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OBJECTIVES

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REPORT and interpret the policies, plans, programmes and achievements of the Union Ministry of Health and Family Welfare.

ACT as a medium of exchange of information on health activities of the Central and State Health Organisations.

FOCUS attention on the major public health problems in India and to report on the latest trends in public health.

KEEP in touch with health and welfare workers and agencies in India and abroad.

REPORT on important seminars, conferences, discussions, etc. on health topics.

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AIDS CONTROL PROGRAMME

—The Strategy and the Action

P. R. DASGUPTA

Why is AIDS so scary? There are two principal reasons. Firstly, there is no vaccine or cure for AIDS. Secondly, it attacks most of the age-group of 15-45 years. The strategy today is to prevent the transmission of infection. This can be attempted only with increased awareness and knowledge about the transmission of infection and the risk behaviour which facilitates such transmission.

AIDS, this apparently innocuous four-letter word, is an enigma which has defied all the efforts of health professionals and scientists to find any effective cure or vaccine against it. Consequently, the prevalence figures during the last few years have been mounting ominously the world over without any manifest sign of remission.

Opinion leaders, decision-makers and a very large number of people generally assume that AIDS should be the concern of health professionals, health administrators and those who are afflicted with it. This is not correct. AIDS has ceased to be a mere health problem and has now acquired dimensions which perhaps have very few parallels in the history of mankind. It affects all of us, either directly or indirectly.

In the year 1978, the Health Ministers from most of the countries in the developing and developed world met at Alma-Ata and

gave a clarion call to all the countries to achieve Health For All by the year 2000 A.D. The task appeared difficult, but certainly not impossible at that point of time. Little did they realise that a dangerous viral infection, which later on was termed as the Human Immuno-deficiency Virus or what is now popularly described as HIV, had already taken roots amongst a group of homosexuals in the U.S.A. and that it would soon spread its tentacles in the most menacing manner possible. **The first case of HIV infective was detected in 1981. Within a span of a little more than a decade, we have now about an estimated number of 10—12 million adults (about 6 to 7 million men and 4 to 5 million women) and one million children infected by HIV. Of these, nearly 1.7 million have progressed to AIDS and a vast majority have most likely died. According to a current estimate, about 5000 people may be getting infected with HIV everyday all over the world. Thus the dream of Health For All by the year 2000 A.D. has been replaced**

by a macabre nightmare in which it is projected that by the year 2000 A.D. a total of 30 to 40 million men, women and children may be infected with HIV and nearly one-fourth of them in Asia.

In India, sero-surveillance about the trend of HIV infection was launched from late 1985 and the first case was detected in 1986. Since then approximately 18,98,670 blood samples from people practising high-risk behaviour have been screened all over the country. Out of these, 13,254 have been found to be HIV positive. This gives a seropositivity rate of 6.98 per thousand which, even though the sampling is biased, is fairly high. The current projections are that at present nearly a million Indian people will be infected with HIV. By 1996 this figure might go up to 2-3 million. This is the grim reality that faces us.

Scary

Why is AIDS so scary? There are two principal reasons. Firstly,

there is no vaccine or cure for AIDS. There are a few drugs available in the market, but so far their only known effect is to lengthen to a limited extent the incubation period or to slow down the progression from HIV infection to serious illness. However, it must be noted that the infection is irreversible, that the drugs have fairly toxic side-effects and that these are frightfully expensive also. Thus, those infected with HIV would, within a period of 8—10 years, develop AIDS or AIDS related illness and would die soon thereafter. The second scary aspect of AIDS is that it attacks most of the age-group of 15—45 years. This age-group represents the sexually active segment of the population. It also happens to provide the major work-forces in the country in the unorganised as well as the organised sector. If this age-group gets decimated, as it has already happened in several parts of Africa, the social and economic consequences would be catastrophic.

How to deal with the situation?

If there is no vaccine or cure, how does one deal with the situation? As of today, the strategy is basically that of preventing the transmission of infection. This can be attempted only with increased awareness and knowledge about how the infection gets transmitted and about the risk behaviour which facilitates such transmission. Thus knowledge and education is the key. Unfortunately, the current levels of knowledge, perception and awareness are rather low. Many have heard of HIV and AIDS in some form or other and quite a few perceive this as a

fall-out effect of sexually errant or deviant behaviour. And of course, there are myths galore about getting AIDS through kissing or hugging or petting. There are people who think mosquitoes can transmit AIDS. If this perception leads to an energetic drive to eliminate the mosquitoes, there would certainly be a beneficial impact on the health scenario. But alas, AIDS would remain.

Fight against ignorance

We have to fight against such ignorance and disinformation if we have to fight AIDS. Let us therefore understand in a common man's language as to how the Human Immuno-deficiency Virus or HIV, i.e., the Virus which leads to Acquired Immuno Deficiency Syndrome or AIDS get transmitted. It is this knowledge which can tell us how one can prevent such transmission and how one can avoid getting infected. It has now been established that there are only three well-defined routes through which HIV can get transmitted. The most common of these is the sexual route. HIV can be transmitted through unprotected homosexual and hetero-sexual intercourse when one of the partners is already infected. It is easier for the virus to be transmitted if the uninfected partner is already suffering some sexually transmitted diseases. The second route of HIV transmission is through infected blood, blood-products, organs and tissues and contaminated needles and syringes either as a part of drug-abuse or bad hospital/clinical practices. The probability of transmission of HIV through infected blood and blood-products is the highest—more than 90 per cent.

The third route of HIV transmission is from an infected mother to her child during pregnancy, at birth or shortly after birth. The probability of transmission of HIV transmission by this route is about 30 per cent.

The challenge and the response

By and large it has been found that the largest number of infections have been transmitted through sexual route in almost all the areas excepting the North-Eastern States. In the North-Eastern States, the incidence of HIV infection is overwhelmingly through the sharing of contaminated needles by the drug-abusers who are mostly the school and college drop-outs. We are now getting disquieting indications that the young drug-abusers in most of the towns and cities are increasingly turning to injectable drugs for getting their kicks. If this is not checked, HIV infection through sharing of contaminated needles would increase by leaps and bounds. HIV therefore poses a grave challenge to the Society and calls for a societal response. The Government of India have responded to the challenge by taking up in hand a programme costing about Rs. 222.6 crores to be implemented during the current Plan period. About one-third of this amount would be spent in promoting public awareness and community support. This involves: (a) promotion of safe practices including safe sex, use of sterilised/disposable needles, use of uninfected blood and blood-products and upgrading the standards of health care; (b) influencing sexual behaviour patterns in the society; and (c) improving the knowledge of risk

behaviour groups, potentially vulnerable groups and health service providers about HIV/AIDS. Since the access to risk behaviour groups as well as the rural communities through the existing government machineries would at best be limited, we expect to draw heavily on all forms of Non-Governmental Organisations for the successful implementation of this programme.

Another one-third of the total budget on this programme would be on ensuring blood safety and rational use of blood. It is, indeed, tragic that in a country of over 860 million people, we generate only about 19 lakh units of whole blood. This is less than 50% of our estimated total annual requirement of blood. More than 20% of our annual generation comes from professional donors who are mostly hosts of several infections including HIV. Unless we therefore augment substantially the voluntary donation of blood, the existing mismatch between demand and supply would continue to be met by professional donors. A big part of our programme would therefore consist of motivational efforts to augment voluntary donation of blood. Simultaneously, component separation facilities would be

provided in 30 major blood banks in the country to ensure that whatever blood is collected is put to optimal and rational use through separation of the various components of blood. This would also facilitate greater storage as frozen components can be stored over a longer period. Meanwhile, 180 Centres have been established throughout the country where blood samples can be tested free and all the blood banks have been provided with linkages to these centres.

Preventing spread of HIV infection

The third component of the National Programme to prevent the spread of HIV infection is building capacity for surveillance and clinical management. The trends in the incidence are being carefully monitored through 62 Surveillance Centres located throughout the country and training programmes have been taken up in hand to tune up the diagnostic and management skills of physicians in all the States. We expect that this would facilitate humane and non-discriminatory treatment of AIDS patients who are often stigmatized both by the society as well as the health professionals.

Another important component of our programme is control of sexually transmitted diseases, as AIDS is basically a sexually transmitted disease. The main objectives are to initiate early and timely diagnosis and treatment; promote knowledge about prevention of STD/HIV and use of condoms; and to emphasise the importance of treating partners/contacts in the community.

All these are however efforts to catalyse a societal response in which the overwhelming emphasis would be on prevention through promotion of a health lifestyle. We are convinced that educationists have a major role to play in evoking and nurturing this kind of a response. Already the National Services Scheme have picked up the awareness generation programme among the +2 and college students through the programme called *Universities Talk AIDS*. This needs to be strengthened and intensified and taken to the target group in Urban slums and rural communities and to those who are outside the educational stream.

You cannot afford to take chances with AIDS; for if you do, life would not be the same again. □

Do You Know?

Age is no safeguard. People of any age can have high blood pressure, but if you are over 25 you are doubly at risk. For most, 3 simple ways to reduce high b.p. are a balanced diet, salt reduction and weight reduction.

COMBATING AIDS: TIME TO ACT

DR. D. SENGUPTA

If proper steps—safe sex and correct consistent use of condoms by adult sector of population—are taken even in the absence of any vaccine or cure for AIDS, the epidemic can be averted. It is time to act, NOW.

AIDS (Acquired Immuno Deficiency Syndrome) currently has swept the Western world and has caused a devastation in the Sub-Saharan Africa. The Plaque's epicentre is likely to be South-East Asia, particularly, Thailand and India. Currently, it is estimated that 15–16 million people are infected by HIV, *i.e.*, the virus causing AIDS. According to the WHO estimate, about 1.5 to 1.6 million people are infected with Human Immuno deficiency virus (HIV). AIDS has a long incubation period. Therefore in the years to come, this country is going to be flooded with late AIDS cases with various opportunistic infections. The disease affects mostly between 20–45 years, which is the most productive group of population both economically and otherwise.

The disease, as is known, appeared first in the medical scenario in 1981. At that time a group of young homosexuals were detected to be suffering from pneumonia caused by some benign organism which by itself does not produce disease in healthy human beings.

This was pneumocystis Carinii. Soon it was discovered that these people were having mucosal candidiasis and peculiar vascular tumour known as Kaposi's Sarcoma. These people were homosexuals, having multiple sexual partners, also suffering from other sexually transmitted diseases like gonorrhoea, syphilis, etc. These people were also using Arryl Nitrate (stimulants) inhalation which also depressed the cell mediated, as it was only detected in the homosexuals to start with. It was given the name of Gay related Immune deficiency (GRID). Soon the physicians discovered that it not only occurs in homosexuals, but also occurs through transfusion of infected blood, in intravenous drug users who were sharing needles. The disease is also transmitted vertically from infected mother to the newborn baby. The scientists realised that the disease is being caused by some transmissible agent similar to hepatitis-B. This new virus is damaging the cell mediated immunity. It is well known that the virus causing the disease was discovered subsequently by Luc Montagnier of the Pasteur Institute, Paris, which was

confirmed by Robert Gallo of the National Institute of Health, Bethesda, USA. Since then, the researchers were active and in a short period of time, the method for detection of antibody in the blood was discovered and kits were developed which could tell who are infected by the virus. But as it is, scientists have not been able to discover any drug or vaccine for containing the virus. The virus causing the AIDS is a member of the Retrovirus group. The characteristic of the virus is to get integrated into the genome of the host cell, so once infected by HIV, it becomes a life-long infection. The other virus remains separate from the genome and could be eliminated easily, this retrovirus cannot be eliminated.

Position in India

In India, the disease first appeared in 1986 when the top research body "The Indian Council of Medical Research" detected HIV in as many as 14 female commercial sex workers of South India. Since then, the disease is spreading and according to the present surveillance report the infection has appeared in the general

population as well. Manipur reports, one per cent of the ante-natal mothers infected with HIV infection. To start with, it was thought that the disease is urban in distribution, but now it is proved beyond doubt that this disease also occurs in the rural section as well.

It is seen from the surveillance records that the disease has in reality entered the Indian Subcontinent. We are in an advantageous position when compared with the sub-Saharan Africa, where it has caused a fearful epidemic. In some parts of the Central Africa, villages after villages have been devastated with the death of the younger age group of population between the age group of 20—45, who have been completely wiped off. Only young orphaned children and old people are surviving. There are hospitals in this part of Africa, where 40—50% of the beds are occupied by people suffering from AIDS. In India, the epidemic is still in the window period; if proper action is taken the rampage of the epidemic can still be averted.

Prevention—the best way

As has already been mentioned, the disease has no cure nor vaccination, but can only be prevented. One has to act now because if proper measures are taken, one can prevent that disease taking an epidemic form. It is necessary to inform the population for a proper awareness that the disease is not a myth but a reality. We may be facing a situation worse than Africa if proper action is not taken at this point of time.

People have to be informed about the gravity of the disease and its potentiality of spreading as an epidemic through the proper use of the media. In common Indian language, facts about AIDS have to be disseminated among the different segments of the people. The mode of spread has to be emphasized not only amongst the general public but also among the various groups of health professionals also—medical and paramedical staff. But at the same time, AIDS Frankenstein is not to be created amongst the Doctors.

Blood is an important source of transmission of AIDS. Hence, proper control of all the Blood Banks is needed. It has to be impressed on every individual that voluntary blood donation is a must and taking blood from professional donors has to be stopped at any cost. The doctors should be educated about the proper use of blood. The use of blood products are in no way less hazardous. All the blood products are to be screened for HIV infection before use.

Infection control measures in all hospitals have to be strengthened. Proper sterilization (including injection syringes), proper barrier precaution and careful disposal of the wastes have to be ensured.

Safe sex and correct consistent use of condoms have to be emphasized to adult section of the population through media, newspapers, hoardings and posters.

If proper steps are taken, even in the absence of any vaccine or cure for AIDS, the epidemic can be averted. It is time to act now. □

Workshop on Orientation Training Programme on AIDS

A workshop for Orientation Training Programme on "AIDS" was organised by the National AIDS Control Organisation (NACO) and the Indian Association of Dermatologists, Venereologists and Laprologists (IADVL) of Delhi branch on 18th July, 1993 in New Delhi.

The subject relating to Diagnosis of HIV infection and AIDS Related Diseases were discussed. The experts also deliberated on overview of an integrated approach for

specific areas relating to prevention and control of AIDS.

Shri P.R. Dasgupta, Project Director for NACO has stressed that Dermatologists and venereologists should take active participation in AIDS control programme in a scientific manner. He asked the medical professionals to come forward for the management of AIDS cases and prevention of HIV infection.

Speaking on the occasion, Dr Vandom, WHO consultant gave a global picture of HIV infection

including India. Dr D. Sengupta, National Consultant, NACO urged the technical groups to examine, in detail, specific areas relating to prevention of AIDS Diseases. He also said that 377 AIDS cases had been detected and Tuberculosis was the main infection occurring in AIDS cases.

