough pre-test counselling," Mehendale said.

According to the IMA guidelines a pre-test counsellor is first supposed to make the patient familiar with all the procedures required for the HIV test. The counsellor is then supposed to ask the patient why s/he has decided to go in for a test. If the patient has had a history of high-risk behaviour involving drugs, multiple sexual partners, homosexual contact, blood transfusion, etc., the counsellor has to explain the degree of risk to the patient.

20/2/02

Preparing the patient to accept the result is the next part of the procedure. After the patient is informed about the various medical facilities that have made it easier for someone to live with HIV, s/he has then to be asked permission to carry on with the HIV test.

Dr Vinay Kulkarni, HIV physician for Jehangir hospital, acknowledged the importance of pre-test counselling. However, he claimed that logistically, in Pune, it was not possible to counsel every patient that goes through an HIV examination. "We give pre-counselling to patients who volunteer for an HIV test. But for patients that are undergoing surgery, we usually suggest a rapid screening since there are more important factors that need to be taken care of. However, in this rapid testing if we do discover an HIV positive case, we then refer them to a counsellor before the news is broken," he informed us.

Noted HIV expert Dr Sanjay Pujari also cited the sheer number of people going in for test as the reason for the absence of pre test counselling for HIV. "The number is so mind boggling that the hospital authorities cannot cater to all the patients that go in for a test. Besides, the tradition of medicine in India has always been very fraternal. The physician always has an upper hand in medical matters and the patient rarely objects to what the physician suggests. If the patients know their rights, they can demand pre-test counselling," Pujari said.

According to Dr Mehendale, the importance of pre-test counselling cannot be neglected. "There is hardly any investment required to set up a pre-test counselling office. Even the counsellor doesn't need a formal degree. We at NARI provide regular training programmes where we train volunteers to become effective HIV/Aids counsellors. If the hospitals are running short of staff they can always turn to us," he suggested.

The situation puts the onus on the person going in for a test. One will be well within one's rights to request for a counsellor before taking the test. It could make all the difference.

geetanjalipatole@indiatimes.com

http://www1.timesofindia.com/articleshow.asp?art_id=1298454&sType=1

Subject: [AIDS-INDIA] Sex workers "Shanti Utsav" in Kolkata.
Date: Thu, 21 Feb 2002 13:16:40 +0530
From: "Sonagachi" <sonagachi@sify.com>
To: <AIDS-INDIA@yahoogroups.com>

Subject: Fwd: Shanti Utsav

From: "Sujit Modak" <dmsc@sify.com>
To: <comite.side@codetel.net.do>, <t.scherer@state.gov>,
<jrichens@gum.ucl.ac.uk>
Cc: <tushai@bdcom.com>
Subject: Shanti Utsav
Date: Fri, 15 Feb 2002 14:01:04 +0530
X-Mailer: Microsoft Outlook Express 5.00.2314.1300

Santi Utsab (Peace Festival)<?xml:namespace prefix = o ns = "urn:schemas-microsoft-com:office:office" />

Organised by

DURBAR

(Durbar Mahila Samanwaya Committee)

Venue : Yuba Bharati Krirangan, Salt Lake, Kolkata, India

From March 3rd to the 9th, 2002.

Durbar, a forum of 60000 sex workers (male, female and trans gender) and their support groups and individuals has been involved in networking among sex workers in India and across the world, helping sex-workers to unite and to uphold the rights of sex-workers. Durbar Mahila Samanwaya Committee(DMSC), the sex workers collective, explicit about its political objectives of fighting for a more secure legal status for sex workers and their children and protection of their rights. DMSC strongly demands decriminalisation of adult prostitution and social recognition of sex work as a valid profession.

KNP+(Kolkata Network of Positive, collective of PLWHA) is part of the umbrella organization of Durbar working together to express themselves to the general mass about the pros and cons of being positive. They want to stand by all people who are positive so that they or their families do not feel to be alien to the community. KNP+ provide Antiretroviral to PLWHA through the support of Durbar.

The members of Durbar, would like to convey the message of peace and harmony across the world. To strengthen the peace movement in city and abroad we have planed to organise a festival named **"Santi Utsab"** in the second year of the new millennium. We wish everybody peace and happiness, breaking all the barriers of state, religion, gender and race. We hope to bring together more than 40 thousands participants during this meet.

Hope we fulfill our aspiration of a peaceful and happy world for the coming future.

Please feel free to forward this message to others who you think are committed to the cause of equality and peace.

Who are we?

Usha Multipurpose Cooperative Society Limited, Usha for short, is a financial cooperative institution, constituted solely by sex workers. Usha is part of a larger loosely affiliated association of sex workers organisations based in West Bengal, India that has collectively come to be known as Durbar (*durbar* in Bengali meaning unstoppable or indomitable).

The affiliated sex workers organisations in **DURBAR**

Durbar Mahila Samanwaya Committee(DMSC)

From 1992 sex workers involved in an internationally acclaimed HIV prevention intervention programme (STD/HIV Intervention Programme, widely known as the Sonagachi Project) operating in red light districts of Calcutta had started mobilising around demands for promotion and protection of sex workers rights. In 1993, they organised themselves into an informal association, which assumed an increasingly formal character and was later registered under the law as DMSC, *Durbar Mahila Samanwaya Committee* (Durbar Committee for Co-ordination of Women) in 1995. DMSC, an autonomous organisation of sex workers, functions an exclusive forum of women, men and transgender sex workers, both brothel-based and mobile populations, and their children, and has 66 branches and a membership of 50000 sex workers across West Bengal, India.

DMSC itself, along with Usha as one of the primary stakeholders, has been running the STD/HIV prevention intervention from 1999 (DFID), having taken over from the consortium of NGOs, CBOs and the All India Institute of Hygiene and Public Health, Calcutta, which initially implemented the programme. Apart from mobilising sex workers in the districts of West Bengal DMSC has started STD/HIV intervention programme, replicating the Sonagachi model, in 19 red light areas. DMSC has also started HIV intervention among street-based sex workers and their clients, covering a population of over 12000, through drop in centres for counselling, referral STD care services and mobilisation among street-based sex workers

Apart from its direct involvement in HIV prevention, DMSC and the other affiliated sex workers organisations under Durbar, has been active in addressing the other structural issues that frame the everyday reality of sex workers lives, be they related to their material deprivation, their social exclusion or the stigma attached be being a sex worker or her child. It is explicit about its political objective of fighting for a secure social existence of sex workers and their children. DMSC demands decriminalisation of adult prostitution it all its aspects; social recognition of sex work as a valid occupation; and establishment of sex workers right to self-determination. DMSC also seeks to abolish or reform all laws that restrict the human rights of sex workers and limits their enfranchisement as full citizens. To regulate the exploitation of sex workers within the sex industry DMSC has already set up a series of local Self-Regulatory Boards in selected red light areas in Calcutta. These Boards, like other professional associations like the Indian Medical Association or the Bar Council, act as the principal arbitrator in cases of violation of sex workers rights within the trade. The Boards also stipulate, once again like other occupational associations, some minimum standards for joining the sex industry of which consent and age are the two main principles. The members of DMSC contend that their own efforts at regulating the norms within the sex industry would act as much more efficient deterrent to exploitation within the industry, be it underage prostitution or trafficking, than state coercion or censure and control by the society at large.

DMSC has been taking other steps to improve the immediate working and living conditions of sex workers too. The members of the DMSC have organised rallies and demonstrations against specific instances of trouble caused by local hooligans, against extortion and harassment by the local police, protested against forcible AIDS surveillance[1] and unauthorised vaccine trial[2] and have stopped eviction of individual or entire groups of sex workers from their homes or localities.

Usha Multipurpose Co-operative Society Limited(USHA)

One of the most significant steps that sex workers united under DMSC had taken to increase their economic security is to register a consumer co-operative (Usha Co-operative and Multipurpose Stores Limited, Usha) in the name of sex workers, in August 1995. The sex workers were successful in persuading the State Government to remove the relevant clause from the Cooperative law so that they could register the cooperative with their occupational status as sex workers rather than being passed off as ubiquitous housewives . The registration of the Co-operative also marks an important strategic advantage for DMSC in their struggle to re-frame the definitions and meanings of their occupation. Members of the Committee hope to use the fact that a state institution has formally recognised prostitution as the Co-operative member s profession, as leverage in their campaign for social recognition of sex work and sex workers' right to self-determination

Through this Co-operative, they provide crèche facilities for children of sex workers during business hours, which also give employment to out-of-work sex workers. They run a thriving savings and credit schemes for Co-operative members. They undertake social marketing of condoms in 40 red light districts of West Bengal through a special team of members, the Basanti Sena and have started training for initiating a production unit.

Usha and DMSC members are very emphatic that the Co-operative is not meant for economic 'rehabilitation' of sex workers who are in the trade, but is designed to provide a financial resource for them to fall back on in moments of crises, and to minimise their economic desperation by creating a space for negotiation. Moreover, they hope that the Basanti Sena will not only travel around different parts of the country for social marketing of condoms, but will also help in acquainting more and more sex workers with the aims and objectives of the sex workers movement. In short, UMSCL provides soft loans and small savings opportunity to sex workers, creates alternative jobs for sex workers, does social marketing of condoms and other essentials and plans to start a large scale production unit for generating employment for retired sex workers and those who want to opt out of sex work.

Having developed the necessary technical expertise and infrastructure, Usha now also operates as the principle financial institution for the range of range of sex workers organisations affiliated loosely under Durbar, and handles grants from external agencies for them

KOMOL GANDHAR

One important way in which the organised sex workers have been attempting to carve out a positive identity for themselves is through cultural self-expression. They formed Komol Gandhar, as a cultural wing constituted exclusively of sex workers and their children, to represent their thinking and lives through music, dance, plays, painting and writing. For a group of sex workers coming from diverse cultural backgrounds Komol Gandhar created an opportunity for them to explore their cultural heritage and preserve and expand their cultural expressions. Komol Gandhar has now emerged as a platform for exchanging various cultural traditions, across linguistic, religious and regional barriers and for forging a common identity as sex workers and has become a critical political tool in the sex workers movement. It has enabled a wide section of the sex workers community to participate in the sex workers movement through cultural activities in which many of them were already skilled.

POSITIVE HOTLINE

DMSC runs testing, counselling and care services for HIV/STD through its independent wing, Positive Hotline. Positive Hotline aims to promote positive attitudes towards care and support for people living with HIV/AIDS. This initiative addresses the needs of serum positive people and their families to cope with the social and psychological traumas associated with being HIV positive and extend its services beyond sex workers communities into the general population. When a sero-positive person contacts the Positive Hotline, Positive Hotline teams visit them in their locality to extend moral and material support and to sensitise the local community. The thrust of this initiative is to challenge social constructions of AIDS patients in general and the misconceptions and apathy among the health professionals. Positive Hotline also provides specialised training to other groups, organises hospital care for people with AIDS and has recently started a city counselling centre for people afflicted with various sexual dysfunction.

Sathi Sangathan

In another dynamic development, the *Babus* or fixed clients of sex worker members of DMSC, have recently formed their own collective. *Sathi Sangathan* or the Companions' Collective, for fighting alongside with DMSC against all kinds of violence faced by sex workers, their children and their clients.

Sramajeebi Mahila Sangha

Sramajeebi Mahila Sangha is one of the oldest surviving self-help groups of sex workers based in Sethbagan and has been an active partner of the Durbar family.

Binodini Srameek Union

Members of DMSC other Durbar affiliates share a common premise, that prostitution is not a moral condition but an occupation and as sex workers they are working women, and men, who like many other working women are engaged in a marginal, sexist, exploitative and low-status job. For most sex workers, working in the sex industry is not an irrational act of desperation, but a rational choice made from the very limited options available, particularly to poor, unskilled women, in a capitalist and patriarchal society. The rallying slogan of the National Conference, - sex work is legitimate work, we want workers rights , has now become the immediate strategic aim for securing basic needs as human beings. To this end sex workers have applied for registration of their own trade union, Binodini Srameek Union. >From 1998 Durbar has celebrated the International Labour Day every year by organising a midnight torchlight rallies foregrounding their demand for workers rights and through the formation of the trade union they want to take this struggle forward and join the larger international labour movement for the autonomy of workers.

The Millennium Mela

As part of Durbar s on-going effort to put sex workers rights on the global agenda in the new millennium, we at Durbar Mahila Samanwaya Committee organized a carnival, the Millennium Mela, as a meeting ground for all sex workers of the world, - of all class, creed or gender, as well as organisations and individuals committed to the rights of sex workers and their children, to gather together and meet face to face. At the Mela we celebrate our lives and our struggle and exchange our stories as part of our unrelenting movement to change histories.Around 25000 sex workers representing 16 countries and about 30000 peoples from different walks of life attended during 5 days of the Mela.

Why are we holding the Mela this year[Shanti utsab]?

From 1996, DMSC has regularly convened state and national level meetings of sex workers organisations in India, which have also been attended by policy makers, politicians and administrators. The most notable of these have been the First National Conference of Sex Workers if India in 1997, on the theme *Gator khaatiye khaai, srameeker adhikar chaai* (We labour for our living, we want workers rights) and its follow-up Strategy Summit in 1998, which initiated the formation of the National Network of Sex Workers in India, and took the sex workers movement to the national arena.

We have also attended numerous national and international meetings, workshops, seminars and conferences to talk about our rights and ourselves. But this time we want to inscribe our identity on the public arena in our own inimitable style. No pre-imposed formats. No centralised control. No faceless formalities. But a celebration of life and of love through debates, discussions and dancing. Through songs and smiles we will build solidarity. We want to get together with other sex workers from across the country and beyond to think through our lives and think beyond our everyday struggles towards building a collective future unfettered by deprivation, stigma and violence. Not just for us, the community of sex workers, but for the entire world.

What will happen at the Mela?The theme of this year is peace,we call it santi utsab.

One of the central focuses of the Mela will be an interactive installation on the history of sex work and sex workers movement in India We will also hold a Health Fair, with facilities of counselling and testing for STDs. There will be a number of open and indoor stages, for continuous cultural performances by sex workers and other performing artists. For those of us wanting to get down to serious discussions, a number of symposiums, workshops and dialogues will be held on a whole range of subjects, from role of sex workers in combating trafficking to peace-building in an increasingly conflict-ridden world. Throughout the Millennium Mela we will also show panorama of Indian films with sex workers as the central characters. Moreover, there will be numerous stalls selling handicrafts and mementos, food and drinks, tricks and treats. And of course no Mela can ever be a success without the big old merry-go-round, and vendors selling candyfloss and balloons. Above all we promise a bundle of fun, a real carnival of colours.

The Objectives of the Mela

- The principal objective of the Mela is to spread the messages of peace,love and soliderity across the class creed and nationality.We aspire for a free, safe and happy environment for the people of the universe as a whole..We the sex workers from across India and other countries will come together to express our views,will share and celebrate our lives, our histories and movements[present and past]

- The Mela would also provide a platform for different sex workers groups to showcase their cultural skills through staging of plays, music soirees, and dances.

- At the Mela skill building workshops would provide capacity building opportunities for sex workers in networking & mobilisation, leadership, violence mitigation and communication skills.

- The Mela would also provide an opportunity for sex workers to sell handicrafts, food and other items produced by them.

- At the Mela sex workers community would have an opportunity to hold face-to-face dialogues with elected representative, political leaders, representatives of state and other civil society institutions like the police, media, performing artists, trade unionists, women activists, gay right activists and intellectuals.

- Foregrounding the rich cultural heritage of our country for the entertainment and intellectual stimulation of the sex worker delegates is another objective. This would be done through continuous performances by various folk artists from Bengal, a festival of films of Indian movies with sex worker protagonists and an Artists Camp where prominent painters would develop paintings on the themes of sex workers movement.

- One principal objective of the Mela is to provide information on HIV/AIDS to the delegates. Towards this purpose a Health Fair will be held, with an exhibition and testing and counselling services for STDs

A central objective of the Mela would be to represent the history of sex workers participation in National freedom movement besides our historical contribution in ensuring peace and prosperity in different countries and in communities.Attempt would be made to track down the process of development of the global sex workers movement . This will be done through staging an interactive installation (exhibition) at the Mela ground.

Registration for Stall Booking at

Shanti Utsab[sex workers carnival or Mela]

Calcutta 3rd to 9th March 2002

At Yuba Bharati Krirangan, Calcutta, India

Please Print or Type.

Please feel free to forward this to others who you think are committed to the promoting sex workers rights and would be interested to participate.

Name of the organisation

(in block letters)

Organisation Represented:

Mr./Ms.

(with address)

Phone: (with STD/ISD code)

Fax: (with STD/ISD code)

e-mail: (if any)

Status of the organisation

Sex Worker s organisation

(please give a 5)

Organisation working for sex workers

NGOs working on other issues

Commercial enterprise

Personal address & Phone No.

of the Representative :

1 / We need accomodation: Yes/No

If yes, Number of heads:

Note: accomodation and food(lunch & dinner) is provided free of cost **only** for sex workers form 3rd March to 7th March 12 noon) those who are

	Name	Male/Female
1.		
2		

not able to pay.

3.

4.

5.

Date of arrival at the Mela:

Date of departure from the Mela:

Size of the stall:

10' x 10' == 100 Sq. Feet

Registration fees:

a. NIL (for sex workers organisation)

b. All other participants have to pay

1. Rs. 5,000/- for the stall (without light fittings).
2. Charges of the light fitting Rs. 500/- per stall.
3. Charges of electricity free of cost.
4. Cost of Insurance will be born by the party at actual.
5. Cost for extra (as per requirement) furniture will be charged as per following details:

i) Garden Chair @ Rs. 5/- each

ii) Furniture (Rack /Self etc.) @ Rs. 20/- each

iii) Tube light Rs. 50/- each

iv) Extra Hallogen light Rs. 125/- each

Terms & Conditions:

- Applicant must declare the purpose for which the stall will be hired.
- Durbar Mahila Samanwaya Committee (DMSC) reserves all right to accept or reject applications for hiring of stalls.
- All the applications should be accompanied by Money Order / Demand Draft of Rs. 2,000/- in favour of Durbar Mahila Samanwaya Committee A/c Millennium Mela payable at Calcutta. If the application for stall is cancelled by the DMSC authority, deposited amount will be refunded within 10 days of the completion of the Millennium Milan Mela in case the applicant wishes to withdraw application after registration for stall, Rs. 1,000/- will be deducted from their deposited amount. Balance amount will be paid by Cash or Demand Draft on 5th of March 2001 in between 12 noon to 4 pm. at Mela Office.
- Last date of application for stall is 21.02.2002
- Last date of scruitiny and allotment is 23.02.2002
- Sex workers organisations will be alloted stall free of cost subject to certain conditions*.

* Application from sex workers organisation will have to be accompanied by documents proving that the organisation is indeed constituted solely by sex workers.

Please Note:

Organisations who are working for sex workers have to bear full charge for hiring a stall.

Mail to:

Santi Utsab

Durbar Mahila Samanwaya Committee

12/5 Nilmoni Mitra Street

Calcutta 700 006, India

Phone: +91 33 543-7451 / 7560

Fax: +91 33 543-7451

e-mail: ship@cal.vsnl.net.in

sonagachi@sify.com

Registration for Participants

At Yuba Bharati Krirangan, Kolkata, India

Please Print or Type.

Please feel free to forward this to others who you think are committed to the promoting sex workers rights and would be interested to participate.

Subject: [AIDS-INDIA] Re: AIDS activists violated: Urgent call for global solidariy
Date: Wed, 20 Feb 2002 10:19:49 +0530
From: "drashok" <drashok@crscal.org>
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

Dear Forum subscribers,

This is really pathetic. Driving out sex workers has never been a solution in any part of the World. I think, NACO and the concerned State AIDS society should take up the issue and try to educate the officials and other leaders. Intervening in such real life situations is only going to prove our credibility as HIV/AIDS workers.

Dr. Ashok Kumar Agarwal, MBBS, MD
South Asia, Regional Technical Advisor- HIV/AIDS
Catholic Relief Services
4/2 Orient Row, Kolkata - 700 017
India
Tel. No. 91-33-247 6433/1969
Fax No. 91-33-240 8652
E-mail : drashok@crscal.org

Subject: [AIDS-INDIA] WTHAT IS NACO DOING? Re: AIDS activists/CSWs violated
Date: Tue, 19 Feb 2002 21:05:45 -0800 (PST)
From: Aditya Bondyopadhyay <adit_bond@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear All,

Breaking the silence is the accepted Mantra in the world of HIV/AIDS prevention. But in India, the apex body responsible for control of the AIDS epidemic is known more for its silence when it comes to such atrocities against AIDS activism.

I urge NACO to shun its silence for once [for gods and political demi-gods and HIV victims sake] and do something, even if it a public statement to the effect that VAMP is entitled to the work they are doing and that it is necessary for the prevention of the HIV epidemic in the country.
Hoping against hope to hear what NACO has done about this soon.
Regards and with grave concern

Aditya Bondyopadhyay
E-mail: adit_bond@yahoo.com>

Mail to:

Shanti Utsab

Durbar Mahila Samanwaya Committee

12/5 Nilmoni Mitra Street

Calcutta 700 006. India

Phone: +91 33 543-7451 / 7560

Fax: +91 33 543-7451

e-mail: ship@cal.vsnl.net.in

sonagachi@sify.com

Name/s of participants

Sex workers

Non-Sex workers

(Block Letters):

1.

(if necessary please attach

2.

separate sheet)

3.

4.

Organisation Represented:

Address:

Phone: (with STD/ISD code)

Fax: (with STD/ISD code)

e-mail: (if any)

Status of the organisation

Sex Worker s organisation

(please give a 5)

Sex Worker s support organisation

NGOs working on other issues

I / We wish to participate as a

Delegate

Speaker

(please giva a 5)

Workshop or sub-event organiser

Exhibitor

Performer

Journalist

I / We need accommodation: Yes/No

If yes, Number of heads:

Note: accommodation and food (lunch & dinner) is provided free of cost **only** for sex workers form 3rd March to 7th March 12 noon) those who are not able to pay.

	Name	Male/Female
1.		
2.		
3.		
4.		
5.		

Date of arrival at the Mela:

Date of departure from the Mela:

Registration fees:

a. NIL (for sex workers male, female, trans gender)

b. Other participants have to buy a ticket of Rs. 5/- to enter the Mela arena.

Please submit your requirements with the following information:

I / We like to use your Flexi Forum for (please give a 5)

Net Work Meeting

Seminar / Workshop

Cultural Programme

Debate session in the mela

Other, please specify

Title of the Topic:

Theme of the cultural programme:

Duration:

Number of participants:

Approximate size of the space for the said programme:

Please note:

Ü Venue and public address system would be provided free of cost to sex workers organisation only. *(Sex workers organisation will have to provide evidence that they are indeed constituted solely by sex workers).*

Ü All the applications should be accompanied by Money Order / Demand Draft of Rs. 5.000/- in favour of **Durbar Mahila Samanwaya Committee** payable at **Calcutta** for arranging the above-mentioned programme.

Ü For special lighting and for other arrangements (like arrangements of light refreshments / lunch, dinner etc. special logistical support for Seminar etc.) Mela authority has to be informed before 25th of February 2001. The costs of these will have to be met by the applicant/s.

