Prevention of HIV/AIDS in Uttar Pradesh
Prevention of HIV/AIDS in Uttar Pradesh

Agra
January 29–31, 2004
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Foreword

The history of infection by Human Immuno Deficiency Virus shows that it does not discriminate people on the basis of socioeconomic characteristics. HIV infection and AIDS are now observed among different population groups and age-groups. The toll that HIV/AIDS has created in our communities in terms of the disease, debility and death is without any insinuation. The social systems and structures were inadequately prepared to cope with the impact that this disease created on individuals, families, communities and the nation. Interventions that have been initiated for prevention, treatment, care and support of people infected and affected with HIV/AIDS is also inadequate due to a variety of reasons.

Evidences on the spread of HIV in different parts of India show different trends. Uttar Pradesh, even though, is classified as a low prevalence state, has all potential to become a high prevalent state, if adequate and appropriate measures are initiated on a war footing. Factors like gender inequality, social and behavioural vulnerability, low level of awareness of HIV/AIDS, high mobility of population to highly prevalent states and districts, high incidence rate of STI/RTI, poor health seeking behaviours and poor reach of media strengthen this assumption.

The workshop on Prevention of HIV/AIDS in Uttar Pradesh, brought together policy makers, bureaucrats, programme managers, people living with AIDS, academicians and activists to discuss and debate the present state of affairs and discuss means of strengthening prevention and control of HIV/AIDS in the state. Distinguished speakers presented papers on various aspects of the programme and the 'best practices' within the state and in other parts of India. This volume, with several papers on different themes will lay the foundation to develop the Uttar Pradesh HIV/AIDS Strategy.

We are thankful to the Futures Group for providing technical assistance in organising the workshop and getting this report published. Thanks are also due to SIFPSA partnering with us in this endeavour.

Aradhana Johri
Preface

Uttar Pradesh, the most populous state, is one of the low HIV/AIDS prevalence states in India. However, in the presence of the second largest national highway network, the highest volume of out-migration, low coverage of vulnerable populations with interventions and poor socioeconomic indicators and health infrastructure, its vulnerability towards spread of HIV/AIDS cannot be overlooked. It may not remain as low prevalence state for a long time unless necessary and immediate steps are taken to control the spread of the virus.

It is in this context, the workshop on Prevention of HIV/AIDS in Uttar Pradesh, was organized on January 29-31, 2004 in Agra. During the three days of workshop facilitated by POLICY/Futures Group funded by USAID, 25 papers were presented by experts on different themes. In order to review the current situation of interventions in Uttar Pradesh, Futures Group prepared case studies of 6 targeted interventions covering sex workers, truckers, people injecting drugs and prison inmates. In addition a study to assess the greater involvement of people living with HIV/AIDS in Andhra Pradesh, Tamil Nadu and Uttar Pradesh was also conducted. Futures Group has also prepared five background papers using a variety of secondary data available.

I would like to thank Ms Aradhana Johri, Project Director, UPSACS for her initiative, leadership and involvement in making this workshop a success. I would also like to thank Mr J. S. Deepak, Executive Director, SIFPSA for his suggestions and encouragement. Special thanks are due to Robert Clay, Meri Sinnitt, Randy Kolstad, Sheena Chhabra and Sanjay Kapur from USAID for their constant support and guidance. Our team consisting of Sherry Joseph, K. M. Sathyanarayana, Nilesh Deshpande, Anantha Rao, Ashok Singh, Dipankar Dutta, Prabuddhagopal Goswami, Mitali Deka, and Nidhi Kaul needs special appreciation for the team spirit they demonstrated in organizing this workshop.

G. Narayana
Country Director
POLICY/Futures Group
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABC</td>
<td>Abstinence, Be Faithful, Use Condoms</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>APAC</td>
<td>AIDS Prevention and Control (Project)</td>
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<td>APN+</td>
<td>Asia Pacific Network for People living with AIDS</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>ASCI</td>
<td>Advertising Standards Council of India</td>
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<tr>
<td>AWW</td>
<td>Anganwadi worker</td>
</tr>
<tr>
<td>BAMS</td>
<td>Bachelor of Ayurvedic Medicine and Surgery</td>
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<tr>
<td>BCC</td>
<td>Behaviour change communication</td>
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<tr>
<td>BCSC</td>
<td>Blood component separation centre</td>
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<tr>
<td>BHMS</td>
<td>Bachelor of Homeopathic Medicine and Surgery</td>
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<tr>
<td>BSS</td>
<td>Behavioural Surveillance Survey</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<td>CCM</td>
<td>Country Co-ordinating Mechanisms</td>
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<tr>
<td>CDC-GAP</td>
<td>Centers for Disease Control and Prevention - Global AIDS Programme</td>
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<tr>
<td>CETC</td>
<td>Continuing Education and Training Centre</td>
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<td>CHC</td>
<td>Community health centre</td>
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<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<td>CII</td>
<td>Confederation of Indian Industries</td>
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<tr>
<td>CMIS</td>
<td>Computerized Management Information System</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>CMS</td>
<td>Chief Medical Superintendent</td>
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<tr>
<td>CMS</td>
<td>Commercial Market Strategies (Project)</td>
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<tr>
<td>CSCT</td>
<td>Central School for Counselling Training</td>
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<tr>
<td>CSM</td>
<td>Condom social marketing</td>
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<tr>
<td>DACC</td>
<td>District AIDS Coordination Committee</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>DG</td>
<td>Director-General</td>
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<tr>
<td>DM</td>
<td>District Magistrate</td>
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<tr>
<td>DMLT</td>
<td>Diploma in Medical Lab Technology</td>
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<tr>
<td>DMO</td>
<td>District Medical Officer</td>
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<tr>
<td>DTO</td>
<td>District Tuberculosis Officer</td>
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<tr>
<td>EQA</td>
<td>External quality assurance</td>
</tr>
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<td>ESIS</td>
<td>Employees State Insurance Service</td>
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<td>FHAC</td>
<td>Family Health Awareness Campaigns</td>
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<td>FP</td>
<td>Family planning</td>
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<tr>
<td>FRU</td>
<td>First referral unit</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>GIPA</td>
<td>Greater involvement of people living with HIV and AIDS</td>
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<td>GNP+</td>
<td>Global Network for people living with AIDS</td>
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<td>GOI</td>
<td>Government of India</td>
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<td>GSA</td>
<td>Global Science Academy</td>
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<td>HLL</td>
<td>Hindustan Latex Ltd.</td>
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<tr>
<td>ICMR</td>
<td>Indian Council of Medical Research</td>
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<tr>
<td>IDU</td>
<td>Injecting drug user</td>
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<tr>
<td>IEC</td>
<td>Information, education and communication</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>IMFC</td>
<td>Indian made foreign condom</td>
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<tr>
<td>INP+</td>
<td>Indian Network of Positive People</td>
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<td>IPC</td>
<td>Interpersonal communication</td>
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<td>ITPA</td>
<td>Immoral Traffic Prevention Act</td>
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<td>JAI</td>
<td>Jail Awareness Initiative</td>
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<tr>
<td>KGVS</td>
<td>Kshetriya Grameen Vikas Sanstan</td>
</tr>
<tr>
<td>MBBS</td>
<td>Bachelor of Medicine and Bachelor of Surgery</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and child health</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>MOIC</td>
<td>Medical officer in charge</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MSCW</td>
<td>Maharashtra State Commission for Women</td>
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<tr>
<td>MSM</td>
<td>Males having sex with males</td>
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<tr>
<td>MTCT</td>
<td>Mother-to-child transmission</td>
</tr>
<tr>
<td>NACO</td>
<td>National AIDS Control Organization</td>
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<td>NACP</td>
<td>National AIDS Control Programme</td>
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<tr>
<td>NARI</td>
<td>National AIDS Research Institute</td>
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<tr>
<td>NFHS</td>
<td>National Family Health Survey</td>
</tr>
<tr>
<td>NFI</td>
<td>Naz Foundation International</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>NIB</td>
<td>National Institute of Biologicals</td>
</tr>
<tr>
<td>NICED</td>
<td>National Institute of Cholera and Enteric Diseases</td>
</tr>
<tr>
<td>NSG</td>
<td>Netherlands Gestalt Foundation</td>
</tr>
<tr>
<td>NSSO</td>
<td>National Sample Survey Organization</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic infection</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-patient department</td>
</tr>
<tr>
<td>OPL</td>
<td>Operation Light House</td>
</tr>
<tr>
<td>ORS</td>
<td>Oral rehydration solution</td>
</tr>
<tr>
<td>ORW</td>
<td>Outreach worker</td>
</tr>
<tr>
<td>PE</td>
<td>Peer educator</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary health centre</td>
</tr>
<tr>
<td>PIP</td>
<td>Project implementation plan</td>
</tr>
<tr>
<td>PLHA</td>
<td>Person living with HIV/AIDS</td>
</tr>
<tr>
<td>POL</td>
<td>Petrol, oil, lubricant</td>
</tr>
<tr>
<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission</td>
</tr>
<tr>
<td>PWN+</td>
<td>Positive Women's Network</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and child health</td>
</tr>
</tbody>
</table>
RHIS Reproductive Health Indicator Survey
RTI Reproductive tract infection
SACS State AIDS Control Society
SARS Severe Acute Respiratory Syndrome
SBGSS Sri Bhardwaj Gramodyog Seva Sansthan
SC Scheduled caste
SES Socioeconomic status
SHG Self-help group
SIFPSA State Innovations in Family Planning Services Agency
SITA Suppression of Immoral Traffic Act
SKS Sarvajan Kalyan Samiti
SMO Social Marketing Organizations
ST Scheduled tribe
STDs Sexually transmitted diseases
STIs Sexually transmitted infections
SWs Sex workers
TB Tuberculosis
TI Targeted intervention
TOT Training of Trainers
TTI Transfusion transmitted infection
TTK-LIG TTK London International Group
UP Uttar Pradesh
UPSACS Uttar Pradesh State AIDS Control Society
UPSRRTC Uttar Pradesh Road Transport Corporation
USAID United States Agency for International Development
VCT Voluntary counselling and testing
VCTC Voluntary counselling and testing centre
VDRL Venereal Disease Research Laboratory (Slide Test)
WHO World Health Organization
WLL Wireless local loop
WLWHA Women living with HIV/AIDS
ZBTC Zonal blood testing centre
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Babus</td>
<td>Boyfriends</td>
</tr>
<tr>
<td>Dalits</td>
<td>Scheduled Castes</td>
</tr>
<tr>
<td>Dhaba</td>
<td>Low-priced restaurant, often found along the roadside</td>
</tr>
<tr>
<td>Girya</td>
<td>A “manly” male (same as panthi)</td>
</tr>
<tr>
<td>Hijra</td>
<td>A male who defines himself as “not man/not woman” but as a “third gender.”</td>
</tr>
<tr>
<td>Kothi</td>
<td>A male who feminizes his behaviour to attract “manly” male sexual partners and/or as part of his gender construction</td>
</tr>
<tr>
<td>Lakh</td>
<td>1 lakh = 100,000</td>
</tr>
<tr>
<td>Paan</td>
<td>Betel leaf, traditionally chewed—it is said to clean the mouth, strengthen the voice, help with digestion, etc.</td>
</tr>
<tr>
<td>Paise</td>
<td>One hundredth of a rupee</td>
</tr>
<tr>
<td>Panchayat</td>
<td>Body of local government at village level</td>
</tr>
<tr>
<td>Panthi</td>
<td>A “manly” male (same as girya)</td>
</tr>
<tr>
<td>Swasth mela</td>
<td>Health camp</td>
</tr>
<tr>
<td>Swasthya Kendra</td>
<td>Health centre</td>
</tr>
</tbody>
</table>
HIV/AIDS in India and Uttar Pradesh

Chairperson
Aradhana Johri

HIV/AIDS Epidemic in India
Sashi Kant

Strategies for Prevention of HIV/AIDS in India
P. L. Joshi

HIV/AIDS in Uttar Pradesh
D. C. S. Reddy

Strategies for HIV/AIDS Response
K. V. Sreenivasan

Discussants
K. Pappu and S. D. Gupta
Prevention of HIV/AIDS in Uttar Pradesh
**Introduction**

The first case of HIV infection in India was detected in 1986. Since then, human immunodeficiency virus (HIV) infections have been reported in all states and union territories. The prevalence of infection in all parts of the country highlights the spread from urban to rural areas, and from high-risk to general populations. The epidemic continues to shift towards women and young people with an accompanying increase in vertical transmission and pediatric acquired immunodeficiency syndrome (AIDS). Even low levels of infection, in a large population base, translate into large numbers of HIV-infected persons. Currently, estimated HIV prevalence among the population aged 15–49 years is 0.7 percent. It is estimated that as of mid–2002, the number of HIV-infected persons was 4.58 million.

**Agent**

HIV-1, subtype “C” accounts for 91 percent of all infections in India. Subtypes “A”, “B”, and “others” account for 3 percent each. Subtype “C” is also the predominant strain of HIV infection in some of the hardest-hit countries in Africa (e.g., South Africa, Botswana, and Tanzania). This subtype accounts for one-third of all global HIV infections. Subtype “B” accounts for one-tenth of the global HIV infections. It is the predominant strain in most of the developed western world, as well as in Japan, China, Myanmar, and among injecting drug users in Thailand.

**Host**

There is no known natural immunity to HIV infection. All ages and both sexes are vulnerable. However, studies have shown that there might be individuals who do not progress from infection to development of AIDS for long periods of time. Women, due to social, biological, and economic reasons, are more vulnerable to HIV infection. The presence of ulcerative sexually transmitted infections (STIs) enhances the risk of acquisition and transmission of HIV infection.

**Environment**

**Organized Commercial Sex and Casual Sex with Non-Regular Sex Partners**

- Organized commercial sex establishments exist in the country. The HIV sero-positivity rate among women in prostitution is generally in excess of 50 percent. One exception is the Sonagachi red light district in Kolkata, where the reported
prevalence is less than 10 percent. The clients of female sex workers often refuse to wear condoms. In a nationwide study (Behaviour Sentinel Surveillance, 2001), it was found that 6.6 percent of the respondents had sex with a non-regular sex partner in the last year. Less than half (49.3%) had used condoms during their last sexual encounter with a non-regular sex partner. Unsafe sex with sex workers, or unprotected casual sex with non-regular sex partners, is the main reason why the epidemic in India is primarily sexually driven.

High Prevalence of STI in Some Areas
- Large-scale population-based studies on the prevalence of STIs are not available. Available literature suggests that STIs may be more prevalent in some parts of the country (e.g., Tamil Nadu and Karnataka). The presence of STIs suggests recent or ongoing sexual behaviour that may result in HIV transmission. Secondly, many STIs enhance the risk of HIV transmission or acquisition.

High Social Stigma on Issues Related to Sex and Sexuality
- Sex and sexuality are taboo topics and not discussed openly. Adolescents most commonly get information on sex from their peers, pornographic books, and movies. The information that is available to youth is often misleading, incorrect, and frequently harmful. Parents do not engage children in healthy discussion on this topic. Introduction of this topic at the higher secondary school level in the form of “Life Skills Development” has had limited success. Many of the potential beneficiaries are out of the school system altogether.

Large Scale Migration
- Large numbers of people, mostly male, migrate from rural to urban areas in search of a livelihood. Migration also takes place from one state to another. Most of the migrants leave low-prevalence states (e.g., Uttar Pradesh, Bihar, Rajasthan, and Madhya Pradesh) for high-prevalence states like Maharashtra. The above-mentioned low-prevalence states have a large population base. Single males living away from the family for extended periods of time are vulnerable to sex outside marriage. It has been estimated that approximately 180 million people migrate annually.

Traditional Beliefs and Practices
- The “Dasi” system is still prevalent in some states (e.g., Karnataka). Polygamous marriages in certain parts of tribal Madhya Pradesh exist. Studies among transport workers have revealed their belief that driving vehicles for long hours make their bodies “hot.” The body can be cooled only if they have unprotected sex. Such beliefs and practices enhance the risk of HIV transmission.

Low Levels of Literacy, Gender Disparities, and Poverty
- These factors have been globally documented to increase the risk of HIV acquisition. The person either fails to recognize the risk involved, is unable to negotiate safe sex, or is unconcerned about the risk involved.

Transmission Dynamics
HIV infection makes its first appearance among what is called a “Core transmitter.” Female sex workers, injecting drug users, and men who have sex with men (MSM)
fall in this category. There is intense sexual interaction within their networks.
Infection then passes on to the “bridge population,” who interact both with the core
transmitter as well as with general populations with low-HIV-risk behaviour. Truck
drivers and cleaners, migrant single workers, and male factory workers are examples
of the bridge population. The bridge population acquires the infection from a core
transmitter and then transmits the infection to their spouses or female sexual
partners in the general population. This results in HIV infection among women and
children. As the epidemic matures, more and more people in the general population
get affected. Core transmitters have intense HIV-risk behaviour. They are 10 times
more sexually active than non-core transmitters. They usually have at least one new
sexual partner every five days as compared with one new partner every 50 days
among non-core transmitters. Core transmitters are more likely to select sexual
partners indiscriminately. HIV prevalence rates and frequency of unprotected sex
vary between core and non-core transmitters.

Unprotected sexual intercourse is the predominant mode of transmission. However,
the risk of transmission through this route is estimated to vary between 0.01 to
0.001 percent. The risk increases 2–10 fold in the presence of ulcerative STIs. The
risk is higher if the source has acquired the infection recently. A receptive partner (the
woman in heterosexual intercourse and receptive male in MSM) is at a higher risk of
acquiring infection. Use of unsterilized needles and syringes also contribute to HIV
infection. The risk of vertical transmission of infection, without any preventive
action, ranges between 13 to 48 percent.

Routes of Transmission
Possible routes of transmission among reported AIDS cases have been analyzed for
the year 2003. It was found that injecting drug use, contaminated blood or blood
products, and perinatal transmission accounted for 2.2 percent, 2.6 percent, and 2.7
percent, respectively. An overwhelming majority (85.7 percent) reported the
heterosexual route. In 6.8 percent of AIDS cases, the route of transmission could not
be identified. It seems likely that most of the members in this group had contracted
the infection through the heterosexual route. Thus, HIV infection in India is
primarily driven by the heterosexual route.

HIV Sentinel Surveillance
The HIV sentinel surveillance (HSS) was started in 1986. It was based on 62 blood-
testing sites and nine reference laboratories. The objective at this stage was to track
the geographical spread of the infection and identify the modes of transmission. By
1994, it was clear that infection had reached all parts of the country, and the major
mode of transmission was heterosexual. Therefore, the objective of the surveillance
was modified to monitoring the trend in the spread of infection. The methodology
was changed to clinic-based sentinel sites. A modest beginning was made in 1994 by
establishing 55 sentinel sites. Over the years, the numbers of sentinel sites have kept
increasing. The type of risk groups covered has also diversified. Blood at sentinel
sites is collected for venereal disease reference laboratory test (VDRL) testing, the
result of which is communicated to the patient. An aliquot of blood is tested for
HIV in an unlinked anonymous manner. The testing strategy is two Enzyme Linked
Immunosorbent Assay (ELISA)/simple/rapid tests.
HIV sentinel surveillance is carried out during the months of August–October every year. During the last round (Year 2003), 455 sentinel sites participated. There were 271 antenatal care (ANC) sites, 166 STI sites, 13 injecting drug user sites, three MSM sites, and two sites for sex workers. Pregnant women attending antenatal clinics were proxies for the low-risk population. The rest of the groups included in sentinel surveillance reflected HIV status among high-risk populations.

**Stage of Epidemic in India**

Based on the results of HIV sentinel surveillance, a state is classified in a “generalized epidemic” stage if the median prevalence of HIV among ANC attendees is more than 1 percent for the last three years. A “concentrated epidemic” stage is defined as HIV prevalence of more than 5 percent in any of the high-risk groups but less than 1 percent among ANC attendees. If the prevalence among high-risk groups is less than 5 percent, then the state is classified as experiencing a “low prevalence” epidemic.

Six states (i.e., Maharashtra, Andhra Pradesh, Karnataka, Tamil Nadu, Manipur, and Nagaland) are currently in the generalized stage of the epidemic. Three states, namely Gujarat, Pondicherry, and Goa, are in the concentrated stage of the epidemic. The rest of the 26 states and union territories are in the low prevalence stage.

Clearly, India does not have a single HIV epidemic. Each state has a different epidemic, with different vulnerability, maturity, and impact. Hence, the response to the epidemic has to be tailored according to local needs. It requires decentralization of decision-making. In order to mount an appropriate response, we require a large number of technically qualified persons and capacity-building at state, district, and community levels.

**Progression of the Epidemic**

The first case of HIV was detected in 1986. Within the next four years, Maharashtra and Manipur progressed to the concentrated epidemic stage. In another four years, these two states progressed to the generalized epidemic stage. During the same time period, two more states, Gujarat and Tamil Nadu, converted to the concentrated epidemic stage. In another four years, six states had progressed to the generalized epidemic stage. Since then, no state has changed its epidemic level.

**Estimation of HIV Infected Persons**

The HSS system was not primarily designed to collect data that could be used for estimating the number of HIV-infected persons. However, in the absence of any other data set, it was decided to use HSS data for estimation purposes. The first estimation exercise was done in 1998, wherein it was estimated that 3.5 million people were infected with HIV. The figure rose to 3.7 million in 1999, 3.86 million in 2000, 3.97 million in 2001, and finally to 4.58 million in 2002.

**Mapping of Generalized Epidemic States**

The total population (in millions) of generalized epidemic stage states is:

- Maharashtra – 96.7
- Andhra Pradesh – 75.2
- Tamil Nadu – 62.1
- Karnataka – 52.7
- Manipur – 2.4
- Nagaland – 1.9

Thus, almost one-third (291 million) of the
total population of India is living in a high-prevalence state. A window of opportunity lies in the fact that 735 million people are still living in low-prevalence states. The challenge is to make sure that the low-prevalence states do not become high-prevalence states.

**AIDS Cases**

**Time Trend**
- In the first decade of the epidemic, the number of AIDS cases reported was negligible. Now in the second decade, the picture has changed. Ever larger numbers of AIDS cases are being reported. The number of new AIDS cases reported between 2001–2002 was approximately 10,000. However, in the next year (2002–2003), the number of new AIDS cases reached almost 20,000. The cumulative number of AIDS cases reported up to December 2003 was 61,201. Clearly, the number of reported new AIDS cases gathered pace and is increasing at an alarming rate.

**Age and Sex Distribution of AIDS Cases in India**
- Of the 61,201 AIDS cases reported through December 2003, 16,226 (26.5 percent) were females. Pediatric AIDS (up to the age of 14 years) constituted 3.7 percent of all AIDS cases. AIDS among young adults (aged 15–29 years) constituted 34.6 percent of AIDS cases. More than half of all AIDS cases (54.7 percent) were seen among persons aged 30–49 years. Seven percent of AIDS cases were observed among persons older than 49 years of age.

**Presenting Signs and Symptoms of AIDS Cases**
- Weight loss (89 percent), fever (88 percent), and diarrhoea (88 percent) were the most common presenting symptoms of AIDS cases. Other presenting complaints were asthenia (72 percent), cough (68 percent), and generalized lymphadenopathy (28 percent).

**Opportunistic Infections in AIDS Cases**
- Tuberculosis was the most common opportunistic infection (65 percent) among AIDS cases in India. The second most common infection (57.5 percent) was candidiasis. Almost one-third (36 percent) reported cryptococcus infection. Unlike in western countries, PCP (3.8 percent) and Kaposi’s sarcoma (0.6 percent) were uncommon opportunistic infections among AIDS cases in India.

**Conclusion**
We conclude by saying that as of mid–2002, 4.58 million people were estimated to be infected with HIV. The epidemic is in the generalized stage in six states. It is spreading fast from high-risk groups to bridge populations and then onwards to the general population. The sexual route is the predominant mode of transmission. Three-quarters of AIDS cases are men. There are wide geographical variations within the country. Sex with non-regular partners is common and often unprotected. Large numbers of people are living in states still in the low-HIV-prevalence stage. However, factors associated with HIV vulnerability are present in these low-prevalence states.
**Introduction**

Globally, 42 million people are now living with HIV or AIDS. Just fewer than 40,000 new cases of HIV infections occur every single day. Ninety-five percent of all AIDS cases occur in the world’s poorest countries. Five million people were newly infected with HIV in 2003. Three million people died from AIDS in 2003, or more than 8,000 persons a day. Nearly two-thirds (69%), of global cases live in sub-Saharan Africa where seven southern African countries have prevalence rates over 20 percent. The vast majority of those affected are in the age groups between 15–49 years. There are emerging and growing epidemics in China, Indonesia, Papua New Guinea, Vietnam, several Central Asian Republics, the Baltic States, and North Africa.

The epidemic has devastating effects on the socio-economic development of the country. It causes tremendous pressure on health care services, impacts on the availability of a productive workforce, and leads to a steep rise in people living in poverty. The average life expectancy in sub-Saharan Africa is now 47 years when it could have been 62 years without the HIV/AIDS epidemic. Africa’s annual per capita GDP growth rate declined by 0.8 percent and the growth rate over the next 20 years is expected to be reduced by one-third.

In India, by the end of December 2002, we have an estimated 4.58 million men, women, and children living with HIV or AIDS, an adult (15-49 years) prevalence rate of about 0.8 percent. India accounts for 10 percent of the global HIV burden and 65 percent of that in South and South East Asia. Viewed across Asia, adult HIV prevalence is highest in Myanmar (3.5%), followed by Cambodia (2.7%), Thailand (1.8%), India (0.8%), and Papua New Guinea (0.7%). India continues to be in the category of low prevalence countries with an overall prevalence of less than 1 percent.

However, there are some challenges ahead. First, the mother-to-child transmission of HIV has been progressively increasing; second, the threat of HIV transmission among injecting drug users is increasing in the Northeast region and in metropolitan areas. Though there has been no significant change in HIV prevalence over the last five years in low prevalence states, site-wise analysis of the sentinel surveillance data
in these states indicates that there are pockets where HIV prevalence is increasing among STI clinic attendees—for example, in Raxaul, Patna, and Gaya in the state of Bihar; Amritsar in Punjab; Varanasi in UP; Kolkata in West Bengal; Indore in Madhya Pradesh; Khozikhode in Kerala; and Udaipur, Barmer, and Ajmer in Rajasthan. There is some evidence of slowing the spread of HIV infection in high prevalence states; the challenge is to make sure that the low prevalence states maintain the status quo into the future as well.

**Burden of HIV Infections in the Country**

India initiated sero-surveillance for HIV in 1985, in order to assess the magnitude and dimension of HIV infection even before AIDS cases were reported in the country. Since 1998, the Government of India has conducted, each year, nationwide sentinel surveillance, covering all states and Union Territories, to evaluate the spread and prevalence of HIV infection in the country. There are 455 sentinel sites throughout India, including sites serving groups that practise high-risk behaviours. Through this process, it is estimated that there are 4.58 million persons infected with HIV in the country (an adult prevalence rate of 0.8%). Given the large population base, even an increase of 0.1 percent in the prevalence rate of HIV infection will generate half a million additional infected persons.

The estimated number of HIV infections was 3.5 million in 1998, 3.71 million in 1999, 3.86 million in 2000, 3.97 million in 2001, and 4.58 million in 2002. These estimates indicate that there has been no dramatic upsurge in the spread of HIV infection across the country. However, these figures are a cause of growing concern to the Government. Persons infected with HIV during the 1980s and 1990s will progress to AIDS, resulting in a steep increase in the number of AIDS patients in the country with consequent medical, economic, and social implications. The Government is also concerned about the spread of HIV among the general population and appropriate steps are being taken to prevent its further spread.

The spread of HIV infection is not uniform across the states in India. Six states are categorized as high prevalence states: Andhra Pradesh, Karnataka, Nagaland, Manipur, Maharashtra, and Tamil Nadu, since the HIV prevalence rates among women attending antenatal clinics in these states is 1 percent or higher. Gujarat, Pondicherry and Goa are categorized as states with moderate HIV prevalence, since HIV prevalence rates amongst high-risk population (STI clinic attendees) has been found to be 5 percent or more, but among women attending antenatal clinics, the HIV prevalence rates are below 1 percent. All remaining states/Union Territories are categorized as low prevalence states since the prevalence rates amongst high-risk populations (STI clinic attendees) are below 5 percent.

**Routes of Transmission in India**

The main mode of transmission is through heterosexual sex; about 85 percent of the infections are attributed to this mode of transmission. The other modes of transmission are through blood and blood products (<3%) and through injecting drug use (<3%), particularly in some of the north-eastern states and metropolitan cities. About 90 percent of the reported HIV/AIDS cases occur in the sexually active
and economically productive age group of 15-49 years. One in every four AIDS cases reported is a woman.

Some key factors fuelling the spread of HIV infection across the country is labour migration in search of employment—from economically backward pockets to more developed regions, low literacy levels particularly amongst marginalized and vulnerable sections of the society, gender disparity, prevalence of reproductive tract infections and sexually transmitted infections (STIs) both among men and women.

**The Response**

Soon after reports were received of the first HIV infection in India in 1986, the Government of India recognized the seriousness of the problem, and

- Constituted the National AIDS Committee in 1986.
- Initiated the National AIDS Control Programme in 1987, to achieve reductions in morbidity and mortality associated with HIV infection through HIV surveillance and screening of blood prior to transfusion to promote provision of safe blood, and to put in place the appropriate awareness generation programmes.
- Established the National AIDS Control Organization (NACO) in 1992, within the Ministry of Health and Family Welfare, and initiated Phase 1 of the World Bank-supported National AIDS Control Programme. At state levels, State AIDS Cells were created for effective implementation of the programme. Subsequently, these were expanded into State AIDS Control Societies (SACS).
- The National AIDS Control Programme, Phase II (1999-2004), has been further expanded and decentralized by strengthening State AIDS Control Societies in every state for a more focused programme which would identify and address perceived and felt needs/priorities at regional and state levels. Currently, 38 State AIDS Control Societies are functioning, which also include three municipal corporations—namely Mumbai, Chennai, and Ahmedabad—with adequate delegation of financial and administrative powers to facilitate a decentralized response to local needs.

The National AIDS Control Programme has two key objectives:

- To reduce the spread of HIV infection in India, and
- To strengthen India’s response to HIV/AIDS on a long-term basis.

India perceives that it is not inevitable that the HIV/AIDS epidemic will continue to accelerate and expand. Admittedly, there is no single solution to prevent the spread of HIV. However, if proven prevention interventions are used in combination and brought to scale to target the diverse populations affected by HIV and the different routes of transmission, there is evidence that a reversal of the AIDS epidemic can be achieved. Cambodia, Thailand, and Uganda have shown that HIV prevention is possible through prioritized and comprehensive action.

Accordingly, the Government of India is implementing a comprehensive National AIDS Control Programme with equal focus on prevention and care and support to people living with HIV/AIDS. The various components of the programme are described in the following sections.
Targeted Interventions (TI)
Experience in several countries have shown that focusing on prevention efforts directed towards groups that are at the core of HIV transmission can greatly reduce the spread of HIV into the general population. Directing HIV prevention efforts among groups with a high rate of partner change, whether sexual or needle-sharing partners, is a proven cost-effective strategy as it has a multiplier effect in preventing spread of infection amongst the general population. Targeted interventions among these groups involve multi-pronged strategies such as behaviour change communication, counselling, health care, treatment for STIs and provision of condoms, along with activities that can help create an enabling environment for behavioural change. TIs are consumer friendly with the aim of destigmatizing the marginalized population, building capacity to face challenges, and motivating behaviour changes for preventing further spread of HIV. The main thrust of TIs lies in interpersonal communication for bringing about desirable behaviour change.

The State AIDS Control Societies (SACS) through NGOs in different locations in the country have undertaken almost 835 TI projects. More than half of these projects are located in the high prevalence states of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland, and Tamil Nadu. The trend is now shifting towards having composite interventions where more than one core group is targeted by the NGO in a given area.

One of the major challenges in the implementation of TIs has been the capacity of the NGO partners to deliver at the grassroots level. The task of dealing with highly marginalized groups and their very intimate behaviours makes the job truly challenging for all concerned. Hence, capacity building of these partners is crucial for the success of these interventions.

Improving the quality of the interventions and increasing coverage coupled with building strategic partnerships with other sectors should be the main focus of all future efforts. To make the programmes sustainable over time, all such projects would be linked to existing health care set-ups, both in the public and private domains. Monitoring and evaluation is being given top priority to ensure high-quality interventions.

Harm Reduction Programmes for Injecting Drug Users (IDUs)
There is high prevalence of HIV in the north-eastern states, particularly Manipur, which is related to injecting drug use as there is a correlation of IDUs with HIV. The interventions particularly encourage and support harm-reduction strategies including needle exchange programmes, bleach and teach programmes, and drug substitution. The Ministry of Health in collaboration with the Ministry of Social Justice and Empowerment is facilitating a demand reduction programme along with harm minimization. Total abstinence from drugs is the goal in the management of IDUs. A comprehensive intervention also has behaviour change communication and sexual health interventions in addition to an integrated scheme of drug abuse prevention programmes. Programmes for IDUs are generally community based wherein outreach workers (some of them rehabilitated IDUs)
approach the high-risk population and link them with Government-run care programmes.

Control of Sexually Transmitted Infections (STIs)

The relationship between sexually transmitted infections (STIs) and HIV is complex. The predominant mode of transmission of both HIV infection and other STIs is through sexual interactions. STIs are biological co-factors for acquisition and transmission of HIV infection. Early diagnosis and treatment of STIs reduce the risk of HIV transmission. Access to STI clinic services provides an opportunity to high-risk groups for education and counselling on prevention of HIV infection. STI clinics usually facilitate referrals and linkages with Voluntary Confidential Counselling and Testing Centres (VCTCs) and encourage usage of other care services.

The National Sexually Transmitted Disease Control Programme was brought under the purview of NACO in 1992 and is an integral component of the National AIDS Control Programme. NACO considers the control and prevention of STIs as a priority strategy to reduce the spread of HIV infection in the community. The STI control component of the National AIDS Control Programme (NACP) has two objectives:
- To reduce the prevalence of STIs, and
- To prevent morbidity and mortality due to STIs.

NACO supports setting up STI clinics at hospitals up to the district level. Each STI clinic functions under a qualified specialist and is equipped with laboratory support for the diagnosis and treatment of STIs. NACO also ensures a continual, adequate supply of STI drugs. For early diagnosis and treatment of STIs among women, support is being given to obstetrics and gynaecology clinics of district hospitals. At present, there are 678 STI clinics functioning in the country in medical colleges, district and some sub-district hospitals, which are being supported by NACO. The aim of the programme is to establish at least one STI clinic in each district hospital and make such services available in rural areas through the primary health care system in collaboration with the Reproduction and Child Health (RCH) Programme.

In areas where there are no laboratory facilities to help diagnose and treat STIs, NACO promotes the World Health Organization (WHO)-approved syndromic management of STIs as a cost-effective strategy for peripheral health institutions. The standard guidelines and algorithms for the syndromic management of STIs have been updated and made available to medical practitioners in the public health care services and in private practice.

In partnership with medical colleges in most states, NACO has conducted a community-based survey to assess the prevalence of STIs in rural and urban areas of the country. Trends emerging from this study would help formulate local strategies for STI prevention and control.
**Promotion of Condoms**

Male condoms are currently the only effective method of protection against STIs/HIV that is widely available. Access to condoms and skills in their effective use are therefore essential for effective preventive behaviour among sex workers and their clients. However, the use of male condoms depends primarily upon the cooperation of the male partner, thus skills building for sex workers should also include negotiation and decision-making skills to allow sex workers to convince clients to use condoms or to refuse the client.

NACO is implementing a targeted condom promotion strategy that includes free distribution of condoms in high-risk groups through NGOs and their teams implementing TI projects. Condoms are made available to NGOs as per their requirements for free distribution in TI projects by the SACS. A targeted social marketing scheme is being implemented through the Social Marketing Organizations (SMOs) identified by the Government of India, which is already implementing the social marketing of condoms for the National Family Welfare Programme. Based on the results of mapping of high-risk locations and high-risk groups conducted by SACS, SMOs are informed accordingly to promote social marketing of condoms to those high-risk groups. The Department of Family Welfare supplies condoms to the National AIDS Control Programme for both free distribution and the social marketing scheme. Efforts are underway to disseminate information on the dual protection value of condoms, that is, for contraception and as a disease prevention tool through multimedia campaigns.

There has been consistent increase in condom procurement and supplies to states as indicated in the following table:

<table>
<thead>
<tr>
<th>Year</th>
<th>Financial Resources</th>
<th>No. of condoms procured and made available</th>
<th>Increase in the number of TIs through which condoms are supplied at high risk sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001–02</td>
<td>Supply from Dept. of Family Welfare</td>
<td>114 million</td>
<td>450</td>
</tr>
<tr>
<td>2002–03</td>
<td>Rs 12 crore</td>
<td>128 million</td>
<td>620</td>
</tr>
<tr>
<td>2003–04</td>
<td>Rs 22 crore</td>
<td>171 million</td>
<td>835</td>
</tr>
</tbody>
</table>

**Information, Education and Communication (IEC)**

The IEC strategy is operationalized at two levels. At the national level, NACO frames guidelines for IEC activities countrywide and undertakes multimedia campaigns, along with political and media advocacy. At the state level, these are implemented in myriad ways. IEC is being designed and disseminated through a gender-sensitive lens, so that messages and campaigns would cease to directly or indirectly portray women as the vector of HIV transmission. Admittedly, health information and awareness of HIV may not by itself be sufficient to bring about behaviour change. However, it is a critical starting point for behaviour change.
A realization grew that existing initiatives on IEC relating to HIV/AIDS are somewhat uni-focused in that they emphasize primarily one route of transmission, that is, the sexual route. Admittedly, the sexual route of transmission accounts for about 85 percent of HIV infections across India. But the almost exclusive emphasis on this route of transmission was in fact contributing to the fear, shame, denial, stigma and discrimination associated with HIV/AIDS. Accordingly, the awareness generation and information, education, and behaviour change communication surrounding the prevention and control of HIV/AIDS has been repositioned into a more holistic and balanced combination of focused messages disseminated through a multimedia strategy that is no longer uni-focused. Prominent features of this paradigm shift are recapitulated below.

- Equal focus on all four routes of HIV transmission: in lieu of a primary focus on one route alone. This has had a positive impact. It is reducing the denial and shame and stigma and discrimination encountered by people living with HIV/AIDS in medical and health care settings. It is also changing the perception of the disease itself among elected representatives, within civil society and within communities.

- The National AIDS Control Programme disseminates accurate and complete information on the four ways in which HIV/AIDS is contracted, together with a listing of at least four ways in which HIV/AIDS is not contracted. This unravels the most popular myths and misconceptions, such as HIV is transmitted through mosquito bites or through working together. This media blitz is widely viewed as a far more balanced projection of HIV/AIDS. While it is clearing myths and misconceptions, it is also becoming a strong basis to de-stigmatize people living with HIV/AIDS as well as the disease itself.

- Promotion of the WHO strategy on ABC, which positions IEC to target specific population segments with appropriate behaviour change messages, using a life cycle approach:
  A: Abstinence, (for adolescents and youth) encourages delayed initiation of sexual activity;
  B: Be faithful to a single partner, encourages mutual monogamy; and
  C: Consistent and correct condom usage.

**Strengthening IEC through Partnerships**

**NACO Prasar Bharati BBC World Services Trust (WST) Partnership**
NACO’s unique collaboration with the national broadcasting corporation, Prasar Bharati, and the BBC World Services Trust has produced TV programmes in the infotainment format. The virtual reality show/serial “Haath Se Haath Mila” won the 2003 Commonwealth Broadcasting Association award. The detective serial “Jasoos Vijay” just won the Indian Telly Award in the category of Best Thriller. NACO succeeded in co-opting serious social messaging into an infotainment format.

**Partnership with the Business Community and Corporate sector**
NACO has initiated significant strengthening of its partnership with the business
community through the Confederation of Indian Industry (CII), and other corporate sector partners for disseminating our messaging on the prevention, care, support, and treatment to its member organizations. Partnership with industry houses will facilitate targeting of the huge migrant labour force, which is among the bridge populations that spread HIV into the general population. Participation from industry will also reduce the burden from the Government and address the general population, which generally does not seek public services. The response from industry also sensitizes employers to reduce the stigma associated with HIV and increase acceptance of people living with HIV/AIDS (PLHAs).

**Reaching out to PLHAs through Greater Involvement of People Living with HIV and AIDS (GIPA) and addressing stigma and discrimination**

NACO has always extended support to PLHAs, and has facilitated fostering and supporting networks of positive people across the high and low prevalence states of India, wherever support has been sought. NACO is an active participant in the ‘enabling environment project’ with United Nations Development Project (UNDP), across six states of India. We have completed a series of advocacy interface meetings with several gatekeepers like local police personnel, media, community leaders, and opinion makers.

**Family Health Awareness Campaigns (FHAC)**

The Family Health Awareness Campaign seeks to reach out to people in the reproductive age group through a camp approach where information and education about the treatment and management of STIs is provided together with service delivery, by medical and para-medical personnel. FHAC advocates the utilization of existing primary health care infrastructure for the early detection and prompt treatment of RTI/STIs by involving the community. The campaign is organized at the district level after detailed micro-planning. Camps are organized at strategic public places, and the cycle of treatment—from diagnosis to administration of free STI drugs and referral treatment, wherever necessary—is facilitated. The main objective of the campaign, which is to contain the spread of RTIs, including STIs and HIV/AIDS, is achieved by

- Raising levels of awareness among the general population as well as vulnerable segments about RTIs/STIs and HIV/AIDS in rural areas and urban slums.
- Encouraging health-seeking behaviour in the general population, especially in the context of RTIs/STIs.
- Making people aware of the services available in the public sector health delivery system for the management of RTIs/STIs.
- Facilitating early detection and prompt treatment of RTIs and STIs by mainstreaming the infrastructure and manpower available under the primary health care system into FHAC.

During 2003, we have shifted the emphasis in the FHAC to include messaging on all four routes of transmission, so that the age group (14-59) becomes equally vigilant about accessing clean and safe blood, about voluntary blood donation, about injection safety, and about the help available to HIV-positive pregnant women at the sites for prevention of mother-to-child transmission.
Advocacy
There has been increasing emphasis on fostering political support and commitment to HIV issues, in India and across South Asia as well.

- In May 2002, the Prime Minister launched an International Policy Makers’ Conference in New Delhi promoted by the International AIDS Vaccine Initiative in collaboration with NACO. The leader of the opposition and Chief Ministers from three of the six high prevalence states addressed the conference, demonstrating strong political commitment at the highest levels and across party lines in support of the HIV vaccine.

- In July 2003, what has been dubbed as a global first, India launched a Parliamentary Forum on AIDS. Elected representatives from the central and state levels as well as elected heads of municipal bodies and from village gram panchayats came together to understand, discuss, and reaffirm commitment to bring HIV/ AIDS centre-stage of the development agenda, and to combat it. The Parliamentary Forum on AIDS was launched by the Prime Minister, and addressed by the Leader of the Opposition, the Speaker of the Lok Sabha (Lower House of Parliament), Chairperson of the Rajya Sabha (Upper House of Parliament), Deputy Prime Minister, Union Health Minister, and political leaders across party lines.

Youth and Adolescents
In order to ensure that young people have the appropriate knowledge and skills to protect themselves, the National AIDS Control Programme has initiated the following programmes:

- A comprehensive School AIDS Education Programme is being implemented to cover all higher secondary schools across the country in a phased manner. This programme is conducted by the State AIDS Control Societies either through NGOs, the Department of Education or a combination of the two. The programme focuses on (a) raising awareness levels about HIV, (b) helping young people resist peer pressure to participate in high-risk behaviour, and (c) helping promote the need for adopting safe and responsible lifestyles like delayed sexual initiation (abstinence). A special module called “Learning for Life” has been developed by NACO and distributed to all the states for utilization in the training of teachers and peer educators. Nearly 50,000 higher secondary schools have been covered so far.

- Students in college and university are addressed through the “Universities Talk AIDS” (UTA) programme. The Universities Talk AIDS (UTA) project is a collaborative partnership between the National Service Scheme (NSS), Department of Youth Affairs and Sports, and NACO. Since its inception in 1991, it is estimated that UTA has reached out to about 8,000 institutions in 176 universities, over 17,000 community leaders, and over 7 million young people in the country.
Out-of-school youth are reached through the “Villages Talk AIDS Programme”, being implemented in partnership with community-based organizations like Nehru Yuva Kendra Sangathan (NYKS) network through the Union Ministry of Youth Affairs and Sports. NACO supports 700 NYKS units spread over 410 districts (out of about 600 districts in India), to disseminate messages on family life education, HIV/AIDS, and appropriate health-seeking behaviour. This collaboration is pivotal to NACO’s efforts in accessing youth in remote rural areas.

In combination, these interventions have served to cumulatively expand outreach and coverage. They ensure that our messages on prevention and mitigation of HIV/AIDS get out to diverse segments among the youth.

**Voluntary and Confidential Counselling and Testing (VCCT)**

There is evidence that voluntary counselling and testing (VCT) is more effective in reducing reported risk behaviours than simple provision of health information. In order to provide social and psychological support to those infected and affected by HIV and to prevent HIV transmission from those who indulge in high-risk behaviour, VCTCs have been established as a key entry point for a range of interventions in HIV prevention and care, like referrals and education about sites for prevention of parent-to-child transmission (PPTCT), access to care and treatment including antiretroviral therapy (ART), and the promotion of condom use. It is a non-coercive, confidential, cost-effective, and inclusive approach that provides a stimulus for behaviour change in both HIV-positive and HIV-negative individuals.

NACO is currently expanding VCTC facilities in district hospitals throughout the country in a phased manner. By December 2003, 542 VCTCs were functioning across the country. We aim to set up at least one centre in each of about 600 districts across India.

In collaboration with WHO, NACO is setting up five model VCTCs to demonstrate and replicate best practices in VCT services, through a ‘hands on training’ schedule at selected sites. NACO has initiated the process of training of trainers for installing a regimen for the sustained supervision of counsellors by conducting regional training of professionals from recognized institutes/universities already having counselling as core subjects. These trained and sensitized professionals will be assigned the responsibility of providing training and supervision to the counsellors at the NACO-supported VCTCs, so as to bring in best management practices and provide high quality services. NACO and WHO have already trained 135 experts from 75 institutes of 17 states as capacity-building efforts for states for continuing enhancement of VCCT services.

In order to maintain the quality of the tests of samples being done at VCTCs, all samples detected as HIV sero-positive and 5 percent detected sero-negative by VCTCs are forwarded to reference laboratories for cross-checking. The External Quality Assessment Programme is in place to evaluate the quality control system in HIV testing laboratories.
NACO is positioning VCTCs as a one-stop shop for care seekers, to provide testing facilities, counselling, advocacy and information, together with products like condoms and sound referral support services.

**Blood Safety**
While the vast majority of HIV infections in India are due to sexual transmission, the transfusion of unsafe blood and blood products accounts for approximately 3 percent of the HIV infections in the country. This form of transmission has nothing to do with the behaviour pattern of the individual. Blood safety remains an important component of the National AIDS Control Programme.

A National Blood Policy was formulated by NACO and adopted by the Government in April 2002. It provides a framework for better management and availability of blood and blood products in the country. This was followed up with an action plan with clear articulation of steps to implement the policy. The National and State Blood Transfusion Councils were registered as societies in 1996 and are funded mainly by NACO. The Councils supplement NACO’s blood safety activities, particularly voluntary blood donation and appropriate clinical use of blood, training and manpower development as well as overall supervision of the programme.

Voluntary (non-remunerated) blood donations are on the rise, particularly in states such as Maharashtra and West Bengal, as the State AIDS Control Societies undertake several activities to promote public awareness of the need for blood donation.

During NACP-I (1992-1999), 815 public sector and charitable blood banks were modernized, 40 Blood Component Separation Facilities established, and a countrywide network of HIV testing facilities set up. During NACP–II (1999-2004), NACO has established 40 additional Blood Component Separation Facilities in different parts of the country and modernized 20 more major blood banks as well as all the remaining district-level blood banks.

State-of-the-art model blood banks are being developed in under-served states. These blood banks are expected to function as demonstration projects for the region in which they are being set up.

NACO’s blood safety initiatives extend beyond HIV to include the screening of blood for hepatitis C virus (HCV) antibodies in addition to testing for hepatitis B, syphilis, and malaria. Screening for HCV has been made mandatory from June 1, 2001, and NACO has already provided the necessary technical resources and training to blood bank personnel.

NACO is committed to providing quality services through the blood safety programme. In order to improve the standards of manufacturing practices in blood banks, NACO supports Quality Management Training Programmes. An accreditation scheme for the blood transfusion services in the country is on the anvil.
An amendment to the Drugs and Cosmetic Rules will enable the establishment of blood storage centres in rural and remote areas along highways. These blood storage centres will take care of emergencies, particularly in the rural areas where it is not feasible to establish full-fledged blood banks.

**Prevention of Parent to Child Transmission (PPTCT)**

Parent-to-child transmission (PTCT) of HIV, or perinatal transmission, accounts for 2.6 percent of the total HIV infection load in the country. More than 27 million women, including over 108,000 HIV-infected women, give birth in India every year. The number of HIV-positive women is increasing, and with it, the number of babies with HIV infection. Fortunately, PTCT of HIV can be prevented with a combination of low-cost, short-term preventive drug treatment, safe delivery practices, counselling and support, and safe infant-feeding methods.

**Feasibility Studies**

Feasibility studies demonstrated that a cost-effective approach to implement PPTCT in the public sector in India is possible. The PPTCT feasibility study using the drug AZT (zidovudine) was conducted from March 2000 to September 2001 in 11 medical colleges. Another feasibility study using nevirapine (NVP) commenced in October 2001 in the same centres and was completed in September 2002. Pregnant women attending antenatal clinics were counselled before taking the HIV test. Pregnant women found HIV positive were offered counselling on prophylaxis and breastfeeding. Women consenting to be included in the programme received prophylaxis, regular antenatal monitoring, and supervised delivery. The women were then introduced to support groups.

**Elements of the PPTCT programme in India**

- Primary prevention of HIV infection especially among women, with measures such as family planning, VCT, antiretroviral prophylaxis, and counselling on infant feeding.
- Prevention of unintended pregnancies through reproductive health services, which include family planning, extended to all women, including women infected with HIV.
- Antiretroviral (ARV) prophylaxis, safer delivery practices, counselling for infant feeding, and support for the many women whose HIV infection is identified only when they are already pregnant.
- Care and support services to HIV-infected women enrolled with the programme and their children and families.

**Scaling up**

To reduce PTCT, NACO is currently implementing the PPTCT programme by adopting a multi-sectoral, decentralized, phased, and incremental approach. PPTCT has been scaled up in a phased manner covering first the medical colleges of the high prevalence states, followed by all the districts in these states, and the medical colleges of the low prevalence states.
Already, 765 doctors and paramedical workers have been trained from 153 public and private medical colleges, as also 710 health workers from 142 district hospitals to form PPTCT teams. Already, 225 PPTCT centres have begun providing PPTCT services with trained counsellors to maintain quality. A summary of the performance from 179 of the 225 institutions till September 2003 is presented below:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>New ANC registration</td>
<td>407,830</td>
<td>-</td>
</tr>
<tr>
<td>Women counselled – ANC</td>
<td>306,972</td>
<td>75.27</td>
</tr>
<tr>
<td>Women tested – ANC</td>
<td>245,299</td>
<td>79.91</td>
</tr>
<tr>
<td>Women who came to pick their test results – ANC</td>
<td>168,444</td>
<td>68.67</td>
</tr>
<tr>
<td>HIV + women – ANC</td>
<td>4,449</td>
<td>1.81</td>
</tr>
<tr>
<td>HIV + women – Labour</td>
<td>748</td>
<td>2.15</td>
</tr>
<tr>
<td>HIV + women who came to pick up their results – ANC</td>
<td>2,153</td>
<td>48.39</td>
</tr>
<tr>
<td>Partners of HIV + women who came for VCCT</td>
<td>2,081</td>
<td>40.04</td>
</tr>
<tr>
<td>Total live births to HIV+ woman</td>
<td>2,200</td>
<td></td>
</tr>
<tr>
<td>Total mother-baby pairs who received NVP</td>
<td>2,198</td>
<td>99.9</td>
</tr>
<tr>
<td>Toxicity with NVP</td>
<td>Nil</td>
<td>-</td>
</tr>
<tr>
<td>HIV+ mothers who chose to breastfeed their babies</td>
<td>1,231</td>
<td>55.95</td>
</tr>
</tbody>
</table>

NACO is also attempting to streamline the process of procurement and logistics of distribution of Rapid HIV tests and nevirapine, and eventually, the complete integration of the PPTCT into reproductive and child health services.

**Capacity Building and Institutional Strengthening**

Capacity building of health care providers through training at the regional level, state level, and below is a key objective of the second phase of National AIDS Control Programme. The training is essential as a sustained tool to strengthen various institutions in dealing with HIV/AIDS control activities.

Capacity building programmes are organized by the National AIDS Control Organization at national and regional levels for training of trainers (TOT). These trained trainers are the key resource persons used by the State AIDS Control Societies to train health care providers in their respective states. The following categories of health care providers have been covered under various capacity building programmes:

- Specialist doctors of Medical Colleges
- General duty Medical Officers
- Nurses
- IEC Officers
- Counsellors
- NGO staff
- Lab Technicians
- Blood Bankers
- District Nodal Officers

**Vaccine and Microbicides Research and Development**

The Ministry of Health and Family Welfare and the Indian Council of Medical Research (ICMR) signed a Memorandum of Understanding (MOU) in December 2000, with the International AIDS Vaccine Initiative (IAVI) to promote and accelerate efforts to develop an indigenous AIDS vaccine that will address the strains of the HIV-1 subtype C predominant in India. The MVA-based vaccine has not yet reached the stage of clinical trial. Two ICMR institutions, namely, National AIDS Research Institute in Pune and the National Institute of Cholera and Enteric Diseases (NICED) in Kolkata, are carrying out vaccine-related work.
The candidate vaccine once developed would go through pre-clinical, safety, and toxicity studies to be followed by Phases I, II, and III trial in humans. The Phase I and Phase II trials will be carried out at the National AIDS Research Institute (NARI) in Pune.

Praneem, an indigenously developed polyherbal microbicide has entered Phase II of clinical trials. Scientists at NARI are conducting the clinical trials. NACO supports this ongoing research and anticipates that the entry of an appropriate microbicide in the market will immediately enable women to protect themselves.

**Care, Support, and ART**

Growing evidence from around the world indicates that the challenge of HIV/AIDS is best met with a strategy that combines prevention and care. HIV disproportionately affects people who are impoverished and socially marginalized. In recent times, as increasing numbers of people are seeking care for HIV-related illnesses and AIDS, the need for care and support is being increasingly felt. NACO is committed to promoting care and support for people living with HIV in order to optimize prevention efforts and reduce the impact of the HIV/AIDS epidemic on individuals and societies.

The Government of India assists the care and support of people living with HIV/AIDS by:

- Supporting the establishment of community care centres, drop-in centres and people living with HIV/AIDS (PLHA) support groups. At present, there are 50 Community Care Centres run by NGOs in various parts of the country. NACO encourages and supports registered organizations of people living with HIV/AIDS to establish drop-in centres to provide counselling and referrals to health and social services. NACO is also supporting 17 networks of PLHA countrywide.

- Ensuring the availability of essential drugs for the management of opportunistic infections. The State and Union Territory AIDS Control Societies fund the treatment of opportunistic infections in government-run hospitals up to the district level. NACO also provides drugs for post-exposure prophylaxis in all government hospitals admitting people living with HIV/AIDS, to eliminate any probability of the health workers and medical practitioners contracting the infection.

- Linking HIV care services to the Revised National TB Control Programme to facilitate the free treatment of TB, the most common opportunistic infection among those living with HIV in India. An HIV/TB co-ordination programme focused on the six high-prevalence states is being implemented with technical guidance and support from NACO and is in the process of being scaled up in a phased manner in the entire country.

- Initiating intensive advocacy and sensitization programmes among doctors, nurses, and paramedical workers to pre-empt, and thereby, counter both the stigmatization of people living with HIV, and the denial of health care on the grounds of HIV infection. Training workshops for doctors on the clinical management of HIV/AIDS and the rational use of antiretroviral drugs are also undertaken.

- Instructing all government hospitals to admit HIV/AIDS cases without any
discrimination and providing care for them in the general wards of the hospitals along with other patients.

- Facilitating the establishment of Infection Control Committees in all major hospitals.
- Expanding district-level VCTCs in a phased manner.
- Scaling up the PPTCT throughout the country in a phased manner.
- Reducing the prices of antiretroviral drugs by:
  - Waiving custom and excise duties,
  - Advocating with state governments to waive sales tax,
  - Negotiating with pharmaceutical companies to lower drug prices, and
  - Promoting manufacture and supply of generic drugs.

Care and support for PLHAs is increasingly becoming the cornerstone of the AIDS prevention efforts in our country. While hospitals and Community Care Centres are expected to render support in difficult and critical situations that cannot be managed at home, the focus has to eventually shift to home-based care. To ensure that the PLHA gets the required medical and psychosocial support at home, the models developed for home-based care have to be revisited to involve greater outreach of existing health care machinery and adequate training of families to provide care and support at home.

**Antiretroviral Treatment: A New Initiative**

Advancement in the management of opportunistic infections and the development of effective antiretroviral therapy mean that the illnesses associated with HIV infection can be treated. PLHAs can now live longer and have better quality of life. The Government of India, at present, provides financial support to states and Union Territories for the treatment of opportunistic infections in all public sector hospitals. But antiretroviral therapies were not supported by the government in the programme because of their prohibitive costs, on account of the indefinite period of treatment and other supportive investigations required for monitoring the progress of the disease. Government, as a matter of policy, has been progressively reducing the excise and custom duties on antiretroviral drugs to make them available to PLHAs at reasonable cost.

The single dose of nevirapine for HIV-positive mothers has been administered in the National AIDS Control Programme for over two years. While this initiative prevents 80 percent of newborn infants born to HIV-positive mothers from contracting HIV infection during childbirth, it does not provide any protection to the HIV-positive mothers. In other words, we are saving infants who very quickly become orphans. This is de-stabilizing families and communities, with long term socio-economic impacts. For this reason, we need to save HIV-positive mothers in the interest of child survival and to save families and communities. Therefore, HIV-infected mothers and children under 15 years of age need antiretroviral therapy.