Earlier, Dr H.K. Kar, President IADVL of Delhi branch welcomed the delegates and outlined the objective of this training programme. —PTB

PREVENTING AIDS :

Educating Youth to Protect Themselves from Infection

DR SHIV LAL

In view of the fact that as many as 20% of HIV infections are projected to be occurring in the age-group of 10-24, it is imperative to initiate appropriately designed interventions for this age-group.

THERE being neither a cure nor a vaccine, the only way to combat the spread of AIDS is through prevention. This necessitates mobilizing all networks in the society to impart information about AIDS and the necessary skills to enable people to protect themselves. Before this process can begin, people need to be convinced that AIDS is indeed, a threat to them personally and to the society at large. They therefore, need help to be convinced to take personal action.

Generating awareness among people practising high risk behaviour constitutes important measure as a part of primary prevention strategy. At the same time educating school children and youth is important to prevent the emergence of such kind of risk practices as such, among these generations as a part of primordial prevention. The school children and the youth who are yet to develop or are in the process of inculcating behavioural patterns

with regard to sexuality can be easy and accessible target groups for education on sexuality and healthy and safe sexual behavioural practices. If on the one hand their vulnerability to be led into promiscuous and unsafe practice is profound owing to lack of sex education, the very same groups are highly receptive and easily adaptable into developing right kind of safe sexual behavioural practices if imparted appropriate kind of sex education.

Strategies for Intervention

Educating school children and youth is important because it will halt the process of passing of the virus to the next generation. There is an urgent need to talk to school children and youth on all aspects of HIV/AIDS including aspects of STD and sexuality. Moreover sex education in any form is not yet part of the functional curriculum of the schools. The school children do not have any access to any formal

sex education, thereby the reliance on peers and substandard literature is great. This leads to the germination of misconceptions and beliefs which in overall, harms the general growth of the individual. The process of moulding behaviour also takes place during this time and thus any education at this point of time would be instrumental in shaping the future course of the individuals.

Communicating about AIDS/HIV and STDs is extremely difficult as it is necessary to discuss sexual practices, a topic many people in many cultures would rather leave alone, and bring the communication to a very personal level for it to be effective. Only if each individual examines his/her behaviour in the light of the AIDS epidemic and makes a positive behaviour change, can any impact be made. Consistent messages from all channels—mass media,

traditional media, health care workers, and interpersonal channels need to work in tandem for achieving this objective. Apart from mass media, targeted programming and development of support services have been successful in achieving this objective.

The strategic plan for AIDS Control in India gives prime importance to information, education, and communication strategies (IEC) to combat the spread of HIV. Since AIDS is a threat to the society, the health sector alone is not sufficient to combat the spread of HIV infection. All sectors must get involved. The National AIDS Control Organisation (NACO) is thus now initiating several programmes which will serve as effective intervention for the young population of our country.

Student Youth

In the year 1991 a programme called "Universities Talk AIDS" was started by the National Service Scheme, Department of Youth Affairs and Sports in collaboration with the WHO and Ministry of Health in 59 universities of the country. Thereafter it generated a lot of enthusiasm and awareness in the country. Various materials for college youth were developed besides numerous seminars, public discussions debates, etc. to sensitize the youth and their Peers.

In 1992 as part of the World AIDS Day observance, 230 colleges all over the country participated in a week-long activity within the campuses and declared themselves as 'AIDS aware'.

Given the success of this programme, the National Service Scheme has now in collaboration with the NACO expanded this programme to the entire colleges going community in the country. A training module for the student youth has also been developed by them with assistance from NACO and WHO. Based on this Training module four master trainer workshops have already been held for over 150 key NSS Officials from the 150 universities of the country. The second phase of training educators would begin soon. A state level training for the colleges and schools of Sikkim has already been completed and follow up activities are in progress.

Non-Student Youth

Similarly, to reach out to non-student youth, the Nehru Yuva Kendra Sangathan has come forward to initiate HIV/AIDS/STD related activities in almost all districts and blocks of India through their *Kendras* and affiliated Youth Clubs. An approach paper for this has already been finalized and action plans have been made. A special initiative by the NYKS has been taken in the North East, especially in Manipur where a massive awareness programme would be initiated in the month of November.

Youth NGOs

Several other Youth NGOs have also come forward to join in the effort of HIV/AIDS Prevention. A workshop on Youth

Action on AIDS was held at Chandigarh to train these NGOs on planning such activities. Five similar workshops would be held throughout the country. Several NGOs like ICYO, AISEC, SPYM, DESH etc. are already working in this area.

Schools

There has been progress in the process of including adolescence education as part of the school curriculum. It is envisaged that this will include all aspects of sexuality, STD/HIV/AIDS besides family life education which is not present as a subject now. The introduction of these in the school curriculum will however take a minimum period of three years before they can find place in the schools. Besides introduction it will also envisage training of a large number of teachers at all levels which will take some time.

A workshop on Curriculum Development was also organised by the WHO in collaboration with NACO and NCERT. A basic framework for introduction into the school curricula has been prepared.

There is however an urgent need to reach out to the students, especially those in the period of adolescence. This is the time when they are experiencing the process of growing up and are ready to experiment. The sociological changes of the recent past have exposed the school population to various sexual practices and

nuances which make them vulnerable to infections related to STD and AIDS.

To reach out to the school population before the incorporation in the curriculum takes place it is suggested that we use an extra curricular approach. This will utilize the various school networks and clubs that exist in the country. The approach would be event-oriented and the participative in nature. A package of activities that can be utilized for the schools is under preparation.

Conclusion

In view of the fact that as much as 20% of the HIV infections are projected to be occurring in the age group of 10-24, it is imperative to initiate appropriately designed interventions for this age group. Sex education which has been a debatable subject so far needs to be viewed with a renewed angle in the context of HIV epidemic. Especially the children in the higher classes in the schools and college

youths need to be focussed for such kind of sex education as would lead to removal of prevailing myths and misapprehensions pertaining to sex. This would further avert their turning to sensational and tantalizing substandard literature of questionable scientific propriety. Above all this would pave the way for development of healthy sexual behaviour among these prospective adults who need to be safeguarded from the tentacles of HIV/AIDS epidemics. □

WORLD BANK TEAM LAUDS AIDS CONTROL PROJECT

A high level World Bank team led by Mr. Salim Habayeb called on Shri B. Shankaranand, Union Minister for Health and Family Welfare on 5 August, 1993. The team was on a two-week visit to India on a supervisory mission to oversee the activities of the National AIDS Control Organisation. Mr. Habayeb expressed deep satisfaction of the progress made in the implementation of the National AIDS Control Programme and said that everything was proceeding satisfactorily and according to schedule. The process of establishing inter-sectoral collaboration, in fact, he noted, had already started ahead of schedule.

Shri Shankaranand noted that World Bank investment in the health sector had been steadily increasing and expressed his appreciation of World Bank assistance to the government in the health sector. The AIDS disease did not recognise any boundaries and was a threat to the whole international community. He urged the World Bank to tackle the problem keeping in mind the global perspective and called for international cooperation in the fight against AIDS. He also hoped that the World Bank would continue to assist the government in the fight against the disease.

—PIB

Programmes Against AIDS At Workplaces

DR KHORSHED M. PAVRI

There is a need for brief (½—1 day) but continuing educational programmes for employers/supervisors of workplaces just as these are required for hospital administrators and deans.

*"In the sweat of thy face
shalt thou eat bread."*

—Bible

EVERY adult must work for his bread (*roti*); while some are able to get it buttered, a few may even manage to get jam. But the majority have no choice of where they work for their own and family's livelihood. They are pushed to take up whatever work, wherever it may be available. Some unfortunate ones are even forced through circumstances into workplaces which may be hazardous. In contrast, there are some lucky people—mostly from high socio-economic strata—who are able to select their careers and thus, their workplaces.

Categorisation of Workplaces: Before observing about programmes against AIDS at workplaces and, whether they are needed at all, let us review various categories of workplaces (Table 1). There are places which pose various levels of potential risk through sexual (A)

and blood-borne (B) modes of transmission. Category C includes workplaces that have no known risk involved.

Programmes at Workplaces: The important question is why should we have programmes against AIDS as a special entity? Should we not have programmes against other STDs as well? What about viral hepatitis which is more likely to spread through blood as compared to HIV? There is a consensus that educational and even intervention programmes for workplaces in categories A and B (Table 1) should take these other entities into consideration. In India, very little has been done for the category A-3 (Mobile services) and category A-4 (women workers). In the category B, *Personal service workers* (PSW)—at risk of transmitting blood-borne infections—have not received much attention except for some concern about barber shops¹.

Since all these workers have occupations involving close personal contact with clients it is

necessary that some educational programme concerning blood-borne infections, like viral hepatitis and HIV be targeted to them. These, however are not within the scope of the present communication; I was asked to write about programmes concerning workplaces which have no known risk for AIDS, i.e. category C. (Table 1)

**Do we need Specific Programmes
against AIDS at workplaces with
No known risk?**

All anti-AIDS programmes—whether educational or for intervention—emphasize the established feature of the three restricted modes of transmission; sexual, blood-borne and perinatal. In these circumstances, there is no apparent risk of HIV transmission in the workplaces shown in category C (Table 1). If some hotels are used mainly for sexual encounters, these could be singled out for certain specific instructions. Similarly if accidental bleedings

occur, these are expected to be handled at these workplaces just as it would be on roads, railways or in homes. In other words, relevant information meant for general population spread through mass media (particularly the electronic ones) could adequately serve this purpose.

An important issue is whether we deal with AIDS as a (i) virological/immunological problem, (ii) a public health problem, or, a (iii) societal problem mainly of human rights. AIDS is all these and more; what is needed is to have these issues in their proper places. For example, the first has its place in laboratories while the second and third are for public, in streets, homes and workplaces. These also need a proper perspective. Only then can appropriate, cost-effective programmes could be made targeted at proper place and in perspective.

AIDS: A public health problem: The C category workplaces are more likely to spread respiratory and water/food borne infections than sexual or blood-borne ones. The former cause not only 'acute' illnesses of varying, short duration, but can also lead to chronic health problems. Therefore, if health educational programmes are to be made, they should include various public health aspects including hygiene and nutrition.

AIDS: A Societal/Socioeconomic Problem: Any such programme should be exclusive for those who need it most, viz., the poor, and the powerless. They constantly encounter various physical and social risk factors as depicted by Wallerstein² (See Box). For such people, stigma and social exclusion are neither new nor linked with AIDS alone. Their fight is not for human rights, it is for their very survival.

The problem of AIDS thus becomes a societal problem, a problem of economics which needs to be tackled on a long-term basis along with other programmes attempting to empower the poor and the powerless.

AIDS: A Human Rights Problem:

**"Absence of Occupation is not rest,
A mind quite vacant is a mind
distressed"**

—Cowper.

Some of the issues peculiar to HIV/AIDS are connected with HIV testing and its aftermath. *Informed consent, confidentiality* of results and the individual's *right to work* are indeed important. Occupational safety and health of employees are responsibility of employers. In governmental as well as large non-governmental private establishments, employers undertake financial responsibilities for providing medical/health care to their employees. The fact that HIV carriers are likely to suffer from a variety of illnesses and ultimately die of AIDS has become an economic concern for many large industries/business establishments. Anecdotally it was learnt that a few very responsible organisations have started HIV testing for fresh recruits in order to reduce this burden by not employing HIV-infected individuals. In the process, not only the individual's right to work but the need for 'informed consent' of the individual is neglected. In fact, this latter concept is little known and less practised even by health care workers including doctors in India.

The concept of confidentiality is likely to be observed; however, it can be maintained if only select few persons are aware of the result. I know at least of two establishments

where strict confidentiality was kept about HIV seropositive employee(s). Counselling programme for them was started at once in addition to various ongoing health education programmes for AIDS prevention.

From the above it appears that programmes to impart appropriate information/knowledge to employers of no (low?) risk workplaces should be given a top priority. Subsequently, these enlightened, well informed employers themselves will organise educational even intervention programmes (if needed) for their employees.

Conclusions: In a very interesting and enlightening communication, Nancy Scheper-Hughes³ quotes a former Commissioner of Public Health for the city of New York: "We came to think of AIDS as fundamentally a crisis in human rights that had some public health dimensions, rather than as a crisis in public health that had some important human rights dimensions." Truly, a profound perception about the reaction of the Western World to AIDS. On the other hand, Cuba reacted to AIDS as a public health problem without much concern for individual human rights. Consequently however, they achieved a remarkable public health accomplishment by controlling AIDS in their country³. As far as AIDS in India was concerned, we took a position along with the Western World, no matter how we had perceived and treated public health problems of leprosy, tuberculosis and STDs.

A desirable spin off from this policy on AIDS has been consideration of certain concepts related to individual human rights by our AIDS policy makers. Whether

TABLE 1

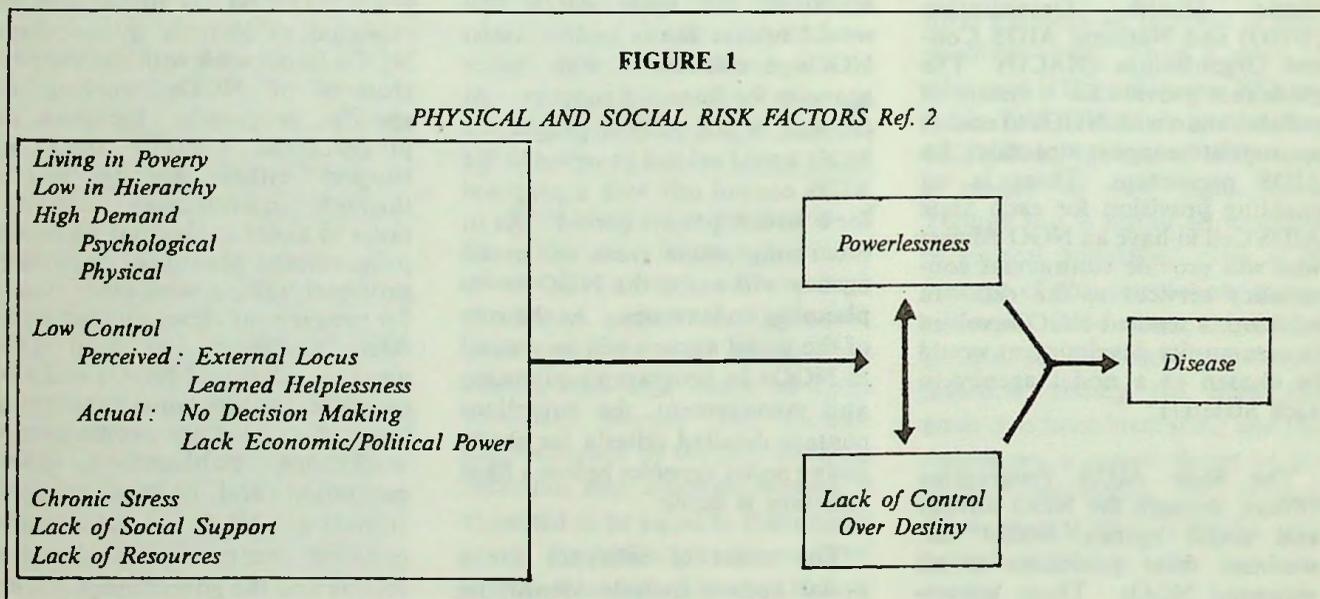
Categories of Workplaces and Potential Risks of Exposure to HIV/AIDS

CATEGORY OF RISKS

A Through Sexual mode of transmission	B Through Blood-borne transmission	C No Known Risk (Potential? very low)
1. <i>High Risk</i> —Commercial sex workers (CSWs) (Male, female, eunuchs)	1. <i>High Risk</i> •Paid (professional) blood donors at commercial Private	Those working in : • Hotels, restaurants, other food services.
2. <i>Intermediate Risk</i> <i>Single migrants (urban areas) working in :—</i> •factories, •Construction sites •offices, Market places	2. <i>Low Risk</i> • <i>Health Care Workers :</i> Hospital staff of different Categories, Blood Banks, Pathology laboratories, nurses, surgeons, dentists, physicians etc.	• <i>Factories</i> (living with families) • Business establishments • Industries • Colleges/schools • Other places
3. <i>Intermediate/Low Risk</i> •Truck drivers, •Sea-farers •Other Mobile services	3. • <i>Personal Service Workers (PSW.) engaged in :</i> tattooing, ear-piercing, acupuncture; barbers, hair-dressers, massage therapists.	
4. <i>Low risk</i> <i>Women in;</i> •Bars and other such services •Domestic service.		