Ü A service centrer will available at Mela arena to provide tools for presentation against service charges (Slide projector / Overhead projector / Laptop / Multimedia etc.).

Ü We can also arrange special events if intimated in advance.

[1]In September 1993, a group of doctors, working under a state institution, in collaboration with a NGO, entered Sonagachi red light area, with police protection and forcibly drew blood sample from 50 sex workers in the name of HIV/AIDS surveillance.

[2]In 1995, an HIV vaccine was tested on sex workers in Boubajar red light district, Calcutta, without informing them or without their consent and even without any clearance from WHO or FDA, USA.

SHANTI UTSAB-2002

Tentative Programme Schedule

Date

First Session

Second Session

3 rd March

seminar on: Promotion And Protection of The Rights of Sexworkers

(12.00 Noon)

State's AttitudeTowards The Role of Sexworkers In Social Movement-A panel discussion

(02.30 P.M)

4th March

The twin brothers-The Terrosism and the War - A dialogue

(10.00 A.M)

Antiretroviral Treatment fot The Positive(+ve) People In The Third Countries - A Dillema or A Dogma ?-a Debate

(12.30 P.M)

5th March

Religion Vs State : Where Are We ? - A Symposium

(10.00 P.M)

Restructuring Health Service - Through People Participation - A Panel Discussion

(12.30 P.M)

6th March

Self-Regulatory Board of Sex-workers - A Viable Answer To The De-criminalisation of Sex Trade - A Debate

(10.00 P.M)

Workshop on - Sexual Repression-One of the Root Causes of Social Violence

(12.30 P.M)

7th March

Panel discussion on:"The Rights of Women Workers' In The Context of Globalization"

(10.00 A.M)

Panel Discussion on: "Significance of Sex workers' Empowerment In Controlling HIV/AIDS"

(12.30 P.M)

8th March

Workshop on :

(10.00 A.M)

Seminar on : Relious Violence & Women's Sub-ordination

(12.30P.M)

Subject: [AIDS-INDIA] AIDS activists violated: Urgent call for global solidariy
Date: Wed, 20 Feb 2002 00:30:48 +0530
From: "meena" <meena@pn3.vsnl.net.in>
To: <AIDS-INDIA@yahoogroups.com>>

Dear friends,

I send you this e-mail with a heavy heart and with a deep sense of being violated and abused. The following unveils a story that turns more and more weird and sordid beyond anything that I have faced in ten years of my work with women in prostitution and sex work. My middle class upbringing never exposed me to the right of men who use abusive language so effectively as a form of violence that silences women such that we can never hold our head up with dignity. I am also deeply shocked that my dignity is so fragile.

It all started with VAMP the prostitutes' collective buying a piece of land in the border town of Nippani in the Belgaum district of Karnataka state. Since the collective had finally bought its own space the regular Monday meetings shifted to Nippani. Women from seven districts of Western Maharashtra and North Karnataka were to atted these meetings as they have been doing for the past ten years in Sangli. Unfortunately from the second meeting the local coporators decided that the women who attended these meetings were defiling the `pure and sacred' space and they decided to put a stop to these meetings.

They first threatened to kill the main leaders i.e. Meena Seshu and Shabana Khazi if the meetings continued. When this did not happen they threatened to break the vehicles that brought the women to the meetings and when we refused to bow down to their wishes they pelted stones on the building in the dead of the night. 25 to 30 boys with swords and thick bamboo sticks beat up every man who dared to pass through the street and robbed them of their gold and their money. The police turned a blind eye. On 18/2/2002 they tried to break down the door to Shabana's rented room and but for her land lord she would have been seriously injured if not dead by now. All this because the terms laid down by them were not acceptable to the collective and SANGRAM the NGO working with the women.

When they realised that legally we had every right to hold a meeting on our own land they decided to negotiate. The terms offered by them were firstly all the women should use the 'Bhangi bol' [the night soil lane of yester years] as they were not to be seen by respectable wives and children. Secondly, they should hold the meetings in the back side of the building under the hot sun because the hall faced the street and meetings held in the enclosed hall would mean that the women can be seen by the naked eye while entering the premises. Thirdly, none of the women in prostitution should come by four wheelers as this dared to offend the richer men in the street!!! They demanded that the jeeps are parked outside and the women walk down the side entrance through the Bhangi Street with their heads properly covered so that the respectability of the upper caste `chaste' women is not offended.

Since all their demands were unacceptable and we rejected the same the women were hounded out of Nippani.

Following is the report written by the reporter of TOI who wanted to cover

Lib
20/2/02

the story. The words in italics are my insertions.

"30-commercial sex workers hounded out from their homes by local gundas and policemen."

Hounded out of their own homes in Nippani by an armed mob, the 30-odd helpless commercial sex workers are not even a living entity today. Cowering in their make shift shelters in Sangli, Kolhapur, Ichalkaranji Shabana (a sex worker) and her frightened acquaintances are a traumatized lot. "For years we have been residing in the Devekar colony red light area. But today, we are homeless," says Shabana as tears spill down her cheeks.

Ever since the prostitutes's collective Veshya AIDS Mukabla Parishad (VAMP) bought a small piece of land for themselves on January 10, 2002 to carry out their HIV/AIDS and STD awareness programme in Nippani, the CSW's have had to face the wrath of local ruffians and few policemen. "On one arm the government is giving us free condoms to carry out HIV/AIDS prevention programmes and on the other hand police officials are harassing us," lamented Meena Seshu, general secretary SANGRAM.

When contacted, the local Shiv Sena coporator, Mr Babasaheb Khambe said: "The CSW's were causing a bad influence in the neighbourhood. Under the garb of HIV/AIDS prevention programme these women are promoting prostitution," he said. Likewise, Congress counselor, Mr Vijay Shetge said, "The women were all 'hardcore prostitutes', and they should leave the place immediately." When asked where they should go, he said: "anywhere that is not our look out."

However, what needs to be mentioned here is that, the red light area has been there for more than 80 years. Ex-MLA, Nippani Mr Subhash Joshi said that the rights of women in prostitution should also be protected, as they too are the citizens of this country.

Furthermore, the so-called, culture vultures and harbingers of peace went on a rampage against these women. In the wee hours of Sunday, an armed mob of some 70-odd ruffians threatened and rattled the doors of a few CSW.

Fearing their lives Shabana and few others fled to the nearest Townhall police station to file an FIR and ask for police protection, but in vain. "The inspector in charge just wouldn't write down the complaint. Instead they shunned us away," said Shabana.

Worst came, when Neil Pata, a correspondent from a reputed national English daily investigated and questioned the Nippani Circle Police Inspector, Mr Satish S Khot for not filing the CSW's complaint. "They are are 'bloody veshyas' and not 'normal citizens' hence their compliant cannot be registered," Mr Khot asserted. In a fit of anger, Mr Khot showered a volley of abusive words and threatened the women saying, "I will strip all 'veshyas' in the public square and beat them black and blue till they die or else I will book all of them under the Immoral Trafficking Act (Prevention) Act 1956."

The circle police inspector Mr Khot used abusive language that is very difficult to translate into English but the gist of all he said was that ' you prostitute - today you have come with this woman and creating this drama. Let her leave and tomorrow I will personally come and pull out your

public hair. I will enter your vagina and tear it apart and do not forget that my penis has the strength of my police job and power.' He said, `hadasu ', bosadi and phodhari,and so on and on. all of which are very abusive and is violence against all women. He shouted raved and ranted to the extent that I had to ask him to please sit down fearing he'll have a heart attack!]

Furthermore, in a very rude manner Mr Khot even had the audacity to accuse Neil Pate of being a `pimp' and `agent' of the CSW's. He even threatened him, if the article was ever published. Mr Khot said, "The HIV/AIDS prevention programme was a big sham. The NGO Sampada Gramin Mahila Sanstha (SANGRAM), managed by Meena Seshu was making money from the government via condoms distribution."

Meanwhile, fearing their lives and the lives of their small children the 30-odd CSW's fled to the neighbouring districts on February 16. Despite all this, the reaction of the local police authorities has been very casual so far.

Western Maharashtra Shiv Sena Mahila Aghadi Coordinator, Ms Neelam Gorhe, who also manages the Stree Adhar Kendra in Pune said: "CSW's also have a right to live and get police protection when they are in trouble. It is erroneous if a police officer says they are not `normal citizens'."

A cursory look shows that, the `hounding episode' in Nippani red light area was a joint operation of the police, local ruffians and some prominent corporators.

"Very few people listen to women issues. In the present situation, only a strong protest from the government and censures from the Human Rights Commission will help," laments Sadhana Zadbuke, a social worker from Kolhapur.

Ends.

in solidarity,

meena saraswathi seshu
E-mail: "meena" <meena@pn3.vsnl.net.in>

Subject: **[AIDS-INDIA] Ashoka Foundation Award for Mr.Ashok Rau of the Freedom Foundation**
Date: Sun, 24 Feb 2002 16:44:44 +0000
From: "Robert Zimmerman" <zimmer_rob@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Subject :
Ashoka Foundation
Date : Tue, 19 Feb 2002

Dear All,
This is inform all of you that Mr.Ashok Rau of the Freedom Foundation India has been conferred the prestigious Ashoka Foundation award for social entrepreneurship(HIV/AIDS) 2001/02. The official notification will be posted shortly.

Robert Zimmerman
Consultant
Public Health Policy
Temple University Beasley School of Law
1719 N. Broad Street
Philadelphia, PA 19122
E-mail:<zimmer_rob@hotmail.com>

Subject: [AIDS-INDIA] Migrant Workers: Sweatshop Conditions/Ignorance Lead to AIDS
Date: Sun, 24 Feb 2002 04:14:49 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Indian Migrant Workers: Sweatshop Conditions/Ignorance Lead to AIDS Epidemic

New Year brought bad tidings for more than 400,000 daily wage labourers in India's diamond capital, Surat. A prosperous city in the western Indian state of Gujarat, Surat is known for its finely cut diamonds and textiles.

But despite a turnover of millions of dollars, individual businesses operate on a small to medium scale and are little better than sweatshops. Most employees who work in these small, congested workplaces are temporary, receiving low pay and no benefits.

Yet year after year, hundreds of migrant labourers from the eastern state of Orissa come to the city in search of employment and a new life. Statistics say that one district alone in the state - Ganjam - provides nearly 900,000 workers to Gujarat.

But on the eve of this year, the dream died for many of them when more than 6,000 powerlooms closed down, protesting a hike in power rates. Nearly 400,000 workers were retrenched overnight and asked to return only when the looms reopened.

Armed with uncertainty, these migrant labourers caught the next train home. But now, two months later, the crisis is no longer limited to their professional life. Though seemingly unrelated, scores of families of migrant workers who lost their jobs are waking up to yet another nightmare. HIV.

A survey of private pathology clinics, Red Cross and government laboratories conducted in the district in October last year revealed that as many as 5000 migrant labourers who work in Surat are infected with the deadly virus.

But this is only the tip of the iceberg, believes Loknath Mishra, who runs Aruna, the first agency to provide counselling services in the area since 1996. He says that the actual figure is likely to be ten times higher since testing for HIV is not mandatory.

HIV counsellors in the area say that migrant labourers are especially vulnerable because they fall in the sexually active age-group of 16 to 35. Only 15% of these take their families along. Long, hard hours at work and an absent family life are some of the reasons why most of them visit sex workers and contract HIV through unsafe sex. Since these workers return home once every year, their wives and children, an additional 600,000 people, are also living under the spectre of HIV.

But the government refuses to acknowledge this medical emergency. Even though the first case was identified way back in 1995, the state has done little to check the spread of HIV. No comprehensive healthcare programme including prevention and control of HIV has been started neither have any awareness programmes been carried out among villagers, most of whom are extremely poor and illiterate.

Data is hard to come by because no baseline surveys have been carried out. Even so, doctors say the available infrastructure cannot handle a medical and social crisis of this scale. Apart from the lack of trained staff, there is only one authorised testing facility in the district - the microbiology lab at the MKCG Medical College. In the suburban areas, some private laboratories do offer the TRIDOT test but since this method is not confirmatory, the labs are not permitted

to inform the patient whether he is positive or not.

In the villages, ignorance has bred fear and myths. Few are willing to talk about the disease, let alone volunteer for blood tests. A person who develops full-blown AIDS faces complete social expulsion. Thrown out of their homes and shunned by their families, AIDS patients live like animals.

Villagers even shy away from disposing the bodies of patients suffering from Aids. In Sunathar village, a 21-year-old migrant worker died of AIDS on January 12th. He had been working at a textile mill in Surat for the last 3 years and contracted sexually transmitted diseases several times. 8 months prior to his death, he began to receive counselling from Aruna. But by then it was too late. He was already a carrier. And when he died, no one in the village, not even his family members, would do the last rites. It was left to volunteers to cremate him.

But the locals have other concerns. Ganjam is among the poorer districts in the state with few job opportunities. Most able people are forced to migrate and every year, fresh groups join the regulars travelling to Surat in search of a livelihood. But with mills closing down, the job market has shrunk significantly. Since all of them are temporary workers and work under exploitative conditions, they enjoy few rights, such as medical benefits. So, if anyone is known to be HIV positive, it would cost him his job. The situation has turned even grimmer now following the powerloom strike in Surat.

Meanwhile, with the return of jobless migrants, tension is building up in Ganjam. The local economy, heavily dependent on the earnings they sent, is nearly shattered. There's also resentment as far too many people vie for too few jobs. The administration is trying its best to prevent a break-down in law and order, but privately officials admit that the threat of HIV/AIDS riding on the back of the current economic crisis is perhaps the biggest challenge they have ever faced.

Submitted by Mohuya Chaudhuri, special correspondent reporting on development related issues based in New Delhi.
E-mail: mohuya_c@yahoo.com

Cross posted from the Communication Initiative site:
http://www.comminit.com/Commentary/sld-4103.html

Subject: [AIDS-INDIA] CORE Protest to violence against women
Date: Sun, 24 Feb 2002 01:19:45 +0530
From: "Laifungbam" <coremanipur@vsnl.com>
Organization: CORE
To: "AIDS-India forum" <AIDS-INDIA@yahoogroups.com>

Subject: Protest to violence against women

CORE centre for organisation research & education
(Indigenous Peoples's Centre for Policy and Human Rights in India's North East)

CORE North Eastern Region: Lane 3 Basishtapur, Beltola (Dispur), Guwahati 781028, TelFax: +91 361 228 709, 228 730, Email: core_ne@sify.com

CORE Sanglen: Ghari, Airport Rd., Imphal 795001, TelFax: +91 385 441 339, Email: coremanipur@vsnl.com

---

23 Feb 2002

To

Shri S M Krishna,
The Chief Minister,
Karnataka
E-mail: cm@kar.nic.in

Sub: Violations of the civil and political rights of women; protest against the threats to life and intimidation unleashed on Ms Shabana Khazi and other women activists by Nippani Circle Inspector of Police, Satish Khot and the Shiv Sena corporator of Nippani

Sir,

We have been informed through reliable sources including persons representing the aggrieved parties that there have been a series of violent threats and actions resulting in the evictions of the women and their children from their homes, directed at the non-government organisations SANGRAM and VAMP and their members and office bearers in Nippani, Belgaum District of Karnataka. According to information we have received, the problem started with harassment of the workers when they bought a piece of land, on January 10, 2002. Since then, systematic tactics of intimidation, including abusive language, threats of violence to their persons and property were made by a gang of 25 - 30 young men armed with staves and sticks, supported by corporators of the Shiv Sena.

According to our information, 30 women and their young children have fled for their lives and are living in makeshift shelter in various neighbouring districts. We have also been informed that when an attempt to register a police complaint according to law was made by the women, the police refused to register the complaint. Further, when a press reporter, Neil Pate, a correspondent from the Times of India, a reputed national English daily investigated and questioned the Nippani Circle Police Inspector, Mr. Satish S Khot for not filing the CSW's complaint the said inspector used abusive and threatening language towards the workers, saying: "They are `bloody veshyas' and not `normal citizens' hence their compliant cannot be registered," Mr Khot threatened the women saying, "I will strip all `veshyas ' in the public square and beat them black and blue till they die or else I will book all of them under the Immoral Trafficking Act (Prevention) Act 1956." you prostitute - today you have come with this woman and creating this drama. Let her leave and tomorrow I will personally come and pull out your pubic hair. I will enter your vagina and tear it apart and do not forget that my penis has the strength of my police job and power.' He abusive terms in the local language including `hadasu ', bosadi and phodhari and so on all of which terms are very abusive.

Mr Khot also accused the reporter Mr. Neil Pate of being a `pimp' and `agent' of the women.

We would like to register our strong protest against the violence and threats to life and dignity and the evictions upon Ms. Shabana Khazi and other women activists, the sex workers and their children and also of the press, by the Circle Police Inspector of Nippani, Satish S Khot and the Shiv Sena corporator of Nippani Babasaheb Khambe

We would like to point out to you that India is a State Party to and therefore has legal obligations under the International Bill of Rights (International Covenant on Civil and Political Rights [ICCPR]and International Covenant on Economic, Social and Cultural Rights [ICESCR] both ratified by India in 1979) to respect, protect, promote and observe the human rights and freedoms of all individuals within its territory and subject to its jurisdiction the rights recognised, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Art. 2.1 ICCPR).

By the authority residing in your honourable position, under the provisions of the Constitutions and laws of India, you are obliged to ensure that any persons whose rights and freedoms are violated shall have an effective remedy notwithstanding that the violation has been committed by persons acting in an official capacity (Art. 2.3 ICCPR).

Under the same treaty, No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Art. 7 ICCPR), Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence (Art. 12.1 ICCPR). Everyone shall have the right to recognition everywhere as a person before the law (Art. 16 ICCPR).

Art. 17 ICCPR also states that

1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.

2. Everyone has the right to the protection of the law against such interference or attacks.

Articles 18 and 19 ICCPR also protects every citizens' rights to freedom of opinion and expression. Article 21 ICCPR further protects the rights of all to peaceful assembly.

Noting that the eviction has had a severe impact on children, by denying them them shelter in their rightful homes and subjecting them to trauma due to the displacement, we would like to draw your attention to Article 24 ICCPR which protects children from discrimination of every kind.

Under the International Covenant on Economic Social and Cultural Rights, which India ratified in April 1979. your government is obligated to protect and recognize the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, and (will) take appropriate steps to safeguard this right (Article 6). Article 11 ICESCR specifically protects the right to adequate housing.

India is also a party to the International Covenant to End All Forms of Discrimination Against Women [CEDAW] ratified in 1994. Article 2.d of this Convention states that the government and its agencies and officials must refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation; and requires your government under Article 2.f, To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;

Under Art.5.a, CEDAW, your government is also required take all appropriate measures To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;

Article 11 CEDAW also protects the inalienable right to work and freedom of choice of profession.

In addition we would like to point out that the action of threats to their mothers, and their homes and the subsequent evictions also violates the rights of the children affected, as per India's commitments under the UN Convention on the Rights of the Child ratified in 1990

We are convinced of the good intentions of your government to fully protect the rights of each citizen under the laws of the country and India's obligations under these and other treaties. We therefore strongly recommend:

1.That the Government of Karnataka and its designated agnecy conduct a thorough and fair inquiry intothe events;

2. That the Government of Karnataka take immediate action first and foremost to take all necessary steps to permit these women and children to return to their own homes in safety and with full assurance of security when they return;

3. To initiate the due process of law and ensure justice to the victims of this gross violations without delays. This will include

a.. the facilitation of the filing of an F.I.R. by the victims with a complete record of the reasons for the delay in the filing
b.. the suspension of the concerned police officials who refused to file the complaint and
c.. appropriate action against those who threatened the victims
We look forward to your immediate action on this matter.

Yours sincerely

Anna Pinto
Director (Gender and Children's Rights)
E-mail: coremanipur@vsnl.com>

Cc:
Chairperson, National Human Rights Commmission
UN Special Rapporteur on the Elimination of Violence Against Women
UN Human Rights Committee
UN Committee on the Rights of the Child
UN Committee on the Elimination of All Forms of Discrimination Against Women

---

Subject: [AIDS-INDIA] Reply to Pravin Patkar's Response to Meena Seshu's Appeal
Date: Sun, 24 Feb 2002 19:24:12 +0530
From: "Laifungbam" <coremanipur@vsnl.com>
Organization: CORE
To: AIDS-INDIA@yahoogroups.com

24 Feb 2002

Dear Praveen

Warm greetings to you and Preeti from all of us. Thank you for your message and your clarification re: you network's position on prostitution. We are aware of this position. Your response to us has raised some points of deep interest to us, which we feel have relevance to others as well. With your permission, we would like to share your note with others along with our response to you. We do this because your position regarding the events at Nippani and the discussion that can ensue would, we believe, immensely contribute to the debate on prostitution vis-a-vis the human rights of women and children in India. Since the note is an organisational/network position we felt it would be OK to share it.

We had responded to the appeal from Meena Seshu and her colleagues from the perspective of human rights - this is very clear in our letter to the CM of Karnataka and we had also forwarded all our information including the first appeal from Meena, from the beginning, to appropriate UN thematic and treaty based mechanisms. International human rights law and fundamental rights as enshrined in our Constitution (and interpreted by the Supreme Court, which is also law) and various municipal legislation are based on the foundations of the inalienable and inherent dignity of all human beings and the principles of non-discrimination and justice. This is not disputed.

Having clarified the basis of our response to the appeal, we are making a some additional clarifications about your note - which are our own positions.

1. In responding to the human rights violations that have occured in NIppani, as reported by Meena Seshu . The reality or extent of her grief or pain or their non-existance is irrelevant as long as the facts of the incident can be verified, which they appear to have been. We are therefore, in our response, implementing our human rights mandate to respond to urgent appeals from the victims or by a relaible source on behalf of the victims. This is our organisational policy as a human rights defender organisation in India.

2. In responding to this appeal, we are not endorsing the organisational position or positions adopted, or to be adopted, by the involved organisations or individuals working for them, i.e., VAMP, SANGRAM or any other organisation or front, vis-a-vis prostitution or sex work itself. We are also not here taking a position on the legality or illegality of prositution or sex work, or even of sexual exploitation of these women. No doubt, Meena and her colleagues work in a very challenging and even life-threatening environment, and the work they engage in on HIV/AIDS should indeed be appreciated. This discussion or action on it belongs to a different context, however.

3. Our appeal is solely concerned with the violence or threats of violence including eviction experienced by some women and their children, who also happen to be prostitutes or sex workers (we use the terms without prejudice to any legal or poltical implications) or women working with them. We would like to re-iterate that the legality or morality of their occupation, profession or way of earning their livelihood does not in any way prejudice their rights or their legal position vis-a-vis India's Constitution as citizens.

We hope that this letter clarifies our stand.

We also appreciate that this issue has been widely circulated and discussed in different forums. We would be interested in discussing this further, beyond the context of this particular incident.

With warm regards

Anna Pinto

Focal Point on Sexual Exploitation of Children, South Asia

CORE centre for organisation research & education
(Indigenous Peoples's Centre for Policy and Human Rights in India's North East)

CORE North Eastern Region: Lane 3 Basishtapur, Beltola (Dispur), Guwahati 781028, TelFax: +91 361 228 709, 228 730, Email: core_ne@sify.com

CORE Sanglen: Ghari, Airport Rd., Imphal 795001, TelFax: +91 385 441 339, Email: coremanipur@vsnl.com

---

----- Original Message -----
From: pppatkar
To: CORE
Sent: Sunday, February 24, 2002 10:04 AM
Subject: Pravin Patkar

Anna

May I request you to kindly see this note? It might not be a very good thing to demand action on somehearsay alone. First a fact finding mission of some independent parties and then petition to the CM would have been apppropriate.