In India, public sector hospitals provide free treatment to the population. However, so far due to budgetary constraints, PLHAs were not provided antiretroviral treatment. Ethically, it may not be appropriate to continue to deny antiretroviral treatment to AIDS cases seeking treatment in government hospitals.
Government is now actively contemplating expansion of the ongoing programme of care and support for people living with HIV/AIDS across the six high-prevalence states, so as to include antiretroviral-specific target groups through the public health care system.

**Greater Involvement of People Living with HIV and AIDS (GIPA)**

The best advocates for HIV prevention and the design of care and support responses are people who are themselves living with HIV and AIDS. In India, the involvement of PLHAs has occurred since the inception of NACP, both in prevention and in care and support related to HIV. A major reason for this is that the voices of HIV-positive people are rarely heard and they are seldom seen in public. PLHAs are afraid to come out without fear of having their future shattered in light of the prevailing climate of denial, stigma, and discrimination that exists. Also the capacity of PLHAs to influence decision-making and participate in programmes that affect their lives is severely limited.

NACO realizes that a high priority must be given to support existing as well as potential PLHA networks and groups, by strengthening their capacity and voices to fight HIV/AIDS. NACO and SACS are involving PLHAs in decision-making bodies such as Technical Advisory Committees and IEC Committees. NACO supports the set up of drop-in centres and PLHA networks in every state, including building their capacity and strengthening intra-state networking. The number of state-level networks of Indian Networks of Positive People (INP+), has grown to 11. In partnership with INP+ and UN partners, NACO is instrumental in building the capacity of PLHAs through leadership development programmes, which are organized from time to time.

**Intersectoral Collaboration**

The HIV/AIDS epidemic is not merely a health concern but also a development challenge that impacts the social, economic, cultural, political, and legal parameters of society. NACO facilitates the involvement of various sectors such as education, defence, labour, youth affairs, steel, railways, industry and transport, rural development, and social justice and empowerment to optimize India’s response to AIDS. To ensure sustainability, NACO promotes HIV/AIDS prevention and care activities into the ongoing governmental programmes.

**Partnership with UN Agencies**

NACO works in partnership with several multilateral and bilateral development agencies which provide technical and financial support for HIV/AIDS prevention and care programmes in India.

The National AIDS Control Programme together with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and its seven (now eight with WFP included) UN co-sponsor agencies (UNICEF, ILO, UNDP, UNFPA, UNESCO, WHO, UNDCP) and the World Bank are striving to combat the AIDS epidemic through a concerted effort.
Bilateral Agencies
Several bilateral agencies have supported India’s efforts for the prevention and control of HIV/AIDS. They include the Department for International Development, UK (DFID); the U.S. Agency for International Development (USAID), APAC and AVERT Projects; and Canadian International Development Agency (CIDA).
HIV/AIDS in Uttar Pradesh

The HIV/AIDS pandemic emerged as a major health and development challenge the world over. The ravages it wrought in Africa are unparalleled. India is witnessing a steadily increasing epidemic with varying levels of prevalence in different states. It is predicted that populous countries, such as India, will be the targets of the next wave of the epidemic. Uttar Pradesh (UP), with a population of 164 million, is the most populous state in India. An increase in HIV prevalence by one percentage point translates to over eight lakh new HIV infections. Identification of the factors that facilitate the spread of the epidemic and development of a timely and adequate response are the needs of the hour in order to prevent its adverse impacts.

Magnitude and Distribution of HIV/AIDS

The first case of HIV was detected in UP in 1987, within a year of its first report in the country. As per the estimates based on sentinel surveillance by the National AIDS Control Organization (NACO), UP had 3.69 lakh HIV infected individuals by the end of 2002. This accounts for an adult prevalence of 0.45 percent. Regular surveillance was initiated in all the states by NACO in 1998. In UP, patients attending sexually transmitted disease (STD) clinics—representing high-risk populations—and mothers attending antenatal care (ANC) clinics—representing the general population—are under surveillance. There are 17 sites of each category spread across the state. The highest prevalence among STD patients was noted in Mirzapur (4.8%) followed by Varanasi (4.4%). Among antenatal sites, the highest prevalence of 3.0 percent was recorded in Etawah. As surveillance was initiated in this district in 2002 only, it is difficult to comment on this figure until we receive the findings of the next round of surveys. The second highest prevalence was again recorded around Varanasi (0.75% each in Mirzapur and Jaunpur) indicating sustained transmission in this area. HIV prevalence rates in some sentinel sites are shown in Figure 1.

Geographical Spread of HIV

HIV infection has been detected in all the STD sites, in one year or the other (13 out of 17 in 2002). Although some sites, such as Lucknow and Ghaziabad, reported zero prevalence in 2002, they had returned positive figures in earlier years (Figure 2). Such variations in prevalence rates from one year to another may be on account of
the small size of the sample surveyed (250 persons in STD sites and 400 persons in ANC sites). Similarly in 15 out of 17 ANC sites, HIV-infected individuals were detected in one year or the other (8 out of 17 in 2002). In Eastern UP, in nearly all sites (of both categories), HIV positive cases have been detected. The prevalence rates among STD patients were also relatively higher than among ANC clients in this region.

Figure 1
Geographical Distribution of HIV in UP
Survveillance Along the International Border with Nepal
Although there are seven districts in UP that border Nepal, there are only two sites—both antenatal—to monitor the problem of HIV. Trafficking and commercial sex are known to thrive along the border. Increased transmission along Nepal’s border is evident from the border districts of Raxaul and Katihar in Bihar. In low prevalence situations, surveillance of antenatal mothers provides an indication, at best. Unless surveillance of high-risk groups, such as STD patients, is initiated, we may not identify the problem until the transmission is well established in the general population.

Course of the Epidemic Over Time
In 1998, the estimated number of infected individuals in the state was 1.3 lakhs and has gone up to 3.69 lakhs in 2002, signifying steady growth of the epidemic (Figure 3). Analysis of time trends in states with different epidemic levels indicates that the rate of increase is higher in low-prevalence states.

Quantum of Reported AIDS Cases in UP
In countries with good reporting systems (e.g., the United States), the reported number of AIDS cases is taken as a reliable indicator of the magnitude of HIV. NACO maintains a register of reported AIDS cases, as a component of its Computerized Management Information System. The number of reported AIDS cases in UP prior to October 2003 was 1,012, as compared with 61,201 in the country prior to December 2003. This is far below the expected number of about 35 to 40 thousand cases. Even if a quarter of them seek care from government institutions, the number should be about 10,000. Under-reporting appears to be one reason for such a small number. In the infectious disease clinic of SS Hospital, Banaras Hindu University (BHU), 712 cases were diagnosed as HIV-positive between January 2001 and December 2003. Out of these, 512 cases satisfied the definition of AIDS. However, these include patients from adjacent parts of Bihar as well.

Who is Affected?
A controlled study of 120 sequential AIDS cases attending SS Hospital, Banaras Hindu University—with age and sex matching controls from the Medicine Outpatient Department—revealed that 87 (72.5%) cases were migrants or wives of migrants (75 males and 12 female cases) and 16 (13.3%) cases were truck drivers or their wives (10 males and 6 females) as against 5 migrants and 14 truck drivers among controls (Goyal, 2002; see Table 1 below). The destination of the majority of these migrants was Mumbai. It is also interesting to note that the proportion of female AIDS cases reporting to the clinic has increased from 15 percent in 2002
Prevention of HIV/AIDS in Uttar Pradesh

(144x18) be positive. Though it is a small number for assessing the size, it establishes the presence of perinatal transmission in the state.

How Big is Migration and Mobility in UP?

An analysis of 1991 census data on immigration to Maharashtra, undertaken by the National Institute of Epidemiology, revealed that there were 16 lakh immigrants in Maharashtra, with over a quarter (26.9%) of them coming from UP. In a pilot survey of migration in five rural districts of Eastern UP (Mishra, 2003), there were 445 long-term male migrants in 1,191 families surveyed, and half of them migrated to areas currently labeled as high-prevalence states. About 63 percent of them were living alone at the place of migration (Table 2).

With 4,307 km of highways, UP has the second longest national highway network in India. Being midway between Calcutta and Delhi, truckers travelling through the state invariably halt in one place or the other. The volume of truckers in UP—both from within the state and traversing through it—indicates high transmission in the region unless effective preventive action is put in place.

Table 1

<table>
<thead>
<tr>
<th>Status</th>
<th>Cases (n=120)</th>
<th>Controls (n=120)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migrants</td>
<td>75 (62.5%)</td>
<td>5 (4.2%)</td>
</tr>
<tr>
<td>NM Tr. Drivers</td>
<td>10 (8.3%)</td>
<td>14 (11.6%)</td>
</tr>
<tr>
<td>NM Males</td>
<td>17 (14.2%)</td>
<td>83 (69.2%)</td>
</tr>
<tr>
<td>NM Females</td>
<td>18 (15%)*</td>
<td>18 (15%)</td>
</tr>
</tbody>
</table>

*12 were wives of migrants and 6 were wives of truck drivers (Goyal, M.K. et al., 2002)

What Are the Behaviours that Facilitate Transmission?

In the series mentioned above, over 90 percent of the cases reported heterosexual transmission as the cause. There were, however, two cases of MSM, two cases of injecting drug use (IDU), and three cases who reported blood transfusion and no other risky behaviour. This is nearly similar to the reported modes of transmission by NACO and highlights the possibility of existence of other modes of transmission in the state. In the first series, the youngest children of 16 AIDS cases were also tested and five (30.1%) were found to be positive. Though it is a small number for assessing the size, it establishes the presence of perinatal transmission in the state.

Can Transmission Be Sustained Within the State?

It is frequently argued that most of the HIV infections in the state are imported, and that internal transmission, if any, is confined to the spouses of migrants. The data cited above amply demonstrate the existence of local transmission. Another way of examining this issue is to assess both risk groups who can harbour the virus and bridge populations who can effectively transmit it to low-risk

Table 2

<table>
<thead>
<tr>
<th>Migration in Eastern UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families surveyed</td>
</tr>
<tr>
<td>No. of families with male migrants</td>
</tr>
<tr>
<td>No. of male migrants</td>
</tr>
<tr>
<td>No. of long-term migrants</td>
</tr>
<tr>
<td>Migrated sans spouse/unmarried</td>
</tr>
<tr>
<td>To high-prevalence states/epidemic areas</td>
</tr>
<tr>
<td>Factory workers/labourers/skilled workers/drivers/p. business</td>
</tr>
</tbody>
</table>
populations. The size of various risk groups in the state (mapped by ORG-CSR, CARE, and NGOs implementing Targeted Interventions) are given in Table 3 (a) and (b) below.

Are There Conditions that Can Increase Vulnerability and Fuel the Epidemic?
Poverty, marriage or loss of virginity at an early age, illiteracy, ignorance, and poor access to health services are known to fuel the epidemic. UP, with a Net State Domestic Product of Rs. 9,721, as against a national average of 16,701, has the third-lowest per capita income in the country. In 1986–87, 42 percent of people lived below the poverty line, which is well above the national average of 35 percent. Since that time, UP has had a low economic growth rate. The average marrying age in UP is 19 for males and 16 for females. By comparison, the average marrying age in India is 21 for males and 18 for females (BSS, 2001). Female literacy, at 42 percent, is well below the national average as per 2001 Census. BSS (2001) revealed that HIV/AIDS awareness in UP is poor. Knowledge levels, condom availability, and utilization of condoms are shown in Table 4.

Table 3(a)
Size of the Core Groups in UP

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>ORG-CSR &amp; CARE data</th>
<th>NGO data (sites)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSW</td>
<td>8,234</td>
<td>4,400 (12)</td>
</tr>
<tr>
<td>IDU</td>
<td>4,207</td>
<td>1,260 (8)</td>
</tr>
<tr>
<td>MSM</td>
<td>693</td>
<td>--</td>
</tr>
<tr>
<td>Eunuchs</td>
<td>849</td>
<td>--</td>
</tr>
<tr>
<td>Total</td>
<td>13,983</td>
<td>5,660</td>
</tr>
</tbody>
</table>

Table 3(b)
Size of the Bridge Population in UP

<table>
<thead>
<tr>
<th>Risk Group</th>
<th>ORG-CSR &amp; CARE data</th>
<th>NGO data (sites)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Children</td>
<td>2,966</td>
<td>--</td>
</tr>
<tr>
<td>Truckers</td>
<td>52,741</td>
<td>166,000</td>
</tr>
<tr>
<td>Out-migrants</td>
<td>58,909</td>
<td>--</td>
</tr>
<tr>
<td>In-migrants</td>
<td>47,406</td>
<td>--</td>
</tr>
<tr>
<td>Total</td>
<td>162,022</td>
<td></td>
</tr>
</tbody>
</table>

Table 4
Knowledge and Behavioural Aspects of HIV in UP

<table>
<thead>
<tr>
<th></th>
<th>UP-Male</th>
<th>UP-Female</th>
<th>Ind-Male</th>
<th>Ind-Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever heard of AIDS</td>
<td>66.9</td>
<td>34.9</td>
<td>82.4</td>
<td>70.0</td>
</tr>
<tr>
<td>Transmission by sex</td>
<td>58.9</td>
<td>31.3</td>
<td>77.8</td>
<td>64.6</td>
</tr>
<tr>
<td>Transmission by blood transfusion</td>
<td>64.4</td>
<td>32.1</td>
<td>79.1</td>
<td>65.9</td>
</tr>
<tr>
<td>Prevention by condom use</td>
<td>58.5</td>
<td>29.4</td>
<td>70.0</td>
<td>48.1</td>
</tr>
<tr>
<td>Genital ulcer disease in previous 12 months</td>
<td>2.6</td>
<td>13.3</td>
<td>2.8</td>
<td>6.3</td>
</tr>
<tr>
<td>Treated for last episode</td>
<td>8.6</td>
<td>13.6</td>
<td>28.6</td>
<td>19.6</td>
</tr>
<tr>
<td>Condom use NRSP*</td>
<td>64.4</td>
<td>32.1</td>
<td>79.1</td>
<td>65.9</td>
</tr>
<tr>
<td>Condom available within 30 min</td>
<td>46.2</td>
<td>26.3</td>
<td>56.8</td>
<td>42.6</td>
</tr>
<tr>
<td>Age at first sex</td>
<td>19</td>
<td>16</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>Condoms easily available</td>
<td>92.5</td>
<td>79.7</td>
<td>91.5</td>
<td>88.0</td>
</tr>
</tbody>
</table>

*Non-regular sex partner

It is evident from the foregoing data that population vulnerability to HIV/AIDS is high in UP. Therefore, it is essential that the infection be prevented prior to reaching critical levels.
Conclusion
Sentinel surveillance reveals the presence of HIV at low levels all over the state, with relatively higher prevalence in Eastern UP. The epidemic shows a slow, but progressive, increase. The primary reason for the spread of infection in this region is migration, followed by mobile populations. Spouses and children of infected migrants are at risk of infection. While the mode of transmission is mainly heterosexual, other modes of transmission—though only in a very small number of cases—are seen. Poverty, illiteracy, and ignorance render UP’s population highly vulnerable. This, coupled with the presence of high-risk groups and bridge populations across the state, displays a potential for further increase. International experiences show that there can be manifold increase in transmission once a critical level of infection is attained in high-risk populations. Improvement in the quality and coverage of interventions is essential to prevent HIV/AIDS infections from reaching such critical levels.

References
1. Goyal MK. *Study of behavioural risk factors of HIV infection in select population subgroups in and around Varanasi city*. Thesis submitted for the degree of Doctor of Medicine to Banaras Hindu University, 2002; Banaras Hindu University, Varanasi, India.
2. Pandey S. *Profiles and illness behaviour of HIV/AIDS patients attending SS Hospital, Varanasi*. Thesis submitted for the degree of Doctor of Medicine to Banaras Hindu University, 2003; Banaras Hindu University, Varanasi, India.
Introduction

There are many ways of looking at strategies needed for HIV/AIDS response. One way is to look at the evolution of strategies over a period of time in India and other countries. Another way could be to look at strategies for specific programmatic issues, like strategies for communication, blood safety, or services for sexually transmitted diseases. There is also the option of examining various strategies for incorporating cross-cutting issues like gender or human rights. Doubtless, these are valid approaches and useful for programme understanding and effectiveness. However, there is a limitation in examining these strategies since their usefulness lies in details. Hence, this presentation stays away from these approaches.

In India, we already have more than a decade of experience in HIV/AIDS programming. As in most programmes, a listing of the lessons learned in strategic issues of HIV programming reveals that there are many areas that need to be strengthened. Strengthening these areas can result in a more robust HIV response programme. Such areas are of intense interest to programme managers. Hence, this presentation looks at those broad areas whose strengthening could lead to more effective programming.

Full Circle Strategizing

Strategy is defined as “the means for achieving an end.” The “end” that this paper deals with is an effective HIV response project, and the strategies described are aimed at achieving this end.

The central issue in this presentation is a proposal to look at strategies as an all-pervading feature in the total life cycle of HIV response. Hence, the proposed name of Full Circle Strategizing.

Every project has a cyclical life cycle, referred to as a Project Cycle. There are many ways of representing a project cycle. This presentation has taken a highly simplified way of representing a project cycle.
A project is seen as a solution to a problem. Hence, it is important first to understand the problem before coming up with a solution. An answer can be found or given only after the question is known! This is the stage of problem definition. The more clearly a problem is defined, the more accurate the solutions will be.

Once the problem is defined in all its dimensions, solutions must be formulated to answer the problem. This is the stage of solution formulation. The natural stage that follows is the implementation of the solution according to the way the solution has been formulated. Implementation of the solution is only a route to solution of the problem, and hence, one needs to evaluate two aspects:
- How well was the solution implemented?
- What effect has the implementation had on the problem/s?

This is the stage of evaluation. By the time the solution was implemented, the problem could have changed due to two factors:
- The effect of implementation of the solution
- Other factors affecting the problem and causing changes in its extent or nature

It is important to evaluate the metamorphosis the problem may have undergone so that, in the next cycle, solutions are developed for the current state of the problem.

This is the stage of re-defining the problem. Thus, there are four fairly distinct phases in a project cycle:
- Problem definition
- Solution formulation
- Solution implementation
- Evaluation leading to re-definition of the problem

One of the shared attributes of these four stages is that there are strategic issues for each.

The strategies that are set up for each phase of a project cycle are not constant. With each phase of project implementation, there is a need to re-evaluate the strategies.
This often leads to strategic changes in one or more of the stages. In Slide 3 above, each of the concentric circles represents one phase of the project. In common practice, it often indicates annual cycles.

Project strategies are not static, and for each project cycle it is necessary to re-examine the strategies.

Now we will discuss each of the stages of the project cycle and see what could be the appropriate broad strategies. The first stage is Problem Definition.

In applying Problem Definition to the HIV epidemic, one needs to have strategies that give information on the following key aspects. The volume and distribution of the following factors are needed.

- Infection: What is the level of infection? Who is getting infected more? Is infection happening uniformly throughout the project area, or is it clustered in geographical areas or among people with some socio-demographic or cultural characteristic?

The common way to obtain such information would be to conduct HIV prevalence studies or to access data of already-conducted studies. Often direct prevalence figures, disaggregated for geographical region or specific groups of population, may not be available. In such situations, the following factors are helpful in understanding the potential distribution of the epidemic.

- Epidemic drivers: These are factors that predispose a person or population to HIV infection. The most direct driver is, of course, practice of unsafe behaviours like multi-partner sex without condom use. Other drivers are poverty, illiteracy, gender inequalities, and poor human rights. An HIV project must have strategies to define these factors in the population where the project is to be implemented.

As in the case of HIV infection, the strategy could be either to conduct studies or collect secondary information on all the possible epidemic drivers.

- Obstacles to response: Since HIV is predominantly a sexually transmitted disease, social norms that prohibit open discussion of matters relating to sex and sexuality may obstruct a response to the epidemic.
Such information must be collected and key people and institutions that influence such opinions be mapped.

- Supports to response: In a community or large geographical area, there are potential individuals and institutions that can support rational responses to the epidemic. In defining the problem, it may be useful to identify such sources of support.

The above factors could change in each succeeding cycle of the project, either as a result of the project or because of other factors.

The next stage to be considered is **Solution Formulation**. This is a logical sequence of trying to find solutions to identified problems.

Typically, people evaluate problems and move on to solutions. Current situations and future possibilities are often defined in terms of aspirations and opportunities. This is essentially only a semantic difference and does not need any modification in approach to **Solution Formulation**.

The basic strategy in solution formulation is to match the current problem with solutions that have effectively addressed similar problems in the past. Thus, it is a process of searching out available knowledge reservoirs. Often these are available as best practices or study documentation. When such knowledge is not available, it is necessary to carry out operations research and test solutions on a smaller scale prior to large-scale application.

After these processes, it is necessary to put together a project proposal that clearly outlines the project’s course of action and resources needed. A key strategy for project formulation includes basing all project activities on proven approaches and ensuring stakeholder consensus on the identified problem and proposed solution.

This is an activity-intensive stage of the project and calls for sound strategies that guide the operations.

Probably the most important strategy during this period is to ensure that planning and re-planning take place. Often, planning is not a very popular activity and re-planning is even less popular! But project experiences have consistently shown that the better the planning, the more effective the project becomes. Each project has to find its own way of
ensuring that the planning function is adequately addressed. Failing to plan is planning to fail!

It is highly desirable that plans follow an accepted framework so that they may be shared with individuals outside the project environment. Three frameworks are commonly used:

- **Classic Framework**: The plan is categorized into goal, specific objectives, and strategies for achieving these objectives, and activities for each of the strategies. Resources needed for carrying out the activities are also included (technical, financial, and managerial).

- **Logical Framework**: Represented in a 4x4 matrix where the project logic runs as goal, purpose, outputs, and activities.

- **Process-based Framework**: This framework is explained in slide 12.

The logical sequence here is as follows—Inputs, Processes, Outputs, Outcomes, and Impacts. Since this framework most closely follows the evaluation framework, it is used in this presentation.

- **Inputs** are resources needed to carry out the processes.
- **Process** refers to what the project does to achieve the output.
- **Output** refers to what the project delivers to achieve the outcome.
- **Outcome** refers to the ‘achievables’ that precede impact. For instance, if the impact is to reduce the prevalence of HIV, one of the outcomes has to be increased condom usage.
- **Impact** refers to the impact that the project seeks to achieve.

This framework permits attachment of a vast array of attributes to these primary elements. For instance, costs can be attached to inputs so that process costs and output costs can be readily accessed. This framework also directly lends itself to integrating project management and knowledge management. It is also useful for web-based project management for geographically dispersed teams.

The indicators set up for Impact, Outcomes, and so forth are project implementation indicators. It is desirable that indicators for Project Governance and Management are also set up.
Examination of HIV (and non-HIV) response project documentation shows that implementation is often highlighted, and Governance/Management issues paid scant attention. Yet without governance and management, implementation cannot be successful.

History has a way of repeating itself; to be forewarned is to be forearmed. The situation described above is not an uncommon occurrence. Such situations often arise when the governance and management functions are neglected and the focus is on implementation only.

A vital project strategy would be to ensure that leadership is effective and management systems are fair.

The next stage in project cycle is Evaluation.

Implementation issues are usually readily submitted for evaluation, while governance and management functions are often not evaluated. This common oversight is preventable and vital to project success.
Once the evaluation is complete, it is necessary to re-define the problem since changes may have occurred. The broad strategic approaches that have been described hold true for further project cycles as well.
UPSACS, Multisectoral Approaches and Migration Patterns

Chairperson
G. Narayana

Structure, Functions and Strategies of SACS in Uttar Pradesh
Monica

Multisectoral Involvement for Prevention of HIV/AIDS in Uttar Pradesh
J. S. Deepak

Migration Pattern of Uttar Pradesh’s Population
Murli Dhar Vemuri

Inter-District Migration of Population in the context of HIV/AIDS – A Study of Uttar Pradesh
K. M. Sathyanarayana

Discussants
R.B. Gupta and Satheesh Chandran
Prevention of HIV/AIDS in Uttar Pradesh
Introduction

Uttar Pradesh (UP) is the most populous state of India, with an estimated population of about 166 million as projected by the 2001 census and a land area of 240,928 sq. km, involving 70 districts. One-sixth of the world’s population resides in India, and one-sixth of India’s population finds refuge in UP. The rural and urban population are estimated at 79.23 percent and 20.77 percent, respectively. The status of women in UP leaves much to be desired. The sex ratio as per the 2001 census was 898 females per 1,000 males. The overall literacy rate is 57.36 percent, with male literacy at 70.23 percent and female literacy at 42.98 percent. The per capita income, which was estimated at Rs. 9721 per annum, is indicative of the well being of the state populace.

“Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” With this objective in view, the state provides health facilities to its citizenry with 4,236 allopathic hospitals, including 3,641 primary health centres (PHCs) and 291 community health centres (CHCs). There are 10,428 medical officers and 139,858 paramedical staff working in collaboration to provide good health services to the citizens of the state. There are 22,041 health sub-centres and a minimum of one male and one female hospital in each district, apart from nine medical colleges scattered all over the state. Specialized services and consultancy in various disciplines is provided through the Sanjay Gandhi Post Graduate Institute of Medical Sciences at Lucknow. Besides this, the state also benefits from the existence of 2,210 ayurvedic and 1,342 homeopathic hospitals/dispensaries in the region.

The first person to test positive for HIV in UP was in 1987. Fortunately enough, the epidemic did not spread as extensively as in the states of Maharashtra and Tamil Nadu. Rather, it remained dormant, and the state is categorized as a “low prevalence state.” The main reason for this was the less than 5 percent rate at sexually transmitted infection (STI) sites and less than 1 percent rate at antenatal care (ANC) sites. The sero-positivity rates as per sentinel surveillance in STI and ANC sites were 1.28 percent and 0.19 percent, respectively. The HIV positivity rate in blood units is 0.14 percent.

The AIDS control activity got off to a flying start in 1992–93 as a 100 percent centrally-sponsored and World Bank-aided project under the aegis of the National
AIDS Control Organization (NACO), Ministry of Health and Family Welfare, and Government of India. The first phase of the programme (1992–98) emphasized the creation of infrastructure, both institutional and technical. The basic objective underlying the strategy was the prevention and control of the AIDS epidemic.

The National AIDS Control Programme–Phase II (NACP–II) was launched in December 1999 with the main objectives to reduce the spread of HIV infection in UP and strengthen UP’s capacity to respond to HIV/AIDS on a long-term basis.

For accomplishing the above objectives, the following strategy would be adopted:

1. Deliver cost-effective interventions against HIV/AIDS by providing
   - Priority interventions for groups at high risk (CSW, migrant workers, STI clinic attendees).
   - Preventive interventions for the general community (conduct information, education, and communication (IEC) and awareness campaigns, family health awareness campaigns (FHAC), folk media, voluntary HIV testing promotion, training grassroots-level health care providers, counselling services in blood banks, and STI clinics).
   - Low-cost AIDS care (treatment of opportunistic infections (OIs), involvement of non-governmental organizations (NGOs), and community-based AIDS care).

2. Strengthen capacity through
   - Institutional strengthening
     - Capacity building of UP State AIDS Control Society (UPSACS) for implementation
     - Expansion and improvement of annual HIV sentinel surveillance
     - STI surveillance through specific surveys like FHAC
     - AIDS case surveillance
     - Staff training
     - Capacity-building for monitoring and evaluation by monthly reports
   - Intersectoral collaboration
     - With private, public, and voluntary sectors, integration with other programmes, industries, etc.

Project Components, Objectives, and Activities

Targeted Interventions (TIs)

HIV/AIDS in India is a serious public health challenge, which has certain socio-economic dimensions. To tackle this problem, the NACP–II has identified the need to develop well planned interventions with vulnerable populations to reduce the rate of HIV transmission in our communities.

An intervention is a set of activities through which a strategy is implemented. Targeted intervention is a comprehensive approach based on certain best practices in the country, combining behaviour change communication (BCC), counselling, general health care, including treatment of STIs, promotion of condom use, and creation of an enabling environment that addresses poverty and social vulnerability.
High-risk groups need information and services in a focused and non-discriminatory manner. Thus, a peer-based approach is developed, which enables and sustains behaviour change. An enabling environment that is conducive to behaviour change must support an intervention. TIs are the most effective way of addressing marginalized populations who are more vulnerable to STIs/HIV. TIs are effective only when comprehensive ranges of services are undertaken together or closely in the same time period.

NGOs are considered critical partners for TIs for care and outreach services for people living with HIV/AIDS (PLHA).

**Why Work with NGOs?**

- As grassroots organizations, they are directly involved with the people of their communities.
- NGOs know the intimate details of the community that are necessary for effective programme planning.
- NGO programmes often spring directly from the needs of the community and should involve members of the community in planning and implementation and would result in community support for the initiatives and greater effectiveness of NGO programmes.

TIs were launched along with the inception of NACP–II with the lessons learnt from NACP–I as guiding principles.

**Lessons Learnt from NACP–I**

- Decentralization of choice of partners and operations
- Operational flexibility
- Transparency in the process
- Addressing capacity issues
- Community ownership

**Objectives of TIs**

- Reduce HIV infection in the state in poor, marginalized populations at high risk of HIV infection and in the population at lower risk of HIV
- Promote safer sexual behaviour of the community, particularly the behaviour of high-risk groups
- Reduce the rate of HIV transmission by creating awareness about HIV/AIDS
- Provide BCC to facilitate the transition to safer behaviour
- Help those who are infected obtain appropriate services
- Help families and partners of infected people to receive prevention services

**High-risk Groups Covered Under TIs in UP**

- Sex workers (SWs) (brothel-based and non-brothel-based)
- Truckers
- Injecting drug users (IDUs)
- Prison inmates
Prevention of HIV/AIDS in Uttar Pradesh

Interventions in UP
The interventions among high-risk groups are implemented in the following districts: Allahabad, Agra, Aligarh, Basti, Barabanki, Bahraich, Bareilly, Fatehpur, Gorakhpur, Kanpur, Lakhimpur Kheri, Maharajganj, Meerut, and Varanasi.

The scaling-up of interventions was grounded on the principle of research followed by action. The following graphs show the growth of interventions from 2000–2003.

Sexually Transmitted Infections
STIs are infections predominantly acquired through a sexual route. The latest STI is HIV/AIDS. Since ancient times, these diseases have been known to cause severe illness and sometimes prove fatal. After the discovery of penicillin and other antibiotics, these diseases have been controlled to a large extent; but, sex being the
biological means of reproduction and a basic need of the body, the spread of STIs continues if either partner is left untreated, especially one who is asymptomatic. The oldest and most commonly known STIs are syphilis and gonorrhoea. Other less common STIs are cancroids and vaginitis, causing ulcers, sores, discharge, and inflammation of internal organs or external genitals.

**Objectives of the STI Control Programme**
The STI control programme of the state has two major objectives—to reduce STI cases and thereby control HIV transmission by minimizing the risk factor and to prevent short-term and long-term morbidity and mortality due to STIs.

**Strategy**
The strategy in the National AIDS Control Policy regarding STI control for prevention of further spread of HIV/AIDS includes controlling STIs among vulnerable groups and promotion of condom use as a preventive measure.

**Laboratory Diagnosis of STIs**
The care of patients with STIs and HIV is provided by different levels of services from specialized STI centres to PHCs. The basic aim is rapid, inexpensive, simple, and accurate diagnosis of the disease and inexpensive and effective treatment.

**Treatment Schedule**
Most STIs can be cured if correct treatment is given. A simple flow chart of syndromic management of STIs and reproductive tract infections (RTIs) is made available at every treatment centre.

**Prevention of STIs**
The following guidelines can do much to prevent STIs:
- Using condoms
- Avoiding sex with partners who have genital rashes, redness, sores, or discharge
- Staying away from casual sex/reducing the number of sex partners
- Urinating and washing the genital area after intercourse

Early treatment is always desirable to prevent complications and further spread of infection.
Future Strategy

- Because of the lack of privacy/adequate space and proper laboratory services, resources are needed to make improvements to infrastructure and strengthen service provision.
- Periodic capacity building sessions to train medical and paramedical staff
- Request for counsellors posted in STI clinics
- Linkages needed with chief medical officers (CMOs) in case of shortage of condoms
- Request to district health system to construct new STI clinics during the extension of buildings in hospitals

IEC

UP is a highly populous state with a low literacy rate of 57.36 percent overall and 36.66 percent amongst the rural populace, which accounts for 79 percent of the state citizenry. The cultural and linguistic diversities also pose a great challenge for developing suitable IEC strategies catering to the needs of all.

Problem Statement: The majority of people are unaware of the routes of transmission and methods of prevention of HIV/AIDS.

Vision: By 2007, no one in UP becomes infected with HIV due to lack of knowledge.

Targeted Area: All 70 districts of the state

Targeted Population: million

Targeted Groups

- Rural women
- Out-of-school children
- Slum dwellers (U)
- Youth (U)
- Bus/jeep/taxi drivers (U)
- Industrial labourers (U)
- Migrants

Objectives

- To raise awareness and improve knowledge and understanding amongst the general population about STIs/HIV/AIDS.
- To make people aware of services being provided by UPSACS in the public health system for the management of STIs/HIV/AIDS.
- To remove the myths and misconceptions about STIs/HIV/AIDS.
- To mobilize all sectors of society to integrate messages and programmes on HIV/AIDS into their existing activities.
- To create a supportive environment for PLHA.
- To increase the level of awareness among women and girls to protect themselves against STIs and HIV.
To motivate vulnerable groups of youth, slum dwellers, and so forth about practising safe sex.

IEC activities are operational at both the state and district levels.

**State Level**

- IEC Committee
- Inter Media Publicity Coordinating Committee
- Family Health Advisory Committee for All India Radio and Doordarshan

**Strategic Plan and Priorities**

- Area-specific awareness campaigns would be conducted in Bundelkhand, Eastern UP, Western UP, Ruhelkhand, and Awadh Region.
- Women-targeted awareness campaigns would be conducted with the help of Anganwadi workers and women's organizations.
- Innovative IEC activities for truckers would be carried out on national highways.
- Hotspots of migration as source, transit, or destination sites would be identified, and an awareness campaign would be conducted for migrant labourers in Eastern UP and the Bundelkhand Region.
- Area-specific IEC efforts would be done at the Indo-Nepal border area for SWs and IDUs.

**Blood Safety**

Human blood is an essential element of human life, and there are no substitutes. Blood transfusion services occupy a vital space in any national health service delivery system. On the one hand, the availability of safe and adequate blood saves lives. On the other hand, if not properly screened, blood becomes a conduit for transmitting life-threatening viral, bacterial, and protozoal infections, including hepatitis B, hepatitis C, HIV/AIDS, syphilis, and malaria.

Blood is also a scarce resource. Following upon the National Blood Policy 2002, the Action Plan on Blood Safety is under process for the availability and safety of blood and blood products and to facilitate a self-sustaining national blood transfusion programme.

Lessons learnt in India from the spread and scale of HIV/AIDS must be shared. Till the mid-1990s, up to 8 percent of new HIV infections in India were attributed to the transmission of unsafe blood. After January 1, 1998, overall improvement in the quality of blood and blood products was noticeable; less than 4 percent of new HIV infections are now traceable to the transmission of unsafe blood. Additional strengthening of blood transfusion services across the country and state with meticulous screening mechanisms and functioning horizontal and vertical linkages within the blood transfusion system will further reduce the transmission of life-threatening infections.

Typically, two categories of persons need blood transfusions—those with emergency requirements, like victims of road/rail accidents or civilian and military disasters, and
those with repeated, frequent, and regular requirements, like patients with thalassemia, haemophilia, leukaemia, renal dialysis, severe anaemia, or cancer.

Patients who must undergo repeated transfusions are at a greater risk of acquiring transfusion transmitted infections (TTIs). The only way to protect patients is to put in place structures, processes, and procedures that will ensure access to safe and sufficient blood supply. This is now a vital medical need. To combat the requirement of the safe blood and blood components to the needy patients, steps have been taken by UPSACS to respond to the following objectives:

**Objectives**
The major objectives of the Blood Safety Programme are to ensure easily accessible, adequate supplies of safe and quality blood and blood components for all, irrespective of economic or social status. Steps were initiated for the following responses to achieve this objective.
- To ensure organized blood banking services at the state and district levels
- To educate and motivate people about voluntary blood donation
- To enforce quality control of blood and blood products

**Status of Blood Banks in the State**
*Target for the Year 2004: enhance* the percentage of voluntary blood donation in the year 2004 by 50 percent.

To enhance voluntary blood donation in the state, the following steps have been taken:
- Advertisement and wide publicity through print, electronic, and folk media.
- Organization of blood donation camps at district hospitals on October 1, voluntary blood donation day, and December 1, World AIDS Day. Blood donation camps on various other important occasions are regularly being done.
- Funds allocated to the government blood banks for voluntary blood donation camps by the state Blood Transfusion Council of UP.
- Arrangement of poster painting competitions for regular blood donation camps and arrangement of rallies and discussion/debates performed to enhance the voluntary blood donation camps.

**Reinforcement**
- Professional blood has been banned in UP since January 1, 1998, by the orders of the Hon. Supreme Court. Since then, the licensed blood banks are supplying the blood units on an exchange/replacement basis.
- The Drug Controller of India and UP issued licenses for blood banks and blood component separation centres under the Drug and Cosmetics Act 1940.
After the initial issue of a license, it is renewed at regular intervals. Regular inspections are done by an additional regional Drug Controller/Drug Inspector and the officers of UPSACS and the Medical Health Department.

It is mandatory to test for the following TTIs: HIV, hepatitis B, hepatitis C, VDRL (syphilis), and malarial parasite.

Blood banks that do not follow the provisions of the Drug and Cosmetics Act face appropriate action taken by the competent authorities.

Monitoring and Evaluation

To maintain the quality control of blood and blood components, regular monitoring is done. Since the blood banks are licensed under the Drug and Cosmetics Act 1940 by the Drug Controller of India and UP, the regulatory and controlling authority remains the Drug Controller of India and UP/Additional Drug Controllers and Drug Inspectors of the districts. Still, the technical monitoring and evaluation of blood is done in addition by: Monthly Progress Reports of blood banks and Blood Count Separation Units reports regularly received by the society; visits/inspections carried out by the officers of UPSACS and the Medical Health Department; and meetings, workshops, and conferences at State Headquarters.

HIV Sentinel Surveillance

HIV sentinel surveillance is the activity to monitor the trends of HIV infection in specific high-risk groups and low-risk groups in order to:

- Know the trend of HIV infection in the population;
- Estimate HIV load in the community;
- Determine which population groups need priority interventions;
- Plan and evaluate interventions; and
- Advocate to obtain political commitment with social and media support.

Sampling Period: 1, 2002–October 31, 2002 (12 weeks)

Sentinel Sites: STI clinics, Gynae out-patient dispensaries (OPDs), ANC clinics, and TI projects

Unit of Study: A new STI patient attending STI clinic of Gynae OPD and TI projects during the sampling period; an ANC case attending ANC clinic (district and CHC level) for the first time during the sampling period.

Criteria for STI Patients:

Male: Genital ulcer/warts/urethral discharge
Female: Genital ulcer/warts/cervical discharge (confirmed by speculum examination)

Criteria for ANC Cases: An ANC case attending ANC clinic for the first time during the sampling period.
Predetermined Sample Size

**High-risk group (STI)**
- Samples from STI clinic: 150
- Samples from O&G clinic: 100
- Collection of additional samples from T.I. Projects (SW/MSM/IDU): 250

**Low-risk group (ANC)**
- Collection of additional samples from CHC/first referral unit (FRU): 400

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**Targeted Interventions for High-risk Groups**

**Objectives**
- Target behaviour change of at-risk populations
- Map out SWs and clients
- Reach transport and industrial workers, migrants, MSM, street children, prison inmates, and eunuchs

**Major activities**
- Mapping vulnerable sites
- Developing interventions for vulnerable groups
- Developing targeted IEC
- Selecting NGOs
- Capacity building
- Evaluating TIs

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**Improve STI Management**

**Objective**
To provide quality STI services to populations with high-risk behaviour through government and private doctors with focus on districts with high HIV prevalence.

**Major activities**
- Baseline assessment
- Training in syndromic management
- Improving referral services for STI management
- Providing medicines and consumables to STI clinics
- Operational research on syndromic management

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**Improve Quality Condom Accessibility and Availability**

**Objective**
To increase condom use by increasing condom outlets and making quality condoms available.

**Major activities**
- Baseline research
- Social marketing
- Increasing condom outlets
- Regularly supplying condoms
- Creating mass awareness for condom use
- Evaluating through client survey

**Care and Support**
"Care and support" covers a multitude of different programming areas and services, such as clinical management, nursing and home care, and counselling and psychological support for those infected with HIV and their families and communities.

NACO recognized clearly that there is a moral and humanitarian obligation to provide appropriate care and support to PLHA. The CARE programme revolves around the given objectives.

**Objectives**
- Improving health service delivery
- Increasing access to psychosocial support and impact alleviation
- Increasing access to OI drugs to PLHA
- Providing quality life to PLHA
- Providing antiretroviral (ARV) drugs to health care providers for post-exposure prophylaxis in order to make them feel secure towards treating PLHA

**Activities done**
- Arrangements have been made through every medical college and all district hospitals of the state to achieve the objectives.
- For care and support of AIDS cases, doctors of all medical colleges in the state and the CMO and chief medical superintendent (CMS) of the entire district were trained through training and workshops.
- STI in-charge and lab technicians of voluntary counselling and testing centres (VCTCs) were trained through workshops.
- For the free treatment of OIs, UPSACS has provided funds to each medical college, district hospital, and female district hospital by way of grants.
- CMSs and medical colleges of nearby districts have been instructed to be vigilant and careful of cases referred by the hospitals of newly created districts where the post of CMS has not yet been created. All hospitals of such districts have been instructed to refer such cases to their nearby district hospitals and medical colleges.
- Guidelines of post-exposure prophylaxis have been sent to all the medical colleges and district hospitals of UP. Principals have been asked to ensure that the health care workers take immediate post-exposure prophylactic measures in case of an occupational exposure to HIV and report the matter to UPSACS for necessary action.
- A meeting with Joint Director, Tuberculosis has taken place for making proper arrangements for the treatment of HIV-Tuberculosis (TB) co-infection cases.
- A session on HIV-TB co-infection has been included in the training schedule of counsellors.
- All district tuberculosis officers (DTOs) have been sensitized to how PLHA with TB are to be treated.
- To ensure and evaluate this component, field visits have been made to different district hospitals and medical colleges.
A monthly report of AIDS cases is sent to NACO after obtaining such reports from different medical colleges and district hospitals.

In order to facilitate training in prevention of parent-to-child transmission, representatives from all medical colleges of the state are sent to the National AIDS Control Society.

Voluntary Counselling and Testing Centres (VCTC)

VCTCs are much more than a place just for testing for HIV. One of the basic elements involved in VCT is a confidential discussion between a client and trained counsellor and the focus on issues related to possible or actual HIV infection. The aim of VCT is to reduce psychological stress and to provide the client with the information and support necessary to make decisions.

Objectives

HIV testing carried out on a voluntary basis with appropriate pre-test and post-test counselling is considered to be a better strategy and is in line with the WHO guidelines on HIV testing. The objectives of HIV testing in India are:

- Mandatory screening of all donated blood for safety of blood and blood products
- Testing donors of sperm, organs, and tissues for HIV to prevent HIV transmission to the recipient
- Diagnosing HIV infection in clinically suspected individuals
- Voluntary testing for high-risk groups after counselling
- Sentinel surveillance to monitor epidemiological trends
- Research

Status and Achievements

During NACP–I, five VCTCs were established for surveillance of HIV/AIDS. These five VCTCs catered to UP’s vast population till 2000. UP is a low prevalence state, but the testing facilities still were not sufficient to cater to the needs of the population at large.

To provide testing and counselling facilities in other places, meetings were organized for principals of medical colleges, heads of departments of microbiology, and CMSs regarding the facilities/feasibility for opening of VCTCs in their institutions.

Before NACO issued the new guidelines on VCT in June 2001, it was necessary to have an ELISA reader to open a VCTC. On the basis of information collected, VCTCs at two medical colleges that managed to procure ELISA readers opened in the beginning of 2000. Opening of VCTCs in remaining medical colleges depended upon the availability of ELISA readers.

After receiving the letter from NACO regarding consignees for the ELISA reader in February 2001, three medical colleges opened VCTCs in March 2001.

The success of the VCT strategy largely depends on the availability of cheap testing facilities that give results in the shortest possible time. This makes the rapid test an attractive option, where the client can receive pre-test counselling, test results, and post-test counselling in one session.
Introduction

In the United States, the first case of HIV/AIDS was detected in 1980, and by 1981 AIDS had assumed the form of an epidemic. The Centers for Disease Control & Prevention (CDC), the U.S. agency responsible for combating epidemics, recognized from the very beginning that the epidemic spread through sexual networks and grew exponentially to reach alarming levels in groups like gays and sex workers (SWs). The implications of this for the public health system were obvious: take prevention measures and stamp out the epidemic before it spreads more widely. However, the government system showed typical inertia and almost ignored the issue in spite of the growing number of AIDS deaths. More and more people became infected. They developed AIDS and died. Their deaths became mere statistics, and Americans did not assign a human face to the growing epidemic. An entire nation with access to the best medical research establishments, vast communication networks, and enormous financial resources remained in a state of denial. A popular book on the beginnings of the AIDS epidemic in the United States was appropriately titled *And the Band Played On*, a reference to the luxury liner *Titanic*, whose captain ordered the orchestra to keep playing on so that the passengers did not panic even as the ship was sinking after hitting an iceberg on its maiden voyage across the Atlantic. Similar denial of the AIDS epidemic has characterized the initial response in countries across Africa and Southeast Asia and in India.

Why did the AIDS epidemic not come on the agenda in the United States, one might ask. It is generally believed that an issue comes onto the national agenda in the United States when the president makes a speech on the issue or the *New York Times* puts it on its front page. Ronald Reagan did not speak about AIDS till 1987 even though his friend and matinee idol Rock Hudson had died of the disease in 1985. The *New York Times* front-paged a story on AIDS only in 1983, a full two years after the epidemic had started. Thus media attention on AIDS remained low.

Public awareness of the AIDS epidemic in the United States did eventually increase, but in the first 20 years, almost 450,000 died of AIDS in that country. The annual death rate came down from 50,000 per year in 1995 to 15,000 in 2001 even though more than 40,000 Americans were newly infected with HIV in 2001. Being a wealthy country, the United States could afford to combat and bring down the AIDS
epidemic, though at a considerable cost. Had effective HIV/AIDS interventions begun early, when AIDS cases were initially identified and before it assumed epidemic proportions, the total cost, the effort required, and the suffering endured would have been a fraction of the eventual amount. Thus, waiting for an epidemic to happen before responding proved costly.

**History: A Poor Teacher**

The AIDS epidemic is everywhere today. The same cannot, unfortunately, be said of the response to it. In India, a national sero surveillance was initiated in 1986 to define the magnitude and dimension of HIV infection in the silent phase long before AIDS cases were reported. However, efforts have been limited thereafter as there appears to be an element of complacence due to the low level of sero positivity, very small proportions of women at antenatal clinics testing positive, and a belief that due to cultural ethos multiple-partner sex and intravenous drug use are very low.

In 2001, there were more than 4 million Indians who were HIV infected comprising 0.7 percent of the adult population. The World Bank estimates that this figure will go up to 20 million by 2005 unless effective action is taken. In Mumbai, 70 percent of SWs are HIV positive, which shows a shockingly high level of prevalence in that high-risk group. Three percent of women showing up at antenatal clinics are HIV positive, indicating that HIV/AIDS is moving from high-risk groups to the general population. Uttar Pradesh is characterized by the Government of India as a low prevalence state, and thus both efforts for detection and prevention are almost non-existent. It is indeed a frightening thought that with the large population base of one billion in the country, even if the low levels of prevalence continue, which is unlikely, India will have the largest number of cases and deaths due to AIDS in the world. Likewise, Uttar Pradesh, with a population of 170 million, is headed for a catastrophe unless we do something to greatly strengthen HIV prevention programmes and do it now. Unfortunately, in the case of U.P., history has been a poor teacher, and in spite of the experience of some sub-Saharan African countries where life expectancy has been reduced by up to 20 years due to AIDS, the only thing that appears certain is that history will repeat itself.

**The Spread Pattern**

The spread of HIV/AIDS follows a pattern. It begins among the high-risk populations of SWs and injecting drug users (IDUs) in urban areas. It then spreads through heterosexual contacts and exchange of blood to others, like migrant workers, truck drivers, and by mother-to-child transmission (MTCT). In the third stage, it spreads to the general population through sexual contacts with those infected in the second phase. Typically, infected migrant workers and truckers transmit the virus to their wives and sexual partners when they return home, thereby setting off a chain of exponential increase.

The impact of AIDS is equally tragic and well documented. The infected men die first, but by the time this happens, they have usually infected their wives, drawn down their savings, and have become indebted to support treatment of HIV-related opportunistic infections. Their wives and daughters are forced into sex work as in
most cases they have no other means of livelihood, and strong stigma associated with HIV/AIDS makes obtaining support from the family or community impossible. By the time they die, they leave behind orphans, often HIV positive, who are condemned to a few years of painful survival. They also infect other men with whom they may have had sexual relations. The whole painful cycle is repeated, and the tragedy unfolds.

The consequences of AIDS are horrendous, and in countries like Zimbabwe and Zambia where the epidemic rages, life expectancies have been cut down by as much as 15–20 years. In the former, 45 percent of children under the age of five are HIV positive, and most will not grow up to see their tenth birthdays; in the latter, one in four children is an AIDS orphan.

The Response
The tragedy of the AIDS epidemic is accompanied by some case studies of effective response by developing countries as diverse as Thailand and Cambodia on the one hand and Uganda and Senegal on the other. Each of these countries used varied strategies at different stages of the epidemic. Thailand focused on its sex industry and condom promotion when the epidemic had reached alarming levels, and Cambodia learnt from the Thailand example before it was too late. Senegal implemented a strong preventive programme as soon as the epidemic was detected while Uganda suffered a high infection rate in 1992 before strong educational efforts, HIV testing, and condom promotion reduced it by half.

All these successful efforts had a few underlying common features, which are the following:

- Strong political commitment and will on the part of the government leadership to combat HIV/AIDS
- Emphasis on preventive measures like condom promotion to reduce the rate of HIV infection
- Effective communication efforts to make people aware of the risks associated with certain behaviours
- Efforts to remove stigma of HIV/AIDS so that people would come forward for testing leading to quicker detection
- Addressing social problems of poverty and gender inequality, which provide a breeding ground for HIV/AIDS

All these efforts are characterized by the fact that preventing HIV/AIDS was not the responsibility of the health department alone, but an agenda for each and every department, official, and agency, galvanized by the national leadership and supported by various partners and donors. These efforts illustrated that a truly multi-sectoral approach is required for combating the scourge of HIV/AIDS.

HIV/AIDS Prevention - The Multi-sectoral Approach
The United Nations General Assembly has declared HIV/AIDS the most formidable development challenge of our time. The negative impact of HIV/AIDS on development cuts across all sectors and social groups. HIV spreads rapidly,
undermining labour forces, business productivity, exports, investments, and ultimately national economies. If the epidemic continues at its present rate in some countries, the hardest hit nations stand to lose up to 25 percent of their projected economic growth over the next 20 years. The time is thus over when one could consider the HIV/AIDS pandemic a problem concerning the health sector only. There is a direct relationship between HIV infection and poverty, inequality, the status of women in a society, social distribution, illiteracy, human rights violations, and all the other factors that define the context for development work. Today it is widely recognized that an effective response to this crisis has to go far beyond the health sector, coordinated by strong governments, and include other sectors such as education, transport, tourism, police, labour, and work with non-governmental organizations (NGOs) and corporate partners. As early as 1987 the World Health Organization (WHO) proposed such a multi-sectoral approach.

**HIV/AIDS and Poverty, Gender, and Human Rights**

The HIV/AIDS problem is inseparably linked with poverty. Poverty leads to migration, uncontrolled population growth, prostitution, and incomplete families, which are all risk factors to having multiple sexual partners and thus increase vulnerability to HIV infection. Mass campaigns intending to raise awareness and improve knowledge of prevention and coping strategies often do not reach the poorest, characterized by high illiteracy rates and living often in remote rural areas where access to modern information channels poses a problem. In these regions, health services are often of poor quality resulting in insufficient detection and inadequate treatment of classical sexually transmitted infections (STIs) and diseases, which in turn lead to the spread of HIV. In addition, lack of accessibility of the poorest to effective antiretroviral (ARV) therapy is combined with a more rapid progression rate from infection to AIDS triggered by malnutrition and repeated, badly managed infections. Poverty is not only a risk factor for HIV infection; the HIV/AIDS epidemic also exacerbates the phenomenon of poverty by causing premature deaths, orphans, social disruption, or shifts in agricultural practices.

Gender is a factor directly related to poverty and consequently to the risk of HIV infection. Women are more likely to live under poverty situations and to be illiterate. Their economic dependence on men makes them more vulnerable to engage in risky sexual activities, often lacking the power to control their sexual relations and insist on the use of condoms for their own safety and that of their partner. They are often blamed for spreading the infection. Infected mothers suffer the double tragedy of coping with their own infection while risking passing on the virus to their newborn baby. In HIV/AIDS-affected communities, girls and elderly women may find themselves as the heads of households. The resulting poverty of the family they are responsible for again exposes girls to sexual exploitation and early marriages. Finally, it is also women who face most of the additional burden in caring for the sick and the orphans of deceased extended family members.

The AIDS epidemic also raises human rights and ethical issues. Stigmatization and marginalization of people living with HIV/AIDS and access to treatment and care for those most in need are just two of them.
When the epidemic first broke out, most interventions were organized within the health sector. Since the 1980s, health education campaigns, safe blood supplies, condom social marketing, and treatment of STIs and opportunistic infections have been prioritized as strategies. As a result, some important successes have been registered, but on the whole, the epidemic continued to spread unabated, and it was recognized that the health sector alone could not change the course. The call for a multi-sectoral response arose. The aim of this strategy is to generate greater political commitment by national governments, to mobilize more resources from within and outside countries, and to replicate on a national scale a more comprehensive programme that includes an increased number of interventions targeted to virtually all groups in society. Looking at HIV/AIDS as a multi-sectoral issue facilitates budgets being made available to different sectors and more human resources getting involved in the fight against the epidemic.

This paper will focus on the non-health sectors and their potential contribution to the so-called multi-sectoral approach, sometimes labeled “expanded” or “intensified.” This should not, however, mean that sustained behaviour change among those most likely to contract and spread HIV, the core activity that is necessary to stop the epidemic, should now be dropped or that the health sector should not continue to play an important role. Involving sectors with more limited knowledge and capacity to act poses a real risk that implementation capacity will be stretched more thinly and in the end less will get done. Priorities need to be set and a small set of core objectives and cost-effective and evidence-based interventions need to be identified in the framework of the state policy on HIV/AIDS.

Equally, a certain number of prerequisites need to be considered when addressing the epidemic in a multi-sectoral way. The importance of the first two prerequisites listed below is underlined by a statement of Dr. Gro Harlem Brundtland, the Director General of WHO, who said in Durban on July 11, 2001, “Wherever there is inequity, conflict or lack of mutual respect, the virus feeds on our divisiveness.”

Prerequisites to a successful multi-sectoral collaboration

- Effective co-ordination amongst the activities in various sectors
- A strong commitment of national governments and high-ranking decision makers of development agencies and donors to a multi-sectoral approach
- “AIDS competence” (capacity building, training in communicating sensitive issues) of those involved
- Commitment and motivation of those implementing the strategy resulting from the awareness of the particular urgency, acknowledging the relevance to their own work rather than perceiving it as another additional burden
- Making the necessary resources available
- Accepting that quick fixes will not be successful, but that multi-sectoral involvement is a gradual process most successful in already established, well running projects
- Assuring monitoring, follow-up, and professional backstopping in order to sustain the process
Multi-sectoral involvement is not completely new. In most cases, however, early actions were limited to low-profile scattered activities that lacked a systematic approach and originated from a personal commitment of concerned individuals rather than a policy backed by the institution itself. Earlier involvement of non-health projects seemed to be restricted to general AIDS awareness talks and condom distribution for their staff and the target population. Prevention messages were included in various project activities, ranging from literacy training in classrooms to professional training courses for adolescents.

We have reached today a stage of a holistic approach where it is recognized that more traditional strategies, such as prevention, care, and support, have to go along with impact mitigation and efforts to change contextual, socio-economic factors that determine the vulnerability of people to HIV infection and AIDS. Integrating AIDS into poverty alleviation strategies as well as identifying those most at risk of contracting and spreading HIV clearly underline the role and responsibility of non-health sector projects in the response at national and decentralized levels.

As mentioned earlier, the health sector would continue to play a key coordinating role and have responsibility for the following:

- Treatment of STIs
- Blood safety by the establishment of a system of blood banks, testing of donors and elimination of professional donors
- Voluntary testing and counselling centers (VCTCs), like sentinel sites and antenatal clinics, to detect HIV infection and provide counselling to those infected by the virus
- To engage with IDUs and provide them disposable syringes
- Make available ARVs like nevirapine for pregnant women free or at subsidized rates to prevent MTCT. This could initially be done on a pilot basis for below poverty line segments and then be extended to others in phases.
- Treatment of opportunistic infections in special outpatient or day hospitals

The aforementioned efforts of the health department would have to be supplemented by vigorous interventions by some other government departments as well.

**Role of Government Departments**

Some departments which could make a quick impact are:

- Transport Department and U.P. Road Transport Corporation (UPSRTC)
- Primary, Secondary, and Higher Education departments
- Department of Tourism
- The Police Department and defence establishments
- Labour and Employees State Insurance Services (ESIS)
- Information and Public Relations
- Food and Civil Supplies
- Milk and Dairy development
- Staff of government departments, agencies, and corporations

The aforementioned departments are indicative, not exhaustive, and similar interventions could be tried out by other departments as agriculture, co-operatives,
and so forth, as per need. Below are descriptions of various activities of these departments that could provide effective channels for carrying messages related to HIV prevention.

**Transport Department and U.P. Road Transport Corporation**

U.P. has a large network of national and state highways and a well established trucking and passenger transport network. Mobility affects the vulnerability of people to contracting HIV/AIDS and helps spread the epidemic. Poor connectivity on the other hand, like extended waiting times at border crossings, toll barriers, and long loading and unloading times, has a similar effect. At many such waiting points for public and private transport, restaurants and fast food shops also offer the possibility of obtaining sexual services.