FIGURE 1

PHYSICAL AND SOCIAL RISK FACTORS Ref. 2



these same concepts have reached all those responsible for actual implementation at the respective workplaces—including hospitals and nursing homes—remains a moot point. Indeed, there is a need for brief (½–1 day) but continuing educational programmes for employers/supervisors of workplaces listed at category C (Table 1) just as these are required for hospital administrators/deans.

Finally, I would like to stress once again what has been stated often, that the cause of most of our public health problems are poverty and ignorance. An opinion in

Nature⁴ on 'India's latest earth quake' sums it all up succinctly. "In short, if the proximate cause of last week's tragedy was the earthquake, its underlying cause was the continuing poverty of rural India. The question to ask is not whether the microseisms of the past few years could have been used to avoid the tragedy, but when India's new-found industrial prosperity will trickle down to relieve some of the most cruel poverty in the world."

Indeed, poverty, not only of rural India but also of urbanised India coupled with ignorance may constitute formidable cofactors for

AIDS also. One can only hope that fear, fascination and finances for AIDS will give the needed momentum to the ongoing programmes against these two enemies.

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Involvement of Voluntary Agencies in AIDS Control Sought

GUIDELINES for the involvement of Non-Governmental Agencies (NGOs) in the AIDS control programme have been finalised for use by the State AIDS Cell in nearly 30 States/Union Territories. These guidelines have been formulated after active interaction with State governments and representatives of NGOs by World Health Organisation (WHO) and National AIDS Control Organisation (NACO). The guidelines provide for a system of collaboration with NGOs to ensure appropriate support structures for AIDS prevention. There is an enabling provision for each State AIDS Cell to have an NGO adviser who will provide contractual consultancy services to the cell. In addition, a reputed NGO involved in community development would be chosen as a nodal agency in each State/UT.

The State AIDS Programme Officer, through the NGO adviser and nodal agency, would disseminate these guidelines to all registered NGOs. Those interes-

ted in taking up the task of AIDS prevention and control would be asked to submit a self-assessment report to the AIDS Control Cell which would then be screened, according to a pre-set criteria for shortlisting NGOs by the NGO Adviser.

Once a proposal has been approved, the State AIDS cell would release funds and/or assist NGOs to collaborate with donor agencies for financial support. At the end of the project period the NGO would submit its report to the AIDS control cell with a proposal for a further project period. As in other programme areas, the nodal agency will assist the NGO in its planning endeavours. As the role of the nodal agency will be crucial to NGOs in programme planning and management, the guidelines contain detailed criteria for shortlisting nodal agencies before a final selection is made.

The terms of reference for a nodal agency include identifying

and mapping various NGO networks, NGO intermediary organisations and groups within the states, examining the potential of involving NGOs in AIDS control activities through an assessment of their performance in addressing issues of health and development and stimulating the response of new NGOs to the HIV/AIDS crisis. The NGOs would also be expected to identify intermediary NGOs to network with the support clusters of NGOs working in specific geographic locations or programmes, organise back up support either directly and/or through intermediary organisations to assist individual NGOs in programme planning, including proposal writing, and other inputs for programme development, monitoring and evaluation based on the need of individual NGOs and also organise training and networking through a systematic programme of workshops, publications, documentation and dissemination to stimulate NGO activity and enhance communication between NGOs and the government. —PIB

SITUATION OF AIDS IN INDIA AND MEASURES FOR PREVENTION AND CONTROL

DR A.K. MUKHERJEE

and

DR S. VENKATESH

The first AIDS case in India was reported in 1986. Since then 494 AIDS cases have been reported from 19 States and U.Ts by 31st October, 1993. A total of 19,33,884 blood samples were screened by the end of October 1993. Out of these, 13,448 were found to be HIV positives. According to current projections, nearly one million people may be infected with HIV at present. By 1996, this figure might go up to 2-3 million. The ominous AIDS clock has started ticking, say the authors. The theme for the World AIDS Day has appropriately been chosen as *Time to Act*. We have to do our best, both individually as well as collectively, to arrest the epidemic before it becomes too late.

THE World witnessed in the past decade what appeared at first to be an illness largely confined to homosexual men and drug injectors in the developed countries turning into a pandemic affecting millions of men, women and children in all continents. 1981 saw the detection of the first case of HIV infection. Twelve years later the world now has an estimated 10-12 Million adults (about 6 to 7 Million men and 4 to 5 Million Women) and One Million children with HIV infection. Of these, nearly 1.7 million have progressed to AIDS and a vast majority have most likely died. Current estimates, place the number of people getting infected with HIV everyday all over the world at about 5,000.

Hetero-sexual transmission of the Human Immunodeficiency Virus is on the rise in both developed and developing world, predominantly in sub-Saharan Africa, Asia and much of Latin America. Women are increasingly affected; by the year 2000, the infection rate amongst women is expected to be equal to that among men. Projections for the year 2000 A.D. indicate that a total of 30 to 40

Million men, women and children may get infected with HIV and nearly 1/4th of them in Asia. Globally there may be one million adult cases and deaths every year. A majority of these deaths will be in developing countries—about half a million in Africa and a quarter of a million in Asia.

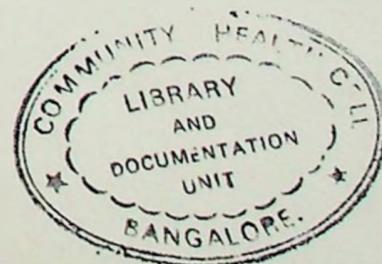
AIDS Situation in India

We had launched Sero-Surveillance for HIV infection in late 1985. The first case was detected in Madras in 1986. Since then, there has been an increase in seropositivity rates. From a mere 2.5 who were HIV positive per 1000 tested in 1985-87 the rate had become 11.2/1000 by the end of 1992—over a period of just eight years. Though this is not at all reflective of general population rates as 90 percent of the population groups screened come from high risk groups, yet it clearly shows that infection among the high risk group has been increasing and this constitutes a major threat to the general population as through these groups the infection gets passed down to the low risk groups.

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While the sero-positivity rates among the groups indulging in multipartner sex have almost trebled from 5.6/1000 to 16.2/1000 during the last two years, a parallel kind of trend, though at a much lower level, has also been observed among the low risk groups. The sero-positivity rates among blood donors increased from 0.37/1000 to 0.85/1000 and among antenatal groups from 0.6/1000 to 1.16/1000 over the last two years.

Tamil Nadu, the state where HIV infection was detected first of all, has, over the last four years shown a consistent and steady escalation of HIV infection among the STD attenders. Similarly, in Bombay, where there are well identified Red Light Areas, the surveillance reports among the commercial sex workers have been really alarming with a marked rise in HIV prevalence from 10% in 1986 to 32% in 1991. This rise, is quite comparable to the trends earlier observed in some of the African cities like Nairobi, Addis Ababa from mid 80s onwards where the spread of HIV in the general population seems to have been preceded by sharper increase in the HIV prevalence among the high risk groups. This fore-warns us about the impending epidemic of HIV involving the general population as has happened in these countries.

Till the end of October 1993, 19,33,884 blood samples have been screened all over the country. Out of these, 13,448 have been found to be HIV positives. This gives a sero-positivity rate of 6.95 per thousand, which is fairly high. The largest number of infected cases have been found in Maharashtra and Tamil Nadu, followed closely

by Manipur, Delhi, Pondicherry, Uttar Pradesh, Karnataka and Goa. No state or Union Territory is totally free from infection, even though the screening and detection is not even in all the places. What is more alarming, however, is the fact that more and more women attending ante-natal clinics are testing HIV positive. It was reported as 0.5% in Bombay and 1% in Imphal in 1992. This clearly indicates that the virus is no longer confined to the high-risk groups but has entered the low-risk groups as well.

In the North-Eastern States, the incidence of HIV infection is overwhelmingly through the sharing of contaminated needles by the drug abusers who are mostly the school and college drop-outs. If this is not checked on a war-footing, HIV infection through sharing of contaminated needles would increase by leaps and bounds. The rapid rise of HIV sero prevalence to as much as 56.1% within a short period of three years *i.e.*, 1989-92 in Manipur, and other North-Eastern States is reflective of the trends observed in similar groups in other parts of the world.

According to current projections, nearly a million people may be infected with HIV at present. By 1996, this figure might go up to 2-3 Million.

The first AIDS case was reported in Bombay in 1986. Since then 494 AIDS cases have been reported from 19 States, and U.Ts by 31st October, 1993. Maharashtra and Tamil Nadu are leading in the number of cases having reported 117 and 152 cases respectively. Among the probable

means of acquiring these infections, multi-partner sex dominates (75.3%), followed by blood transfusion (12%), sharing unsterilized equipments by injecting drug users (6.5%), 83% of all infections were below age of 50 years and more, 2/3rd were between the ages of 20-40 years.

Strategies for Prevention and Control of AIDS/HIV Infection

Realizing the gravity of the epidemiological scenario prevalent in the country the government of India has accorded utmost priority to this problem and launched a comprehensive multisectoral programme for the prevention and control of AIDS in India.

The establishment of surveillance centres was done by ICMR upto 1990. Thereafter, surveillance and all other aspects of AIDS Control were assumed by the AIDS Cell located in the Directorate General of Health Services. From October 1992, a separate dedicated wing, called the National AIDS Control Organisation (NACO), has been established within the Ministry of Health & Family Welfare to co-ordinate the programme.

A strategic plan is being implemented for prevention and control of AIDS in India for a period of 5 years (1992-97) at an estimated cost of Rs. 222.6 crores through assistance from World Bank in the form of a soft loan of US\$ 84 million, a grant of US\$ 1.5 million from the World Health Organization and the balance in Indian Rupees made available by the Government through budgetary grants. A third of this amount would be spent in promoting public awareness and

community support. Another one-third would be for ensuring blood safety and rational use of blood. The third component of the National Programme to prevent the spread of HIV infection is building capacity for surveillance and clinical management. Other important components of our programme are control of sexually transmitted diseases and hospital infection, and strengthening programme management.

Multi-sectoral approach

As control of the disease cannot be achieved solely by the health sector, a multisectoral approach has been adopted. A National Committee functions, under the chairmanship of the Hon'ble Union Minister of Health and Family Welfare, to bring together various ministries and NGOs. It is the highest level deliberative body which oversees the performance of the Programme and provides policy directions. A multi-sectoral committee under the chairmanship of the Secretary (Health), assists in the development of a co-ordinated policy to prevent and control the spread of HIV/AIDS in the country.

All Union Ministries and Departments which could have any conceivable link with NACO and its programme have identified focal points in their Ministry/Department who will serve as the responsible officers for the development of Ministerial/Departmental plans of action in the battle against this new challenge. Similar steps are envisaged at State and Union Territory Government level.

A sensitization meeting was held for all the Secretaries of the

Government of India under the chairmanship of the Union Cabinet Secretary. Key officials of the State governments have been sensitized and oriented about the problem of HIV/AIDS and the need for IEC. At the meeting of the Central Council for Health & Family Welfare the State ministers of health as well as the health secretaries were sensitized to the need for concentrating efforts on to HIV/AIDS/STD prevention. Several State governments have also initiated steps to foster inter-sectoral collaboration within the various State government departments. We have also initiated a dialogue with the various chambers of commerce like CII, the Bengal Chamber of Commerce, PHD chamber of Commerce, TISCO, Educational organizations like NCERT, Nehru Yuvak Kendras, Schools and the uniformed sector like the police, Army, Navy and the Air Force. Organizations like Rotary, Lions and Interact have also come forward with proposals for integration in their ongoing programmes. STD/HIV/AIDS awareness programmes have also been introduced in the Jails.

Efficient Programme Management

The National AIDS Control Programme is currently being implemented in the country through the States/UTs, as a Centrally Sponsored Scheme. Under this scheme, each State Government/UT Administration has established State AIDS Cells for planning, coordinating, implementing and monitoring the project. Their staffing pattern has already been agreed upon and the entire cost is being met by the Government of India.

For ensuring efficient programme management, a *National AIDS Control Board* has been constituted at the National level, under the chairmanship of Secretary (Health), to approve NACO policies, to expedite the sanctions to approve procurement, etc.

In order to strengthen the technical and research capabilities of the programme, a *Technical Advisory Committee* meets, under the chairmanship of Director General of Health Services (DGHS), with eminent experts from the different fields in the area of health. A number of Technical Sub-committees have been created on the different issues, *i.e.*, control of Sexually Transmitted Diseases, Blood Safety, Surveillance, Research, etc.

Safety of Blood and Blood Products

The very first AIDS patient reported from India was a person who had been infected with HIV through multiple blood transfusions received during a coronary by-pass surgery in USA. Subsequently the first blood donor seropositive for HIV was detected in July 1987. Infusion of blood and blood products has emerged as one of the most efficient modes of transmission of HIV infection, the estimated infection rate through this route being 90%.