Pravin

File has not been scanned

Checked by AVG anti-virus system (http://www.grisoft.com).
Version: 6.0.325 / Virus Database: 182 - Release Date: 2/19/02

File has not been scanned

Checked by AVG anti-virus system (http://www.grisoft.com).
Version: 6.0.325 / Virus Database: 182 - Release Date: 2/19/02

File has not been scanned

Checked by AVG anti-virus system (http://www.grisoft.com).
Version: 6.0.325 / Virus Database: 182 - Release Date: 2/19/02

File has not been scanned

Checked by AVG anti-virus system (http://www.grisoft.com).
Version: 6.0.325 / Virus Database: 182 - Release Date: 2/19/02

Subject: [AIDS-INDIA] AIDS activists violated: Protest letter from Seattle, Washington USA
Date: Sat, 23 Feb 2002 10:14:14 -0800
From: "amelia seraphia derr" <seraphia28@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

To

Shri S M Krishna,
The Chief Minister,
Karnataka

Sub: Our protest against the threats to life and intimidation unleashed on women activists of social work organization, SANGRAM and of VAMP by the Nippani Circle Inspector of Police Satish Khot and the Shiv Sena corporator of Nippani.

Sir,

I am deeply shocked and disgusted at the intimidation, threats and verbal assault launched against women activists of the well-known social work organisation, SANGRAM and of the prostitutes' collective Veshya AIDS Mukabla Parishad (VAMP) by the Circle Police Inspector of Nippani, Satish S Khot and the Shiv Sena corporator of Nippani Babasaheb Khambe.

SANGRAM has achieved renown worldwide in the area of AIDS prevention. It has been hugely successful in its recent initiative to form prostitutes' collectives under the banner of Veshya AIDS Mukabla Parishad (VAMP) in seven districts of Western Maharashtra and North Karnataka.

However, for several weeks now, the work of both organizations, and VAMP in particular, has been under severe attack by the local politicians. We regret to learn that the police, who are expected to provide security to ordinary citizens, have completely abrogated this responsibility and instead, threatened to kill, and even rape, Ms Shabana Khazi, the general secretary of VAMP.

The abusive and undignified behavior of the concerned police inspector and of the local politicians expose their completely feudal and regressive notion that prostitutes are somewhat sub-human, unworthy of basic dignity and respect due to any human being. Their patriarchal mindsets are unable to accept the fact that women, the world over, have a right to organize against their oppression.

We earnestly request you to ensure that your government is not tainted by the prejudicial and unjust behavior of your functionaries. Please suspend the police officer concerned and institute an inquiry into the incident. Simultaneously, please direct your administration to help VAMP and its activists conduct their legitimate meetings and activities without fear and intimidation.

Sincerely,

Amelia Seraphia Derr, MSW
Auxiliary Faculty
University of Washington School of Social Work
Seattle, Washington USA
E-mail: seraphia28@hotmail.com

Subject: [AIDS-INDIA] Forget Soho, give me Sonagachi: UK
Date: Sat, 23 Feb 2002 21:56:34 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
Organization: François-Xavier Bagnoud (INDIA)
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Forget Soho, give me Sonagachi: UK

The Asian Age 23rd February, 2002-New Delhi
Kolkata, Feb. 22: The British want Kolkata to teach them how the city goes about preventing STD's and HIV. Programme in Kolkata will be used as model for red-light districts in the UK, British foreign office minister Ben Bradshaw said on Friday. He was impressed by the success of the Sonagachi Project for sex workers and their children. The project is funded by the department for international development of the UK government. "It is a model for the UK and the world. Britain has lot to learn form it," he said.

Sexually-transmitted diseases are on the rise in Britain. "The drugs used are strong and toxic, so the stress should be on prevention," he said. He promised financial aid for the education of Sonagachi sex workers children

****
Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] AIDS activists violated: The solution is education and awareness
Date: Sat, 23 Feb 2002 06:00:14 -0800 (PST)
From: vijayabhaskar kandula <emailreddy@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear Forum members:

This is my first posting on this site. However, I read the post regulary.

I am a native of Bellary in Karnataka. I am presently in New york working on MD in Medicine.

That was a very well drafted letter. However, it is my personal belief that suspending anyone will do any good. Rather than a tit for tat we should try to understand why those law keepers and law makers acted the way they did. For all we know they (violaters) themselves might/are be at risk of AIDS-which rightly treats all beings equally! The great equalizer of modern times if I may say so.

These events were emotionally charged and each party strongly felt they were doing the right thing. If this were an isolated incident, disciplinary action might have helped. I will not be surprised if the attitudes are similar in other talukas or districts of karnataka or for that matter any where in India.

I feel, any solution to this issue should include creating awarenss or educating these people about the disease and then we may expect their attitudes to change. I for one am not at all surprised at this incident. Let us not forget that some, if not a significant number amongst us us have gone through different stages in relating to HIV/AIDS-beginning with absolute ignorance.....with bad attitudes like the people above with half baked knowledge of the disease.... to people who feel stronly about this issue and emathize with the victims of the disease.

In summary, I feel it was ignorance and fear (of unkown?) that made them behave so unprofessionally and inhumanely. We would be better serving the cause if we can educate the poice force. Disciplinary actions in isolation or as a major form of remedy will be nothing more than a knee jerk reactions.

Vijayabhaskar Reddy Kandula MD MPH
E-mail: <emailreddy@yahoo.com>

Subject: [AIDS-INDIA] Reply from NACO director on AIDS activits violated
Date: Sat, 23 Feb 2002 05:05:27 -0000
From: "J V R Prasada Rao" <nacodel@del2.vsnl.net.in>
To: AIDS-INDIA@yahoogroups.com

>From "J V R Prasada Rao" <nacodel@del2.vsnl.net.in>
Date: Thu Feb 21, 2002 2:13 pm
Subject: Reply from NACO director on AIDS activits violated: Urgent call for global solidariy

Dear Meena,

I am shocked and infuriated at the treatment meted out to you at the hands of the 'custodians of law'.We should not leave it at this stage.I suggest you and some other NGOS meet Mr Manmohan Singh PD MPSACS and the Health Minister and take up the case strongly.Such an incidentcan't be allowed to go unpunished in a civilised society.

I shall personally take it up with the Maharastra Govt.

Regards,

JVR Prasada Rao
NACO Director
nacodel@del2.vsnl.net.in

Subject: **[AIDS-INDIA] Re: AIDS activists violated: Silence is disconcerting.**
Date: Sat, 23 Feb 2002 09:37:07 +0530 (IST)
From: Lakshmi Ramakrishna <lakshmi@jncasr.ac.in>
To: AIDS-India forum <AIDS-INDIA@yahoogroups.com>

Hello all,
The silence following the VAMP mail is disconcerting. I remember the spate of mails that each one of us had got relating food issues or discrimination at an international meet. Has it hit so close at home that we time need to digest it or is it that we are feeling helpless at the sheer dimensions of the issue? It is at this very real and grass root level that one has to act and act fast at that.

Lakshmi

Lakshmi Ramakrishna (lakshmi@jncasr.ac.in)
Research scholar ,
Molecular Biology and Genetics Unit
JNCASR, Jakkur, Bangalore - 560 064
Ph. no : +91-80-8462750, Fax: +91-80-8462766

Subject: [AIDS-INDIA] Re: Query about the ethics of HIV testing for Children
Date: Sat, 23 Feb 2002 06:05:57 -0800 (PST)
From: vijayabhaskar kandula <emailreddy@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

I am aware of instances where new borns are breast fed
by other women. In a suvey that i conducted in 1996 in
adivasis in heggadedevanakote taluk of mysore district
this practice was noted among the betta kuruba tribes.

Vijayabhaskar Reddy Kandula MD MPH
E-mail:emailreddy@yahoo.com>

Subject: [AIDS-INDIA] Re: AIDS activists violated: Letter to the CM
Date: Fri, 22 Feb 2002 18:08:20 +0530
From: "meena" <meena@pn3.vsnl.net.in>
To: <AIDS-INDIA@yahoogroups.com>>

Dear all,

Thanks a million for all the solidarity. can we send this letter to the C.M? his e-mail ID is encl. in solidarity, meena

To

Shri S M Krishna,
The Chief Minister,
Karnataka
E-mail: cm@kar.nic.in

Sub: Our protest against the threats to life and intimidation unleashed on women activists of social work organisation, SANGRAM and of VAMP by the Nippani Circle Inspector of Police Satish Khot and the Shiv Sena corporator of Nippani.

Sir,

I/we are deeply shocked and disgusted at the intimidation, threats and verbal assault launched against women activists of the well-known social work organisation, SANGRAM and of the prostitutes' collective Veshya AIDS Mukabla Parishad (VAMP) by the Circle Police Inspector of Nippani, Satish S Khot and the Shiv Sena corporator of Nippani Babasaheb Khambe.

SANGRAM has achieved renown worldwide in the area of AIDS prevention. It has been hugely successful in its recent initiative to form prostitutes' collectives under the banner of Veshya AIDS Mukabla Parishad (VAMP) in seven districts of Western Maharashtra and North Karnataka.

However, for several weeks now, the work of both organisations, and VAMP in particular, has been under severe attack by the local politicians. We regret to learn that the police, who are expected to provide security to ordinary citizens, have completely abrogated this responsibility and instead, threatened to kill, and even rape, Ms Shabana Khazi, the general secretary of VAMP.

The abusive and undignified behaviour of the concerned police inspector and of the local politicians expose their completely feudal and regressive notion that prostitutes are somewhat sub-human, unworthy of basic dignity and respect due to any human being. Their patriarchal mindsets are unable to accept the fact that women, the world over, have a right to organise against their oppression.

We earnestly request you to ensure that your government is not tainted by the prejudicial and unjust behaviour of your functionaries. Please suspend the police officer concerned and institute an inquiry into the incident. Simultaneously, please direct your administration to help VAMP and its activists conduct their legitimate meetings and activities without fear and intimidation.

Subject: [AIDS-INDIA] Re: AIDS activists violated: Global support
Date: Fri, 22 Feb 2002 08:25:34 -0500
From: "George M. Carter" <gmc0@ix.netcom.com>
To: AIDS-INDIA@yahoogroups.com
CC: cm@kar.nic.in

To: Shri S M Krishna,
The Chief Minister,
Karnataka
By email: cm@kar.nic.in

Sub: Our protest against the threats to life and intimidation unleashed on women activists of social work organisation, SANGRAM and of VAMP by the Nippani Circle Inspector of Police Satish Khot and the Shiv Sena corporator of Nippani.

Sir,

We are deeply shocked and disgusted at the intimidation, threats and verbal assault launched against women activists of the well-known social work organisation, SANGRAM and of the prostitutes' collective Veshya AIDS Mukabla Parishad (VAMP) by the Circle Police Inspector of Nippani, Satish S Khot and the Shiv Sena corporator of Nippani Babasaheb Khambe.

SANGRAM has achieved renown worldwide in the area of AIDS prevention. It has been hugely successful in its recent initiative to form prostitutes' collectives under the banner of Veshya AIDS Mukabla Parishad (VAMP) in seven districts of Western Maharashtra and North Karnataka.

However, for several weeks now, the work of both organisations, and VAMP in particular, has been under severe attack by the local politicians. We regret to learn that the police, who are expected to provide security to ordinary citizens, have completely abrogated this responsibility and instead, threatened to kill, and even rape, Ms Shabana Khazi, the general secretary of VAMP.

The abusive and undignified behaviour of the concerned police inspector and of the local politicians expose their completely feudal and regressive notion that prostitutes are somewhat sub-human, unworthy of basic dignity and respect due to any human being. Their patriarchal mindsets are unable to accept the fact that women, the world over, have a right to organise against their oppression.

We earnestly request you to ensure that your government is not tainted by the prejudicial and unjust behaviour of your functionaries. Please suspend the police officer concerned and institute an inquiry into the incident. Simultaneously, please direct your administration to help VAMP and its activists conduct their legitimate meetings and activities without fear and intimidation.

This letter is being distributed to interested parties and the media. I hope you will be able to respond to this letter at your earliest convenience.

Sincerely,

George M. Carter
Director, FIAR
Brooklyn, NY 11217
"George M. Carter" <gmc0@ix.netcom.com>

cc: ACT UP
HealthGap

Subject: [AIDS-INDIA] Letter to the CM, Karnataka regarding the SANGRAM/VAMP issue.
Date: Fri, 22 Feb 2002 23:24:28 +0530
From: "lawyers" <aidscaw@bom5.vsnl.net.in>
To: <AIDS-INDIA@yahoogroups.com>

Friends,

This is the letter we have written to the CM, Karnataka regarding the SANGRAM/VAMP issue. In solidarity,

Lawyers Collective HIV/AIDS Unit

Subject: Human rights abuses suffered by HIV/AIDS NGOs

Shri S M Krishna,
The Chief Minister,
Karnataka

Sir,

We introduce ourselves as an NGO providing legal services to HIV+ people. You will recall that we had facilitated a meeting between yourself and Justice Michael Kirby of Australia and Justice Edwin Cameron of South Africa in early January 2002. We write to you regarding an issue we had discussed at that meeting -- that of harassment and human rights violations suffered by vulnerable communities and HIV/AIDS interventions working with them, from the state machinery. As you have shown personal interest on HIV/AIDS in Karnataka, we urge you take note of the following and act on the same.

We are deeply shocked at the intimidation, threats and verbal assaults launched against women activists of the well-known social work organisation, SANGRAM and of the prostitutes' collective Veshya AIDS Mukabla Parishad (VAMP) by the Circle Police Inspector of Nippani, Satish S Khot and the Shiv Sena corporator of Nippani Babasaheb Khambe.

We are personally aware of SANGRAM's work, which has achieved renown worldwide in the area of AIDS prevention. It's success in its recent initiative to form prostitutes' collectives under the banner of Veshya AIDS Mukabla Parishad (VAMP) in seven districts of Western Maharashtra and North Karnataka is acknowledged by all those connected with HIV/AIDS and prostitution.

However, it has come to our knowledge that for several weeks now, the work of both organisations, and VAMP in
particular, has been under severe attack by the local politicians. We regret to learn that the police, who are expected to provide security to ordinary citizens, have completely abrogated their responsibility and instead, we reliably learn, threatened to kill, and even rape, Ms Shabana Khazi, the general secretary of VAMP.

The behaviour of the concerned police inspector and of the local politicians indicate their mindset and notion that prostitutes are somewhat sub-human, unworthy of basic dignity and respect due to any human being. These patriarchal mindsets are unable to accept the fact that women, the world over, have a right to organise against their oppression.

We earnestly request you to ensure that your government and its functionaries are not tainted by the prejudicial and unjust notions as stated above. We call upon you to institute an inquiry into the incident and in the meantime suspend the police officer concerned. Simultaneously, please direct your administration to help VAMP and its activists conduct their legitimate meetings and activities without fear and intimidation.

Regards,

Lawyers Collective HIV/AIDS Unit
E-mail: <aidscaw@bom5.vsnl.net.in>

Subject: [AIDS-INDIA] Query about the ethics of HIV testing for Children
Date: Thu, 21 Feb 2002 02:06:00 -0800 (PST)
From: Trupti Desai <truptid_69@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear friends,

My query is to all who are concerned about people infected and effected by HIV/AIDS. I am a clinical psychologist and counsellor working in this field for last seven years. Presently, I am working in one of the cities in Rajasthan. One physician here had a difference of openion with me. What he does is, when a patient is tested for HIV, and if his wife is tested negative still he advice his child to go for the test who falls in the age group of 5-8 years without any counselling, even when the counsellor is available just because the parents are anxiuos.

When I confronted him about the professional ethics of this practice, He asked about the reference where we cannot advice the child for HIV test even when the mother is tested HIV negative.

According to the Doctor, in this part of India, especially rural areas, there are higher incidences of child being breast fed by any woman other than the mother and that too without the knowledge of the mother. And many a times, the Elisa report could be false negative, he says. He is not aware about the H/o of child for blood transfusion or sexual abuse.

My question to all is how far this is ethical? Please support your answers with references.

With Regards,
Trupti Desai
E mail: <truptid_69@yahoo.com>

Subject: [AIDS-INDIA] about UNAIDS in India
Date: Thu, 21 Feb 2002 18:54:40 +0700
From: "Yuli" <tingtong@bdg.centrin.net.id>
To: <AIDS-INDIA@yahoogroups.com>

Dear Forum!!

I want to ask some questions, Does anyone know about these?
If you know, could you please reply email to me.

1.. Sine when (year) UNAIDS was exist in India?
2.. I want to know, Does UNAIDS help to take in hand the AIDS problem in India? and What are there effort that have been done in India?
3.. Which parties are involve/cooperate with UNAIDS to contend spread HIV/AIDS in India ?
4.. Is UNAIDS working together with India goverment?

Thank you!

Yuli
"Yuli" <tingtong@bdg.centrin.net.id>

Subject: [AIDS-INDIA] HIV Testing without counseling.
Date: Thu, 21 Feb 2002 18:21:28 +0530
From: "Juhi Sahai" <jsahai-modicare@modi.com>
To: <AIDS-INDIA@yahoogroups.com>

Dear Forum members,

Its very unfortunate that HIV Testing is commonly taking place without counseling. !!

Our foundation has been working in this field only since the last year and a half, and since the last few months we have been facing situations where tests are conducted by reputed institutes, without pre test counseling and the reports are handed over without any post test couseling.

Further these reports are handed over to anyone coming to receive them.We have lost patients because of this callous behaviour. They vanish, disappear, are thrown out, and we don't know what becomes of them.

This hampers the entire purpose of all the care and support work that organisations are undertaking.

We request the govt agencies along with key opinion makers, if mandatory counseling can be reinforced, in whatever manner possible. It seems the entire purpose for testing in some places is only to find out if the person is positive and then refuse to treat them.

Please look into this urgenlty.

regards,

Juhi Sahai.
E-mail: <jsahai-modicare@modi.com>

Subject: [AIDS-INDIA] Alternative views to SANGRAM/VAMP activities
Date: Thu, 21 Feb 2002 15:31:24 +0530
From: "Pravin Patkar" <pppatkar@giasbm01.vsnl.net.in>
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

Dear Forum subscribers,

[Note from MODERATOR: As a moderating policy AIDS-INDIA eFORUM do not post messages which appears as personal attack. However, this message is posted as there is A STATEMENT OF WOMEN IN PROSTITUTION is also presented as part of this message: When you reply, please be specific to issues which are presented and refrain from personal attack and keep the discussion dignified. Messages, which do not comply with this policy will not be posted on the forum. Sorry.]

This is in response to the message from Meena Seshu, the leader of SANGRAM/VAMP. We had some horrible experiences of interacting with Meena Seshu and her colleague Shabana. We then took a decision not to accept any invitation for a dicsussion with Meena or her close leaders of VAMP.

I do not know how many of the list readers have read the ideological position of Meena Seshu's SANGRAM/VAMP. It is repeated at the end of this letter for their kind information. It unnecessarily gives a facade of being very radical. Actually it is the most stinking piece of patriarchal formula that degrades and enslaves women. The ideology stinks particularly when it is reserved fro a whole lot of disadvantaged women who find themselves in th flesh trade as a result of some mishap. It also stinks since none of the while collared intellectual leaders of this ideology follow it in their own lives or initiate their own children to this radically emancipating life.

During an in house training programme conducted by their own organization SANGRAM the women who had been gathered to for a collective when asked by Meena to react to a point "about inducting minor girls in flesh trade" stated, "We do not want our children to go through what we have been going through. Hence we would educate them or get her married." (Page 34), "We shall not put our children in prostitution. We do not them to have the same fate that we have suffered from." (Page 35) "(Muktatechi Bharari (Flight of Freedom) Marathi publication by SANGRAM the parent organization of VAMP the front of Meena Seshu Sangli).

On that the organizational leader Meena Seshu states, "Girls should be brought into prostitution 3 to 4 years after they start menstruating. If put into prostitution earlier they have to face many difficulties. As it is their body is not adequately grown, they do not know much about condom and they have to undergo stitches, suffer from STD, and other diseases." (see Page 29 Op. Cit)

The same organization echoing yet another international position states, "We believe that when involuntary initiation into prostitution occurs, a process of socialization within the institution of prostitution exists , whereby the involuntary nature of the business changes increasingly into one of active acceptance, not necessarily with resignation .this is not a coercive process." Page 27 "Of Veshyas, Vamps, Whores, and Women)

This is a dangerous logic that no civilized society can accept. Apply the same logic to any crime where someone is "involuntarily initiated" into exploitation and subsequently accepts it under the "internal socialization" of that crime. A lot of people believe that this involuntary initiation is called trafficking, abduction, kidnapping, criminal force, coercion deception, fraud, etc etc. A lot of people also believe that the "internal socialization" of a new recruit into flesh trade is nothing other than starvation, beating, and rape, repeated rape and repeated gang rape by the pimps and the henchmen of the brothelkeepers till the self esteem of the victim and her desire to

all papers for AIDS-India Forum
for 25/2/02 Feb

VAMP holds that once in prostitution women like to remain in it since they experience more empowerment, emancipated status and subjectively more happiness as compared to a household woman.

The white collared leaders of SANGRAM and VAMP reserve this emancipation for the helpless women who are uneducated, illiterate, and disadvantaged and who come from the drought affected regions, Dalit landless families or the deserted women.

On its HIV/AIDS control efforts the leader of SANGRAM/VAMP writes, "Responsible sex is a whole gamut of things that together constitute a way of life. " Says Mena Seshu of SANGRAM. "It is responsibility to yourself that makes you ensure you use a condom every time you have penetrative sex." Responsible sex is not a moral concept, but a concept that encompasses more human dimension than safe sex. " Even in schools, we never say, you should not have multiple sex relationships." explains Seshu. "We say, "be responsible to yourself in multiple sex relationships." (Of Veshyas, Vamps, Whores & Women SANGRAM / VAMP Publication P.36

One has to only imagine the age group of schooling children to understand the full meaning of this advice by VAMP/ SANGRAM.

There are some terms used deceptively by the legalization decriminalization lobby. "Women in prostitution" is one such deceptive term. The term includes the brothel keepers, brothel managers, the pimp women, the procurer women and not just the victim women and young girls who are trafficked taking criminal advantage of their vulnerability and helplessness. The two groups are not merely entirely different in terms of their role, profits, and damages in the flesh trade but they are mutually antagonistic. It is a great intellectual error to categorize them together.

There are no two opinions that the incidence of trafficking of children, minors and young women has shot up phenomenally in the past few years all over the globe. It is the third largest illicit trade next to trade in arms and narcotics run by organized gangs.

Jean D'Cunha in her book Legalization of Prostitution (1990) gives detailed accounts of the real nature of the organizations floated in the name of the victim women and shows that largely they are formations floated by the brothel keepers and pimps and do not represent the interests of the victim women who are prostituted.