Being mobile often implies spending time away from home. Long distance truck drivers often spend less than a month at home every year. This of course creates opportunities for sexual activities with new partners. The role of truck and other drivers in spreading HIV/AIDS through multiple sexual contacts and irregular condom use in India is well known.

The sectoral response should be targeted at two main groups—people who work in the transport sector, such as truckers and bus drivers of UPSRTC, and owners of rural hotels or *dhabas*.

The most common and certainly most effective response that could be used is behaviour change interventions and social marketing of condoms targeted to all of the above-mentioned risk groups. Information, education, and communication (IEC) activities like talks, including video presentations on STIs and HIV/AIDS, could be regularly organized at important bus stops and dhabas. Bus drivers as well as dhaba owners could act as outreach information workers and condom distributors. This would help to bring condoms into remote villages. UPSRTC buses most commonly used for long distance and in-city transport could be painted with messages on HIV/AIDS and condom use.

**Primary, Secondary, and Higher Education Departments**

U.P. has a network of 115,000 schools and educational institutions catering to 20.8 million students in the public and private sector. Most private schools get financial aid from the government and hence have to obey government directions. It is imperative that the education department declare policy and establish principles and an implementable framework. School managers and teachers need to be prepared for their new role and get appropriate training to be able to sensitize students to the dangers of HIV/AIDS and risky behaviour.

Schools and colleges need to be the place where children get information and learn to shape their future behaviour. Schools and colleges must provide them with skills to prevent HIV infection and cope with the impact of AIDS on their small “world.” They need to play a trial role in breaking stigma and taboo. Teachers and headmasters play an important social role in molding the thinking of children, and their influence can be utilized in conveying messages related to HIV/AIDS.
School children may serve as peer educators for their friends who are not enrolled in school. By enrolling girls in schools, their vulnerability to the risk situations of prostitution and economic dependence on men will be reduced. In the long term, education has the potential to alleviate root causes of the epidemic, such as poverty, ignorance, and gender discrimination—all of which help spread the epidemic. Finally, schooling has to be provided for the children of AIDS-affected families and AIDS orphans within the system.

All of the above is not only true for the formal education sector, but for all organized learning occasions, such as literacy classes for adults, vocational and professional trainings, as well as education interventions for adolescents.

**Tourism Department**

The flourishing tourism industry in areas like Agra, Allahabad, Varanasi, and along the Buddhist circuit has led to an increase in the mushrooming of sex sites and hence vulnerability to HIV/AIDS. The tourism department can take up a number of activities like:

- Intensive IEC at these centers through posters and wall paintings to bring home the dangers of risky behaviour; and
- Advocacy activities with taxi drivers, guides, lodge and hotel owners, and employees of these tourist locations for counselling tourists and acting as sources of condom distribution.

**Police Department and Defence Establishments**

U.P. boasts a police force of about 170,000. In addition it has a large number of cantonments and military establishments which are non-family stations where personnel are deployed for long periods. The macho image associated with these professions and the age groups to which they belong make these groups specially susceptible to risky behaviour. This coupled with their regular home leave makes them dangerous networks for transferring HIV infection from high-risk groups like SWs to the general population. Recruits of the armed forces and the police need to be sensitized to various issues related to HIV/AIDS. Counselling needs to be done for members of the defence forces and armed police force who have to spend many months each year at military or police camps on duty away from their families. Aspects related to safe sex need to be highlighted in such sessions.

**Labour and Employees State Insurance Service (ESIS)**

The vast network of ESIS hospital and dispensaries in urban areas can be used for expanding sentinel survey sites and for antenatal clinic surveillance to help track the spread of HIV.

**Information and Public Relations**

Releases of the Information and Public Relations Department on various occasions like Republic Day and World AIDS Day provide an opportunity for effective use of the press for information and advocacy. District Information Officers can be effectively harnessed for getting articles and stories written in the vernacular press, thereby bringing the issue of HIV/AIDS on the media agenda.
Food and Civil Supplies
Ration cards issued by the Food and Civil Supplies Department reach out to 38 million families, most of them belonging to low income groups. They can be used for messages related to safe sex, condom use, and so forth.

Milk and Dairy Development

Village dairy cooperative societies have been established in 5,000 villages and cater to a population of 11.3 million. Outreaching wall paintings, van painting, and messages on milk vans provide an avenue for IEC messages on HIV/AIDS.

Staff of Government Departments, Agencies, and Corporations
U.P. has a vast network of about 3 million government employees in almost 100 departments. As a result of a deep feudal tradition in Uttar Pradesh, these employees enjoy considerable respect and peer influence and can be effectively harnessed in the cause of combating HIV/AIDS. As a first step, each department needs to assess how HIV/AIDS may affect its staff and target groups and what opportunities exist for using them as resources in the fight against HIV/AIDS.

Efforts therefore need to be made to sensitize staff to avoid risky behaviour and thereby reduce their chances for contracting HIV. The staff also has to be HIV/AIDS aware, trained, and capable of basic information sharing with their target groups about the risks of HIV/AIDS and referring them to sentinel centres for voluntary testing or to AIDS clinics.

The Power of Partnerships
HIV/AIDS can also be addressed through a wide range of activities that reach many different groups of people who may not be in contact with government departments and services. Thus, it may be necessary to supplement the efforts of the government departments with private sector resources like NGOs, corporations, and other strong institutions. This could be in the area of providing HIV/AIDS-related information, behaviour change communication (BCC) messages, medical services, care and support for people living with AIDS, and counselling and testing facilities.

NGOs
NGOs that are active in other fields like reproductive and child health (RCH), environment, rural development, education, or economic activities like self help groups (SHGs) and micro-planning could be used. They could provide critical outreach to raise awareness, counsel, advise, and help infected people cope. Through a transparent and innovative selection process, NGOs could be selected for this task, their capacity enhanced and funds provided to them to run community-based projects. These projects would have well designed systems of monitoring and evaluation, which would in turn have a bearing on the extension of these grants. Some of the activities for which NGOs could be most suitable are:

- HIV/AIDS counselling through help lines. NGOs at state and district levels could opt to establish services at dedicated toll-free numbers, primarily for HIV/AIDS counselling. All relevant information on topics related to HIV/AIDS could be disseminated confidentially through this number via pre-recorded
messages and interaction with trained counsellors. The information provided to the users of the help line could range from basic information on HIV/AIDS to the diverse routes of transmission to services available. The primary reason for the popularity of this service would be that the callers would get quality information and still maintain anonymity.

- **HIV/AIDS counselling using rural outreach.** NGOs/community-based organizations (CBOs) in the development sector can run custom-designed interventions and implement innovative community-level, need-based programmes. This will augment the efforts of government departments. Government has to be responsive and needs to further expand access to these services to slowly but surely forge inter-sectoral links that will mainstream HIV/AIDS prevention and control with broader concerns.

- **Low cost of community-based home care support through day hospitals.** New specialized outpatient services like day hospitals provide a full range of counselling and HIV testing, observation, medical and dental care, and psychological and social support while enabling patients to continue to live at home and avoid hospitalization. NGOs and other community support organizations can be contracted to support home-based care and provide hospices and small group homes for patients who would otherwise be hospitalized or homeless. Care and support services for people living with HIV/AIDS (PLHAs) becomes a crucial component to any and all efforts at prevention. NGOs need to be identified, funded and facilitated to support home-based and community-based care, short-term hospices, or cost-effective common opportunistic infection interventions.

- **Capacity building to manage and run hospices for orphans who have lost a parent to AIDS.**

- **Targeted interventions, like spreading awareness and condom promotion amongst SWs, truckers, prisoners, and migrant workers at large project construction sites, along highways, and in urban slums where government infrastructure is weak.** Targeted interventions are globally seen to be a most effective strategy for arresting the spread of the HIV/AIDS epidemic. Essentially, marginalized and vulnerable populations at high risk for HIV are informed, educated, counselled, and provided with some preliminary care and support so that they move towards behaviour change and healthy living practices. These high-risk groups typically are SWs, men who have sex with men (MSM), IDUs, street children, truck drivers, migrant labour, and so on. Multi-pronged strategies such as BCC, safe sex education, condom promotion, and treatment for STIs have definitely helped in slowing the rate of spread of HIV. Attempts have to be made to enable the high-risk group to access services and care by creating an enabling environment. This involves working with a range of external stakeholders like opinion leaders, community or religious leaders, as well with formal structures like police and local government. Peer education strategies help to organize and strengthen these initiatives.
Family Life Education Programme for Adolescents. The most widely deployed strategies to promote and protect the needs and rights of adolescents against acquiring HIV are to provide young people with knowledge and information and to equip young people with life skills to put knowledge into practice.

Research and worldwide experiences have shown that information alone is not enough to protect young people from health risks. Young people also need skills to manage challenging situations and take charge of their own health within supportive communities and environments.

The issue of HIV/AIDS must be placed in context within more holistic issues of family life education. Efforts need to be made to integrate HIV/AIDS education in the regular curricula of classes IX to XI. Additionally, education should be provided through extracurricular activities and promotion of sports to prevent adolescents from getting into risky sexual relationships while just “hanging out,” as was the experience in Uganda.

Schools AIDS Programme. This could be implemented through NGOs working with a certain number of schools to carry out tasks like training teachers and peer educators and monitoring ongoing school AIDS education activities. All this should be done in close collaboration with the education authorities. Inputs should also be provided towards building leadership to deal with aspects like abstinence and value education. Simultaneously, the family life education programme should be expanded to non-school-going youth in rural and urban areas to reach the most at-risk group among adolescents, who constitute 20 percent of the total population of U.P.

Gender sensitization and dealing with issues related to stigma and discrimination. Because more than 75 percent of HIV infections are transmitted through sexual contacts between women and men, an awareness of the forces affecting these relations is required when planning interventions. Gender dynamics have to be understood in terms of roles, expectations, identities, needs, opportunities, and obstacles that women and men face.

Many women are made vulnerable to infection as a consequence of their being powerless to negotiate the use of condoms during sex, discrimination, violence, and poverty. Programmes that provide health information and services and advance the right of women to exercise their rights and control their sexuality must be supported. Women, especially young women, need to be empowered to understand and protect themselves from the risk of infection.

Partnering with men in HIV/AIDS and other reproductive health programming to reach out to boys and men is another essential area. Improving information levels, use of condoms, treatment of STIs, and other services to help them make decisions regarding their own health, support responsible sexual behaviour, and take more responsibility for stopping the outbreak by protecting partners and themselves would fall in this category. These initiatives would include discussing
the need for men to be good role models by respecting their wives as partners, educating their daughters, and avoiding behaviour that endangers health.

Women empowerment and skills development will enable women to access economic opportunities to support themselves. Income-generating activities play an important part in women’s empowerment. Interventions are required that empower poor women to become involved in HIV prevention interventions. Micro-credit finance schemes, training in business leadership, and courses on HIV/AIDS, gender, and domestic violence enable women to stand on their own feet, speak out, and gain community support.

Corporate Sector and Workplace Education

It must be realized that no government alone can take on the challenge of HIV/AIDS. A new expanded approach to public health, combining all available resources including business, to play critical role in spreading awareness of HIV/AIDS and clinical facilities for treatment is needed.

U.P. has a wide network of large and small industrial enterprises, corporate entities, and businesses both in the public and private sectors employing more than 5 million people. The government could initiate income-generation activities for HIV-positive partners and their families working closely with the corporate sector for skills training for income generation and supplementation for families of industrial workers and in their neighbouring communities.

Realizing that the industrial sector is particularly vulnerable to the AIDS epidemic, the Confederation of Indian Industry (CII) has taken the lead in mobilizing support and involving the corporate sector in prevention, care, and control of HIV/AIDS at the workplace and extended communities in some high prevalence states. The objective is to mobilize industry to implement non-discriminatory policies towards employees with HIV/AIDS and implement behavioural change programmes for prevention and control of STIs/HIV/AIDS. To augment its advocacy initiatives, CII has put forth industrial policy guidelines on HIV/AIDS. This set of guidelines can help companies in U.P. to adapt or modify and ratify the policy to suit their respective needs and support programmes for BCC and condom promotion.

The sensitivity and awareness created at all levels in the industry can lead to the protection of legal rights of those workers infected with HIV. PLHAs in the industry can continue to work and enjoy the same status and relationship with their colleagues within and outside the factory. The industry can continue to provide for health and medical care and counselling services. As part of its outreach programme, the industry can reach out to persons infected and affected by HIV/AIDS and in supporting vocational skills training for income generation. Using chambers of commerce and industry like CII and large corporate sector entities, a network can be established in the industry for better advocacy, identification of needs, and designing future interventions in support of creation of an empowering and enabling environment for PLHAs.
State Innovations in Family Planning Services Project Agency (SIFPSA)
U.P. needs more effective HIV prevention programmes. Existing National AIDS Control Organization (NACO)/U.P. State AIDS Control Society (UPSACS) communication interventions are largely informative and leave much to be desired in achieving the goal of preventing the spread of HIV from high-risk groups into the general population.

HIV prevention programmes also lack adequate resources and thus can rarely be scaled up for creating impacts. Further they do not use an effective communication strategy, leveraging either opinion leaders or using the entertainment with education approach. Moreover, they are often very narrow in approach and do not use a multi-disciplinary strategy combining elements of epidemiology, public health, and BCC theory.

SIFPSA has rich experience of using experts, advertising agencies, and research in the design and implementation of BCC campaigns. It has also pioneered wide use of entertaining folk media for carrying RCH messages to target audiences. This format could be utilized for stimulating peer communication for HIV prevention in U.P. The most efficient system would be for UPSACS to subcontract the design and implementation of communication activities to SIFPSA which, in turn, could leverage its strength for media buying at the most competitive rates. SIFPSA could also function as an agency for other HIV/AIDS prevention initiatives like condom social marketing, assisting in selection of NGOs, monitoring and evaluation of NGO projects, and decentralized activities at district and municipal levels.

Condom Promotion through Social Marketing
Two important components in encouraging greater use of condoms are increased availability and affordability. Both of these are achievable through a programme of condom social marketing (CSM). In a CSM intervention, the price of condoms is subsidized either by government or a donor so that implementing organizations can aggressively market condoms by strengthening distribution and promotion, especially in unserved areas, using a variety of innovative, non-conventional outlets.

Once condoms are widely available, motivational efforts to increase condom use can be mounted using NGOs for outreach or using an opinion leadership strategy through peer educators. Condom use can dramatically reduce HIV infection rates, and it is easy to target high-risk audiences like SWs, making CSM a very effective strategy when the epidemic is first detected. The vast experience of SIFPSA in the field of social marketing can be effectively leveraged to develop a multi-pronged strategy for safe sex through condom use, giving dual protection from HIV/AIDS and unwanted pregnancies in partnership with appropriate public and private sector organizations.

Decentralization and Strengthening Capacity at State, District, Municipal, and Panchayat Levels
- The capacity of the state health department at the state and district levels and UPSACS needs to be strengthened for operating health care and other programmes to deliver STI/HIV/AIDS information and services.
District societies affiliated with UPSACS and functioning under the guidance and leadership of district magistrates need to be set up to monitor, coordinate, and manage HIV/AIDS interventions at the district level.

Looking at the urban origin of the epidemic, it is imperative to add municipal corporations and municipalities as partners for the above activities and strengthen their capacity to create awareness and deliver services. Technical assistance and funds need to be provided to municipal bodies to take up effective programmes specifically targeted at HIV/AIDS prevention. In addition, they could channel efforts and work with marginal groups in society, such as transvestites and SWs. These groups have high incidences of STIs and are at risk of HIV infection and must be reached with education, health, and other services if the epidemic is to be prevented.

Orientation of local self-government leadership at the district, block, and village levels is imperative and needs to be done urgently. The charter of village education and health committees should be expanded to include HIV/AIDS prevention activities through local level communication, condom distribution, and so forth.

Conclusion
HIV/AIDS is, in the words of our Prime Minister, “the most serious public health challenge that the country is facing today. AIDS is a global problem—sadly, with a strong Indian dimension.” Addressing the approaching HIV/AIDS epidemic in U.P. requires immediate action and a long-term strategy and capacity building. This is possible by treating HIV/AIDS as one of the biggest development challenges with strengthened high-level leadership support at the state level. Though a public health issue, the epidemic cannot be tackled through medical/clinical interventions alone. HIV/AIDS prevention and control requires a multi-sectoral approach, involving a variety of sectors other than health and all possible partners including the government, the private sector, and NGOs.
Introduction
Among all the states in India, the state of Uttar Pradesh is well known for its migrant population. In recent periods, migrants from this state have predominated in the national context; the population censuses of India have recorded the highest numbers of migrants from Uttar Pradesh. Though Uttar Pradesh is listed in the low prevalence category of HIV/AIDS, the population is exposed to HIV/AIDS on account of its high volume of migrants. The importance of the risk of spreading HIV can be better appreciated when we consider the fact that the migrants from this state are mainly to those states where HIV/AIDS is reported to be high. Migrants who are in search of employment generally do not move with their families, and they contribute to the transmission of HIV through sex workers (SWs). In Uttar Pradesh, where fertility rates are high, the migrant population can also substantially increase mother-to-child transmission of the virus. Migrants as a group have the potential of rapidly spreading HIV, and to study this phenomenon, it is important to examine migration and its patterns. In this study, we analyse migration patterns of the population in the state of Uttar Pradesh.

Data
In order to examine migration in India, there are two sources of data that are available. The first source is the well known population censuses of India, which collect data on migration from the population of the entire country. The censuses are conducted every 10 years, and the data on migration are compiled from two questions based on place of birth and duration of residence. From the responses to these questions, members of the population can be classified as either migrants or non-migrants. Though the last population census was conducted in 2001, migration data for this census are not yet available. Therefore, we have used the data of two censuses prior to the 2001 censuses, namely, census data from 1981 and 1991. The analysis presented below utilizes these data. Recently, carving the state of Uttarakhand from Uttar Pradesh altered the administrative boundaries of the state. However, the population census of 1981 did not classify migration data at the district level, so the districts that now form part of Uttarakhand cannot be segregated from Uttar Pradesh.

Another important source of data on migration is the National Sample Survey, which is regularly conducted throughout the country on topics of interest. Migration
Prevention of HIV/AIDS in Uttar Pradesh

Data from the National Sample Survey Organization’s (NSSO’s) 49th round (1993) and 55th round (1999–2000) are also used. These data are more recent than the data from the population censuses. The data in the NSSO surveys are not as detailed as in the census, but they can be of use in understanding the recent pattern of migration.

Migration Patterns in India

From the population censuses that routinely collect data on migration, we find that the population of India is becoming less mobile. As shown in Figure 1, in the 1991 census, 27.6 percent of the total population were considered migrants. This percentage translates into 230 million persons who are considered migrants (the population of India in 1991 was 838 million persons). The 1991 percentage of migrants was considerably less than that of the 1981 census, which was 31.2. The figure also presents migrants according to sex. The percent of female migrants far exceeds that of males—in both 1981 and 1991 the percent of females was more than two and a half times that of males. For both males and females, the percentage of migrants also declined between 1981 and 1991.

More recent data on migration are available from NSSO. Figure 1 also gives the percentage of migrants in the total population for 1993 and 1999–2000. Unlike the data from the censuses, migration has shown an increasing trend in the last decade. The percentage of migrants in the population increased from 24.7 percent in 1993 to 26.6 percent in 1999–2000. In case of males and females, there is also an increasing percentage of migrants between 1993 and 1999–2000. NSSO data also shows the sharp contrast in the numbers of male and female migrants.

Migration Pattern in Uttar Pradesh

Trend in Migration

Migrants as a percentage of the total population of Uttar Pradesh have shown, as in the case of the country as a whole, a declining trend. Table 1 presents the data. While in 1981, 24.2 percent of the persons were reported as migrants in Uttar Pradesh, in 1991 the percentage was 21.0. When the data include Uttaranchal, the decline in the percentage of migrants is maintained. By sex, the proportion of female migrants was nearly seven times that of male migrants. This may appear to be anomalous but, as mentioned, female migration is related to change in the place of residence due to marriage. The percentage of men who migrate, on the other hand, in 1991 in Uttar Pradesh was only 5.7. In the case of both males and females together, there was been a decrease in the percentage of migrants in Uttar Pradesh. While it is difficult to determine if such a decline occurred in Uttaranchal, the proportion of male migrants in Uttaranchal far exceeds that of Uttar Pradesh. When the data are separated for rural and urban areas (Tables 2 and 3), the percentage of migrants in rural areas is similar to that described for the whole state. Urban areas, as can be expected, record

Figure 1


a higher percentage of migrants. One out of nearly eight males in urban areas of Uttar Pradesh is a migrant. This number is higher in Uttaranchal where migration is more prevalent.

Table 4 shows migration according to distance for 1981 and 1991. Here again, the distance-wise migration pattern in Uttar Pradesh follows the same pattern as that of all migration in India. Amongst all the distances we consider, intra-district migration predominates despite a marginal decrease from 1981 to 1991. In intra-district migration, the percentage of female migrants is more than that for males. Whereas in 1991 the percent of males in intra-district migration was 47.8, the percentage for females was 64.0. In the case of female migrants, there is a steady decline in their proportion as distance increases. Inter-district and inter-state migration has remained more or less the same for both males and females. As can be observed from the table, the percentage of migrants decreases with increases in distance.
Migration data can also be classified according to the four streams of migration, shown in Table 5. In both the census years shown in the table, there is no major change in the percent of migrants according to the streams. For 1981 and 1991, migration from rural areas far exceeds the migration from urban areas. Nearly 76 percent of the migration occurs from rural to rural areas and about 4 percent from urban to rural areas. Migration to urban areas from rural or urban areas has shown an insignificant increase. This table also shows that females move to rural areas while males move to urban areas.

Table 5

<table>
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<th>Stream</th>
<th>Total</th>
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<th>Female</th>
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</tr>
<tr>
<td>Urban-Urban</td>
<td>8.4</td>
<td>8.8</td>
<td>20.4</td>
</tr>
</tbody>
</table>


Inter-State Migration

Among all the states and union territories of India, the population of Uttar Pradesh has the distinction of having the largest volume of migrants. According to the 1991 census, UP’s share in terms of in- and out-migration was 22.6 percent and 6.7 percent, respectively; in other words, one out of five migrants of the country are from Uttar Pradesh (Figure 2). Though UP has the largest share of out-migrants, it is also an important state in terms of in-migration. Among all the in-migrants in the country, the fourth largest number of in-migrants are in UP. According to the 1991 census, UP has lost 17.2 million people due to migration (Figure 4). A similar picture also emerges from the 1981 census in terms of the position of UP in respect to in- and out-migration (Figure 3), though it had lost more population (29.3 million) through net migration (Figure 4).
Uttar Pradesh being an out-migrating state, the flow of the migrants is towards industrialized and urbanized states mainly for employment reasons. As shown in Table 6, most migrants to Delhi are from Uttar Pradesh, and the flow towards Delhi has significantly increased over the last two decades. Maharashtra is the next state to
Prevention of HIV/AIDS in Uttar Pradesh

Figure 4

Net Migration of States in India, 1981 and 1991

<table>
<thead>
<tr>
<th>State</th>
<th>1981</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andhra Pradesh</td>
<td>0.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Assam</td>
<td>0.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Bihar</td>
<td>27.4</td>
<td>27.8</td>
</tr>
<tr>
<td>Gujarat</td>
<td>0.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Haryana</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Karnataka</td>
<td>4.9</td>
<td>6.2</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>16.2</td>
<td>13.3</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>19.6</td>
<td>17.7</td>
</tr>
<tr>
<td>Orissa</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Punjab</td>
<td>4.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>6.2</td>
<td>5.7</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>West Bengal</td>
<td>7.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Delhi</td>
<td>24.7</td>
<td>31.3</td>
</tr>
</tbody>
</table>

Note: States in bold show increase in proportion between 1981 and 1991


Table 6
Share of States in Terms of Out Migration from Uttar Pradesh, 1981 and 1991

<table>
<thead>
<tr>
<th>State</th>
<th>1981</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andhra Pradesh</td>
<td>0.4</td>
<td>0.7</td>
</tr>
<tr>
<td>Assam</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Bihar</td>
<td>7.9</td>
<td>3.5</td>
</tr>
<tr>
<td>Gujarat</td>
<td>4.0</td>
<td>4.7</td>
</tr>
<tr>
<td>Haryana</td>
<td>7.8</td>
<td>9.1</td>
</tr>
<tr>
<td>Karnataka</td>
<td>0.3</td>
<td>0.5</td>
</tr>
<tr>
<td>Kerala</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>16.2</td>
<td>13.3</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>19.6</td>
<td>17.7</td>
</tr>
<tr>
<td>Orissa</td>
<td>0.5</td>
<td>0.3</td>
</tr>
<tr>
<td>Punjab</td>
<td>4.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>6.2</td>
<td>5.7</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>West Bengal</td>
<td>7.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Delhi</td>
<td>24.7</td>
<td>31.3</td>
</tr>
</tbody>
</table>

Note: States in bold show increase in proportion between 1981 and 1991


Table 7
Share of States in Terms of In-Migration to Uttar Pradesh, 1981 and 1991

<table>
<thead>
<tr>
<th>State</th>
<th>1981</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andhra Pradesh</td>
<td>0.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Assam</td>
<td>0.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Bihar</td>
<td>27.4</td>
<td>27.8</td>
</tr>
<tr>
<td>Gujarat</td>
<td>0.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Haryana</td>
<td>9.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Karnataka</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Kerala</td>
<td>0.8</td>
<td>1.2</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>21.9</td>
<td>18.8</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>2.3</td>
<td>3.4</td>
</tr>
<tr>
<td>Orissa</td>
<td>0.4</td>
<td>1.1</td>
</tr>
<tr>
<td>Punjab</td>
<td>12.4</td>
<td>6.2</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>10.4</td>
<td>7.8</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>0.5</td>
<td>1.0</td>
</tr>
<tr>
<td>West Bengal</td>
<td>4.9</td>
<td>6.2</td>
</tr>
<tr>
<td>Delhi</td>
<td>7.6</td>
<td>15.8</td>
</tr>
</tbody>
</table>

Note: States in bold show increase in proportion between 1981 and 1991

attract migrants from Uttar Pradesh, and the volume migrating to Maharashtra has shown a small decline from 19.6 percent in 1981 to 17.7 percent in 1991. Over the last two decades, the flow has increased towards the states of Punjab, Haryana, Gujarat, Karnataka, Andhra Pradesh, and Tamil Nadu.

In terms of in-migration from other states to Uttar Pradesh (Table 8), Bihar and Madhya Pradesh dominate the flow, though the volume has declined from Madhya Pradesh. The percent of migration from Bihar was 27.4 in 1981 and 27.8 in 1991 and for Madhya Pradesh 21.9 percent in 1981 and 18.1 in 1991. Similarly the flow from Punjab and Rajasthan has shown a decline over the last two decades. A significant increase has been from Delhi, which is due to the spread of population to NCR like Noida and the western districts of Uttar Pradesh.

**Purpose of Migration**

The population censuses also permit an analysis of reasons for migration. The reasons for migration that the census enumerates are employment, business, education, family moved, marriage, natural calamities, and others. The first two reasons can be combined to indicate the extent of migration that occurs for economic reasons. In Table 8 we have given the percentage distribution of migration by reason and gender in Uttar Pradesh.

In 1991, migration after marriage is cited by more than three-fourths of the migrants, and in the case of females, this migration accounts for almost all migration. Among males, economic, other, and family reasons are the major causes of migration. Nearly one-third of male migration is for economic reasons (we do not know what comprises the other category). The reasons for migration show minor changes between 1981 and 1991.

Since a sizeable proportion of male migrants have mentioned economic reasons, we further examine it with respect to distance. From the data on proportion of migrants citing employment as their main reason for their mobility (Table 9), the proportion migrating intra-district and inter-district has remained almost the same over the last two decades, whereas the migrants migrating from other states to Uttar Pradesh for employment has shown an increase. This is especially so among the male migrants.

From the data given in Table 10 on migrants cross-classified by industrial categories, we find that a majority of the migrants is engaged in the primary activity, mainly as cultivators. In this category, the proportion is high among female migrants. Male migrants are mainly listed in the category of other workers that comprises tertiary and non-household industries.

### Table 8

<table>
<thead>
<tr>
<th>Reason</th>
<th>1981</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Male</td>
</tr>
<tr>
<td>Employment</td>
<td>5.7</td>
<td>31.3</td>
</tr>
<tr>
<td>Business</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Economic</strong></td>
<td>5.7</td>
<td>31.3</td>
</tr>
<tr>
<td>Education</td>
<td>1.3</td>
<td>6</td>
</tr>
<tr>
<td>Family moved</td>
<td>10</td>
<td>29.9</td>
</tr>
<tr>
<td>Marriage</td>
<td>73.6</td>
<td>4.6</td>
</tr>
<tr>
<td>Others</td>
<td>9.4</td>
<td>28.3</td>
</tr>
<tr>
<td>Natural Calamities</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Occupational classification of migrants (Table 11) shows that for males and females separately, a majority are engaged in production-related activities: 38.2 and 41.7 percent, respectively. Among male migrants, sales and clerical activities are the other occupations in which they are also employed in large proportion (14.4%). Among female migrants, a significant proportion, 24.7 percent, are engaged as professional and technical workers.

In summary, the state of Uttar Pradesh records the highest percent of migrants in the country. Migrants from Uttar Pradesh usually move to the capital city of the country, Delhi. A large percentage of migrants to Maharashtra are from Uttar Pradesh. From 1981 to 1991, the flow of migrants increased to other states such as Punjab, Haryana, and the southern states of India. Moreover, migration to Uttar Pradesh for reasons of employment, particularly to urban areas and among males, has also increased. Migrants to urban areas are generally employed in the informal sector of the economy. Changes in the administrative boundary of Uttar Pradesh do not appear to significantly alter the findings presented above.
Conclusion

As mentioned, we do not have information on the relationship between migration and spread of HIV/AIDS. Despite lack of sufficient information from the above analysis of migration patterns of the population of Uttar Pradesh, certain preliminary inferences can be drawn. The census data have clearly shown that migrants from Uttar Pradesh move to the state of Maharashtra. In addition, the number of persons migrating from Maharashtra to Uttar Pradesh has increased. While 2.3 percent of immigrants to Uttar Pradesh in 1981 were from Maharashtra, this percentage increased to 3.4 in 1991. Movement of persons, especially males, from Uttar Pradesh to the southern states of Andhra Pradesh, Karnataka, and Tamil Nadu is also on the rise. The number of migrants to Uttar Pradesh from these states has also increased, though the percentages are rather small. For example, migrants into Uttar Pradesh from Tamil Nadu increased from 0.5 percent to 1.0 percent from 1981 to 1991. These percentages may appear to be small, but the number of migrants from Tamil Nadu in 1991 was 1.2 million.

It is indeed the above-mentioned states that have a high percent of patients with sexually transmitted infections (STIs) testing positive for HIV. In 2002, the highest percentage of HIV/AIDS cases was detected in Andhra Pradesh—among all HIV/AIDS cases, 30.4 percent were found in Andhra Pradesh (PFI, 2003). In Tamil Nadu, Karnataka, and Maharashtra, this percentage is 14.7, 13.6, and 7.8, respectively. Given these percentages and the migration scenario in Uttar Pradesh, the population of Uttar Pradesh is at high risk for contracting HIV. Transmission of the virus to a large section of the population of Uttar Pradesh is a possibility.

Another observation from the migration data obtained from the censuses is the type of work that migrants perform. The data have shown that migrants, usually males, are engaged in secondary and tertiary activities. It is interesting to note that the percentage of HIV cases reported at STI sites is higher among the kind of jobs that the migrants from Uttar Pradesh perform. In 2001, in the state of Maharashtra, the largest percent of HIV cases (26.9) was for workers in the hotel industry (PFI, 2003). Among drivers and their helpers the percentage was 23.4, unemployed 21.1, and business 16.2. For the southern states to which migration from Uttar Pradesh is increasing, the percentage of HIV cases is also high. While we cannot link migrants to HIV/AIDS from the data we have, there appears to be a relationship between the two.

References

Background
Uttar Pradesh, being the most populous state, also has the distinction of having the largest volume of migrants as nearly one out of five migrants in the country is from Uttar Pradesh. Classified as an out-migratory state, it has witnessed movement of people between and within districts as well. The movement of people is of particular significance from the perspective of the HIV/AIDS programme because the National AIDS Control Programme–Phase II (NACP–II); that is, the implementation document has accorded priority on targeted intervention for groups at high risk. The high-risk group categorization considers migrants as one of the vulnerable groups. In this context, as many as 260 projects related to migrants have been sanctioned and are operational at the national level, but surprisingly, there are none in Uttar Pradesh. Uttar Pradesh, as a matter of fact, has in 2003 conducted the mapping of vulnerable population groups, including migrants. Given this scenario, it becomes important to specifically understand the pattern of migration and spatial distribution not only from a demographic view but also from the HIV/AIDS standpoint so that the intervention projects can be appropriately targeted and exclusively addressed for this segment of the population.

Data Sources
Data has been compiled from the 1981 and 1991 censuses as the 2001 census results on migration are yet to be published. Information on place of last residence by place of enumeration compiled by the Registrar General of India has been used along with the published HIV/AIDS data from the Uttar Pradesh State AIDS Control Society (UPSACS). Regarding analysis of data, in, out, and net migration of population by place of enumeration have been analyzed in conjunction with HIV/AIDS information.

Findings
It can be observed in Table 1 that every fourth person enumerated in 1981 was a migrant and in 1991 every fifth person. The proportion of migrants in both urban and rural areas and by sex dropped between the two censuses.
Table 1

Percentage of Migrants to Total Population in Uttar Pradesh

<table>
<thead>
<tr>
<th></th>
<th>1981</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Male</td>
<td>19.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Female</td>
<td>34.8</td>
<td>44.9</td>
</tr>
<tr>
<td>Total</td>
<td>26.5</td>
<td>23.6</td>
</tr>
</tbody>
</table>

Not-stated category include Total Migrants: 29.8 million; Male: 4.4 million; and Female: 25.4 million.


In regard to the movement of migrants (both in and out) in the state (Table 2), it was found that intra-district migration, also termed as short-distance migration, dominated over the other distances. Over three-fifths of migrants enumerated in the state were intra-district migrants, followed by about one-third inter-district migrants, and the remaining 6 percent were inter-state migrants. The trends between 1981 and 1991 were similar except for slight variations in the proportions between the distance categories. Females were found to be dominating the intra- and inter-district migration in terms of sheer numbers as eight out of ten migrants at the inter-district level were females, which strongly proves that females exceed males in inter-district migration.

Table 2

Percentage Distribution of Migrants According to Distance Level in Uttar Pradesh

<table>
<thead>
<tr>
<th>Distance</th>
<th>1981</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Intra-District</td>
<td>46.5</td>
<td>66.1</td>
</tr>
<tr>
<td>Inter-District</td>
<td>41.9</td>
<td>28.9</td>
</tr>
<tr>
<td>Inter-State</td>
<td>11.6</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>


It is important to mention that since inter-district migration is the focus, about one-third of migrants mentioned in the above table are being discussed, and they form the basis of further analysis. This apart, as less than one-third of inter-district migrants had made a move during the inter-census period, the study has taken into account migrants as a whole, irrespective of duration of stay. A cross-classification analysis of place of last residence by place of enumeration has been attempted in Table 3.
It can be seen that one-third of migrants were enumerated in urban areas and the remaining two-thirds in rural areas of the state. Nearly two-thirds of male migrants were found in urban areas while over three-fourths of female migrants were found in rural areas. When analyzed by place of last residence, it was found that a higher proportion of male migrants in comparison with female migrants were found in urban areas. Both the streams of migration of urban-urban and rural-urban were male dominated while females dominated the rural-rural stream. The urban-rural stream was more or less similar for males and females. In other words, it can be inferred that male migrant movement is more towards urban areas and females towards rural areas, irrespective of the place of last residence.

One interesting aspect that can be reflected from the above tables is that an equal proportion of females from urban and rural areas are moving towards urban areas. Subsequently, the reasons for migration to urban areas/agglomeration were analyzed separately for male and female migrants in Table 4. The reasons included employment, business, education, family moved, marriage, natural calamities, and others. Among male migrants, the important reasons mentioned were employment, family moved, and others in that order, while for females, the majority reported marriage, followed by family moved, and others. Inter-district variations in terms of these urban centres existed. For instance, for males who cited employment as a reason, it varied from a minimum of 22 percent in Allahabad to a maximum of more than half in Moradabad while the other cities were in the range of 30–45 percent. Likewise, marriage as a reason among female migrants varied from a minimum of 54 percent in Modinagar to a maximum of 83 percent in Farrukabad. The finding that males migrate for economic reasons and females for social reasons is in line with that found elsewhere in the country.

<table>
<thead>
<tr>
<th>Place of Last Residence</th>
<th>In other districts of the state of enumeration</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Urban</td>
<td>28.9</td>
<td>11.8</td>
<td>14.9</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>5.4</td>
<td>5.2</td>
<td>5.2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>34.3</td>
<td>17.0</td>
<td>20.1</td>
</tr>
<tr>
<td>Rural</td>
<td>Urban</td>
<td>36.5</td>
<td>12.8</td>
<td>17.2</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>29.2</td>
<td>70.2</td>
<td>62.7</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>65.7</td>
<td>83.0</td>
<td>79.9</td>
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<tr>
<td>Total</td>
<td>Urban</td>
<td>65.3</td>
<td>24.6</td>
<td>32.1</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>34.7</td>
<td>75.4</td>
<td>67.9</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4
Percentage of Migrants by Reasons for Migration in Urban Agglomeration of Uttar Pradesh, 1991

<table>
<thead>
<tr>
<th>U.A</th>
<th>Employment</th>
<th>Business</th>
<th>Education</th>
<th>Family moved</th>
<th>Marriage</th>
<th>Natural cal</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T M F</td>
<td>T M F</td>
<td>T M F</td>
<td>T M F</td>
<td>T M F</td>
<td>T M F</td>
<td>T M F</td>
</tr>
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<td>Moradabad</td>
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<td>2.3 5.2 0.7</td>
<td>1.8 2.6 1.4</td>
<td>16.1 19.3 14.4</td>
<td>50.1 8.0 72.6</td>
<td>0.1 0.0 2.2</td>
<td>10.5 13.9 8.7</td>
</tr>
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<td>Muzaffarnagar</td>
<td>14.5 30.9 2.5</td>
<td>4.5 9.6 0.7</td>
<td>2.6 4.3 1.3</td>
<td>27.1 31.9 23.7</td>
<td>35.5 2.0 59.9</td>
<td>0.2 0.4 0.0</td>
<td>15.7 20.9 11.9</td>
</tr>
<tr>
<td>Meerut</td>
<td>12.0 34.9 2.3</td>
<td>2.6 6.9 0.9</td>
<td>0.9 2.0 0.5</td>
<td>19.4 27.3 16.0</td>
<td>52.6 8.2 71.3</td>
<td>0.1 0.1 0.1</td>
<td>12.4 20.6 8.9</td>
</tr>
<tr>
<td>Ghaziabad</td>
<td>12.9 28.7 3.3</td>
<td>1.7 3.4 0.7</td>
<td>0.5 0.7 0.3</td>
<td>25.2 20.1 28.2</td>
<td>52.4 38.0 61.0</td>
<td>0.1 0.1 0.1</td>
<td>7.4 8.9 6.4</td>
</tr>
<tr>
<td>Mathura</td>
<td>10.8 30.3 1.9</td>
<td>2.6 7.2 0.6</td>
<td>1.8 3.6 1.0</td>
<td>22.7 35.7 16.7</td>
<td>51.0 2.0 73.5</td>
<td>0.2 0.3 0.2</td>
<td>10.8 21.1 6.1</td>
</tr>
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<td>Agra</td>
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<td>2.3 7.3 0.5</td>
<td>1.0 2.0 0.6</td>
<td>14.3 24.7 10.7</td>
<td>60.9 16.5 76.6</td>
<td>0.2 0.3 0.1</td>
<td>12.4 21.8 9.1</td>
</tr>
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<td>Firozabad</td>
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<td>3.3 8.9 0.5</td>
<td>0.7 1.5 0.3</td>
<td>15.0 23.8 10.6</td>
<td>52.0 3.1 76.5</td>
<td>0.1 0.2 0.1</td>
<td>14.0 21.1 10.4</td>
</tr>
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<td>Bareilly</td>
<td>14.6 33.3 2.7</td>
<td>2.1 4.8 0.4</td>
<td>1.9 3.5 0.9</td>
<td>23.0 28.3 19.6</td>
<td>44.8 7.6 68.4</td>
<td>0.2 0.3 0.2</td>
<td>13.4 22.2 7.8</td>
</tr>
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<td>Shahjahanpur</td>
<td>14.8 37.7 1.6</td>
<td>2.8 6.6 0.6</td>
<td>2.1 3.4 1.4</td>
<td>20.5 25.1 17.8</td>
<td>42.7 3.9 65.3</td>
<td>0.2 0.2 0.1</td>
<td>16.9 23.0 13.3</td>
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<tr>
<td>Lucknow</td>
<td>20.1 38.3 2.8</td>
<td>4.4 8.0 0.9</td>
<td>5.6 8.8 2.5</td>
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<td>28.6 2.4 53.5</td>
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<td>0.2 0.3 0.2</td>
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<td>44.2 2.8 67.9</td>
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<td>18.6 19.9 17.8</td>
<td>41.1 2.8 67.8</td>
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<td>0.1 0.1 0.0</td>
<td>17.9 21.9 14.5</td>
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Having examined the state trends, migration streams, and reasons for migration, the district-wise data related to in and out migrants have been standardized and ranked in descending order and analyzed.

In terms of in-migration, 11 districts in the state received more than two lakh population, 29 districts between one and two lakhs, and the remaining 14 districts less than one lakh population. Of the districts receiving more than two lakhs population, it was found that Lucknow, which is the state capital, received the maximum number of people, followed by Kanpur Nagar, Aligarh, Muzaffarnagar, and Ghaziabad (Map 1).
Regarding other districts in the two lakhs plus classification, the districts of Varanasi and Allahabad from the eastern region and the districts of Etah and Meerut from the western region figure in the list. Observing the inflow of migrants to these districts, it seems to indicate movement from different parts of the state towards a relatively better district.

In terms of out-migration from the districts, 16 districts have experienced an outflow of population to the extent of over two lakhs while 35 districts having experience an out-migration of between one and two lakhs and the remaining 13 less than one lakh (Map 2). At least six districts that have experienced more inflow of population have also experienced more outflow of population, implying greater volume of migration or turnover of population. As found in the case of in-migration, out-migration is also spread across the different regions of the state and is more confined to eastern and western districts. Following the analysis of migrants by in- and out-migration, the districts were analyzed by urban and rural net migration (Tables 6a and 6b).
Table 6a

<table>
<thead>
<tr>
<th>Characteristic of Districts</th>
<th>Number of Districts</th>
<th>Name of Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaining Population</td>
<td>35</td>
<td>Lucknow, Kanpur Nagar, Ghaziabad, Firozabad, Sonbhadra, Aligarh, Muzaffarnagar, Jhansi, Meerut, Bareilly, Mathura, Jalaun, Unnao, Bulandshahar, Saharanpur, Shahjahanpur, Gorakhpur, Rae bareli, Allahabad, Mau, Sitapur, Mainpuri, Etah, Badaun, Hamirpur, Mirzapur, Maharajganj, Banda, Rampur, Lalitpur, Siddharthnagar, Pilibhit, Gonda, Bahraich, Fatehpur</td>
</tr>
<tr>
<td>Losing Population</td>
<td>19</td>
<td>Sultanpur, Varanasi, Deoria, Agra, Ghazipur, Kheri, Pratapgarh, Hardoi, Barabanki, Faizabad, Jaunpur, Kanpur Dehat, Ballia, Azamgarh, Farrukhabad, Bijnor, Etawah, Basti, Moradabad</td>
</tr>
</tbody>
</table>

Note: Top five districts gaining/losing population in italics
### Table 6b
District-Wise Distribution of Rural Net Migrants in Uttar Pradesh, 1991

<table>
<thead>
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<th>Characteristic of Districts</th>
<th>Number of Districts</th>
<th>Name of Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaining Population</td>
<td>17</td>
<td>Firozabad, Maharajganj, Sonbhadra, Siddharthnagar, Mathura, Bairwa, Mau, Gonda, Jhansi, Muzaffarnagar, Sultanpur, Mirzapur, Raebareli, Faizabad, Kanpur Nagar, Lalitpur, Lucknow</td>
</tr>
</tbody>
</table>

Note: Top five districts gaining/losing population in *italics*

It can be seen in Table 6a. that districts such as Lucknow, Kanpur Nagar, and Ghaziabad that have gained maximum population have gained through urban
migration while the districts of Farrukhabad, Bijnor, Etawah, Basti, and Moradabad have lost population due to out-migration (Map 3). While the movement of population towards urban areas is clear, the rural areas (Table 6b) exhibited a different pattern that was more spread across the state. The districts that have gained population include Firozabad, Mathura, Maharajganj, Siddharthnagar, and Sonbhadra, implying movement towards the eastern and western regions of the state while the districts losing population mainly due to rural migration were Deoria, Gorakhpur, Meerut, Moradabad, and Basti, the common districts between urban and rural migration being Moradabad and Basti (Map 4).

While differentials existed between urban and rural migration streams, at the aggregate level the districts of Lucknow, Kanpur Nagar, Firozabad, Ghaziabad, and Sonbhadra have gained population while the districts of Etawah, Deoria, Basti, Meerut, and Moradabad have lost population. If the districts that have gained population due to net migration in urban and rural areas are listed, then the eight districts of Lucknow, Kanpur Nagar, Ghaziabad, Firozabad, Sonbhadra, Maharajganj, Siddharthnagar, and Mathura figure prominently (Map 5). This clearly brings out the fact that migrants within the state have moved towards the mega cities of Lucknow, Kanpur Nagar, and Ghaziabad, and also towards the rural districts.
Likewise, listing of districts losing population reveals that the districts of Farrukhabad, Bijnor, Etawah, Basti, Moradabad, Deoria, and Gorakhpur figure prominently (Map 6).

Table 7
District-Wise Distribution of Net Migrants in Uttar Pradesh, 1991

<table>
<thead>
<tr>
<th>Characteristic of Districts</th>
<th>Number of Districts</th>
<th>Name of Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaining Population</td>
<td>21</td>
<td>Lucknow, Kanpur Nagar, Firozabad, Ghaziabad, Sonbhadra, Mathura, Maharajganj, Jhansi, Muzaffarnagar, Siddharthnagar, Mau, Bahraich, Aligarh, Saharanpur, Gonda, Raebareli, Jalaun, Sultanpur, Mirzapur, Lalitpur, Sitapur</td>
</tr>
<tr>
<td>Losing Population</td>
<td>33</td>
<td>Etah, Rampur, Faizabad, Pilibhit, Bulandshahr, Bareilly, Allahabad, Mainpuri, Badaun, Bijnor, Hardoi, Shahjahanpur, Unnao, Hamirpur, Pratapgarh, Banda, Fatehpur, Kheri, Barabanki, Farrukhabad, Azamgarh, Varanasi, Ghazipur, Agra, Gorakhpur, Ballia, Kanpur Dehat, Jaunpur, Etawah, Deoria, Basti, Meerut, Moradabad</td>
</tr>
</tbody>
</table>

Note: Top five districts gaining/losing population in italics

in the western and eastern regions.

Map 5
Districts having gained population due to net migration
A comparative ranking of all indicators has been presented in Table 8 on how the districts rank on various indicators in relation to net migration. Examination of the ranks derived from various indicators reveal that female net migration strongly influences net migration and this goes on to prove the point made earlier that inter-district migration is dominated by females. However, to have a fair degree of clarity of migration patterns, a rank correlation analysis on in- and out-migration was attempted. The correlation analysis revealed a positive relationship between in- and out-migration ($r=0.686; p=0.01$). The implication of this is that districts that have experienced substantial in-migration have also experienced out-migration, meaning high turnover of population. This is specifically true in districts such as Lucknow, Meerut, Varanasi, Aligarh, and Muzaffarnagar that have clearly exhibited high turnover of population.
### Table 8

**Ranking of Districts by Net Migration Considering Overall Rank as Constant in Uttar Pradesh, 1991**

<table>
<thead>
<tr>
<th>District</th>
<th>Net Migration</th>
<th>Overall Rank</th>
<th>In-Migrants</th>
<th>Out-Migrants</th>
<th>Urban</th>
<th>Rural</th>
<th>Male</th>
<th>Female</th>
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<td>Lucknow</td>
<td>275,222</td>
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<td>28</td>
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<td>17</td>
<td>1</td>
<td>1</td>
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<td>31</td>
<td>2</td>
<td>15</td>
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<td>3</td>
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<td>-80,813</td>
<td>52</td>
<td>40</td>
<td>22</td>
<td>53</td>
<td>50</td>
<td>49</td>
<td>52</td>
</tr>
<tr>
<td>Meerut</td>
<td>-86,841</td>
<td>53</td>
<td>7</td>
<td>1</td>
<td>9</td>
<td>54</td>
<td>51</td>
<td>54</td>
</tr>
<tr>
<td>Moradabad</td>
<td>-93,653</td>
<td>54</td>
<td>26</td>
<td>6</td>
<td>54</td>
<td>51</td>
<td>53</td>
<td>53</td>
</tr>
</tbody>
</table>
Following the analysis of census data and the results from the correlation, the other available data source related to mapping of population groups vulnerable to HIV/AIDS was examined in relation to the findings of the study (Table 9).

Table 9
Mapping of Migrants in Uttar Pradesh, 2003

<table>
<thead>
<tr>
<th>District</th>
<th>In-Migrants</th>
<th>Out-Migrants</th>
<th>Net Migrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB Nagar</td>
<td>7,433</td>
<td>0</td>
<td>7,433</td>
</tr>
<tr>
<td>Lucknow</td>
<td>4,720</td>
<td>0</td>
<td>4,720</td>
</tr>
<tr>
<td>Kanpur nagar</td>
<td>4,217</td>
<td>0</td>
<td>4,217</td>
</tr>
<tr>
<td>SR Nagar</td>
<td>3,302</td>
<td>0</td>
<td>3,302</td>
</tr>
<tr>
<td>Ghaziabad</td>
<td>3,167</td>
<td>365</td>
<td>2,802</td>
</tr>
<tr>
<td>Meerut</td>
<td>2,924</td>
<td>150</td>
<td>2,774</td>
</tr>
<tr>
<td>Muzaffarnagar</td>
<td>3,735</td>
<td>1,020</td>
<td>2,715</td>
</tr>
<tr>
<td>Varanasi</td>
<td>2,930</td>
<td>820</td>
<td>2,110</td>
</tr>
<tr>
<td>Moradabad</td>
<td>1,990</td>
<td>0</td>
<td>1,990</td>
</tr>
<tr>
<td>Saharanpur</td>
<td>1,800</td>
<td>0</td>
<td>1,800</td>
</tr>
<tr>
<td>Bareilly</td>
<td>3,230</td>
<td>1,535</td>
<td>1,695</td>
</tr>
<tr>
<td>Mathura</td>
<td>1,690</td>
<td>40</td>
<td>1,650</td>
</tr>
<tr>
<td>Kheri</td>
<td>1,605</td>
<td>70</td>
<td>1,535</td>
</tr>
<tr>
<td>Bulandshahar</td>
<td>1,807</td>
<td>390</td>
<td>1,417</td>
</tr>
<tr>
<td>Chandauli</td>
<td>1,210</td>
<td>25</td>
<td>1,185</td>
</tr>
<tr>
<td>Mainpuri</td>
<td>1,055</td>
<td>0</td>
<td>1,055</td>
</tr>
<tr>
<td>Allahabad</td>
<td>1,950</td>
<td>955</td>
<td>995</td>
</tr>
<tr>
<td>Agra</td>
<td>1,894</td>
<td>999</td>
<td>895</td>
</tr>
<tr>
<td>Firozabad</td>
<td>640</td>
<td>0</td>
<td>640</td>
</tr>
<tr>
<td>JP Nagar</td>
<td>1,724</td>
<td>1,290</td>
<td>434</td>
</tr>
<tr>
<td>Bhagpat</td>
<td>355</td>
<td>0</td>
<td>355</td>
</tr>
<tr>
<td>Mirzapur</td>
<td>450</td>
<td>125</td>
<td>325</td>
</tr>
<tr>
<td>Aligarh</td>
<td>305</td>
<td>0</td>
<td>305</td>
</tr>
<tr>
<td>Badaun</td>
<td>270</td>
<td>120</td>
<td>150</td>
</tr>
<tr>
<td>Sitapur</td>
<td>395</td>
<td>290</td>
<td>105</td>
</tr>
<tr>
<td>Gorakhpur</td>
<td>150</td>
<td>130</td>
<td>20</td>
</tr>
<tr>
<td>Sonbhadra</td>
<td>705</td>
<td>693</td>
<td>12</td>
</tr>
<tr>
<td>Etah</td>
<td>157</td>
<td>150</td>
<td>7</td>
</tr>
<tr>
<td>Jalaun</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Etawah</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pratapgarh</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Aurriya</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kannauj</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lalitpur</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Farrukabad</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ambedkarnagar</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fatehpur</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kanpur Dehat</td>
<td>0</td>
<td>7</td>
<td>-7</td>
</tr>
<tr>
<td>Sultanpur</td>
<td>60</td>
<td>70</td>
<td>-10</td>
</tr>
<tr>
<td>Mau</td>
<td>210</td>
<td>290</td>
<td>-80</td>
</tr>
<tr>
<td>Hathras</td>
<td>42</td>
<td>140</td>
<td>-98</td>
</tr>
<tr>
<td>Ballia</td>
<td>0</td>
<td>115</td>
<td>-115</td>
</tr>
<tr>
<td>Pilibhit</td>
<td>476</td>
<td>650</td>
<td>-174</td>
</tr>
<tr>
<td>Jhansi</td>
<td>0</td>
<td>200</td>
<td>-200</td>
</tr>
<tr>
<td>Hardoi</td>
<td>53</td>
<td>265</td>
<td>-212</td>
</tr>
<tr>
<td>Faizabad</td>
<td>0</td>
<td>232</td>
<td>-232</td>
</tr>
<tr>
<td>Rampur</td>
<td>285</td>
<td>625</td>
<td>-340</td>
</tr>
<tr>
<td>Unnao</td>
<td>0</td>
<td>380</td>
<td>-380</td>
</tr>
</tbody>
</table>
According to the observations from the census data, the 10 districts of Lucknow, Kanpur Nagar, Aligarh, Ghaziabad, Muzaffarnagar, Meerut, Varanasi, Aligarh, Jaunpur, and Etah have been listed as districts with high proportions of in- and out-migrants. Against this, the mapping of districts for bridge groups measured in terms of in- and out-migrants revealed that the top four ranked in-migratory districts of Ghaziabad, Lucknow, Kanpur Nagar, and Muzaffarnagar commonly figure in both lists. In the case of out-migrants, there was no one-to-one match possible, as the districts did not match. Nonetheless, according to the mapping, the districts of Banda, Bijnor, Hamirpur, and Bahraich were classified as the top out-migratory districts.

Furthermore, from Table 10 it is found that in 2002, 48,455 new cases of sexually transmitted infections (STIs) were registered in the 36 STI clinics located in public health institutions of the state. In terms of its distribution, Mirzapur recorded the highest percentage with about 15 percent of the total STI cases, followed by Agra, Gonda, Jhansi, and Saharanpur in that order. Surprisingly, Meerut, being migratory and in close proximity to the national capital, recorded only 0.1 percent. The state being migratory and the migrants exhibiting high-risk behaviour and testing positive for STIs both at STI and antenatal care (ANC) clinics (Tables 11 and 12), it is important to identify the settlements of migrants within the districts for appropriate interventions. In terms of percentage of persons visiting the STI sites and testing positive, the districts of Varanasi, Mirzapur, Azamgarh, Etawah, and Agra revealed a high percentage of STI positive clients in comparison with the remaining districts. Given all these findings, if one were to call out the common
districts across the various classifications from different sources, an overall picture is expected to emerge. Such an attempt has been made in Table 13.

Table 11

**Percentage Distribution of Persons Tested Positive for STI at STI Clinics in Uttar Pradesh**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>+ve</td>
<td>%</td>
<td>No.</td>
<td>+ve</td>
<td>%</td>
</tr>
<tr>
<td>Migrant</td>
<td>371</td>
<td>13</td>
<td>3.5</td>
<td>342</td>
<td>5</td>
<td>1.5</td>
</tr>
<tr>
<td>Non-Migrant</td>
<td>1,603</td>
<td>29</td>
<td>1.8</td>
<td>1,760</td>
<td>9</td>
<td>0.51</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,974</td>
<td>42</td>
<td>2.1</td>
<td>2,102</td>
<td>14</td>
<td>0.66</td>
</tr>
</tbody>
</table>

Table 12
Percentage Distribution of Persons Tested Positive for STI at ANC Clinics in Uttar Pradesh

<table>
<thead>
<tr>
<th></th>
<th>Total No.</th>
<th>+ve</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migrant</td>
<td>1,630</td>
<td>8</td>
<td>0.49</td>
</tr>
<tr>
<td>Non-Migrant</td>
<td>5,055</td>
<td>17</td>
<td>0.33</td>
</tr>
<tr>
<td>Total</td>
<td>6,685</td>
<td>25</td>
<td>0.37</td>
</tr>
</tbody>
</table>


Table 13
Overview of Districts for Intervention

<table>
<thead>
<tr>
<th>Census</th>
<th>Mapping</th>
<th>Sentinel Surveillance</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Migration</td>
<td>Out-Migration</td>
<td>In-Migration</td>
</tr>
<tr>
<td>Lucknow</td>
<td>Meerut</td>
<td>Ghaziabad</td>
</tr>
<tr>
<td>Kanpur Nagar</td>
<td>Varanasi</td>
<td>Lucknow</td>
</tr>
<tr>
<td>Aligarh</td>
<td>Aligarh</td>
<td>Kanpur Nagar</td>
</tr>
<tr>
<td>Muzaffarnagar</td>
<td>Jaunpur</td>
<td>Muzaffarnagar</td>
</tr>
<tr>
<td>Ghaziabad</td>
<td>Etah</td>
<td>Varanasi</td>
</tr>
</tbody>
</table>

Of the 24 classifications considered above, 17 districts figure in all, and six districts are common across the various indicators and figure in 13 out of 24 cells. A mapping of these districts will give an idea of the spatial distribution of migrant population in the state (Map 7).