To study the status of blood banks and transfusion services in the country, we had engaged a professional agency in 1989. The Ferguson Report revealed that there are an estimated 1018 Blood Banks in the country handling about 19 lakh units of blood

(350 ml. per unit) per annum. Of these 1018 Blood Banks, 567 are under the State Government Municipal Sector, 41 under Central Government managed hospitals, 56 are in the voluntary sector and 203 Blood Banks are in the private sector. As per WHO norms of 7 units of blood per bed per annum, the present collection is short by 50% of our total requirement.

Our Strategic Plan for blood safety has eight objectives:

- strengthening the National Blood Transfusion Services
- ensuring an adequate supply of blood to all blood centres
- ensuring the safety of blood and blood products
- developing and strengthening facilities for plasma fractionation and the production of components
- strengthening external quality control of blood and blood products
- developing and strengthening effective management, monitoring and evaluation of blood transfusion services
- undertaking research on blood transfusion services operations to improve safety, efficacy and supply

During the past three years, 180 HIV Zonal Blood Testing Centres have been established in 112 cities. These Centres have linkages with Blood Banks both in public and private sector and provide free testing facilities. All samples are tested either by ELISA or rapid/simple test. The unit found positive for HIV is discarded by heat treatment at 60 degree Celsius upto 90 minutes followed by incineration.

We have launched a central scheme of assistance to States to upgrade and provide minimum facilities to all blood banks in the public sector. In the 7th five year plan, 138 Blood Banks had been modernised and 90 more Blood Banks were taken up during 1992-93. All the 380 remaining Blood Banks in the public sector will be modernised during 1993-96.

We have set a target of establishing 31 components separation centres. During 1992-93 work began on the establishment of an initial six centres. The remaining centres shall be established during the next two years. One Plasma Fractionating Centre has already been set up in Bombay. We propose to start a post-graduate degree and diploma course in blood transfusion services towards promoting Rational Use of Blood.

The Drugs & Cosmetics Act and the rules framed there-under regulate the working of Blood Banks, and provide for two Drug Inspectors in the major States and one Drug Inspector for the smaller States to ensure a better control on their working. The Act has been suitably amended in the wake of HIV epidemic with appropriate provisions like mandatory testing for HIV, and conforming of Blood and Blood components to standards laid down.

Controlling STDs

The HIV/AIDS epidemic has brought into resurgence concern about sexually transmitted diseases. Not only do STDs share common epidemiological determinants, *i.e.* common risk behaviour features with HIV/AIDS, but they also catalyze the acquisition and transmission of HIV. The strength of the association between STDs and HIV can be gauged

by the simple fact that the relative risk of transmission for HIV zooms up as much as ten fold in the presence of ulcerative STDs such as Syphilis, Chancroid, etc. There is a considerable body of evidence to suggest that HIV on its part, not only aggravates the severity of manifestations but also renders the response to the conventional therapeutic regimens less effective.

The National STD control programme in operation in India since 1946, was based on the provision of clinical care through a limited number of specialised STD clinics, could reach not more than an estimated 5-10% of all STD patients. There was practically no attention to primary prevention.

To increase the effectiveness of STD control activities, we have chosen a two-pronged approach. On the one hand, we are strengthening the existing infrastructure of STD clinics so that these facilities become referral centres for primary level health care providers. At the same time, we are supporting the development and implementation of targetted interventions, with priorities for the groups with risk behaviour. Such interventions integrate Information, Education and Communication (IEC) for safer sexual behaviour with the provision of clinical services for STD case management and the provision of condoms.

Services for STD case management will be integrated in general health care facilities, so as to avoid stigmatisation. To provide non-stigmatising and easily accessible services for women, STD services will be integrated into existing MCH/FP and antenatal clinics.

Linkages with MCH Activities

Women and children constitute the target group not only for

National Family Welfare Programme but also for AIDS Control and also because of the fact that both the programmes directly or indirectly pertain to common area of sexuality/reproductive behaviour. So, the development of suitable linkages is especially appropriate. Some of the areas for the linkages are programme Management and IEC. This is by promoting dual role of condoms as a contraceptive and as a prophylactic against HIV/STD, and expanding family welfare campaigns to include an AIDS prevention component. Health workers are also being involved to create an environment which is conducive to healthy interaction on areas such as sexuality, and reproductive health. They play a key role in generating support for the AIDS control programme, in the health sector, as well as in influencing attitudes to this new disease.

Health workers also play an important role in the reduction impact. The main thrust for reducing the negative impact involves creating a supportive, caring and accepting environment, with no moral judgments on the patient and his family, as well as coming to terms with the prognosis. Health and Family Welfare personnel have a very important role to play in this regard, as they are the first point for care in the community, and can also educate the family on how to care for patients at home.

Condom Programming

The condom serves the dual role of a contraceptive as well as a prophylactic against HIV/AIDS. Hence we are reshaping Condom Programming for the country to dovetail with the latest needs. To ensure the quality, necessary amendment is being made in the existing schedule to bring the condom specifications within the

quality parameters as prescribed by WHO.

Hospital Infection Control

Hospital infection control measures have been targeted for improvement since the beginning of the epidemic. The fear of accidental infection from HIV invariably influences the behaviour of health care workers towards their patients. It is also essential that the patient feels confident that he will not acquire HIV infection from the health care facility. Towards this end, we have made substantial efforts in training, strict enforcement of antisepsis and asepsis and adoption of universal precautions in infection control.

Generation of Awareness

With no vaccine or cure for AIDS in sight, prevention is our only hope. This entails changing behaviour through Information, Education and Communication and social mobilization. Consistent messages from all channels—mass media, traditional media, health care workers, and interpersonal channels need to work in tandem to achieve this objective.

We have adopted a multi-pronged strategy comprising of a national awareness campaign, targeted interventions for people practising high risk behaviours, collaboration and support to NGOs, intersectoral collaboration, training and operational research.

A national advertising agency has been awarded a contract to produce a national umbrella awareness campaign. We are working with communications professionals and NGOs to develop target materials for identified risk behaviour groups, such as commer-

cial sex industry, injecting drug users, truck driver and other mobile men, industrial workers, and many more. We plan to identify and strengthen, in conjunction with the States, IEC institutions to support State level IEC activities. Model interventions with identified risk groups for replications will be supported. Guidelines have been developed on how to integrate NGOs into programme activities. We are setting up a structure to ensure good quality counselling services, through a comprehensive training programme. A nationwide high risk behaviour survey is planned in conjunction with existing social science institutions in 65 major cities.

IEC programming cannot exist in isolation. Educational messages and information need to be backed up with condom programming, STD services and informed, well-trained health care workers.

The National Service Scheme (NSS) of the Department of Youth and Sports has, with its innovative "Universities Talk AIDS" programme, initiated with the assistance of WHO, undertaken a process of providing information to one of the most important target audiences—young adults. The project aims at raising awareness of AIDS/HIV among student populations, sensitizing and mobilizing students to initiate peer group and community discussions on AIDS and AIDS prevention, and developing a series of targeted messages for students in India.

In the first phase, 69 universities were involved and over 100,000 student Youth covered. In 1992 over 200 colleges were declared AIDS aware. NSS has also developed a series of posters and leaflets and other media messages which are

also being used in our awareness programme. A standard training module and a manual, have been developed, and are being used to train Trainers of youth. In the next phase, it is proposed to cover all colleges and universities in the country.

A National Action Plan for involving the Nehru Yuvak Kendras, as a way of reaching non-student youth, is being finalized. Key officials of this organization including the five Zonal co-ordinators, 40 regional co-ordinators and 100 district level co-ordinators, besides several Block level workers have been sensitized. The South Zone kendra has already conducted three workshop for their grass-root level workers. A meeting of the NYKs in the north-east was convened recently.

The national workshop on Youth Action on AIDS was held at Chandigarh; about 30 participants from various youth NGOs participated. Action Plans were developed for organizing grassroots level activities for youth. Similar workshop are also being planned in the five regions of the country.

The Scouts and guides have initiated steps to integrate HIV/AIDS as one of their priorities activities for the next five years. The World Scouts headquarters manual is also being adapted for use in India.

We have established close liaison with NCERT (the National Council for Education, Research and Training) to integrate STD/HIV/AIDS in the School Curriculum.

Counselling

As the epidemic progresses, it is essential to be prepared to reduce its overwhelming sociological and psychological impact on indi-

viduals, families and communities. This can be accomplished by planning and training counsellors, setting up community based care structures and improving access to health care facilities for those afflicted. In this, we require the co-ordinated efforts of government, the private sector and NGOs.

A comprehensive training Module for development of counselling services and a plan for training have been finalized and would be operational soon. For various organizations, both in the governmental and non-governmental, who can respond to the need of counselling urgently and efficiently, a counselling handbook has been prepared, which can be used for training.

For the training and monitoring of the counselling programmes, five regional centres would be established at leading social/medical institutions in different parts of the country. 40 intermediate centres at the State level would identify and train community level counsellors at the peripheral level. Trained counsellors would be available at major hospital, social institutions, community health centres and places where the incidence of STD/HIV/AIDS is high.

Community Based Care

AIDS patients and those with related illnesses can be taken care of in the home setting with proper support and backup from the community and local health facilities. The fears of health care and community workers need to be allayed with clear information and education. A plan of action is being developed, which includes community based health care services. This necessitates training which will help dispel misconcep-

tions and prejudices among health care personnel. A start in this direction has been made by initiating training of doctors, and preparing a module for pre-service and in-service training of nurses.

Surveillance

For planning, mobilizing the required inputs, and designing the interventions, monitoring the trend of the HIV/AIDS epidemic is extremely essential. We have established a nation-wide network of 62 surveillance centres in different cities of India. These centres are carrying out screening activities among the different categories of people which include high as well as low risk groups. To monitor the trends and pattern of infection, a sentinel surveillance approach has been adopted.

Combating Discrimination

Protection against any kind of discrimination and stigmatization and maintaining of dignity of those afflicted with HIV/AIDS is an integral part of every component of the programme. For surveillance and clinical diagnostic purposes, the element of confidentiality is strictly adhered to. Guidelines have been issued to protect the HIV infected from any kind of discrimination in the hospitals. In addition, a social, legal and ethical sub-committee has been specially constituted to take views on HIV/AIDS related issues which have legal, social and ethical implications.

Operational Research

Operational research leads to outputs which can be used for designing of appropriate interventions. This activity is being carried out with the partnership of colleges in different cities, to

simultaneously gain their involvement and strengthen their capacity to deal with the problem of HIV/AIDS.

Targeted Interventions

A number of high risk behaviour practices which are associated with higher rates of HIV infection will need targeted, integrated approaches. This includes the development of special IEC approaches and materials, and the provision of support services such as condoms and STD services. Some targeted populations we have identified are injecting drug users, migrant workers, industrial workers, women, military personnel, the commercial sex industry, street children, truck drivers and slum dwellers.

A targeted intervention with sex workers in Bombay is under way by the Bombay Municipal Corporation in conjunction with local NGOs and the Xavier Institute of Communications. The project targets 10,000 sex workers and their clients along with pimps, madams, police and transportation workers. IEC is being effectively combined with condom promotion and the provision of STD services through a newly opened general clinic in the heart of the red light area.

In Calcutta, the All India Institute of Hygiene and Public Health is carrying out an intervention with 6,000 sex workers, their clients, pimps and local community of Sonagachi. Local NGOs along with a development communications organization, are active collaborators. A community based programme it has involved local youth clubs who have donated space for general clinic. Peer educators among the sex workers spread important messages about AIDS. Again the integrated approach of IEC, condom programming and the provision of services is a major aspect of the activity. The Community Action Network, a new NGO, is tailoring this integrated approach with the more hidden sex industry in Madras.

Targeted interventions are also planned with groups like those practising Multi-partner sex, Uninformed sector (CISF, BSF, Army, Police), Industries, Women Slum populations, Youth and Jails.

Role of NGOs

NGOs are in a unique position to intervene in facilitating the adoption of safer behaviour. By their unique relationship with the community and targeted group, and their acceptability, NGOs can

make a strong impact. It is imperative that NGOs integrate HIV/AIDS components into their existing programmes, building on the base they already have. The areas in which they can assist are: Advocacy, targeted Communication, Condom Promotion, Counselling Services, Support Services, Research, and in safeguarding human rights. Each area and each NGO will have a unique response to the challenge presented by AIDS.

In order to optimize the participation of NGOs and maximize the returns of intervention, it is necessary to have close coordination and collaboration between NGOs and the Government. Much can be gained by sharing experiences and approaches, by basing innovations on past experience, and learning from each other.

The ominous AIDS clock has started ticking. The theme for the World AIDS Day has appropriately been chosen as TIME TO ACT. We have to do our best, both individually as well as collectively, to arrest the epidemic before it becomes too late. □

Think about all the good reasons for giving up smoking :

- your children's health,**
- your own health,**
- the cost of smoking,**
- the smell.**

HIV Infection and Tuberculosis

DR S. K. KATE

The World Health Organization has declared tuberculosis as a global public health emergency. And infection with Human Immuno Deficiency Virus (HIV) is the greatest risk-factor for tuberculosis.

THE World Health Organization (WHO) has recently declared tuberculosis (TB) as a global Public Health emergency¹. The number of cases of tuberculosis reported annually in the United States declined steadily from 1953 to 1984. In a dramatic reversal of this trend, the number rose by 3 per cent in 1986, 5 per cent in 1989 and 6 per cent in 1990². In 1991, K. Stablo and D. A. Enarson³ observed that infection with immunodeficiency virus (HIV) is the greatest risk-factor for tuberculosis.

Pathogenesis

During the initial (Primary) infection of immunocompetent persons with *Mycobacterium tuberculosis*, macrophages ingest the organisms. After processing, it is presented to 'T' cells. CD4 cells secrete lymphokines that enhance the capacity of macrophages to ingest and kill mycobacteria. The hallmark of HIV infection is progressive depletion and dysfunction

of CD4 cells, coupled with defects in macrophage and monocyte function⁴. Because CD4 cells and macrophage have central role in antimycobacterial defences, dysfunction of these cells places patients with HIV infection at high risk for tuberculosis. Tuberculosis in an infected HIV individual can occur due to (i) multiplication of tubercle bacilli in quiescent foci (ii) Progression of recent infection to disease and (iii) Superinfection^{5,6}.

Epidemiologic Relation of Tuberculosis & HIV infection

According to the Indian National Tuberculosis Control Programme, the prevalence of infection for all age group is 38.0% as indicated by a positive Mantoux test⁷. It is estimated that one undiagnosed smear positive case of tuberculosis will infect ten persons during one year of contact⁸.

Two types of virus (HIV-1 & HIV-2) have been identified as causing

AIDS. The median period following infection, free of AIDS is about 11 years. An estimated 13 million men, women and children have already been infected with HIV⁹. Tuberculosis develops at an earlier stage in HIV disease than other opportunist infections³. The two have become such close partners that TB has become the most important opportunistic disease associated with AIDS in India¹. The incidence of tuberculosis in patients with AIDS is almost 500 times the incidence in the general population². Out of 65 sputum positive for AFB patients, studied at our centre from March 1993, three cases were HIV Seropositive.