We the members of NACSET (Network Against Commercial Sexual Exploitation & Trafficking) representing over 273 voluntary sector organizations and over 500 individual professional members including some of the women's organizations (Stree Mukti Sanghatana, Stree Adhar Kendra included) from the state of Maharashtra as well as NACSET Karnataka condemn the position of decriminalization taken by VAMP as well as that of legalization taken by some other groups floated in the name of the victim women. In this we are also joined by the other voluntary organizations such as the Joint Women's Project Delhi, Sanlaap Kolkata. The network of organization working against trafficking and commercial sexual exploitation from Andhra Pradesh NATSAP also condemns this position.

It is important to note that some of us have been working for the rights of the women and children victims of CSE&T for over 14 years now and Prerana runs 24 hours services for them in the redlight areas of Kamathipura, Falkland Rd., Turbhe etc. Let the readers not be misdirected by the likes of Meena Seshu and VAMP. The victim women of Kamathipura and Falkland rd have their collective called NISHANT which fights for the dignity and rights of the victim women. They in no uncertain terms demand abolition of the flesh trade as it is incompatible with the basic dignity of women. A social wrong must be corrected even if it is late. It should never be regularized. The likes of VAMP and Meena Seshu should have no respectable place in any civilized society.

This is not at all to justify what is being quoted to have been said by the concerned

police officer. Responsible platforms must verify if the police officer truly used such words. Appropriate action must be initiated against anyone who might have used such indecent words. At this stage however I am not sure if the officer did really say such a thing.

Nevertheless nothing lessens the damage caused by Meen Seshu to the cause of the women victim of commercial sexual exploitation and trafficking. We must learn to differentiate between tears and tears.

Pravin Patkar

Coordinator
Network Against Commercial Sexual Exploitation & Trafficking (NACSET)

A STATEMENT OF WOMEN IN PROSTITUTION

Prostitution is a way of life like any other. It is a survival strategy that is parallel to any other occupation. It is not created for the benefit of men as is the common perception; rather it is primarily for the women who live off it. Women in prostitution make money out of sex and we are the breadwinners of our families.

We disagree with the statement that prostitution is a profession. We make a distinction between profession(vyavasay) and occupation/ business(dhandha). For instance, if we are presently occupied by making money out of sex, then that is our occupation for a short span of time. The nature of the business itself is time bound. Therefore, by using the term profession, we are necessarily being pushed into a category for a lifetime. We are women who are practicing this time-bound business of prostitution for a short and specific period in our lives. Please remember that when we are not making money out of sex, we are engaged in other income-generation activities.

We believe that all occupations stereotypical to women adhere to so-called 'femine values'. They capitalize upon qualities like tolerance, sympathy, tenderness, endurance, understanding, patience, forbearance and much more, be they housewives, typists, nurses, teachers, office assistants, receptionists, women in prostitution etc. We believe that the socialization of the girl child to accept such occupations as the only alternative is also a major reason for the perpetuation of sexual discrimination in the female work-force. We believe that women in prostitution are no different.

We believe that we are more empowered than most women within male-dominated patriarchal structures. For instance, within the family structure (which we know is the most oppressive), we are the breadwinners and the heads of our households. The relationships we share with the men from our families are more honest and equal because the purdah of double standards is not necesary.

Economic independence from men is a reality that we enjoy with pride and dignity. Brothel-owners, goons, the police and the self-appointed crusaders of morality in society harass us , try to curb our independence and are forever trying to douse our spirit. Control structures have a vested interest in criminalizing prostitution. What we demand is the decriminalization of prostitution such that we can live safely and continue to choose to make money from sex without stigmatization. We demand the eradication of all laws concerning prostitution, which are oppressive and help in further criminalizing.

We believe that making money from sex is but selling a part of our body which is in no way different from selling our brains or physical labour. We protest against a society that deems our work contribution as less prestigious than other traditional forms of work. We believe that we challenge and undermine structures of power by using a part of our womanhood - our sexuality, as a source of our power and income.

We also protest against all laws and value systems that treat soliciting for sex as indecent while sanctioning other forms of sexual contracts from advertisements to

As People who experience violence as a part of our daily, we are being more and more penalized by increasing violence in a society that is trying to order and control our lifestyles. As women in prostitution, we protest against a society that forces on us the violence of a judgmental attitude.

We believe that a woman's sexuality is an integral part of her as a woman, as varied as her mothering, a domestic and such other skills. We do not believe that sex has a sacred space and that women who have sex for reasons other than its reproductive importance are violating this space. Or if they choose to make money from the transaction they are immoral or debauched.

We believe that child prostitution is akin to child sexual abuse, molestation and child labour, and that it exist in a society that is fraught with crimes of abduction, kidnap, rape, assault and violence against women. We believe that as comparable to poor, weak and marginalized communities, we are unable to have reasonable control of our lives and destinies. We share the same experiences of women who live in the Third world.

We believe that there is a distinction between trafficking, which is a criminal issue, and adult prostitution. While we agree that choice is a cruel mirage for all women within capitalist patriarchy, we feel the need to acknowledge that adult prostitution as an option, exists. We also believe that women who are in prostitution , choose to continue to remain in business for many years.

We believe that when involuntary initiation into prostitution occurs, a process of socialization within the institution of prostitution exists, whereby the involuntary nature of the business changes increasingly to one of active acceptance, not necessarily with resignation. This is not a coercive process. We believe that, despite living within a capitalist patriarchal society and having experienced the freedom of living outside the patriarchal system, it is almost impossible for us to contemplate entering such a system with its inherent double standard, lopsided value system and inequalities.

We protest against a society that deems us immoral and illegal mainly because we don't accept its mores, rules and governance. We protest against the various forces of mainstream society that deny us the right to liberty, security, fair administration of justice, respect for our lives, discrimination, freedom of expression and association.

We also protest against a society that aggressively promotes objectification and commercialization of women and their sexuality. We protest against the sale of our sexuality in the international market by unscrupulous individuals and governments who reap huge profits off our bodies. We are in a business where the control has shifted from traditional members of our community to criminal syndicates. We were not for sale. In today's world, unfortunately we are sacrificed and commodified by vested interests, sometimes from within our own communities.

Globalization and the economic liberalization is further breaking up our communities and forcing us to accept the sale of our bodies and the sale of our young in the urban industrial centres for prostitution. Movement in search of work is not new for us; the problem however is the criminalization of the trade which is forcing us to turn to debt bondage, forced labour and slavery-lime practices. Consequently, we find ourselves in the trap of criminal syndicates in our search for work.

We believe that it is imperative that we must unite with each other to rease the stigmatization of women in prostitution and restore our dignity as workers and citizens of civil society. We must build alliances with other segments of society and, together we must struggle against the forces who have a vested interest in eroding the rights of all women.

We believe that a woman's sexuality is an integral part of her as a woman, as varied as

Subject: [AIDS-INDIA] Plight of an HIV infected Howrah housewife
Date: Fri, 8 Mar 2002 19:12:09 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

HIV trauma trail dogs Howrah housewife

The Telegraph March 7, 2002 - Tarak Nath De
Rude shocks are in store for many a Howrah resident. Three months ago, a 30-year-old housewife from Kadamtala was told by experts that she had been detected with HIV. The pre and post-test counselling could have helped her tide over the trauma, but for her insensitive in-laws.

Five years ago, newly-married Surupa (name changed) had arrived at her new home with a lot of expectations. Till her husband, a BSF jawan, fell ill and was advised an HIV test. When it turned out positive, she and her baby daughter were asked to take the tests as well.

The child had escaped, the mother had not. But the worst was yet to come. When her in-laws got to know of the development, they held her responsible for her husband's plight. According to Surupa, her in-laws have been torturing her, despite her husband admitting that he was responsible for contracting and spreading the virus.

Sitting in the counselling room at Calcutta School of Tropical Medicine (STM) last week, Surupa was a shattered woman. What is worrying her the most is: "who will look after my child when we are gone?"

Relating her story, she said: "I could not believe my ears when I heard that I was infected. My husband had hidden from me the fact that he was HIV positive. It was at the insistence of the counsellors and doctors that he took me to STM. I believe he used to frequent brothels when posted outside. When he fell sick, his superiors told him to get a test done. Once the result was known, he was counselled and advised to inform me and take precautions."

Surupa's husband, however, hid the truth - a price for which his wife is paying dearly now. Perched on her lap, her three-year-old daughter asked: "Ma tumi kandcho keno? Tomar ki oshuk koreychey?" (Ma, why are you crying? What illness do you have?)

Surupa is more worried about her child than her life. "I am lucky that my daughter is not infected. But what will happen to her after my death? I wanted to see her as a doctor, but now I do not know whether I will live that ling." She is grateful to doctors "who are trying to motivate me. But the ultimate saviour is God."

Surupa is not the only woman in the state to face this ordeal. "There are quite a number of housewives - both in the city and the rural areas - who have been infected by their husbands," said Prof D.K. Neogi, head of the virology department at STM. The detection rate in all sections of society has "definitely increased over the years." In the early '90s, it was two to four new cases a year. "Then it grew by 10s and 100s. in 2001, there were 700 new HIV cases detected. The epidemic is spreading and awareness, along with behaviour change, are the only true weapons we have," he adds.

****
Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
François-Xavier Bagnoud (INDIA) (www.fxb.org)

Subject: [AIDS-INDIA] Report of Training of trainers course of Naz Foundation International
Date: Wed, 27 Feb 2002 14:21:46 +0000 (GMT)
From: Aditya Bondyopadhyay <adit_bond_2@yahoo.co.in>
To: aids-india@yahoogroups.com

Hi,

Pasted below is a report on the recently concluded TOT course at Lucknow conducted by NFI. This is for your information.

Regards

Aditya

Training of MSM Trainers
an NFI Regional Office Programme

The NFI Regional Liaison Office in Lucknow, India hosted a Training of Trainers Course (1st Phase) between 14th - 23rd February, 2002 for potential MSM trainers and consultants. The second phase training programme will be held in September.

21 participants from Bangladesh, India, Myanmar and Vietnam, took part in this training programme. The 9 day intensive workshop took participants through the first part of the NFI Handbook for developing MSM sexual health CBOs.

These training programmes enable NFI to expand its technical capacity and human resources, allowing a faster implementation process for developing new MSM sexual health CBOs in the region, beyond the 18 projects already developed with NFI technical assistance.

The required person specification of the recruited potential trainers and consultants were:

a. must be from the MSM networks
b. literate in both his own language and English
c. good reporting skills in both languages
d. good communication skills
e. good working knowledge of MSM and the sociocultural contexts in which they exist
f. reasonable working knowledge of HIV/AIDS
g. an ability to make people feel at ease and comfortable
h. an ability to easily and comfortably be able to discuss male to male sex behaviours openly
i. a reasonable knowledge of the male and female body, as well psychosexual issues of concern for MSM
j. a proven commitment to the issues
j previous experience in training and conducting workshops (but not necessarily on HIV/AIDS) would be preferred
k. experience of working in an NGO environment
l. experience of working with MSM

Process of using these trainers

Participants who have been deemed to have successfully completed the training of trainers programme will be selected to be a part of the Regional Trainers and Consultants Network for Naz Foundation International's South Asia MSM programme implementation.

Feb 28/2/02

Course length
1st Course: 9 days
The course took the participants through the Naz Foundation International Handbook for developing MSM CBOs and its effective use. These courses are highly participatory and experiential.

Course One: Conducting a Situational Asessment Among MSM

Participants actively participated in presenting materials as part of their training. Each participant also had a range of materials to read prior to the training courses.

Day One Setting the context
Naz Foundation International and its work
outline of the course, its purpose
using the Handbook
exploring sex, sexualities and behaviours within a South Asian context
i.e. defining sex
exploring different sexual behaviours and their meanings, social values, and attitudes and contexts
sexual messages from surroundings
cultural and social expectations
labelling, identities, gender and sexual stereotypes
stigmatisation, denial and invisibility in South Asia

Day Two The sexual body
knowing your own body
mapping your own body
discussions on sexual organs
nomenclature and terminology, including slang
knowing a womanís body
mapping your own body
discussions on sexual organs
nomenclature and terminology, including slang
the language of sex and behaviour
the practice of MSM sex in a South Asian context

Day Three Males who have sex with males
an exploration of personal sexual histories
the framework of South Asian MSM experience
desire or semen discharge?
exploring MSM desires, identities, and behaviours
localised structures of male to male sex
exploring your own city
exploring culture, religion and history
female partners

Day Four Sexual health: part one
what is sexual health?
what are STIs? - get treated
HIV and AIDS - information and facts
HIV/STDs and transmission
spreading the virus
who is vulnerable?

Day Five Sexual health: part two
what are risk behaviours?
personal risk analysis
practising safer sex
condoms and lubricant
myths about condoms
condom care
negotiating condom use

Day Six Developing a situational/needs assessment
what is a situational/needs assessment
what information needs to be collected
methods of information collection
questionnaire
focus group discussion

in-depth interviews
secondary-stakeholders - who are they
ethical issues
conducting the analysis

Day Seven Sharing the knowledge
personal and social impact of STD/HIV infection
changing sexual practices
sharing information

developing peer intervention programme
where do we go from here?

Day Eight Assessing training skills
how to use a manual
constructing the workshop
methods of communication
including: explicitness
ethical issues
workshop behaviours
humour
language (English v vernacular)
evaluation of workshops
outcomes

Day Nine The Way Ahead
Review of course and materials
Developing the NFI work programme
evaluation through
a. discussion
b. questionnaires
what next?

Subject: [AIDS-INDIA] New Member
Date: 26 Feb 2002 07:56:36 -0000
From: "Salam Gautam Singh" <gautamsalam@rediffmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear Friends,

My name is Goutam and I have been working in the field of drug abuse and HIV/AIDS for the last 15 years. Right now I am the Secretary of an organisation known as "ECHEMA" in Manipur. It focus is work only on female drug users,CSW, widow and children affected/inflicted with HIV/AIDS.

Any person interested can share or exchange information with the organisation.
Thanks.
Warm regards,
Goutam
E-mail : echema@sify.com

Subject: [AIDS-INDIA] Need help to fullfill the basics needs of a person living with AIDS
Date: Tue, 26 Feb 2002 07:54:00 -0800 (PST)
From: Srujana Sunku <skolishetti@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Hi,
My name is Srujana. I am trying to help two kids whose dad is suffering from AIDS and mom is trying hard to fulfill the basic needs for the kids. Mom is working 7 days a week but is not able to get medication for her husband.I myself am not able to fulfill the needs of this family and need your help.

I would be glad if you can help them in any form.

Thank you.
Srujana Sunku.
Srujana Sunku <skolishetti@yahoo.com>

lib
27/2/02

Subject: [AIDS-INDIA] Re: AIDS activits and social sensibility: Reply
Date: Tue, 26 Feb 2002 23:52:00 +0530
From: "Meena" <meena@pn3.vsnl.net.in>
To: <AIDS-INDIA@yahoogroups.com>,

[This message is in response to the posting from Anju of "Jackindia" on social responsibility of AIDS activists. Moderator]

Dear Anju,

It is interesting that not accepting regressive social norms sex workers should use the bhangi bol `night soil lane', should not be seen by the naked eye, should not use a Jeep, should keep their head covered] should be considered as offending sensibilities. By the way, we have been doing this work `discreetly' for ten years now.

1. There has been a long history of violence against women in prostitution in this area. women have been ill-treated, used by the police, gundas and petty criminals for many years now. It was only when the women got empowered enough to say that they will not accept being raped and abused both physically and mentally that the men in the locality got angry.

2. I am as upset about this episode as you are. not for the same reasons but because i am aware that what for us is an academic discussions at the best of times, for the women it is their lives and livelihood. i am not as judgemental as you are about women who are fighting for their rights. this hapless sex worker image is not a wholly true one. Because the rights of sex workers have been denied and they are fighting this battle it is not correct to say that their intention was to offend the sensibilities of their neighbours.

3. The men who visit the women for sex belong to the same town. It is my understanding that more often than not it is these very same men whose vested interest needs to keep the voice of the women underground. Let us at least acknowledge the strength of the women who are fighting a heroic battle against the virus on an everyday basis and `saving and educating' their male clients about HIV and STD's.

4. For your information this organisation uses/ distributes 3,50,000 condoms per month in seven districts among 5000 women. And has been doing so for more than eight years now. These condoms are used by men and women. Let us not forget that most of these men are regular clients and are thus locals. When the women ask questions as to why only they should cover their heads with shame- we have no answer.

5. The police officer could use such language because we do not want to challenge men who are abusive to women in prostitution. It is society that uses the women and demeans them by degrading their means of livelihood. It may take time but the women will be reinstated in Nippani. It is possible. I will keep you informed about the details.

But ten years of good work cannot disappear.

We will win with your blessings.

In solidarity,

Meena Saraswathi Seshu.

Feb 27/2/02

Subject: [AIDS-INDIA] Request for information regarding NGO collaboratives
Date: Mon, 25 Feb 2002 10:02:28 -0800 (PST)
From: Rashna Ginwalla <arcturus4p@yahoo.com>
To: AIDS-INDIA@yahoogroups.com

Dear all,

I am an Indian graduate student studying Public Health in the U.S. A colleague of mine and I are very interested in designing a project that establishes a collaborative "Umbrella Agency" (for lack of a better term at the moment) in India that serves as a focal point not only for disseminating information, but also as a networking tool that will allow NGOs working in the field of HIV/AIDS and, especially, those involved in addressing the particular needs of street children and those orphaned due to the disease. We envision that this Collaborative will enhance the scope of services provided to these high- risk populations, and will also, perhaps, prove to be a useful catalyst for the establishment of key public- private partnerships in this area.

In order for this proposal to go forward, we would like to invite suggestions from you, those who are directly and indirectly involved in the provision of services to street children (including those affected by HIV/ AIDS. We ask for any information or recommendations that you can make as to what kind of a role you envision such a collaboration will play. We do realise that NACO is the governmental arm that represents just such an "Umbrella Agency", and we do not wish to re- invent the wheel, so to speak, but we would like to see this collaborative emerge from within the NGOs and other groups working in this area themselves.

Additionally, we would appreciate it if you could provide us with any information on collaborative efforts that are already under way. We are aware of, for example, the Kerala Partners Forum, but only through information disseminated on these list-serves. If you could provide us with more detailed information on such collaboratives, who is involved, and what your goals and objectives are, and, also, whether you think that an overarching collaborative, such as the one we envision, is useful, pertinent and/ or necessary, that would be a great help.

Thank you so much for your time. We look forward to hearing from you soon.

Regards,

Rashna Ginwalla
The George Washington University
School of Public Health and Health Sciences
E-mail: Rashna Ginwalla <arcturus4p@yahoo.com>

Feb 26/2/02

Subject: [AIDS-INDIA] AIDS activits and social sensibility
Date: Mon, 25 Feb 2002 09:32:37 +0530
From: Jackindia <hifd@bol.net.in>
To: AIDS-INDIA@yahoogroups.com

Friends,

While it is distressing to learn of the abusive manner in which the sex workers at VAMP were handled - we have are a few concerns in this regard about the manner in which the HIV/AIDS prevention activites are being conducted.

Are we promoting and demanding a social sanction for prostitution?
As I gather from Meena's mail -the sex-workers were not simply hounded out of their homes -the locals of Nippani initially just asked them to stop their highly visible weekly meetings. Which they refused - then the locals then used threats and then attempted to negotiate and asked them to be discreet. Which was again refused - leading to a standoff and the police getting involved.

Now I can imagine the impact that a weekly gathering of sex workers - arriving in four wheelers from seven districts - would cause quite a stir anywhere in this country. In communities where people are struggling hard to make a honest day's living and existing with the bare minimum of resources - it seems ironical that sex workers (under the leadership of a few AIDS workers) appear to be going on an aggressive roll, with resources, government and donor support, land, their own vehicles to travel around every week and the ability to organize themselves.

Have we lost all sensibility and sense of reality in the name of HIV/AIDS?

Do prevention activities - but do it without flaunting something that is to be socially discouraged. As I can see - the sex workers have been living in the area for over 80 years without such an incident to date. So we need to ask ourselves what led to the seemingly sudden intolerance among the locals now? It ought to be obvious that the sensibilities of the locals got offended only when the situation became very 'in your face' - questioning their very way of life. The repeated attempts of the locals to get the women to stop the meetings should have alerted the workers to how they were offending sensibilities - and should have led to some changes/adjustments in the mode of functioning so that everyone could continue to co-exist peacefully. But no - we have our self-righteous "AIDS work" to do - which justifies all. Why could not they agree to be more discreet? As I see it, the attitude of the AIDS workers led to the situation spinning out of hand - and the leaders of SANGRAM & VAMP are as responsible for the humiliation of the hapless sex workers as the police. Let me ask them - that even if they are able to garner the best of national, international and legal support for the sex workers - how are they planning to assimilate them back in the same locality after they have turned it into a prestige issue between the sex workers and the locals of Nippani?

There are many aspects that ought to have been considered. What impact would this have on young boys and girls of the area - whose folks cannot afford the resources or the clout the sex workers seem to be enjoying? And seeing that this is the method and manner of prevention efforts across the country - how are our social structures like the family and related values, expected to stand up in the face of more visible, dominating and powerful sex workers?

HIV/AIDS work does not give one the right to turn all social norms upside down - just as it should not end up demanding respectability for what is fundamentally a degrading means of livelihood.

- if it happened the manner described. But anyone even slightly familiar with the concept of social change ought to understand that any natural change (for better or for worse) takes time, sometimes even a whole generation to manifest - and attempting to force 'unacceptable' notions on people can only lead to social chaos and violent responses.

With concern,
Anju
Jackindia
E mail: hifd@bol.net.in

Subject: [AIDS-INDIA] Personal thoughts on Voluntary Testing & Counselling in India
Date: Mon, 25 Feb 2002 09:07:16 +0530
From: Bitra George <bitra_george@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear All,

I would like to place my personal thoughts on the state of Voluntary Testing & Counselling programs in India before the forum members. These comments are not to criticise but to initiate discussion on the issue along with list some of the possible options.

(1) NACP -II target: One Voluntary Testing & Counselling centre has to be established in each district in the country according to the targets set in National AIDS Control Program Phase II.

* Will the targets be realised at the present rate of expansion? There might have to be either revision of the targets or speeding up of the scale of expansion especially in the Northern states (Uttar Pradesh & Bihar). There are quite a few VCT models, which could be replicated or scaled up.

* Will the expansion program compromise the counselling process? The worry is that the rapid expansion of VCTs might compromise the counselling process for more HIV testing. It is important to distinguish the goals of VCT from surveillance testing. A system of safeguards needs to be set in place, which could prevent VCTs from being misused for gathering data on HIV prevalence & incidence in local areas. VCTs can at best be used as an adjunct for monitoring trends in the acceptance of the concept of voluntary testing among populations that it caters to.

(2) Structure of existing counselling centres: 2 counsellors have been posted in each Voluntary Testing & centre for 5 6 days a week.

* Is the remuneration to counsellors enough? Counsellors are paid Rs 4000/ month as honorarium. Lot of counsellors in big metropolitan cities have told me that it was not enough to sustain them and their families. There is a need to look again at the pay structure of counsellors especially in big cities.