Conclusion
Uttar Pradesh is a migratory state and has the distinction of having the largest volume of migrants as nearly one out of five migrants in the country represent the state. Inter-district migration accounts for one-third of all migration in the state, and the majority of inter-district migrants are short-distance migrants—predominantly females. The major reason for male migration is employment while for females it is marriage and family movement.

The mega cities in the districts of Lucknow, Kanpur Nagar, and Ghaziabad have attracted the majority of migrants into urban areas while districts such as Meerut, Varanasi, Aligarh, Jaunpur, and Etah have lost population due to out-migration. Even though the districts identified as more in-migratory matched with the independent mapping exercise, the important thing to be considered is the relationship with the findings from sentinel surveillance at the STI and ANC clinics. The surveillance data clearly showed higher STIs among migrants at both STI and ANC sites. Furthermore, based on the correlation results and evidence of seropositivity data collected at STI/ANC sites, it becomes a prerequisite to examine
the migration data in totality by in- and out-migration and by urban and rural areas. By doing so, a better picture is expected, and this will provide clarity about the migrant population. Nevertheless, the findings of the present study in terms of spatial distribution very clearly depict in- and out-migration around the cluster of districts within the region that can be used to plan appropriate targeted interventions for migrants in the state.

References
Behavioural Surveillance and Communication Strategies

Chairperson
J. S. Deepak

Behavioural Dynamics of HIV/AIDS in Uttar Pradesh
K. K. Singh

The Balbir Pasha Story
Kaveeta Jayaraman

Media Advocacy on HIV/AIDS
Sumita Thapar

Discussants
Sheena Chabra and Sonalini Mirchandani
Prevention of HIV/AIDS in Uttar Pradesh
Introduction

Human society is facing a fatal challenge in the form of AIDS and it has put the whole human civilization at risk. Its implications and repercussions are uneven in different parts of society. Most Indians do not realize this, due to a lack of awareness and a feckless attitude of care-giver agencies involved in providing solutions to the problem. About 6,10,000 of our compatriots contracted HIV as of 2003 (Population Foundation of India, 2003). Information available on AIDS indicates that, due to significant regional variations in some parts of the country, the epidemic has reached an alarming level. First it was found that the epidemic was largely confined to metropolitan cities such as Mumbai, Chennai, and other places where migration and slum formation is a common phenomena, but when the literature on the subject is thoroughly scrutinized it is found that the HIV virus has started spreading to rural areas and the general population. Moreover, the demographic impact of AIDS is much higher than what the prevalence rates would suggest (Sharma, 2002). Understanding of the virus is growing, but many behavioural aspects of the AIDS epidemic remain vaguely documented and poorly understood in India. Change in HIV infection rates over time has been hard to interpret in many contexts due to lack of complementary information on changes in behaviour. The virus is spread mainly by behaviours (i.e., sexual (hetro- as well as homo-) and drug-injecting behaviours) which are generally private, sometimes illegal, and often difficult to discuss openly. These behaviours are also dynamic, sometimes altering radically in short periods of time as social and economic changes sweep through countries. Unless efforts are made to understand the behaviours more thoroughly, it will not be possible to determine who in the population is at risk of infection or to measure changes in behaviour that may increase or reduce people’s risk and vulnerability to HIV/AIDS.

Unlike in African countries and in countries in the developed world, the AIDS epidemic in India and the rest of Asia is expected to wreak greater havoc (Brown and Xenas, 1994). The size of the population engaged in risky behaviour, the predominantly heterosexual mode of HIV transmission, the already precarious socio-economic standards of living, and the less than adequate health care system in India create a particular vulnerability to the AIDS epidemic that is extremely disturbing. Initially, AIDS was detected in the high-risk behaviour population, but now it is...
found also in the general population. A common notion is that people in India generally don’t believe in having sex outside the context of marital life. But the reality is different; most females in the general population of India were infected by their heterosexual activity. In the patriarchal Indian society, hierarchically arranged by gender, male supremacy is granted in all ways of life and it is more effective in matters relating to sex. Thus, it is considered natural for men to indulge in premarital and extramarital sex. But the norms for women’s sexual life are extremely rigid in comparison with men’s sexual activity. Women in India are expected to be virgins at the time of marriage and to remain faithful within marriage. Women in the general population are not expected to disclose their extramarital sexual relations prior to or following marriage.

It is a well-known fact that there is no proper treatment of AIDS despite having spent two decades struggling with it. Constant efforts are going on in various parts of the world to find a favourable solution to get control over the epidemic, but so far fruitful results are yet to come. If we peep into the background of the epidemic, it is evident that it is completely a by-product of human ignorance and the struggle between social values and the extreme of unfulfilled desires. This reveals that there are some loopholes in checking and balancing human sexual behaviour. To understand these issues, it is necessary to scrutinize the dynamics of behaviour, particularly sexual behaviour of the people. It is unclear how much control society should exercise over sexual behaviour.

Studies of sexual behaviour are generally lacking in India. Few studies are carried out from diverse perspectives and among diverse groups of people (Nag, 1994). Some studies have been done on the premarital and extramarital sexual activities that are accepted as a common phenomenon (Reddy et al., 1983; Savara and Sridhar, 1993a, 1993b, 1994; Sehgal et al., 1992). The age of first sexual encounter among men is found to be 12–14 years of age (Choudhary et al., 1988; Chopra et al., 1990). In this paper, an attempt has been made to study the pattern of premarital and extramarital sex according to some socio-demographic characteristics.

**Sexual Behaviour**
The extreme authoritarian point of view claims that sexual problems can disappear if sexual mores are observed. Mores have been tried out during thousands of years and reflect the wisdom of cumulative human experience. The anarchic position holds that sex is natural and private; hence attempts to regulate it are contrary to nature and an invasion of privacy. According to this view, the effort to suppress and control sexual expression creates hypocrisy, subjects individuals to the risk of public disgrace, and often leads to excessive guilt and neurosis. The discussion over sexual regulation thus boils down in practice to a conflict between ‘conservative’ and ‘liberal’ points of view, neither of which can give an absolute solution.

**Sexual Norms**
The reason behind existence of sexual norms can be understood in terms of their application in human society. Like other forms of behaviour, sexual behaviour must be learned. The sex norms are like other norms in society, which help the business of
society and contribute to smooth functioning of the system as well. While lack of regulation may bring ‘confliction and disruption’. Sexual gratification cannot be entirely suppressed after puberty. Again, the sex drive can be subjected to an extraordinary amount of both situational and emotional conditioning. This gives the sex norms an amazing variety of possible behaviours to regulate.

The Problem of Enforcement
Having taken into account the characteristics of the sex drive, it is easy to understand the difficulty of enforcement of sexual norms. The role of informal and personal enforcement—by gossip, resentment, retaliation—is often overlooked. A girl may refrain from suggestive behaviour because friends might talk or become aggressive.

In almost all societies, informal control probably bears the major share of sex regulation. This involves the elevation of sex mores to sacred realms, where they are surrounded with mystery and imbued with deep moral significance. A related mechanism is ignorance and silence. Women and children are particularly protected from the “facts of life.” Under such circumstances, “sin” tends to be contemplated with deep fear.

Societies
Most of the world’s people live in societies that have a “double standard” of sexual morality—double in two ways. Respectable women are held to very strict rules, while respectable men are free to philander. The women are divided into two categories, reputable and disreputable, the disreputable being ones who make male freedom possible. The present system accentuates the woman’s family role and usually supports marital permanence. The husband, once married, is theoretically bound to the woman for life. In return he is given sexual freedom both before and after marriage, and he is given reasonable assurance that the offspring will be his own. The wife gets affection when she is newly married, is jealously watched afterwards, and has little or negligible opportunity for sexual experience apart from marriage. In other ways as well, the feminine sphere is sharply demarcated from the masculine, thus reinforcing the double standard.

In such a system, the women available for extramarital sex (prostitutes, call girls, clean girls, mistresses, servants, and pickups) come predominantly from all classes. The distinction between them and respectable women is sometimes so pronounced that sexual relations for enjoyment are felt to be almost inappropriate for a married couple. The wife, on the other hand, is like one’s mother: holy, pure, and saintly. Husbands seem concerned about the fidelity of their wives and the chastity of their daughters to an almost phobic extent.

Premarital Sexual Relations
Of the various kinds of sexual deviation, the most debated in contemporary societies is premarital intercourse. Due to increasing age at marriage and other reasons, premarital sexual relations are on the rise and a common trend among the people. Premarital sex has always been in existence, in some primitive societies openly and disguised in civilized societies. Premarital sex is widely debated because its regulation
Prevention of HIV/AIDS in Uttar Pradesh is less fundamental than the regulation of many other aspects of sexual life. In most societies, it has always been forbidden because societies seek to avoid illegitimacy. Unmarried sex can have one or more of several outcomes: nothing at all beyond the act itself, venereal disease, an illicit pregnancy ending in abortion, a forced marriage, or an illegitimate child. Despite the diffusion of contraceptive and prophylactic techniques, it is strange that the undesired consequences have tended to rise rather than fall.

**Prostitution**

Among the types of extramarital sex, prostitution is noteworthy for the dichotomy it evokes. Frequently condemned, it is nevertheless defended as an escape valve for pent-up sexual energy. Dichotomy cannot be discussed in terms of consequences. If prostitution has bad effects, these are the results, not the cause, of the attitude toward it. Its effect in spreading sexually transmitted diseases and HIV/AIDS is as much because of carelessness as the prostitution itself. Its close association with organized crime and neighbourhood deterioration has often attracted the attention of various researchers.

**Prostitution and Sexual Freedom**

With the rise of sexual freedom among single, married, widowed, and divorced women, the role of prostitution has necessarily declined. The frequency of sex with females who are not prostitutes has increased to an extent, which largely compensates for the decreased frequency with prostitutes.

In a complex mobile society, any sexual status except marriage is a temporary and anonymous one for a woman. Some types of prostitution are not a permanent occupation; prostitution is pursued at the age when it is most lucrative and then abandoned by clean girls. The most persistent form of prostitution is the purely commercial form. Whether it is through brothels, in streets, under bridges, or in automobiles, this form is practised everywhere and remains at the bottom of the social scale. However, its scope may be reduced by sexual freedom in society. Due to mass media exposure and modern institutions, the span between the genders has been reduced. This definitely has contributed to sexual freedom and other autonomies.

**Homosexual Behaviour**

In a behavioural context, it is necessary to understand the attitudes toward homosexuality. Some of the strongest sexual norms are those that define permissible partners. Masturbation involves no partner at all; adultery, a partner other than one’s spouse; homosexuality, a partner of the same sex.

A sociological theory of homosexual behaviour does not preclude biological influence, but the main biological contribution appears to lie in the human capacity for conditioning. That social factors play a role is demonstrated by differences in the amount and style of homosexual behaviour from one society or group to another. Research has attempted to focus on the factors influencing people’s behavioural dynamics, which really are contributing to increasing the rate of the HIV/AIDS epidemic at an alarming level.
Data and Methodology

The basic data used for this analysis have been taken from a survey entitled “Behavioural Dynamics of HIV/AIDS in Uttar Pradesh, India” funded by the National Institutes of Health, USA, and conducted by the Centre of Population Studies, Banaras Hindu University, Varanasi, in collaboration with the University of North Carolina at Chapel Hill, USA. The field work was done from January to July 2003. The main objective of the survey was to study extramarital sexual behaviour, female autonomy and communication with their spouses, knowledge of HIV/AIDS and sexually transmitted diseases (STDs), and attitudes about and perceptions of AIDS.

The data was collected from all five regions of undivided Uttar Pradesh. From each region, the two most populated cities were selected for urban coverage, while a district was selected randomly from each region for rural coverage. Thus, a total of 15 districts were selected out of which 10 cities were taken for urban coverage and five districts for rural coverage. More districts were selected in urban areas keeping in view that more variation about the knowledge of STDs as well as HIV/AIDS might be probable in urban areas.

From each selected city, 10 wards were selected systematically and from each selected ward, 22 households were selected systematically. For rural coverage, five blocks were selected from each district randomly and two villages (one small and one large in terms of population) were selected randomly from each selected block. Then, 22 households were selected systematically from each selected village. A couple (or female) was defined as eligible if both partners were alive on the reference date and she was under 50 years of age. All the eligible couples (both husband and wife) were interviewed. At least 220 households were covered from each district. Logistic regression has been used to explore the impact of some socio-demographic characteristics on the high-risk behaviour of married men.

Findings

The analysis shows that about one-fourth of the sampled population has experienced sex prior to marriage and the mean age of first sex prior to marriage is found to be 18.7 years. The incidence of premarital sex is highest (30.1 percent) in the Western region. In the Eastern region, low age at marriage and return marriage and more observance of social taboos may be the reason for lowering premarital sexual activities. Premarital sex in the Hill region is found more frequently than in the Central and Bundelkhand regions. The percentage of premarital sex is almost the same in rural and urban areas, but the mean age at first sexual experience is higher in the urban areas. This clearly shows that in rural areas premarital sex is common just like in urban areas, but people have premarital sex at younger ages. This may be also
due to younger age at marriage in rural areas. Differences between age at first sexual union with wife and with someone other than a wife is found to be four years in urban areas; however, in rural areas it is three years. This difference is more in the Hill region leaving behind the Central region. As the age of respondents increases, the age of experience of first sexual union with wife or other than wife also increases. The results also show that younger people are significantly more indulged in premarital sex than older people. The percentage of premarital sex decreases with age. Education has a strong negative association with premarital sexual activity. As education increases, premarital sexual activity decreases. About 31 percent of illiterate people have experienced premarital sex; however, only 14 percent of highly educated people have. The age at first sexual union with other than wife or premarital sex increases as education increases. Alcohol use was found to be associated with higher rates of premarital sex. 34.1 percent of married men who had first sex with someone else had taken alcohol in the last two weeks. Less than 18 percent of men who had first sex with someone else had never used alcohol. Premarital sex among Muslims is found to be more than among Hindus. Among Hindus, 20.2 percent of married men belonging to upper castes have premarital sex, while among scheduled caste/scheduled tribe (SC/ST) it is 28.3 percent.

Table 2 shows that 11.1 percent of males indulged in post-marital sexual activities. More than half of the married men who have already experienced post-marital sex have at least two partners and the mean number of partners is found to be 3.44. The post-marital sex in the Eastern and Bundelkhand regions is found to be less than in other regions. In the Hill as well as Western regions, more post-marital sex is observed. Also the mean number of partners is highest in the Hill region. Urban males are more likely to have post-marital sex than rural males because of the availability of sex markets and lower social taboos. Older people are less active in post-marital sex than younger people. As education increases their post-marital activity decreases significantly. The number of people who had used alcohol in the last two weeks was significantly high in engaging in post-marital sex with five or more partners (31.3 percent). Muslims are found significantly more sexually active in extramarital sex within their marital life than Hindus. Among Hindus, SC/ST males are more active than upper and middle caste married males.

Table 3 shows that more than 7 percent of married men have recently (within one year) had sexual relations with someone other than their wives. About 52 percent of men responded that their partners were girlfriends, while 25 percent said that they had sex with someone whom they paid. Very few said that they had used condoms while having sex with someone other than their wives. Again, extramarital sex is found least in the Eastern region and most in the Central region. Sex with a girlfriend is more prevalent in the Western region and paid sex is about 42 percent in the Hill region. In urban areas recent extramarital sex is more than in rural areas. Recent extramarital sexual activity is much more prevalent among younger males than older males. Also, married men who are childless are more sexually active than others. Hindus are less sexually active than Muslims in terms of recent post-marital sex. Recent post-marital sex is more prevalent in SC/ST than in other caste groups among Hindus.
Table 4 shows the distribution of married men who have paid for sex by selected socio-demographic characteristics. It is observed that about 6 percent of married men in the general population are going for extramarital paid sex. Among the men who are going for extramarital sex, one-fifth pay their partners for sex. More than 40 percent of married men have paid for sex after marriage. If we take a close look at the data, we can observe that in Uttaranchal the highest percentage of married men pay for sex. In the rest of the regions the percentage is almost the same. Of the 10 percent of men in Uttaranchal who have ever paid for sex, nearly 70 percent of them have paid for recent sex. In urban areas, the ever paid sex or paid extramarital sex is found to be higher than in rural areas. Alcohol use has been found to be highly associated with paid extramarital sex.

Table 5 represents the distribution of married men having STD symptoms recently among those who had extramarital sex after marriage. It is observed that a high proportion (21.1 percent) of married men who had sex recently suffer from STDs. Of those who do not have extramarital sex after marriage, only 4.3 percent are suffering from STDs, but this share is 21.1 percent if men had extramarital sex within a year. Education of husbands has a very strong affect on STDs among those who already had recent sex outside marriage. About one-fourth of the population whose education is up to grade 8 are suffering from STDs if they have had recent sex outside marriage. It is only 8 percent if the husband has more than a secondary level of education. Alcohol use is also found to be associated with having STDs among the men who have had extramarital sex. More than 27 percent are suffering from STDs among those who have taken alcohol in the last two weeks, whereas this percentage is only 12.3 if the married men have not taken any alcohol in his life. Married men who have had extramarital sex and belong to the upper castes among Hindus are less likely to suffer from STDs than those from other castes.

**Multivariate Analysis**

To assess the independent effects of various background characteristics on premarital sex, logistic analyses have been conducted (Table 6). In the logistic regression, premarital sex is specified as the dependent variable and all the other variables—region, place of residence, age, and education of married men, religion/caste, and alcohol use—are analysed for their predictive role. Significant predictors of men having premarital sex are age and education of married men, alcohol use as well as religion/caste to which they belong. Men living in the Western region of Uttar Pradesh are more involved in premarital sex than any other region of the state as well as Uttaranchal and the difference with the Eastern region is statistically significant. Men residing in urban areas are neither appreciably nor significantly more likely to have premarital sex than men in rural areas. Results reveal that the younger married men (<25 years) are significantly more likely to have premarital sex than older men (>50 years), and it is clear from the table that as the age of married men increases, the chance of having premarital sex decreases.

The multivariate analysis confirms that as the education increases, the likelihood of premarital sex decreases significantly. Married men with a very high level of education (above grade 12) are significantly less likely to have premarital sex than
any other education group. Religion/caste is also found to be a good predictor of premarital sex. Married men belonging to the Muslim religion are significantly more likely to have had premarital sex. The prevalence of premarital sex is lowest for married men belonging to upper castes among Hindus. Upper caste Hindus have 36 percent less chance of premarital sex than Muslims. Alcohol use among the married men has been found to be a very strong predictor for premarital sex. The married men who have taken alcohol in the last two weeks have 2.5 times more chance of having premarital sex than the men who have never consumed alcohol.

When data was analysed taking post-marital sex as the dependent variable, it is found that the age and education of the husband, alcohol use, and religion/caste have a significant effect on post-marital sex of married men (Table 7). If we include in the model the variable premarital sex (Model III, Table 7) the effect of religion/caste vanishes, and it is observed that if a married man has premarital sex with more than one woman then he is 17 times more likely to go for extramarital sex than the married man who has no premarital sex.

Recent alcohol use was also found to be a very strong predictor for extramarital sex after marriage. A man who has taken alcohol in the last two weeks has twice the chance of going for post-marital sex than the man who has not taken any type of alcohol in his life. As the education of married men increases, the chance of having post-marital sex decreases. The married men belonging to age group 25–50 years have more chance of post-marital sex than the male aged <25 years and e” 50 years.

Table 8 presents the estimate of the logistic model taking recent sex (extramarital sex within one year after marriage) as a dependent variable. The results clearly show that the men living in the Central region are more likely to indulge in recent extramarital sex than any other region of Uttar Pradesh and Uttarakhand. The place of residence has a significant effect on recent sex of married men. There is more chance that the married men living in urban areas will go for recent extramarital sex than the men living in rural areas. If the independent variable alcohol use is included in the model (Model II, Table 8), no significant effect of place of residence is observed. Still, from the results, it is clear that there is higher chance that the married man living in urban areas has gone for recent extramarital sex than the man who is living in rural areas.

Complementary to post-marital sex, younger married men are more involved in recent extramarital sex. Results show that married men of less than 35 years of age are more involved in recent sex. The married men whose ages are <25 years are 3.35 times more likely to have gone for extramarital sex than the men whose age is e” 50 years.

Education has a significant role in driving recent extramarital sex. The men who are highly educated have less chance of having recent extramarital sex than the men who are illiterate. After controlling for some of the socio-demographic variables, it is observed that alcohol use is the strongest predictor for recent extramarital sex. The men who are taking alcohol regularly or have done so recently, are about 3.5 times more likely to have had recent extramarital sex than the married men who have never
consumed alcohol in their lives. A higher proportion of Muslims in the society is involved in recent extramarital sex than Hindus and the difference is statistically significant.

**Conclusions**

Premarital sex or sex with someone other than a wife is gaining popularity in modern society. It is clear that most people are in need of extramarital sex and think that it is natural and gives maximum pleasure. Thus, they explore the ways and means to get it. To satiate sexual lust, married men are in search of women and if women are not freely available, they are ready to pay to have sex with them.

Premarital sex and recent extramarital sex is found to be least prevalent in the Eastern region of Uttar Pradesh. This may be due to the fact that in the Eastern region custom, tradition, taboos, and other types of social as well as behavioural control mechanisms are quite strong in comparison with other regions and Uttarakhand. It is clear that a higher proportion of married men engage in extramarital sex in urban areas than rural areas. But the differences are not statistically significant.

The younger married men (<25 years) are more likely to have experienced premarital sex and recent extramarital sex than the married men who are in other age groups. As the age of married men increases, the probability of having had premarital and extramarital sex decreases. This may be the influence of modernization and industrialization, which in turn weakens social customs and taboos prevalent in the society. Also due to mass media exposure, the difference between the genders is reduced which definitely provides opportunities of sexual freedom.

Education also plays a role in determining the incidence of premarital and extramarital sex. As education increases, the chance of having had extramarital sex decreases significantly. This may be the effect of education, which is increasing awareness about the consequences of extramarital sex, thus reducing extramarital sex, or it may be that educated married men don’t want to disclose their extramarital relationship in front of others. Married men who are consuming alcohol regularly or once in while have a high probability of going for extramarital sex than the men who have never taken alcohol. It is worthwhile to mention that due to modernization, the use of alcohol is increasing among men and in the younger generations, but it is not accepted by the families in the society. It is well documented that alcohol usually works as a stimulating force for sexual desire or thirst. Thus, after taking alcohol, men lose control of themselves and go for sex with women other than their wives. Also after taking alcohol, they don’t want to face their married partner and, thus, if they have sexual desire, they look for extramarital sex. Easy availability of paid sex workers encourages the mind of men in the society to have extramarital sex with them, which is going to fulfill the desire and thirst after taking alcohol.

From the results, it is clear that more than 40 percent of married men who are having extramarital sex are paying for sex. Also, the married men who have gone for recent extramarital sex have a higher chance of getting STDs. More than one fifth of
the married men who have gone for recent extramarital sex are suffering from STDs. It is a well known fact that the men who are suffering from STDs are more vulnerable to HIV/AIDS. Thus, the men who are going for recent extramarital sex and who have STDs are at high risk of getting HIV/AIDS.

In the urban population under study, the proportion of paid sex is significantly higher than in the rural population. This may be due to the fact that prostitutes or paid sex workers are more easily available in urban areas than in rural areas. This may be why a higher proportion of married men have recent STD symptoms in urban areas. It should be pointed out that the married men engaged in extramarital sex having STD symptoms in rural areas are more likely to spread the disease in the general population due to less accessibility of medical facilities and less awareness than in urban areas.

Educated husbands (>12 years of schooling) are less likely to pay for sex than men at lower educational levels. Less number of educated have recent STD symptoms. This could be either due to higher levels of awareness among educated or could be false reporting because of stigma attached to such symptoms. Thus, in a nutshell, it can be concluded that consequences of extramarital heterosexuality must be communicated to the society and awareness of the consequences increased.
### Table 1
Distribution and Mean Age at First Sex among Husbands Having Sex with Wife or Someone Else by Selected Background Characteristics

<table>
<thead>
<tr>
<th>Background Characteristics</th>
<th>N</th>
<th>First Sex with Wife</th>
<th></th>
<th>First Sex with Someone</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Percent</td>
<td>Mean Age (in years)</td>
<td>Percent</td>
<td>Mean Age (in years)</td>
</tr>
<tr>
<td>Total</td>
<td>3412</td>
<td>75.8</td>
<td>22.41 (4.25)</td>
<td>24.2</td>
<td>18.70 (3.37)</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundelkhand</td>
<td>687</td>
<td>76.5</td>
<td>21.42 (3.95)</td>
<td>23.6</td>
<td>18.19 (3.41)</td>
</tr>
<tr>
<td>Central</td>
<td>671</td>
<td>77.2</td>
<td>22.65 (4.71)</td>
<td>22.8</td>
<td>18.39 (3.72)</td>
</tr>
<tr>
<td>Eastern</td>
<td>691</td>
<td>79.7</td>
<td>21.91 (4.36)</td>
<td>20.3</td>
<td>18.98 (3.13)</td>
</tr>
<tr>
<td>Western</td>
<td>685</td>
<td>69.9</td>
<td>21.91 (3.88)</td>
<td>30.1</td>
<td>18.68 (3.18)</td>
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<tr>
<td>Uttaranchal (formerly, Hill region)</td>
<td>678</td>
<td>76.0</td>
<td>24.04 (4.32)</td>
<td>24.0</td>
<td>19.29 (3.36)</td>
</tr>
<tr>
<td><strong>Place of Residence</strong></td>
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<td></td>
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<td>75.7</td>
<td>23.24 (4.45)</td>
<td>24.3</td>
<td>19.21 (3.47)</td>
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<tr>
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<td>20.71 (3.64)</td>
<td>23.9</td>
<td>17.68 (2.90)</td>
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<td><strong>Age of Husband</strong></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>&lt; 25</td>
<td>370</td>
<td>72.2</td>
<td>19.43 (2.68)</td>
<td>27.8</td>
<td>17.19 (2.21)</td>
</tr>
<tr>
<td>25–35</td>
<td>1333</td>
<td>75.0</td>
<td>22.10 (4.01)</td>
<td>25.0</td>
<td>18.41 (3.21)</td>
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<tr>
<td>35–50</td>
<td>1539</td>
<td>76.7</td>
<td>23.03 (4.52)</td>
<td>23.3</td>
<td>19.28 (3.55)</td>
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<tr>
<td>≥ 50</td>
<td>170</td>
<td>82.9</td>
<td>24.54 (4.93)</td>
<td>17.1</td>
<td>20.21 (4.19)</td>
</tr>
<tr>
<td><strong>Number of Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>310</td>
<td>68.1</td>
<td>23.62 (4.42)</td>
<td>31.9</td>
<td>18.97 (3.37)</td>
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<tr>
<td>1–2</td>
<td>1294</td>
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<td>23.56 (4.53)</td>
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<td>19.17 (3.55)</td>
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<td>3–4</td>
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<td>21.59 (3.85)</td>
<td>24.0</td>
<td>18.47 (3.37)</td>
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<tr>
<td>5 or more</td>
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<td>20.79 (4.09)</td>
<td>22.4</td>
<td>17.87 (2.69)</td>
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<td><strong>Education of Husband</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Illiterate</td>
<td>750</td>
<td>69.3</td>
<td>20.67 (3.85)</td>
<td>30.7</td>
<td>18.21 (2.91)</td>
</tr>
<tr>
<td>1–8</td>
<td>881</td>
<td>72.4</td>
<td>21.53 (3.79)</td>
<td>27.6</td>
<td>18.12 (2.99)</td>
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<td>9–12</td>
<td>1102</td>
<td>77.0</td>
<td>22.47 (4.33)</td>
<td>23.0</td>
<td>19.16 (3.48)</td>
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<tr>
<td>≥ 13</td>
<td>679</td>
<td>85.7</td>
<td>24.72 (4.39)</td>
<td>14.3</td>
<td>20.13 (4.32)</td>
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<tr>
<td><strong>Alcohol Use</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Nil</td>
<td>1741</td>
<td>82.3</td>
<td>22.37 (4.35)</td>
<td>17.7</td>
<td>18.98 (3.92)</td>
</tr>
<tr>
<td>Took but not within last two weeks</td>
<td>702</td>
<td>73.6</td>
<td>22.54 (4.13)</td>
<td>26.4</td>
<td>18.94 (3.12)</td>
</tr>
<tr>
<td>Taken in last two weeks</td>
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<td>65.9</td>
<td>22.39 (4.11)</td>
<td>34.1</td>
<td>18.30 (2.89)</td>
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<td><strong>Religion</strong></td>
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<tr>
<td>Hindu</td>
<td>2817</td>
<td>76.6</td>
<td>22.25 (4.27)</td>
<td>23.4</td>
<td>18.45 (3.25)</td>
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<td>Muslim</td>
<td>550</td>
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<td>22.82 (4.67)</td>
<td>28.9</td>
<td>19.82 (3.70)</td>
</tr>
<tr>
<td>Other</td>
<td>45</td>
<td>84.4</td>
<td>25.76 (3.95)</td>
<td>15.6</td>
<td>17.14 (1.07)</td>
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<td><strong>Castes among Hindus</strong></td>
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<tr>
<td>Upper</td>
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<td>23.48 (4.31)</td>
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<td>19.26 (3.53)</td>
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<tr>
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<td>21.77 (4.09)</td>
<td>22.8</td>
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<tr>
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<td>71.7</td>
<td>21.04 (3.98)</td>
<td>28.3</td>
<td>17.89 (2.85)</td>
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</table>

Standard deviations are given in the parenthesis.
Table 2
Distribution of Husbands Reporting Post-marital Sex and Mean and Percent Distribution of Number of Partners by Selected Background Characteristics

<table>
<thead>
<tr>
<th>Background Characteristics</th>
<th>Post-Marital Sex Percent</th>
<th>Number of Partners</th>
<th>Mean</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>11.1</td>
<td>41.5</td>
<td>15.6</td>
</tr>
<tr>
<td>Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundelkhand</td>
<td>9.5</td>
<td>47.7</td>
<td>10.8</td>
</tr>
<tr>
<td>Central</td>
<td>10.7</td>
<td>65.3</td>
<td>11.1</td>
</tr>
<tr>
<td>Eastern</td>
<td>9.8</td>
<td>45.6</td>
<td>23.5</td>
</tr>
<tr>
<td>Western</td>
<td>12.3</td>
<td>34.5</td>
<td>17.9</td>
</tr>
<tr>
<td>Uttarakshal (formerly Hill region)</td>
<td>13.1</td>
<td>21.3</td>
<td>14.6</td>
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<td>Place of Residence</td>
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<td>11.6</td>
<td>38.9</td>
<td>18.3</td>
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<tr>
<td>Rural</td>
<td>10.1</td>
<td>47.4</td>
<td>9.5</td>
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<tr>
<td>Age of Husband</td>
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<td></td>
<td></td>
</tr>
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<td>&lt; 25</td>
<td>10.3</td>
<td>60.5</td>
<td>7.9</td>
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<td>25–35</td>
<td>11.8</td>
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<td>≥ 50</td>
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<td>66.7</td>
<td>8.3</td>
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<td>52.9</td>
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<td>9.7</td>
<td>42.4</td>
<td>15.2</td>
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<tr>
<td>3–4</td>
<td>12.1</td>
<td>37.4</td>
<td>20.0</td>
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<tr>
<td>5 or more</td>
<td>12.1</td>
<td>43.8</td>
<td>14.1</td>
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<td>Husband's Education</td>
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<td>40.7</td>
<td>12.0</td>
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<td>1–8</td>
<td>13.4</td>
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<td>9–12</td>
<td>10.1</td>
<td>40.5</td>
<td>18.0</td>
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<td>≥ 13</td>
<td>6.0</td>
<td>48.8</td>
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<td>Alcohol Use</td>
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<tr>
<td>Nil</td>
<td>6.9</td>
<td>45.0</td>
<td>17.5</td>
</tr>
<tr>
<td>Took but not within last two weeks</td>
<td>11.3</td>
<td>45.6</td>
<td>19.0</td>
</tr>
<tr>
<td>Taken within last two weeks</td>
<td>18.5</td>
<td>37.4</td>
<td>12.8</td>
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<tr>
<td>Religion</td>
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<tr>
<td>Hindu</td>
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Table 3

Distribution of Husbands Having Most Recent Sex (Within One Year) with Other Than Wife and Their Relationship With This Person

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<tr>
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</tr>
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</tr>
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<td>Rural</td>
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<tr>
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<tr>
<td>Nil</td>
<td>1721</td>
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</tr>
<tr>
<td>Took but not within last two weeks</td>
<td>696</td>
<td>6.8</td>
</tr>
<tr>
<td>Taken in last two weeks</td>
<td>961</td>
<td>12.4</td>
</tr>
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<td><strong>Religion</strong></td>
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<tr>
<td>Hindu</td>
<td>2784</td>
<td>6.7</td>
</tr>
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<td>Muslim</td>
<td>549</td>
<td>9.3</td>
</tr>
<tr>
<td>Other</td>
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<td><strong>Castes among Hindus</strong></td>
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</tr>
<tr>
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</tr>
<tr>
<td>Middle</td>
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<td>SC/ST</td>
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### Table 4
Distribution of Husbands Ever Paid for Sex by Selected Background Characteristics

<table>
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<tr>
<th>Background Characteristics</th>
<th>Ever paid for sex</th>
<th>Ever paid for Sex if the husband have Recent extramarital sex*</th>
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<tr>
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</tr>
<tr>
<td>Central</td>
<td>4.9</td>
<td>18.3</td>
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<tr>
<td>Eastern</td>
<td>4.8</td>
<td>17.9</td>
</tr>
<tr>
<td>Western</td>
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<td>16.0</td>
</tr>
<tr>
<td>Uttaranchal (formerly Hill region)</td>
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<td>32.5</td>
</tr>
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<td><strong>Residence</strong></td>
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<td>24.4</td>
</tr>
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<td>Rural</td>
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<td>10.5</td>
</tr>
<tr>
<td><strong>Age of Husband</strong></td>
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<td></td>
</tr>
<tr>
<td>&lt; 25</td>
<td>3.8</td>
<td>11.7</td>
</tr>
<tr>
<td>25–35</td>
<td>6.6</td>
<td>22.5</td>
</tr>
<tr>
<td>35–50</td>
<td>5.9</td>
<td>19.5</td>
</tr>
<tr>
<td>≥ 50</td>
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<td>20.7</td>
</tr>
<tr>
<td><strong>Number of Children</strong></td>
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<td>20.2</td>
</tr>
<tr>
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<td>5.3</td>
<td>18.7</td>
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<td>7.1</td>
<td>19.6</td>
</tr>
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<td>1–8</td>
<td>8.3</td>
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</tr>
<tr>
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<td>12.6</td>
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<td>Taken in last two weeks</td>
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<td>27.9</td>
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<tr>
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<td></td>
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<tr>
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*This means the husband’s has extramarital sex within a year and this partner is most recent partner other than wife.
### Table 5

**Distribution of Males with STDs Who Had Extramarital Sex by Selected Background Characteristics**

<table>
<thead>
<tr>
<th>Background Characteristics</th>
<th>Recent sex</th>
<th>Post-marital sex (not within a year)</th>
<th>Recent Post-marital sex</th>
<th>No post-sex</th>
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<td>17.7</td>
<td>4.9</td>
<td>6.1</td>
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<td>18.1</td>
<td>17.6</td>
<td>6.4</td>
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<td>7.4</td>
<td>9.7</td>
<td>4.3</td>
<td>4.9</td>
</tr>
<tr>
<td>Western</td>
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<td>17.3</td>
<td>3.7</td>
<td>5.3</td>
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<td>14.4</td>
<td>2.4</td>
<td>4.0</td>
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<td>1.7</td>
<td>2.9</td>
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<td>12.3</td>
<td>4.5</td>
<td>5.5</td>
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<td><strong>Education of Husband</strong></td>
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<td>21.8</td>
<td>6.7</td>
<td>8.9</td>
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<td>16.7</td>
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<td>6.5</td>
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<td>11.6</td>
<td>3.8</td>
<td>4.6</td>
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<tr>
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<td>4.7</td>
<td>2.0</td>
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<td>15.6</td>
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<td>5.6</td>
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<td>18.0</td>
<td>18.5</td>
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<td>8.6</td>
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</tr>
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<td>18.6</td>
<td>18.6</td>
<td>5.2</td>
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<td><strong>Caste among Hindus</strong></td>
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<td>6.0</td>
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Table 6
Logistic regression analysis with premarital sex of married men as time dependent co-variate

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<th>Model II</th>
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<td>Odds Ratio (CI)</td>
<td>S.E.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bundelkhand</td>
<td>1.278 (0.99,1.66)</td>
<td>0.132</td>
<td>1.280 (0.98,1.67)</td>
<td>0.134</td>
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<tr>
<td>Central</td>
<td>1.194 (0.91,1.55)</td>
<td>0.134</td>
<td>1.232 (0.94,1.61)</td>
<td>0.136</td>
</tr>
<tr>
<td>Western</td>
<td>1.585** (1.23,2.04)</td>
<td>0.128</td>
<td>1.607** (1.25,2.07)</td>
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</tr>
<tr>
<td>Uttaranchal (formerly Hill region)</td>
<td>1.325* (1.02,1.73)</td>
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<td>1.167 (0.89,1.53)</td>
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<td></td>
<td></td>
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<td>1.054 (0.88,1.53)</td>
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<td><strong>Age of Husband</strong></td>
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<td></td>
</tr>
<tr>
<td>&lt; 25</td>
<td>1.648* (1.09,2.49)</td>
<td>0.211</td>
<td>1.725* (1.13,2.62)</td>
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<td>1.289 (0.91,1.83)</td>
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<td>35 – 50</td>
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<td>0.173</td>
<td>1.173 (0.83,1.65)</td>
<td>0.175</td>
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<tr>
<td><strong>Education of Husband</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>2.434** (1.83,3.24)</td>
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<td>2.222** (1.66,2.97)</td>
<td>0.148</td>
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<td>2.174** (1.66,2.85)</td>
<td>0.138</td>
<td>1.924** (1.46,2.55)</td>
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<tr>
<td>9 – 12</td>
<td>1.768** (1.36,2.30)</td>
<td>0.134</td>
<td>1.647** (1.26,2.15)</td>
<td>0.136</td>
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<tr>
<td><strong>Alcohol Use</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Took but not within last two weeks</td>
<td>-</td>
<td>-</td>
<td>1.784** (1.44,2.21)</td>
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<td>2.509** (2.07,3.04)</td>
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<tr>
<td><strong>Religion/Caste</strong></td>
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<tr>
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<td>0.795 (0.61,1.03)</td>
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<td>0.641** (0.49,0.84)</td>
<td>0.136</td>
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<tr>
<td>Middle</td>
<td>0.820 (0.64,1.05)</td>
<td>0.126</td>
<td>0.665* (0.52,0.86)</td>
<td>0.130</td>
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<tr>
<td>SC/ST</td>
<td>0.987 (0.77,1.27)</td>
<td>0.129</td>
<td>0.728* (0.56,0.95)</td>
<td>0.110</td>
</tr>
</tbody>
</table>

S.E.: Standard Error; CI: Confidence Interval; Statistical Significance: **p<0.001, *p<0.05
Omitted Categories: *Eastern; ^Rural; ^= 50; *= 13; "No alcohol use; ^Muslim.
<table>
<thead>
<tr>
<th>Co-variates</th>
<th>Model I</th>
<th>Model II</th>
<th>Model III</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds Ratio (CI)</td>
<td>S.E.</td>
<td>Odds Ratio (CI)</td>
</tr>
<tr>
<td>Regiona</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundelkhand</td>
<td>1.026 (0.72,1.47)</td>
<td>0.185</td>
<td>1.012 (0.70,1.47)</td>
</tr>
<tr>
<td>Central</td>
<td>1.133 (0.80,1.62)</td>
<td>0.181</td>
<td>1.181 (0.82,1.69)</td>
</tr>
<tr>
<td>Western</td>
<td>1.187 (0.84,1.67)</td>
<td>0.175</td>
<td>1.195 (0.84,1.70)</td>
</tr>
<tr>
<td>Uttarakhand(formerly Hill region)</td>
<td>1.480* (1.04,2.10)</td>
<td>0.178</td>
<td>1.278 (0.89,1.83)</td>
</tr>
<tr>
<td>Place of Residenceb</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>1.253 (0.98,1.60)</td>
<td>0.125</td>
<td>1.107 (0.86,1.42)</td>
</tr>
<tr>
<td>Age of Husbandc (in years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 25</td>
<td>1.834 (0.95,3.54)</td>
<td>0.336</td>
<td>1.933* (0.99,3.76)</td>
</tr>
<tr>
<td>25 – 35</td>
<td>2.138* (1.23,3.73)</td>
<td>0.284</td>
<td>2.099* (1.20,3.68)</td>
</tr>
<tr>
<td>35 – 50</td>
<td>2.129* (1.23,3.68)</td>
<td>0.280</td>
<td>2.028* (1.17,3.53)</td>
</tr>
<tr>
<td>Education of Husbandd</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>2.541** (1.70,3.80)</td>
<td>0.205</td>
<td>2.249** (1.49,3.39)</td>
</tr>
<tr>
<td>1 – 8</td>
<td>2.358** (1.61,3.46)</td>
<td>0.196</td>
<td>2.019** (1.37,2.99)</td>
</tr>
<tr>
<td>9 – 12</td>
<td>1.790* (1.23,2.61)</td>
<td>0.193</td>
<td>1.168* (1.10,2.38)</td>
</tr>
<tr>
<td>Alcohol Usee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took but not within last two weeks</td>
<td>-</td>
<td>-</td>
<td>1.868** (1.37,2.55)</td>
</tr>
<tr>
<td>Taken in last two weeks</td>
<td>-</td>
<td>-</td>
<td>3.205** (1.50,2.69)</td>
</tr>
<tr>
<td>Religion/Castef</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper</td>
<td>0.684* (0.49,0.96)</td>
<td>0.173</td>
<td>0.520** (0.37,0.74)</td>
</tr>
<tr>
<td>Middle</td>
<td>0.665* (0.48,0.92)</td>
<td>0.166</td>
<td>0.511** (0.36,0.72)</td>
</tr>
<tr>
<td>SC/ST</td>
<td>0.842 (0.61,1.67)</td>
<td>0.167</td>
<td>0.568** (0.40,0.80)</td>
</tr>
<tr>
<td>Premarital Sexg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With one woman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>With more than one woman</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

S.E.: Standard Error; CI: Confidence Interval; Statistical Significance: **p<0.001, *p<0.05

Omitted Categories: aEastern; bRural; c> 50; d> 13; eNo alcohol use; fMuslim; gNo Premarital Sex.
Table 8
Logistic Regression Analysis with Recent (Post-marital Sex within One Year Other Than Wife) Sex of Married Men as Time Dependent Co-variates

<table>
<thead>
<tr>
<th>Co-variates</th>
<th>Model I</th>
<th></th>
<th>Model II</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds Ratio (CI)</td>
<td>S.E.</td>
<td>Odds Ratio (CI)</td>
<td>S.E.</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bundelkhand</strong></td>
<td>1.237 (0.79,1.95)</td>
<td>0.231</td>
<td>1.235 (0.78,1.95)</td>
<td>0.233</td>
</tr>
<tr>
<td><strong>Central</strong></td>
<td>1.696* (1.11,2.60)</td>
<td>0.218</td>
<td>1.787* (1.16,2.76)</td>
<td>0.221</td>
</tr>
<tr>
<td><strong>Western</strong></td>
<td>1.272 (0.82,0.97)</td>
<td>0.223</td>
<td>1.279 (0.82,1.99)</td>
<td>0.226</td>
</tr>
<tr>
<td><strong>Uttaranchal (formerly Hill region)</strong></td>
<td>1.375 (0.87,2.18)</td>
<td>0.234</td>
<td>1.186 (0.74,1.89)</td>
<td>0.239</td>
</tr>
<tr>
<td><strong>Place of Residence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urban</strong></td>
<td>1.444* (1.07,1.96)</td>
<td>0.155</td>
<td>1.244 (0.91,1.70)</td>
<td>0.158</td>
</tr>
<tr>
<td><strong>Age of Husband</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 25</td>
<td>3.190* (1.34,7.57)</td>
<td>0.441</td>
<td>3.351* (1.40,8.00)</td>
<td>0.444</td>
</tr>
<tr>
<td>25 – 35</td>
<td>2.752* (1.26,6.04)</td>
<td>0.401</td>
<td>2.677* (1.22,5.90)</td>
<td>0.403</td>
</tr>
<tr>
<td>35 – 50</td>
<td>2.251* (1.03,4.92)</td>
<td>0.399</td>
<td>2.107 (0.96,4.63)</td>
<td>0.401</td>
</tr>
<tr>
<td><strong>Education of Husband</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Illiterate</strong></td>
<td>3.094** (1.88,5.10)</td>
<td>0.255</td>
<td>2.724** (1.64,4.53)</td>
<td>0.259</td>
</tr>
<tr>
<td>1 – 8</td>
<td>2.332** (1.44,3.79)</td>
<td>0.248</td>
<td>1.971* (1.20,3.23)</td>
<td>0.252</td>
</tr>
<tr>
<td>9 – 12</td>
<td>1.754* (1.09,2.83)</td>
<td>0.245</td>
<td>1.584 (0.97,2.58)</td>
<td>0.248</td>
</tr>
<tr>
<td><strong>Alcohol Use</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took but not within last two weeks</td>
<td>-</td>
<td>-</td>
<td>1.867* (1.26,2.76)</td>
<td>0.199</td>
</tr>
<tr>
<td>Taken in last two weeks</td>
<td>-</td>
<td>-</td>
<td>3.462** (2.50,4.79)</td>
<td>0.165</td>
</tr>
<tr>
<td><strong>Religion/Caste</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper</td>
<td>0.831 (0.54,1.27)</td>
<td>0.217</td>
<td>0.616* (0.40,0.96)</td>
<td>0.224</td>
</tr>
<tr>
<td>Middle</td>
<td>0.792 (0.53,1.19)</td>
<td>0.206</td>
<td>0.591* (0.39,0.90)</td>
<td>0.213</td>
</tr>
<tr>
<td>SC/ST</td>
<td>0.992 (0.67,1.48)</td>
<td>0.204</td>
<td>0.647* (0.43,0.99)</td>
<td>0.215</td>
</tr>
</tbody>
</table>

S.E.: Standard Error; CI: Confidence Interval; Statistical Significance: **p<0.001, *p<0.05

Omitted Categories: *Eastern; tRural; 50; 13; *No alcohol use; *Muslim

References
Executive Summary
From November 2002 through February 2003, Population Services International (PSI) executed an aggressive, innovative communications campaign in Mumbai, as part of an integrated behavioural change HIV/AIDS prevention programme entitled Operation Lighthouse. The Operation Lighthouse project is being implemented in 12 major port communities across India with the financial support of the United States Agency for International Development (USAID) through the AIDSMark funding mechanism.

The campaign was based on consumer research analysis that suggested daunting HIV infection rates coupled with flawed risk perception as being widely prevalent, especially among the poorest sectors of the bustling Indian metropolis of Mumbai.

The foundation of the campaign was the principle that people can learn by observing the behaviour of others (i.e., the Social Learning Theory of Albert Bandura), on the basis of which PSI and its advertising agency, Lowe, created an ‘alter-ego’ in the form of a fictional character named Balbir Pasha. Through a mixture of strategically placed outdoor communications, hard-hitting television and radio messaging, and comprehensive newspaper exposure, this character was quite visibly portrayed in various intriguing scenarios, serving as a behavioural model for consumers of Mumbai mass media to relate to, learn from, and empathize with. By gradually unraveling each of the Balbir Pasha scenarios in an approachable and familiar manner, the campaign succeeded in building intrigue, personalizing HIV risk, and bringing the topic of HIV/AIDS ‘out of the closet’ in a way that previous didactic HIV/AIDS communications campaigns in India had not done.

In addition to strategic media creation and placement, the successful integration of support services—promotion of an HIV/AIDS help-line, promotion of voluntary counselling and HIV testing services, and on-the-ground interpersonal communications—were hallmarks of this campaign. Though faced with some criticism for its cutting-edge frankness, impact studies and other data demonstrated that the campaign achieved phenomenal reach, and that those exposed to its messages exhibited marked knowledge acquisition, attitude change, understanding of risk, and behavioural change with regard to HIV/AIDS.
Situational Analysis: Context of HIV/AIDS in India

India is poised on the precipice of a devastating HIV/AIDS epidemic. Fifteen years after the first case of AIDS was reported in India, it is now home to the second-largest number of HIV-infected people in the world. Although national HIV prevalence currently hovers at about 1 percent, the sheer volume of cases in this country of 1 billion people makes India’s AIDS problem explosive, particularly in certain states where the epidemic has been localized since the earliest stages of the epidemic. In the states of Maharashtra (where the Balbir Pasha campaign was launched), Tamil Nadu, Karnataka, Andhra Pradesh, Manipur, and Nagaland, over 1 percent of antenatal women tested positive for HIV infection. The latest estimates by the Indian government and international agencies suggest that there are now 3.5 to 4 million HIV-positive Indians. Although intensive efforts to promote awareness of HIV/AIDS have been made, the disease remains widely misunderstood in India.

Given the stage of the epidemic, it is clear that HIV/AIDS incidence is escalating in high-risk groups such as sex workers (SWs) and truckers. Tragically, key bridging populations (for example, clients of SWs) are rapidly expanding the reach of the epidemic into the general population. In fact, data from sentinel sites in Maharashtra suggest a time lag of just two to three years for HIV infection to spread from high-risk groups such as sex workers to their clients, who in turn can infect their non-commercial partners such as wives and/or lovers. If not addressed immediately, the total number of HIV-infected people in India could skyrocket to 35 million over the next five years, nearly doubling the total number of HIV infections globally.

Approximately 80 percent of HIV cases in India have been attributed to heterosexual encounters. Mumbai sits at the epicentre of India’s HIV/AIDS problem and has been the city ravaged most by the disease. A review of existing research reveals high-risk attitudes and behaviour prevail among men in the lower socio-economic groups in Mumbai. This city is home to the largest brothel-based SW area (“red light district”) in India, and therefore, most HIV/AIDS preventions in Mumbai have focused on educating and empowering the 6,000–10,000 SWs in the district with varying degrees of success. However, very little work has been done in motivating the clients of sex workers to practise safe sex across the city in a sustained and effective manner.

Operation Lighthouse

With funding from USAID, PSI is currently implementing a five-year (2001–2005) HIV/AIDS/STI intervention programme in India: Operation Lighthouse (OPL). This national programme is being implemented across 12 port communities along the east and west coasts of India, with a core technical team coordinating the activities from Mumbai. This programme deploys a set of integrated communications and service provision strategies to decrease the spread of the epidemic among vulnerable groups associated with the port facilities. Supporting this effort is an advocacy component targeted to the senior management staff of the ports, related industries, and the local government and public health facilities. This component is designed to support the institution of supportive HIV/AIDS workplace policies and the extension of communications and education programmes for employees.
The project has documented notable success, including the inception of targeted communications activities in all port communities, expansion of condom access in areas of high-risk behaviour, the creation of mobile or conveniently-located voluntary counselling and testing (VCT) facilities for vulnerable populations, and, most notable for the purposes of this case study, the development and dissemination of a groundbreaking, mass media campaign targeted to men in Mumbai.

Underlying programme success is the PSI/OPL team’s ability to conceive, implement, and monitor integrated HIV-prevention programmes in cities separated by great distances. This allows PSI to target resources effectively in the Indian context, where concentrated epidemics of varying severity are separated by vast geographical, socio-cultural, and linguistic divides but connected by vulnerable, migratory populations.

In sum, OPL is a behavioural change project designed to promote safer sexual practices among those with multiple partners, particularly those who engage in commercial sex.

Three principles guide the OPL approach

**Targeting**
When achieved, targeting allocates scarce resources to activities that promise the highest impact among those likely to contract and transmit the virus. This concept is upheld in designing all of OPL’s activities, from communications to counselling.

**Integration**
In an integrated approach, mass media, mid-media, and inter-personal communications are designed to inform, motivate, and create demand for services and products, which include phone help-lines, STI and VCT services, and condoms.

**Information**
Changing behaviour is an iterative process, demanding an ever-expanding base of knowledge across a wide range of topics, including beliefs and habits, socio-cultural characteristics affecting gender and empowerment, patterns of migration, and sexual behaviour. Over time, steady production, analysis, and use of good information feeds into continuous programme improvement.

The Campaign

1. Inherent Communications Challenges: *Breaking the mold*
The design and implementation of a hard-hitting communications campaign tackling a sensitive issue such as HIV/AIDS in the current socio-political context of India poses some key challenges. Until now, health communications campaigns in India, particularly HIV/AIDS communications, were largely informative/educational in nature and rarely addressed the consumer directly (e.g., “Let’s keep Mumbai AIDS-free” or “HIV/AIDS does not spread through touch”). These bland approaches, which were neither engaging nor consumer-oriented, have, perhaps complacently so, set the standard for the limited HIV/AIDS communications work in India.
Further, HIV/AIDS communications campaigns, in general, have perpetually portrayed the disease in a completely morbid and fearful manner. They have used scare tactics to warn the consumer about “the killer disease,” rather than offering positive preventive messaging. Such messages tend to further distance the consumer from the messages as they allow people to naturally seek the security of the “it can’t happen to me” mindset.

Therefore, it is quite evident that perhaps most debilitating to the goal of HIV/AIDS communications is the fact that although the Indian public, particularly urban populations such as that of Mumbai have some basic knowledge regarding HIV/AIDS, communications campaigns have failed to personalize risk for the individual. In other words, there is a significant disconnect between AIDS and the individual consumer, thereby rendering communications messages personally irrelevant and subsequently not being internalized.

2. Campaign Objectives: Filling a need
On the basis of research pertaining to the HIV/AIDS scenario in Mumbai, programme staff determined that young men in Mumbai between the ages of 18 and 40, who hail from lower socio-economic groups and are among the highest risk for HIV infection, should be the primary targets for prevention messages. An extensive mass media HIV/AIDS campaign was designed, to meet the following key objectives:

- To increase perception of HIV/AIDS risk from unprotected sex with non-regular partners by personalizing the message and creating empathy through identifiable real-life situations. (ATTITUDINAL CHANGE)
- To generate discussion about HIV/AIDS among the target populations and opinion leaders in order to facilitate understanding and knowledge acquisition. (CHANGING SOCIAL NORMS)
- To motivate people to access HIV/AIDS help-line and VCT services. (BEHAVIOURAL CHANGE)

Execution: Introducing...Balbir Pasha!
Evolution of a Behavioural Role Model
The bedrock of the campaign was the principle that people can learn by observing the consequences of behaviours of others (the Social Learning Theory of Albert Bandura). An ‘alter ego’ in the form of a fictional character named Balbir Pasha was created as the centerpiece of the campaign. This character was portrayed across various communications channels in intriguing scenarios, serving as a behavioural model for consumers to relate to and empathize with. Using this character, HIV/AIDS messages were conveyed in an approachable and familiar manner, rather than the didactic approach that previous HIV/AIDS communications campaigns have unsuccessfully tried.

Social psychologists such as Bandura argue that observing can lead to behavioural change, especially when behaviour is reinforced by the consequences of the role model’s actions. Therefore, if the manufactured symbolic model of Balbir Pasha
engages in behaviour that may put him at probable risk for HIV/AIDS, the consumer will be vicariously motivated to avoid repeating this behaviour.

**Key Consumer Insights and Campaign Direction**

Data from studies carried out by the Maharashtra State AIDS Control Society (MSACS) reveal that although men in the general population feel clients of SWs are vulnerable to AIDS, they fail to recognize themselves as being at risk for HIV infection. The data point to a strong link between alcohol consumption and high-risk sexual activity, indicate that young men harbor negative attitudes towards condom use, and reveal a failure to recognize asymptomatic “healthy looking” people as potential carriers of the HIV virus.

In order to meet the campaign’s main objectives, three main campaign themes were developed and pre-tested among sexually active males from low socio-economic groups.

- Alcohol and high-risk behaviour: “I often use condoms, but when I get drunk, I sometimes forget.”
- Faith in a “regular” partner: “I only have sex with this one person and hence I am safe.”
- Failure to recognize asymptomatic carrier: “If a person looks healthy, he/she must be safe from HIV/AIDS.”

**Surround and Engage: Effective Media Selection**

The campaign achieved incredible visibility and reach through a strategically developed mix of various media. Executions in the form of print ads, television and radio commercials, and, most visibly, outdoor communications (i.e., billboards, posters in trains and on bus shelters) were launched in five phases over a period of four months. As each phase was revealed progressively, the intrigue and ‘gossip value’ of the campaign increased, akin to the way plots are revealed in a TV soap opera.

With innovative media developed with the advertising agency Lowe, Mumbai was simultaneously inundated from all possible media angles. The extent to which each type of media was used and the placement/timing of each message was directly related to the location and lifestyle of the target population in mind. Baseline research findings uncovered characteristics of the target group of young men in lower socioeconomic status (SES), which helped to define the following strategically placed communications media:

**Outdoor communications in the red light district:** As many men in this target group frequent sex workers, placing messages on billboards and bus shelters in this area helped the campaign achieve high reach and visibility.

**Outdoor communications and public transport:** With over 4 million people travelling the Mumbai train network daily, many of whom are men practising high-risk sexual behaviours, placing posters in trains and at train stations allowed PSI to geographically target this population while also creating a buzz in the general population.
Outdoor communications at cinema halls: The high popularity of Hindi and Marathi films provides an opportunity to communicate complex audiences to a captive audience through the use of various outdoor media, especially as many B and C grade cinema halls are located in areas where this population resides and/or frequents.

Mix of TV and radio channels: As the target group profile is quite heterogeneous with regard to ethnic/language groups, religious communities, socio-economic profiles, and so forth, there was a need to feature messages across a broad mix of television networks and radio stations. This allowed the campaign to reach the general population of Mumbai.

Print media: Next to television, print media has the highest penetration in the target group, and therefore the Balbir Pasha campaign was featured in the major language papers (Hindi/Marathi) available in Mumbai. This promoted high visibility of the campaign’s messages via a medium that allows the consumer to engage himself and ponder as he receives information.

Campaign Rollout

Communication Plan

Teaser: Building Intrigue (Nov. 11, 2002–Nov. 30, 2002)
The first phase of the campaign was aimed at building intrigue and cutting through the clutter of advertising in Mumbai through a cleverly crafted “teaser” campaign. This teaser campaign also served to build intrigue and prepare the campaign for subsequent phases. The teaser campaign, which ran in all media channels discussed above, depicted typical Mumbai lower- and middle-income men asking each other the following question: “Will Balbir Pasha get AIDS?”