Poverty is an important cofactor of double trouble tuberculosis and HIV¹⁰.

General Clinical Features

Tuberculosis is often first clinical manifestation of immunodeficiency. The most striking clinical

feature of tuberculosis in patients with HIV infection is the extremely high frequency of extrapulmonary involvement, usually with concomitant Pulmonary tuberculosis¹¹.

Disseminated infection with mycobacterium avium intra cellulare (MAI) is common in the terminal phase of AIDS¹². Other non-tuberculous mycobacterial infection include *M. Xenopi*, *M. Kanasasii*, *M. gordonae*.

Retrospective studies have suggested that at least one-half of patients have no other indication of HIV infection at the time of diagnosis of tuberculosis; such patients usually demonstrate a significant reaction on tuberculin testing only those who develop tuberculosis after onset of AIDS are likely to have no reaction to tuberculin⁵. In HIV infected tuberculosis patient without AIDS, the clinical appearance does not differ from that of other tuberculosis patient³. Lymphadenitis, Bacteremia, Tuberculous abscesses and tuberculomas in the brain paranchyma, presence of AFB in stools are frequent abnormalities in patients with HIV infection. A chest roentgenogram and acid fast smears of sputum are essential for suggesting the diagnosis of tuberculosis.

Chest Roentgenogram

Apart from Hilar adenopathy, upper lobe infiltrates, miliary pattern, cavitation, atypical radiography appearance *i. e.*, disease extending beyond apex is more frequent. Pleural effusion is also reported¹³.

Histology Study

The presence of AFB bacilli in different organs (liver, spleen, kidney, Supra renal) without tissue response was observed in one of the centres in India¹⁴.

Treatment

The tuberculosis unit of WHO¹⁵ has issued guidelines for drug management. The guideline states that optimal six month regimen (HRZE, *i. e.*, isoniazid rifampicin, pyrazinamide, ethambutol for 2 months followed by (HR) Isoniazid rifampicin for 4 months) or 8 months regimen (HRZE isoniazid, rifampicin pyrazinamide, ethambutol for 2 months followed by isoniazid, ethambutol (HE) for 6 months) should be adopted. Guideline also recommended that streptomycin in the initial phase be replaced by ethambutol to avoid the potential for transmission of blood borne pathogens through contaminated needles. Severe Stevens Johnson syndrome (Severe skin reaction) limits the use of Thiacetazone.

The fatality rate of tuberculosis is rising. Death is more likely to be due to causes other than tuberculosis. Such patients often develop severe diarrhoea or overwhelming bacterial infection to which they succumb. Of the patients who survive, response to therapy does not appear to differ whether the patient is infected with HIV or not¹⁶.

Primary Prophylaxis for tuberculosis is the most promising preventive intervention¹⁷. Preventive therapy with isoniazid has been

shown to reduce the incidence of tuberculosis reactivation and is the recommended prophylaxis in the USA for tubercular positive and HIV positive individuals¹⁸. Further studies of efficacy and feasibility are under way to evaluate this intervention¹⁷.

The Centre for Disease Control and Prevention (CDC) in the USA has published a new case definition, where pulmonary tuberculosis is included as an additional AIDS indicator disease. In HIV Seropositive individuals, tuberculosis can develop before the CD4 T cell count drops to less than 200/ μ l. Extra pulmonary tuberculosis has been included in the definition since 1987. The addition of pulmonary tuberculosis will bring completeness to AIDS case definition, especially for a country like India, where it is endemic¹⁹.

In the fight against these, the following factors are important.

Faster diagnosis, affordable treatment, education and incentives to patient, development of new drugs including vaccine and fight against poverty are commitments mentioned by Prof. Keith (10-20). Poverty, tuberculosis and HIV are partners in crime. (10).

The Government of India has shown its commitment to fight against it by establishing a National TB task force. (10).

It is time to act for our health care managers, policy makers, politicians and doctors to control both HIV and tuberculosis.

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POTENTIAL VACCINE FOR AIDS

An important discovery in the search for an AIDS (acquired immuno deficiency syndrome) vaccine has been revealed by a research team from the University of Reading and the Institute of Cancer Research. They have found a potential vaccine against a dozen different strains of the human immuno-deficiency virus (HIV).

Specialists had thought an AIDS vaccine may be as elusive as one against influenza because, like flu, HIV changes its outer coat to avoid being detected by antibodies in the vaccine. However, the researchers reported that they have merged a polio vaccine, one of the safest known, with a portion of the outer coat of HIV.

The result is a potential vaccine that in laboratory studies has prevented 12 HIV strains from infecting human blood cells. Dr. Jane McKeating of the Cancer Institute said the hybrid vaccine was "as good, if not better" than any other candidate vaccine presently being tested.

(Source: *IPPF Openfile*, 9 June 1989)

AIDS AND WOMEN

DR S. KANT & DR C. SINGH

Improving the social status of the women will determine not only their vulnerability to AIDS but also their access to health care system in case of contracting the disease.

AT the start of the AIDS epidemic it was noticed that the victims were mostly homosexual males. Sexually active young men were the focus of attention. The realisation that predominant mode of sexual transmission of HIV in Africa and South East Asia is heterosexual rather than homosexual altered the perception regarding potential AIDS victims. The World Health Organisation has estimated that by the year 2000 AD, the number of HIV infected women will reach 13 million. Infact, one million women will be infected in 1993 alone. By 2000 AD, four million women will be dead because of AIDS. Thus, within a short span of time, women and children have moved from the periphery to the centre of concern.

Vulnerability to the infection

There are various reasons why women are more prone to get HIV infection as compared to men. Briefly, they are :

(a) *Biological causes* : Though all body fluids of a seropositive person contains virus, the concentration of virus is different in different fluids. Chances of contracting the infection is partly dependent upon the virus concentration in the infecting fluid. Concentration of virus in vaginal secretion is considerably less than that of seminal fluid. Thus, an uninfected woman is at

significantly higher risk of contracting the infection from a seropositive male partner as compared to the uninfected male from a seropositive woman.

(b) *Epidemiological reasons* : Women marry men who are generally older than themselves. Being older, men would have had more pre-marital sexual experience. Therefore the marital alliance puts the women at a higher risk of getting the infection from their spouses. Additionally, child bearing may necessitate medical intervention, including blood transfusion. The risk of getting infection from unsafe blood makes the women more vulnerable to infection.

(c) *Social reasons* : Most of the women are economically dependent on men. There is a general belief that supporting a woman economically, automatically entitles the man to have sexual privilege : Absence of good social welfare measure makes the women vulnerable to sexual exploitation and hence at a higher risk of contracting the infection. The woman may be willing to use condoms in order to protect herself but it is the male partner who has the final say. This reflects the poor social status of the woman in the society.

HIV infection and pregnancy : Pregnancy in a seropositive woman

does not alter the natural history of the disease. There is no increase in the risk of developing clinical AIDS among seropositive women. Even when the woman develops clinically manifest AIDS, pregnancy does not adversely accelerate the eventual death. However, the chance that the foetus will escape the infection is dependent upon the seropositivity status of the mother. The chance of *in-vitro* infection to foetus is high if the mother has AIDS. It is also high if the mother contracts the infection while she is pregnant. The risk is again high if the mother had delivered a HIV positive baby in her earlier pregnancy. The chance of *in-vitro* infection to foetus is low if mother is already seropositive but does not have AIDS when she conceived the child.

HIV infection and obstetric care : It is neither economically feasible nor scientifically advisable to screen every pregnancy for HIV status. Quality of the screening test cannot be maintained at grassroot level. It could lead to false positive reporting with disastrous consequences to the couple. There is no recognisable high risk group among pregnant women (except for female commercial sex workers); therefore high risk group screening cannot be applied. In such a situation it is advisable that all deliveries be conducted with

necessary precautions if it is known that the woman is a HIV positive.

Breastfeeding by seropositive mother: Breast milk is the best baby food in the world. It not only nourishes the child but also protects against many communicable diseases. However, it is also a known fact that HIV is secreted in the breast milk and can cause infection to an uninfected child. One has to weigh the benefits of breastfeeding in protecting the child against malnutrition and infection *vis-a-vis* the potential small possibility of transmitting the infection. WHO-UNICEF consensus statement on breastfeeding by HIV positive mother recommends that in areas where primary causes of infant death are infectious disease and malnutrition, breastfeeding should remain the standard advice to pregnant women, including those who are known to be HIV positive. Baby's risk of becoming infected through breast milk is likely to be lower than risk of dying of other causes if deprived of breastfeeding. In median context, breastfeeding should remain the standard advice irrespective of the HIV status of the mother.

Immunization of HIV positive children: Infant mortality due to vaccine preventive diseases is still high in India. HIV positive infants develop the same immunological response to six vaccines used in the immunization programme in India, as any other normal child. Therefore, all children, except those suffering from AIDS, should receive the primary immunization and booster doses of the vaccine. Children suffering from AIDS should not be given vaccine against tuberculosis (B. C. G. vaccine).

Health care of female AIDS patients: The stigma attached to the patients of AIDS along with general discrimination towards

women effectively precludes a reasonable expenditure on health care of female AIDS victim. In the absence of early and vigorous treatment of opportunistic infections, these female AIDS patients are likely to die earlier than their male counterparts. Access to even free governmental health care system is dependent upon the societal outlook towards female AIDS patients. The general disapproval of the society towards these patients will inhibit the women to avail of health care which is even unrelated to their AIDS status.

Social impact of AIDS amongst women

In India, sexual transmission of AIDS is mostly through heterosexual contact. Therefore, in coming years, more and more women in the reproductive age group are expected to get infected with HIV. It is known that two-thirds of the children born to seropositive mothers escape the infection. These children run the risk of death of one or both parents in the next ten years. Illness and eventual death of the mother has profound impact on the health of the child. Lack of care due to maternal illness or absence of maternal care due to her death could hasten the death of even the uninfected child.

The biggest challenge in coming times would be to provide care to these unfortunate AIDS orphaned children. The amount of social welfare that would be needed to cope with the situation would be truly enormous.

Prepare for the worst: The standard measures (e.g. immunization, isolation, chemotherapy etc.) to prevent the spread of a communicable disease are not applicable to AIDS epidemic. Availability of a potent and effective vaccine against AIDS is not in sight. Whatever chemotherapeutic agents are being used, are still surrounded in con-

troversy. There is no unanimity regarding their beneficial effect on HIV positive persons. Health education is the only available tool to fight this dreaded disease. There is an urgent need to provide information/education regarding the disease. NGO's and voluntary bodies can provide significant contribution in this effort.

In the long run, improving the social status of the women will determine not only their vulnerability to the disease but also their access to the health care system in case of contracting the disease. Women probably require greater access to health care as compared to men because it is not only their health which is at stake but also the health of the dependent children. It is the death of the mother which would cause the disintegration of family, community and society.

The trend of the AIDS epidemic cannot be wished away. All of us must prepare ourselves to face the future challenge. There is a need to train all categories of health personnel, more so obstetricians, in providing health care to seropositive and AIDS cases. Social welfare measures need to be strengthened and widened in scope so that orphaned children are not materially abandoned. Many young men, may be the sole bread winner of the family, would die. Their families who survive this death may be in the worst possible situation. How to provide them with a source of income that would keep their body and soul together must worry us. Society must also learn to change its values so as to deal with the possible change. Health indicators including IMR, CDR, life expectancy at birth would also be expected to take a beating. The future scenario is indeed daunting and we must prepare ourselves now to meet it effectively. □

CONTACT TRACING:

Method and its importance in S. T. D. and AIDS Control Programmes

DR V. K. TEWARI

In view of the AIDS problem, "contact tracing"—actual contacts from whom the patient has contracted infection—has become all the more important.

SEXUALLY transmitted diseases are major health problems the world over. India is no exception. It is, indeed, an impossible task to assess the magnitude of the problem in India due to lack of reliable data and gross under reporting. It is the most prevalent communicable disease in India. Health education is one of the most important links in the S.T.D. control programme. Amongst different strategies/activities, like, clinical services, screening and contact tracing. Contact tracing is by and large an economical measure in the sense that it may help in checking further spread of S.T.D. which require more medical inputs for the cure of the patients.

In view of the recent emergence of dreaded disease of A.I.D.S., it is

necessary to check the sexual acquaintances of the patients visiting S.T.D. clinics. Besides finding out the preventive aspects of S.T.D.s including the A.I.D.S., it is equally important to find out actual contacts from whom the patient has contracted the infection. Therefore, "Contact Tracing" has become all the more important in the present scenario.

What is Contact Tracing ?

Contact tracing refers to find out the sexual contacts of the patient during the critical period of his/her sexual transmitted infections.

Contact tracing is therefore, an essential part of the S.T.D. control programme. Because there must be at least one sexual contact

behind every S.T.D. patient. There is every apprehension that the infected person will spread the infection to others if he/she is not brought under proper medical treatment.

Methods of Contact Tracing

The method of contact tracing used depends on staff available, literacy status of the patient as well as of the infected source, clinic hours, distance of medical institution, socio-economic condition of the patient as well as the infected source.

Interviewing the patient about their contacts requires tactful behaviour and special communication skills. The commonly used

methods used for contact tracing are :—

1. Discussion/persuasion.
2. Follow up over telephone.
3. Letter.
4. Home visit.
5. Contact card/slip.

In some countries like the U.K., contact tracing is undertaken on a voluntary basis with the help of trained social worker or health visitor. In some part of the U.S.A., contacts are sought as quickly as possible using telephone, telegram and other rapid means of communication.

Importance of Contact Tracing

Effective contact tracing can reduce the S.T.D. including the incidence of diseases and their complications and psycho-social consequences; and can improve the efficiency of the services.

In brief, the foremost importance of a contact tracing are as follows :—

1. Helps in controlling the S.T.D. Diseases by bringing out the infected source under medical treatment and follow up.

2. Helps in protecting the health of individual as well as community at large.
3. Helps in spreading out health education related preventive aspects in the community.

Merits

1. Helps in checking further transmission of infection from the infected source.
2. Provides an opportunity to medical and paramedical staff to impart the health education related message with special reference to S.T.D. control. Hence, this is a useful health education exercise.

De-merit

1. Sex being a taboo in the Indian situation a detailed probing irritates the contact sometimes as he/she considers it an intervention into his/her privacy.

Precautions

1. Case-probing should be as targetted at only few in order to avoid the embarrassment of patients/infected source.

2. Flexible attitude towards the convenience of the patient/infected source in respect of their reporting to the hospital.

3. Message given to the patient/infected source should be, by and large similar to avoid any confusion.

4. Privacy should be strictly maintained.

5. Information to be recorded in contact card/slip should preferably be entered in pre-decided code.

Undoubtedly, the contact tracing is a highly appreciable technique in the field of case-finding; however, it requires expertise before applying it in real situations. Sex being a taboo in the Indian context further acts as a barrier in the success of this technique.