* Are there sufficient support systems in place for counsellors? There are no support systems for the counsellors to vent their feelings at the end of the day/week etc. There is a felt need for having a structure in place where in the counsellors will debrief on a daily/ weekly basis to a supervisor. In addition, the counsellors should also be provided space & time to ventilate their feelings. This could at least partly stem the growing cases of burnouts occurring among counsellors. There is also a need to clearly lay down the job description of counsellors.

* Are there sufficient linkages to ongoing care & support services? At the present time, very few VCTs offer linkages with care & support programs and are usually run by NGOs (Torch in NICD, Delhi) or Consortium of NGOs (NGO Forum in Safdarjung hospital, Delhi). There is a need for greater involvement of NGOs who have expertise in HIV/AIDS programs in running counselling centres.

[AIDS-INDIA] Personal thoughts on Voluntary Testing & Counselling in India

* Is there a resource directory of care & support services available at all counselling centres? Very few counselling centres have a comprehensive resource directory for referring PLHAs to locally available care & support services. This needs to be addressed at the earliest.

* Is HIV testing procedure up to the mark? It has been seen that the quality of HIV testing kits and the expertise required for routine HIV testing leaves a lot to be desired in large number of centres. In addition, there is also the perennial problem of periodic shortages of testing kits, reagents etc. Quality control at HIV testing centres and adequate supply of testing material is essential for the smooth functioning of VCTs.

* Is confidentiality being maintained in counselling centres? One of the most important elements of HIV/AIDS counselling is the maintenance of confidentiality. Experiences from various counselling centres around the country has shown that there is breach of confidentiality at various levels - at the HIV testing level (everybody knows the result especially HIV positive result in the laboratory), relay of test result to client or treating doctors, at ward level (all the doctors, nurses, ward boys, sweepers along with other patients know earlier than the admitted client) and at the time of disclosure (consent of the client is not taken before family members are informed). It is important that a protocol is set up for the relay of HIV test results to clients only by a trained counsellor. There is also a need to clearly define the term 'treating health care worker' as there are at least 10-15 doctors (Head of unit, consultants, Senior residents, Post graduate students, junior residents and interns), 10 nurses on rotation duty and 10 ward boys & sweepers in each unit in major hospitals. Who decides who needs to know and who need not know?

(3) Quality of counselling

* Who are the counsellors? Most of the counsellors posted in VCTs in most of the Northern states had little or no experience in counselling or HIV/AIDS issues. There needs to be a set criterion for selection of counsellors, which should not be influenced by any other consideration. Opportunity should also be provided for PLHAs to become counsellors. There is also a need to differentiate between lay counsellors & professional counsellors and clearly demarcate the roles & responsibilities of each category.

* What is the content of counselling in VCTs? Most of the counsellors seem to be providing advice rather than providing options/choices for the clients attending VCTs. In addition, there seems to be little effort to explain the implications of HIV tests (both positive & negative) and clients are advised to undertake the HIV test. There should be a standard protocol for all counsellors to follow in pre & posttest counselling. It has becomes even more important to be careful that HIV positive mothers are provided all possible options and are not advised to undertake a particular step with the introduction of PMTCT programs all over India.

* Is periodic training available for counsellors? There is an acute

lack of periodic training for counsellors in VCTs. The refresher training courses should deal with upgrading skills & information levels of counsellors. In addition, the counsellors must also be provided with the opportunity to work in grass root level organisations & conduct field work in the afternoons so that they get a better understanding of the needs of clients especially PLHAs.

(4) Monitoring & Evaluation systems

* Are there established systems for maintenance of documents and monitoring quality of counselling? Very few centres have put into place proper systems for monitoring of counselling that is provided by the counsellors. A standardised system for documentation needs to be instituted. Format for weekly/monthly quantitative & qualitative reports needs to be devised.

* Has there been evaluation of VCTs? Only a handful of VCTs have been evaluated to date. Internal & external evaluation is essential for measuring systems & procedures, quality of counselling and impact of VCTs. One could use existing tool kit of UNAIDS to evaluate VCTs.

(5) Training programs for counsellors

* Are there sufficient training centres for counsellors in India? The number of counsellors required to man all VCTs and antenatal clinics in India is mindboggling. There are very few training centres (Naz Foundation - Delhi, Torch - Delhi, NIMHANS - Bangalore, Christian Medical College - Vellore, TISS - Mumbai, CINI & Vivekananda Education Society - Calcutta, SIIAP - Chennai & NARI - Pune) are the NACO recognised regional training centres in the country. Existing centres are not sufficient to train sufficient numbers of counsellors. There is a real need to augment & continually fund existing centres and identify new ones to meet the demand without any compromise on quality of training provided.

* Is there a standard protocol followed for training counsellors? Most of the regional training centres have a 5-7 day training program with a follow-up training for 3 days. SIIAP, Chennai has a much more intensive training course for the period of one year with field/community work & supervision. Naz Foundation conducts training on various modules for 4 -7 days each. NACO is shortly coming up with a protocol for ensuring standardised training to counsellors all over the country. There is also a need to ensure that training is periodic and regular. Evaluation of existing training centres in terms of quality, content, cost effectiveness and impact also needs to be conducted.

* What happened to all the master trainers & counsellors trained in the NACP -Phase 1? No attempt has been made to find out what happened to all the master trainers & counsellors who have been trained earlier during NACP -Phase I. The biggest failure of the previous round of training was the absence of any clear criterion for selecting master trainers and counsellors in each region and development of an action plan to ensure further training of counsellors. For the next round of training, these aspects will need to be kept in mind.

(6) Relationship between counsellors & health care workers

* Is there tension and friction between counsellors & health care workers? In most of the counselling centres that are situated in health care settings, there is a lot of friction between counsellors & health care workers. Most of the counsellors are seen as activists for patients/clients without any appreciation of the constraints in which health care workers function. There is a need for dialogue between both groups so that there is a better understanding of each others role in meeting different needs of clients/patients. There should also be a monthly/quarterly meeting between the counsellors & health care workers to ensure smooth functioning of the VCT.

(7) Improving accessibility of Voluntary counselling centres

* Is there sufficient publicity of existing counselling centres? There is still lack of awareness about the existence and the location of VCTs in various parts of the country. There is a need for a publicity campaign carried out with a great detail of sensitivity so as to prevent stigmatisation of the VCTs. Care should also be taken while naming/labelling the counselling centre - avoid HIV or AIDS counselling centre tags wherever possible. Social marketing of VCTs is another possibility. Linking telephonic counselling with VCTs could also be strengthened.

* Is there any other method for increasing accessibility of VCTs? Unfortunately almost all of the VCTs are located in health care settings. There is a need for establishment of community based counselling centres with linkages to HIV testing centres. Identification & training of staff in counselling & sample collection & transport will need to be provided to community-based organisations.

(8) Innovations

Have new innovative methods been introduced in VCTs? Innovative steps have not been incorporated in improving the functioning of VCTs in India. Availability of rapid HIV testing kits has led to a revolution in VCTs around the world with pre & post test counselling being conducted on the same day without any delay. Unfortunately, as yet, there are not enough rapid HIV kits available for VCTs in India.

VCTs play a very important role in 'normalising' the epidemic. If VCT were more available and more people were counselled and tested, more would know their status and it is likely that this would decrease the stigma and fear attached to the disease and lead to a more open approach to HIV prevention and care. VCT could act as a catalyst to improve HIV care in other hospital departments and health services, as well as raise awareness and acceptance among health care workers. VCT may allow more appropriate care for patients with HIV in general. VCT also serves as an entry point into Continuum of Care and is an excellent link between prevention & care HIV/AIDS programs. But in India, NACO & State AIDS Societies really need to accelerate their efforts if VCT program is to succeed and help in controlling the HIV/AIDS epidemic.

Regards,
Dr Bitra George
Salaam Baalak Trust & Sharan

Subject: [AIDS-INDIA] Response to: Alternative views to SANGRAM/VAMP activities
Date: Mon, 25 Feb 2002 08:40:34 +0530
From: "Meena" <meena@pn3.vsnl.net.in>
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

This is in response to the message posted by Mr Pravin Patkar of..

I am shocked at the tone of hostility and prejudice the message is suffused with. His personal diatribe against me and my organisation, his complete dishonesty in distorting and taking our words and position statements out of context these are not ingredients for fruitful debate and discussion.

I refuse to respond to these references to 'crocodile tears'. If only Mr Patkar really heard the voices of the women who were hounded, attacked and abused, he would understand their plight better. Shababa Khazi, general secretary of VAMP told a reporter that being abused as a woman in prostitution was not the same as facing abuse for helping to organise women against their oppressive conditions. Can there be a better indication of the collective sense of self-worth and self-respect the women have wrested for themselves as a collective? If this is what the local politicians and police fear, are the Patkars of this world any different?

Unfortunately or fortunately, I know Mr Patkar well, both as a lecturer in the TISS, which I graduated as a master in social work, and as a fellow social worker who slogged for several years running an organisation in Raigad district of Maharashtra called Parivartan '84. I feel that he is a sincere person, misguided certainly, but still sincere. Hence, I shall make one last attempt to explain my position and reply to the charges he has levelled against me.

Here goes:

1. As far as the quote in the book the heading actually says `Do not bring children into prostitution.'

That was a campaign we did requesting women in the devadasi belt to push the age of entry because it gave us breathing space for negotiation. besides i deeply beleive that women who are in prostitution once empowered can take informed decisions about such issues. and we can then together deal with the violence that exists within prostittuion.

The outside world is so hostile to the women. i feel it is wrong to direct them, raid them, rehabilitate them from the outside. a collective once built will take informed decisions and it is their life. Durga who is a devadasi, after our non-judgemental intervention has decided not to make her girl child a devadasi. i am happy for her and we are doing everything to help her educate her girl child. i firmly beleive that our intervention will help many such Durgas. this is a process it will take time and it is a process that encourages women to collectively help redirect their lives. it is so convenient to say Ban prostitution. this only helps it to go underground.the women suffer. they have suffered for generations because no one cares enough to hold their hand and help them help themselves.

2. Sangram supports the human rights of women regardless of the nature of the work they do. We believe that rights are essential tools for fighting exploitation and abuse, including in the sex industry. Mr. Patkar's solution to the problem of `prostitution' and `exploitation' is not through supporting the human rights of these women, but to eliminate the women, that

Hob
26/2/02

exploitation of oppressed and stigmatized groups has always been to provide them with the rights to fight the abuse, not to eliminate the group altogether, (which happens in totalitarian regimes.) Our fight for women's rights is quite simple and consistent with what Mr. Patkar describes as a 'radical' idea - that these women are human and that human rights are non-negotiable.

The allegations of Mr Patkar are not only false and malicious, they undermine and are harmful to the rights of the very women he professes to be helping.

3. Working with women in prostitution and sexwork in the HIV/AIDS prevention program has helped address our own double standards and biases while dealing with issues of sexuality and prostitution. As our involvement in the program deepened, our beliefs, ideas and notions about prostitution and women in prostitution underwent a sea change. Our perception of prostitution as `exploitation, victimization, oppression, loose, immoral, illegal`, was shaken to the core.

Prostitution and sexwork as experienced by Women.

Women in prostitution, have had to bear the specter of being wanton [liberated sexual beings], worthless [making money from sex] and weak [morally]. The whore stigma emphasized the `evil' [sic] influence of such `base' women on the good moral behavior / character of society, deeming them `deviant' women who transgressed the norms of acceptable social behavior.

The concept of the debauched, debased and deviant woman has always governed public opinion. Women have therefore been policed, coerced and raided, to be rescued, reformed and rehabilitated by a society that would "like to order and control their life styles"1, regulate or abolish prostitution.

It is apparent that while the "prostitution question"2 will be continued to be debated and arguments for and against, whether voluntary/forced, `agency' / victim, trafficked / socialised, legal/ criminal, sexual slavery/ sexual autonomy, exploited / liberated, will continue to occupy theorists, activists, and Governments, prostitution as experienced by the women themselves is not given the kind of recognition it deserves in these debates.

In recent years, the discourse around prostitution has changed and is now in the frame work of human rights. Feminists, theorists and prostitutes rights activists are involved in unravelling the complex and complicated world of sexual autonomy, free choice, sexual exploitation and the agency versus victim debates. This discourse has helped in that it has shifted the focus from blaming the woman and her sexual preference to a continuum ranging from the `beneficial exploitation of the institution of prostitution ' to the `inherent victimisation of the woman in prostitution'.

Though the prostitutes` rights movement started in the late 60's and early 70's, the rights approach has been challenged and will remain a dream as long as it is plagued by advocates of the moral brigade or the proponents of sexual autonomy and free choice, as mutually exclusive positions. While the moral brigade argues that prostitution is inherently sexual exploitation and violent, the free choice advocates argue that women `choose' sexwork as an option and therefore they have a right to the kind of work they choose.

The discourse however, fails to recognise the dynamics of an institution

that encompasses a wide spectrum of elements from violence, exploitation on the one hand and autonomy, agency to choose the best possible available options, on the other. Prostitution is a way of life. All women are not victims and to believe that all women are there out of free choice is also utopian.

I appeal to everyone to come together and fight for the the rights of all women irrespective of how they make a living.

In Solidarity,
meena saraswathi seshu.
E-mail: <meena@pn3.vsnl.net.in>

Subject: [AIDS-INDIA] NACO director acts when AIDS activits violated !
Date: Thu, 21 Feb 2002 21:36:27 -0800 (PST)
From: Aditya Bondyopadhyay <adit_bond@yahoo.com>
To: aids-india@yahoogroups.com

Dear Mr. Prasada Rao,

As a concerned citizen and AIDS activist I am writing to express my thanks and appreceation at the concern that you have publicly expressed regarding what has happened with VAMP and its activists.

In india the most vulnerable segments affected by HIV/AIDS are also culturally and legally highly marginalised. This increases their vulnerability. When state agencies actively violate their rights, it affect that vulnerability. In that situation they look up to NACO as the apex body responsible for the prevention of HIV/AIDS for support and strength. The reason is not far to seek. The NACO policies are probably the only one in the entire corpus of law and policies, that recognise the human rights of these vulnerable groups, and recognise the human dignity of these groups. Also it is a fact that many NGOs are in the activity of HIV prevention because of their having reposed faith NACO policies. In that there is also a responsibility of NACO to come to their aid.

Under such a situation when something happens to impede the HIV/AIDS work with such marginalised groups as CSW or MSM, a public statement of support from NACO becomes a source of strength. But silence from NACO results in a feeling of having been let down. While the former has a positive impact on HIV prevention, the later sets back the progress made, sometimes maybe by years.

I again state that I appreceate the fact that in spite of your constraints, this time you have chosen to break the silence. It is very courageous of you and will surely have a positive effect on HIV/AIDS prevention work.
Regards

Aditya Bondyopadhyay
E-mail: <adit_bond@yahoo.com>

Leib
26/2/02

Subject: [AIDS-INDIA] NATIONAL AIDS PREVENTION AND CONTROL POLICY
Date: Mon, 08 Apr 2002 00:47:28 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Dear Forum subscribers,

The latest National AIDS Prevention and Control Policy is posted on the NACO webpage.
http://naco.nic.in/vsnaco/nacp/ctrlpol.htm
The following is the introduction of the policy document.

Moderator

1. INTRODUCTION

1.1 In India the Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS) epidemic is now 15 years old. Within this short period it has emerged as one of the most serious public health problems in the country. The initial cases of HIV/AIDS were reported among commercial sex workers in Mumbai and Chennai and injecting drug users in the north-eastern State of Manipur . The infection has since then spread rapidly in the areas adjoining these epicenters and by 1996 Maharashtra , Tamil Nadu and Manipur together accounted for 77 per cent of the total AIDS cases with Maharashtra reporting almost half the number of cases in the country. Even though the officially reported cases of HIV infections and full-blown AIDS cases are in thousands only, it was realised that there is a wide gap between the reported and estimated figures because of the absence of epidemiological data in major parts of the country. The latest estimate for the HIV/AIDS infected adult population in the country is 3.8 million in 2000. The overall prevalence in the country is still, however, very low, a rate much lower than many other countries in the Asia region.

Subject: [AIDS-INDIA] World Bank Induced Primary Health Care User Fees in Punjab, India
Date: Wed, 06 Mar 2002 13:32:42 -0500
From: vineetag@sancharnet.in
To: "AIDS-INDIA-yahoogroups.com" <AIDS-INDIA@yahoogroups.com>

Sign on campaign demanding abolition of User Fee charges for the poor in World Bank funded state health sector in Punjab, India

In the mid 1990s, the World Bank provided a loan to India to create the Punjab Health Systems Corporation (PHSC). At the time, the Bank claimed the program would promote transparency, accountability, and efficiency in the health care system; and that the project would pay significant attention to the needs of women and the poor. In reality, the project has far from lived up to intentions. Most significantly, the PHSC project mandated the application of user fee charges to those in need of medical services regardless of patients' income levels. Marginalized groups, chiefly the poor and women, have faced severe hardship in receiving medical attention, because they cannot afford to pay the user fee charges as required for health assistance.

In theory, the poor are exempt from the user fees charged for medical care. However, exemption mechanisms have failed to ensure the poor and women's access to health care in Punjab, as well as in other Indian states that have implemented similar World Bank projects. Exemption entitlements have also been ineffective and counterproductive in Mali, Zimbabwe, and Ghana where World Bank sponsored user fees have also been imposed.

In the case of the Punjab Health Systems Corporation, poorer patients must request a 'yellow card' from the government in order to have the user fees waived. Yet most poor patients are not even aware of the exemption card. If they are aware, then the complex and costly procedures required to obtain and retain their exempt status still excludes most of them from receiving medical attention. As a result, they have to pay a user fee in addition to bribes (to doctors, nurses, and other hospital staff) so that they might be treated. In early 2001, only 44 'yellow cards' were distributed in a city of about 270,000. This has led many poor people to seek medical care from unqualified persons, using superstitious methods of treating medical problems.

Therefore, INSAAF International in India has launched a campaign, forcing the World Bank and PHSC to acknowledge and rectify the vast gap between their stated policy goals and the realities of its implementation. Moreover, in September 2001, after years of pressure by NGOs and citizen groups, the World Bank was forced to change its policy on user fees, to forbid the imposition of user fees on access to primary health care. This change in policy must be applied to all of the World Bank's existing and previous projects, such as the PHSC project in Punjab.

In February 2002, INSAAF International released a report documenting the effects of the World Bank sponsored corporatization of Punjab's health care system. India Together, a web magazine has summarized the report in the adjoining article, "Yellow Cards for the Poor".

http://www.indiatogether.org/health/reports/insaaf01.htm

Please support INSAAF International's efforts by participating in a signature campaign for the letter being sent to the World Bank and the PHSC.

- Vineeta Gupta, General Secretary, Insaaf International,
vineetag@sancharnet.in

LETTER
Please send your sign - ons to Shrayas Jatkar at shrayas@econjustice.net

.] World Bank Induced Primary Health Care User Fees in Punjab, India

Mr. James Wolfensohn
President
World Bank
1818 H Street, N.W., Washington, DC 20433
U.S.A.

Special Secretary Health cum Managing Director
Punjab Health Systems Corporation,
S.C.O 341-42, Sector 34A
Chandigarh, INDIA 160022

Dear Sirs,

The orders of the World Bank-funded Punjab Health Systems Corporation (PHSC), Punjab, India to hike the user fee for health services and elimination of subsidized fee structure for low income group is clearly another example of the insidious World Bank strategy of charging the poor when in fact its mission should be to deliver them services they could not otherwise afford.

India is a welfare state, and the National Health Policy (NHP) emphasizes the role of the state in providing basic health care. The objectives stated in the project under which PHSC was created were to improve efficiency in allocation and use of health resources through policy and institutional development, improve the performance of the health care system, increase coverage and effectiveness of services at the primary and secondary levels, and to better serve the neediest sections of the population. But practically it is resulting in denial of the right to health and undermining state responsibility in providing basic health care to its citizens. The poor and women are worst hit with the increased costs of the treatment.

This is being done at a time when even the U.S. Congress has passed legislation that strongly opposes this practice and when the World Bank itself supposedly opposes user fees on primary health care. We strongly condemn PHSC for its anti poor and anti women policies.
We demand that these orders be reversed immediately.

Sincerely,

Dr. Vineeta Gupta
General secretary, INSAAF International,
Punjab, India
Email guptahr@yahoo.com

Please add your name to the letter by sending your sign-on to
shrayas@econjustice.net
Name
Organization (if applicable)
Country/Address

++++++++++++++++++++++
Neil Watkins
World Bank Bonds Boycott
Center for Economic Justice
733 15th St., NW, Suite 928
Washington, DC 20005
Tel: (202) 393-6665
Fax: (202) 393-1358
Web: www.worldbankbondboycott.org

To receive occasional updates on the World Bank Bonds Boycott, join our listserve: Send blank e-mail to <bank-boycott-subscribe@yahoogroups.com>.

Subject: [AIDS-INDIA] Require social worker
Date: Wed, 20 Mar 2002 11:42:10 -0530
From: "Juhi Sahai" <jsahai-modicare@modi.com>
To: <AIDS-INDIA@yahoogroups.com>

Dear Members,
We are a foundation working on adolescent health & HIV in Delhi, both public and govt. schools. Require a female social worker preferably MSW, with atleast 1-2 years work experience in the field of HIV.

The job responsibilities will include taking sessions with adolescents on growing up and sexual issues. Communication skills are of prime importance, vibrant and young, willing to take initiative and be innovative. Presence of mind to outdo these extremely smart young adults.

Salary: to be discussed

Please send in your resumes through email or fax.

Thanking you,

Regards,

Juhi Sahai.

Juhi Sahai
Project Manager

The Rai Bahadur Gujarmal Modi Foundation
4, Community Centre
New Friends Colony
New Delhi -65
Ph: 011 6321441-50; Ext 116.
Fax: 011 6846732.
E-mail:<jsahai-modicare@modi.com>

TN
21/03

Lib- AIDS India file

Subject: [AIDS-INDIA] Health minister has been misquoted
Date: Wed, 20 Mar 2002 10:25:39 -0000
From: Mona Mishra <plife@vsnl.com>
To: AIDS-INDIA@yahoogroups.com

Hello all,

Information from NACO sources - the Health minister has been misquoted on the issue of barring foriegners with HIv entering the country. There is no such proposition by the ministry.

Mona Mishra
Positive Life, Delni
E-mail: <plife@vsnl.com>

AIDS - India file
Lib
for
2/3

TN
21/03

Subject: [AIDS-INDIA] An open letter to Hon. Minister Dr. C.P.Thakur
Date: Tue, 19 Mar 2002 08:59:10 -0000
From: "Vimla Nadkarni" <vimlanadkarni@hotmail.com>
To: AIDS-INDIA@yahoogroups.com

Dear Hon. Minister Dr. C.P.Thakur, For a change, we have a ``professionally qualified'' person as a Minister which is most unusual in our polity. Hence, we expect enlightened responses as far as health issues are concerned. Sir, you surprise us sometimes when your policies contradict themselves. On the one hand, the NACO draft policy on HIV/AIDS is definitively against mandatory HIV testing; on the other hand, you have declared that all foreigners entering India will be tested. This reveals a wide gap between what is advocated in principle and what is being preached in practice. Are you not expecting a boomerang effect of other countries practising the same on us Indians who travel abroad? Should we not be focusing all our energies on using our limited resources on curbing the spread of HIV/AIDS among our own people rather than concentrating on a comparatively smaller group of tourists entering our country. What if these persons develop infection after visiting our country? Will you be able to identify them and then desire to throw them out? Do you think with such archaic practices, we will be even considered for a share in the Global Health Fund? In the process of globalisation, cross-border mobility is increasing through different access and exit routes. How will you map those and control the movements of so-called infected persons? Are you planning testing centres along our borders? It is possible that you have made these statements under provocation. We look forward to your withdrawing these plans and instead, concentrating on adopting a rational comprehensive multi-sectoral secular po[redacted]on HIV/AIDS in letter and spirit. Vimla Nadkarni E-mail.