The second phase was more strategic, in that it leveraged key insights about a particular target group, specifically young men of lower SES, and composed of three personalized messages targeted at making these individuals question their own behaviour:

Theme 1
The indoor and outdoor media produced contained dialogue and/or text that communicated the following line:
“Balbir Pasha sometimes forgets to use condoms when he is drunk. But by not wearing a condom just one time, it is possible to get AIDS. Will Balbir Pasha get AIDS?”

**Theme 2**
This message, as with the others, appeared in newspapers, on train posters and bus shelters, and via television and radio programming.
“Balbir Pasha only goes to [has sex with] Manjula. But others go to Manjula too. Will Balbir Pasha get AIDS?”

**Theme 3**
The execution of this last ‘main message’ was the first time the Saadhan help-line number was mentioned, almost as a precursor to the final “Connect to Help-line” phase that immediately followed the rollout of this message.
“Balbir Pasha only has ‘relationships’ with healthy-looking people. But you can’t tell by looking who has AIDS. Will Balbir Pasha get AIDS?”

**Connect to Help-line (Jan. 28, 2003–Feb. 11, 2003)**
Following this period of ‘introspection’, the final stage comprised messaging that directly approached consumers, and asked them to access available HIV/AIDS services. The final phase of this campaign was motivating consumers to call the state-of-the-art, quality Saadhan HIV/AIDS help-line that PSI established. During this period, the hoardings (billboards) used in this campaign carried messages such as “I don’t want to become Balbir Pasha. What should I do? Call the Saadhan help-line if you have any questions on HIV/AIDS.”

In this manner, through the careful evolution of communications phases, the campaign aimed to increase perception of HIV/AIDS risk through personalized messages, generate discussion about HIV/AIDS, and motivate people to access HIV/AIDS services.

**The Immediate Response: Bouquets and Some Brickbats**
The astonishing response to the campaign caught both PSI and Lowe, the advertising agency, quite unprepared. While the individuals involved in the development of the campaign knew that they had a “winner,” they were overwhelmed with the volume and quality of discussion that the launch of the campaign generated.

**Creation of an Icon**
One of the most celebrated achievements of the campaign is the way in which the Balbir Pasha icon became entrenched in popular culture, so much so that numerous outside groups and individuals in Mumbai parodied or ‘borrowed’ elements of the ads, and continue to do so.

Amul, one of the nation’s leading dairy co-operatives, cleverly borrowed the concept of ‘regular partner’ in butter advertising, which could be seen throughout Mumbai.
“Whom does Balbir Pasha wake up with every morning? Amul Butter. Regular Item.”
As stated in the January 14, 2003, issue of Mumbai’s Economic Times, “to qualify for an execution in Amul’s long-standing series of satirical topical ads, a campaign must have really made it into the city’s everyday talk.”

Numerous press and TV articles and reports were generated noting the sheer audacity and refreshing boldness of the campaign. For the first month of its launch, the campaign dominated the mind-set of the Mumbai audience as no social communications campaign had ever done in the recent past.

The Balbir Pasha icon has truly become an integral part of popular culture in Mumbai. Four months after the last Balbir Pasha message appeared in the city, the leading English daily featured a cartoon, referring to the worldwide scare of SARS (Severe Acute Respiratory Syndrome). The cartoon replaces the word “AIDS” from the campaign’s well-known tag line, “Will Balbir Pasha get AIDS” with the word “SARS”.

The Balbir Pasha name has even been used in the promotion of an independent film on sex and AIDS and a website containing basic information and frequently asked questions on HIV/AIDS (www.balbirpasha.com), both done by individuals unrelated to PSI.

**Criticisms**

Though the Balbir Pasha campaign achieved phenomenal reach, the attention generated was not all positive. It is important to note that while the teaser campaign and first theme of alcohol and condom use were more readily accepted, a few critics strongly voiced their discontent from the time the second theme of regular partners was introduced. It was at this time that some individuals criticized the campaign for its cutting-edge frankness (“bringing the bedroom into the living room”). This criticism was more specifically aimed at the television commercials that were produced as part of the Balbir Pasha campaign, rather than the outdoor billboards and posters and other communications media. Furthermore, this criticism also speaks to the aforementioned complacency and denial with which HIV/AIDS was spoken about in India prior to the launch of this campaign. Some parents simply did not want to handle the extra burden of having to explain HIV/AIDS to their children, nor did educators want their adolescent students to discuss issues like sex or sexuality among their peers, despite the fact that the epidemic has become a devastating mainstay in Mumbai, as was explained by PSI via press releases and quotes to the groups who voiced these concerns.

Another criticism was that the campaign was perceived to be “anti-women” as it depicted that the male character (Balbir Pasha) could be at risk for AIDS since he is having unprotected sex with a woman (Manjula), thereby implying that HIV is passed on from the woman to the man. This concern was particularly voiced after the second theme of the campaign, in which it is suggested that Balbir’s “regular” partner Manjula has several “regulars” of her own. In addition to women named Manjula who took personal offense (and called the Saadhan help-line to express their outrage), some women’s groups made a point to argue that as the name Manjula is a
Hindu name, the campaign targeted this specific religious group. PSI staff responded by explaining that rather than trying to stigmatize women working in the commercial sex industry, the campaign aimed to protect them, by motivating their male clients to adopt safer sex practices. This principle follows the UNAIDS approach of ‘men make a difference’, which places greater responsibility on men to change attitudes and behaviour, which in turn would enable the empowerment of women necessary for protection from HIV infection.

Still others felt that the campaign was not “complete” as they felt it only focused on the heterosexual mode of transmission of HIV/AIDS. The Mumbai NGO sector in particular felt the campaign did not address the behaviour of men having sex with men, intravenous drug use, or pre-natal HIV testing. These complaints expose an important deficiency among parties that were most vocal on this issue (i.e., lack of a basic health communications understanding, which advises a streamlining of messages within one campaign). PSI staff responded to this criticism during meetings with various NGO members, explaining that future Balbir Pasha phases were planned to address the other modes of transmission, target groups, and so on, but that research supported the prioritization of young sexually active men.

Below are the main complaints raised and how they were handled:

**Maharashtra State Commission of Women (MSCW):** At a meeting in January 2003, the MSCW asked PSI to withdraw the campaign after a very superficial discussion with key PSI staff members. PSI representatives were neither given the rationale for this decision nor were they given an adequate opportunity to defend the campaign. PSI requested the MSCW to put down their concerns in writing and clarify what rules/laws the campaign had broken. No response was obtained from the MSCW. However, as a note of respect to the chairperson of the commission, PSI agreed to end the theme-based campaign four days earlier than planned.

**Ministry of Health (MoH), Government of Maharashtra:** PSI was asked to defend the campaign to a senior MoH representative in early January. The representative had an open and meaningful discussion with the PSI team and concluded that the campaign was appropriate. However, a member of the Legislative Assembly, Government of Maharashtra brought up concerns about the campaign to the attention of the minister of health. PSI has not heard officially from the MOH on this matter.

**Advertising Standards Council of India (ASCI):** Upon receipt of a complaint, ASCI asked PSI to defend its campaign. PSI submitted a written defense of the campaign. ASCI subsequently notified PSI that the complaint had not been upheld upon review of the material submitted by PSI. It should be noted that the support to PSI given by all USAID staff when faced with this criticism was excellent. USAID staff (from the PHN team and the mission director/deputy director) understood and supported the position taken by PSI.

**Significant Consumer Impact**

Notwithstanding the criticism, the direct impact of the campaign on the target group with regard to the campaign’s objectives has been extremely impressive. PSI
commissioned an independent research agency, TNS MODE, to conduct an evaluation of the impact of the campaign, which pointed to the key successes of the Balbir Pasha campaign. In order to evaluate the campaign’s effectiveness, TNS MODE gathered data from interviews with individuals belonging to the target group at two specific points in time: in November, prior to the launch of the Balbir Pasha campaign, and again in mid-February through early March, immediately following the last phase of the campaign.

The sampling method used was street intercepts around the city, particularly in the red light district to ensure representation of men visiting sex workers. Individuals were interviewed with the purpose in mind of evaluating three specific aspects of the campaign: the messages’ noticeability, comprehension of the various executions, and the subsequent attitudinal/behavioural change that may/may not have resulted after being exposed to the campaign:

**Noticeability:** Following the execution of the campaign, one in every four respondents (25 percent) that were included in the evaluation recalled Balbir Pasha spontaneously. This demonstrates incredible brand recall when compared with similar estimates for major commercial brands that have been heavily advertising for decades, such as Pepsi (28 percent spontaneous recall), Honda (10 percent), and Colgate (18 percent). In addition to recognizing the name, respondents also were able to link Balbir Pasha with the issue of HIV/AIDS.

After running for just four months, the campaign most likely achieved such high noticeability within a relatively short period due to an optimal mix of mass media coupled with the teaser campaign which built intrigue and made the public familiar with the name Balbir Pasha. Most respondents identified their source of recall as posters in trains (85 percent), while billboards (hoardings), TV, and newspaper also aided in message recall. Further analysis shows that over half of the respondents recalled the main message of the campaign.

**Comprehension:** The Balbir Pasha campaign was also evaluated on the extent to which the target consumer understood the messages. As one of the objectives of the campaign was to promote condom usage as a preventive method, it is notable that over one-third of respondents stated that one should not engage in sexual intercourse with non-regular partners without a condom after being exposed to the campaign’s messages. Additionally, the impact evaluation highlighted the fact that a majority of individuals interviewed found the campaign both interesting and useful (74 percent) as well as recognizing Balbir’s story as believable (88 percent). If individuals reacted so positively to the messages, there is a greater likelihood that they would be better able to personalize HIV risk and internalize the campaign’s messages.

**Attitudinal/Behavioural Change:** Perhaps one of the hardest-to-reach expectations for a mass media campaign is behavioural change, though “Balbir Pasha” did achieve remarkable successes in this regard. Most notable among the attitudinal changes are the respondents’ perceptions about their personal HIV risk with regard to their sex partners. Among those individuals who report visiting sex workers, there were
tremendous shifts in risk perception from the baseline data collected in November, compared with corresponding data collected after the campaign ended. At the time of the baseline evaluation, only 39 percent of men interviewed considered themselves at risk for HIV if they visited only “healthy-looking” sex workers, but this number jumped to 56 percent following the execution of the Balbir Pasha campaign.

The campaign aimed to bring AIDS into the forefront of public consciousness and provide information about HIV/AIDS resources to consumers. Therefore, an evaluation of the overall effectiveness of the campaign would require an analysis of its progress towards these two ends. It is quite promising that more than half (54 percent) of respondents recalled having discussed “Balbir Pasha” with somebody else, which speaks to the extent to which discussion of HIV/AIDS would have entered the public sphere. Also notable is the fact that more than one-fourth of respondents (28 percent) recalled the name of PSI’s confidential Saadhan HIV/AIDS help-line that was featured as part of the Balbir Pasha campaign, and 60 percent of respondents stated that they might call it in the future. Indeed, calls to the help-line were measured before the start of the mass media campaign, and again when the campaign ended; this comparison uncovered a 250-percent increase in the number of calls to the Saadhan help-line following the execution of the Balbir Pasha campaign.

To summarize, among the most salient indicators of success for the Balbir Pasha campaign are the following:

- Increased risk perception among those exposed to the campaign
  - Proportion of target audience who have sex with sex workers who feel they are at high risk for HIV if they have unprotected sex with a non-commercial partner increases from 17 percent to 43 percent.
  - Proportion of target audience who feel at risk for HIV if they have sex with “healthy-looking” sex workers increases from 39 percent to 56 percent, while risk associated with “expensive” sex workers increases from 50 percent to 72 percent.
- Increased tendency to discuss HIV/AIDS with others
  - More than half of the target audience report having discussed the Balbir Pasha ad campaign with someone else.
- Increase in number of people accessing HIV/AIDS prevention products and services
  - 250-percent increase in number of calls to PSI’s Saadhan HIV/AIDS helpline, and shift in types of queries from superficial to more invasive and informed.
  - Increase in proportion of individuals reporting last-time condom usage with sex workers from 87 percent to 92 percent.
  - Retail sales of condoms in the red light district, the priority focus area for the campaign, tripled after the launch of the campaign compared with before it started.

**Why Was Balbir So Successful?**

Although the impact evaluation clearly demonstrates the incredible impact that the Balbir Pasha campaign achieved, it is also important to understand the reasons for
this success, in order to assist future replications of a similar communications strategy. An analysis of the process that six main elements of the campaign contributed to its phenomenal success:

1. **Consumer insight:** The Balbir Pasha campaign was built on the basis of an in-depth study of the target consumer, his behaviours, knowledge, and lifestyle. By developing a character that the target consumer could relate to, the campaign was able to personalize HIV risk, which resulted in attitudinal shifts among those exposed to the messages.

2. **Building of intrigue:** Much of the reason the campaign’s main messages made such an impact in Mumbai is attributable to the intrigue that was built up by the preceding teaser campaign. This allowed the public to get familiar with the name Balbir Pasha and gave the target consumer the opportunity to form a relationship with this character before the main precautionary HIV/AIDS messages were introduced.

3. **Optimal media mix:** As mentioned earlier, a variety of communications media were utilized in order to effectively target the consumer in mind. The use of outdoor media, such as train posters, billboards, and so on was especially relevant to achieving the high visibility of the campaign’s messages.

4. **Link with on-the-ground activities:** Associating each phase of the Balbir Pasha campaign with the promotion of the Saadhan help-line, the themes of interpersonal communication, and the provision of voluntary counselling and testing services ensured valuable synergies.

5. **Infiltration into popular culture:** The infiltration of “Balbir Pasha” into street-talk, independent art projects, other advertising campaigns, and so forth further provided a ‘hook’ for the target consumer to relate to and personalize HIV risk.

6. **Hard-hitting messages:** Although criticized by some for their relative frankness, PSI managed to deliver HIV/AIDS messages in a way that spoke directly to the target consumer, rather than attempting to passively persuade the consumer as previous HIV/AIDS communications had unsuccessfully done.

**Lessons Learnt**

Following the execution of this revolutionary communications campaign, several lessons were learned, pertaining to better handling of criticism, implications for replicating such a strategy in other locales, and developing an implementation plan for the continuation of Balbir Pasha messaging.

It is difficult to predict the reception of this mass media campaign in other communities outside of Mumbai, since much of the campaign’s replicability depends on prevalent attitudes in that community regarding HIV/AIDS. For example, in other Indian cities not facing such a devastating AIDS epidemic, lethargy and distance from the issue of HIV/AIDS might allow the Balbir Pasha campaign to be
executed fairly quietly, without much criticism from other NGOs or the public which will not relate to the messages. This may not be altogether a positive development, as often, the level of controversy stirred indicates the extent to which the campaign has permeated the public’s attention. However, in a town where there has been very little public information provision or discussion about HIV/AIDS, such a bold campaign could generate criticism and anger, which could ultimately be devastating to its cause.

Therefore, aside from understanding the factors that did allow the campaign to succeed relatively well in Mumbai, the most important lesson to learn from the execution of the Balbir Pasha campaign would be on how to handle criticism of future campaigns from NGOs and other organizations. It may serve PSI well to take one or two key stakeholders in a city into confidence prior to reintroducing “Balbir” into Mumbai, in order to build up an ally base that can help protect the full execution of the campaign messages. It is important not to have these individuals dictate the course of the campaign, but rather to help mediate criticism from those who may react negatively on the basis of envy, misinformation, or misunderstanding of the campaign’s objectives. Having stated this, it is also very important to take into consideration the sentiments of individuals who may be exposed to campaign messages, and control the hype that media campaigns can create by determining appropriate compromises that will ultimately benefit the cause of HIV/AIDS communications. By ending the campaign earlier than initially intended with messaging about the Saadhan help-line, PSI communicated that it was concerned about the sentiments of those who were offended. This step also legitimized the objective of the campaign by providing “solutions”, services, and resources for a public that had just been encouraged to seek more information about HIV/AIDS.

As PSI is working on the next phase of this campaign, to be launched in Mumbai in the last quarter of 2003, and also planning to take this campaign to other towns, these lessons should be kept in mind.

Defining Media Advocacy
Recognizing the critical role media plays in shaping policy and public opinion, media advocacy is defined as the partnering with news outlets in print and electronic media to gain an informed and sensitive media discourse on HIV/AIDS.

Flagging Key Issues for Media Advocacy

Any media advocacy initiative must:
- Recognize HIV/AIDS as a development concern
- Deal with linkages such as migration, poverty, adolescence, women’s rights, children Make issues collaborative and holistic rather than competitive and fragmented
- Ensure that vulnerable groups are not stigmatized further
- Put people affected by HIV/AIDS at the centre of the advocacy
- Constantly provide positive groups empathetic space in media.

Media Scan: What the Media Are Saying About HIV/AIDS in Uttar Pradesh (UP)
At present, the prevalence of HIV/AIDS is low in the state. Vulnerability factors like high migration, a large population, and a poor development index exist. The current status is the tip of an iceberg—more an indication of ineffective surveillance.

“The number of people suffering from AIDS in Uttar Pradesh has risen to 316 this year as against 185 in 1998, official sources say. Unofficial reports, however, claim the figure is much higher as several patients who get treatment done at private clinics and the undiagnosed ones do not get registered in government records. However, the State’s average was far below the national figures which stood at around 3.5 million till March 2001.” (National Herald, August 3, 2001)

Issues like violence against women and dalits in UP have received media attention strengthening public opinion on the difficult circumstances in the state. News reports from Jharkhand and Bihar suggest that migrants to metropolitan areas are bringing infections back to rural areas. There is a sense this may also be true of UP.
“Penury and the hope of a better life are driving hundreds from a rural pocket of Jharkhand to faraway cities in search of work only to be locked in the deadly embrace of AIDS. Local activists say the disease is slowly making a firm grip in this area of Hazaribagh but the State government refuses to accept the magnitude of the threat. Family after family has been silently falling victim to the scourge. Migration from here to metropolitan cities like Mumbai, Delhi, Kolkata for a living is common.” (Free Press Journal, Mumbai, December 8, 2002)

Other media stories include the following:
“Noida patients being sent to Meerut for tests: Since there are no government facilities in the district for HIV testing, the alternative is quacks or private labs.” (The Times of India, New Delhi, October 15, 2002)

Doctors get AIDS: “Four doctors in two medical colleges of the State were infected with HIV virus, which causes the dreaded AIDS disease during treatment of patients, a top official said. Project director Uttar Pradesh AIDS Control Society Bachittar Singh added that the doctors were immediately administered post exposure profilaxis and were now out of danger.” (Indian Express, Chennai, August 30, 2001)

“The porous India-Nepal border is an HIV/AIDS bomb waiting to explode, says a new finding which blames the spread of the disease on sex workers, narcotics traffickers and drug addicts. The survey conducted by UPSACS says the region could see the outbreak of an HIV/AIDS epidemic and needs immediate attention. Said Bachittar Singh, director, UPSACS: In spite of aggressive efforts, the danger of importing AIDS from neighbouring states and countries is a stumbling block.” (The Pioneer, Lucknow, January 14, 2003)

◆ The lack of HIV testing facilities in places like Noida and Ghaziabad are forcing people to visit private labs or quacks.
◆ The story from Kanpur Medical College of doctors getting infected while treating an infected person received wide coverage.
◆ HIV/AIDS has been linked with trafficking at the India-Nepal border.

What is emerging most strongly is:
◆ The state and public are unprepared to respond to HIV/AIDS.
◆ There is a feeling that, if the epidemic takes root in UP, given high vulnerability factors, it will be very difficult to contain.
◆ Finally, that in all probability the state is experiencing a silent epidemic.

Good practices and breakthroughs that have received media attention include:
◆ Awareness building campaigns like the BBC World Service Campaign
◆ The Kalyani programme on Doordarshan
◆ Emerging practices like the prison intervention in Kanpur.

“The BBC-NACO project will be the largest broadcast campaign in terms of volume and output ever mounted. “ (The Pioneer, July 8, 2002)

DD, BBC tie-up to take on AIDS: Watch Doordarshan in a polished avatar, thanks to a partnership with the BBC World Service and National AIDS Control Organisation. Part
of one of the most intensive and expensive AIDS media campaigns in the world, viewers in Delhi, Uttar Pradesh and Rajasthan can now watch a tri-weekly detective series, a reality show and nine advertising spots in regional languages to create AIDS awareness.” (Indian Express, New Delhi, July 11, 2002)

Using Gaps in Coverage as an Opportunity
Given the current media scan, if we were to use the gaps in coverage as an opportunity to reverse how the media project HIV/AIDS in UP, the following concerted advocacy would be needed:

- Take media into confidence about the nature of the challenges.
- Impress on the media that HIV/AIDS needs to be addressed as a development problem—it cannot be reduced to only a clinical issue.
- Build genuine appreciation of the interventions and challenges.
- Make the response/interventions transparent.
- Consciously put out initiatives in the making. (At present even good interventions are not emerging.)
- Work with trusted outlets so they understand the odds.

Sample Model for Media Advocacy on HIV/AIDS: The multi-pronged approach
1. Know the media
   Use media clippings to:

- Assess public opinion for secondary research
- Keep abreast of new programmatic interventions; emerging spokespersons
- Create a database of journalists
- Constantly update the database to include new outlets and writers
- Identify new spaces and new outlets.

“There has been some valid criticism of the sentinel surveys which have yielded estimates of a large HIV/AIDS population for India. Based as they are on prevalence rates among particular socio-economic groups and in specific geographic areas, there is scope for errors in projections of the future incidence of the virus. However, once the virus takes root in a populous country, there is no escaping its spread across a large population. This is what is happening in India and has begun to happen in China as well.” (Edit, The Hindu, December 2, 2002)

2. Engage the media
   - Establish a rapport with journalists.
   - Build an information base of journalists by facilitating
     - Press briefings with experts
     - Media visits to programme sites

“Making them aware, Uttar Pradesh leads the way: For UPSACS, the project in the Kanpur prison has become a ‘pet project’ and a role model for many other prisons in the
State. It is already being implemented in three prisons including Lucknow. The UPSACS officials have approached the State Jail Department urging them to extend the programme to all 68 prisons in 70 districts in a phased manner. (New Indian Express, December 1, 2002; News feature based on a visit to a programme site)

3. Voices from the ground
- Ensure that voices from the ground, from surveys, studies, field-based research, find a space on mainstream media.

4. Research and documentation
- Create media background briefs on a range of issues (e.g., legal rights, safe blood norms, gender and HIV/AIDS).
- Create a story bank for project sites which can be visited.
- Liaise with civil society groups working on the issue and collect data from them.

5. Facilitate civil society dialogue across institutions and sectors
Organize symposiums, workshops, and seminars to create a unified response and ownership.

Example: Event-based Advocacy

The advocacy was pegged to an event of national importance bringing together legislators from across the country. Participants included political leadership from the highest quarters, the UNAIDS global director, HIV/AIDS experts, and people living with HIV/AIDS.

As media advocates, we used the opportunity to make visible a wide range of concerns around the issue.

What worked:
- Working closely with the PFA; identifying spokespersons and ensuring consistency of media messages.
- Preparing a range of media backgrounders, press releases, and media materials.
- Translating media materials into Hindi.
- Pre-event press briefing generated curtain-raisers; press conference for the event resulted in wide coverage.
- NACO’s release of sentinel surveillance data at the same time gave another news peg.
- Arranged media interviews with visiting leaders, experts, and positive people for different media outlets.
- Worked closely with channels to carve stories: BBC’s in-depth story on the event gave a human dimension to the issue; P. Kousalya, Positive Women’s Network, Chennai, was interviewed.
Key Lessons Learnt

- Take media into confidence about the nature of the challenges
- Consciously put out initiatives in the making
- Partner with trusted outlets so that they understand the odds.

Any media advocacy initiative must:

- Recognize HIV/AIDS as a development concern and deal with linkages such as migration, poverty, adolescence, women’s rights, children.
- Ensure that vulnerable groups are not stigmatized further.
- Put people affected by HIV/AIDS at the centre of the advocacy and constantly provide positive groups empathetic space in media.
Successful Interventions in India

Chairperson
Rajendra Bhanwal

HIV/AIDS prevention programmes with sex workers in Tamil Nadu
R. Lakshmibai

Working with MSM in South Asia: A Model of Best Practice
Arif Jafar

Injecting Drug Use: How Uttar Pradesh can learn from the Experiences of Other States in India
Samiran Panda

Discussants
Randy Kolstad and Pawan Dhall
Prevention of HIV/AIDS in Uttar Pradesh
Background

The AIDS Prevention and Control (APAC) Project has been implementing HIV/AIDS prevention programmes in Tamil Nadu since 1996, with financial support from the United States Agency for International Development (USAID). The project’s main goal is to reduce the sexual transmission of HIV/AIDS. This project has been in place for the past eight years.

Targeted interventions were carried out with various vulnerable groups, including sex workers (SWs) and their client populations. The AIDS Prevention and Control (APAC) programme provided technical support to non-governmental organizations (NGOs) implementing targeted interventions and had programmes designed to improve the quality of treatment for sexually transmitted infections (STIs) and to supply condoms in intervention areas.

The Need for Prevention Programmes with SWs

Research studies indicate that women are more vulnerable to infection than men due to anatomical and sociological factors. Among sex workers, the frequency of exposure to STIs/HIV through sexual intercourse is high. Sex workers must be empowered to negotiate condom usage with clients who refuse to wear condoms. The importance of condom usage in all sexual encounters and treatment-seeking should be stressed. This necessitates the implementation of holistic, participatory, gender-specific, and cultural sensitivity prevention programmes among women who are involved in the sex trade.

A prevention programme with SWs in Tamil Nadu was challenging for various reasons. First, the sex trade is not organized, as it is in other states like Kolkata and Mumbai. It is hidden from the general community. Second, the sex trade is an age-old profession—it was related to religious practices in the early days and was institutionalized in the devadasi system. When the Suppression of Immoral Traffic Act (SITA) and Immoral Traffic Prevention Act (ITPA) were passed in 1956 and 1986, respectively, prostitution went underground. Because the sex trade does not have legal or social acceptance in Tamil Nadu, it is practised secretly. Therefore, suitable strategies and innovative activities designed to reach out to SWs were difficult to put into place.
Prevention Programmes
APAC supported 16 NGO partners in implementing prevention programmes. These prevention programmes were selected based on the density of sex workers in the 16 locations. APAC’s NGO partners had prior experience implementing HIV/AIDS prevention programmes. The NGO partners conducted a needs assessment study to adequately understand the various issues related to programme implementation. They incorporated the intervention components of APAC as per the needs of the target community in their intervention area. Since SWs are socially disadvantaged, prevention programmes were designed holistically, integrating APAC-funded STI/HIV/AIDS prevention activities with other on-going programmes—such as health and non-formal education—and training in economic activities, micro-enterprise, education, and child care.

The Target Community
The prevention programmes classified the target community into primary and secondary groups. The primary target group was composed of SWs, including occasional or seasonal sex workers. The secondary target group was composed of pimps, brokers, lodge owners and boys, auto and rickshaw drivers, and brothel owners. Target community service providers, including health care providers, condom retailers, and pharmacists, were also addressed by the programmes.

Objectives of the Prevention Programmes
The prevention programmes had both long-term and short-term development objectives. The long-term objectives are:
- Reduction in STI/HIV/AIDS infection and re-infection among commercial sex workers
- Perceptible change in their behavioural pattern

The short-term objectives include:
- Increasing awareness of STI/HIV/AIDS among sex workers
- Increasing health-seeking behaviour
- Stressing the importance of quality treatment for STIs from a qualified doctor
- Promoting safe sex behavioural practices
- Increasing knowledge of correct condom usage
- Stressing the importance of treatment of a live-in partner
- Organizing sex workers into self-help groups

Prevention programmes targeted secondary and service provider groups as key sources of communication and providers of care services.

Strategies Adopted
The main strategies that were adopted to achieve the above objectives are:
- Communication/education for behavioural change
- Condom availability and promotion
- Quality STI services
- Peer promotion
- Advocacy
Capacity Building of NGO Partners
The NGO partners were given special skills to implement prevention programmes among SWs. Intensive capacity-building exercises were conducted in the early phases of the programme. Several of the capacity-building activities are listed below:
- Orientation for NGO partners on intervention with sex workers
- Training on situational assessment/ethnographic mapping
- Training of health care providers on quality STI care by the Continuing Education and Training Centre (CETC)
- Training of counsellors
- Training-of-Trainers for NGO staff on street theatre
- Training on social marketing of condoms
- Training of condom retailers

Service Delivery to the Target Group
Mapping and Assessment Study
Prevention programmes started with a situational assessment study made by an NGO. The study helped in understanding the nature and extent of the problem in a target area. Then mapping exercises were done in various geographical locations to identify the size/site of the target community.

Enabling Environment
In implementing prevention activities, effort must be taken to create an enabling environment in the targeted locations. NGOs should establish a rapport with key individuals who influence the target population, like law enforcement authorities, local leaders, and health care providers.

NGOs can educate health care providers, policymakers, police, and others directly or indirectly associated with SWs, to be sensitive to the special needs and problems of this target group. In already-implemented prevention programmes, intensive interaction with health care providers focused on eliminating the stigmatized attitude towards SWs. The police force also received sensitivity training on HIV/AIDS-related issues to help enable the easy implementation of prevention programmes.

Outreach Work
The foundation for the implementation of intervention activities was the outreach work done with SWs and other key individuals. The outreach worker moved around the community where SWs were available—places like brothels, lodges, pick-up spots, and so forth. Outreach education focused on increasing knowledge of STIs, HIV/AIDS, condom usage, and the early treatment of STIs. Outreach workers facilitated quality STI care and other support services, as well as one-on-one communication with SWs. All target groups were addressed by outreach workers.

Educational efforts included one-on-one interaction, discussions at the group level, and meetings with the target community. Educational materials prepared by APAC were used in educating the target community. Materials commonly used in the field included flip charts on STI symptoms, condom negotiation, and so forth.
**Peer Promotion**

Peer education is an important component of any prevention programme. Outreach work helps to identify peer educators from a community who can promote the intervention. Peer education is an informal, low-cost method of education and allows culturally sensitive messages to be delivered by a member of the community who is working to benefit the target group. Peer educators should be easily accessible to the target group, be able to influence the majority of his/her peers, and show concern for the health of his/her peers. He or she must also have good inter-personal communication skills and speak the language of the target group.

Peers effectively changed the behaviour of sex workers, and increased the possibility of sustained behavioural change. Sensitive messages can only be passed on to target communities without stigma through a respected peer. Peer promotion involves less cost when compared with other approaches. Peer training was conceptualized by APAC, and an NGO support organization was identified to train NGO staff on peer education.

Peer educators were trained on the basic facts of STIs and HIV/AIDS. These peer educators in turn motivated and trained their peers to adopt safe sex practices, enhance condom negotiation skills, and seek appropriate treatment for STIs. Peer educators met regularly at self-initiated associations and conventions held by the NGOs.

**Counselling Services**

Drop-in centres were established to serve several functions. The centres allow individuals to receive counselling by trained counsellors, distribute condoms, and serve as spaces for small focus group discussions, SW meetings, and audio visual programmes. These centres were established in locations where SWs can comfortably access the services when convenient to them. The centres’ counsellors are all trained by APAC support organizations.

**Condom Promotion**

APAC has adopted a multi-pronged approach to promoting distribution, sales, and usage of condoms. APAC collaborates with the private sector to increase production volume and distribution and motivates retailers to sell condoms. NGO partners motivate non-traditional retailers to stock and sell condoms as well.

Educational outreach stressed the consequences of unprotected sex to target communities, specifically in the form of STIs, HIV/AIDS, and pregnancy. Social workers and peer educators demonstrated correct condom usage to the target audience. Outreach workers ensured the availability of all brands of condoms at outlets convenient for SWs and their clients. Potential outlets for stocking condoms were identified and were encouraged to stock condoms.

**STI Referral Services**

The main objective of STI prevention and control is to make high-quality STI services more accessible to SWs. NGO partners promoted outreach work that helped improve SW access to comprehensive STI care services. The programme motivated
STI health care providers to undergo training programmes in quality STI care, to provide comprehensive services to STI patients and their live-in partners, and to stress condom usage.

**Support Services**

Since SWs are socially disadvantaged, NGO projects have designed their interventions to address sex worker needs holistically. NGOs have initiated activities that integrate STI/HIV/AIDS prevention with other on-going activities, including micro-enterprise, education, and child care. Several of the innovative activities initiated by APAC’s NGO partners have been a thrift society, a care home for orphans and the destitute, and economic development activities. Special efforts are taken to empower SWs to recognize their health and economic rights and to say no to unsafe sex.

**Research**

APAC conducted research studies to strengthen and monitor the existing interventions. Since 1996, eight waves of Behaviour Surveillance Surveys (BSS) have been conducted. The main objective of the surveys is to obtain trends in sexual behaviour and to determine knowledge of STIs and STI-prevention methods. Highlights of these surveys are presented in this paper.

**Demographic Profile of Sex Workers**

The demographic profile of SWs remained the same in all waves of the BSS. The mean age in the last wave was 30.7 years (Figure 1).

More than three-fifths of SWs are involved in the full-time sex trade. Part-time sex workers are involved in occupations like vegetable/fruit/flower sellers, construction workers, agricultural coolies, and housemaids (Figure 2).

The mean number of working days of SWs has increased in the last year by five days per month (Figure 3).
There is no major difference in the average number of clients SWs encountered in their last working day (Figure 4).

SW knowledge of HIV/AIDS prevention methods continues to remain high in Tamil Nadu (Figure 5).

However, correct knowledge of HIV/AIDS prevention has reduced considerably from the year 2000, with only a slight increase (8%) in 2003 (Figure 6).

The increasing spread of HIV/AIDS-prevention misconceptions among SWs is a result of a belief in magical remedies offered by “quacks” and unauthorized medical service providers (Figure 6).

Interestingly, SWs have learned to negotiate condom usage with their clients. As intervention programmes in the last year have focused on imparting negotiation skills to SWs, the above graph shows that a higher proportion of SWs reported that they refuse unsafe sex and generally re-negotiate condom usage (Figure 7).

Voluntary condom procurement levels among SWs have increased continuously over the last eight years. A significant increase in recent years is shown (Figure 8).

Prevention programmes have been successful in increasing condom usage among SWs from 56 percent to 87.5 percent. In 1998, sex workers were not using condoms with their regular clients. When the programme began to promote safe-sex messages targeting regular clients, condom usage increased from 51.5 percent to 87 percent. However, condom usage with a live-in partner is still at only 28.5 percent (Figure 9).
Among SWs who did not use condoms, the perception of risk of contracting STIs has increased from 60 percent to 87.5 percent (Figure 10).

**Future Challenges**

Ethnographic mapping conducted every year by APAC shows that the number of SWs is increasing. The first challenge is to increase coverage of sex workers in prevention programmes. It is important to understand the changing dynamics of the sex trade in order to strengthen the programme accordingly.

High numbers of SWs (64.75%) get tested for HIV voluntarily. Seventy-six percent have also sought counselling. However, it is important that counselling services be strengthened to bring about a change in the quality of life of sex workers.

New misconceptions continue to arise among SWs that may affect their consistent safe sex practices. Therefore, it is important to address these misconceptions in one-on-one education. Many sex workers who are HIV-positive must be addressed by care programmes. It is very important to sustain behavioural changes which have occurred among SWs.
Introduction
Since 1996, Naz Foundation International (NFI)- experienced in working with males who have sex with males (MSM)- has provided technical assistance and support to develop 28 community-based organization (CBO) MSM sexual health projects in South Asia, 15 of which are in India.

Several countries in South Asia, India, Nepal, and Bangladesh, have been identified as having common male-to-male behavioural dynamics, shared terminologies and gender frameworks, and similar meanings attached to sexual behaviours, gender identities, and social constructions of masculinity. Based on this information, NFI has developed a range of replicable development tools and resources that support local CBO MSM interventions. The model of service delivery, management and programme tools, and resources used by Bharosa in Lucknow, India are also used by the Bandhu Social Welfare Society in Bangladesh, the Blue Diamond Society in Kathmandu, Nepal, and Vision in Lahore, Pakistan.

While a best practice document is being developed by UNAIDS for the Bandhu Social Welfare Society in Bangladesh, no such independent study has been done in India. The following is based on NFI’s model of MSM sexual health interventions.

The Context
India is a male-dominated society, where social and public spaces are primarily male-owned. As a homo-social and homo-affectionate society, sexual boundaries between men can be easily crossed. Significant numbers of males play feminized gender roles and have sexual contact with those deemed “real men.” Male-to-male sexual behaviour does exist in India at substantial levels.

Male-to-male sexual encounters typically do not exist within a strict heterosexual/homosexual context. There are a number of factors that lead to MSM. A perceived “body heat,” leading to a perceived urgent need for semen discharge, easy access to male sexual partners, and gender segregation—in the form of social policing of females, delayed marriage, and a rigid conception of masculinity and femininity—all influence MSM.
The frameworks of male-to-male sex, often substantially divergent, involve males who self-identify primarily as *Kothis* and are usually penetrated; males who take on the penetrating role in male-to-male sex (known as *girya/panthis* by kothis), accessing kothis; *hijras* also are accessed by normative males, and at times, adolescent males. Hijras are usually perceived by giryas/panthis as feminized males/females, which enables the girya/panthi to maintain his sense of manliness and be seen as a part of the normative male society. Other dynamics include males who access other males for discharge and/or desire to be penetrated; males who desire male-to-male sex and do not gender themselves and usually indulge in mutual sexual activity—“giving and taking”; friends who have sex with friends for mutual pleasure; and males in all-male institutions. Alongside these indigenous forms of labelling, gay-identified males, primarily among English-speaking, middle and upper classes, also exist with their own networks.

These networks of differing MSM contexts may at times mix. Individuals may shift along differing networks, but usually they are mutually exclusive. In other words, there are complex dynamics and diffusion in relation to male-to-male sex.

The most visible of these networks are those involving kothis and hijras because of their public performative role, which is a part of their self-identification. In some cities in India there are also male massage networks and other normative masculine males working as male-to-male sex workers.

This, if course, does not tell the whole story of male-to-male sexual behaviour in the country.

Male-to-male sex work is a significant factor in Indian cities and towns (and perhaps villages also). A broad range of frameworks also exists here. Hijras, kothis, massage boys/men, male youth, and other males/men will sell sex to men because of poverty and unemployment. Without a welfare system and with significant levels of unemployment or low incomes, male sex work can be a way out in terms of supporting the self and family. This is not to imply that males involved in sex work do not enjoy the sex with other males. Often they will also have a regular male or female partner.

*Kothi*—A self-identifying label for those males who feminize their behaviours (either to attract “manly” male sexual partners and/or as part of their own gender construction and usually in specific situations and contexts), and who state that they prefer to be sexually penetrated anally and/or orally. Kothi behaviours have a highly performative quality in social spaces. Self-identified kothis use this term for males who are sexually penetrated, even when their performative behaviour is not feminized. This is the primary and most visible framework of MSM behaviours. Kothis state that they do not have sex with others like themselves, only “real men”. However, many may also be married to women as a family obligation.

*Girya/panthi*—A kothi label for any “manly male.” A girya/panthi is by definition a man who penetrates, whether it is a woman and/or another male. Giryas/panthis would most likely also be married to women and/or access other females. Their occupations vary across the social class spectrum from rickshaw drivers to businessmen.

*Hijras*—A self-identifying term used by males who define themselves as “not men/not women” but as a “third gender.” Hijras cross-dress publicly and privately and are a part of a strong social, religious, and cultural community. Ritual castration may be part of the hijra identity, but not all hijras are castrated. Sex with men is common, and like men who have sex with kothis, such men would see themselves as “real men” and not homosexuals.
It should be recognized that a male being anally penetrated by another male is highly stigmatized, and those who are perceived to be recipients are usually treated with A girya/panthi or any normative male who is sexually penetrated, orally or anally, will make extensive efforts to hide his practice and/or desire, both from his friends as well as from kothis, hijras, and others in their sexual networks to avoid such stigmatization. It cannot be assumed that gendered sex roles are exclusively maintained at all times. It further needs to be recognized that a similar crossing of “gender” boundaries exists amongst kothis. It is also known for some kothi-identified males to penetrate other males. But like the penetrated girya/panthi, this behaviour would also be kept secret from other kothis.

Such stigmatization further produces a range of human rights abuses, blackmail, violence, and male-on-male rape by local men, thugs, and beat constables.

While there are substantial networks of kothis of all gradations in urban centres—from the very feminized and cross-dressing type to those who have moustaches and dress in shirt and trousers—their sexual partners could well be any masculine male. Similarly, there are significant levels of hijras communities in major urban centres.

Massage boys/men and other similar male sex workers are not only being accessed by men for masturbation and discharge as part of the massage process, but are also being accessed by males across the economic and class spectrum for penetrative sex. Women may also access many of these massage boys/men for sex.

There are other networks of male-to-male sex, not only in a range of male-only institutions, such as prisons, hostels, orphanages, or between young male friends in neighbourhoods, but also between older men and adolescent boys. Such frameworks can be seen within the contexts of:

- Desire for a specific sexual act, i.e., anal sex and oral sex (“Wives/women don’t do this.”)
- “Body heat” that requires discharge (“When my body gets hot, I just can’t control myself.”)
- Mutual desire for male-to-male sex
- Desire for adolescent boys known in the historical literature as “beardless youths” (“Boys are like women, soft.”)

Accessing masculine male sexual partners is not considered very difficult by kothis and hijras. All urban areas appear to have sexualized spaces, such as parks, toilets, railway and bus stations, specific bazaars, streets, and other public areas where kothis would go to meet potential giryas/panthis, often marketing sexual availability through their feminized social behaviours. Many “real men” also go to these sites, not only to meet such accessible males but often for quite legitimate purposes, where they can get caught up “in the heat of the moment” and access kothis who are there at the time.

What is clearly seen in many of the MSM sexual networks is that language, behaviour, and identity are to a large extent gendered within a invisible context of
polymorphous behaviours, and that behaviour and actual sexual practice are more significant markers for the majority of males involved in male-to-male sex than a specific sexual identity. In a way, it could be said that there are limited numbers of MSM with specific gay/homosexual identities but significant numbers with a gendered identity (either feminized or masculinized) or with perceived masculine “body needs” that shape sexual practices.

One more point needs to be made. Relationships between the various networks (I use this term advisedly rather than groups) are often self-stigmatizing, tense, and sometimes abusive because of the social construct of penetration being perceived as feminine. Gender ‘politics’ and relationships come to the fore. Thus, masculine male sex workers may abuse kothi sex workers because of their feminization; kothis may abuse male sex workers and gay-identified men because they also are penetrated; giryas/panthis may abuse kothis; and substantial tensions exist between hijras and kothis since most kothis are not castrated nor want to be. These tensions can explode into verbal and physical abuse at times.

The issue of female sexual health is also highly pertinent among MSM. Cultural tradition makes marriage socially compulsory. Many MSM, of whatever framework or gender identification, are married or are going to be married, even those who self-identified as kothis. Many manly sex partners from the general male population are also married or are going to be married and may well have other females as sexual partners.

Such MSM frameworks and structures thus require parallel strategies to address HIV/AIDS and sexual health concerns and needs:

- Focused interventions addressing the specific needs of kothis, who do have a framework for community building and mobilizing based on shared feminized sensibilities, sexual practices, and visibility.
- Focused interventions for gay-identified men with shared sexual identity being the community framework.
- Similar interventions among hijras.
- Education, awareness, and STI service delivery that ensures that knowledge of anal sex as a risky practice is a part of any intervention with the general male population.

Based on NFI experience, the psychosocial needs of kothis, hijras, and gay-identified men are often very different, and it may be more appropriate to have different interventions for each of these networks.

Along with this needs to be the recognition that the majority of males involved in MSM behaviour also access women as wives and/or sexual partners. This means that to a significant extent, the pattern of infection could well be male-to-male-to-female. Thus, all MSM sexual health programmes must include risks to female partners, and STI service delivery must also address the concerns of female partners of MSM.

While NFI has primarily worked with focused interventions with feminized males (kothi-identified), it has encouraged the resultant CBOs to work with female sexual
health programmes and with those working with specific groups of vulnerable males from the general male population, including truck-drivers, clients of female sex workers, IDU projects, and so on. It has also encouraged its partner agencies to provide assistance to hijra and gay-identified networks wherever possible, along with male sex worker networks and other dynamics of male-to-male sex.

There are only 2 main strategies for promoting sexual health:

- The moral strategy—*don’t do it*
- The pragmatic strategy—*do it safely*

**Mapping male-to-male sexual Behaviours in South Asia**

![Mapping Male to Male Sexual Behaviours Diagram](image)

Which strategy would be most effective in reducing the spread of HIV/AIDS?

It therefore needs to be clearly stated here that behaviour change does not mean promoting abstinence or changing the male-to-male sexual behaviours and gendered identities to male-to-female behaviours, both of which are unrealistic and arise from a moralistic approach to HIV prevention. It means empowering MSM to reduce their own risks to STI/HIV infection through changing their risky behaviours to less risky behaviours and creating an empowering environment where this becomes possible. It is a risk-reduction strategy that NFI promotes.

**NFI Process Model for MSM Sexual Health Interventions**

NFI has developed a replicable model for the implementation of interventions for MSM, their partners, and their families to prevent HIV transmission and other STIs and improve the general health and welfare of this population. This model has been implemented in India, Nepal, and Pakistan with only minor variations in terms of terminology and field service structure, but all key elements and tools are the same. The model has a number of key features, processes, and tools. These are described below, and a summary of the model appears at the end of this paper.

**Key Features of the Model**

*An intimate knowledge of MSM issues and needs.* This is gained from:

- A range of studies and needs assessments that NFI has undertaken and documented over the last seven years;
Ongoing monitoring and evaluation (M&E) from existing community-based initiatives;

Ongoing development of new research partnerships to address specific concerns; and

A clearly defined community development strategy. This includes the development of state-level CBOs addressing MSM behaviours, which in turn develop district-level activities within their state, with ongoing support from NFI.

**A strong advocacy, policy, and ongoing support strategy.** The model includes a strong component of upstream advocacy and policy development to help create a positive political, social, legal, and policy environment for the work to be sufficiently well resourced and enabled. NFI also provides a range of ongoing support activities to MSM intervention programmes.

### Key Processes

**State/country MSM CBO programme development.** Using an NFI-developed framework and tools, NFI provides training and support to develop new or existing state or country partner organizations to undertake needs assessments and develop MSM-led CBO programmes.

**Scaling-up across a state/country: Support for local MSM CBO programme development.** Building on established state-level MSM CBO programmes, NFI provides support and training for these CBOs to develop locally-based, MSM-led CBO programmes across their states.

**Upstream advocacy and policy development and ongoing support of upstream advocacy and policy development work is undertaken to create the necessary political, social, legal, and policy environment for the resourcing and enabling of state- and district-level MSM CBOs services to take place.**

NFI also provides a range of ancillary support services to the MSM CBO programmes, which includes regular training events, provision of an M&E service, help in developing intervention resources, and organizational development support.

### Key Tools

NFI has developed a broad range of comprehensive tools for MSM CBO development, which includes:

- Training manuals, guidelines, and handbooks specific to the needs of MSM-led CBO programmes;
- An M&E system; and
- Model behaviour change communication (BCC) resources for MSM CBO programmes.

Under development:

- An enhanced and computerized version of the M&E system
- Multiple languages of the NFI MSM CBO development toolkit
- Anal STI algorithm
**Process Model Summary**
A summary of the model, in terms of inputs, outputs, outcomes, and processes is described in the figure below:

**Key Signifiers for Best Practice**
As far as NFI knows, no legitimate and independent study has been done on best practices for MSM sexual health interventions in India. Nor, as far as can be determined, has any national impact study been done in regard to sustained changes of levels of risk reduction or consistent condom use among MSM accessing sexual health services, either NGO- or CBO-led.

We are hesitant to discuss best practice models in this context in this paper. Therefore, we have identified key elements in the NFI model of service delivery for marginalized MSM that have been successfully replicated in a number of different localities where NFI has provided technical support for locally-based MSM sexual health CBOs to be developed.

The only one of these replicated interventions where such a best practice evaluation has been conducted is based in Bangladesh. While it is recognized that there are differences between Bangladesh and India, the evidence gained from the range of social assessments of kothi-identified MSM and their sexual partners* in both India and Bangladesh have clearly revealed more similarities than differences in the psychosocial-sexual dynamics of male-to-male behaviours, masculinities, and
sexualities. In both countries, amongst feminized males, similar (if not the same) terminologies are used, and similar gendered dynamics exist along similar socio-cultural frameworks. It is therefore believed that where the Indian MSM CBOs are implementing the NFI service model, similar results are being achieved.

A study undertaken by Tim Mackay, consultant to the Department for International Development, U.K., looked at the Bandhu Social Welfare Society in Bangladesh and Sahodaran in Chennai, India, where both these agencies had accessed NFI technical expertise to develop MSM-led sexual health interventions. Both had utilized NFI’s training and development manuals, key monitoring tools, and financial management, as well as service delivery models. The study was conducted in 1999*

The following was taken from the report:
A major result of the work undertaken so far has been the testing of a number of key strategies and service delivery components that make up a response to the sexual health needs of males who have sex with males and their female partners in South Asian countries. These strategies can be characterised as an integrated, flexible “framework” or “model” that can be adapted and used in different locations and circumstances.

In the work reviewed, the “framework” has demonstrated a strong value. There are observable weaknesses, but these relate more to quality of implementation and circumstances beyond the control of the projects than any inherent fault in the concept. The framework is not rigid or static and will evolve as further work is undertaken.

While the results to date are impressive, there remain enormous challenges if the full potential of the organisations and the main goal of the work, is to be realised…

The framework or model, which has been generated by NFI, Bandhu, and Sahodaran to respond to the needs of males who have sex with males, is sound, has proved to be adaptable, and has produced exciting results so far. It can be used as a starting point for individuals and agencies in other locations in South Asia to create their own responses to their specific needs.

**Conclusion**

**Key Signifiers**

Based on their global experience, most stakeholders (international, national, and local), including UNAIDS, now recognize that for an effective, appropriate, and sustainable HIV/AIDS prevention programme that focuses on marginalized and socially excluded populations, certain key indicators are required. These are:

*See NFI Social Assessment Reports for Bangalore, Lucknow, New Delhi, Hyderabad, Pondicherry (all in India), Dhaka and Sylhet in Bangladesh; and Lahore in Pakistan on NFI’s website: www.nfi.net

- **Focused participatory interventions.** Strategic focusing of participatory prevention programmes for populations most at risk.
- Ownership of the issue. **Those most at risk will also need to acknowledge their own risk and own the issues involved.**
- Beneficiaries as service providers. **For a sustainable programme on risk reduction, those most at risk must be directly involved in developing, implementing, and providing prevention services for their peers.**
- **Self-help community-based organizing.** To ensure involvement of and management by beneficiaries, key individuals within marginalized populations should be recruited, provided training and skills building, and empowered to develop their own service organization.
- **Access to appropriate and affordable STI treatment services.** It is essential that clinicians providing STI treatment services are sensitized to the specific sexual health needs of vulnerable MSM, which includes providing STI management in regard to anal STIs and symptoms. Such services should be confidential, not only around STI status, but also with regard to sexuality and behavioural choices.
- **Access to appropriate HIV voluntary testing and counselling.** Ensuring that confidential testing and pre- and post-test counselling are appropriate and sympathetic to the needs of MSM is essential.
- **Access to appropriate treatment, care, and support services.** Many MSM living with HIV/AIDS are stigmatized not only by their positive status but also by the route of infection and their feminized sensibilities. Treatment, care, and support programmes need to be sensitized to these different frameworks of stigmatization and address them appropriately.
- **Access to affordable appropriate condoms and water-based lubricants.** Reducing the risks of STI/HIV infection is central to any effective HIV/AIDS prevention programme. The most significant risk is through anal sex, both for the penetrated as well as for the penetrator. Regular use of condoms for anal sex is an essential component for any risk-reduction strategy. However, in addition to this, ready access to appropriately packaged water-based lubricant is also an essential component of this since anal sex increases the stress on condoms and can cause rectal damage.
- **Access to appropriate IEC materials.** These materials need to be appropriate to the issues and concerns of MSM in language, terminology, and imagery that are meaningful and understandable to them.
- **Long-term technical and financial support.** It is most likely that the level of technical knowledge to develop, implement, and manage an HIV/AIDS prevention and care programme for peer beneficiaries will be low, if existent at all. Developing these skills and knowledge will require a sustained effort to share such information with those developing the service. At the same time, these self-help initiatives must also be ensured appropriate levels of funding over a sustained period of time in order to develop skills and continuity of service provision.
- **Advocacy on legal, judicial, and social impediments to promoting HIV/AIDS prevention and sexual health.** Along with advocacy on the above signifiers, advocacy on addressing the legal, judicial, and social impediments to HIV/AIDS
prevention and care programmes focusing on MSM is an essential requirement towards developing an empowering environment so that affected populations can modify their sexual practices to reduce their risks to HIV/STI infection.

In addition to the above, it must be remembered that many MSM have no gender or sexual identities and that primarily, they perceive themselves as normative males who penetrate non-men. Such men are invisible within the general male population. It will therefore be essential to ensure that education, awareness, and STI treatment programmes for occupational groups and the general male population along with condom promotion should also address anal sex as risky sexual behaviour.

Why Not Use an Existent NGO to Implement an MSM HIV/AIDS Intervention?
The difficulty for private and government donors is that very few community-based MSM service providers exist. In an environment where the epidemic is growing and spreading, where an urgent response is required, and where other NGOs exist, the tendency has been to fund these NGOs to deliver HIV/AIDS prevention services to MSM populations.

However, such a strategy tends to utilize a “top-down” approach, which does not lead to ownership or empowerment of the beneficiaries towards maintaining safer sex behaviours.

One approach, if non-MSM NGOs are to be used, is that these NGOs should work provide technical support to specific groups/networks of MSM to build self-help organizations and empower such groups to develop their own response through promoting community-based organizing/organizations. This is the NFI approach.

However, many NGOs are involved in HIV prevention and sexual health programmes for other risk populations as well as the general male population. Such NGOs should be sensitized in regard to male-to-male sexual behaviour and include issues of risk and risk reduction in their programmes. After all, MSM as a category and behaviour crosses all risk populations.

Some Key Components in Developing Any Intervention Focused on Self-Identified MSM
- Identifying key MSM individuals and MSM networks within the specific target city/area
- Provide such individuals with appropriate skills building and ongoing technical support
- Map and network within the focused city/area
- Form a self-help group and build members’ knowledge and management skills towards developing their own CBO
- Identify safe spaces for group meetings, education programmes, and socializing activities towards community building
- Ensure adequate supplies of condoms and water-based lubricant
- Ensure ready access to appropriate STI clinical services
Provide adequate long-term funding
Address legal, judicial, and social impediments

There are four primary components in an MSM-led HIV/AIDS prevention and care programme:

Field Services
- Outreach and friendship building
- Community development and mobilizing
- Education and awareness
- Advice and information
- IEC materials distribution
- Condom/lubricant distribution
- Referrals to drop-in centre, STI treatment, counselling, and HIV testing

Centre-based Services
- Drop-in services
- Social group meetings
- Skills-building vocational classes
- Sexual health awareness-raising and condom and lubricant distribution
- Counselling
- Telephone helpline
- Recreational activities
- Community-based research

Health Services
- STI treatment and management
- HIV testing and counselling
- Access to ARVs and treatment for opportunistic infections
- Psychosexual counselling
- General health care

Technical Assistance
- On-going accessibility to technical support when requested
- Training and skills building
- Access to a range of BCC and training resources
- Research
- Advocacy
- Participation in policy development
- Networking and developing partnerships

While the above signifiers and components of an MSM sexual health intervention are believed to be crucial to build a sustainable, effective, and appropriate MSM-led programme, without an effective sero and behavioural surveillance programme conducted by external evaluators, impact and outcomes for such a programme cannot be measured. Appropriate M&E at all levels is essential, in terms of process, management, finance, service delivery, and change. Such M&E is not just data.
collection of how many condoms are distributed and so forth, but includes qualitative evaluation of processes and outcomes. An annual sero and behavioural surveillance programme significantly adds to this by providing an effective tool to measure the impact of such interventions.

Conclusion
To ensure that MSM who are at risk for STI/HIV infection have access to appropriate sexual health services and that risk-reduction strategies can be implemented effectively requires knowledge, understanding, and openness by key stakeholders to the realities of the sexual lives of many males. It requires a strong commitment and leadership from donors and policymakers to invest adequate funds to protect the lives of many people. It requires creating an enabling and empowering legal, judicial, and social environment in which positive actions can be taken, and it requires that networks of MSM can take charge of their own lives and well being. It can be done. It should be done. It must be done.
Annex 1

NFI Sexual Health Promotion Service Model

Field Services
Outreach and friendship building
Community building and mobilising
Education and awareness
Information and advice
Condom and lubricant distribution
Referrals

Naz Foundation International/others
Technical assistance and support
Advocacy

Clinical Services
STI syndromic management
General health management
HIV testing and counselling
Psychosexual counselling
Treatment

Centre-Based Services
Safe socializing spaces
Sexual health education
Helpline
Community building and development
Vocational and literacy training
Condom and lubricant distribution
Psychological counselling
Advocacy
Support and care
## Annex 2
Examples of Outputs from a Number of NFI Partner MSM CBOs

All services developed and self-managed by beneficiaries themselves.