However, proper experience, adequate patience and establishment of rapport with the patient may bring about unexpected positive results and facilitate the S.T.D. control by making the sexual promiscuous persons aware of risk involved in the undesirable sexual practices. □



AIDS : A SELECT BIBLIOGRAPHY (1991—1993)

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We publish below a Select Bibliography on "Acquired Immunodeficiency Syndrome" with reference to Indian context, compiled by the National Medical Library (DGHS) as part of its activities aimed at providing Documentation Services to the Health Science community in the country. It covers selected contributions on Acquired Immunodeficiency Syndrome during 1991-1993. Entries follow a classified arrangement using Main Subject headings and Sub-headings. Photocopies of these articles can be ordered from National Medical Library (DGHS), Ansari Nagar, Ring Road, New Delhi-110 029.

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THE INHERITED LOTTERY OF HEART ATTACK RISK

Some people may be more susceptible to a heart attack because they have not inherited a natural ability to contain the level of a blood protein implicated in clot formation, according to researchers at London's Charin Cross Sunley Research Centre.

In recent years, high levels of Factor VII have been found to be associated with increased risk of heart attack. While it is known that the protein is affected by environmental factors such as smoking and diet, the new studies have identified important inherited factors which also help to decide individual risk levels.

Dr. Fiona Green from the London centre's arterial disease research unit says she has pinpointed a genetic variant responsible for a change in Factor VII that reduces its presence in the blood by up to 23 per cent. This variant, which is found in around 20 per cent of the population in the UK, is therefore likely to give a degree of protection against clotting and so reduce the risk of a heart attack.

The unit's studies of another blood protein involved in clot forming, fibrinogen, have conformed previous suggestions that it is also affected by inherited factors. But this time the genetic component has been found to have the effect of slightly raising its levels by one to two per cent in both non-smokers and smokers. However, this is not thought to be enough to influence the risk of a heart attack.

△

—British Information Services

Talking About AIDS : Communicating with Youth

AIDS is a special concern for youth. Globally, about 20 to 25 percent of all HIV infections is roughly estimated to occur in young people aged 19 to 24 years. This age group also accounts for a disproportionate share of the increase in reported cases of syphilis and gonorrhoea worldwide.

In the South-East Asia Region where young people constitute at least 50% of the total population, a growing proportion of young people are involved in behaviour which places them at higher risks of acquiring HIV infection.

Many of the young from their early teens are engaging in high risk sexual activities; they are also experimenting with drugs and sharing contaminated injecting drug equipment. In some poverty stricken societies, both girls and boys are known to sell sexual services to make a living for themselves and for their families. And yet on the other hand there is no doubt whatever that the young constitute one of our greatest resources for health. With the aspirations they harbour and with their abounding energy and zest for living, youth possess tremendous capacities and capabilities to make this world a better and healthier place to live in. They also possess a vast potential for mobilizing people for social action and for creating effective networks between themselves for achieving their goals.

The time has come to mobilize this excellent resource, to harness

its untapped energies and to actively involve youth in health activities.

Youth have a very significant role in the prevention and control of AIDS, through various ways which include educating others, adopting exemplary healthy lifestyles thereby being a role model to other youth and by taking up advocacy roles by using youth power to influence peer groups and arouse public opinion.

However, it is suspected that currently a very small proportion of youth in the Region can effectively play this role, an important reason being that they do not know enough about AIDS and how it can be prevented.

Talking about AIDS to youth is therefore an activity that must receive high priority. The need to disseminate to youth correct and complete information about the disease using all channels available is urgent. Often this in itself is not enough. The vulnerability of youth to HIV infection must be understood in both its biological and social contexts. The biological sexual drive during adolescence, and the susceptibilities to group pressure are not easy to overcome even when knowledge is complete. Besides there are a number of misconceptions associated with AIDS which must be dispelled. These cause unnecessary worry and paralysing fears especially when young people are not informed of how HIV is not transmitted. Youth are also very often faced with conflicting

messages. While their religion and parents place high value on abstinence from sex before marriage, their peers expect them to defy such values. For this main reason, it is important to link counselling with information and education programmes for youth. Counselling will help not merely to provide correct information but also to guide the young person in the decision he or she may have to make, if it is necessary to change behaviour.

Additionally youth must be also equipped with prevention skills which they can apply to practice safer sex, to negotiate safer sex practice and to stay away from alcohol and drugs. Alcohol and drugs through altering the normal functions can be held responsible for making even knowledgeable people behave irresponsibly at critical moments. Youth may also have to be imparted skills in safe injecting practices. In some societies, prevention skills are particularly important to develop in those who have not yet begun to experiment with sex and drugs. As it is easier to change behaviour before it becomes firmly established, all efforts must be aimed at those who are not yet sexually active to help them maintain the safer status for as long as it is possible.

A serious shortcoming in the Region is the taboo against talking to the young about sex and sexuality. The school curricula does not provide such knowledge even when it covers such topics as

A mass sensitization campaign to reach university students to educate them about AIDS was launched in India in 1991 through the National Social Service Scheme (NSS) in collaboration with WHO. The programme entitled "Universities Talk AIDS" planned a nationwide message and materials development contest, the aim being to generate among students open discussions about AIDS and produce effective messages for university students. Students from 65 universities in India were involved in designing messages and materials for students through regional training workshops on the process of message design and material development. The materials prepared were judged on the basis of the methodology used for their development, creativity of design and effectiveness in conveying the message, and Awards were presented at a national ceremony held close to World AIDS Day. The experience gained from this campaign will be found most useful in developing a comprehensive programme on AIDS education for university students.

human reproduction and family planning; out-of-school youth have even less orientation to such topics. Talking about sexual issues comfortably is however crucial for AIDS education, more so when talking to adolescents who have been conditioned into thinking that sex is dirty and something that can only be enjoyed clandestinely. Issues related to sex and sexuality must be discussed in the context of the socio-cultural influences which mould and influence group and individual beliefs and values regarding such issues. The range of sexual orientations must be explained including homosexual, bisexual and heterosexual practices.

Messages and Channels of Communication

In communicating to youth, the major risk factors for HIV infection in the local youth population must be known. It is also important to know what specific behaviours expose young people to risk. Is it multiple sex partners, injection drug use, sexual exploitation or any other commonly practiced behaviour? Only then can relevant and realistic messages be designed. It is useful to conduct behavioural and focus group discussions among representative samples of young people to determine this. Their level of knowledge about AIDS and especially their misconceptions must be known. It is also necessary to explore what motivational forces will lead to preventive action, and to involve the youth themselves in designing appropriate messages.

In HIV education, as in most other educational programmes, it

is equally important to identify the effective communication channels to reach the target population. Selecting an appropriate channel to communicate, often depends upon the needs and concerns of the audience. Both personal and mass communication approaches have a place. By and large, personal communication may be more effective if the audience is small, easily identified and at high risk after HIV exposure. This group is also best reached through peer education approaches. Another advantage of personal communication is its potential for talking about issues which would not be possible or permitted through mass communication channels. On the other hand, mass communication may be appropriate for reaching and influencing larger youth audiences.

What is important is that whatever channel is used, whether singly or in combination, it must capture the attention and interest of the audience.

"Talking AIDS" to youth can be carried out in a variety of settings—in schools and colleges, at youth clubs and within non-formal education programmes addressed to out-of-school youth. Non-governmental organizations have a vital role in this effort, reaching out to school drop outs, street children, drug users, youth involved in prostitution, and other such hard-to-reach youth.

There are also today several youth organizations in the countries of South-East Asia who, through their networks, can spread the AIDS message to both urban and rural audiences.

In a Regional Statement on Youth Involvement in AIDS Prevention and Control at a WHO workshop participants from eight countries of the South-East Asia Region expressed their strong belief that organized youth efforts have an important role to play in AIDS prevention programmes, especially in "youth to youth" motivation and behavioural change and recommended that youth and youth organizations be provided with adequate information and knowledge of how HIV is transmitted and prevented with the ultimate objective of effecting behavioural change.

Talking AIDS to youth thus goes far beyond just telling the young all about AIDS and how it is caused. Youth must also be helped to take action and to be motivated to adopt and maintain safe behaviours. The WHO Global Programme on AIDS is giving high priority to activities related to youth and adolescents with an increasing focus on prevention activities for youth. Curricula guidelines for AIDS education programmes in schools have been prepared. Guidelines are being developed for out of school youth and the effectiveness and reach of the peer education model and community outreach programmes are being assessed. The Programme is convinced that the epidemic of HIV infection and AIDS cannot be brought under control unless more AIDS prevention efforts are directed at young people. Talking about AIDS to youth would certainly be the first step.—WHO Kit □

Developing and implementing school policies to address HIV infection and other health policies

A. ISAKSSON, S. BAHRI, D. O'BYRNE, S. CHOWDHUNG, J. REINDERS, K. FRASER

This report is based on the deliberations of a working group that was facilitated by Andri Isaksson, UNESCO. The participants were: Sonia Bahri, UNESCO; Shankar Chowdhury, All India Institute of Medical Services; Katherine Fraser, National Association of State Boards of Education (USA); Desmond O'Byrne, WHO; and Jo Reinders, Dutch Centre for Health Promotion and Health Education. The report was presented at the conference by Sonia Bahri, UNESCO.

BECAUSE of the urgent need to enable young people to void HIV infection, it is important for schools to be able to plan and implement HIV-related policies and programmes without delay.

However, there are obstacles to the successful implementation of any new educational effort within most educational systems. Due to the sensitive nature of behaviours related to HIV transmission, these obstacles may be greater for education about AIDS and HIV than for other new efforts. In many regions of the world, formal education on sexual matters either does not exist, is inadequate or is provided too late in adolescence (1).

Establishing an HIV-related school policy is fundamental to the successful involvement of schools in the prevention of HIV/AIDS. In the context of this report, HIV-related school policy means a general direction or strategy for action adopted by a government, responsible authorities or institutions to address issues related to AIDS, HIV infection, STD and other significant health problems.

Why are HIV-related school policies needed?

The policy development process engages education and health officials, teachers, school counsellors, community leaders, parents and students in determining the role schools will play in preventing AIDS/HIV, STD and other important health problems. It also can help facilitate understanding, commitment and support among leaders and concerned citizens.

HIV-related policies can help overcome some of the most common institutional barriers to implementing new educational efforts. These include: assignment of responsibility, conflicting priorities, fragmented programming and overloaded curricula; and lack of defined ways of addressing the issue, resources and training for school personnel.

Frequently, HIV-related school policies are needed for the following reasons:

- To develop understanding, commitment, and support among leaders and community members as to the problem, intervention methods and expected results. Without commitment and support, schools will have difficulty addressing sensitive health issues such as HIV/AIDS.
- To provide a context for changes in school programmes. School personnel will be reluctant to accept responsibility for implementing the necessary changes for providing education to prevent HIV infection, if they have not been given a reason and strong direction and support.
- To promote consistency in education about HIV and sex between the school and the home.
- To help establish a framework for the evaluation of school's HIV-related activities.

(1) WHO Features, No. 152, December 1990

- To provide parameters and direction to outside organizations that offer or are asked to help the school provide education about HIV for students and teachers.
- To address ethical and legal issues related to sex education.

The nature and scope of HIV-related school policies

HIV-related school policies commonly reflect the goal of preventing the spread of HIV infection and minimizing the negative impact of HIV/AIDS. They often include a statement providing a rationale and support for the necessity of school-based HIV-education.

HIV-related school policies can provide vision and context for integrating education about HIV into a more comprehensive and holistic approach, such as one that includes education to prevent pregnancy and STD, that promotes a positive and healthy view of sexuality, and that addresses other relevant and interrelated health issues. They can help establish coherence between HIV-related education, school health services and the school climate. They also can provide support for education designed to help young people acquire the knowledge, values, attitudes, skills and support needed to avoid important health problems, including HIV infection, and discrimination.

HIV-related school policies can provide guidance about:

- Resources for planning and implementing education about HIV, including provision for supporting personnel preparation, materials development and dissemination and cooperation with other organizations.
- How explicit education about HIV and AIDS should be, taking into account the age and development levels of students.
- The amount of time that should be devoted to education about HIV.
- The placement of HIV in the curriculum.
- Qualifications and training of staff.
- Instructional materials.
- Programme evaluation.
- Involving parents in the programme so as to progressively build support and minimize concerns.

- Establishing a supportive environment that does not discriminate against students or teachers based on their sexual orientation or gender.
- Accommodating student and school personnel who are infected with HIV, protecting their privacy and confidentiality, and taking appropriate hygienic precautions with exposures to blood.

Suggestions and considerations in planning and implementing HIV-related school policies

Some important considerations and suggestions for planning and implementing HIV-related school policies follow:

- In initiating the development of HIV-related school policy, information should be provided to school personnel and the wider community about the extent to which young people are at risk of HIV infection, STDs, unintended pregnancies and other important health problems; about evidence that school-based efforts can influence behaviours associated with important health problems; and about the extent to which young people worry about sexual issues.
- The health agency, school assisting institutions, teacher's unions, students and parents, should be involved in policy development.
- HIV-related school policy should be based on three essential components: prevention, solidarity, and care, with the greatest emphasis on prevention.
- Encourage schools to develop local policies, within the general guidance and framework of governmental or national policy to be able to meet their specific needs and concerns.
- Controversy should be addressed immediately, openly and diplomatically.

A process to find consensus is essential for establishing a broad supportive base. For policies to be effective, there should be consensus and a willingness to cooperate with other implicated parties, such as parents, teachers, and religious organizations.

Once HIV-related school policies are developed, they must be communicated to those persons for whom they are intended. This is an essential part of the process, and will help assure their implementation.