TN
20/3.

A] Pune KEM Hospital to pay for HIV treatment

A] Looking from Youth Teacher Volunteers from India

Subject: [AIDS-INDIA] Looking from Youth Teacher Volunteers from India
Date: Tue, 19 Mar 2002 16:29:09 +0700
From: "Subidita Chatterjee" <subidita@loxinfo.co.th>
To: <AIDS-INDIA@yahoogroups.com>

Dear Forum members

We are looking for youth teacher volunteers for India for training in life skills through an international forum.We aim at getting atleast one member from every state.They will be given free training on life skills to spread the message to 5 more persons of their choice.They in turn will train 5 more and the chain reaction should go on till it reaches the village levels.

Right now we are in the pilot stages to see if this works. If it works we would seek funding and could pay them too in the future.But right now we want persons who wish to change the situation of that part of the world they are living in. Mexico is going ahead compared to other countries are slow to respond.
Please respond early if you or any one you recommend should be interested.

Criteria is the person should be able to read and understand English and read and write and understand his/her native language. Should preferably me less than 35 years of age. 15 to 25 years preferable.

Thanks

Moderator, LIFE SKILLS
Subidita Chatterjee
E-mail: <subidita@loxinfo.co.th>

FN
20/3

3/20/02 9:06 AM

3/20/02 9:08 AM

Subject: [AIDS-INDIA] Pune KEM Hospital to pay for HIV treatment
Date: Tue, 19 Mar 2002 10:33:35 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Blood transfusion that was Pune girl's `death sentence'

ANURADHA MASCARENHAS

PUNE, MARCH 14: FOR 13 years, Shahrukh and his family have been living a ``death sentence''. In December 1988, his 13-day-old daughter went into the Pune-based King Edward Memorial Hospital with neo-natal septicemia and came out with AIDS.

Five days ago, the Bombay High Court ordered the hospital to bear all the medical expenses of keeping alive Mitra, who is believed to have contacted the disease during blood transfusion.

But this is small consolation for 47-year-old Shahrukh and his wife, who have lost their jobs, contemplated suicide and begged for money to fight off AIDS.

Or for Mitra, who speaks excitedly about her love for English and maths but was told to leave school in Standard IV. ``Yes, my daughter can live for a few more years but...,'' Shahrukh's voice trails off.

A long uncomfortable silence follows as he looks around at the cluttered mess that his one-bedroom house has become — bills which run into Rs 20,000 every month for some 30-60 tablets of Fortovase Saquinavir capsules, Lamivudine and Zidovudine tablets, newspaper clippings speaking of the devastating effect of the HIV virus on the brain and the stress of living with the illness.

Or is he remembering the years of sleepless nights, the frequent visits to the hospital and the toll the disease has taken on his family — his frequent fights with his wife, and his outbursts at his son for touching his sister with unclean hands.

http://www.indian-express.com/ie20020315/nat8.html

TN 2013.

Subject: [AIDS-INDIA] Why NACO has not come out with a statement as yet?
Date: Tue, 19 Mar 2002 10:40:20 -0000
From: Aditya Bondyopadhyay <adit_bond_2@yahoo.co.in>
To: AIDS-INDIA@yahoogroups.com

Hi everybody,

We often have politicians and other persons in powerful positions who comment on HIV without being properly educated on the consequences of their statements, or what the consequences could be if these statements are put into action.

In the past, for example, we have had the Supreme Court of India Pass the Judgement in the "Mr. X -Vs- Hospital Z" case without a single hearing where the issues around HIV could be placed before the court. After dismissing the matter in limini, the court proceeded to write a judgement that can only be described as BAD, Uninformed, and Harmful. The basic principle of Natural Justice that nothing shall be decreed without giving hearing to the party affected was not followed by the Apex Court and the Rights of all HIV positive persons to get married was effectively taken away.

The statements of CP Thakur, seems to be in this light too. It does not seem to be informed by the scientific discourse on HIV and appears to have been made mostly from the perspective of a plebian display of what the masses would want to hear from a politician who does not have the acumen to use his leadership to educate the masses himself. It is indicative of a deficient mind doing his political brinkmanship without an iota of understanding as to the consequences.

But in this whole saga what needs to be noticed is that NACO has not come out with a statement as yet. The reason is not far to seek. It is the Duty of NACO (As the apex policy maker on HIV) to ensure that the minister is duly and scientifically briefed. The very fact that the minister has made the statement that he has is proof that NACO has failed in discharging this duty.

Now all that can be hoped is that the statement of the minister is not put in action. It will reflect badly on India. Also what will the state do about persons of Indian Origin coming back to India after prolonged stays abroad. Would they also be tested? What if they test Positive, would India then deny entry to its own citizens?? Or would it again go back to the days of quarantine and repeat the atrocities that it heaped on Dominique D'Souza on a further 3.8 million or 8 million or whatever is the real figure numbers of its citizenry.

Every agency has to justify its existence, and its time NACO did this by giving the Honourable minister a thorough debriefing on the basics of HIV, the Rights discourse around it, and educate him why artificial and politically motivated barriers like to one the minister proposes is no stopper to the spread of the infection.

The real stopper would be if the state recognised the rights of all vulnerable groups, be they CSWs or MSM or Hijras or IDUs, promote their rights, empower them to take the necessary decisions to protect themselves, and live as equal citizens. It would happen if state agents like to police and the constabulary do not impede intervention and education work every stage of the way for fear of loosing out their traditional 'over the top income'. It would happen if more than mere lip service, treatment for HIV positive persons become a reality happening out there to be accessed and not in fancy policy documents that delevers jack-shit to the one dying without medicine. Maybe all this will happen partially if the Honourable Minister ensures there is a five fold increase the health budget.

But then because there is no one to listen to sanity, and because those responsible for spreading sanity do not do so, do we have

A] Why NACO has not come out with a statement as yet?

insane comments from ministers.

Regards
Aditya Bondyopadhyay
E-mail: <adit_bond_2@yahoo.co.in>

Subject: [AIDS-INDIA] 'AIDS Free Certificate' Mandatory for foreigners
Date: Sun, 10 Mar 2002 12:36:10 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

PTI [SUNDAY, MARCH 10, 2002 1:06:24 AM]
PATNA: The Centre is considering a proposal to make it compulsory for foreigners to present 'AIDS free' certificate before they are allowed into the country, Union Health and Family Welfare Minister C P Thakur said on Saturday.

The measure had become necessary to check the rise of HIV cases following contacts with foreigners visiting the country, he said quoting reports. High-level meetings of the Union health and tourism ministries and ministry of external affairs have already been held to give final touches to the proposal and necessary details are being worked out so that the tourism industry is not affected, he said.

He said many countries in the world have taken similar steps to contain the growth of AIDS. North Korea has made it compulsory for its citizens to undergo Aids check-up before leaving the country and after arrival from abroad. He stressed the need for mobilising additional funds for the health sector and said several schemes were being planned by the Union health ministry to attract NRIs.

He had also held many rounds of talks with top industrial houses and requested them to spend time in the improvement of healthcare in the country, particularly in the rural areas, the minister added.

A low cost health insurance scheme would be introduced soon for the poor in which people would be asked to contribute a small amount to get benefit of the scheme, Thakur said.

He said a committee has been formed in the Union health ministry to keep a tab on the spread of plague in the country, particularly in Himachal Pradesh, Maharashtra and Gujarat. On providing medical assistance to Afghanistan, he said the ministry had sent doctors, large quantities of medicine and health equipment.

Forwarded by Chandrashekhar Vyas
FXB Madhya Pradesh
fxbmadhyapradesh@fxbinindia.org
****

Subject: [AIDS-INDIA] Women and HIV in India
Date: Fri, 8 Mar 2002 19:20:31 +0530
From: "Jagdish Harsh" <jamworld@vsnl.com>
Reply-To: "Jagdish Harsh" <jharsh@afxb.org>
To: "AIDS INDIA" <AIDS-INDIA@yahoogroups.com>

HEALTH

The Pioneer March 8, 2002
Women are becoming increasingly affected by HIV. About 42 per cent of estimated cases are women, and the number of infected women touched 15 million by the year 2000. One in 13 women in India dies from pregnancy or childbirth related causes. Awareness of AIDS among women has increased but it is still quite low - 40 per cent nationwide. One-third of women, who have heard of it, do not know ways to avoid it. Awareness is lowest in Bihar (12 percent) and also Uttar Pradesh (20 percent).

****
Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
Fra[redacted]is-Xavier Bagnoud (INDIA) (www.fxb.org)

Library
11/03.

From: Anuarg Bharadwaj <anurag_bharadwaj@hotmail.com>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Tuesday, May 14, 2002 5:45 PM
Subject: [AIDS-INDIA] On AIDS vaccine trial in India

Moderator

Thanks for inviting me to join the group. Still I am intrigued by the fact how you came to know me and how am I got included in this list. Anyway, Thanks for that. I am working in the field of HIV and actively involved in the treatment of patients in HIV. For two years I worked in Nepal and we had largest number of HIV patients in Nepal.

Regarding HIV vaccine: I attended the "International congress of Immunology" held in New Delhi in Nov 1998 when preliminary discussion regarding AIDS vaccine in trial started.

I want to bring the fact that there are many clades of HIV virus in circulation like clade A and B which are common in US and Europe and Clade C and D which are common in Thailand and India respectively. The vaccine which has been developed on the basis of trials on one clade cannot be tried in a society which has a different clade in circulation. I would like to know - How the vaccine has been developed. Secondly if the trials are also starting in US simultaneously or not.

Dr. Anurag Bharadwaj
MD, DM clinical Immunology
Associate Professor of Medicine
Melaka- Manipal Medical College
Jalan Batu Hampar, Bukit Baru, 75150 Melaka.Malaysia
Tel: 60-6-2925851 Ext.1041(Off)1076(Res)
Fax: 60-6-2925852
Email: anurag@manipal.edu.my

5/20/02

5/20/02

sochara

From: Jagdish Harsh <jamworld@vsnl.com>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Monday, May 13, 2002 1:48 PM
Subject: [AIDS-INDIA] Industry takes to AIDS control

Industry takes to AIDS control

The Times of India 9 May, 02
New Delhi: With close to four million people estimated to be infected with HIV in India, a few business houses are already having to reimburse huge medical bills even as most of them incorporate programmes to prevent higher incidence of sickness.

At a two-day workshop organised by the Federation of Indian Chambers of Commerce and Industry, representatives of sugar mills were urged to take up prevention programmes.

Some of the well-known industrial houses such as Larsen and Toubro, Glaxo, Mahindra and Mahindra, Tata Tea, Bajaj, TISCO as well as the Steel Authority of India already have a clearly defined policy towards HIV, which addresses their concerns and is not violative of any human rights, he said.

In fact, the government is now actively turning to the industry for help in AIDS prevention efforts. Labour ministry joint secretary K Chandramauli said a tripartite mechanism involving employers, trade unions and the government to prevent the spread of AIDS was being evolved.

The major challenge before the government was to reach out to the more vulnerable informal sector, which forms about 93 per cent of the total workforce in the country, he said. This, he agreed, would need a multipartite strategy. The labour ministry was trying to evolve programmes targeting this workforce, he said.

In the African countries, the epidemic has resulted in loss of skill and experience, rising labour costs and reduced supply of labour. The workplace, it is felt, could play an important role in limiting the spread and mitigating the impact of AIDS.

Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
François-Xavier Bagnoud INDIA (www.fxb.org)

---

sochara

From: Burma Centrum Nederland <bcn@xs4all.nl>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Monday, May 13, 2002 3:22 PM
Subject: [AIDS-INDIA] Conference on 'HIV/AIDS in Burma'

CONFERENCE PROPOSAL 'HIV/AIDS IN BURMA'

INTRODUCTION

A major concern in Burma in the last few years is the rapid spreading of HIV/AIDS. It is clear that the infection rate in Burma qualifies as a widespread generalised epidemic of HIV, with international estimates of hundreds of thousands victims.

Burma faces a most unfortunate set of factors that increases the magnitude of the HIV/AIDS epidemic: drugs use, large sex-industry and trafficking of women, large population mobility due to migrant labour, forced relocations and civil war. Other causes of the current epidemic are the failing health system and the lack of large-scale education campaigns on this issue.

The military junta's original response went from complete denial to beginning to admit that there is an HIV/AIDS problem.

A Burma Center Netherlands (BCN) mission to India, Thailand and Burma (November-December, 2001), assessed the needs of Burmese civil society organisations in Burma and Thailand. One of the conclusions was that, in relation to health and HIV/AIDS, information flows between health and relief organisations, and organisations specifically offering HIV/AIDS programmes could be promoted and enhanced. Many of the people interviewed during the mission welcomed the suggestion of organising a conference to start addressing this.

In December 1997 BCN organised a conference on 'Strengthening Civil Society in Burma - possibilities and dilemmas for international NGOs'. Participants came from INGOs working inside Burma, working cross-border or working with Burmese communities in Burma's neighbouring countries. Our experience is that as a non-stakeholder, meaning BCN neither being a funding agency nor a development agency, we are well situated to organise such a conference.

On this matter we like to invite you to share your organisational and personal opinions, views, policies and particularly practical and motivating perspectives during a 2-day conference.

THE CONFERENCE

The conference will be held October 2002, in Bangkok (Thailand). This will enable participants from inside Burma as well as people working in the border area, to participate. The conference will be a 2-day activity, during which the participants exchange their experiences in relation to their HIV/AIDS programmes and activities. The sessions are closed for public and journalists. The atmosphere should be open and participants should feel free to speak

openly.

CONFERENCE GOALS

By providing a platform for organisations working on HIV/AIDS in Burma where they can exchange views, the conference wants to:

- Assess the HIV/AIDS situation in Burma and among Burmese refugee communities;
- Assess HIV/AIDS programmes being carried out by INGOs, UN agencies and Burmese organisations in terms of programme activities and effects;
- Strengthen the capacity of such organisations to deal with the HIV/AIDS epidemic;
- Contribute to an improvement of the effects of health programmes in general.

TARGET GROUPS

- Burmese organisations, INGOs and UN agencies with programmes and activities on HIV/AIDS in Burma.

INPUT, OUTPUT AND FOLLOW UP

- A BCN staff will collect information about the different HIV/AIDS related activities beforehand and synthesise this into a (pre)conference paper;
- The inputs during the conference will be published into a conference report. Depending on sensitivity of the inputs and/or upon the request of participating organisations part or all of the inputs will be kept internal;
- Any other follow-up activity proposed by the conference participants, like a lobby paper on HIV/AIDS towards governments.

THE CONFERENCE AGENDA
(for now)

Date: week 42: 17 - 18 October, 2002

Place: Royal Benja Hotel
Sukhumvit Soi 5
Bangkok 10110

Day 1 17 October, 2002.

1. Opening and welcome 10.00 - 10.15

2. Introduction meeting participants
10.15 -
11.00

3. HIV/AIDS in Burma: present situation
11.00 -

5/20/02

11.30

4. Exchange of programmes
11.30 -
12.30
- organisational background
- history of HIV/AIDS programmes
- development in HIV/AIDS programmes
- present HIV/AIDS programmes:
. target group(s)
. objective(s)
. contents
. materials
. expected effects
. relation to health, relief or other programmes
. co-operation with other organisations.

Lunch
12.30 -
14.00

5. Exchange of programmes (continuation)
14.00 -
15.30

6. Conclusions of day 1
15.30 - 16.00

Day 2 18 October, 2002.

1. Exchange of opinions concerning the programmes
10.00 - 11.30

2. Exchange of further perspectives
11.30 - 12.30
. expected developments
. short term perspectives
. long term perspectives
. relation to civil society developments

lunch
12.30 - 14.00

3. Final standpoints
14.00 - 15.00

4. Conference's conclusions
15.00 - 15.30

5. Closing
15.30 - 16.00

sochara

From: <AIDS-INDIA@yahoogroups.com>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Sunday, May 12, 2002 3:03 PM
Subject: [AIDS-INDIA] India's politicians bury differences in fight on HIV/AIDS

India's politicians bury differences in fight on HIV/AIDS
Sat May 11, 6:07 AM ET

By NIRMALA GEORGE, Associated Press Writer

NEW DELHI, India - Faced with an emerging HIV/AIDS epidemic, India's ruling and opposition party leaders buried their differences briefly Saturday to map out a campaign to tackle the disease.

"This is a concern that is shared equally by the central and state governments, as also by all political parties," said Prime Minister Atal Bihari Vajpayee.

He was speaking at the opening of a conference to encourage lawmakers and officials at federal, state and village levels to increase awareness about the disease and how to prevent its spread.

After South Africa, India has the second highest number of HIV/AIDS carriers of any country in the world, with 4 million, according to India's official AIDS control body. The United Nations estimates there are 40 million people infected worldwide.

Experts said that India had lost precious years in the initial stages of the epidemic when authorities denied HIV/AIDS was a problem. Many sufferers have shied away from seeking help because of the stigma of the disease, they said.

"Valuable time was lost in the late 80s when the epidemic could have been caught in its early stages and could have been stamped out, as the government's health agencies were in denial," said Suniti Solomon, a doctor working with a non-governmental organization in western Maharashtra state.

Vajpayee said lawmakers must take the initiative in shedding prejudice and helping HIV/AIDS sufferers lead normal lives. Sonia Gandhi, leader of the opposition Congress party, asked Indians to be "compassionate in their approach and passionate in their commitment to prevent HIV/AIDS."

Gandhi said India, a nation of 1.02 billion, has succeeded in eliminating small pox and will soon have eliminated polio. HIV/AIDS should be tackled with the same zeal, she said.

Lib

5/20/02

The conference, organized by the International AIDS Vaccine Initiative and other groups, brought together parliamentarians, health policy-makers and non-governmental organizations from eight developing countries.

---

sochara

From: <AIDS-INDIA@yahoogroups.com>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Saturday, May 11, 2002 3:00 PM
Subject: [AIDS-INDIA] New CDC Treatment Guidelines for Sexually Transmitted Diseases

New CDC Treatment Guidelines Critical to Preventing Health Consequences of Sexually Transmitted Diseases"
Morbidity and Mortality Weekly Report (MMWR) (05.10.02)

The CDC has issued national guidelines to help health care providers protect their patients from the health consequences of sexually transmitted diseases (STDs). CDC revises the guidelines periodically (approximately every four years). This is the fifth CDC edition of the guidelines. Major recommendations include:
*Chlamydia screening is advised annually for sexually active adolescent (19 years old and under) and young adult (20- to 24 years-old) women. Even without symptoms, screening is recommended, as well as screening older women with a risk factor for chlamydia (a new partner or multiple sexual partners). It is also now recommended that all women with chlamydial infections be rescreened three to four months after treatment is completed.

This is the first time CDC has recommended rescreening in the management of chlamydia. Chlamydia is concentrated among female adolescents. In the United States, millions of cases go unrecognized. Reinfection with chlamydial infection is a key risk factor for pelvic inflammatory disease (PID). PID can damage the fallopian tubes, uterus and ovaries, and cause chronic pelvic pain. One in five women with PID also become infertile. Moreover, women infected with chlamydia are up to five times more likely to become infected with HIV, if exposed. Chlamydia is the most commonly reported infectious disease in the United States; 702,093 cases were reported in 2000.

*Alternative gonorrhea treatments in the wake of increasing drug resistance in California. Gonorrhea is the second most common infectious disease reported to CDC, with nearly 360,000 cases in 2000. Drug-resistant strains are becoming increasingly common in the United States. Ciprofloxacin-resistant gonorrhea was found to be endemic to Hawaii in 2000, when CDC recommended that the state cease its use of fluoroquinolone antibiotics - ciprofloxacin, ofloxacin, and levofloxacin - for treating gonorrhea.

Ciprofloxacin-resistant strains have become so common on the west coast that the use of fluoroquinolone antibiotics to treat gonorrhea is inadvisable in California. Previously, CDC recommended that fluoroquinolones not be prescribed for treating

gonorrhea in Hawaii and in those patients who visited the island state, other Pacific Islands, or Asia, because a substantial proportion of the gonorrhea cases in those areas are resistant to ciprofloxacin. The antibiotics cefixime and ceftriaxone are now recommended as first-line drugs to treat gonorrhea in Hawaii and California.

CDC made these new recommendations after examining data from the Gonococcal Isolate Surveillance Project (GISP), a CDC-sponsored surveillance system, which monitors drug resistance of gonorrhea. The GISP project is limited to several areas in the United States. It is critical therefore that local data are available to guide prescribing recommendations. Most importantly, data from local drug susceptibility testing are necessary to guide local treatment recommendations. CDC requests that local and state public health professionals and health care providers report cases of gonorrhea that are resistant to any recommended antibiotics. If not treated successfully, gonorrhea can cause PID and can facilitate HIV transmission.

*Expanded risk assessment and screening among gay and bisexual men. Recent data have shown a higher frequency of unprotected sex and increased rates of syphilis and gonorrhea in many US cities among men who have sex with men (MSM), many of whom are HIV infected. To highlight the critical need for health care providers to expand screening and treatment of STDs among MSM, the new guidelines include detailed recommendations for this high-risk population.

The new guidelines urge health care providers to assess the sexual risk for all male patients, including the gender of partners. For MSM patients who are sexually active, the guidelines recommend annual screening for STDs - HIV, chlamydia (anal, urethral), syphilis and gonorrhea (anal, pharyngeal, urethral) - and vaccination against hepatitis A and B. More frequent STD screening may be indicated for those who indicate having multiple anonymous partners or having sex in conjunction with illicit drug use.

*New serological tests available to help diagnose genital herpes. An estimated one million people are newly infected with the Herpes Simplex Virus (HSV) each year. While most people have mild or unrecognized symptoms and remain undiagnosed, many individuals seek medical attention when they begin to suffer from the painful ulcers characteristic of this viral disease. Now, new testing procedures may help providers with diagnosing and managing genital herpes type one (HSV-1) or type two (HSV-2).

Since antiviral therapy may benefit individuals with herpes symptoms, providers can tailor counseling and treatment plans to

best fit their needs. Patients infected with HSV-2 (the most common) can choose from suppressive or episodic antiviral treatments. Genital HSV-1, which is often caused by oral-genital sexual contact with a person with an oral HSV-1 infection (fever blister), is much less likely to recur, and treatment may only be needed in patients with initial symptoms.

HSV may play a major role in the spread of HIV. HSV stays in the body indefinitely and is incurable. In the United States, an estimated 50 million people are infected.

*Prevention of STDs. The guidelines encourage health care providers to focus on risk assessment and counseling in addition to the clinical aspects of STD control - screening and treatment. Providers are encouraged to use client-centered counseling approaches tailored for each of their patients. To avoid the spread of STDs, the guidelines suggest patients should abstain from oral, vaginal or anal sex. Patients who are sexually active should be counseled to be in a mutually monogamous relationship with an uninfected partner or use a condom during each sexual act.