**Programme Period: October 2001–March 2002**

<table>
<thead>
<tr>
<th>Project</th>
<th>City</th>
<th>No. contacted Total</th>
<th>News</th>
<th>Condoms</th>
<th>Referred</th>
<th>Clinic Treated</th>
<th>IEC</th>
<th>Counselling</th>
<th>Drop-ins</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BSWS Dhaka</td>
<td>Dhaka</td>
<td>15314</td>
<td>4271</td>
<td>76540</td>
<td>3102</td>
<td>2871</td>
<td>49150</td>
<td>2818</td>
<td>8256</td>
<td>Funded by NORAD/FHI</td>
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<td>BSWS Chittagong</td>
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<td>6214</td>
<td>3120</td>
<td>25600</td>
<td>1512</td>
<td>1324</td>
<td>31500</td>
<td>956</td>
<td>4210</td>
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<td>-----</td>
<td>8110</td>
<td>122</td>
<td>1820</td>
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<td>BSWS Sylhet</td>
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<td>19700</td>
<td>1261</td>
<td>1211</td>
<td>24860</td>
<td>912</td>
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<td>2300</td>
<td>116</td>
<td>58</td>
<td>1510</td>
<td>126</td>
<td>256</td>
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<tr>
<td>Gelaya</td>
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<td>4680</td>
<td>1440</td>
<td>13500</td>
<td>425</td>
<td>398</td>
<td>14150</td>
<td>436</td>
<td>-----</td>
<td>No drop-in service as yet/ funded by KPSACS</td>
</tr>
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<td>2910</td>
<td>25600</td>
<td>516</td>
<td>509</td>
<td>31500</td>
<td>723</td>
<td>4860</td>
<td>Additional NFI support + funding from APSACS</td>
</tr>
<tr>
<td>Milan-Naz India</td>
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<td>3105</td>
<td>68450</td>
<td>2716</td>
<td>2430</td>
<td>35400</td>
<td>1816</td>
<td>8270</td>
<td>Funded by Lottery</td>
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<td>4275</td>
<td>38350</td>
<td>1988</td>
<td>1898</td>
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<td>3200</td>
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<td>2960</td>
<td>1655</td>
<td>15600</td>
<td>591</td>
<td>482</td>
<td>7850</td>
<td>396</td>
<td>3185</td>
<td>Limited funding /NFI</td>
</tr>
<tr>
<td>Snetithudu</td>
<td>Visak</td>
<td>1785</td>
<td>1615</td>
<td>7540</td>
<td>615</td>
<td>491</td>
<td>8910</td>
<td>426</td>
<td>1432</td>
<td>Limited funding /NFI</td>
</tr>
<tr>
<td>Udaan–Mumbai</td>
<td>Mumbai</td>
<td>7325</td>
<td>4315</td>
<td>15600</td>
<td>1816</td>
<td>1540</td>
<td>22500</td>
<td>710</td>
<td>1816</td>
<td>Limited funding/NFI</td>
</tr>
<tr>
<td>Udaan – Pune</td>
<td>Pune</td>
<td>355</td>
<td>355</td>
<td>4300</td>
<td>208</td>
<td>156</td>
<td>2450</td>
<td>96</td>
<td>215</td>
<td>Initiated 10/01—limited funding NFI</td>
</tr>
<tr>
<td>Vision</td>
<td>Lahore</td>
<td>1962</td>
<td>1315</td>
<td>5760</td>
<td>1215</td>
<td>1090</td>
<td>8960</td>
<td>454</td>
<td>-----</td>
<td>Limited funding/NFI</td>
</tr>
</tbody>
</table>
Injecting Drug Use: How Uttar Pradesh Can Learn from the Experiences of Other States in India

Samiran Panda

Introduction
Uttar Pradesh, still considered a low HIV-epidemic state, is faced with several issues that affect vulnerability to infection from HIV and other sexually transmitted infections (STIs). These issues include a growing migrant population that travels from Uttar Pradesh to “high” and “concentrated epidemic” states, poor performance of the health care delivery system, and a newly recognized opiate and injecting drug use problem. This paper examines how Uttar Pradesh could benefit from lessons learnt by other Indian states with regard to the development of HIV/AIDS risk-reduction interventions for drug users. The arguments presented here are based on available secondary data and are discussed below.

HIV and Drug Use
A rapid spread of HIV among injecting drug users (IDUs) was reported in several northeastern states in the early 1990s (Sarkar et al., 1993), specifically among white sugar (a pure variety of heroin) and dextropropoxyphene users. Injecting drug use is no longer restricted to the northeastern states bordering Myanmar, and many newly affected states have reported HIV infection among local IDUs. This diffusion of injecting drug use in major metropolitan cities of the country (Kolkata, Delhi, Mumbai, and Chennai) is characterized by the non-medical use of synthetic opioid pharmaceuticals (buprenorphine injection) (Dorabjee and Samson, 2000).

The speed of the spread of HIV has, of course, been different in different regions due to various socio-economic, health, and drug-use network-related factors. In Manipur, 50 percent of IDUs became infected with HIV within nine months of the virus’s entry to the region; in Chennai, it took longer to attain a similarly high prevalence (Table 1). The public health lesson learnt from both these regions is of great importance: if comprehensive interventions are not launched in time, and with adequate coverage, HIV will closely follow the injecting drug use epidemic. Lessons from these regions also show that drug and alcohol use can negatively impact one’s ability to practise safe sex and, thus, is

<table>
<thead>
<tr>
<th>Year</th>
<th>Sentinel Surveillance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>27%</td>
</tr>
<tr>
<td>2001</td>
<td>24%</td>
</tr>
<tr>
<td>2002</td>
<td>33%</td>
</tr>
<tr>
<td>2003</td>
<td>63%</td>
</tr>
</tbody>
</table>

Source: Tamil Nadu State AIDS Control Society

The earliest record (1994–95) on HIV prevalence in IDUs, admitted to the Institute of Mental Health in Chennai, revealed a figure of 17 percent (Joseph, 1996).
equally important from an HIV intervention point of view. Switching from a non-injection form of opiate use to injection is also common.

**Is HIV Restricted to IDUs?**
Reports from Manipur and other states clearly show that HIV in drug users is not restricted to the drug-using population. As many drug users are married and sexually active, are in relationships with sex partners, or interact sexually with other population groups and/or female sex workers, HIV interventions directed towards drug users and injecting drug users should also address the issue of safe sex practices. Since the report of high HIV prevalence in non-injecting wives (45%) of HIV-positive injecting heroin users (Panda et al., 2000), this assertion has gained firm ground. Nagaland and Mizoram, two northeastern states that witnessed the HIV epidemic first in IDUs, are now seeing a rising trend of HIV infection among women attending antenatal clinics who represent the female general population.

**An Opportunity to Learn from Other States**
The rapid assessment of a situation and development of appropriate responses form the mainstay for generating risk-reduction interventions in Uttar Pradesh—a region that recognizes the extent of the injecting drug use problem and is committed to developing interventions based on assessment findings. Involvement of ex- and current drug users in such an endeavour is a must, not only because the population in question here is a “hard to reach” population, but also for the development of appropriate interventions and delivery approaches. When conducting a rapid assessment, it is important to examine available secondary data and to try to foresee where the problem might peak—an exercise known as epidemiological forecasting. For example, in light of the documented injecting drug use problem in the district of Nepal that borders Bihar and Uttar Pradesh, it would be pragmatic to start with rapid assessment exercises in the adjacent districts of Uttar Pradesh and Bihar. Three essential areas that must be explored when conducting an assessment are detailed in the diagram below (Figure 1).

![Diagram](image-url)

**Figure 1**
**Essential Elements to be Explored When Conducting a Rapid Assessment Study**

- **Macro-Social and Political Environment**
  (Law enforcement personnel must understand various aspects of drug-related interventions, including harm-reduction approach)

- **Quality and reach of existing interventions**
  (need for capacity-building)

- **Status of peer outreach**
  (for HIV-risk reduction intervention, primary health care with abscess management, referral for STI treatment, treatment for TB and addressing the needs of spouses/regular sex partners)
When conducting a rapid assessment, it is also important to identify what potential resources (human and financial) can be used to launch subsequent interventions based on the assessment findings. Finally, any rapid assessment should not be seen as a one-time activity, and should be conducted at regular intervals in order to make necessary modifications of on-going interventions. India has a wealth of experience regarding the rapid assessment of opiate drug use conducted in different parts of the country. Any district newly recognizing injecting drug use can draw upon this expertise by contacting the United Nations Office on Drugs and Crime (Regional Office of South Asia) in New Delhi.

How the Law Looks at Behavioural and Intervention Issues

After a considerable period of drug use, one must use a larger quantity of the same drug or similar drug (chemical structure-wise, as well as the effect of the drug on the human body) to get the same effect that s/he used to get with a smaller quantity—a phenomenon known as tolerance. This holds true for both non-injecting and injecting opiate users. It is, therefore, easy to understand that, due to increased tolerance to drugs, IDUs would require increasingly frequent injections in a day.

While harm-reduction approaches towards intervention recognize this need and try to make all injections free of infection without necessarily condoning drug use, current laws are yet to be explicit in these terms. The National AIDS Control Organization (NACO)—under the Ministry of Health and Family Welfare, Government of India—recognizes that transmission through injecting drug use is one of the major causes of the spread of HIV/AIDS in the country (Box 1). It also recognizes that the most important strategy in combating the problem of injecting drug use and its serious consequences is the “Harm Minimization” approach. This approach is now being accepted worldwide as an effective prevention mechanism. Moreover, the government maintains that harm minimization, in the context of injecting drug use, would require not only appropriate health education and improvement in treatment services, but, in the most practical terms, providing bleach solution, syringes, and needles for the safety of IDUs. In order to implement this pragmatic approach, the Government of India intends to encourage NGOs working in drug de-addiction programmes to take up harm minimization as a part of the HIV/AIDS control strategy (NACO Policy 2001) in areas with large numbers of IDUs.

The current Indian legal regime, however, focuses on:

- Criminalizing possession and consumption
- Drug paraphernalia
- Abetment, attempt, and criminal conspiracy
- Referral/de-addiction

On these counts, many HIV intervention activities can be interpreted as illegal. The creation of a positive legal environment, where drug users are seen as victims rather
than criminals, is of paramount importance at this juncture. Continued legal assistance to drug users in cases of harassment and injustice remains a responsibility of the interventionists until such an environment is created.

**Concluding Remarks**

Drug users, including IDUs, are not in isolation and are sexually active. Interventions based on an assessment of the situation should be introduced at the earliest possible instance. Ex- and current drug users should assist the assessment team. This team should focus on both injection and sexual practices of drug users and their sex partners. As drug use scenarios change rapidly, the gap between rapid assessment and intervention development should not be long. Otherwise, the intervention is in danger of being irrelevant, and the opportunity for the prevention of HIV among drug users lost. Finally, interventions should address issues regarding drug users, their immediate family, NGOs, and law enforcement personnel.

**References**

Targeted Interventions in Uttar Pradesh

Chairperson
Sanjay Kapoor

Targeted Interventions in UP: Brothel and Non-brothel Based Sex Workers
Jyoti Mehra

Targeted Interventions in UP: Truckers, IDUs and Prison Inmates
Sherry Joseph

Blood Banks and Safety Measures in UP
S. K. Chakravarty

Condom use in Uttar Pradesh
Rita Leavell

Discussants
Udayan Pandya and Akash Gulalia
Targeted Interventions Among Brothel- and Non-Brothel-Based Sex Workers in Uttar Pradesh

Jyoti Mehra

Background

With 4.58 million people living with HIV/AIDS (PLHAs), India accounts for nearly 10 percent of the global HIV/AIDS burden (UNAIDS, 2002). Currently, six states in India have a generalized epidemic with an HIV prevalence rate among women of over 1 percent. In most states in northern India, HIV prevalence is still low, with less than 1 percent prevalence in women attending antenatal clinics, and with less than 5 percent prevalence among clients seeking treatment for sexually transmitted infections (STIs) and among other vulnerable groups (UNAIDS, 2002). Over 60 percent of India’s adult population (approximately 260 million people) live in states where the epidemic is currently at a low level. However, a significant number of young adults (almost three million) migrate from these areas to states that are currently experiencing generalized epidemics. Moreover, women are becoming increasingly vulnerable to HIV infection with more than one-fourth of all new infections occurring among them (UNAIDS, 2001). It is important to note that most infected women tend to have no risk behaviour and tend to be in what they perceive to be monogamous sexual relationships. There is an increasing recognition that low prevalence rates in several states conceal serious, localized epidemics and that national prevalence figures do not tell the full story of the epidemic.

Uttar Pradesh

Current information indicates the prevalence of HIV in northern India is still low, but some states, such as UP, are extremely vulnerable because of their significant migrant populations (UNAIDS, 2002). Clearly, low prevalence does not equate with low risk, especially when we take into account socio-economic, behavioural, and epidemiological contributing risk factors such as high levels of STIs, low awareness levels about HIV/AIDS, gender inequalities, poverty, and mobility of populations. In addition, in most of these areas, health care systems do not have the capacity to address HIV/AIDS prevention and care issues.

However, due to the current low HIV prevalence rate in UP, the state has a window of opportunity to put in place strategies to prevent the further spread of the epidemic and address primary prevention in a comprehensive and cost-effective way.
Core Group Populations
Since the beginning of the HIV/AIDS epidemic, sex workers have been one of the groups most vulnerable to HIV infection due to the frequency of unprotected sex with multiple partners. Sex workers are often in a poor position to negotiate safe sex because of social, economic, and cultural factors. Because of high infection rates and large numbers of sexual partners, sex workers have been considered a core group for HIV transmission. Because of the important role of core groups in HIV dynamics, programmes to reduce transmission of HIV infection within these groups could have a considerable effect in slowing the spread of the HIV/AIDS epidemic, at a relatively low cost. There is increasing evidence now that targeted programmes to reduce transmission of HIV infection within core groups are feasible and effective. Targeted interventions (TIs) have led to successful risk reduction and decreased levels of infection (Lamptey and Gayle, 2001).

Estimates of Sex Workers in Uttar Pradesh
A total of 8,234 female sex workers are estimated across 456 sites in UP in a study carried out for mapping of population groups vulnerable to HIV/AIDS (ORG-MARG, 2003). To date, this is the only study available for estimating this component of the core population in the state.

NGO Case Studies
The Uttar Pradesh State AIDS Control Society (UPSACS) is currently funding 12 TI projects for sex workers across the state. A review of three TI projects* was undertaken for carrying out case studies.

This paper aims to analyze and synthesize the data from three NGO case studies of TI projects among sex workers in UP with a view to:
- Identify the gaps and, thus, the areas for strengthening; and
- Provide future directions for more effective implementation.

This section will address several broad issues, illustrated by discussions of the case studies. The interested reader can refer to the full case studies (provided in the background materials for the workshop) for a more complete discussion.

Methodology
All project sites were visited and documents reviewed. Interviews were conducted with managers and project staff. A checklist for the case studies was developed for gathering the required information. The tools for data collection were a mix of the methods: group discussions, interviews, and observation. Secondary data sources include information collected during the baseline assessment, Computerized Management Information System (CMIS) records, project proposals, and sanction letters from UPSACS.

The case studies are constructed from information gathered from the projects at two levels: at the organizational level and at the stakeholder level. All levels of project

*I acknowledge the use of two case studies (SKS and SBGSS) conducted by The POLICY Project in this paper.
staff including project co-ordinators, clinic doctors, counsellors (where available), and outreach workers and peer educators were interviewed. Discussions with secondary stakeholders were also initiated. It was not possible to interview sex workers and their clients at the Global Science Academy (GSA). However, this was possible at Sri Bhardwarj Gramodyog Sewa Sansthan (SBGSS) and Sarvajan Kalyan Samiti (SKS), where discussions were held with the sex workers.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>SKS</th>
<th>SBGSS</th>
<th>GSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>District</strong></td>
<td>Varanasi</td>
<td>Maharajganj</td>
<td>Basti</td>
</tr>
<tr>
<td><strong>Type of sex workers</strong></td>
<td>Brothel-based</td>
<td>Brothel- and non-brothel-based</td>
<td>Brothel-based</td>
</tr>
<tr>
<td><strong>Area of operation</strong></td>
<td>Red Light Area</td>
<td>UP State Highway 8</td>
<td>Lohiya Nagar</td>
</tr>
<tr>
<td><strong>Target population</strong></td>
<td>240</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td><strong>Administrative sanction of the project</strong></td>
<td>N/A</td>
<td>May 2002</td>
<td>January 2002</td>
</tr>
<tr>
<td><strong>Financial sanction of the project</strong></td>
<td>April 2001</td>
<td>November 2002</td>
<td>January 2002</td>
</tr>
</tbody>
</table>

Two NGOs, GSA and SKS, are implementing TIs with brothel-based sex workers and one NGO, SBGSS, is addressing the sex worker population as a part of a larger prevention project that also addresses injecting drug users (IDUs) and truck drivers. It is important to note that these sex worker interventions are quite similar in design as the guidelines for TIs developed by the National AIDS Control Organization (NACO) have been followed for developing the intervention design. The interventions have been on the ground for the past 2–3 years.

There are some instances where a delay in receipt of funds has affected the intensity and scale of the intervention. GSA was sanctioned Rs. 4,39,350 for the period January 2002–January 2003. There was subsequently a gap in funding for the period January 15–February 28, 2003. GSA was subsequently sanctioned two small grants—Rs. 32,000 and Rs. 34,000—for the months of March and April 2003, respectively. Subsequent delay in the actual receipt of the grants and the payment of salaries to the staff and honoraria to the peer educators had a temporary effect on motivation levels as well as the scale of intervention activities. One of the peer educators at GSA reported that it was not even clear whether the project would continue or not. Peer educators mentioned that there was a delay of 2–3 months in receiving the honoraria.

Profile of Sex Workers
Sex workers, their partners, and clients are generally a very mobile and hard to reach population. Contact with some sex workers is extremely difficult, as in the case of SBGSS where the sex workers are mobile and not easy to identify as they work part time. The multiple forms of sex work (e.g., clandestine, occasional, under the guise of small business) add to the challenges faced by NGOs in implementing the TIs. An analysis of the data provided in the case studies is presented in Table 2.
Table 2
Profile of Sex Workers

<table>
<thead>
<tr>
<th></th>
<th>SKS</th>
<th>SBGSS</th>
<th>GSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of sex workers</td>
<td>240</td>
<td>300</td>
<td>148</td>
</tr>
<tr>
<td>(baseline)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td>Majority married</td>
<td>Majority married</td>
<td>Married</td>
</tr>
<tr>
<td>Age group (in years)</td>
<td>15–35</td>
<td>15–35 and above</td>
<td>14–42</td>
</tr>
<tr>
<td>Literacy level</td>
<td>Majority illiterate</td>
<td>Majority illiterate</td>
<td>Majority illiterate</td>
</tr>
<tr>
<td>Type</td>
<td>Brothel based</td>
<td>Casual and mobile</td>
<td>Home-based and mobile</td>
</tr>
<tr>
<td>Source of origin</td>
<td>West Bengal, Bihar, and Nepal</td>
<td>Nepal and neighbouring districts</td>
<td>Nepal and neighbouring districts</td>
</tr>
<tr>
<td>Clients</td>
<td>Truck drivers, rickshaw pullers, and students</td>
<td>Truck drivers</td>
<td>Petty shop owners, ricksha pullers, and daily wage earners</td>
</tr>
<tr>
<td>Place for sex work</td>
<td>Brothel</td>
<td>Truck, shop, open fields, and highway</td>
<td>Home</td>
</tr>
<tr>
<td>Average number of</td>
<td>6–7</td>
<td>5–6</td>
<td>3–4</td>
</tr>
<tr>
<td>clients per day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average rate per</td>
<td>Rs. 50</td>
<td>Rs. 30–50</td>
<td>Rs. 15–20</td>
</tr>
<tr>
<td>client (in rupees)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working time</td>
<td>10:00am–8:00pm</td>
<td>9:00am–11:00am</td>
<td>9:00am–8:00pm</td>
</tr>
<tr>
<td>Negotiations</td>
<td>Through madams</td>
<td>Directly with clients</td>
<td>Directly with clients</td>
</tr>
</tbody>
</table>

GSA and SKS project staff report that there are fluctuations in the total number of sex workers in their project areas. Frequent police raids force the sex workers to migrate to other areas. At the time of data collection, both SKS and GSA reported a decline in the total population of sex workers residing in the project areas. GSA reported an estimate of 50–60 sex workers and SKS reported 150 sex workers residing in the area.

The sex workers at Maharajganj (SBGSS) can be classified into three categories:

- **Floating sex workers** come to the project area from the nearby villages. They are mobile and solicit truckers across the Indo-Nepal border.

- **Sex workers who are resident of the area** and normally operate small *paan* shops, tea stalls, and petty shops along the highway. Soliciting of the clients is carried out at the shops. The sexual activity takes place in temporary establishments, such as the huts, etc.

- **Casual sex workers** who have links to public call offices (PCOs) and/or with the above two categories of sex workers. Soliciting is done by a third party and the client belongs to the upper socio-economic class. The clients are entertained in private places such as hotels, lodges, and houses.
Economic Vulnerability
The very low rates charged to the clients by the sex workers in the SBGSS and GSA projects reflect the severe economic deprivation of the sex workers. It is also indicative of the fact that there is probably less room for negotiations with clients than what the project staff and programme planners would like to believe. The peer educator at GSA reported that there is little scope to negotiate rates as both the sex worker and the client belong to the lowest economic class. While the sex workers cannot afford to lose the client due to intense competition, the clients (e.g., rickshaw pullers, petty shop owners, daily wage earners) have limited capacity to pay and are aware of the prevailing rate in the area.

Clearly, the economics of demand and supply dictate the business of sex work. This has programmatic implications for the intervention design also. Most of the health promotion activities (e.g., behaviour change communication [BCC], STI service delivery, and condom programming) in the projects strongly encourage sex workers to insist on condom use with each and every client. It is not realistic to expect the sex workers to follow this advice due to the limited scope of negotiations on an individual level.

The interested reader can also refer to the Appendix for more detailed data on the profile of the sex workers as reported in the Behavioural Surveillance Study (BSS) for UP and Uttaranchal Pradesh (2001–2002).

Behaviour Change Communication
The projects use a mix of one-to-one, one-to-group, and community meetings for delivering messages to the target population. The outreach workers and peer educators conduct the educational activities in the field. Project staff at all the three NGOs reported that they faced resistance from the community in the initial phase of the project. The community of sex workers avoided outreach workers at SKS and referred to them as “AIDS people.” The project staff then decided to adopt a broader approach by including messages related to reproductive tract infections (RTIs)/STIs in the outreach activities. This information was found to be more relevant for the sex workers and facilitated an increase in the acceptance of the outreach workers.

At the time of data collection, a new team of three outreach workers had recently joined the project at GSA and the team was still in the process of establishing rapport. The prior presence of peer educators who are respected in the community facilitated the acceptance of the new team. In SBGSS, one-to-one communication by the outreach workers is the most preferred method of communication. Approximately 4,960 sex workers were contacted over the past 10 months by the staff through one-to-one contacts. The absence of specific data related to first time contacts and repeat contacts does not allow scope for further analysis.

In SBGSS, discussions indicate a high level of awareness among the target population on routes of transmission of HIV, its prevention, and the availability of clinical services for treatment of RTIs/STIs.
Community Involvement
The three projects have undertaken various activities over the past 2–3 years to increase awareness among the general community. Awareness generation had been carried out through one-to-group communication and community meetings. The range of advocacy activities carried out by the TI projects includes skits, mobile exhibitions, video shows, local cable network, puppet shows, films, rallies of school children, poetry recitation, folk songs, and street theatre. These activities have involved a range of secondary stakeholders, who have influenced sex work activity, either directly or indirectly.

SKS organized a street play titled *Janki Ki Kahani* twice a month during 2002. Two folk songs performances were also organized during 2003. SBGSS has developed a skit that is being performed at truck stops along the state highway. The project also organizes mobile exhibition in the field to attract high-risk population groups, including IDUs, truck drivers, and sex workers. GSA has organized approximately 80 events, including seminars, workshops, video films, and poetry recitations since January 2002.

Information, Education, and Communication (IEC) Materials
SBGSS has produced a few IEC materials that include a packet to repack condoms, stickers, and notice. GSA has developed handouts and small posters and has used wall paintings in the project area. SKS has also developed a sticker and a pamphlet containing messages on routes of transmission of HIV and means of prevention. A tri-fold referral card and a small brown paper cover has been developed with IEC messages. Project staff distributes 200 pamphlets and 25 stickers on average per month. The materials at SKS and GSA are printed with a number of messages. The materials are text heavy.

<table>
<thead>
<tr>
<th>Table 3</th>
<th>IEC Materials Used in BCC Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SKS</strong></td>
<td><strong>SBGSS</strong></td>
</tr>
<tr>
<td>Focus of message and content</td>
<td>Motivating condom use</td>
</tr>
<tr>
<td>Type of print materials</td>
<td>Stickers and pamphlets</td>
</tr>
</tbody>
</table>

Messages
Messages are general in nature and focus primarily on information related to HIV prevention and transmission. Outreach staff at SKS report that misconceptions, such as the belief that washing genitals with soda will cure STIs, continue to prevail among the sex workers. There is considerable scope for designing more specific messages, such as “Seek early treatment for STDs.”

Peer Education
The use of peer educators has been recognized as an effective strategy for reaching targeted populations with behaviour change and condom promotion messages.
However, peer educators require considerable training and supervision to gain credibility and full acceptability by the sex workers. Out of the three projects, two projects, SKS and SBGSS, had provided training for peer educators. SKS had trained nine peer educators at the beginning of the project. Currently, there are four peer educators in SKS. The three peer educators at GSA were found to be highly motivated and well respected in the community.

Table 4

<table>
<thead>
<tr>
<th>Peer Educators</th>
</tr>
</thead>
<tbody>
<tr>
<td>SKS</td>
</tr>
<tr>
<td>Number of peer educators</td>
</tr>
<tr>
<td>Payment (per month)</td>
</tr>
<tr>
<td>Training of peer educators</td>
</tr>
</tbody>
</table>

**Internal Monitoring of BCC Activities**

SKS and SBGSS have internal monitoring systems in place for measuring the BCC activities in place. The project staff at SKS maintain daily records of the number of contacts made in the field, which are then collated at the field office in the project area. GSA has discontinued the practice of maintaining the records of contacts/outreach in the field.

**STI Diagnosis and Treatment**

**Clinics**

There was no separate clinic for sex workers in the projects reviewed. The clinic at Varanasi managed by SKS was located within the project office, while the one at Basti (GSA) was located at a distance of 2 km from the project area and also provided services to the general population. SKS has a target of treating 600 patients for RTIs/STIs annually.

There was also no separate clinic for the sex workers at the Maharajganj area. The outreach workers at SBGSS indicate that the clinic hours of operation are not well scheduled. Most of the time the clinic functions more as an STI detection camp. The fact that this project reaches out to approximately 10,600 people belonging to high-risk populations (300 sex workers, 300 IDUs, and 10,000 truckers) indicates an urgent need to increase the frequency of operating the clinic.

The data from the case study of SBGSS indicate that the extent of counselling offered to the patients diagnosed with STIs was low, which implies that partner notification and treatment was ineffective.

Both GSA and SKS also assisted UPSACS during the seventh round of sentinel surveillance (2003) in referring RTI/STI cases to the district hospitals.
Table 5

**STI Service Delivery**

<table>
<thead>
<tr>
<th></th>
<th>SKS</th>
<th>SBGSS</th>
<th>GSA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location of the clinic</strong></td>
<td>Within the office</td>
<td>Within the office</td>
<td>2 km away from project (central part of the city)</td>
</tr>
<tr>
<td><strong>Availability of qualified health care provider</strong></td>
<td>1 female BAMS</td>
<td>2 (1 MBBS and 1 BAMS)</td>
<td>1 MBBS</td>
</tr>
<tr>
<td><strong>Trained in syndromic management</strong></td>
<td>Trained</td>
<td>Trained</td>
<td>Not trained</td>
</tr>
<tr>
<td><strong>Place for physical examination</strong></td>
<td>Limited</td>
<td>Available</td>
<td>No space available</td>
</tr>
<tr>
<td><strong>Privacy and confidentiality</strong></td>
<td>Limited space allows less scope for privacy</td>
<td>Limited space, no privacy</td>
<td>Lack of privacy</td>
</tr>
<tr>
<td><strong>Referral cards</strong></td>
<td>Available and used</td>
<td>Available</td>
<td>Available, but not being used currently</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Free</td>
<td>Free</td>
<td>Free and charged</td>
</tr>
<tr>
<td><strong>Working hours at clinic</strong></td>
<td>1:00–5:00 pm</td>
<td>Clinic functions three times a month</td>
<td>8:00am–8:30pm</td>
</tr>
<tr>
<td><strong>Counsellor availability</strong></td>
<td>Counsellor does not attend to the clinic patients</td>
<td>Counsellor not sanctioned by UPSACS</td>
<td>Counsellor not sanctioned by UPSACS</td>
</tr>
</tbody>
</table>

**Provision of Free Medicines**

The clinic at Varanasi is used for storing medicines. The medicines are provided free of cost to the sex workers by SKS. GSA also has a provision for free medicines, but it is not provided to all the sex workers. The doctor tries to identify the poorest sex workers and ensure complete free supply of drugs to them.

**Availability of Trained Doctors**

Personnel well trained in current STI diagnosis and treatment must oversee the establishment and management of clinics for sex worker projects. The availability of trained personnel was found to be inadequate in the three projects. While in SKS the doctor had undergone training at the district hospital on syndromic case management, the doctor providing services at the clinic at GSA needed a refresher course.

**Use of Clinic Services**

Outreach staff and peer educators in GSA and SKS reported reluctance on the part of the sex workers to use the clinic services. One of the reasons reported by the project staff at GSA was the lack of trust in the quality of services provided.

The project team had to rename the STI clinic at Varanasi as Swasthya Kendra to reduce the stigma attached with HIV/AIDS. This has helped them to overcome the problem to a great extent.
Referrals
SKS offers referral services to the sex workers who are reluctant to come to the clinic by establishing linkages with the STI clinic at the district hospital. Cases that need to undergo blood tests also are referred and the counsellor follows up with the STI clinic at the district hospital in Varanasi to ensure that the needs of the clients are attended. GSA also reports referrals to the district hospital, but the system is not well established. There are no referral cards or subsequent follow ups at the district hospital in Basti, once the patient is referred by the project. Referral cards are used at SBGSS.

Condom Programming

Condom Supply
Condoms are being given free to sex workers in the three projects. GSA has had recurrent problems in steady supply of condoms from the district hospital and UPSACS. The project now uses the budget allocated for repackaging to buy the Milan brand of condoms for distribution. The condoms are manufactured by Hindustan Latex Ltd. and cost 50 paise per piece. There is no repackaging carried out.

In the case of SKS, the free supply of condoms is obtained from UPSACS or the district hospital and the condoms are repackaged. At the time of shortages in condom supplies, the project purchases the condoms from the market and attempts to sell them to those who have the capacity to buy. The organization has not faced many problems in regular supply of condoms. SBGSS also reports not facing any problem in regular supply of free condoms from UPSACS and the District Medical Officer (DMO). SBGSS repackages the packet of 20 Nirodh condoms into a smaller packet containing five condoms. These packets are easier to carry and ensure some privacy.

Condom Distribution
SKS distributes 18,000–20,000 condoms on average per month. Condoms are distributed through outreach staff, peer educators, small tea shop owners, and at the project clinic. The distribution of free condoms also helps outreach workers to provide an incentive to sex workers to attend an STI clinic managed by SKS.

GSA distributes approximately 9,000–10,000 condoms per month. Condoms are distributed more aggressively through the tea shops owned by the three peer educators, which are located in the heart of the project area. Peer educators report that there is strong demand for condoms by the sex workers.

SBGSS, in addition to condoms supplied by peer educators and outreach staff, has set up 10 condom depots across the stretch of the State Highway 8. These are located at dhabas and tea stalls. Few of the shops are owned by sex workers and pimps. The project has supplied gas petro max lights as an incentive to the shop owners who have allowed condom distribution outlets to be maintained at their premises. A consistent supply of condoms is maintained by the field staff at these 10 outlets.
Condom demonstrations are carried out regularly by the outreach staff from all three projects as a part of the one-to-one and one-to-group interactions. The outreach workers at SBGSS also focus on clarifying the misconceptions about condom use.

**Social Marketing of Condoms**

A few sporadic attempts at selling condoms have occurred in the TI projects reviewed, but there has not been any consistent effort for ensuring social marketing of condoms. Most of these efforts by SKS were done during the period when there was no free supply of condoms.

**Monitoring Condom Use**

Monitoring of condom use is done by the outreach and peer educators in SKS. They check the dustbins where condoms are disposed in the brothels. Peer educators in SKS also admitted that if the clients offer more money, 5 out of 10 sex workers would agree to have sex without condoms. The peer educators at GSA reported that the large number of used condoms found in the community garbage dump is the concrete evidence of use. The project staff at GSA indicate that they ask the sex workers to report the number of condoms used and subsequently feed back the information to the project co-ordinator. However, this is not a very practical and reliable process indicator in the sex worker projects.

**Care and Support for Sex Workers Living with HIV/AIDS**

Two NGOs, SKS and SBGSS, reported deaths of sex workers in the last few months. The sex workers were suspected to have died of AIDS-related illnesses. Though we know that sex workers should be referred to specialized clinics that offer good, affordable services in a non-stigmatizing environment, in most districts in Uttar Pradesh these services are scarce.

**Enabling Environment**

The strategy for creating an enabling environment is built into the design of TIs to address the long-term need to reduce vulnerability of women in sex industry. An analysis of the implementation activities related to this strategy by the three NGOs, however, reveals that it is probably the least understood among the project staff. Project staff had limited understanding of the strategy and their role in facilitating the creation of an enabling environment to promote safer sex practices. One of the programme co-ordinators reported that while BCC primarily focuses on the target audience, the enabling environment approach aims for increased involvement of secondary stakeholders in the project.

Police raids have become a major problem in the SKS and GSA project areas, which keeps the sex workers insecure and frightened. The NGOs have been using various short-term solutions to address the situation, including publicity in newspapers and conferences to draw attention to these issues, but they are still grappling with the problem.

The sale of sex work is legal in India if it takes place within a room. In order to avoid arrest, freelance or “flying” sex workers must also rent rooms at high hourly rates.
The Prevention of Immoral Traffic Act, which aimed at regulating the flow of new women into the trade, in fact, simply makes it easier for sex workers to be beaten, extorted, raped, and otherwise abused when the act is used to raid brothels on the pretext of removing younger women. This problem will recur as is evident from the experiences of sex worker collectives across India. The problem of police raids continues to plague even established sex worker projects. As recently as January 2004, the Durbar Mahila Samanwaya Committee, which has been the major mover of the Sonagachi Project in Kolkata, West Bengal, highlighted the problem of police raids in the area.

**Monitoring**

Most projects are quite capable of maintaining process indicators (e.g., the number of condoms given out and the number of meetings held). The CMIS requirements from the UPSACS are instrumental in ensuring that NGOs maintain process indicators. The process or progress indicators are of value if project personnel are able to critically review their meaning and adjust activities accordingly. However, this does not appear to be a practice adopted by the project staff.

**Recommendations**

- While most of the reviewed projects recognize that sex workers do not use condoms with boyfriends (*babus*) and husbands, the projects have to design specific programmes that strengthen sex workers’ ability to negotiate condom use. The projects need to consider developing a separate set of messages targeting sex workers that encourage their condom use with non-commercial sex partners.
- It is evident that certain groups of sex workers are mobile in the three projects. The NGOs need to consider carrying out repeated surveys to monitor the flow of these groups and conduct qualitative assessments to understand their specific health needs.
- One common negotiation strategy advocated to the sex workers is to charge a higher rate from clients who refuse to use condoms. The economic compulsions on both sides may not allow this advice to be followed in reality. Collectivization of sex workers could ensure that no sex worker agrees to have sex with a client who refuses to use condoms.

**Behaviour Change Communication**

- The IEC materials should be made more needs-based and user friendly. Low literacy levels among sex workers necessitate designing health promotion messages that use simple colloquial terms and more visuals.
- Messages that include safer sex options (e.g., lubrication and encouraging non-penetrative sex) should be included in the set of messages that are conveyed to sex workers.
- Use of incentives (e.g., in cash or in-kind) would further increase the motivation of the peer educators among the sex worker community.
- SKS could consider refresher training of peer educators. GSA and SBGSS should provide training to address the frequent problems and issues faced by the peer educators in working in the community.
- Specific training of peer educators in human sexuality could be considered by the projects. This will facilitate the peer educators’ ability to speak about sex with ease and convey explicit messages.
There is scope for strengthening the internal monitoring system, including maintenance of field records to manage outreach activities more efficiently, particularly at GSA.

**STI Services**
- Information about the availability of the services should be included in the communication messages to the target population to increase awareness about the provision of services by SBGSS and GSA.
- There is a need to ensure that doctors working in the projects are trained in syndromic case management.
- Placement of trained counsellors with specific job descriptions is needed in two projects, SKS and SBGSS.
- Projects may consider relocating their clinics so as to increase access and privacy for the sex workers.
- Provision of appropriate space for physical examination is a high priority.
- Referral cards need to be developed and used on a regular basis for effective case management.
- Messages informing sex workers about improved quality services being provided by professionally-trained doctors and counsellors should be used intensively.
- Provision of mobile health care services should be considered for the mobile sub-section of the population.

**Condom Programming**
- Efforts should be made by UPSACS to ensure a steady supply of condoms to the sex worker projects.
- The projects should not consider monitoring condom use by sex workers as a reliable monitoring indicator. Data on this aspect of the outcome are only available through repeated surveys (Vuylsteke and Jana, 2001). Self-reported condom use is always a difficult measure, though heavily depended upon by most projects. It is well recognized that women are under pressure by these projects to claim improved condom use and are highly likely to exaggerate.
- Projects should aim to sell condoms to sex workers and this could serve well to confirm the rising levels of condom use.
- It is recommended that social marketing or selling condoms at subsidized prices, which is more sustainable than supplying free condoms, be adopted by projects. Social marketing of condoms and distribution of condoms to sex workers through multiple approaches—free, targeted distribution, community-based distribution programmes, clinic facilities, and other commercial outlets such as pharmacies, tea shops, and village stores—could complement each other to achieve a maximum availability of condoms. Condom social marketing and free distribution of condoms should complement one another.

**Enabling Environment**
- The project staff across the three projects need to develop an understanding that addressing the problem of recurrent police raids also requires a long-term solution. It requires the empowerment of the sex workers with information and
awareness about their legal rights and organization as a collective to deal with the police as a group rather than as individuals.

**Future Directions**
There is no single “best practice” approach to delivering an effective HIV prevention package to sex workers, their clients, and partners. However, critical lessons have been learnt over the past 15 years in India and across the world whereby intervention packages can be delivered in a more efficient way. This section draws upon the lessons and provides some future directions for the projects reviewed.

**STI Services**
It must be stated here that different projects have tried to increase the accessibility of services by promoting sex-worker-only clinics. For reasons of confidentiality, the clinic is located in a discreet place in a popular area in town, and does not advertise itself as a clinic. It offers free STI treatment, HIV counselling and testing, and condom promotion to sex workers and their regular partners. Specialized services for sex workers could provide them with additional safe and confidential options for sexual health services. Specialized services may also offer better opportunities for targeted educational sessions and regular screening activities (Vuylsteke and Jana, 2001).

**Using More Reliable Indicators**
While most of the TI projects simply ask women about their condom use, more recently, some projects in India and across the world have moved to asking how many condoms they are buying. This is a far better measure, assuming poor women will not buy what they do not plan to use, and is only possible when free condoms are not being distributed (UNAIDS, 2000). This can only be possible if the social marketing component is strong.

**Measuring Effectiveness**
Unless a project creates sound modes of measuring its success, it is very difficult to defend its practices, even if they are subjectively thought to be successful. Measures of impact or effectiveness, however, are often less well developed than process indicators. The type of impact indicators used must fit what the project is trying to accomplish and must accommodate all its major effects. The case studies indicate that there is no such effort to address this issue. Project personnel should also be able to use the data effectively for efficient programme management. Lack of any impact indicators for the projects would make it very difficult to measure the effectiveness of the interventions. UPSACS needs to consider capacity building for the programme management staff in designing responsive monitoring and evaluation indicators.

**Increased Community Involvement**
Community involvement is especially important to understand and address the needs of sex workers. These needs may have little to do with HIV/STI prevention,
but taking them into account helps to enhance the credibility and acceptance of the intervention. However, if intervention programmes targeting core groups are to succeed, they must be undertaken in full partnership with the targeted population. In the Sonagachi Project, for instance, peer educators were represented in several forms, such as the steering committee, participatory council, field committee, and NGO coalition (UNAIDS, 2000). TI projects could consider adopting these strategies for increased involvement of the sex worker community in the projects.

**Qualitative Research**
The three projects reviewed have conducted a quantitative baseline at the proposal development stage. There has not been any subsequent attempt at data gathering to inform the programme development of the projects. Qualitative situational assessments of sex workers, clients, boyfriends, and sex workers’ children could lead to a better understanding of the power structure as well as needs of the sex workers. This could further enable the projects to tailor the activities to the felt needs (both long- and short-term) of the community. The TI projects have now to start looking for information that will not only strengthen their implementation of prevention strategies but also help in designing long-term strategies for change.

**Documentation**
It was quite evident that NGOs had done a good job of maintaining photo documentation of the events organized by the project. However, process documentation of the project is equally important. Writing and/or using tapes and films to document the history of a project is a worthwhile endeavour of its own and has potential value for many others. NGOs could make efforts to document the success stories as well as actions that have not yielded results.

**Care and Support for Sex Workers**
Few sex worker projects in Southern India have involved HIV-positive sex workers in project implementation activities, which would help reduce stigma and discrimination.

**Creating an Enabling Environment**
There are often two contrasting perspectives that prevention projects for sex workers often grapple with as they go through the learning curve. One perspective is that the sex worker is a person whose livelihood places her in a highly vulnerable situation for acquiring HIV. Their livelihood, being illegal, is surrounded by layers of uncontrolled and abusive persons.

The other is that sex workers are a highly stigmatized group of people as their very existence challenges the standard family and reproduction-oriented sexual morality found in India. Sex worker projects must grapple with these variant perspectives, both in the society at-large surrounding the sex worker and in the views of the project personnel. The strategies taken by HIV prevention projects for female sex workers reflect these perspectives and set the tone in which the project is implemented. The TI projects reviewed seem to address high-risk behaviour on the level of the individual with advice, counselling, and peer education. However,
enabling approaches that remove social constraints to safer sex (or conversely, put barriers to unsafe sex in place) have demonstrated greater success (UNAIDS, 2000).

One of the most effective enabling approaches adopted by sex worker projects in other parts of India has been formation of sex worker collectives. Programmes around the world and in India have shown that collective bargaining strategies have not only forced clients to use condoms, but have helped sex workers access basic needs that further empower them to protect themselves. Different NGOs have uniformly found collectivization to be the least exploitative and the most effective strategy to build sustainability of safer sex practices, reduce stigma and discrimination, and promote health-seeking behaviours among sex workers. Over the last 10 years, work in different parts of the country has resulted in the formation of independent collectives of women in sex work in Andhra Pradesh, Delhi, Gujarat, Karnataka, Kerala, Maharashtra, Rajasthan, Tamil Nadu, and West Bengal. Currently, there are over 100 collectives with nearly 50,000 members.

It is recommended that efforts to collectivize sex workers should be made an integral part of creating an enabling environment for sex worker intervention projects in UP. Technical expertise within country should be made available to ensure that sex worker collectives/organizations are developed and made central to the planning, implementation, and monitoring strategies in the TI projects for sex workers.

Sex workers should be involved in project design and should make their priorities clear. PLHAs, whenever possible, should also be incorporated into project activities. This can help them and everyone else remember why they are working so hard.

**Conclusions**

The importance of designing and implementing successful TIs for sex workers as part of HIV prevention and control cannot be over-emphasized. Sex workers comprise a focal point of the epidemic, because infections can easily accumulate among them. The review of the three NGO case studies indicates that the projects are still in the early stages (2–3 years) of implementation and are in the learning phase. While there is a clear need for capacity building in technical and programmatic areas, it is important not to lose sight of the critical lessons learnt across India in working with sex workers.
Appendix 1

Profile of Female Sex Workers
A total of 288 respondents were covered among female sex workers during the 2001–2002 BSS in UP and Uttaranchal Pradesh. Around 28 percent of the respondents were ages 25–29 and 45 percent were in the age group of 30–39, with the median age being 30 years old. About 8 percent of the respondents were educated from Grade I–V and around 90 percent of respondents were illiterate. The mean age at marriage was 19 years old. Approximately 7 percent travelled to other places for sex work.

Awareness Related to HIV/AIDS
Awareness levels among the sex worker population were high: 96 percent had ever heard of HIV/AIDS and 84 percent were aware that HIV could be transmitted from mother to child. Among the 288 sex workers interviewed, 92 percent were aware that consistent condom use could prevent HIV and about 73 percent were aware that having one faithful uninfected sex partner could prevent HIV.

Awareness of STIs, Self-reported STI Prevalence, and Treatment-seeking Behaviour
Seventy-one percent of respondents were aware of common symptoms of STIs in men and 69 percent were aware of common symptoms in women. Genital ulcer/sores was reported by 3 percent of the target population. Of respondents who suffered from any symptom of STI in the last 12 months, the most popular source of treatment was private clinics and hospitals (36%) followed by government health centres (24%). Overall, 66 percent of the respondents reported private clinics and hospitals as the preferred source of treatment in case of future episodes.

Sexual Behaviour and Condom Usage
The mean age at first sex was 18 years old and the mean age when first started sex work was 20 years old. The mean number of paying clients on the last working was 2.6. Last time condom use with paying client was reported by 69 percent of respondents and with non-paying partner by 42 percent of respondents. In the category of paying clients, most of the respondents (93%) reported that their partners objected to using a condom and about 4 percent reported non-availability of condoms.

Other Salient Observations
Ninety-three percent of respondents usually insist that their clients use a condom, 69 percent reported that their client refused to use a condom in the last three months and, of these, 63 percent refused to have sex without a condom. Around 11 percent of respondents felt that they had a moderate chance of contracting HIV. Around 60 percent of all respondents felt that a confidential HIV test was possible in the area. Nearly 49 percent of respondents ever had an HIV test, of which 86 percent had a voluntary HIV test.
References


Targeted interventions (TIs) aimed at reducing the spread of HIV infection among groups that practise high-risk behaviours comprised one of the nine components in the National AIDS Control Programme (NACP)-I. In NACP-II, TIs became a very important programmatic strategy with a budgetary allocation of Rs. 265.6 crores, which was about 23 percent of the total budget.

One year after the first AIDS case was reported in Chennai in 1986, UP’s first AIDS case was identified. However, interventions in the state started five years later, with the formation of the State AIDS Control Cell under NACP-I. The Project Implementation Plan (PIP) for the NACP-II (1999–2004) for the State of UP, with its goal to reduce the spread of HIV infection, has a specific objective for TIs: “Reducing the spread of HIV infection in poor, marginalized populations at highest risk of HIV infection, especially commercial sex workers and their clients, truck/taxi operators, STI patients, industrial and migrant workers, street children, remand home inmates, jail inmates and intravenous drug users in the state” (UPSACS, 1999).

At the policy level, the PIP mentions targeting the following high-risk population in UP: brothel and non-brothel based sex workers and their clients, transport workers, industrial workers, migrant labourers, men who have sex with men (MSM), street children, prison inmates, and eunuchs. However, programmatic strategies were made only for projects targeting truckers, sex workers (SWs), and industrial workers with a budgetary allocation of Rs. 4314.421 lakhs (29.4 %). This allocation is somewhat in tune with the national pattern and that which followed in other states.

Even though a few TIs were piloted earlier, most of the TI projects were initiated in the state during 2001. This was the period of scaling up of TIs in the state. Table 1 shows details of the TIs planned and achieved by

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Planned Projects</th>
<th>Project Sanctioned</th>
<th>Percentage of Allocation to Different Target Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Truckers</td>
<td>20</td>
<td>19*</td>
<td>41.3</td>
</tr>
<tr>
<td>Sex Workers</td>
<td>17</td>
<td>12</td>
<td>26.0</td>
</tr>
<tr>
<td>Prison Inmates</td>
<td>0</td>
<td>9</td>
<td>19.6</td>
</tr>
<tr>
<td>Injecting Drug Users</td>
<td>0</td>
<td>6*</td>
<td>13.1</td>
</tr>
<tr>
<td>Industrial workers</td>
<td>7</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
<td><strong>46</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

* Inclusive of composite intervention in the Indo-Nepal border
the UP State AIDS Central Society (UPSACS) during NACP-II. Even though only 44 projects were planned in the PIP, it can be seen that the state is implementing 46 projects. Initially, no interventions were planned for injecting drug users (IDUs) and prison inmates, but six projects for IDUs and nine projects for prison inmates have been initiated. The baseline study conducted in the five districts bordering Nepal (UPSACS, 2001) has given the impetus to intervene with IDUs. There were seven TIs planned for industrial workers, but none have been implemented.

The largest percentage of the interventions (41.3%) is for truckers followed by SWs (26%), prison inmates (19.6%), and IDUs (13.1%). As per the 2003 National AIDS Control Organization (NACO)/Sexual Health Resource Centre report, populations practising high-risk behaviours are classified into two categories: core high-risk groups and other high-risk groups. SWs, MSM, and IDUs fall in the first category, and truckers, street children, migrant workers, and prison inmates fall in the second category.

Table 2 shows the coverage of vulnerable populations by TI in UP. About 50 percent of SWs and 30 percent of IDUs are already covered by different TIs in the state. However, no interventions are made with the other two core vulnerable groups, namely MSM and eunuchs. Even though networks of MSM exist in UP, such as Barosa in Lucknow, there has been no response in supporting TIs for MSM in the state. Since the objective of UPSACS is to reduce HIV infection among high-risk behaviour populations, TI programmes should now focus on MSM and eunuchs, and also on street children and migrants.

However, caution has to be made while doing an analysis based on the population sizes using the above two sources. This is illustrated by taking an example of the size of the SW population estimated by the Department for International Development (DFID) and CARE Mapping Study compared to estimates (e.g., target to be achieved in the interventions) of the partner NGOs. Table 3 shows the extent of variation in the estimates from the two sources. Except Aligarh and Lakhimpur Kheri, in all other places, the estimates made by NGOs of SWs are much higher in number than the estimates made by the DFID and CARE studies. In Basti, for instance, a project targeting brothel-based sex workers make an estimate of 300 SWs. On the other hand, DFID and CARE data estimate only 86 SWs in the entire district covering two sites. Thus, it can be seen that there is a big discrepancy in the available data. This could have been either due to the over estimation of the NGOs or the under estimation of the DFID and CARE Mapping Study.

An analysis of the districts that have vulnerable populations and those covered by TI projects in UP is presented in Table 4. It is interesting to note that TIs are initiated in
some districts that do not figure in the list of the first five districts having the largest vulnerable populations. On the contrary, Lucknow district, which figures in all the four ‘core high-risk group’ categories, does not have a single TI project. Similarly, Kanpur Nagar also figures out in the list of the first five districts that have maximum number of IDUs, MSM, and eunuchs and Agra for MSM and eunuchs. Hence, it can be concluded that the allocation of TI projects is not in proportion to the availability of vulnerable population in each district.

The following analysis is based on the data from four case studies conducted by the POLICY Project in 2003–2004. The objective of the study was to document the process, inputs, and outputs of a few TI projects and to generate some data relevant to UP. Analysis of data from the case studies of Sarvajan Kalyan Samiti (SKS) in Allahabad, Kshetriya Grameen Vikas Sansthan (KGVS) in Kanpur, Sri Bhardwaj Gramodyog Seva Sansthan (SBGSS) in Maharajgang, and Project Jail Awareness Initiative (JAI) in Lucknow is synthesized in this paper.

### Table 3
**Estimates of Population and Sites of SWs by NGOs and Mapping Reports**

<table>
<thead>
<tr>
<th>Districts</th>
<th>Population estimates by NGOs (1)</th>
<th>Sites covered by NGO interventions (2)</th>
<th>Estimates of sites in the district (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aligarh</td>
<td>64</td>
<td>202</td>
<td>1</td>
</tr>
<tr>
<td>Basti</td>
<td>300</td>
<td>86</td>
<td>1</td>
</tr>
<tr>
<td>Kanpur Nagar</td>
<td>1,180</td>
<td>818</td>
<td>2</td>
</tr>
<tr>
<td>Varanasi</td>
<td>600</td>
<td>231</td>
<td>1</td>
</tr>
<tr>
<td>Lakhimpur Kheri</td>
<td>350</td>
<td>487</td>
<td>3</td>
</tr>
<tr>
<td>Maharajganj</td>
<td>500</td>
<td>139</td>
<td>2</td>
</tr>
<tr>
<td>Bahraich</td>
<td>500</td>
<td>147</td>
<td>1</td>
</tr>
<tr>
<td>Allahabad</td>
<td>600</td>
<td>354</td>
<td>1</td>
</tr>
</tbody>
</table>

1. Data from UPSACS, 2003
2. ORG, 2003

### Table 4
**Districts that Have Vulnerable Populations and Coverage of TIs**

<table>
<thead>
<tr>
<th>Vulnerable population</th>
<th>First 5 districts having largest population (1)</th>
<th>Districts with TIs (2)</th>
<th>Districts not not covered by TIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Workers</td>
<td>Kanpur Nagar, Hardoi, Lakhimpur Kheri, Lucknow, Allahabad</td>
<td>Lakhimpur Kheri, Maharajganj, Kanpur, Aligarh, Basti, Allahabad, Bahraich, Varanasi</td>
<td>Hardoi, Lucknow</td>
</tr>
<tr>
<td>IDUs</td>
<td>Kanpur Nagar, Barabanki, Lucknow, Ghazipur, Maharajganj</td>
<td>Lakhimpur Kheri, Maharajganj, Bahraich</td>
<td>Kanpur Nagar, Barabanki, Lucknow, Ghazipur</td>
</tr>
<tr>
<td>MSM</td>
<td>Lucknow, Agra, Kanpur Nagar, Ballia, Mau</td>
<td></td>
<td>Lucknow, Agra, Kanpur Nagar, Ballia, Mau</td>
</tr>
<tr>
<td>Eunuchs</td>
<td>Kanpur Nagar, Lucknow, Barabanki, Hardoi, Lakhimpur Kheri, Agra</td>
<td></td>
<td>Kanpur Nagar, Lucknow, Barabanki, Hardoi, Lakhimpur Kheri, Agra</td>
</tr>
</tbody>
</table>

1. ORG, 2003
2. Data from UPSACS, 2003
Background of the Projects
Like all other TI projects, these projects are also implemented through NGOs, except the one for prison inmates that is managed by the Director General, Jail. For selecting the NGOs for implementing the TI, a panel of NGOs was initially prepared by the District Magistrate (DM) and Chief Medical Officer (CMO). The empanelled NGOs were trained on TIs by UPSACS and asked to submit a proposal. The final selection of the agency was based on the quality and viability of the proposal.

Among the four projects studied, two were initiated in 2001 and two in 2002. However, one of the truckers projects, implemented by SKS, was functional since 1998 under the Healthy Highways Project (DFID). Except SKS, none of the above organizations had prior experience in working with the target group or in the field of HIV/AIDS. Although NGOs have limited experience in HIV/AIDS, they are striving hard to reduce the spread of HIV/AIDS/STIs. None of the TI projects conducted needs assessments prior to project implementation.

Staff Structure
The staff structure in all similar projects is almost uniform, except for the post of counsellor. The project for truckers implemented by KGVS has a counsellor, while that implemented by SKS does not have a counsellor. There are minor changes in the designations of the project management staff. Out Reach Workers (ORW) are only available in projects for truckers and Peer Educators (PEs) only for projects targeting SWs, IDUs, and prison inmates. The ratio of the number of ORWs to the target population in the two TIs for truckers show striking differences and is inadequate. For instance, in KGVS, the ratio between the number of ORWs and the number of truckers is 1:4,032 and, in the case of SKS, it is 1:3,000. In other words, this shows that one ORW should establish contact with 4,032 truckers in a year and conduct information, education, and communication (IEC)/behaviour change communication (BCC), as well as provide condoms and STI care and treatment services. For these projects to be more effective, they need to develop an additional structure below the ORW, where Community Educators can be recruited and trained among the dhaba/tea stalls/workshops/petrol bunks, etc. It is also important to keep in mind that ORWs normally work during the day, while the sexual activity and the halt of long distance trucks are more during the night. These types of field-level issues are yet to be addressed systematically.

The projects have not internalized the concept of peer education completely. Some of the PEs are not from within the vulnerable community. For instance, the PEs for IDUs (e.g., from SBGSS) are not detoxified drug users or current drug users.

Even though the honoraria earmarked for ORWs and PEs in the project is the same, it was found that the projects are paying varying honoraria to PEs depending upon the time they invest in the project and the population they cover. It is understood that UPSACS has given a verbal consent to this practice and the respective NGOs are trying to manage it at their level. However, the field staff has expressed discontent towards this practice and also to the fact that there is no provision for
increments in their honoraria. It should be mentioned here that the salary structure of staff of TI projects is determined by the Steering Committee for Targeted Interventions constituted by UPSACS.

**Target Population**
The projects that were studied intervene with populations who practise high-risk behaviour, making them vulnerable to HIV/AIDS. They include SWs and IDUs, who are considered as core high-risk populations, and truckers and prison inmates, who are considered the bridge populations. The projects have been sanctioned by UPSACS depending upon the size of the vulnerable population in a particular area. For instance, Kanpur and Allahabad projects have a large number of truckers. In Maharaiganj (Sonouli) a mixed population of truckers, IDUs, and SWs exists and so a composite intervention project was sanctioned.

TI programmes in the NACP are focused interventions on a particular population group—a population practising high-risk behaviours and the bridge population. Such an approach was not feasible for the entire country because of the stipulation in the number of target population per unit and the area-specific nature of vulnerable populations. In some places, it was found that the issues of the target population were complex and the power dynamics with the stakeholders were crucial in intervention. For instance, if a TI project on truckers is to be effectively implemented, it has to deal with the truckers, on the one hand, and SWs, on the other. Only when there is a synergy in the intervention that meets the needs of both the clients (truckers) and the providers (SWs) will issues such as condom usage and behaviour change be effectively addressed—thus evolved the composite interventions. The project of SBGSS is one of the six composite interventions implemented in the districts bordering Nepal.

Through baseline studies and in-depth interaction with target audiences, the project team has developed a fairly good knowledge about the nature and environment of high-risk behaviours and the power dynamics in the field.

The baseline data collected by the organizations indicates multi-partner sexual behaviour, less condom use, and high rates of STIs among the vulnerable groups. Only male-to-female sexual behavioural practices were explored in these studies. Thus, male-to-male sexual behaviour is not explored or addressed in the interventions, even in projects for truckers. Poor knowledge levels regarding HIV/AIDS/STIs were reported and also a low level of health-seeking practices among the vulnerable population.

**Prison Project**
The project for prison inmates, JAI, has two major components: awareness building and STI counselling and treatment. The first component is achieved through one-to-one communication and motivation through peer educators; weekly interaction sessions led by the project coordinator and assistant project coordinator; and information provided through wall paintings, posters, and folk media with the help of NGOs.
In order to reduce the incidence of STIs, inmates identified through outreach are either referred to the jail hospital or treated during the routine health check-ups. Medical assistance is also obtained from a charitable hospital. Along with the issue of HIV/AIDS/STIs, the prison project also deals with the problems of tuberculosis (TB) and drug addiction. While the doctors provide treatment for TB, the NGO NIRVAN helps in drug counselling.