—Courtesy: Hygie

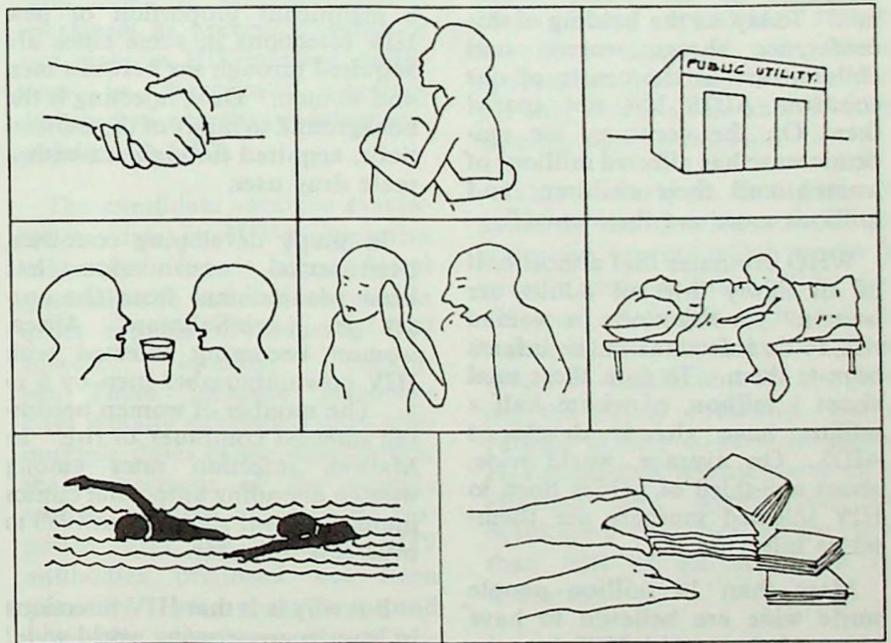
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ROADS THAT HIV WILL NOT TAKE

The range of present attitudes towards AIDS is similar to the attitudes once seen towards syphilis in the early 19th Century. Myths and emotional hysteria can be generated due to misinformation about AIDS. Many myths about HIV today centre around the manner in which it can be transmitted. Extensive research has shown that there are only three well defined routes of HIV transmission. The studies show that :

HIV Does Not Spread By:

- Drinking water from the same glass as an infected person.
- Swimming in pools used by people with HIV or AIDS.
- Getting bitten by a mosquito that has already bitten an infected person.
- Getting bitten by an infected person.
- Socialising or casually living with people with HIV or AIDS.
- Caring and looking after people with HIV or AIDS.
- Use of the same toilets as AIDS patients or people infected with HIV.
- Shaking hands with people with AIDS or HIV.
- Hugging or kissing a person with HIV or AIDS.
- Casual contact such as sitting next to an infected person, or by coughing and sneezing, or from water, food, clothing, cups, glasses, plates, forks, spoons and other shared objects.



- Receiving and reviewing literature from areas of the world where there is AIDS.
- Donating blood.

Bedbugs, flies, lice, fleas and other insects and pests DO NOT spread HIV. □

* * *

13 MILLION HIV POSITIVE WOMEN BY 2000

NEW figures released by the World Health Organization on 7 September 1993, show that by the year 2000, over 13 million women will have been infected by HIV and about 4 million of them will have died. More than 1 million women will become infected in 1993 alone.

Speaking at the opening of the 2nd International Conference on HIV in children and mothers in Edinburgh, Dr Michael Merson, Executive Director of the WHO Global Programme on AIDS said:

"A decade ago women and children seemed to be on the periphery of the AIDS epidemic. Today, as the holding of this conference shows, women and children are at the centre of our concern. AIDS has not spared them. On the contrary, the epidemic wave has affected millions of women and their children, and millions more are threatened."

WHO estimates that almost half of all newly infected adults are women. As infections in women rise, so do infections in the infants born to them. To date, these total about 1 million, of whom half a million have already developed AIDS. On average, world wide, about one-third of babies born to HIV infected mothers are themselves infected.

More than 14 million people world wide are believed to have become infected with HIV since the start of the epidemic. However, so far less than one-fifth of these have gone on to develop AIDS, and fewer still have died of the infection:

"We are still in the early stages of the epidemic in terms of the disease and death it will cause," says Dr Merson. "So many people have already been infected that the

cumulative number of AIDS cases will quadruple by the year 2000. But, though there is no cure yet for HIV infection or AIDS, people's suffering and isolation can be lessened by appropriate treatment, support and care. At the same time we need to prevent new infections in women and children."

In industrialized countries, transmission is still often through homosexual contact or injecting drug use. But there is an ominous rise in heterosexual transmission. Last year in the USA, AIDS cases in women were almost 10% higher than the year before. In 1992, sex became the leading cause of AIDS in American women. In Scotland a significant proportion of new HIV infections in some cities are acquired through sex between men and women. Drug injecting is the background to many of these infections, acquired through sex with a male drug user.

In many developing countries, heterosexual transmission has been predominant from the outset. In sub-Saharan Africa, women becoming infected with HIV now outnumber men by 6 to 5. The number of women becoming infected continues to rise. In Malawi, infection rates among women attending ante-natal clinics increased from about 3% in 1985 to over 30% this year.

But why is it that HIV infections in women are growing world wide? Dr Merson outlined three main reasons.

* **Women are biologically more vulnerable.** As the receptive partner, women have a larger mucosal surface exposed during sexual intercourse; moreover, semen contains a far higher concentration of HIV than vaginal fluid. Hence

women run a bigger risk of acquiring HIV infection — and other sexually transmitted diseases (STDs).

* **Women are epidemiologically vulnerable.** Women tend to marry or have sex with older men, who may have had more sexual partners and hence be more likely to have become infected. Women are also epidemiologically vulnerable to HIV transmission through blood. In the developing world women frequently require a blood transfusion during pregnancy or child birth — for example, because of anaemia, or hemorrhage.

* **Women are socially vulnerable to HIV.** Men are expected to be assertive and women passive in their sexual relationships. In some cultures, men expect sex with any women receiving their economic support. Whenever these traditional norms predominate, the result is sexual subordination, and this creates a highly unfavourable atmosphere for AIDS prevention. An environment in which it is difficult or even impossible for women to protect themselves from sexual transmission, through mutual fidelity or condom use.

Summing up what can be done to reduce the vulnerability of women to HIV infection, Dr Merson highlighted a number of suggestions. Among them are:

- biomedical scientists should give top priority to developing a vaginal virucide or microbicide active against HIV and other STDs
- national AIDS programmes should implement effective interventions aimed at men, such as needle exchange pro-

grammes for injecting drugs users and vigorous condom promotion

- young girls, who are especially vulnerable, should be taught how to protect themselves from HIV infection

— women should be encouraged to seek and should receive good STD care

- and, men everywhere can help put an end to social traditions which lead to women's subordination

"Women face extra challenges in protecting themselves and their children from HIV infection" concludes Dr Merson. "But this social vulnerability is hard for women to challenge as individuals, or even through female solidarity alone. It will take an alliance of women and men working in a spirit of mutual respect."—WHO.

Promising progress on HIV vaccine, says W.H.O. AIDS Chief

DR MICHAEL MERSON, Executive Director of the World Health Organization Global Programme on AIDS, said that there has been important progress in HIV vaccine development but that an effective HIV vaccine was still years away. In his keynote address, Dr Merson called on researchers to intensify their efforts—especially in basic research—in the search for an HIV vaccine. He was addressing the 9th International Congress of Virology meeting in Glasgow on 9th August, 1993.

"The progress to date on HIV vaccine development is encouraging," says Dr Merson, "but there must be no let-up in research to develop a safe, effective and universally available vaccine. We know it is possible to prevent the sexual transmission of HIV through the adoption of safer sex practices, including condom use, and the treatment of sexually transmitted diseases. We know the pandemic can be slowed—and we can do it, with sufficient commitment and resources—but this is not enough. We need a vaccine to complement our existing prevention strategies. AIDS is already devastating some societies, and the worst is yet to come."

Since 1987, 15 so-called candidate vaccines have entered Phase I and, in some cases, Phase II human trials to assess their safety and immunogenicity. Thirteen of these 15 candidate vaccines have been tested in HIV-seronegative volunteers as preventive vaccines and eight in HIV-infected volunteers as therapeutic vaccines designed to prevent or delay progression to AIDS.

The candidate vaccines evaluated to date in HIV-seronegative volunteers have been found generally safe and well tolerated in doses capable of inducing HIV specific immune responses. These immune responses have usually developed only after multiple doses of the immunogen, the component of the vaccine which produces an immune response; and the level of HIV antibodies produced has been generally low, short-lived and relatively strain-specific. Their relevance to protection is not yet known.

In the trials involving HIV-seropositive volunteers, the candidate vaccines have been shown to be well tolerated, safe, and capable of inducing increased and broader immune responses. No information is yet available on their

efficacy in preventing or delaying the onset of AIDS.

The largest group of the candidate vaccines being developed and tested in humans today are subunit recombinant vaccines. Some promising results have been obtained using these approaches, but they may not be the only way to a safe and effective vaccine, says Dr Merson.

"One scenario we should like to avoid is the development of an expensive vaccine which works in specific areas, and that will be useable and affordable exclusively in industrialized countries. This would be insufficient for controlling the global epidemic. For a vaccine to help control the global HIV pandemic, it must above all be effective and appropriate for developing countries, where more than 80% of all infections are occurring."

All the candidate vaccines now being developed and tested in man are using the following approaches:

- * synthetic peptides
- * subunit recombinant
- * live vectors
- * inactivated virus

But, recently, WHO decided to put the development of a live attenuated HIV vaccine on today's research agenda. A meeting of leading scientists and experts in medical ethics convened by the Global Programme on AIDS recommended that a live attenuated approach for HIV vaccines should be intensively explored, in parallel with other vaccine research.

"With the millions of lives at stake in this pandemic, every possibility must be examined," says Dr Merson. "For instance, we know that some of the most effective and affordable vaccines, such as those against polio, measles and yellow fever, are based on live attenuated vaccines which use a virus weakened or altered so that it does not result in disease. Before human trials could ever be considered, numerous studies in

animal models should be conducted. Other candidate vaccines must proceed into efficacy trials as soon as possible, before such human trials could ever be considered seriously. The results of these efficacy trials, either positive or negative, will be critical for the risk/benefit analysis that will help us decide whether to proceed to testing live attenuated HIV vaccines in humans."

WHO estimates the cost of effective AIDS prevention in developing countries to be between \$ 1.5 and \$ 2.9 billion a year. Such an investment could halve the number of new adult infections this decade, from nearly 20 million to 10 million. This would not only save many times this figure in the cost of AIDS cases averted but more importantly, it would also save millions of lives and untold human suffering.

However, it is clear that although behaviour change which will help slow the spread of HIV can be achieved, behavioural interventions alone can never stamp out the transmission of HIV. A safe and effective vaccine is needed to complement the existing prevention strategies:

"We now have a number of effective interventions to prevent HIV transmission, such as promoting safer sex and providing condoms, and diagnosing and treating sexually transmitted diseases. But these have been only partially successful, and a safe and effective vaccine would be an important tool to complement the existing prevention strategies," concludes Dr Merson.—WHO.

REVAMP MEDICAL EDUCATION, Says W.H.O. AIDS Programme Director

DR MICHAEL MERSON, Executive Director of the World Health Organization (WHO) Global Programme on AIDS, speaking at the World Conference on Medical Education in Edinburgh (8-12 August 1993) has called for a fresh look at the way doctors are educated.

"AIDS is a catastrophe in slow motion that will be with us for decades to come. It poses a challenge to medical education because of the kind of care it requires, the approaches needed for AIDS prevention and in its interactions with society. Doctors need to learn how to work as part of a team with other health and social workers, and they need to encourage and support families in caring for their loved ones at home. Above all, they need to consider the patients as knowledgeable allies, not as passive recipients of care, and involve them fully in the entire care process, including decision-making about treatment."

Dr Merson said that the doctor of the future would need:

- * greatly improved communications skills
- * a better understanding of the interplay between health and human rights
- * greater familiarity with infectious diseases
- * a serious grounding in public health
- * an appreciation of the social environment of the disease

The existing medical school curriculum must be changed to meet the needs not only of AIDS but also of other diseases, Dr Merson added. These include:

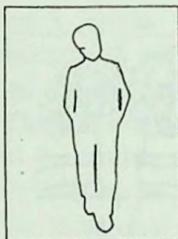
- * chronic diseases such as arthritis and diabetes which lend themselves far less to cure than long term care and support, with the full involvement of the patients themselves;

- * preventable conditions such as lung cancer and heart disease, where information and education about life style is the key to prevention; and
- * drug dependency where a sound public health approach including provision for needle exchange and other supportive programmes should take priority over repressive practices.

"If the challenges I have outlined were confined to AIDS and AIDS alone, I would not be arguing for a revamped medical school curriculum. Medical education needs rethinking precisely because AIDS is not unique. Many of the features of AIDS can be seen in illnesses prevalent today not only in the industrialized world but in developing countries as well" he said.—W.H.O.

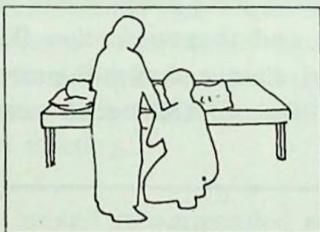
Contributions to "Swasth Hind" from health and social welfare workers on public health topics are invited. Articles should be typewritten and suitably illustrated. They ordinarily should contain about 1200 words and sent in triplicate to the Editor, Central Health Education Bureau, Kotla Road, New Delhi-110 002. Reproduction of contents of "Swasth Hind" is welcome. Due acknowledgement is, however, requested.

Preventing the Spread of HIV: Whose Responsibility?



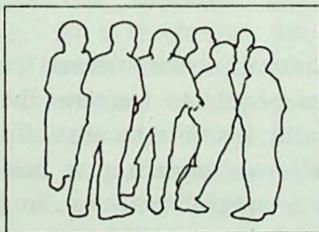
Individual

Individuals must adopt a lifestyle and behaviour which is compatible to health and curtails the transmission of HIV. Individuals with HIV/AIDS must take personal responsibility to ensure that they will stop the further spread of the virus.



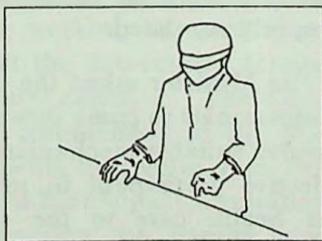
Family

Families must adopt values which promote health. The family must provide understanding, compassion and care to help any family member with HIV/AIDS in coping with the unusual situation and maximizing his or her health potential to refrain from infecting others.



Society

Societies must avoid discriminating against people with HIV/AIDS and promote a supportive environment characterized by protective social norms. Societies must also strive to minimize socioeconomic factors like poverty which tends to aggravate the situation.

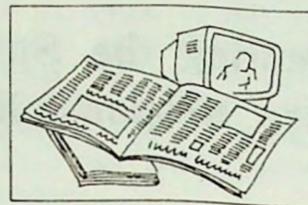


Health Personnel

Health Personnel have the dual responsibility of providing care and counselling to people with HIV/AIDS. They must take appropriate precautions to prevent the spread of the infection in other patients and among themselves; act as a role model for their community by providing compassionate and respectful care; and educate individuals and groups about the facts related to HIV.

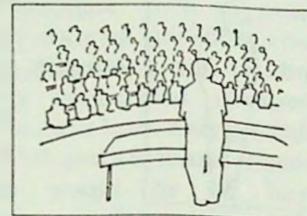
Media

The mass media represent the most readily available and potentially most economical means of imparting information about HIV/AIDS. Along with other forms of communication, the mass media can effectively raise public awareness and concern about HIV/AIDS. However, mass media has to adopt a responsible attitude in reporting about HIV/AIDS, avoiding inaccuracies which may generate, rather than clarify, misconceptions about HIV/AIDS.