*The use of Nonoxynol-9 (N-9). Recent studies have found that frequent use of N-9, a spermicide contraceptive, can cause genital lesions (in the vagina) and, therefore, may increase the risk of HIV transmission. It has also been found to cause damage to the lining of the rectum, providing an entry point for HIV and other STDs.

Spermicides - especially those that contain N-9 - should not be used for STD prevention. Furthermore, N-9 lubricants should not be used during anal intercourse. While the level of N-9 used as a lubricant in condoms is much lower than the level found to be harmful, condoms lubricated with N-9 spermicide also are not recommended because they have a shorter shelf life, cost more and have been associated with urinary tract infections in women. However, previously purchased condoms with N-9 can be used, provided they have not passed their expiration date, since the protection provided by the condom against HIV outweighs the potential risk of N-9.

The 2002 Guidelines for the Treatment of Sexually Transmitted Diseases can be ordered at http://www.cdc.gov/std.

---

sochara

From: <AIDS-INDIA@yahoogroups.com>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Wednesday, May 15, 2002 2:41 PM
Subject: [AIDS-INDIA] US Lawmakers Propose New Protections for Human Research Subjects

Lawmakers Propose New Protections for Human Research Subjects

WASHINGTON (Reuters Health) May 09 - Human subjects would have a legal right to be made aware of researchers' conflicts of interest under a bipartisan bill introduced in the US House on Thursday. The proposal would require researchers conducting studies with tax dollars to disclose their conflicts of interest both to patients and to institutional review boards (IRBs). Similarly, members of IRBs would have to report their financial ties with industry to academic institutions.

The bill, introduced by Reps. Diana DeGette (D-CO) and James Greenwood (R-CA), also writes into law the federal Office of Human Research Protection. The office already operates within the Department of Health and Human Services but has no authorization from Congress.

The bill is a largely a rehash of a proposal introduced in the US House in 2000. But the new legislation avoids several controversial areas that thwarted agreement among lawmakers in the past.

Momentum for passing human research rules in Congress has mounted in the wake of several highly publicized deaths of patients involved in experiments at US universities. They include the death of 18-year-old Jesse Gelsinger during a gene therapy trial at Baltimore's Johns Hopkins University in early 2000.

The proposal applies the Common Rule -- a set of federal research regulations -- to all public and private research conducted at hospitals and academic medical centers and by contract research organizations.

It allows IRBs to pay for heightened responsibilities by taking overhead costs out of grant money coming from funders like the National Institutes of Health. The money could go to enhanced education and training of members and new federal reporting requirements ordered under the proposal.

The bill avoids forcing IRBs to obtain federal accreditation before reviewing research. Some Democrats in the Senate, which is working on its own research protection legislation, have called for such a requirement.

Pob 2/5

5/20/02

Sponsors said that they worked closely with the health industry and academic research groups in crafting the legislation. Those groups have warned that overly restrictive laws could slow down important research.

"The goal of this legislation is to improve, and not to hinder, medical research," DeGette said.

The bill calls on federal officials to harmonize government research regulations that have been a source of confusion for some investigators. It would compel the HHS Secretary to come up with regulations that find a middle ground between rules in the Food, Drug and Cosmetics Act, which governs privately funded research, and the Public Health Services Act, which governs publicly funded experiments.

Recommendations issued in April 2000 by the HHS Inspector General urged Congress to address conflicts of interest, mounting IRB workloads, and spotty federal oversight of human studies.

"We've adopted virtually every one of the recommendations," said Rep. Greenwood, who chairs the Energy and Commerce health subcommittee.

The new proposal includes no civil or criminal penalties on researchers, institutions, or companies who break the law. "We want to see how well compliance works with what we've proposed," one House Democratic aide said.

Greenwood said that the Biotechnology Industry Organization has thrown its support behind the proposal, though the group was not available to comment on the bill by press time.

---

sochara

From: Amrik Kapoor <amriksingh35@yahoo.co.uk>
To: <aids-india@yahoogroups.com>
Sent: Saturday, May 18, 2002 5:17 PM
Subject: [AIDS-INDIA] Re: AIDS vaccine raises many questions

Dear all,

The vaccine is still miles away. Since in view of catastrophic repercussions of the AIDS pandemic, the vaccine is badly needed, such an initiative or news will have a lot of reamifications. Therefore the concerns express in the times of india news are not without basis.

But as pionted out rightly that the vaccine is miles away and raising eyebrows so curiously is not fair, even though granted that it is a great public concern.
To me the announcement made at the press conference on the eve of the constitution of a Parliamentarians forum on AIDS is an encouraging news on the face of it.

Unless something is started the deep anxiety in the minds of the affected and infected cannot be set at rest. I too feel that strict adherence to ethical
demands must be the rule and nothing on possible side effects of the trial dose should be hidden and enlightened and informed acceptance must be ensured
without any hesitation whatsoever.

I am not a scientific expert and would not like to support or counter the move without knowing its all implications. I have seen LAVI in active parleys in
the African countries. For India also, it is very crucial and I concede that mere need should not dictate the means and the ends. Public must be kept
well informed about both sides of the coin so that this effort receives the much needed credence.

sincerely
Amrik
E-mail: <amriksinghkapoor@hotmail.com>

5/20/02

sochara

From: Jagdish Harsh <jamworld@vsnl.com>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Friday, May 17, 2002 10:45 PM
Subject: [AIDS-INDIA] Mumbai Hospital will distribute free AIDS drug

Mumbai hospital will distribute free AIDS drug

The Asian Age 17 May, 2002:MUMBAI, MAY 16: The K.J. Somaiya Hospital and Medical College will be the first private hospital to offer Nevirapine prophylaxis to patients of its gynaecology department free of cost.

The drug has proved effective in preventing the transfer of HIV/AIDS from pregnant women to their unborn foetus and is being promoted by the Maharahstra District AIDS Control Society as part of a programme to prevent and control the spread of AIDS.

It has been found that there is a 25 to 14 per cent chance of HIV being transmitted from mothers to their babies in developing countries, as opposed to a 15 to 25 per risk in developed countries due to the practise of breast feeding. 100,000 HIV-infected women deliver every year, leaving the world with 30,000 infected infants.

In a study conducted between April 2000 and September 2001 in 11 institutions in Maharashtra, Tamil Nadu, Andhra Pradesh, Karnataka and Manipur by the National AIDS Control Organisation and the government of India, 40 per cent of the woman in ante natal care said their spouses had multiple sex partners. The programme was conceived by the National AIDS Control Society under the guidance of UNICEF and is being worked out through state level bodies like MDACS.

Dr. Shanta Shivkumar of MDACS said: "The project has been running in other medical colleges like Nair, KEM, and JJ Hospital. But among private hospitals, Somiaya is the first one."

Under the programme, certain centres are selected and provided with basic infrastructure such as diagnostic kits, a refrigerator, infant meter and of course, the drug. Speaking about the rationale behind the project, Dr Lalit Mehta, dean of K.J. Somaiya Hospital and Medical College, said: "The disease is being fought at different levels. Since there is no treatment available, the only cure is prevention. Banners and slogans are one way by which prevention can be done. Another front is the prevention of transmission from mother to baby.

Dr.Jagdish Harsh (jharsh@afxb.org)
Director of Administration and Operations
François-Xavier Bagnoud INDIA (www.fxb.org)

sochara

From: Integration Society <integration99@rediffmail.com>
To: <aids-india@yahoogroups.com>
Sent: Friday, May 17, 2002 9:38 AM
Subject: [AIDS-INDIA] Re: Questions from the Fire Brigade staff

Dear Mr. Shadab
This is in response to questions received by you from the fire brigade staff. I asked our Advisors working in the field of HIV/AIDS and their answers are given below :

1) Body fluid of a dead person is likely to have lost potency and hence the virus may not be able to live.

2) To get infected you need to get it inside your body fluid. If you have a cut your blood will be gushing out and not in hence I don't think you have any chances of getting infected.

Others' comments on these points would be welcome.

Regards
Pawan Dhall
Secretary, Integration
E-mail:<integration99@rediffmail.com>

Feb 20/5

sochara

From: John O. Lall <jol@softhome.net>
To: AIDS INDIA <AIDS-INDIA@yahoogroups.com>
Sent: Friday, May 17, 2002 5:54 PM
Subject: [AIDS-INDIA] Re: Questions from the Fire Brigade staff

Dear Mr. Shadab:

In addition to the feedback from Pawal, i would like to suggest the fire brigade staff to use rectified spirit and rub their hands first before holding any decomposed body. Rubbing spirit would help identify cuts which cant be seen with the naked eye. If you have cuts or wounds, using surgical gloves would be a wise precaution. If the department could supply the rectified spirit in every Fire Engine that goes to the scene of the indicidents that would help the brave men of our Country who are enlisted in the Fire Department prevent themselves from infection.

John
El Shaddai Resource Centre
e-MAIL: jol@softhome.net

Feb 20 15

sochara

From: khsrc <khsrc@sancharnet.in>
To: <aids-india@yahoogroups.com>
Sent: Thursday, May 16, 2002 2:26 PM
Subject: [AIDS-INDIA] KSSP- AIDS Candle Light Memorial inTrivandrum.

[KSSP is one of the largest people's science movement in the country and it is significant that KSSP is geting involved in AIDS Candle Light Memorial and Dr B.Ekbal Vice chancellor, University of Kerala will deliver the memorial oration. Moderator]

Dear All,

On May 19th thousands of individuals in more than 1500 communities in 85 countries will participate in the world's largest and eldest annual grassroots HIV/AIDS event. The International AIDS Candle Light Memorial is designed to honor the memory of those lost to HIV/AIDS, show support for those living with HIV/AIDS, raise awareness of HIV/AIDS and mobilize community involvement in the fight against HIV/AIDS .

Thrani , KSSP and KHSRC are jointly organising the International AIDS Candle Light Memorial on Sunday 19th May 2002 at 5 pm. The venue is Parishad Bhavan (KSSP office), Kuthiravattom Lane,Trivandrum.

Dr B.Ekbal Vice chancellor, University of Kerala will deliver the memorial oration. Kindly make it convenient to attend the function.

With Regards from

Thrani

Kerala Sastra Sahitya Parishad
Kerala Health Studies and Research Centre
E-mail: <khsrc@sancharnet.in>

5/20/02

sochara

From: <AIDS-INDIA@yahoogroups.com>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Saturday, May 18, 2002 6:50 AM
Subject: [AIDS-INDIA] AIDS prevention in Kashmir: A jihad against Aids

A jihad against Aids

Campaigners in Kashmir, desperate to stop the disease spreading, are enlisting the unlikely services of conservative holy men

Amrit Dhillon. Guardian. Thursday May 16, 2002
If the best vehicle for educating a Muslim population about Aids is one that carries authority, enjoys mass reach and possesses the power to convince, who better than the person who leads prayers at a mosque? Particularly in a predominantly Muslim region such as the Kashmir Valley?

That, at least, is the thinking behind the latest campaign to stop Aids spreading in this part of India. Imams are being enlisted because every Friday they preach to a group of captive and receptive Muslim males. Before prayers, they deliver the khutba, or sermon, during which, in addition to religious topics, they may choose to educate their congregations on education, civic sense, hygiene or health.

"When a polio vaccination programme is going on, for example, imams often use the khutba to remind people to get their children vaccinated," says Kamal Faruqi of the Muslim personal law board in New Delhi. "The turnout is higher than it would be otherwise. If this platform is used for spreading Aids information, it could be really effective."

Aids campaigners in Kashmir are hoping that imams preaching the need for sexual restraint and the use of condoms will be more effective than leafleting or radio and television campaigns have been so far in Kashmir's deeply conservative society. The views of Sayeed Agha, a teenager in Srinagar, are typical. He says he has never discussed the topic of safe sex with his parents. "They would think I was being disrespectful."

Although the Kashmir Valley has one of the lowest rates of Aids in India, the latest figures from the National aids control organisation (Naco) suggest that the number of HIV-positive cases has increased by 66% in the past four years. A UN Aids report puts India's HIV population at 4.1 million, the largest in the world after South Africa. Experts believe that the epidemic could shatter the country. But so far, the government has been in stubborn denial, with some

5/20/02

Lib
20/5

5/20/02

officials even claiming that the UN figures are "part of a western

conspiracy to trap India into dependence on multi- nationals for anti-Aids drugs".

What frightens Aids campaigners is the widespread ignorance, a fact that emerged during the first "orientation" workshop held last month in Srinagar for 25 imams chosen to lead the project. "The aim of the workshop was to raise their level knowledge about the virus, ethical issues, and the impact it is having on human lives," says Ashok Parmar, the project director at the Jammu & Kashmir Aids control society. "Many of them were shocked at the tragedies unfolding every day here. In fact, one of the younger imams turned angrily to an older imam sitting next to him and said 'if things have got to this stage, it's because you lot have kept quiet about it'. The whole thing was a kind of wake-up call for them."

The plan to enlist imams has been inspired by a hugely successful experiment in Africa. It involved motivating and training imams in Uganda, Senegal and Ghana who then went to their mosques and told people how to avoid getting Aids; in Uganda, it was called the "Jihad Against Aids". The model, hailed by the UN, is now inspiring other countries with large Muslim populations to devise a specifically Islamic approach to Aids prevention that combines health information with Koranic teachings proscribing adultery and pre-marital sex.

The first training workshop for Kashmiri imams will be held next month. "There is really so much in the Koran that imams could use to buttress the whole Aids message," says Sayeeda Hameed, of the Muslim women's forum. "The only drawback is that it leaves out women, who are not allowed to pray in mosques, but they can be reached in other ways. And if men become aware, that's half the problem solved anyway."

But by far the most contentious issue, both in Africa and in Kashmir, is the use of condoms. Imams fear that recommending them could promote sex outside marriage. It took Aids project leaders in Africa a year to convince imams that the condom was only being promoted after the failure of the first two lines of protection - abstaining from sex and having sex only within marriage. "Don't forget that human beings have weaknesses," Islamic leaders were told. Needless to say, the message was ignored.

Then campaigners tried another tactic, pointing out that knowledge of condoms did not imply that they would be used irresponsibly. After all, they argued, Muslims know all about alcohol but it doesn't mean they run around guzzling the stuff. This seemed to do the trick. After much theological angst, Islamic leaders consented to let imams promote condom use. In Kash mir, meanwhile, Parmar and his colleagues will have to wait to see what stand the imams take.

Dr Mohammed Shaukat, who works with Naco, foresees no major problem although he acknowledges that Islamic thought on condoms varies considerably. "It will look very odd if someone who has been thundering against the use of condoms, even for family planning, suddenly says that the Aids threat makes using them all right, so the imams will have to take the masses with them gradually. But I don't

see why it should be a problem, particularly if he warns them that condoms are not a licence for licentiousness."

Another vital message the imams will be expected to put across is the need for humane behaviour towards those who are HIV-positive. Parmar says imams will be urged to teach compassion and to condemn the tendency to stigmatise. Cruelty, bred of fear and ignorance, is widespread in India, from the cities to remote villages. When Govind Singh, a labourer who contracted the virus in Bombay, returned to his village in Uttar Pradesh last year members of his own family and almost the entire fear-crazed population dragged him into a gote (an enclosure where cows and goats are kept) and locked him up. His wife and children threw chapattis to Singh. In the last stages, he was usually lying on the floor, unable to stand or wash. He died a few weeks later.

Mufti Nazir Ahmed, a religious scholar in Kashmir who has written a booklet on Islam and Aids, conducted the first workshop and spoke at length about the human suffering. "I told them about a migrant labourer who caught the virus from a prostitute and came back and infected his wife. When he found out about his wife, he tried to kill her, their two children and himself with poison. They died but he survived. These are the tragic stories that need to be exposed."

Kashmir is a delicate area for Aids campaigners for another reason, too. Muslim separatists have been fighting for secession from India for years. Extremist groups have proliferated and the atmosphere is volatile. It would be very easy for a Muslim fanatic to portray the way Islam can be a tool in the war against Aids as another mark of its "superiority" to other faiths. For example, one Muslim journalist who attended the workshop went away and wrote an ecstatic report on "how only Islam, because of its power and majesty, can be effective against this scourge".

Even Mufti Nazir Ahmed, in his booklet on Islam and Aids, talks of how 15 centuries earlier, the prophet had predicted the "spread of a terrible and hitherto unknown disease as a result of people indulging in obscene practices".

So some things about the project need to be watched, a point conceded by Parmar and his colleagues who say it will be monitored closely. As one local government official said: "We've got enough problems here without turning the fight against Aids into an explosive issue."

http://www.guardian.co.uk/Archive/Article/0,4273,4414325,00.html

---

Subject: [SAATHII] Declaration from the Policy Makers Conference
Date: Mon, 20 May 2002 20:10:58 -0000
From: emrafi@md4.vsnl.net.in
Reply-To: saathii@yahoogroups.com
To: saathii@yahoogroups.com

(This Declaration was issued at the International Policymakers Conference on HIV/AIDS, May 2002 in New Delhi.)

A WORLD WITHOUT AIDS
PARLIAMENTARIANS' COMMITMENT TOWARDS A WORLD WITHOUT AIDS
May 11-12,2002

The HIV/AIDS epidemic constitutes a global health emergency of unprecedented magnitude that impacts economic and social development worldwide and in particular the developing world. To combat this global tragedy, a comprehensive strategy is needed to focus on issues including health care, prevention, support, and treatment, within a legal framework designed to protect human rights. With 15,000 new HIV infections daily, there is no time to delay.

We, the undersigned, pledge to provide leadership and take concrete action to address the complexities and challenges presented by the epidemic, building on the UN Declaration of Commitment on HIV/AIDS' and other international, regional, and national agreements.

We pledge to actively involve affected communities, including organizations of people living with HIV/AIDS in policy formulation and implementation.

We pledge to inform, educate, communicate and develop strategies, working closely with affected communities, to promote effective AIDS prevention initiatives.

We pledge to identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment, poverty, illiteracy, lack of empowerment of women, and all types of sexual exploitation.

We pledge to promote social acceptance and respect for the dignity and rights of all people affected by HIV/AIDS and to oppose all forms of stigma and discrimination.

We pledge to increase awareness and upgrade knowledge in societies inhibited by ignorance and deep seated cultural and social prejudices.

We pledge to make every effort to provide progressively and in a sustainable manner, the highest attainable standard of treatment and care to people living with HIV/AIDS.

We pledge to support research and development of AIDS vaccines and other prevention technologies, keeping in mind the pressing needs of the developing world.

We pledge to support the acceleration of scientific progress, adhering to the highest ethical standards in the research, development, delivery, and use of prevention technologies.

We pledge to work to build infrastructure and take other measures to ensure access to and effective use of affordable, life-saving AIDS treatment and future AIDS vaccines when they become available.

21/5/02

We pledge to create an enabling environment and build capacity among policymakers in our respective countries, and in particular, seek to strengthen legislation and regulatory systems and procedures.

We pledge, as members of a global community, to strive for equitable distribution of essential resources needed to control the AIDS epidemic and to enhance the quality of life of people living with HIV/AIDS.

We pledge to mobilize political commitment with peoples' representatives to propel a comprehensive response at notional, regional, and global levels.

We pledge to promote collaborative efforts among governments, peoples' representatives, private industry, international agencies and nongovernmental organizations to move forward the commitments made in this Declaration.

We pledge to put in place ongoing mechanisms for the implementation, monitoring, and review of the Delhi Declaration.

(This Declaration was issued at the International Policymakers Conference on HIV/AIDS, May 2002 in New Delhi.)

Subject: |SAATHII] FOCUSSING ON YOUNG ADULTS
Date: Tue, 21 May 2002 22:25:58 +0530
From: "Dr. E. M. Rafique" <emrafi@md4.vsnl.net.in>
Reply-To: saathii@yahoogroups.com
To: <aids-india@yahoogroups.com>, "Saathi egroups" <saathii@yahoogroups.com>
CC: "Dr. Subha Raghvan, Ph.D." <subharaghvan@aol.com>

INTERNATIONAL POLICYMAKERS CONFERENCE ON HIV/AIDS

FOCUSSING ON YOUNG ADULTS

"The only universal definition of adolescence is to mark it as a period in which a person is no longer a child, and not yet an adult".

INTRODUCTION

At an estimated one billion young adults, today's world has the largest adolescent population in history. The words - youth and adolescent - are broad and gender neutral. But they connote a homogeneity that does not exist. They encompass a variation of gender, age, needs, marital status, geographic location and socioeconomic status and conditions.

"Adolescence (10- 19 years) is a powerfully formative time of transition to adulthood. What happens in this age, whether for good or ill, shapes how girls and boys live out their lives as women and men - not only in the reproductive arena, but in the social and economic realm as well. "

Yet, what adolescents do share across these boundaries is a barrier to information and counselling, skills and services. This covers a wide spectrum, from nutrition necessities, drug abuse, literacy, sanitation, employment opportunities and maternal mortality to sexually transmitted infections (STIs), including HIV/AIDS.

The centre of the adolescent problematique remains sexual and reproductive behaviour. But concerns about adolescent fertility have been demographically motivated. In particular, gender issues have been greatly neglected despite the fact that many more girls marry early and have little or no control over their bodies and face high risks associated with early sexual activity. Gender differences also ensure that the world expands for boys and contracts for girls. Boys gain autonomy, mobility, opportunity and power (including power over girls' reproductive and sexual lives); girls are systematically deprived of these assets. Young women and girls' social and economic disadvantages have many direct and indirect influences on their sexual and reproductive health.

Adult discomfort with young people's sexuality is almost universal. For sexually active young people, particularly those who are not married, obtaining reproductive health services is even more difficult than gaining accurate, culturally relevant, age-specific information. Few clinics are designed, prepared or even willing, to provide services to young people. Many young people are left with an unmet need for contraception and other reproductive health services. Growing concern within the health community about the alarming increase in the number of HIV-infected youth, particularly females, have spawned the need for research on adolescent sexual behaviour and reproductive health.'

THE HIV/AIDS BURDEN ON YOUNG ADULTS
While not recognized at the onset, the HIV/AIDS epidemic is clearly the worst among young adults. Over 20 years, more than 60 million people have been infected with HIV/AIDS; half of them between the ages of 15 and 24.

Statistics show that every day over 7,000 young people are being infected with HIV/AIDS, about five per minute. Worldwide, ages 15-24 account for 30% of all people living with HIV/AIDS. In South and South-East Asia, the number of young people living with HIV/ AIDS is 1,500,000. WHO estimates that half of all people infected with HIV are younger than 25 years and, in developing countries; up to 60% of all new infections occur among ages 15-24. Every day, 7,000 young people worldwide acquire the virus, which amounts to around 2.6 million new infections over one year among youth. Some 1.7 million of these are in Africa and 700,000 in Asia and the Pacific. New infections among females outnumber males by a ratio of 2 to 1.1 Such numbers underscore the urgency of addressing HIV/AIDS among youth and reaching out to them with reproductive and sexual health information and services.

WHY ARE YOUNG ADULTS VULNERABLE TO HIV/AIDS?

Available studies confirm that young people - both male and female, married and unmarried - are highly vulnerable to HIV/AIDS because of various physical, psychological, social and economic reasons. Young people tend to indulge in high-risk sexual behaviour because of a lack of awareness and an embarrassment of admitting ignorance.