Another interesting observation is that the project is dealing with the issue of spirituality and HIV/AIDS. Religious people are brought in to preach about spirituality and HIV/AIDS.

Another finding is that legal barriers prevent jail authorities from providing condom supplies. In order to scale up the intervention, the project should now focus on BCC in the place of awareness generation.

**Behaviour Change Communication**

Rather than IEC (which is appropriate for the general population), TIs conduct BCC activities. The major difference between IEC and BCC is that BCC has an objective of inducing, reinforcing, and sustaining behaviour change among populations that practise high-risk behaviours. The aim of BCC is to provide communication that is designed specifically to support the change from unsafe behaviour to safe behaviour. It has a motivational component that is absent in IEC campaigns.

The projects aim at behaviour change among the vulnerable groups using a multi-pronged approach of one-to-one, one-to-many, and media-based communication. None of the projects had a BCC strategy written down to address vulnerable populations. There is a general understanding in all projects that one-to-one communication is the best means for behaviour change. Attempts are made to achieve this through verbal interaction and with the use of IEC materials. The case studies show that the IEC materials prepared by the projects, which include leaflets, pamphlets and stickers, provide information about HIV/AIDS/STIs and are meant for literate people. In order to effectively reach vulnerable populations, as many members of the vulnerable populations have a low literacy level, it is important to have more illustrations and presentations. Use of supportive materials such as flipcharts during one-to-one interactions will also be an effective strategy. Moreover, there is an urgent need to develop a comprehensive BCC strategy to motivate people for behaviour change.

One of the indicators for monitoring outreach in the computerized management information system (CMIS) and also the performance of the field staff is the number of contacts. It was noted that all the projects have achieved more than what is planned in terms of contacts established. However, discussion with the field staff shows that repeated contact with the same subject is counted more than one.

The one-to-many approach is also used through group meetings in all the TIs. The projects are also using folk media and video shows for community meetings.
The project office also functions as the drop-in centre. The signboard of SBGSS spells out the word HIV/AIDS in bold fonts and the office is located on the main road. Since the location of the office is strategically inappropriate, many of the target audience who are already marginalized and stigmatized hesitate to visit the drop-in centres.

**Condom Programming**
Under this component, the TIs should ensure that knowledge, skills, and services that are necessary for accessing and using condoms consistently and correctly in penetrative sexual acts are available for the high-risk populations. An enabling environment should also be created that will encourage the community to use condoms. While social marketing of condoms has not been initiated, condoms are distributed free of cost to the target population. The supply of condoms from UPSACS is not regular and, therefore, the projects make their own arrangements to collect condoms from the CMO in the district. Throughout the state, condoms are repacked into small packets/boxes that carry messages on HIV/AIDS. Condoms are mostly distributed to the target population by the field staff and through condom outlets (e.g., in the case of the truckers project). Field staff are making attempts to educate the target populations on correct condom usage. While all other projects make use of a model of the penis to demonstrate correct use of condoms, KGVS is not using this means.

All TIs studied have kept a target to raise condom use up to 90 percent, in accordance with the NACP-II objective. Large numbers of condoms are distributed to the target populations, but consistent condom use is very low. Since there is no system for independent verification of condom usage and projects rely on reported condom usage, the achievements claimed by the projects in terms of condom use are not reliable. Condom usage is given emphasis in interventions with truckers, but it has not been an integral part of the intervention with IDUs.

**STI Care and Treatment**
This component of TIs aims to provide knowledge, skills, and services that are necessary for detection and treatment of STIs among the target population. Even though preference is given for involving doctors with MBBS degrees, two projects (SBGSS and KGVS) involve doctors with BHMS and BAMS degrees. UPSACS has organized a session training on syndromic management of STIs for the doctors involved in the TI projects, but it was found that the doctor working in KGVS has not received training. In the interventions with truckers and IDUs, it was observed that the STI clinics were not systematically organized.

UPSACS has changed its policy from having mobile clinics with full-time doctors to static/mobile doctors who work on a part-time basis in TIs for truckers. Hence, the doctors visit makeshift clinics in places such as dhabas and, based on the oral description of symptoms (as there is no privacy for physical examination), offer treatment (KGVS and SBGSS). In the case of SKS, it runs a mobile clinic six days a week from its own resources and has developed linkages with referral doctors. The field staff identifies cases with symptoms of STIs and refers them to the clinic. The study of KGVS shows that there is an over-emphasis on STI identification and
treatment in the project, while the counselling associated with STI care and treatment is very ineffective. Much less attention is given to issues such as completing the course of treatment, abstaining from sex during treatment, partner treatment, myths regarding STIs/HIV and follow-up treatment.

**Enabling Environment**
There is not much clarity among the project staff, in general, about creation of an enabling environment and it is often considered as awareness generation. The objective of an enabling environment is to support and facilitate changes in the environment that enable the community to practise safer behaviours. SKS, which has previous experience in the Healthy Highways Project, has approached this component in a much more organized manner than other projects.

**Needle Exchange**
Needle exchange programmes are a behaviour change tool that is an integral part of TIs in UP for IDUs. It acts as a motivational tool by inviting drug users to the agency or drop-in center, where BCC efforts can occur while sterile needles are also provided. In SBGSS, it was found that new needles are “distributed” instead of “exchanged” for used needles. It was also observed that disposable syringes are provided by the project. However, the volume of the syringe does not meet the requirements of making the cocktail of the drug and “booting”* which is the practice in the project area.

**Data Collection and Reporting Systems**
Different formats and systems are in place for collecting and reporting data from the field (e.g., monthly, semi-annual, and annual). While SKS has a well-developed system to collect data from the field, in other NGOs there is no such formal system. Indeed in other NGO’s data collection relies entirely on verbal reporting.

As per UPSACS guidelines, the NGOs inform the members of the District AIDS Coordination Committee (DACC) about all programmes they undertake and the financial statements are sent to UPSACS through DACC. This system has a control function, but the NGOs were concerned about the delays involved in this process.

All projects experienced a delay in the release of funds from UPSACS. One organization did not receive half of the approved budget (the one instalment) in 2002–2003 and another experienced a delay of four months in getting the second instalment in 2002–2003. The delay in flow of funds has affected the programmes. Staff salary and other payments are made in cash.

**Recommendations**
- UP-specific TI operational guidelines can be prepared with the consent of NACO.

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*“Booting" is a practice where blood is drawn into a syringe, mixed with the drug, and then injected back into the vein*
On the basis of the report of mapping vulnerable populations in the state, TIs should be initiated for MSM and eunuchs in the core group and street children and migrants in the bridge group.

NGOs should conduct needs assessment studies before initiating interventions.

NGOs should ensure that field offices are located in an appropriate place that is more accessible by vulnerable populations. Signboards highlighting HIV/AIDS should be avoided.

TI projects for truckers should be encouraged to build capacity of Community Educators selected and trained from people in the dhaba/workshop/pan shops, etc., through whom condoms and IEC materials can be distributed round the clock.

Interventions for prison inmates should scale up by moving from awareness generation to BCC activities.

A comprehensive BCC strategy should be developed covering different vulnerable groups.

The quality of BCC materials has to be improved in the TI projects. Workshops for developing this should be organized involving partner NGOs and communication experts.

In order to motivate people for behaviour change across the continuum of high risk/low risk/no risk, BCC strategies should address all forms of sexual behaviours, including male-to-male sexual behaviours.

The practice of distributing needles should be changed to exchanging used needles.

The practice of “booting” among IDUs should be changed to reduce the spread of HIV infection through contaminated syringes that they might share.

Social marketing of condoms should be initiated in the state.

UPSACS should ensure that there is a regular and sufficient supply of condoms as required by the projects.

Capacity building of project staff is essential. A capsule training module should be developed and training should be imparted in a phased manner.

Regular flow of funds should be ensured from UPSACS to the projects to avoid disruption in services and to maintain quality.

In order to make the programmes more transparent, salary of the project staff should be made through cheques.

The projects should provide the same honorarium to all PEs.

References
Blood transfusion services have a vital role in the national health services delivery system. Blood resources are plenty in our country, but we are not able to mobilize and utilize them efficiently. Adequate, safe, and quality blood can save lives whereas contaminated and infected blood is life threatening. In the National AIDS Control Programme (NACP), blood safety is a major component because the likelihood of HIV infection by the blood route is 100 percent while the likelihood of infection through sexual contact is 0.1-1 percent.

**Objectives**

The major objectives of the blood safety programme is to ensure easily accessible, adequate supplies of safe and quality blood and blood components for all, irrespective of economic or social status. To achieve the above aims, the following objectives are drawn:

- To reiterate firmly the government’s commitment to provide a safe and adequate quantity of blood, blood components, and blood products;
- To make available adequate resources to develop and reorganize the blood transfusion service in the entire country and in UP;
- To make the latest technology available for operating the blood transfusion services and ensure their functioning in an updated manner;
- To launch extensive awareness programmes for donor information, education, motivation, recruitment, and retention in order to ensure adequate availability of safe blood;
- To encourage appropriate clinical use of blood and blood products;
- To strengthen the manpower through human resource development;
- To encourage research and development in the field of transfusion medicine and related technology; and
- To take adequate regulatory and legislative steps for monitoring and evaluation of blood transfusion services and to take steps to eliminate profiteering in blood banks.

To fulfill the above objectives, the actions described below are being taken in our state.
Organization of Blood Donation Camps:
- Voluntary Blood Donation Day on 1st October
- World AIDS Day on 1st December
- National festivals:
  - 26th January (Republic Day)
  - 15th August (Independence Day)
  - 2nd October (Birth Anniversary of Mahatma Gandhi)
- Other occasions:
  - 7th April (World Health Day)
  - 8th May (World Red Cross Day)
  - 1st July (Doctors’ Day)
  - 24th November (International Blood Donation Day)
  - Dates of personal importance (e.g., birthday anniversary, marriage anniversary, parents’ death anniversaries, etc.)

Allocation of funds to all government and charitable blood banks for voluntary blood donation camps.

The donor motivation programme has been made to aim at creating general awareness and to encourage firm determination in the minds of potential donors.

Target for the Year 2004: To increase the percentage of voluntary blood donation in the year 2003 by 50 percent.

Voluntary Blood Donation

To enhance voluntary blood donation in the state, the following steps have been taken:
- Advertisements and wide publicity through:
  - Print
  - Electronic
  - Folk media (undertaken from time to time)
The motivation of donors is being carried out as follows:

- By holding symposia, seminars, talk discussions, get-togethers, and street corner meetings at regular intervals;
- By displaying posters and hoardings at prominent places; and
- By holding competitive contests and public exhibitions.

**Reinforcement**

- Professional blood (paid blood donation) has been banned in the UP State since 1st January 1998 by the orders of the Honourable Supreme Court. Since then, the licensed blood banks are supplying the voluntary and exchange/blood units.
- The Drug Controller of India and of UP are issuing the licenses for blood banks and blood component separation centres under the Drug and Cosmetics Act of 1945. Licenses are renewed at regular intervals. Regular inspections are being done by the Regional Additional Drug Controller/Drug Inspector and the officers of UPSACS and the Medical Health Department.
- It is mandatory to test all donated blood for the following transfusion-transmitted infections:
  - HIV
  - Hepatitis B
  - Hepatitis C
  - VDRL (Syphilis)
  - Malarial Parasite
- Appropriate actions are taken by the competent authorities for blood banks that do not follow the provisions of the Drug and Cosmetics Act of 1945.

**Monitoring and Evaluation**

To maintain the quality control of blood and blood components, regular monitoring is done:

- Since blood banks are licensed under the Drug and Cosmetics Act of 1945 by the Drug Controller of India and UP State, the regulatory and controlling authorities are the Drug Controller of India/UP State/Additional Drug Controllers and Drug Inspectors of the Districts. The technical monitoring and evaluation of blood is done by UPSACS and the Department of Medical Health.

**Future Strategic Plans**

**Blood Safety**

To promote 100 percent voluntary and non-remunerated blood in the state, the following strategies should be implemented:

- Qualified and adequate staff should be posted as per Medical College of India/NACO/UP Government recommendations.
- In addition, one immunologist/serologist for each blood bank should be posted.
- Voluntary Blood Donation Officer to be employed on contract (Subject to approval of NACO).
- Incentives should be offered to blood bank personnel in the form of awards at district, state, and national levels:
  - Funding for maintenance, repair, and purchase of equipment, consumables and disposables;
- One Generator set of 25 KVA with POL and attendant; Male and female counsellors have to be posted in blood banks (subject to sanction by NACO);
- Mobile blood donation van to major blood banks; and
- Sufficient supply of condoms for free distribution.

**Administration**

- National blood policy is being implemented.
- All the blood banks in the state must be under the complete administrative technical and financial control of UPSACS or the Director-General (DG) for Medical and Health Services of UP.
- Formation of a separate cadre for blood banking services by the government.
- Transfer of medical and para-medical workers from one blood bank to another blood bank only.
- Uniform and reasonable testing charges for public and private sector blood banks. The generated revenue must be utilized like user changes.
- Free insurance to blood bank personnel against inherent risk to be covered by the government.
- The State Blood Transfusion Council to be strengthened to provide assistance and guideline to blood banks—separate office, officer, staff, and funds—should be arranged.
- There should be blood component separation facilities at every district-level blood bank.
- Training programmes and continuing medical education for government and private blood bank personnel should be organized at regular intervals.
- Regarding voluntary blood donation, awareness programmes should be started at regular intervals at the district level under the supervision of the State Blood Transfusion Council.
- Annual Maintenance Contracts for all electronic and sophisticated equipment should be done by UPSACS, irrespective of the supply agency (e.g., UP Government or charity).
- Ensure a regular supply of consumables and disposables, reagents, kits, etc.

**Documentation**

- Blood banks supplying more than 5,000 units per annum must be computerized with networking with other blood banks and UPSACS/DG Medical and Health Services, UP.

**Quality Control**

- A revised list of testing materials, such as chemicals, consumables, disposables, and reagents, must be released by NACO along with reasonable funds.
- Equipment should be supplied to the blood banks as per the provisions of license rules and the Drug and Cosmetics Act of 1945.
- ZBTCs should be strengthened and recognized as zonal training centres for para-meds.
- A Technical Resource Group is formed at the state level to provide technical assistance to blood banks and blood component separation units.
Clinicians should be sensitized for rational use of blood and blood components.

Introduction of transfusion medicine in the syllabus of MBBS course.

Provision for in-service diploma course in transfusion medicine, like the diplomas in Child Health, Clinical Pathology, Gynaecology and Obstetrics, etc.

Disposal of Infected Material

- Sufficient supply of disinfectants.
- Separate incinerator and autoclave should be supplied to the blood banks.

Steps to be taken

UPSACS is committed to the provision of safe blood to the needy patients in the state. To achieve the goal of 50 percent voluntary blood units in the current year, the following steps are proposed:

- More voluntary blood donation camps to be organized on regular basis.
- Targeted information, education, and communication (IEC) materials to be developed for voluntary blood donation for rural and urban populations separately.
- All single-time voluntary blood donors should be motivated and counselled to become regular, periodic donors.
- Sufficient funds are arranged for the strengthening of the State Blood Transfusion Council for various activities.
- Regular inspections should be done by the officers of UPSACS/DG Medical and Health Services and the Drug Controller of India and UP State for surveillance and quality control. Sufficient funds for TA/DA should be arranged.
- Infrastructure of the blood banks should be fulfilled by the government.
- Every district hospital should have at least one blood bank. Steps are under process.

Table 3

Details of Blood Units Collected

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Background
As of December 2002, India was estimated to have 4.58 million people living with HIV/AIDS (PLHAs) (National AIDS Control Organization [NACO], 2003). UP currently is still in the NACO category of a low prevalence state, as the HIV prevalence rate is less than 5 percent in groups that practise high-risk behaviours and less than 1 percent in women who attend antenatal clinics. However, UP has many of the characteristics that may lead to increased prevalence, including a high population of migrant labourers to high prevalence areas, and indications such as high rates of sexually transmitted infections (STIs), which suggest significant levels of high-risk behaviours. As in many other countries, the main route of spread is sexual, with over 84 percent of HIV in India transmitted sexually.

NACO has outlined its strategy to decrease sexual transmission routes with the “ABC” approach. Specifically, this is defined as “Abstaining from sex, mutual monogamy between uninfected sexual partners, and correct and consistent condom use.” These are the only existing options for avoiding infection through the sexual route. Evidence suggests that in those places where HIV prevention efforts have been successful in reducing the prevalence and infection rates, condoms have invariably played a key role. Prevention efforts through condom promotion are highly cost effective, providing an option that is simple, affordable, and life saving.”

The approach has been shown to work in Uganda, where the focus has been abstinence for adolescents, faithfulness to partners, and condom use for those who are not using the first two methods. (Or else “D, you die”, states Ugandan President Museveni.) In Thailand, the focus has been on ensuring 100% condom use in brothels, monitored via STI prevalence rates and enforced through the joint efforts of the police and business interests. By focusing on reducing sexual transmission of HIV, Uganda has decreased its HIV prevalence from 30 percent to 11 percent, while Thailand has kept the general population rates low and avoided a health system crisis. The key is to either reduce the number of sexual partners or reduce transmission between partners.

Given the important role that correct and consistent condom use can play in keeping UP a low prevalence state, it is necessary to understand the current situation...
regarding use, availability, and attitudes. Since India has primarily focused on the condom for family planning for the last 50 years, it is not surprising that most of the surveys and available data focus on use for prevention of pregnancy. However, some studies among the general population are available that look at use for prevention of STIs, including HIV, and use in high-risk behaviour. Very few studies are available in UP that document condom use among populations in areas or situations subject to high-risk behaviour (see other workshop papers).

In developing a strategy for condom use in HIV prevention, the tendency is to focus only on targeted interventions to specific locations or groups. However, due consideration must also be given to the condom’s key role in family planning and the continuous efforts over the last 50 years to make condoms an acceptable health product. In addition, as the virus spreads, important sexual transmitters, such as clients of sex workers or men with more than one partner, may only be reached through efforts in the general population. The special properties of the condom for dual purpose protection can be used to advantage in the UP strategy.

**Condom Use in the General Population**

The National Family Health Survey-2, 1998–1999, revealed that condom use nationally was 3.1 percent, with 7.2 percent use in urban areas and 1.6 percent in rural areas. This survey was conducted among married women of reproductive age and is therefore indicative of use primarily for family planning purposes. Over 70 percent of respondents were aware of condoms as a method of family planning. Users reported their main condom source as the private sector, ranging from 83 percent in urban areas and 67 percent in rural areas.

In UP, the most recent survey of condom use statewide is the Reproductive Health Indicator Survey (RHIS) that was conducted in October 2003 (see Figure 1). The survey of women of reproductive age showed condom use in total as 4.7 percent, making it the major spacing method. Urban use is much higher at 12 percent, with rural use only at 3 percent. Condom users tended to be highest in the 25–34 age group (6.7% vs. 3.4% for ages 15–24 and 3.8% for those over 35); among those with higher income levels (12.1% are in the highest income group vs. 1.9% in the low income and 4.5% in the middle income groups); and among those with higher education levels (12.9% for those with high school or more vs. 2.5% for illiterates).

Interestingly, the 2003 RHIS also surveyed men and found higher reported condom use, at 6.3 percent statewide. This could be due to over-reporting or this figure may be due to use outside marriage and for non-family planning purposes.

The BBC World Service Trust baseline survey in 2001, which included sexually active men in UP,
Prevention of HIV/AIDS in Uttar Pradesh

From April 2002–March 2003 was approximately 31.1 crore, including reporting of 11.9 crore condoms distributed through the public sector. ORG retail surveys show a volume of 19.2 crore condoms sold during the same period. Since the commercial market is the primary source for condom users, it is important to look at the trends in sales and availability in the market.

On a statewide basis, the total volume of condoms sold has increased from 3.8 crore for July–September 2000 to 5.5 crore in the most recent report available, July–September 2003 (see Figure 3). This represents an increase of 45 percent in three years. Urban sales of condoms have been fairly flat over this period, showing more in trends of brand share changes. Commercial condom brands have decreased while social marketing brands have increased, yet the total urban volume has been steady. This is at least better than the trends in other North India states where urban sales of both segments have been decreasing over the last two years by over 7 percent.

Condom Availability and Accessibility in UP

The total volume of condoms available for use in UP from April 2002–March 2003 was approximately 31.1 crore, including reporting of 11.9 crore condoms distributed through the public sector. ORG retail surveys show a volume of 19.2 crore condoms sold during the same period. Since the commercial market is the primary source for condom users, it is important to look at the trends in sales and availability in the market.

Rajasthan, and Delhi, found that 70 percent had not used a condom in the last year, while 4 percent used it every time and 26 percent sometimes.

The source of condoms in the survey of women was reported as primarily the private sector, with 87 percent from the market and 4 percent from private clinics in urban areas (see Figure 2). In rural areas, private sources decreased somewhat, with 70 percent from the market and 7 percent from other private sources. Government supply accounted for 23 percent in rural areas. Male respondents reported much the same sources, with the majority of condoms coming from shops in the market.

Figure 2
Source of obtaining condoms as reported by women in UP (RHIS)

Figure 3
Condom sales volumes in UP (ORG Retail Unit, 1997–2003)
Most of the increase in statewide condom sales in UP has been in the rural areas, where the volume has finally surpassed urban sales. According to ORG, over 3.2 crore were sold in rural UP from July–September 2003 compared with 1.55 crore from July–September 2000. This represents a 100 percent increase in volume. UP is the only northern state with significant increases in condom sales, with Madhya Pradesh a very distant second and only a slight increase in rural sales.

These noteworthy increases in rural sales are due to the strategic efforts of the State Innovations in Family Planning Services Project Agency (SIFPSA) to increase not only the promotion, but also the availability, of condoms in villages of UP. According to specially commissioned surveys by the ORG Social Research Division, in June 2003, condoms were available in 71 percent of UP villages, as opposed to only 39 percent of villages in 2000.

In 2001, NACO conducted a survey of the general population in 35 states. It was found that condom accessibility was fairly high, as 91 percent of urban respondents and 83 percent of rural respondents felt that a condom could be procured in less than 30 minutes time. In UP, the same survey showed 86 percent of respondents felt that condoms were easily procured in their area. Time for procurement of less than 30 minutes from residence dropped from 71 percent for urban respondents to 27 percent in rural areas; however, as noted above, there has been significant improvement in condom stocking in rural areas since 2001.

In India, the vast majority of the 65.5 crore condoms in the market are sold through chemist shops. However, grocers, general stores, and paan shops also sell significant numbers of condoms and represent a much larger number of current and potential outlets. Non-chemist outlets become especially important in rural areas as chemist shops are not present in most rural villages. One of the key strategies of SIFPSA’s rural marketing efforts was to make condoms available in non-chemist outlets.

**Condom Brands and Pricing**

A wide range of good quality condom brands at a range of prices is available in UP. The urban market has a much wider selection of choices (see Table 1). The social marketing brands Nirodh Delux and Masti lead the market with brand shares of 37 percent and 26 percent, respectively. At the next level, the two commercial brands Kohinoor and Kamasutra have 10 percent and 6 percent shares, respectively. The remaining social marketing and commercial brands all make up less than 5 percent of the market. A special category of condom known as the “Indian Made Foreign Condom” (IMFC) has increased in the markets of India over the last few years. These are essentially condoms produced in India, but packaged to look as though they had been imported. Approximately 110 brands are available in this category, but do not appear to have significant sales or presence in UP yet.

### Table 1

**Market Share of Condoms in UP**

<table>
<thead>
<tr>
<th>Brand</th>
<th>Urban</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nirodh Deluxe</td>
<td>37%</td>
<td>86%</td>
</tr>
<tr>
<td>Masti</td>
<td>26%</td>
<td>5%</td>
</tr>
<tr>
<td>Kohinoor</td>
<td>10%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Kamasutra</td>
<td>6%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Zaroor</td>
<td>5%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Sawan</td>
<td>4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Moods Supreme</td>
<td>3%</td>
<td>-</td>
</tr>
<tr>
<td>Rakshak</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Sajan</td>
<td>2%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
In rural areas, again, Nirodh Delux and Masti have captured the market. However, in rural areas, Nirodh Delux is the clear winner at 86 percent, with Masti and Rakshak coming in at a distant 5 percent and 3 percent share, respectively, and others all capturing less than 1 percent of the market. This is not surprising given Nirodh’s long history in the market, its very low price suitable for low-income users, and the intense promotion in the SIFPSA marketing activities over the last three years.

Prices of condoms range from a high of Rs. 30 for a three-pack of Durex to a low of Rs. 2 for Nirodh Delux as a pack of five pieces. Within this range, there is much choice according to the pocket and the loyalty of the user. The second market leader, Masti, costs Rs. 5 for a pack of four, while the commercial leaders Kohinoor and Kamasutra are available at Rs. 10 and Rs. 14, respectively, for a pack of three. The social marketing brand Nirodh Delux has been available at Rs. 2 since 1989, although the cost of manufacture has increased significantly since then. Commercial product prices have necessarily increased over time as cost of products and marketing have increased, and also partly due to the need to maintain profits in the face of decreasing market shares as social marketing subsidized products increase in share.

Condom quality was considered a major concern in the late 1980s as the threat of HIV/AIDS was anticipated. However, much of this concern has been addressed through improvements in the manufacturing and testing processes, especially for producers Hindustan Latex Ltd. (HLL), J.K. Ansell, and TTK London International Group (TTK-LIG). World Bank and USAID funds and technical assistance have ensured that these condoms meet World Health Organization (WHO) standards for quality at the point of manufacture and the Government of India routinely samples products procured for public sector or social marketing supplies. However, a recommended packaging change to a more durable packaging has not yet been implemented and there are concerns about storage at the retail shop level. Condom quality at the field level is addressed in other programmes (e.g., the AIDS Prevention and Control (APAC) Project in Tamil Nadu) through occasional testing of samples from the market. SIFPSA also introduced a requirement for quality assurance for the rural marketing activities. Any strategy to address condom use in UP for HIV prevention should include an element of quality assurance and monitoring at production and market levels.

**Condoms and HIV/AIDS: Knowledge, Attitudes, and Behaviour**

The Behavioural Surveillance Survey (BSS) commissioned by NACO in 2001 shows a high awareness of condoms in UP respondents, at 81 percent overall. Female respondents had slightly less awareness than male respondents at 77 percent. Knowledge of sexual transmission of HIV was fairly low at 44 percent overall. Urban levels were higher at 65 percent, but only 40 percent of rural respondents...
were aware that HIV could be transmitted sexually. Men were more knowledgeable (59%) than women (31%). Knowledge of sexual transmission was almost directly reflected in knowledge that condom use could prevent sexual transmission of HIV, with an overall average of 44 percent. Only 29 percent of women were aware of this vital protective information.

The 2001 BSS in UP estimated that 4 percent of respondents had sex with a non-regular partner. Positive response was slightly higher in rural areas (4.1%) than in urban areas (3.1%). Over 8 percent of men reported sex with a non-regular partner compared to only 0.4 percent of women. This large difference may be due to under-reporting by women or it could be a reflection of a survey of the general population (e.g., not including female sex workers).

Prevention of HIV transmission requires correct and consistent condom use. A standard measure of most HIV/AIDS prevention programmes is condom use with the last non-regular partner. A more rigorous method is consistent use with non-regular partner(s) in the last three months or last 12 months. However, knowing the role a condom can play in preventing transmission of HIV does not ensure use, even in potentially risky situations. Of the 2001 BSS respondents with non-regular partners, only 28 percent used a condom at all and only 18 percent reported consistent use.

The BBC World Service Trust survey of 2002 shows similar results a year later (see Figure 4). The survey of sexually active adults shows that 4 percent report sexual relations with a non-regular partner. Yet, of these, only 16 percent use a condom consistently and 41 percent report sometimes using a condom.

Why is it that despite knowing the increased risks of HIV transmission through sex, men are still not using condoms? Among reasons given for non-use are shyness and embarrassment (26.3%), partner unwilling to use (23.7%) and reduction of pleasure (1.4%). Some say that a woman would lose respect if she insisted on condom use (15%). Social pressure for use does not appear to be strong, either for family planning or HIV prevention. The perception that many people in the community use condoms has decreased from 50 percent to 41 percent over the last one year. (BBC World Trust Service, 2002).

Successful interventions in other HIV prevention programmes have shown that interpersonal communication is a key element to increasing the sense of personal risk and encouraging risk reduction measures. It is also important to ensure that condom negotiation and use skills are taught. Anecdotal evidence suggests that many men in UP may not know how to use a condom correctly and, in fact, may never have physically handled or tried one. The 2002 BBC World Service Trust survey shows that respondents have received interpersonal communication in the following

<table>
<thead>
<tr>
<th>Purpose for Using Condoms (BBC World Service Trust, 2001 and 2002)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STI Protection</td>
</tr>
<tr>
<td>HIV Protection</td>
</tr>
<tr>
<td>All Three</td>
</tr>
</tbody>
</table>
areas: HIV/AIDS (11%), condoms (6%), STIs (5%), sexual relations (5%), and safe sex (4%).

In the last few years, with the increased awareness of HIV/AIDS, the perception of the use of the condom may be changing. In the baseline BBC World Trust Service survey of 2001, 86 percent of respondents said that the purpose of the condom was for family planning; 42 percent said for HIV/AIDS; and 16 percent said for STIs. All three uses were mentioned by 8 percent of respondents. However, in 2002, those reporting family planning as a purpose decreased to 60 percent, while STI protection and HIV protection had increased to 39 percent and 47 percent, respectively (see Table 2). This is a clear shift in perception of the condom as a tool for disease prevention rather than for family planning.

**Summary of UP Condom Situation**

Many of the elements for condom use promotion for prevention of HIV/AIDS are already in place in UP. Most users get their condoms from the market and condoms are widely available in the markets in both urban and rural areas. Stocking by non-chemist outlets may need to be increased to ensure availability beyond shop hours. The 2001 BSS suggests that accessibility (e.g., procurement in less than 30 minutes) may need to be increased, especially in rural areas. However, the latter may already have been addressed through the rural marketing activities.

There is a wide choice of brands and prices available in the urban market. The rural market is more limited and may need some increased choice of brands. Quality does not appear to be an issue at the manufacturing level, but monitoring of condom quality at the market level is a recommended practice to ensure its protective nature.

Awareness of HIV and its transmission routes appears to be growing, although there is room for increased knowledge at the rural level and among women. Awareness of the role of the condom in HIV prevention is much lower than awareness of condoms and is consistent with the lower level of understanding of sexual transmission of HIV.

Condom use in the general population is still low compared with other countries, especially in the rural areas and there is still room for an increase in condom use for family planning. There is also clearly a need to increase the correct and consistent use of condoms in high-risk situations. Condom use in high-risk situations in the general population (e.g., non-regular partners) is very low at 28 percent, with consistent use at only 18 percent. A sense of personal risk needs to be increased, with encouragement of the benefits of condom use through various communication avenues, including interpersonal and localized interventions.

Correct use among users in UP has not been studied and is difficult to measure. However, efforts to increase familiarity with the condom and its correct use often break barriers to trial and eventual usage.

Finally, there are some potential concerns in the focus on condoms as a weapon in the battle against HIV/AIDS. India has successfully promoted the condom for over
50 years as a family planning method. The Nirodh has achieved a level of acceptance and respectability for this purpose. In UP, a male-dominated society, it is still the major spacing method. There are some warning signs in the decreasing perception of the condom for family planning and more for STI/HIV prevention. Once the condom becomes associated more with “illicit” sex, it will no longer be seen as a socially acceptable product and both men and women will be more hesitant to be seen using it. Therefore, every effort must be made to promote the condom for its dual role in prevention of both pregnancy and HIV transmission and to ensure social and environmental support for its use.

**Recommended Way Forward for Condom Use in UP Strategy**

At the level of the general population:
- Promote condom use for its dual function: prevention of pregnancy and HIV transmission;
- Improve acceptance of condom use as normal responsible behaviour for men;
- Continue to expand the sales and availability of condoms;
- Increase visibility of condoms and point-of-sale brand promotion;
- Reach out to population with “Abstinence” and “Be Faithful” messages, but ensure that condom use is expected for high-risk behaviour; and
- Monitor quality and conduct market checks.

For targeted interventions in high-risk behaviour locations and vulnerable populations:
- Increase local environmental and community support for condom use;
- Display localized media promoting condom use;
- Increase availability in high-risk locations (e.g., ensure accessibility beyond shop hours);
- Provide free or sell priced products according to target group needs; and
- Conduct interpersonal communication for
  - Increased perception of personal risk;
  - Increased consistent use for high-risk behaviour; and
  - Increased knowledge of condom correct use and encouragement of trial.

**References**

GIPA and PLHA Network

Chairperson
Anjali Gopalan

Common Ground: The Greater Involvement of People Living with HIV/AIDS in India
Satheesh Chandran

Networking for Change: The Indian Network of People Living with HIV/AIDS
Geetha Venugopal

Involvement of Women Living with HIV/AIDS: Experiences of Positive Women’s Network
P. Kausalya

Discussants
David Stephens and Anandi Yuvaraj
Prevention of HIV/AIDS in Uttar Pradesh
Executive Summary
HIV/AIDS is the most stigmatized of diseases. The history of the epidemic is replete with examples of prejudice and discrimination. It is also a history of human courage and endurance. People living with and affected by HIV/AIDS (PLHA), including communities perceived as vulnerable to HIV infection, have borne the brunt of societal attitudes and actions aimed at excluding them from the resources they need to live in dignity. The response from PLHAs has been one of the most remarkable features wherever the epidemic has taken hold. This has taken the form of people supporting each other and establishing groups and networks where they can feel safe and secure, reaching out to the general community to educate people about HIV/AIDS, and fighting HIV/AIDS related stigma and discrimination. It is through these efforts that the concept of PLHA involvement in the response to the epidemic has grown. In Paris in 1994, an international conference representing 42 governments including India, declared the concept of the ‘greater involvement of people living with HIV/AIDS’ or GIPA.

The greater involvement of PLHA (GIPA) has become the most enduring legacy of the Paris Declaration. GIPA has been incorporated into national and international programme and policy responses and has been taken up as a model of best practice in the response to HIV/AIDS. GIPA calls on governments to support a greater involvement of people living with HIV/AIDS through an initiative to strengthen the capacity and coordination of networks of people living with HIV/AIDS and community-based organizations. By ensuring their full involvement in our common response to the pandemic at all national, regional and global levels, this initiative will, in particular, stimulate the creation of supportive, political, legal and social environments. (ICASO 1996)

Effects of GIPA over time in the national HIV response
The value of the GIPA approach lies in the impact that greater visibility and involvement of PLHA has on all aspects of HIV/AIDS programming and policymaking. The core elements are summarized below.

- Programmes to prevent further transmission are enhanced because people become aware that HIV is relevant to them, as they meet people similar to themselves who are already infected with HIV.
• PLHAs are able to access more effective family and community support and care as others become more accepting of HIV as an illness and people become less fearful.
• Adverse consequences of HIV infection are reduced, including stigma, fear, rejection, discrimination, and divisions between rich and poor, as the human face provided by PLHAs becomes a more common feature of community life.
• Other initiatives to promote sustainable human development are enhanced through lessons learnt in the people with AIDS (PWA) mobilization process, about how to involve vulnerable people in the development decisions that affect them.

Findings
This report outlines the preliminary findings of a research project aimed at assessing perceptions and levels of GIPA in responses to the epidemic in three states in India. The research was carried out in Andhra Pradesh, Tamil Nadu, and Uttar Pradesh. A total of 18 interviews were conducted with leaders of national, state, and district PLHA networks, state HIV/AIDS programme managers, and representatives of non-governmental organizations (NGOs).

The report provides a qualitative account of GIPA based on the perceptions and views of the respondents interviewed. GIPA remains an elusive concept, and one which is difficult to quantify. In part this is a reflection, as this report will show, of the differing and sometimes conflicting ideas of what involvement means and how it can be realized. The findings of the study are illustrative rather than general. However, the findings of the study are consistent with similar research conducted in India and in other countries around the world.

The following table presents the key findings of the research. A full account is presented in the main text of the report.

Discussion and Recommendations
Responding to the challenges: “No one is born with skills—skills have to be developed.”

The study shows a highly varied picture of GIPA in the states visited. However, within this variation there are commonalities.
• Understanding of GIPA is limited for both PLHAs and other stakeholders.
• The practice of GIPA is also limited and there has yet to be a significant GIPA response.
• The barriers to implementing GIPA are mostly factors which are manageable.
• There is a need to continue and expand the dialogue on GIPA and develop greater clarity on how GIPA principles can be converted into programme activities.
• There is a clear need to build the capacities of all concerned—especially PLHA—to implement these programmes.

The findings also show that the promotion and implementation of GIPA-related activities in India has the potential to significantly improve the response to
HIV/AIDS. There are a diversity of views on the value of the concept and the degree to which GIPA should be implemented. However, the study suggests there is significant common ground among stakeholders on issues that are central to meaningfully incorporating GIPA as a theme of the Indian response to HIV/AIDS. All participants expressed the opinion that GIPA needs to be understood as an idea that makes sense in the context of the epidemic in India, and that it should be developed and implemented in ways that advance the interests of those it is designed

### Table 1

**Overview Table: Perceptions of GIPA**

<table>
<thead>
<tr>
<th></th>
<th>PLHA networks</th>
<th>Programme managers</th>
<th>NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Knowledge of GIPA</strong></td>
<td>National level PLHA network people have a clear understanding of GIPA.</td>
<td>Most state-level programme managers have very little knowledge about GIPA.</td>
<td>NGO networks have a limited awareness of the concept of GIPA.</td>
</tr>
<tr>
<td></td>
<td>State and local-level PLHA networks have less clarity about GIPA and some of them are unaware of the concept.</td>
<td>All are aware of the need to involve PLHAs in the various aspects of HIV programmes. Perception of the value of GIPA varies.</td>
<td>They are aware of the need to involve PLHAs in programme development and implementation.</td>
</tr>
<tr>
<td><strong>PLHA involvement</strong></td>
<td>The national PLHA network is involved in the national level programme planning and implementation.</td>
<td>Needs-based involvement of PLHAs in some of the programmes found in Tamil Nadu.</td>
<td>Involvement at the consultation level in Tamil Nadu.</td>
</tr>
<tr>
<td></td>
<td>State level PLHA networks are involved in the programme but perceive this involvement as tokenism.</td>
<td>In Andhra Pradesh, the participation and involvement is limited. No involvement is found in Uttar Pradesh.</td>
<td>PLHAs invited as resource persons in some of the programmes and utilized to access resources.</td>
</tr>
<tr>
<td></td>
<td>In two states and at the district level, PLHAs are not at all involved.</td>
<td></td>
<td>No involvement in Uttar Pradesh.</td>
</tr>
<tr>
<td><strong>Benefits of involvement</strong></td>
<td>Personal and PLHA level—confidence building, skills development and acceptance from family and friends.</td>
<td>Personal/PLHA level—More capacities for PLHAs and care and support programmes.</td>
<td>Personal/PLHA level—Reduction in stigma and more care and support.</td>
</tr>
<tr>
<td></td>
<td>Programme level—more realistic, wider participation.</td>
<td>Programme—Needs-based support for involvement, more reach in service delivery (wider coverage).</td>
<td>Programme level—More realistic programmes and enhances the care and support component.</td>
</tr>
<tr>
<td><strong>Barriers to involvement of PLHAs</strong></td>
<td>Lack of understanding and clarity about the HIV issues and GIPA illness.</td>
<td>Individual perceptions and attitudes of the programme managers.</td>
<td>Lack of understanding on GIPA and HIV issues.</td>
</tr>
<tr>
<td></td>
<td>Lack of necessary capacities and skills.</td>
<td>Lack of understanding and clarity on HIV issues and GIPA.</td>
<td>Lack of confidence in PLHA networks.</td>
</tr>
<tr>
<td></td>
<td>Conflicts among the networks. Stigma and discrimination.</td>
<td>Non-availability of clear HIV programme guidelines for GIPA.</td>
<td></td>
</tr>
</tbody>
</table>
to serve. While there is much work to be done in creating greater awareness of the value of the GIPA approach where it has been implemented, all stakeholders recognize the value of meaningful PLHA involvement and its contribution to reducing the impact of HIV/AIDS.

**Recommendations**

A significant concern of all respondents was the need to build the capacities of PLHAs. Special emphasis was placed on skills for advocacy, leadership training, governance, and management. Conflicts between the networks have to be resolved and there is the need to develop a common agenda on which the networks can work together.

- PLHAs need to be encouraged and supported to take part in HIV/AIDS policy and planning forums, particularly at the state level.
- National and state-level policy regarding GIPA/PLHA involvement should be developed and widely disseminated.
- Every State AIDS Control Society (SACS) should provide a department or unit operated by PLHAs, so that they can be closely associated with other programmes and systems.
- Appropriate guidelines have to be developed to deal with the different aspects of the HIV/AIDS programme, as with ARV and care and support. If this is not possible, operational freedom has to be given to the states to develop state-specific and need-based systems and guidelines. The development of such guidelines should be undertaken with the full participation of PLHAs.
- Increased training and awareness raising regarding GIPA has to be provided for NGOs and other organizations working with the national and state programmes.
- Appropriate information and resource support systems have to be set up to provide timely assistance to the PLHA networks.
- More structured capacity-building modules and programmes with a strong GIPA content are required for PLHAs, programme managers, and the other organizations (including NGOs) managing and implementing HIV/AIDS programmes.
- Policy advocacy on GIPA needs to be initiated with bilateral, donor agencies, and state-level authorities in order to increase the adoption of the GIPA principles in their respective HIV/AIDS agendas.
- More information, education, and communication (IEC) materials (including best practice documents) need to be developed and disseminated that outline GIPA and address apprehensions and misconceptions related to it.
- Service delivery systems at the state level—especially the health care systems—need to be oriented towards GIPA.
- State-level advisory committees need to be formed to deal with the issues related to GIPA. These committees can provide a needs based inputs and guidance for state-level programme implementation.
- In order to address the regular change of HIV/AIDS programme managers taking place in all the states, a mechanism to orient the state-level executives on PLHA and GIPA issues on a regular basis should be created. This could be incorporated into induction training programmes of bureaucrats and programme managers.
Capacity building on organizational development and governance has to be organized for PLHA networks and NGOs.

Gender-sensitive capacity building programmes and systems have to be developed and the participation of more women in programmes should be encouraged.

Alternative and additional income generation for PLHAs needs to be supported by state-level actors and planned and implemented through PLHA networks.

State-level and district-level PLHA require core funding and support to develop and maintain organizational systems.

Introduction

This report outlines the preliminary findings of a research project aimed at assessing perceptions and levels of GIPA in the responses to the epidemic in three states: Andhra Pradesh, Tamil Nadu, and Uttar Pradesh.

The report provides a qualitative account of GIPA based on the perceptions and views of the respondents interviewed. GIPA remains an elusive concept and one that is difficult to quantify. In part this is a reflection, as this report illustrates, of the differing and sometimes conflicting ideas of what involvement means and how it can be realized. The findings of the study are illustrative rather than general. However, the findings of the study are consistent with similar research conducted in India and in other countries around the world. The POLICY Project has conducted a number of similar studies in Benin, Brazil, Cambodia, Nepal, South Africa, the Ukraine, and Viet Nam. The results of the Indian research are consistent with the GIPA findings in these countries. While the socio-economic, cultural, and political landscapes in each country are unique, the underlying concerns of all stakeholders are very similar. In each of the countries surveyed, issues of PLHA capacity, stigma and discrimination, and the need to understand GIPA as an integral part of the response to HIV/AIDS were common themes.

India accounts for the second highest number of people living with HIV/AIDS in the world. The PLHA population in India was estimated in 2002 to range from 3.82 million to 4.58 million HIV infections (NACO Estimates 2002). The increasing number of PLHAs in India remains a major cause for concern. HIV/AIDS related stigma and discrimination are significant problems affecting the lives of PLHAs and hampering prevention efforts. Internationally, recognition of the value and importance of PLHA involvement has been gathering strength for some time and is marked by a series of declarations that have committed governments around the world to advancing the concept of GIPA. This recognition provides a counterpoint to the view that PLHAs are at best a burden on scarce resources and have little to offer. This counterview recognizes the valuable role PLHAs can and do play in the response to the epidemic, and is supported by a small but growing number of research studies and the experiences of practitioners in the field. However, GIPA is not without controversy. The increasing involvement of PLHAs as meaningful

partners in the response to HIV/AIDS involves rethinking traditional public health arrangements to accommodate stakeholders who have not been associated (except as recipients) with health related policy and programme implementation. In addition, the application of GIPA in non-western settings has raised questions from some observers regarding the cultural and social appropriateness of a concept perceived as based on western values with limited utility in societies and cultures that have little or no tradition of these values.

While policymakers and people living with HIV/AIDS have made headway in many countries in adopting and implementing principles of involvement, a considerable divergence exists between the principle and practice of greater involvement. A lack of clarity over what constitutes ‘meaningful involvement’ hampers efforts to progress the vision articulated by GIPA. Social research has confirmed what most people working in HIV/AIDS learn very quickly, that the involvement of positive people is central to effective AIDS education, confronting societal myths about HIV, and breaking down fear and stigma (Scollay et al., 1992; Pitts and Jackson, 1993; UNICEF, 1995; Takai et al., 1998; Stephens, 1999; Paxton, 2002).

Governments have also endorsed this recognition. In June 1994, at the Paris Summit, 42 nations declared their support for the greater involvement of people living with HIV/AIDS (PLHA*) in prevention and care, policy formulation, and service delivery. Signatory governments to the Paris Summit undertook to support a greater involvement of people living with HIV/AIDS through an initiative to strengthen the capacity and coordination of networks of people living with HIV/AIDS and community-based organizations. By ensuring their full involvement in our common response to the pandemic at all national, regional and global levels, this initiative will, in particular, stimulate the creation of supportive, political, legal and social environments. (ICASO 1996)

The greater involvement of PLHA (GIPA) has become the most enduring legacy of the Paris Declaration. GIPA has been incorporated into national and international programme and policy responses, and has been taken up as a model of best practice in the response to HIV/AIDS. Since the Paris Summit, GIPA has been endorsed by numerous international statements and most recently by the UNGASS Declaration of Commitment on HIV/AIDS which acknowledges the particular role and significant contribution of people living with HIV/AIDS, young people and civil society actors in addressing the problem of HIV/AIDS in all its aspects and recognizing that their full involvement and participation in design, planning, implementation and evaluation of programmes is crucial to the development of effective responses to the HIV/AIDS epidemic. (United Nations 2001, paragraph 33)

*The term people living with HIV/AIDS is abbreviated in a number of forms: people living with HIV/AIDS (PLHA), positive people, and people living with AIDS (PWA). The abbreviation used throughout this report is PLHA.

*In this report ‘involvement’ and ‘participation’ are used interchangeably.
As well as continued activism and advocacy, GIPA has increased a commitment to ensuring that people living with HIV/AIDS have an involvement in, and some control over, HIV/AIDS research, programme development, and policymaking. The argument for the importance of GIPA in promoting the health, rights, and well being of PLHA, as well as in the overall improved response to the HIV/AIDS epidemic, makes intuitive sense. GIPA is also supported by human rights principles and precedents and progressive public health policy. The GIPA principle now refers to “more meaningful” rather than simply “greater” involvement of (PLHA*)

Effective responses to HIV/AIDS need to marshal the widest possible spectrum of stakeholders in order for programmes and policies to be effective, including people living with HIV/AIDS.

**GIPA in India**

India was among the first nations to endorse the principle of GIPA at the Paris AIDS Summit in 1994. It might be expected therefore, that the promotion of GIPA in India is at a relatively advanced stage. However, recent research by the Indian Network for People Living with HIV/AIDS (INP+) concludes that almost no importance is given to the quality, meaningfulness, or appropriateness of PLHA involvement, and in the many organizations that claim to have PLHA involvement, the involvement is tokenistic. The research reported in this paper builds on the work of INP+.

The adoption of GIPA (its principle and practice) has been debated for some time at the national and, to a lesser extent, the local level in most countries where there is an active response to the epidemic and at least some visible PLHA presence. In India, GIPA-related debates, discussions, and initiatives have been slow to gain prominence as a significant approach in the public health response to the epidemic. Recently, however, GIPA related issues are being given more attention by the National AIDS Control Programme (NACP) which has committed itself to supporting and implementing greater involvement. INP+* (the national network for PLHA in India) has adopted GIPA as the cornerstone of its work. These developments as well as increasing interest among other HIV/AIDS stakeholders, notably NGOs and the international community working in HIV/AIDS, mean that interest, if not yet implementation, in GIPA is gaining momentum.

In order to understand more fully the principle and practice of GIPA in India, the POLICY Project commissioned this study. Despite more intensive interest in GIPA, the practice (and to some extent the principle) remains vague and ill defined. For PLHA, GIPA represents a powerful platform from which to address a number of critical issues including stigma, discrimination, and increasing access to treatments. However, activities designed to increase PLHA involvement can often flounder through illness, lack of support, and the disinterest of other stakeholders. For HIV/AIDS policymakers and programme managers, GIPA is perhaps less well known but offers the potential to significantly advance the public health, and more broadly, the multi-sectoral response to the epidemic. This study therefore seeks to

*See directive L-1240/AS&PD/3003, from the Director of National AIDS Control Organization (NACO), which asks state project directors to involve PLHA as genuine partners.*
provide a greater understanding of the ways in which GIPA is understood in India—what are its benefits and what are the barriers to its implementation. The study focused on three states in India: Andhra Pradesh, Tamil Nadu, and Uttar Pradesh. The study collected information from PLHA networks at national, state, and local levels. The study also sought the views of state level programme managers on GIPA principles and its application in HIV/AIDS programmes.

**Defining GIPA**

Despite agreement that GIPA makes a meaningful contribution to the public health agenda, there has been little research to date on how GIPA is being implemented, or its impact on HIV/AIDS policy. A four-country study conducted by the Horizons Project and the HIV/AIDS Alliance analyzed the involvement of people living with HIV/AIDS in the activities of non-governmental organizations (NGOs) and community-based organizations (CBOs) (Horizons, 2002). The Horizons study provides a valuable framework for understanding the various levels at which PLHAs are involved in NGO and CBO programmes. 1999, UNAIDS published a paper analyzing the levels of PLHA involvement in the response to HIV/AIDS (see Annex).

The models developed by the Horizons/Alliance study and UNAIDS represent GIPA as a hierarchy of involvement. Progress is measured by the degree to which PLHAs are able to influence and ultimately direct HIV/AIDS policy and programme responses. GIPA is also a process that reflects a way of thinking. Implementing GIPA requires a partnership approach on the part of all stakeholders working with people living with HIV/AIDS. In this partnership, those affected by HIV/AIDS have an equal role. It should be noted that although GIPA calls for a progressive approach to involving PLHA, the extent and level of involvement must necessarily be one that meets the needs of all stakeholders and adheres to basic principles of equity.

**Methodology**

The research process was designed to collect information on the influence of GIPA at the state level. The research focused on three sectors: PLHA, HIV/AIDS programme managers, and NGOs. The research questions were designed to elicit information on perceptions of GIPA, that is, current understanding of the concept and the principles that underlie it, the actual level of PLHA involvement in the response to HIV/AIDS, and perceptions of the benefits and barriers to GIPA.

**Interviews**

Interviews were conducted with state programme officers of the State AIDS Control Society (SACS). This category was selected according to seniority and familiarity with the subject of inquiry. The leaders of the national, state, and local PLHA networks were also invited to take part, as were members of two NGO networks (covering more than 200 NGOs working in HIV/AIDS). Eighteen interviews were conducted in the three states. The researcher used a semi-structured interview guide organized in sections that addressed the following areas: participants’ awareness of GIPA; the formal or institutional level of involvement of PLHA in national HIV/AIDS planning; benefits of involvement to national HIV/AIDS policies and
programmes; and the barriers and challenges to PLHA involvement. In addition, a number of informal discussions were conducted with stakeholders from all sectors that have added additional insight to the findings.

**GIPA Knowledge and Perceptions**

National and state-level PLHA networks and their functionaries have a fairly good knowledge of the language of GIPA and the principles it is based on. They also believe that adopting GIPA principles will increase the effectiveness of the planning and implementation capacities of the National AIDS Control Programme (NACP). They suggested that the application of GIPA should be contextualized according to the demands of local situations and be carried out within the overall framework of the NACP. PLHA networks also expressed satisfaction that a more focused advocacy agenda is emerging on GIPA and is aimed at influencing policymakers and programme personnel to apply GIPA principles. Support from bilateral and multilateral agencies (notably, UNDP and UNAIDS) are also appreciated by the networks. They argue that this support is crucial to increasing their capacities and needs to be extended to all PLHA networks and organizations in India.

The PLHA networks also reported the following perceptions on the approach and attitude of different sectors involved in the NACP. There was a consensus among those interviewed that in all sectors there are at least some people who are aware of GIPA and what it represents. However, they also felt that many academics and health care providers do not seem to be clear about GIPA or the need for greater involvement. There is also a perception that many NGOs have reacted to GIPA as an intrusion into their mandate rather than as an opportunity to work in closer partnership with PLHA. The Positive Women’s Network of Chennai felt that the GIPA principles are a valuable framework, but that there are often conflicting ways of interpreting them and that most programme managers understood GIPA as a PLHA centric concept with little value in the wider HIV/AIDS programmatic response.

Representative of the networks feel that the adoption and application of GIPA principles is occurring more meaningfully at the national level but that there is less understanding and commitment from the states. In part this is a result, in the view of PLHA, that state-level programme managers have not yet been exposed to GIPA principles. State-level awareness of GIPA, however, is not limited to HIV/AIDS health authorities. Among the six local PLHA networks that the study covered, none had heard about GIPA, although they were aware of the approach it represents and feel strongly that PLHAs should be involved in programmes.

“We don’t know much about terms and words, but we know what we need, what we can give and what others can get from us.” — Mr. Ganesh of GNP+

Ganesh is from a rural area and the president of the local network initiated by an NGO. The intention of initiating a network may be different for the NGO and Ganesh, but in practice, it has made, in his view a significant contribution to addressing the needs of PLHAs and raised awareness of HIV/AIDS in the local area.
PLHAs also reported that they felt that government officials dominate programme and policy debates and do not allow space for PLHAs and others to have input, leading to a perception that PLHAs are judged as inferior. Programme managers reported that PLHAs are often lacking in the skills required to take part in complex and often technical discussions on HIV/AIDS programming, and in some cases are motivated by opportunity rather than a desire to make a contribution to the response. Of the programme managers interviewed, only one was able to describe the concept in some detail. The others had not heard the term GIPA but had some understanding of the need to involve PLHA in their programme activities. The programme managers, however, were aware of the need and necessity to involve PLHAs in programme development, management, and implementation. They also reported that they themselves require a greater understanding of GIPA and how to develop activities that support involvement.

PLHA Involvement in NACP
At the national level, INP+ is represented in several activities related to the country’s HIV/AIDS programme. Representatives of the INP+ are members of national-level committees including the National AIDS Control Organization (NACO) executive committee and CCM (Country Coordination Mechanism), which is responsible for overseeing India’s application to the Global Fund. PLHAs representing various states are invited to some national consultation meetings and it was reported that their input was taken seriously. A specific committee has been formed at the national level by NACO to discuss and develop a strategic approach to PLHA concerns. The PLHA interviewed felt that for the last two years there has been a growing awareness of GIPA by national HIV/AIDS actors and that this is creating a greater momentum for change and implementation of GIPA inspired policies and programmes. At the national and state levels, respondents were aware that initiatives are being taken to mobilize and increase political will as well as provide adequate resources to address the needs of the PLHAs and create more meaningful involvement. People pointed to the Sushma Swaraj announcement on an antiretroviral (ARV) treatment initiative for five states as well as the increasing policy commitment at the national level, which is noted above, and more generally the greater financial and technical support, particularly from multilateral and bilateral agencies, being provided to PLHAs.

However, at the state level there is less optimism. In Tamil Nadu, the PLHA network feel that, though the SACS supports them and is involved in some of the committees, this representation is more tokenistic than truly participatory. They argue they are mainly consulted on care and support-related programmes and have little input into the wider programme. This has led to a perception that their participation in the programme is only to fulfill the statutory requirements of involvement.

In contrast, the Tamil Nadu SACS argued that PLHAs are involved in most of the committees and planning processes. The networks also receive financial support from the SACS though there can be delays in disbursing funds.

In comparison to the Tamil Nadu scenario, in Andhra Pradesh, PLHAs are not at all
involved in any of the programme processes. They report that they receive very limited support from the government or other agencies. However, individual-level support is extended to the PLHAs by some of the programme managers and PLHAs are invited as resource persons to some activities and paid an honorarium.

In Uttar Pradesh, PLHA involvement is virtually non-existent. In fact, the study could not find any PLHA networks or PLHA involvement in the programme.

In some of the cases, PLHA networks feel that although state programmes have clear instructions and directions regarding PLHA involvement, there is complete disregard and no attempt to initiate any form of participation and that they are more supported by external agencies than the national agencies.

Local-level PLHA networks reported that they are denied involvement in district programmes. In the view of the local networks, district authorities are not at all oriented to the issue of involvement and have little or no understanding of the complexity of the HIV epidemic and its multiple linkages to other areas of development or the need to involve vulnerable communities including PLHAs. These officials tend to take unilateral decisions.

“We didn’t get any support, but we tried to get some opportunities and those also have been denied.” — Mr. Karunanidhi of HUNS

Local level PLHA awareness of national level systems and policies is also limited. They report that they very occasionally receive information on developments that take place at the national and state levels. Some PLHA also reported a sense that representation in committees and invitations to the consultation meetings can be decided by programme managers on the basis of a personal preferential system rather than a representative one. This means involvement is often contingent on pleasing the manager in question.

“We need to be in the good books of the managers, then only we will be invited for the meetings.” — Noorie of South India Positive People Network (SIP+)

When asked about the challenges in involving the PLHAs, a respondent from one SACS who wished to remain anonymous said, “It is not a challenge, it is a matter of combined effort, joint responsibility and mutual recognition.”

Awareness of the GIPA principle and capacity to implement GIPA activities is a recurrent theme at the state and local levels. Programme managers interviewed felt that they were hampered in their desire to initiate GIPA programmes by a lack of understanding. They reported that although policies have been developed, very little guidance was available at the level of practice, and as a consequence, very little have been implemented at the programme level. They feel that this situation could be addressed if they were to receive adequate capacity building in this area.