Health Educators and NGOs

Health educators and NGOs can help in spreading the right messages about HIV/AIDS by initiating a learning process for mass audiences in communities. With their involvement at the grassroots, NGOs can provide the critical link between health educators and the community.



One of the most important and challenging preventive measures against AIDS have been indeed directed towards preventive interventions, including the use of information, education and communication (IEC), to increase knowledge and change attitudes. This aims to facilitate behavioural change that will prevent the spread of HIV/AIDS. WHO on its part focuses on an important theme related to AIDS each year on 1 December—the World AIDS Day. —W.H.O.

HEALTH MINISTER LAUNCHES WORLD DEVELOPMENT REPORT, 1993

WORLD Development Report, 1993 is an important landmark in our understanding and appreciation of the place of health in the process of development. This was disclosed by the Union Minister for Health and Family Welfare, Shri B. Shankaranand on 7th July, 1993 in New Delhi while launching of the World Development Report, 1993.

Shri Shankaranand commended the initiative taken by World Bank for mobilising assistance to prevent and control the pandemic of AIDS and health programmes.

The Minister further said that important changes had taken place in the global and Indian health scenario. There had been significant achievements, and also avoidable failures. Life expectancy had continued to increase and infant mortality continues to decline. The expanded programme of immunization had drastically reduced the occurrence of measles and polio.

The Minister also said that the government had agreed with the three pronged approach, advocated by the Report, for improving health in developing countries. The governments need to foster an

economic environment that enables people to improve their own health; it would be cost-effective to reallocate government investment from specialised care in tertiary health care facilities to programmes of control of infectious diseases and mal-nutrition that would help the poor most and greater private sector involvement in health should be facilitated and properly regulated.

The Minister asked the medical professionals to come forward and involve suitable mechanism for its effective participant in providing the health care to the community. —PLB

CCH & FW RECOMMENDS EDUCATION COMMISSION IN HEALTH SCIENCES

THE Central Council of Health and Family Welfare (CCH & FW) has endorsed in principle the draft National Education Policy in Health Sciences providing for the educational needs and training requirements of all major categories of health care professionals. The Council also recognised the need for setting up an Education Commission in Health Sciences. The three-day conference of the CCH & FW which concluded on 16th July, 1993 in New Delhi has also recommended that a detailed programme of action based on the policy framework be developed and placed before the Council at its next meeting.

The Council recommended setting up of Family Welfare Committees at the village/Panchayat, intermediate and District level Panchayats to promote family planning. In a resolution, adopted, the Council took note of the 73rd Constitution Amendments Act and felt that the Village Committees can play a significant role in promoting the acceptance of family planning by creating awareness and persuading couples to adopt spacing methods and promote maternal and child health care, ensure compliance of the Child Marriage Restraint Act and monitor working of health providers at the sub-centres through community sanction. The Council also commended to the State governments to involve Zila Parishads and Municipal Corporations for promoting the Family planning programme.

An important conclusion of the Council related to the need to streamline the financing of the health sector to ensure optimal utilization of resources. The Council recognized the need to maintain full sectoral allocations for the national programmes as originally planned and noted that funds provided for national programmes, especially for essential consumables and drug should not be diverted, as they affected the most vulnerable and poor.

The Council noted the emergence of HIV/AIDS as a serious public health problem affecting all the States and Union Territories. The need to ensure strict observance of the mandatory requirements relating to blood-safety was stressed. It was also noted that the control of sexually transmitted diseases (STD) would have to be an important component of the AIDS Control programme. The need to integrate it with general and primary health care to provide easily accessible and non-stigmatised counselling and services was stressed. It was recognised that the ultimate solution was to launch an innovative communication strategy, encompassing all the target groups.

The Council emphasised the need to upgrade the standards of Indian System of Medicines (ISM) & Homoeopathy colleges to meet their realistic needs. The setting of specialized treatment centres and strengthening drug control was also supported. The Council

welcomed the central government's initiative to intensify the malaria control programme in tribal areas by meeting 100 per cent of the cost. It called upon state governments to strengthen primary health care infrastructure in tribal areas, and felt that the programme in the non-tribal areas should continue on the existing equal cost sharing basis between the states and the centre.

In view of the added danger of spread of TB on account of HIV the Council supported urgent measures for uninterrupted drug supply to those undergoing treatment and strong public health education campaign on TB control. The CCH & FW appreciated the progress made under the National Leprosy Eradication Programme. It also welcomed the inclusion of the MDT programme to all endemic and moderately endemic areas with a view to eliminate the disease by the 2000 A.D. Special emphasis was also placed on the need for establishing District Blindness Societies.

It was noted by the Council that 167 million people were exposed to the risk of iodine deficiency, leading to goitre, cretinism and neurological disorders. All the states were enjoined to issue notifications banning the consumption of non-iodised salt and to enforce the ban orders strictly while involving the public distribution system in the sale of iodized salt.—PIB

COMBAT AIDS COLLECTIVELY, Health Minister tells SAARC Members

SHRI B. SHANKARANAND Union Minister for Health and Family Welfare, has called upon the South-Asian Association of Regional Cooperation (SAARC), countries to make a collaborative effort to combat spread of the AIDS disease. Inaugurating a SAARC Seminar on AIDS on 21st June, 1993 in New Delhi, the Minister said sharing of knowledge and expertise among the member countries of SAARC on Sexually Transmitted Diseases (STD) and AIDS would strengthen the National AIDS Control Programme of each member country.

Noting that AIDS was not isolated among one group of people, the Minister said it is estimated that the South-Asian region had about 1.5 million HIV cases. Since there was no vaccine or cure, the only possible intervention strategy was prevention, he said. Stressing the need to generate enough awareness to avoid the kind of risk-behaviour which facilitated the spread of HIV infection, he said, this required an imaginative communication strategy, as communicating about AIDS/HIV and STDs necessarily involved discussion on sexual practices.

AIDS is a social disease and involvement of all sectors was needed, he said. It was necessary to integrate efforts of STD/HIV/AIDS prevention in all aspects of development and training that take place in this region, he added. Special targetted intervention needs to take place for youth, school children, women, industrial workers, road transporters, unformed personnel and various other segments of society who are vulnerable to this infection. Efforts in this regard must be taken up in earnest, he urged.

As more and more number of HIV/AIDS cases are reported, there was urgent need to ensure confidentiality and social protection to those affected by this disease. He pointed out that the health system by itself would not be able to take care of all the HIV infected persons. The focus would thus shift to home-based care. To make this possible, it was necessary to ensure that the community was favourably disposed to people living with the virus. Lessons learnt from leprosy and Tuberculosis control had given enough indicators to learn that society needed to be geared up from the very beginning through aware-

ness programme on these issues. Care had to be taken to not stigmatize any one particular group or individuals, said Shri Shankaranand.

Valedictory

The first step towards a collective effort by the SAARC countries to combat the AIDS disease was taken with the conclusion of a three-day 'SAARC Seminar on AIDS' on 23rd June, 1993 in New Delhi. Delivering the valedictory address, Shri Paban Singh Ghatowar, Deputy Minister for Health and Family Welfare noted that the HIV infection had no respect for international borders and posed common threat to the countries of the South-Asian region.

The Minister said that AIDS was not merely a health problem, it had socio-economic, moral, legal and ethical ramifications. A unity of efforts, he stressed, was thus required not only within countries but between countries of the world and all sections of the community. He said the government had launched a comprehensive AIDS control programme involving a multi-sectoral and multi-disciplinary approach. —PIB



Dr P. Raja Ram, Deputy Director General (Medical) seated in the centre, addressing the symposium on Stop Disasters. On his left is Mr A.K. Sharma, Divisional Officer of Delhi Fire Service and Dr V.S. Singhal, Director, CHEB on his right.

DISASTER PREPAREDNESS

The Central Health Education Bureau, Directorate General of Health Services organised a symposium on "Stop Disasters : Focus on Schools and Hospitals" on the occasion of International Day for Natural Disaster Reduction on 13th October, 1993 in New Delhi.

While introducing the subject, Dr V. S. Singhal, Director, Central Health Education Bureau said that although natural disasters cannot be stopped but definitely we can prevent the damage and destruction due to such disasters.

Dr P. Raja Ram, Deputy Director General (Medical) while inaugurating the symposium said that the natural and man-made disasters in the world are on the increase during the past decade. And methods are available for reducing the loss of lives and goods caused by these disasters. There is a need to create public awareness about prevention and mitigation of the ill-effects of these disasters. It is better to prevent than regret, he said.

The other speakers were Dr B. K. Verma, Director (Emergency Medical Relief), Mr. A.K. Sharma, Divisional officer of Delhi Fire Service and Mr. J. S. Manjul, Deputy Director (School Health Education).

An exhibition on Disaster Preparedness was also organised by Central Health Education Bureau on the occasion.



Shri Paban Singh Ghatowar, Deputy Minister for Health and Family Welfare, inaugurating the Health Education Campaign for inmates of Tihar Jail, New Delhi.



A view of the inmates of Tihar Jail, New Delhi.

HEALTH EDUCATION CAMPAIGN IN TIHAR JAIL

The Central Health Education Bureau organised a 'Health Education Campaign' for the inmates of Tihar Jail. The Deputy Minister of Health & Family Welfare, Shri Pawan Singh Ghatowar, inaugurated the month-long activities on 2nd October, 1993 at the Jail premises in New Delhi.

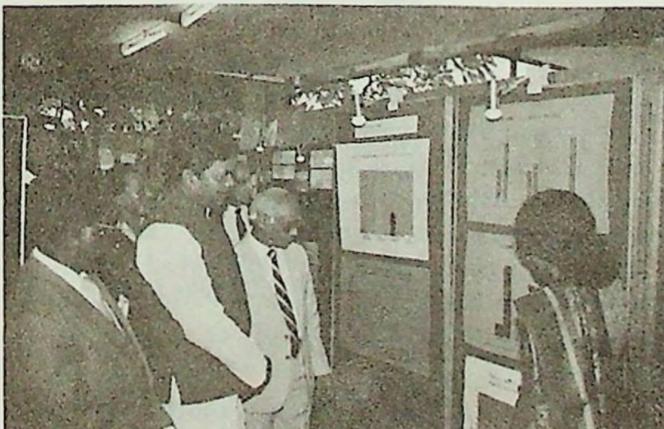
The campaign aimed at providing health education for the 9,000 jail inmates to enable them to look after their own health. There were special groups like women and juveniles among them.

Considering the need of this very special group of the society, various activities like exhibition, group

talk, skit, film shows and painting exhibitions were organised on AIDS and prevention of tobacco consumption.

An evaluation of the campaign revealed that the effort was appreciated by jail authorities and inmates equally. It created awareness on both the topics so executed for practicing safe health.

The exhibition was concluded with a positive note by both Director, CHEB and the Inspector General (Prison) to have these exhibitions in future, too on other topics.



Shri Paban Singh Ghatowar, Deputy Minister of Health and Family Welfare, viewing the exhibition set up at the Tihar Jail, New Delhi.



Dr V.S. Singhal, Director, CHEB, addressing the valedictory function. Mrs. Kiran Bedi, Inspector General (Prison)—extreme right—presided.

Role of Mass Media in AIDS Prevention

Mass media particularly has a vital role to play in the prevention of AIDS. Media has to be careful and responsible in the reporting of AIDS and HIV. According to the London-based UK NGO AIDS Consortium for the Third World, media reports can be misleading due to :

- Inaccuracies, or careless use of language.
- Indiscriminate reporting on scientific information, or unbalanced selection of scientific stories.
- Misinterpretation or sensationalizing of information.
- Personal attitudes of reporters and editors which have influenced their reporting.
- Misleading headlines, subheads and editorial introductions.
- Repeating information, which though reported accurately at that time, has later been proved wrong.
- Failure to keep pace with rapidly changing information.
- Unfortunate use of quotes which seem to give credence to inaccurate and sometimes damaging misinformation.

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BOOK REVIEW

Implementation of the Global Strategy for Health for All by the Year 2000 : Second Evaluation

Eighth Report on the World Health Situation

This seven-volume work provides a detailed assessment, at global, regional, and country levels, of the extent to which strategies to develop health systems based on primary health care are being successfully implemented. The assessment, which also constitutes the Eighth Report on the World Health Situation, draws upon findings from national evaluations and data submitted by 151 countries covering 5200 million people and representing 96% of the world population, thus providing an unprecedented basis for a frank appraisal of health conditions and the factors that influence them.

Emphasis is placed on changes in the world health situation as measured through data, covering the period 1985-1990, on several well-defined indicators of health status and progress in reaching the social goal of health for all. Noting that the health for all strategy is essentially a quest for social justice and equity, the report gives particular attention to changes in the health status of vulnerable or disadvantaged groups and to the plight of populations in the least developed countries. Throughout, an effort is made to identify the lines of action needed to move forward in a world characterized by continuing population growth, increasing health problems, and shrinking funds for health and development.

The report consists of seven volumes: a global overview (volume 1) followed by individual reports from each of WHO's six regions (in press). All regional reports were prepared according to a common outline. Each begins with an overview of socio-economic developments, changes in the health system, and changes in health status as indicated by statistics on morbidity and mortality. An evaluation of overall achievements, particularly concerning implementation of the strategy for health for all, is followed by an analysis of problems likely to dominate the future and the actions that might be taken. Each regional volume also features a series of richly detailed profiles on health conditions for each country.

—Volume 1: Global Review

1993, vi + 183 pages (available in English, Arabic, Chinese, French, Russian and Spanish in preparation)

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The first volume provides a global overview of changes in the world health situation as determined through an analysis of data submitted by 151 countries for 1985-1990. Focused on a number of well-defined indicators of health status and its socioeconomic and environmental determinants, the report aims to discern trends, measure progress, define problems, and thus guide countries in their continuing efforts to strengthen health systems and improve the accessibility and quality of care. Emphasis is placed on factors linked to progress in the achievement of coverage by primary health care, equity in health, and sustainability in the national approaches employed.

The book has eight chapters. The first evaluates global political, economic, demographic and social trends and considers their health implications, including several consequences linked to the continuing global recession. The second chapter, devoted to health systems, evaluates the success of national efforts to achieve universal access to essential health care. Factors that have slowed progress are identified together with other factors consistently linked to the successful development of health systems. Subsequent chapters review progress in health care coverage and assess changes in financial resources, human resources, and health technology. Expanded immunization is identified as the greatest public health success story of the past decade.

A chapter devoted to health status uses data on mortality, morbidity and disability to discern trends, identify the leading causes of death and ill-health, and profile the major determinants of health. Environmental policies, hazards and risks are covered in the next chapter, which concludes that national capabilities for controlling environmental pollution have improved very little since 1984. The remaining chapters analyse the main achievements in terms of health care coverage and changes in health status, discuss major trends in health and consider how these trends may develop. The final chapter identifies issues that need to be addressed in order to accelerate progress towards health-for-all goals.