An inconsistent use of condoms is reported for reasons of reduced pleasure and the inability to use a condom when intoxicated. Substance abuse - alcohol and drugs, which are experimented with or taken under peer pressure - leads to a further laxity in protection measures.

High-risk behaviour also results in STIs. Each year, one out of every 20 adolescents contracts an STI, some of which can cause lifelong health problems (such as infertility) if left untreated.'

Once infected with an STI, the young - especially the unmarried - may ignore the problem.

An untreated STI in either partner multiplies the risk of HIV transmission by up to 10-fold.' This is because it is easier for HIV to penetrate through an already existing wound or sore caused by an STI.

VULNERABILITY OF YOUNG WOMEN

BIOLOGICAL VULNERABILITY

Research shows that the risk of becoming infected with HIV during vaginal intercourse without a condom is as much as 2-4 times higher for women than men.

As compared with men, women have a bigger surface area of mucosa exposed during intercourse to their partner's sexual secretions. (In women, the genital mucosa is the thin lining of the vagina and cervix.) Semen infected with HIV typically contains a higher concentration of virus than a woman's sexual secretions. This makes male-to-female transmission more efficient than female-to-male. Younger women are at even greater biological risk. Their physiologically immature cervix and scant vaginal secretions put up less of a barrier to HIV.

Tearing and bleeding during intercourse, whether from "rough sex", rape or prior genital mutilation (female "circumcision") multiplies the risk of HIV infection. Throughout the world, women run a similar risk from unprotected anal intercourse. Sometimes preferred because it preserves virginity and avoids the risk of pregnancy, this form of sex often tears the delicate tissues and affords easy entry to the virus. Between half and four-fifths of STI cases in women go unrecognized because sores or other signs are absent or hard to see and because women, if they are monogamous, do not suspect

they are at risk. Even when symptomatic, STIs in women often go untreated.

SOCIAL VULNERABILITY

Biologically vulnerable does not mean unprotectable. Past experience has shown that both men and women can be helped to avoid HIV. Around the world, infection rates have been lowered by screening blood for transfusion, by frank information about how HIV can spread, by clear prevention messages urging abstinence, fidelity or safer sex, by condom promotion, by needle exchange programmes for drug users, and by encouraging and enabling people to get prompt care for STIs.

However, for millions of women, many services are inaccessible or unavailable, and many of the messages irrelevant or inapplicable. Often, young girls are brought up with little understanding of their reproductive system, let alone the mechanics of HIV/STD transmission and prevention. Girls are at a disadvantage even when human sexuality is taught at school, because in many countries they are taken out of school earlier than boys. At the same time, girls are taught to leave the initiative and decision-making in sex to males, whose needs and demands are expected to dominate. Male predominance often comes with a tolerance for violent sexuality. It also internalizes double standards whereby women are blamed or thrown out for infidelity, real or suspected, while men are tacitly expected or allowed to have multiple sex partners.

A woman, who is economically dependent on her partner, even if she suspects he has a STI or HIV, finds it difficult to refuse him sex or ask him to use condoms. By doing so, she is breaking the conspiracy of silence that surrounds his extramarital activity - or, even worse, intimating or admitting that she was unfaithful. And while some men agree to use condoms, many react with anger, violence or abandonment. A further dilemma is that condoms are incompatible with pregnancy.

Failure to respect the human rights of girls and women in terms of equal access to schooling, training and employment opportunities reinforces their powerlessness and economic dependence on men.

ECONOMIC VULNERABILITY

Young people living in poverty, or facing the threat of poverty, may be particularly vulnerable to sexual exploitation through the need to trade or sell sex in order to survive. Estimates suggest that as many as 100 million young people under the age of 18 live or work on the streets of urban areas throughout the world. Many are at heightened risk of acquiring STIs, including HIV. Street children in Jakarta, Indonesia, have reported that being forced to have sex is one of the greatest problems that they face living on the streets.

Young girls forced or sold into sex work, even before puberty, are generally unaware of the HIV/AIDS risk and unable to take protective action. The sexual exploitation of girls is one of the most pernicious forms of child abuse. Admittedly, not all sex work is forced. Many women turn to occasional or steady sex work as an alternative to dire poverty, exchanging sex for the basic necessities of life for themselves and their children. Indeed, for girls and women in many cultures, sex is the currency with which they are expected to pay for life's opportunities, from a passing grade in school to a trading license or permission to cross a border.

While many sex workers risk violence or loss of income if they request condom use, in some places sex workers have banded together to demand condoms from all clients, or work in brothels where a "condoms-only" rule has been specified. Ironically, these women may enjoy more protection than housewives who have no "social permission" to request or negotiate safer sex.

PREMARITAL SEXUAL BEHAVIOUR

As far as the unmarried population is concerned, although sexual awareness and attitudes remain poorly explored topics, and available findings are not entirely representative, between 20-30% of all males and up to 10% of all females are sexually active during adolescence before marriage.

Among sexually experienced males, a substantial proportion report multiple partners, and between 15-25% report relations with sex workers. Male-to-male contact is also reported (60% in one study). Despite this high-risk profile, condom use is rare and irregular, even among the educated. Misconceptions abound, as do the risk of infections.

MARRIAGE PATTERNS

Early marriage continues to be the norm in India. Despite laws stipulating the legal age for marriage as 18 for females and 21 for males, the median age at marriage for women is 16 years and as many as 40% of all women aged 15-19 are already married. In rural areas, almost two in three females aged 20-24 were married by age 18; in fact, a third were married by the time they were 15, and 15% before they were 13."

HEALTH RISKS OF EARLY MARRIAGE AND CHILD BEARING

Early marriage results in about half of all young women becoming sexually active by the time they are 18. Married adolescent women face higher reproductive health risks, as they are more likely than older women to suffer obstetric complications. Moreover they are subjected to considerable sexual violence. Recent evidence suggests that they may also experience unexpectedly high rates of STIs (I 8%) and RTIs (49%)."

AWARENESS OF CONTRACEPTIVES AND SEXUAL AND REPRODUCTIVE HEALTH

Adolescents tend to be extremely poorly informed about their own sexuality and physical well-being, their health and their bodies. Moreover, if informed, their knowledge is incomplete and confused. Low rates of educational attainment, limited sex education and inhibited attitudes towards sex only accentuate this ignorance.

As for HIV/AIDS, while there is recent acknowledgement of the urgent need to deal with this 'invisible epidemic'. there is little or no understanding among educational authorities of how to communicate HIV/ AIDS related culturally sensitive information to adolescents.

NON CONSENSUAL SEXUAL ACTIVITY

Although data is sparse, there is evidence that a disturbingly large number of adolescent girls are subjected to rape and forced prostitution. It is estimated that almost 25% of rape victims are young adolescents under 16 years, and 20% of all commercial sex workers are adolescents. Small-scale studies are rare, but evidence from one such study points to alarming rates of sexual abuse against female children and adolescents.

USE OF SERVICES BY ADOLESCENTS

The reproductive health needs of adolescents have not yet been seriously considered by the government, municipal authorities or voluntary agencies. Even medical and health professionals are ignorant about the subject and how

to deal with adolescents. Few materials exist that are suited to the needs of the Indian adolescent. Adolescent and pre-marital counselling services

cultural inhibitions surrounding the subject, few adolescents seek services for their reproductive and sexual problems, information and counselling needs. (adapted from "Women's Reproductive Health in India, eds. Radhika Ramasubbhem and Shireen J. Jeejebhoy, Centre for Social and Technological Change, New Delhi, Rawat Publications, 2000).

WHAT CAN BE DONE

ADDRESSING REPRODUCTIVE AND SEXUAL HEALTH NEEDS

Intensify efforts to postpone early marriage among adolescent girls:
It is important to raise awareness among girls, their parents, schools and communities, of the harmful health consequences of early marriage and childbearing. It is also important to make people aware of the legislation prohibiting marriage for girls less than 18 years.
Girls' social and economic disadvantages are the driving forces behind early marriage and childbearing. Because the health and family, planning communities have generated most of the interest in adolescence, much of the adolescent policy remains centered in the health sector Yet, thoughtful investment in the education sector is arguably the most powerful governmental instrument for improving the life of adolescents and empowering them, particularly girls.

Address the lack of autonomy of married adolescent girls:
Service providers must be trained to address the special and sensitive needs of married adolescent girls and recognize their powerlessness within their husband's family. It is equally important that service providers must treat pregnant adolescents as a high-risk group and monitor their pregnancy closely. Since married girls have low decision making autonomy in their husband's family, providers should also try and raise awareness among the more powerful decision-makers like husbands and mother-in-laws.

Address the nutritional needs of adolescent girls:
Gender disparities in feeding patterns and anaemia are widespread in India. Interventions should be sought to provide iron supplements to all poor adolescent girls, irrespective of their pregnancy status.

Provide education to adolescents on anatomy and physiology:
Create innovative ways of providing information on changes during puberty, menstruation, conception, infections, sexuality, contraception and the prevention of STIs, in a non-threatening environment. Adult resistance to education on these sensitive topics also needs to be overcome in resourceful ways.

Respond sensitively to the special needs of unmarried adolescents:
It is critical that privacy and confidentiality are supported by legislation where necessary. This is of crucial importance in cultures where adolescent sexual activity outside marriage is considered unacceptable, especially for girls.

ADDRESSING THE HIV EPIDEMIC

Building support for HIV prevention
Until more leaders speak out about the HIV crisis among youth and give it top priority for funding and action, there is little hope of a solution.

Offering education and communication
Young people need help to become aware of risks related to HIV/AIDS and how to avoid them.

information and foster risk avoidance skills, such as delay of sexual debut, abstinence, and negotiation with sex partners. HIV/AIDS education should begin early, even before children become sexually active.

Addressing cultural and social norms
Many traditions and cultural practices increase risks for young people more than adults, and for young women even more than young men. Efforts to involve communities and to change social norms are as crucial as efforts to reduce individual risk-taking.

Promoting condoms for dual protection
Condoms - the only contraceptive method that can protect against HIV as well as against pregnancy are vital to controlling HIV/AIDS among youth. Condoms should be widely accessible, and their use promoted among sexually active people of all ages."

Need for research
Any interventions, programmes and projects undertaken have to be based on solid and relevant research. The urgent need for more community-based behavioural research along with biomedical studies throughout the country cannot be over-emphasized. It is also important that the research is conducted in a proper manner. This means that it should be:
Legal and ethical - conducted in a conducive, non-threatening manner, with care towards protection of human rights.
Professional and standardized - methodology, structures and evaluations should be constructed in a standardized fashion that allows for wider regional analysis and comparison.

Prevention programmes for working with young people:
Help adults (such as parents and teachers) to improve their skills and increase effective communication about sex with young people.
Work with young people in schools.
Work with young people out of school. Many young people in developing countries do not attend school consistently, especially those from communities impacted by war, famine and other catastrophes, including HIV/AIDS.
Work with young people at heightened risk, such as those living in abject poverty, in refugee camps and on the streets.

Principles for success of HIV prevention programmes with young people:
Challenging prevalent ideologies of masculinity and femininity that prescribe virginity in unmarried girls and promiscuity for boys.
Challenging unhelpful stereotypes about young people and adolescent sexuality.
Encouraging better and more open communication between young people and adults. Sex education should include messages about safer sex as well as abstinence. ,
Training and support for teachers delivering HIV-related education programmes.
Improved access to non-judgmental and user-friendly health services, and to good quality condoms.
Reducing cost of services.

JOHN D. AND CATHERINE T. MACARTHUR FOUNDATION

WORK ON ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH

SAATHI: FOCUSSING ON YOUNG ADULTS

The MacArthur Foundation has been a supporter of the comprehensive reproductive and sexual health and rights approach for the last few years. This inclusive paradigm places women's well being at the centre of population policy, and emphasizes the rights of individuals to determine and plan family size. Central to the approach is the belief that people will make wise individual choices if they have information and access to adequate

reproductive decisions.

Two thematic focus areas have been identified for the India Population Programme:
a. achieving reduction in maternal mortality rates; and
b. ensuring the reproductive and sexual health and rights of young people.
The Foundation in India hopes for inter-linkages, synergy and clustering between the two theme areas and recognizes the need to work at different levels: building models on the ground; scaling up these models over time: undertaking research and converting findings to effective training programmes; and networking for advocacy at the state and national levels.

Dr. E. Mohamed Rafique.vcf

Name: Dr. E. Mohamed Rafique.vcf
Type: VCard (text/x-vcard)
Encoding: quoted-printable

sochara

From: joe_thomas123 <joe_thomas123@yahoo.com.au>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Saturday, May 18, 2002 6:58 AM
Subject: [AIDS-INDIA] HIV/AIDS Telephone Counselling Service at the University of Kerala

HIV/AIDS: Empowering the Youth. Telephone Counselling Service
University of Kerala, Thiruvananthapuram, Kerala

Dr.B.Ekbal, Vice-Chancellor, University of Kerala

The Telephone Counselling Service of the University of Kerala has the following objectives:

1. To provide information on Reproductive and Sexual Health of adolescents and youth, HIV/AIDS, Sexually Transmitted Infections, socio-psycho-familial problems, anxieties, suicide tendencies, gender, sexuality and other related areas.

2. To facilitate educational Counselling and guidance to students and parents.

3. To help sort out problems of youth and reduce their anxieties.

4. To recommend referrals in the case of the needy.

5. To offer solace to those who are utterly frustrated and miserable.

At an average the service replies 150 calls a day per month. Out of these more than 50 percent are HIV risk calls. The nature of risk arises from multiple sex partners, homosexuality among men (MSM), child sex abuse and substance abuse. Very few calls came from AIDS patients.

The Telephone Counselling Service organized under the Centre for Adult Continuing Education and Education (CACEE) of the University concentrates on the following types of service for HIV/AIDS:

1. Informative: Under this type of calls we give information on the nature of contraction of HIV, the types of tests for HIV detection including the Voluntary Counselling and Testing Centre (VCTC) facility recently established in the Public Health Laboratory, circumstances and risk factors leading to HIV infection.
2. Preventive: For this type of calls we explain the clients about abstinence, safe sex, responsible sexual behaviour, and avoidance of risk factors including Commercial Sex Workers and multiple sex partners and avoidance of marriage in the case of unmarried HIV infected clients.

3. Reassuring: This is a confidence building process for the clients who are badly in need of Counselling, a sort of 'dial before you dig'. Clients are thwarted from unwanted suicide attempt and hope

that life is instilled in them. They are also given Counselling to seek medical assistance and mingle in society without any possibility for contracting HIV to others.

Impact of the Service

The service is found to be highly useful and society at large as noted from the repeated calls that we get from clients. They take the service in full confidence and confide in us their innermost sorrows and anxieties. Some clients have demanded personal Counselling as they were convinced that they could trust us. They seek our assistance for referrals also for which we direct them to the members of our panel of resource persons.

Special characteristics of the service in brief

Referral linkage with State AID Cell, State Mental Health Programme, Legal Aids Cell, Department of Psychology, Medical College Hospital, Department of Health Services and the Thiruvananthapuram Medical College Women and Children's Hospital.

Behaviour Change Communication (BCC) for clients having risk taking behaviour.

On-line and ongoing training to counselors.

Timely and accurate intervention of and networking with patients.

Documentation of all calls for case analysis.

Linked to Dt. PRAM (Physician Responsible for AIDS Management and Deputy Nodal Officer, AIDS Management) and operate a direct hotline with PRAM.

Immediate psychological management by Clinical Psychologist.

Counselling mainly aiming at broadening knowledge base, bringing in attitudinal change and modifying behaviour.

---

sochara

From: joy_chatterjee1965 <joy_chatterjee1965@yahoo.co.in>
To: <AIDS-INDIA@yahoogroups.com>
Sent: Saturday, May 18, 2002 9:00 PM
Subject: [AIDS-INDIA] United voice to fight . Declare AIDS as an emegency health problem

Dear all,

I am very surprised and deppresed to know the facts about the Global Funding on India from Mr. J V R Prasad Rao .

In India right in the year of 1986 HIV was diagonised first and now we are having the second highest number of HIV/AIDS people in the world , stil we are getting just 1.8% of the fund . This is amazing .

What the Government of India was doing since these long 15 years ? Lot of people are talking about the awarenes but what is the success rate of that? Did the Government of India surveyed about the result of awareness ?

What wil happen to the people who are already effected ? Wil they die or live with proper access to the treatment (ART) ?

I have being waching people dying of AIDS without doing anything regarding the proper treatment . We just cannot acept this .

According to me the Government of India should declear it as an emegency health problem immidiately before it is too late .
The day is not so far when thousands of HIV+ people wil merch in the capital of India .

I hope more and more people wil vew there opinion about this .
Regards .

Joydev Chatterjee(HIV+)
Network for positive people in West Bengal(En-joy)
Calcutta. West Bengal .
E Mail : joy_chatterjee1965@yahoo.co.in

5/20/02

Subject: [AIDS-INDIA] Mapping of Vulnerable Populations in Rajasthan
Date: Mon, 20 May 2002 12:24:42 -0700
From: "shama afroz" <afroz-shama@mailcity.com>
Reply-To: afroz-shama@lycos.com
Organization: Lycos Mail (http://www.mail.lycos.com:80)
To: aids-india@yahoogroups.com

Dear members,

I have been following the interesting line of discussions taking place in this forum and I feel this is the best place to place my queries. Presently I am working on "mapping of vulnerable population to HIV/AIDS in the state of Rajasthan", the biggest province of India. To start with, I have begun working on listing of parameters for vulnerability index through secondary data.
I would request the readers to assist me in the following:-

1. Has there been a similar kind of study/researches conducted in South Asia or elsewhere?
2. What is the vulnerability index for HIV/AIDS and its determinants?
3. What are the key issues to keep in mind while mapping of vulnerable population?
4. The immediate problem which I am facing is lack of concrete official database of the vulnerable groups especially street children, migrant labourers, CSWs, etc. This may involve lot of approximation to get to the estimated number of the above vulnerable populations. Has some work similar to this been done? If yes, what was the methodology to get to the estimated numbers?

Regards,

Shama Afroz
E-mail: afroz-shama@mailcity.com

Lib 21/5/02

Subject: [AIDS-INDIA] Sex on the move: 'Mobile' brothels a huge hit in Chennai
Date: Wed, 22 May 2002 04:58:23 -0000
From: AIDS-INDIA@yahoogroups.com
To: AIDS-INDIA@yahoogroups.com

Sex on the move: 'Mobile' brothels a huge hit in Chennai

By our Chennai Correspondent

Mobile brothels manned by cell-phone toting operators are proving to be a hit in Chennai, according to a new study. For those in the trade, running a mobile unit makes sound business sense as it cuts down on operational costs of renting a building and bribing the cops.

As for the client, it promises 'pick and drop' facility of sex workers at a place of his choice. More than 17 mobile units operate from cars in the city, according to Chennai-based NGO Indian Community Welfare Organisation (ICWO), which works with Commercial Sex Workers (CSWs).

The ICWO estimates the volume of sex business in the city at Rs 3.33 crore per month in its latest study. According to the study, there are 6,300 women sex workers operating from all over the city, around the year. "They are spread over in all parts of the city," says A J Hariharan, secretary, ICWO.

The sex workers have been broadly classified as family girl, street worker, brothel based, and mobile. Family girls form the majority of the lot, numbering 4500. There are 350 street workers, and 90 mobile workers, according to the study. It was found that 55 percent of the sex workers came from Andhra Pradesh, 24 percent from Tamil Nadu and 11 percent from Kerala. The study identified 150 full time brokers and an estimated 4500 part time brokers.

It has been found that clients are serviced at 'normal houses', besides brothels, hotels and lodges. These houses are used for short-term stay and rent is paid for the hours used. At least 91 such houses exist in the city. According to the study, an estimated 11,111 paid sexual encounters take place in the city.

It was found that 93 percent of the CSWs were into the trade out of compulsions and not out of choice. 78 percent of the respondents said they would not allow their children to enter the profession. It was found that 69 percent of the respondents used condoms regularly during sex. The 32 percent who did not use condoms on a regular basis gave different reasons for not using them.

Thirty percent said they couldn't use condoms with regular clients. Another 30 percent said they would forget to wear it at times and 10 percent felt that condom usage would prolong sexual activity. Another 10 percent said some clients would object to it. About 20 percent said they knew better techniques to avoid infection! As for reasons why they chose to be sex workers, 31 percent respondents said they entered the profession due to family debts and 29 percent said their husbands deserted them. About 29 percent said their lovers had ditched them.

Clients were asked why they visited sex workers. 21 percent said

feb

...more males had health problems. ... About 17 percent said they came for oral sex and 10 percent said their wives were not interested in sex. Seven percent said they had grown up children at home and six percent said their wives refused to have sex with them. Eleven percent came for a change, for 12 percent it had become a regular practice, and for six percent, sex was a passion.

The objective of the study was to map areas in the city where commercial sex workers operated and to "understand the sex industry" in Chennai. The Tamil Nadu State AIDS Control Society supported the study with the intention of using the information to frame suitable strategy for HIV/AIDS intervention programs.

About 43 percent of the sex workers who were interviewed for the survey were in the 26-35 age group. 26 percent was in the 19-25 age group. About 20 percent was in the 36-40 age group and 10 percent was in the above-40 age group. The team interviewed 300 women sex workers. Among the 300, 180 belonged to the family category, 80 street workers, 30 brothel based, and 10 from the mobile units. Twenty pimps, 20 lodge/house owners, and 20 hotel room boys were also interviewed.

http://headlines.sify.com/875news2.html

Subject: [AIDS-INDIA] Report of International AIDS candlelight memorial
Date: Tue, 21 May 2002 08:14:48 +0530
From: "AASRA" <aasra@vsnl.net>
To: <aids-india@yahoogroups.com>

Dear All:

The candlelight memorial was a community affair indeed! And we were thrilled to see so many on our E-list there.

Being the marriage season, it was great to have someof you take time out to drop in on the way to your other evening engagements.

Aditya Bandhopadhyay spoke about the probems faced by positive people as well as social workers working in the HIV/AIDS programme. We were encouraged by strong support at short notice from groups like The Patliputra round table, who rang us up on the morning of the 19th and offered to send over 200 packs of refreshments. Thanks Khurshid and Rohit.

The South Indian Cultural Association, Mobile Theatre, and the All India Anglo Indian Association put up cultural items, while the group Integration from Calcutta presented a theme piece called from bondage to bonding.

Mr Joseph Galstaun, the nominated Anglo-Indian MLA from Jharkhand was present along with Glen Galstaun and boys from St. Dominic Savio's.

We were thrilled to see, several members of this E-group: among whom were Augustine. Anamika (from Jamshedpur), Fr Paul, Sr Jyosita, Avhinav (who has been a pilar of strength and the one who gave willingly of her new car for transportation)

The candle lighting ceremony and walk was impressive as usual, this time the large number of street children from Bal Sakha/Childline made several Hindi papers write "Children carried candles to commemorate the memory of AIDS victims"

Thanks must go out to Swituja, Aditya, Lok, Augustine, Rachna, Jean, Sanat, Glen,Christina, Birendra,Margaret Martin for enabling us to meet the expenses of the project.

Frank Krishner
on behalf of AASRA, patna
E-mail:<aasra@vsnl.net>