“Both the low level insight of PLHAs and lack of understanding of programme managers
negatively influence the effective adoption of GIPA principles at state level programmes.” — Mr. K. Deena Bandu, Project Director, Tamil Nadu SACS

Not all programme managers were convinced of the value of GIPA beyond the immediate issues that concern PLHAs. This view was argued in relation to the following perspective. Only 1 percent of the population is infected with HIV, 99 percent of the people are not infected. Utilizing just 1 percent of the population to meet the needs and requirements of the rest of the group is not viable or feasible. From this perspective, the rationale for GIPA is restricted to involvement based on need (defined by the programme managers) and the capacity and competence of PLHA.

Several programme managers questioned the value of GIPA in the Indian context, arguing that attempts to implement the principle involved the de-contextualized transfer of an idea based on adopting western-inspired approaches, which had little value and limited use in the context of the epidemic in India. Respondents who argued this view felt that initiatives should be needs based and realistic and that involvement of PLHA should not be implemented mechanically to satisfy a policy requirement. As part of this, the people who are involved should display some level of required competence or be supported to acquire it before they are involved in responsible positions.

A similar theme emerged in the interviews with NGO representatives. The NGO respondents interviewed felt that PLHA groups and networks were organizationally distinct from the wider category of NGO and that they more clearly occupied the role of community-based organizations (CBOs). In this capacity they could not be defined as NGOs and were not competent to take on mandates beyond the needs of PLHAs. The table below represents the essential differences from this perspective.

Table 2

<table>
<thead>
<tr>
<th>CBOs (PLHA Network)</th>
<th>NGOs</th>
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<tbody>
<tr>
<td>Mobilize public opinion</td>
<td>Programme management</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>Addressing other needs of the society</td>
</tr>
<tr>
<td>Programme support</td>
<td>Professional support to the programme and CBOs</td>
</tr>
</tbody>
</table>

Table 3

Participation levels (perceived by the PLHA networks)

<table>
<thead>
<tr>
<th>Agencies</th>
<th>Level of participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tamil Nadu</td>
<td>Sometimes tokenism Sometimes assigned but informed</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>Some times manipulative Sometimes decorative</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>No participation</td>
</tr>
<tr>
<td>National</td>
<td>Sometimes assigned but informed Sometimes consulted and informed</td>
</tr>
<tr>
<td>Bilateral</td>
<td>Management initiated, shared decision with the implementers</td>
</tr>
<tr>
<td>Multilateral</td>
<td>Management initiated, shared decision with the implementers</td>
</tr>
<tr>
<td>Other donors</td>
<td>Management initiated, shared decision with the implementers</td>
</tr>
</tbody>
</table>

Level of participation based on Roger Hart’s Ladder of participation
Benefits of Involvement

This section of the report discusses respondents’ views of the benefits of involvement and participation and it begins with the views of people living with HIV/AIDS.

“How I am talking to you is the example for how one can benefit out of this.”

Mr. Abraham, President, INP+

The benefits of involvement to people living with HIV/AIDS begin at the personal level. A diagnosis of HIV or an AIDS-defining illness is much more than a medical event in the life of the person concerned. Throughout the history of the epidemic and almost universally, stigma and discrimination directed at PLHAs has been a constant feature of the experience of living with the disease. As a disease, HIV/AIDS involves a decline in the ability of the body to fight off illness, and if not treated, will result in eventual death. But it is the social death caused by stigma that causes the individual to lose hope. Involvement, activity, and acceptance are central to reestablishing the social networks that diagnosis and illness often fracture and remove. Over a period of time, exposure and involvement—a sense of taking control—will strengthen the confidence and competence levels of PLHAs. It can also bring back the sense of meaningful living and increases the acceptance level among families, friends, and in the society as a whole. During the early days of the epidemic in India, acceptance of PLHAs was very low generally, and it was a challenge for them to overcome these barriers. The negative attitude of the general community and programme managers also affected the day-to-day living experiences of PLHAs. Advocacy and activism efforts taken by various individuals and organizations led by PLHAs have made significant inroads and helped many people to live more satisfying lives.

“I lost my friends when I got this virus, but through the network I made colleagues and friends. Now I know for what, and why I am working.” — Ram Mohan Rao of CNP+, AP

Swapna of HPN+ shared, “Earlier I used to curse my fate a lot, now I feel that it is not fate—it is ignorance and circumstances that bring you what you don’t want. But I have accepted this virus as a constant companion in my life and I am adjusted to it as I have adjusted to other people in my environment. After this acceptance, I have done a lot of things. I am recognized and I am happy.”

“My CD-4 count is less than 50, I never bother about that. I work hard, so that I can live as a friend, social worker, father, husband, brother more than that just as a man.” — The Secretary of Guntur Network of Positive People

PLHAs felt that people who are affected have the experience that enables them to think more realistically about what works and what does not in HIV/AIDS programmes and could, if given the proper support and opportunities, develop more focused programmes. This will lead to more effective initiatives on care and support of PLHA, and a reduction of the impact of the epidemic among the general community. For example, PLHA point to the success of PLHAs as counsellors in
voluntary counselling and testing centers (VCTC) units and the high level of support for drop in centers and care centers run by the networks.

“I learned how to survive—not only with virus but also with dynamics of the programme”
— Ms. Kausalya, President, PWN+

Though involvement of PLHAs has increased compared to the earlier stages of the epidemic, the participation of women is still at a low level. Women PLHAs felt that they were not provided with enough opportunities for participation in programme planning and implementation. If opportunities are not provided, people cannot come up and contribute to programmes. Gender is a central determinant of the experience of living with HIV/AIDS. Research in the Asia and Pacific region, including India, has found that women living with HIV/AIDS are nearly twice as likely to face HIV/AIDS related discrimination as men (APN+, 2003). Added to this, women are generally the primary care givers and shoulder the burden of support in HIV/AIDS-affected households. In this context, it is not surprising that women face more formidable barriers in attaining meaningful involvement.

PLHA feel that a number of benefits have accrued from greater involvement. These are summarized in the table below according to the level of primary impact.

Table 4

<table>
<thead>
<tr>
<th>Sectors</th>
<th>Benefits</th>
</tr>
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<tbody>
<tr>
<td>Personal</td>
<td>◆ Greater ability to overcome the personal impact of stigma and discrimination</td>
</tr>
<tr>
<td></td>
<td>◆ Wider perspective on the HIV/AIDS issue and programme response</td>
</tr>
<tr>
<td></td>
<td>◆ Greater awareness of the need for empowerment and advocacy</td>
</tr>
<tr>
<td>Other PLHAs</td>
<td>◆ Accessibility to more services</td>
</tr>
<tr>
<td></td>
<td>◆ More acceptance in the community</td>
</tr>
<tr>
<td></td>
<td>◆ Greater understanding by PLHA of their rights and responsibilities</td>
</tr>
<tr>
<td>General community</td>
<td>◆ Visibility of PLHA increases, providing counter to negative images. This has the following impact:</td>
</tr>
<tr>
<td></td>
<td>◆ Changes in environment take place</td>
</tr>
<tr>
<td></td>
<td>◆ New infection rate can be reduced</td>
</tr>
<tr>
<td></td>
<td>◆ The public health system can be improved</td>
</tr>
<tr>
<td></td>
<td>◆ More effectiveness in prevention aspects</td>
</tr>
<tr>
<td>National response</td>
<td>◆ More balanced (including gender sensitivity) programmes</td>
</tr>
<tr>
<td></td>
<td>◆ Better programme reach</td>
</tr>
<tr>
<td></td>
<td>◆ Increased programme objectivity</td>
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</tbody>
</table>

The majority of programme managers interviewed reported that they are convinced of the benefits that come from greater involvement of PLHAs. They specifically pointed to the benefits of PLHA involvement in care and support in order to overcome the intense stigma of caring for people who are unwell and dying.
However, unlike the PLHAs, programme managers were less enthusiastic about involvement in areas that did not directly affect PLHA, and there was a consensus that the degree and frequency of involvement has to be determined based on the nature of the programme rather than imposed policy.

**Barriers**

This section of the report outlines the barriers to GIPA from the perception of those interviewed. The major points of this discussion are summarized in the table below.

<table>
<thead>
<tr>
<th>Challenges</th>
</tr>
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<tbody>
<tr>
<td>Capacity of the PLHAs as well as the programme managers</td>
</tr>
<tr>
<td>Proper orientation on GIPA and capacity building</td>
</tr>
<tr>
<td>Advocacy with the programme managers</td>
</tr>
<tr>
<td>Illness, death, and sustainability of PLHA networks and organizations</td>
</tr>
<tr>
<td>Advocacy to convince all stakeholders of the value of GIPA</td>
</tr>
<tr>
<td>Unity among the PLHA networks and organizations</td>
</tr>
<tr>
<td>Development of GIPA rationale within a broader public health framework</td>
</tr>
<tr>
<td>Increasing state and district level acceptance of GIPA</td>
</tr>
<tr>
<td>Stigma and discrimination</td>
</tr>
<tr>
<td>Allocation of resources</td>
</tr>
</tbody>
</table>

The barriers to greater involvement are multiple. The general perception that PLHAs have limited abilities and capacities, and a lack of awareness of GIPA (on the part of both the PLHAs and programme managers) is a major impediment. More broadly, lack of awareness of the social dimensions of HIV/AIDS, for example, the privileging of medical over social viewpoints, and sometimes insufficient awareness and knowledge of the HIV/AIDS programme among programme managers themselves does not facilitate actions aimed at increasing PLHA involvement. Public attitudes, or the perceptions of negative views among the general community and service providers, also act as a disincentive. In addition, other factors such as institutional resistance from other HIV/AIDS stakeholders, either because of fear of loss of resources to PLHAs or a lack of confidence in the capacity of PLHAs to make a meaningful contribution, provide a significant brake. Perhaps most significant though is the burden of illness and the high attrition rate of leaders and activists.

“Discrimination by the general community we can understand, but discrimination by the officials is so sad.” — Noorie of SIP+

Stigma prevents many PLHAs from being more open about their HIV status and coming forward. This weakens networks and gradually limits their capacity to expand activities, as well as placing an intense burden on those who are involved. The decision to become involved, especially in rural areas, is often the result of the onset of illness. Those who are asymptomatic are more reluctant to expose themselves to possible discrimination. Thus, in many cases, members join networks only when they experience illness or opportunistic infections (OIs). Some of the networks reported that the death toll of their members is increasing year by year.
Some service providers, especially health care service providers, deny PLHAs services and care due to fear and stigma. Two people who experienced this, narrated their experiences as follows:

“I lost my left eye, not because of virus, but because of the fear of virus. The hospital people didn’t do the surgery because of fear. I wonder about the cause of my loss of vision in the left eye—whether the virus caused it or the doctors fear about the virus caused it.” — Mr. Ramesh of TNP+, AP

“I have a hernia problem and for the last 6 months I am trying my level best to get the surgery done, but it’s no use. Is it ignorance or discrimination?” — Noorie, a transgender HIV positive person and President of SIP+

PLHAs also reported that conflicts among the network members were not uncommon and negatively affect the involvement of PLHAs and the capacity to speak with a united voice. Some of the networks also reported they felt that there is a limited vision among some PLHAs who prefer to pursue activities with short-term gains rather than see the value of setting goals in the longer term. There is also a lack of effective information dissemination systems among the networks, which is seen as a barrier in adopting GIPA. PLHAs also said they felt that programme managers use intra-network conflict as an opportunity to manipulate network interests, and in some cases, have deliberately created conflicts between PLHA groups.

Low socio-economic status is also a significant factor. Poorer people are more affected than those with access to greater economic and social resources. Economic status is clearly a central factor in determining the needs of PLHAs. Addressing basic needs such as nutrition and illness may be a far more urgent task than providing skills on programme management. Local-level networks also felt that in each local area there should be organizations catering to the needs of people affected by HIV. PLHAs in rural areas face a number of additional problems hampering involvement, particularly a lack of services, transport, and communication systems.

Priorities over the use of resources for PLHAs also emerged as a theme among PLHAs at the local level. Regarding national and international programmes, local networks felt that instead of spending money on organizing conferences and other meetings, the priority should be meeting the basic needs of people, for example, food and employment in order to enable PLHAs to generate an income and care for their dependents.

“Feeding is more important than getting accepted.” — Ram Mohan Rao, CNP+

Frequent changes in the programme managers at the state level also affected GIPA initiatives. New officials take at least two to three months to understand the programme. This affects the flow of programme activities and the rapport or understanding developed between the networks and the programme managers.
Programme mangers, however, feel that one of the major barriers in involving PLHAs is the lack of capacities of PLHAs. They feel that PLHAs were often more confrontational than constructive in their approach to working with state and local officials. They also feel that there is a lack of depth in the involvement, and coming together with PLHAs is more for immediate gains and not for a lasting impact on the epidemic.

Some managers felt that rapid changes as well as rigidity in some of the existing national guidelines prevent the state people from useful initiatives or adopting some of the best practices.

“I am not only here to discuss about the infected people, also to think about how I can help those who are not infected but may be affected in future.” — Ram Mohan Rao

**Tokenism versus Authenticity**

The question of legitimacy is one that is central to the concept of GIPA. How a PLHA organization or network deals with this has important implications for its success and development, and its ability to meaningfully work towards realizing involvement. The problem of token representation is one that surfaces throughout the life cycle of PLHA organizations.

In some instances, representation of PLHAs in high-level committees is decided by the SACS rather than appointed through a representative process by the PLHA network in the state. In more blatant examples, PLHAs are sometimes called upon to perform little more than ceremonial functions (for example, greeting guests with flowers). In other cases, while representation may be in place, PLHAs reported that they often feel like the ‘poor relations.’ This perception arises from not being listened to or having views dismissed, and the very real sense of power imbalance between PLHAs and other stakeholders. Often PLHAs are requested to attend meetings at very short notice and are not supplied with information or materials to help them take part on an equal footing.

“Dialogues and discussions are going on in global level, but things are not in that pace at local level … the responsibility is not only with PLHAs, we also need to do something concretely.” — Dr. Dhanikachalam, Team Leader, Technical Resource Unit, AP

**Economic Challenges**

The entry of GIPA into the international and national HIV/AIDS agenda is exerting more than moral pressure on NGOs and governments to take positive involvement seriously. Increasingly, international donor agencies require that the programmes they fund demonstrate a commitment to involving positive people. While this is a positive step, it has introduced a new economic dimension to the role of positive people in HIV/AIDS interventions, which as argued below, does little to advance meaningful involvement. GIPA is attracting resources, and this is increasing the competitive edge of those PLHA networks able to undertake project activities. This is resulting, in the view of some PLHA respondents, in a backlash from other HIV/AIDS organizations who now see PLHA as a threat to their funding base. NGOs compete to develop
networks to impress the donors and to access resources. It is also reported by some PLHA that the resources accessed this way do not reach the beneficiaries. This development can also increase PLHA marginalization as agencies seek to discredit PLHA as ‘not genuine’ and therefore not legitimate as recipients of HIV/AIDS funding.

**Authenticity**

However, it was reported by PLHAs, as well as other respondents, that the problem of non-genuine PLHA organizations created only to access funds is evident, if not as widespread. In the course of the research for this study, the researcher was unable to contact two PLHA organizations in Tamil Nadu. Neighbours reported that the offices for these organizations had been closed for several months. Discussing this with other stakeholders, it was reported that these organizations had been funded by the SACS but had provided no reports or outcomes as a result of the funding. The perception of local SACS officials, NGOs, and PLHA organizations was that they were established only to access HIV/AIDS funding with no intention to provide services or represent the needs of PLHAs.

“Sometimes it is found that networks are formed only for accessing some funds…Conscious efforts should come from networks to address the local issues.” — Mr. Bimal Charles, Director, APAC, Chennai

**Discussion and Recommendations**

Responding to the Challenges: “No one is born with skills—skills have to be developed.”

The study shows a highly varied picture of GIPA in the states visited. However, within this variation there are commonalities.

- Understanding of GIPA is limited for both PLHA and other stakeholders.
- The practice of GIPA is also limited and there has yet to be a significant GIPA response.
- The barriers to implementing GIPA are mostly factors which are manageable.
- There is a need to continue and expand the dialogue on GIPA and develop greater clarity on how GIPA principles can be converted into programme activities.
- There is a clear need to build the capacities of all concerned—especially PLHA—to implement these programmes.

The findings also show that the promotion and implementation of GIPA related activities in India have the potential to significantly improve the response to HIV/AIDS. There are a diversity of views on the value of the concept and the degree to which GIPA should be implemented. However, the study suggests there is significant common ground among stakeholders on issues that are central to meaningfully incorporating GIPA as a theme of the Indian response to HIV/AIDS. All participants expressed the opinion that GIPA needs to be understood as an idea that makes sense in the context of the epidemic in India, and that it should be designed and implemented in ways that advance the interests of those it is designed to serve. While there is much work to be done in creating greater awareness of the
value of the GIPA approach where it has been implemented, all stakeholders have recognized the value meaningful PLHA involvement contributes to reducing the impact of HIV/AIDS.

- PLHAs need to be encouraged and supported to take part in HIV/AIDS policy and planning forums, particularly at the state level.
- National and state-level policy regarding GIPA/PLHA involvement should be developed and widely disseminated.
- Every SACS should provide a department or unit operated by the PLHAs, so that they can be closely associated with other programmes and systems.
- Appropriate guidelines have to be developed to deal with the different aspects of the HIV/AIDS programme, as with ARV and care and support. If this is not possible, operational freedom has to be given to the states to develop state-specific and need-based systems and guidelines. The development of such guidelines should be undertaken with the full participation of PLHAs.
- Increased training and awareness raising regarding GIPA has to be provided for NGOs and other organizations working with the national and state programmes.
- Appropriate information and resource support systems have to be set up to provide timely assistance to the PLHA networks.
- More structured capacity-building modules and programmes with a strong GIPA content are required for PLHAs, programme managers, and the other organizations (including NGOs) managing and implementing HIV/AIDS programmes.
- Policy advocacy on GIPA needs to be initiated with bilateral, donor agencies, and state-level authorities in order to increase the adoption of the GIPA principles in their respective HIV/AIDS agendas.
- More IEC materials (including best practice documents) need to be developed and disseminated that outline GIPA and address apprehensions and misconceptions related to it.
- Service delivery systems at the state level—especially the health care systems—need to be oriented towards GIPA.
- State-level advisory committees need to be formed to deal with the issues related to GIPA. These committees can provide a needs based inputs and guidance for state-level programme implementation.
- In order to address the regular change of HIV/AIDS programme managers taking place in all the states, a mechanism to orient the state-level executives on PLHA and GIPA issues on a regular basis should be created. This could be incorporated into induction training programmes of bureaucrats and programme managers.
- Capacity building on organizational development and governance has to be organized for PLHA networks and NGOs.
- Gender-sensitive capacity building programmes and systems have to be developed and the participation of more women in programmes should be encouraged.
- Alternative and additional income generation for PLHAs needs to be supported by state-level actors and planned and implemented through PLHA networks.
- State-level and district-level PLHA require core funding and support to develop and maintain organizational systems.
References


11. UNAIDS. 2000. Enhancing the Greater Involvement of People Living With or Affected by HIV/AIDS (GIPA) in sub-Saharan Africa. Geneva: UNAIDS.


Annex

GIPA Models

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<th>Reproduced from the UNAIDS paper ‘From Principle to Practice’ (UNAIDS 1999)</th>
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**Decision Makers:** PLHAs participate in decision-making or policy-making bodies, and their inputs are valued equally with all the other members of these bodies.

**Experts:** PLHAs are recognized as important sources of information, knowledge and skills who participate – on the same level as professionals – in design, adaptation and evaluation of interventions.

**Implementers:** PLHAs carry out real but instrumental roles in interventions, e.g. as careers, peer educators or outreach workers. However, PLHAs do not design the intervention or have little say in how it is run.

**Speakers:** PLHAs are used as spokespersons in campaigns to change behaviours, or are brought into conferences or meetings to “share their views” but otherwise do not participate. (This is often perceived as “token” participation, where the organizers are conscious of the need to be seen as involving PLHAs, but do not give them any real power or responsibility.)

**Contributors:** activities involve PLHAs only marginally, generally when the PLHAs is already well-known. For example, using an HIV-positive pop star on a poster, or having relatives of someone who has recently died of AIDS speak about that person at public occasions.

**Target Audiences:** activities are aimed at or conducted for PLHAs, or address them on mass rather than as individuals. However, PLHAs should be recognized as more than (a) anonymous images on leaflets, posters, or in information, education and communication (IEC) campaigns, (b) people who only receive services, or (c) as “patients” at this level. They can provide important feedback which in turn can influence or inform the sources of the information.

The Horizons/Alliance study provides a similar evidence-based framework that helps to clarify what meaningful involvement is in practice. The study identifies four categories of involvement. These are summarized in the table below.

### Access to services

This level of involvement—access to services—is defined as PLHA taking part in NGO activities as beneficiaries of services. It was most typically observed among the 17 NGOs that took part in the study.

### Inclusion

Inclusion is characterized by PLHAs acting as support staff for HIV/AIDS NGOs, and as volunteers in HIV/AIDS service delivery. The research found that PLHA involvement at this level is not formally supported by structured training or wage remuneration.

### Participation

Participation moves PLHA involvement into a more structured and recognized role within NGOs. In this category, PLHA expertise is recognized and work is financially rewarded.

### Greater participation

Greater participation is defined as the most advanced stage of PLHA involvement. This level is characterized by PLHAs working in management, and as significant policy and strategic organizational actors. At this level, PLHAs may also have a significant representative role outside the NGO.

(More information about the Horizons/Alliance study is available at [www.popcouncil.org/horizons](http://www.popcouncil.org/horizons))
**Genesis, Structure, and Needs of PLHA**

All the networks affiliated with INP+ are registered under the Indian Societies Registration Act. Among the 10 networks covered under the research, six are initiated by the PLHAs, three by the NGOs and one by a person with non-HIV status.

The major needs identified by the networks are:

- Strengthening of governance systems of the networks
- Need-based resource support for strengthening of networks
- Adequate and appropriate mechanisms to address the treatment care and support needs of PLHAs
- Capacity building in programme management, communication, and other areas relevant for the empowerment of PLHAs
- Measures for adopting GIPA principles at all levels of the programme
- Legal protection to safeguard the rights
- Gender-based budget in National AIDS Control Programme
- Skill development of PLHAs for income generation
- VCTC facilities in all Taluks
- Need-based programme for people affected with HIV/AIDS
- Programmes to address the issue of discrimination
- Nutrition support for infected
- Advocacy with existing health systems and capacity building of health care providers
- IEC materials in local languages
- Proper information delivery channel for information dissemination

**The structure**

- **General Body**
  Consisting of all the members – PLHA
- **Governing board**
  Consisting of 7 members elected by the General Body
- **Advisory committee**
  Constituted by governing board
Introduction

This paper provides an overview and an outline of the evolution of the Indian Network for People Living with HIV/AIDS (INP+). INP+ is based in India but is also part of a regional and global movement of people living with and affected by HIV/AIDS. INP+ and similar networks in other countries have been formed by people with HIV/AIDS to challenge the stigma of the disease and to provide critical services and support for people living with HIV/AIDS. INP+ has 12 state-level member networks. Whilst these networks are independent organizations, together they form a federated structure, which constitutes INP+. INP+ has reached 58 districts through state-level networks and works closely with the Indian Positive Women’s Network (PWN+).

The development of networks for people living with HIV/AIDS (PLHA) represents perhaps one of the most innovative but also under-utilized resources in the response to the epidemic. In India, as in most other countries, PLHA networks have evolved from support groups providing much needed safe spaces for people to meet and share experiences. The growth of PLHA networks arises from the solidarity and strength derived from a collective approach to HIV/AIDS. As such, networks perform as significant (although in many cases unrecognized) partners in the response to HIV/AIDS. The importance of network development lies in the framework it establishes for the development of activities aimed at supporting PLHA, and in the focus it provides for advocacy, policy, and programme development. INP+ is a member of a regional group of networks which operates under the Asia Pacific Network for People Living with HIV/AIDS (APN+). APN+ is one of five regional PLHA networks which together are represented by the Global Network of People Living with HIV/AIDS (GNP+). This worldwide configuration of PLHA networks represents a wealth of PLHA talent and experience.

INP+ is a national, community-based, non-profit organization representing the needs of PLHA. Formed in 1997 by 12 people living with HIV in India, INP+ aims to improve the quality of life for PLHA in India. The formation of INP+ was inspired by similar developments in the region. Regional and international networking among PLHA activists provided the platform for people to learn from each other and use the experience to strengthen networking in their own countries.
The links created among PLHA in the region continue, and provide an important resource, as well as promoting solidarity in the Asia Pacific region. Regional and international networking are also important in raising the profile of national networks among international agencies working in HIV/AIDS. The fundamental principle guiding the work of INP+ is the centrality of PLHA in decision-making processes that affect their lives. Consequently, INP+ is organized and managed by people living with HIV/AIDS. The essence of INP+ is to provide a voice for PLHA at the local, regional, and national levels in order to facilitate systemic change in critical areas such as care and support, access to treatments, and addressing issues of discrimination facing PLHA in Indian society. The need for a strong and active set of state-based (as well as a national) network was underscored by the results of a needs assessment carried out by INP+ in 1999.

**INP+: Responding to the Need**

In 1999, INP+ conducted the first needs assessment of PLHA. The study was carried out in Mumbai, New Delhi, Imphal, and Bangalore.* The study was designed and conducted by people who are themselves living with HIV/AIDS. The study highlighted the general lack of information and services available to PLHA, as well as high levels of stigma and discrimination resulting in generally poor self-esteem and self-stigma. The study also found that many self-help groups, while providing a safe environment for people to meet, were isolated from the wider networks of HIV/AIDS services and organizations. The study reported that in most cases this resulted from fear of conflict or co-option by other HIV/AIDS organizations, low self-esteem, and lack of confidence. The study also found that many self-help groups had not engaged in communication planning or networking with other PLHA groups. Together with similar studies in other countries, the INP+ research points to the need to support PLHA network development in India, specifically at the state level. The benefit of an active set of networks accrue to a wide set of HIV/AIDS actors, as well as to network members themselves, and therefore add significant value to the response to the epidemic. In India as elsewhere, the existence of PLHA networks provides an important communication point for other HIV/AIDS actors working with PLHA. In policy development terms, a network can provide the most representational PLHA voice and thus goes a long way in satisfying the need for consultation in HIV/AIDS policy and programme development as well as implementation. Networks are also able to mobilize communities and ensure that HIV/AIDS programmes are appropriate and accessible to those they are designed to reach. The results of the study have been used to create the current strategic directions for the network.

**From the Personal to the Political**

INP+ was formed by 12 people living with HIV/AIDS from different states of India in February 1997. Since that time, membership has grown to 5,000 individuals from 14 of India’s 25 states. Some members have created networks in their own states and currently INP+ comprises 12 state-level networks in Andhra Pradesh, Assam, Goa,

Gujarat, Karnataka, Kerala, Maharashtra, Manipur, Mizoram, Rajasthan, Tamil Nadu, and West Bengal. PWN+ is also an important part of INP+. The people who established INP+ met at a series of national HIV/AIDS workshops. Some of these individuals had been in contact with PLHA networks outside India and saw the value in creating a national network capable of responding to the advocacy needs of positive people in India. The discussion among PLHA activists on the need for a national network in India had been ongoing since 1992. In 1995, a workshop for PLHA at Pune provided the forum for the initial development of a national network. By 1997, the right factors were in place to establish a network (personal skills confidence, the support of funding bodies, and the government). The Tamil Nadu State AIDS Control Society was important in providing support and exposure for the network in Delhi.

Dr. Tokhugha Yepthomi was the founding President of INP+. The initial activities included running a counselling centre in Chennai. With Family Health International (FHI) support, the secretariat received funding and the network was able to mobilize other PLHA across the country through a series of skills building workshops. From the early days, the network has had to grapple with the complex issues of organizational development in a politically charged and demanding environment. A key question during the early stages of the network was how to establish an independent and representative voice for PLHA. A central figure during this period of the network’s development was Ashok Pillai. He was among the first people with HIV/AIDS to articulate the vision of PLHA participation and the role that PLHA could play in the response to the epidemic. The ability to articulate the issues and position PLHA as central to the response has been an enduring legacy of Ashok Pillai’s leadership. His ability to provide a critical voice on policy issues has helped to establish INP+ as an important stakeholder.

As the network grew, issues of representation and support needed to be developed and strengthened to ensure that the network was positioned to represent fairly and equitably (as far as possible) the largest number of people living with HIV/AIDS in India. Initial organizational arrangements, important in gaining a foothold for the network, have had to be continually modified to meet this aim. The importance of attending to organizational structure, while placing stress on network leaders, forced a more strategic approach and marked the development and increasing maturity of the network as an actor in the field of HIV/AIDS, particularly in the period between 1997–2002.

While the tensions involved in running a network have not been completely resolved, the current phase, under the leadership of K.K. Abraham, has seen the emphasis focus on establishing a strong nationally-based federation of networks and a clarification of the roles of INP+ and its constituent state and district-level networks.

**Key Milestones**

The development of INP+ has been characterized by a series of phases as the network has responded to increasing growth and the challenges of the epidemic in India. In terms of a simple typology, the shift has seen the emphasis move from
support to advocacy, and currently to the development of a more structured and organized set of relationships between the constituent parts of the network. While support services and advocacy remain central to the work of the network, establishing a strong and independent PLHA voice in India and developing a larger PLHA movement means that the current phase is concerned with strengthening and expanding the activities and relationships between local, state, and national organizations. Many challenges remain however, not least of which is the problem of maintaining clear communication between the various levels of the network across large distances and different language groups, and communicating the vision of INP+ to the state-level network while enabling state concerns to be incorporated into a national advocacy agenda.

The history of INP+ illustrates the move from support group activities towards a more strategic advocacy role with other HIV/AIDS stakeholders. An important feature of the development of PLHA networks and INP+ specifically is the importance of leadership and the ability of the members to cope with the stress of managing the personal and organizational demands of maintaining a network and advocating for the rights of PLHA. For the leadership and others involved, this means dealing with the personal impact on health. Openness about HIV status is also necessarily a prerequisite as leaders have to represent PLHA as well as provide a role model and an alternative image to the often very negative constructions of HIV/AIDS in the public discourse.

**Achievements**

INP+ can point to many achievements since its inception, including the following:
- Strengthening and forming district-level networks
- Clarification of the roles of the different levels
- Achieving greater credibility with other HIV/AIDS stakeholders, including members of the National AIDS Control Organization (NACO), the UN Theme Group on HIV/AIDS, and the Global Fund’s Country Coordinating Mechanism (CCM).
- Development of a greater involvement of people living with HIV/AIDS (GIPA) strategy
- Positive living centre in the Namakkal District
- Development of organizational policies, governance, and transparency
- The announcement of free access to antiretroviral treatment (ARV) in high prevalence states. INP+ gave input to ARV national guidelines and is an important stakeholder in the mobilization of PLHA on treatment issues, particularly in relation to adherence.

**Current Activities**

INP+ and the state networks are currently involved in a varied series of activities with a number of different partners aimed at progressing the strategic vision of network and the rights and well-being of people living with HIV/AIDS. These include a Centers for Disease Control and Prevention Global AIDS Programme (CDC-GAP)/Tamil Nadu state-supported project aimed at enhancing the efficiency of care of PLHA in South India through the establishment of a counselling and
education centre, which provides information on life after infection. In partnership with FHI, INP+ is building the capacity of the network to more effectively respond to the epidemic, through meaningful rather than token involvement. In the Namakkal District, INP+ is conducting a Positive Living project aimed at demonstrating the effectiveness of a comprehensive prevention, care, and support programme, that involves people living with HIV/AIDS. Several projects have been initiated with the goal of strengthening state and district-level networks. An important activity is the Positive Speakers Bureau. The Speakers Bureau provides positive speakers to various institutions and other organizations. These speakers are able to portray personal and human faces of the epidemic. In addition to providing an important service that addresses the root causes of HIV/AIDS stigma, the Speakers Bureau has created employment opportunities for PLHA. INP+ has also conducted a study, in partnership with APN+, which documents discrimination against PLHA. INP+ is also providing technical assistance to a project promoting safer sex behaviour among men who have sex with men (MSM).

**Structure of the Network**

INP+ is managed by a governing board of nine drawn from the state networks. The nucleus of INP+ are the state-based networks. In turn, district groups elect state network representatives. The diagram below represents the current structure and organization of the network.
Strategic Directions
At present six strategic objectives encompass the goal of INP+ to “improve the quality of life of people living with HIV/AIDS in India.”

1. To facilitate and improve access to treatment for people living with HIV
INP+ believes that treatment is crucial. Three Positive Living Centres have been established in the high prevalence district of Numskull, Tamil Nadu to provide comprehensive medical care and psychosocial support to PLHA and their families. Workshops on treatment education were conducted for PLHA. INP+ advocated for treatment access in various forums and at the government level as well.

2. To provide access to information to people living with HIV
INP+ has established a Family Counselling Centre at the Government Hospital for Thoracic Medicine in Chennai, Tamil Nadu. The centre provides information specific to issues relating to life after infection for both PLHA and their families.

3. To promote and protect the human rights of people living with HIV
A documentation of human rights violations of PLHA is being conducted by INP+. Recommendations will be made to the government based on the findings of the study. Currently INP+ is fighting a case against Majeed for claiming that his medicine can cure HIV. INP+ also partners with organizations like the International Labour Organization and the Lawyers Collective to address human rights issues.

4. To promote involvement of people living with HIV in all levels of decision making
GIPA is promoted by INP+ at all levels. INP+ initiated the national consultative group on GIPA and has prepared and submitted strategies to NACO to make GIPA operational in India.

5. To promote social acceptance of people living with HIV and to end stigma and discrimination
The Positive Speakers Bureau puts a human face to HIV. Positive speakers talk to student bodies, corporate workers, factory workers, and others about living with HIV and other issues concerning HIV/AIDS. An open forum towards the end of the positive speaking session gives an opportunity to address the fears, myths, and misconceptions that often characterize discrimination.

6. To provide opportunities for networking for people living with HIV
State and district-level positive networks are continually being formed. INP+ provides its affiliated networks with capacity-building training and the technical support to function effectively in their response to the HIV epidemic. The networks work towards garnering community support and involvement.

The strategic directions have helped focus our energies on the challenges that lie ahead. Stigma and discrimination against people living with HIV remains a serious and major challenge to those living with the disease as well as inhibiting prevention and care activities. While we can point to major achievements in raising the profile of
the national network and the centrality of PLHA to the response to HIV/AIDS, much work remains to be done in order to fully and meaningfully involve people living with HIV/AIDS in the response to the epidemic. Finally and most importantly, it is now acknowledged that the advent of ARV treatments have created the potential to change HIV/AIDS from a terminal to a manageable disease. HIV/AIDS remains one of India’s foremost public health issues, yet only a privileged few have access to the medicine that can save thousands of lives. INP+ will continue to take a leading role in advocating for greater access to these treatments.
“Women living with HIV are often blamed, ostracized or thrown out of their homes, while care is provided to the infected male partner; they are also denied access to training, shelter and care and support.”

(Dr. Shalini Bharat, Positive Speaking, 2003)

Need for Positive Women’s Network (PWN+)

Women generally are less informed and have an inability to safeguard themselves due to societal norms and cultural attitudes about women. This, along with a lack of resources and support systems within families, compounded by their lack of education and work inexperience, has rendered many women homeless. The unimaginable stigma and discrimination women in general face from their in-laws’ families is harder and fiercer post-HIV diagnosis.

To address these issues with one collective voice, PWN+ was started in 1998 with 18 women living with HIV. It now has 250 members from various parts of the country advocating for the issues affecting women living with HIV in India. Started as a support group for women in South India, PWN+ is the main advocate for positive women in India. The activities primarily focus on organizing positive women from various parts of India, advocating with the government, non-governmental organizations, health care and every other related sector, and providing services to women living with HIV to alleviate the problems they face.

National consultation on women living with HIV/AIDS (WLWHA), March 8, 2002 was one advocacy initiative of PWN+. The consultation focused on identifying issues and concerns faced by women living with HIV, and looked at possible ways of addressing them. Some of the issues are expressed in the section below.

Increase in HIV Infection Among Women

The prevention programmes in the first decade targeted women belonging to the so-called high-risk group. This not only ostracized sex workers, but gave women from the general population a false sense of security that HIV would not affect them. The percentage of infections among women has steadily increased from 41 percent in 1997 to 47 percent in 2000 (UNAIDS). This situation is not limited to sub-Saharan...
Africa, where the estimated number of women living with HIV is 12.2 million. The last decade of the epidemic in India has seen an increase in the number of women testing positive for HIV.

The study jointly conducted by the Centre for Research and Advocacy (CFAR), PWN+, and the United Nations Development Fund for Women (UNIFEM) published as “Positive Speaking, Voices of Women Living With HIV/AIDS,” confirms that the factors responsible for the increase in infection rate among women are low levels of awareness, spiralling violence within the home, and limited access to health care. Compounding these factors are the sudden role reversal of becoming a bread winner, being blamed by in-laws as the cause for infection, non-acceptance by the neighbours, and the sudden shock of knowing the status.

**Impact of Existing Information, Education, and Communication (IEC)**
Existing IEC activities target men, while the women are usually projected as victims; it gives them almost nil information or options to protect themselves from HIV infection. IEC materials produced conform to the existing stereotype of women and thereby offer no protection options for young unmarried women who are sexually active other than abstinence. The issue of women being sexually active before and outside marriage is often one that the entire HIV programme in India is silent about. The impact of this silence has been shame and fear of revealing HIV status especially when one is unmarried. This marginalizes women based on how they got their infection; in such an environment the worst affected are the sex workers.

PWN+ is currently attempting to address this gap by involving women from all walks of life in their programmes.

**Economic Impact on Women Living with HIV**
A study conducted by the International Labour Organization (ILO) and state-level networks of people living with HIV on the psychosocial impact of HIV on the household has revealed that being HIV positive causes a severe physical and economic crisis among people living with HIV. This has been found to be more difficult on women. At the same time, there has been an undue stress on home care as a main component of the continuum of care. This increases the burden of care on women infected or affected by HIV, and prevents them from accessing jobs, which will make them economically self-sufficient.

PWN+ is actively advocating for programmes that will consider the economic sustainability of households affected by HIV.

**Prevention of Parent-To-Child-Transmission (PPTCT) and Women Living with HIV**
Until recently, women were viewed as the vector of HIV infection, and while PPTCT programmes concentrated on preventing the transmission from the mother to child, it did not place any importance on providing antiretroviral (ARV) treatment to maintain the health of the woman after her delivery.
The government’s current announcement to increase the access to ARVs has brought hope to many women in the country.

**Creating a Positive Image for Women Living with HIV**

Recognizing the role of the media, the national consultation recommended conducting sensitization workshops for media professionals on the following topics:

- Building skills in communication
- Media advocacy campaign for agencies
- Establishing systems to monitor media for accountability particularly around portrayal of women in print and electronic media. This would mean documenting success stories to establish role models.

Following this, PWN+ in partnership with CFAR and the support of UNIFEM, released a media tool for gender-sensitive reporting on HIV/AIDS.

**Bringing Women Living with HIV in India Together**

PWN+, assuming a greater role in an effort to provide a voice for women’s issues at the national level, has initiated a forum for women in each of the state-level networks affiliated with the Indian Network for People Living with HIV/AIDS (INP+). PWN+ has been instrumental in creating safe spaces for women to share and exchange their experiences in a supportive environment. Sex education and safe behaviour are highlighted in every programme. The members of the support group have been trained to become advocates in prevention and care programmes in their own regions.

PWN+ has formed state and district-level groups of women living with HIV in various parts of Tamil Nadu and has initiated similar networking in other states in India.

**Legal Advocacy and Legal Literacy**

PWN+ recognized that women living with HIV were not aware of their needs and thereby not in a position to claim their rights. PWN+ organized legal advocacy workshops in the southern region of India and Mumbai, and highlighted issues on discrimination of HIV positive children at schools, denial of treatment at the hospitals, and so forth.

PWN+ has been instrumental in creating a support network of lawyers and the media in order to highlight the human rights violations and gather support from the general public for women to access legal support.

**Providing Psychosocial Support**

PWN+ focuses on the psychosocial component by providing information, counselling, initiating support groups, generating family support, organizing training, and conducting income-generation programmes for women and the general population.
Developing IEC Materials
IEC materials have been found to play a major role in adopting positive living. PWN+ has produced a poster on positive living, which has been welcomed by the government programmes as a model for internalizing the messages on taking care of one’s health. The posters show positive women giving information on positive living. This, PWN+ believes, will help integrate the message more effectively. These IEC materials have also resulted in clarifying the misconception that “HIV is a dreaded/killer disease. HIV affects only people who indulge in unfaithful sex.”

Education Programmes with the Involvement of Positive Speakers
PWN+ has been a pioneer in integrating the positive living component into the youth programme on HIV/AIDS. This has brought the epidemic closer to young people and helps them personalize it. The common misconceptions prevalent among youth includes, “HIV infected people are usually sick. An HIV-positive person can be identified through their appearance.”

When a positive woman publicly speaks about living with HIV, these myths are clarified. This programme has also generated immense support from youth and has helped them understand issues affecting people living with HIV.

Recommendations from PWN+ for addressing gender issues in the current HIV/AIDS programme are as follows:

- **Greater involvement of people living with HIV/AIDS (GIPA) has to be implemented in all programmes in planning and policymaking.** Policymakers should consider the benefits of involving women living with HIV in programme planning and implementation of the programmes.
- **Prevention programme.** The national programme addresses only two categories, one under the PPTCT Programme and the other target intervention (condom promotion and reproductive and child health) for the programmes on women. It fails to recognize the awareness level of young women of their reproductive health and their ability to safeguard themselves from any kind of infections. College programmes and school interventions do not target sexual health and the HIV/AIDS programmes administered are moralistic.

**PWN+ recommends:**

- The programme managers at the national, state, and district levels should address women directly and not as a co-target for HIV and AIDS prevention programmes.
- Information must be first given to teachers and government staff and channelled through them to the general public.
- Political involvement is essential.
- Information must be given on how to avoid sexually transmitted infections (STIs).
- Campaigns on avoiding HIV/AIDS are essential. Campaigns must also address what to do if you have AIDS, provide addresses and telephone numbers of the networks, help lines, and so forth.
**Care and Support**

*Care only through STI departments.* The common prevalent mode of treatment for women living with HIV is through STI departments. There are no proper diagnostic and medical procedures for other opportunistic infections. For example, though the TB programme has been focused on providing appropriate medications, there has been little recognition of drug resistance among people living with HIV/AIDS (PLHA). General ailments and reproductive health as a vital component has been the least considered.

**PWN+ recommends:**
- It must be made compulsory for both government and private hospitals to provide treatment and care to PLHAs. Legal action should be taken for failure to do so.
- Treatment must be made available to PLHAs in all departments and not just STI or dermatology departments.
- STI departments must have women doctors.
- Information on sex, sexuality, and medication must be available in the hospitals.
- Hospitals must have medicine for opportunistic infections.
- ARV medicine should not be subject to sales tax, especially for women in the third stage and poor women.
- WLWHA must be involved in workshops for medicals and paramedicals.
- Private labs, nursing homes, and hospitals must have a counsellor.

**PPTCT Programme**

Though recognized as successful, the programme has failed in many ways. Lack of proper administration and monitoring has seen many negative implications. From field and study knowledge, PWN+ is aware of women denying ARV at the time of delivery due to lack of proper counselling. Group counselling, though recognized as an effective tool in reaching the general population, has also caused a serious fear among women accessing antenatal care (ANC). To resolve this, it can be called an information centre, with HIV counselling comprising only one part of the services provided and not the sole component.

**PWN+ recommends:**
- Reproductive health information desks in every hospital, staffed with the participation of PWN+ in PPTCT.

**Support System**

*Specific capacity building for women living with HIV and creating space and systems for gathering their inputs for the programme.* Many women infected have no access to any kind of support system. With the growing number of widows facing the peak of stigma as a result of their status, a support group is essential. The study with ILO and UNIFEM has revealed the greatest fear among women is the future of their children and therefore a need arises for a support system.

**PWN+ recommends:**
- Development schemes for women must give preference to HIV+ women.
- Support groups for women should be supported to initiate programmes in their own regions.
VCTCs, Treatment, Care and Support

Chairperson
William Emmet

Voluntary Counselling and Testing: The SIAAP Experiences
Maya Ramachandran

Voluntary Counselling and Testing Centres in Uttar Pradesh
Nilesh Deshpande

Care, Treatment and Support
Bitra George

Discussants
Paul Perchal and P. R. Balgopal
Prevention of HIV/AIDS in Uttar Pradesh
Background
The South India AIDS Action Programme (SIAAP) started its work in HIV and AIDS in 1989 when it challenged the illegal detention of the first women in India who had tested positive for HIV back in 1986. In a landmark judgement in 1990, the Madras High Court ruled that the women be released. Nearly 900 women were released from jails and remand homes in Tamil Nadu, and a precedent was set against detaining people living with HIV and AIDS (PLHAs).

SIAAP then started setting up support structures for the released women, most of whom were sex workers. One of its earliest interventions was to improve treatment and care services for PLHAs at the Madras General Hospital. Another was prevention outreach with women in sex work, and their clients, mainly truckers, in and around Chennai (1992). We quickly saw that there was something missing in our work despite everything we were putting into it—advocacy for care, referrals, nutritional assistance, support for patients and families, prevention education, condoms, referrals for sexually transmitted infection (STI) treatments, and other activities.

In 1993, we set up a pilot counselling service in the sexually transmitted diseases out-patient department (STD OPD) of the Royapettah General Hospital. The “counselling” itself was little more than education and sensitization about STIs and HIV. But we arranged for some important changes, for example: the label “STD Department” was replaced by a number; for the first time ever, patients were examined in private, and their permission was asked if an intern wished to be present; routine visits to their homes were stopped along with the practice of sending postcards asking them to report to the hospital for follow-up; and all staff were encouraged to be as non-judgemental and supportive as possible. In addition, the hospital allowed itself to be persuaded to drop the practice of testing for HIV without the explicit consent of the patient.

Getting it all going was a credit to the doctors in the department who were quick to see that the changes were getting more patients in and giving the department a good name. Within a year, attendance doubled, more women started coming in, and men started bringing their wives upon understanding issues of re-infection and being
assured that the counsellor would not break confidentiality. More people began completing treatment and learning the correct way to use condoms to prevent reinfection. In fact, insisting that the client demonstrate condom use to us became a critical part of the intervention. Sometimes clients, particularly women, were embarrassed. But the counsellor persisted and this served to underscore the importance of condom use. The best testimony came from the sex workers themselves—not only did they start using the services, they even began to refer their clients to the hospital! It was a win-win situation.

The biggest lesson we learnt was the value of combining hospital-based counselling with community outreach. Each day, after OP hours, the counsellor would visit the community areas, talk to the women and invite them to the hospital assuring them of her presence at the STI clinic, and help with other referrals they might need in the hospital. Trust grew when they found that hospital staff treated them with respect and a genuine desire to help. There were no nasty or suggestive remarks, and no attempts to moralize. They came back and brought their friends along.

This experience helped us to understand the value of counselling in the area of HIV and AIDS prevention and care. In 1996, SIAAP set up a structured training, placement, and supervision programme for STI, HIV, and AIDS counselling in collaboration with the State AIDS Control Societies in Tamil Nadu, Andhra Pradesh, and Karnataka. The 24-hour day, on-the-job training, and supervision was done in collaboration with the Netherlands Gestalt Foundation (NSG) in Amsterdam, and the Central School for Counselling Training (CSCT) in London. By 2001, we had trained and placed nearly 120 counsellors in STI clinics in district government hospitals in these states. The counsellors were later absorbed by the voluntary counselling and testing centres (VCTCs) as they were established in each state.

Almost exactly 10 years later, in 2003, SIAAP was invited to help set up a model VCTC at the Stanley Medical College Hospital in Chennai in collaboration with the National AIDS Control Organization (NACO) and the World Health Organization (WHO). The experience has again underlined some of the lessons we learned at the Royapetah Hospital all those many years ago.

**VCTC Part of Care Continuum**

As part of an effective strategy for prevention and care for HIV and AIDS, the VCTC has been conceptualized as an integral part of the continuum of care, and not as a stand-alone testing facility, as its location in the immunology section of a hospital may imply. The VCTC offers its clients four distinct, yet connected services.

- Access to care services (medical referrals)
- HIV diagnosis (testing)
- Information, sensitization, and emotional support (counselling)
- Access to social support services (community/other referrals)

A client must feel free to walk into the VCTC and access one or more services as she/he may need at that specific time. For instance, a person may walk into the VCTC with a skin rash. It is for the counsellor to make the appropriate referrals as well as to
inform the person about the availability of an HIV testing facility if it is so warranted. However, the client must feel free to choose whether to go on to the dermatologist without having the test, or to go ahead with the testing first. It is precisely this availability of a range of services, as well as the freedom to choose, that will bring clients back into the VCTC and encourage them to recommend it to their family and friends.

**VCTC Client-Centered**

The customer/client is king! This about sums up what being client-centered means. It has to do with locations and times convenient to clients (not VCTC staff), good visibility, easy access to and within the VCTC, cheerful service areas and staff, adequate privacy, strict confidentiality, and most important, freedom for the client to choose from the services available. At the Stanley Hospital, the VCTC was shifted closer to the out-patient dispensary (OPD), timing was changed to coincide with OP timing, the waiting area had information on general health as well as HIV, and blood was collected for all tests to improve confidentiality and non-discrimination. Within the VCTC, the route of the client to the medical officer, the counsellor, or the technician was simplified, and test results were given as soon as possible, by the same counsellor who had provided the pre-test counselling. The VCTC staff understand that they are there for the client, and not the other way around.

**VCTC Connected with Community**

This is a fundamental and often overlooked part of a VCTC function. At the Stanley Hospital we have found that the times our interactions with non-governmental organizations (NGOs) and community-based organizations (CBOs) fall off, there is a corresponding fall in the number of clients. One of the strategies we are exploring is the possibility of having our counsellors set up a part-time community counselling service in specific areas in addition to NGO referrals. We are still trying to find an effective and consistent way of maintaining the community connection, but there is little doubt about its importance.

**Training and Supervision**

Ongoing training and supervision is an essential ingredient for professional excellence in any area. This is of particular relevance in a VCTC because of the high levels of stress that staff face when having to cater to the never-ending needs of clients. Counsellors in particular require a lot of support to help them deal with the inevitable emotional overload that they will experience as they work with the emotional needs of their clients. In addition, the high chances of losing clients to illness and death can cause severe distress and lead to early burnout.

Supervision must be understood as a provision of both personal as well as professional support to the counsellor. It must not be confused with monitoring or evaluation, though observation of the counselling session and feedback is a key element of the process. If the objective of supervision is seen as helping the counsellor, then the essence of the process becomes clear. Supervisory records and formats, as well as formats for self-assessment by the counsellor have been prepared in consultation with NACO.
One important lesson we have learned is to recruit and train a mixed group of counsellors—people belonging to affected communities themselves such as PLHAs or their family members, men having sex with men (MSM), or women in sex work, along with the traditional set of Master of Social Work (MSW) graduates. This combination seems to help the non-community members become accepting and non-judgemental very soon, and helps the lesser educated community members to work harder to achieve and maintain professional standards of work.

**NGO/CBO-Government Partnerships**

The most enriching experience by far has been the creative and productive partnership between an NGO and the government that has married the strengths of both sectors. NGOs bring with them an understanding of and commitment to communities, a degree of flexibility, and a willingness to experiment. Governments contribute professionals, infrastructure, service and material resources, an ability to scale up, and the authority to effect policy. Working together with a common objective and a shared vision has been the most effective and satisfying way of making a positive difference in the lives of our people.
Overview of Voluntary Counselling and Testing Centres (VCTCs) in Uttar Pradesh

India has the second largest population of HIV-infected individuals in the world. The prevalence rate varies in different states; for example, Maharashtra and Tamil Nadu are high prevalence states while Uttar Pradesh (UP) is a low prevalence state. The prevalence of HIV among the general population is 0.19 percent, and among high-risk groups it is 1.28 percent. The total number of AIDS cases in India as reported to the National AIDS Control Organization (NACO) on December 31, 2003, was 61,201. In UP, the number was 1,202.

One of the reasons for low prevalence in UP could be the efforts taken by the UP State AIDS Control Society (UPSACS) in establishing VCTCs. VCT has been shown to have a role in both HIV prevention and as an entry point to care. It provides individuals with an opportunity to learn and accept their HIV sero status in a confidential environment, as VCT is the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV. VCT has become an integral part of HIV prevention programmes in many countries, as it is a relatively cost-effective intervention in preventing HIV transmission. VCT is a cornerstone for early access to care and support services. High public awareness of HIV, increasing numbers of AIDS cases, increasing numbers of people dying of AIDS, and the knowledge of personal risk behaviours result in an increased desire to learn one’s sero status.

The need for VCT is increasingly compelling as HIV infection rates continue to climb, and countries recognize the need for their populations to know their sero status as an important prevention and intervention tool. Those people who learn they are sero negative can be empowered to remain disease free. For those HIV-infected, less costly interventions to reduce mother-to-child transmission of HIV and HIV-associated infections like tuberculosis (TB) can be effectively developed. In addition, other medical and support services can help those living with HIV to live longer, healthier lives and prevent transmission to others.

One of the ways in which effective intervention can be brought about is by establishing VCTCs throughout the state. NACO has allocated budgetary provisions...
to state AIDS control organizations to set up VCTCs. In UP, the first initiative to introduce VCTCs was in 1999. Since then, 70 VCTCs have been established all over the state. Of these, eight were in medical colleges, four were in major blood banks, one in a blood bank of a district hospital, 51 in district hospitals, and the remaining in a community health centre, eye hospital, National Institute of Biologics, and so forth.

The year-wise number of VCTCs established is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of VCTCs established</th>
<th>Total VCTCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999–2000</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2000–2001</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>2001–2002</td>
<td>34</td>
<td>45</td>
</tr>
<tr>
<td>2002–2003</td>
<td>25</td>
<td>70</td>
</tr>
</tbody>
</table>

**Objectives**

The main objective of this study was to assess the current status of VCTCs in Uttar Pradesh with the following specific objectives:

- To get an overview of VCTCs in Uttar Pradesh in terms of the accessibility, infrastructure, and client load
- To assess the type and quality of services provided through VCTCs
- To understand the level of satisfaction of the clients visiting VCTCs
- To understand the capacity of the staff

**Methodology**

As of December 2003, 70 VCTCs were established in Uttar Pradesh. Out of these, 11 VCTCs were selected, taking into consideration the geographical coverage and the managing bodies. Accordingly, four VCTCs managed by medical colleges and seven VCTCs managed by district hospitals were selected.

Data were collected from the medical officers in charge (MOICs), counsellors, and lab technicians of the centres. Client satisfaction was assessed through a type of “exit poll.” The counsellor explained the purpose of the study to the clients who were available on the day and obtained the consent of the clients to be interviewed. After the consent was obtained, data were collected from the clients through unstructured interviews. An interview guide was prepared that guided the interviews.

Twenty counsellors were interviewed from the 11 VCTCs. In one VCTC, since there has not been any appointment of counsellors, the doctor in charge was interviewed. The doctor conducts pre-test and post-test counselling. Ten VCTC in-charges (one was on leave) and eleven lab technicians were interviewed. Four clients were interviewed from four different VCTCs.

**Profile of VCTCs**

Out of the 11 VCTCs reviewed, four were associated with the microbiology departments of medical colleges, three were associated with blood banks at district hospitals, two were associated with medical OPDs, and one was associated with the pathology department at a district hospital. There was only one freestanding VCTC at Faizabad.
**Timings of VCTC**
The working hours of the VCTCs correspond with the OPD hours of the hospitals in which they are located. The medical college-related VCTCs are open from 9 a.m. to 5 p.m., and district-level VCTCs range from 8 a.m. to 2 p.m. The timings of the VCTCs are accessible to the clients who want to get tested.

**Financial System**
Each VCTC has a budgetary provision of Rs. 198,000 annually. Of this, Rs. 78,000 is for the salaries of the lab technicians; Rs. 96,000 is for the salary of two counsellors; and Rs. 24,000 is for furniture and other consumables.

For the successful functioning of each VCTC, resources have been provided for appointing a lab technician in an agreement/contract and for placement of a male and a female counsellor through non-governmental organizations (NGOs). During the contract period, every lab technician gets Rs. 6,500 per month and every counsellor gets Rs. 4,000 per month. There is also a provision for annual increases. There is also a provision of TA/DA for staff travelling for official purposes.

However, in two of the VCTCs, it was observed that the staff were not paid their salaries for five months because of administrative systems. This has to be looked into and streamlined by the concerned authorities as it deters the effective functioning and morale of the staff.

In all the VCTCs, it was seen that budgets were available and all the necessary documents were maintained properly. The budgetary system for VCTCs is centralized.

**Fee Structure**
All 11 VCTCs reviewed receive funding from UPSACS. Testing patients referred by a doctor for the purpose of diagnosis is done for free, whereas in the case of a person voluntarily going for an HIV test, a testing fee of Rs. 10 is charged. In the case of very poor patients who are unable to pay the nominal charge of Rs. 10, the fee is waived. The authority to waive the fee lies with the MOIC of the VCTC. A contingency budget is not found to be adequate. In one VCTC it was observed that Rs. 10 was charged to all ward patients.

**Medical Support**
Under the programme, free treatment is provided for incidental infectious diseases. Out of 11 labs, only six have post-exposure prevention (PEP) drugs for lab
technicians. According to the provisions, every hospital is allowed to buy PEP drugs using their contingency funds. They can get reimbursed later through UPSACS. However, in some district hospitals, there was no availability of PEP drugs, and they had to order them from other places.

**Accessibility of the VCTC**

Accessibility of the VCTCs was difficult in some cases. There were no proper signboards that would enable the clients to locate the VCTC easily. There was no standardization in the display boards, and every centre was using its own format for the same.

**Infrastructure**

The aim of the VCTC is to reduce psychosocial stress and to provide the client with the information and support necessary to make decisions. Therefore, it needs a private and peaceful setting. Infrastructure of the VCTCs was reviewed using a checklist.

Although waiting space was available, it was found to be inadequate. Clients had to wait outside the hospital building for their turn to see the counsellor. Only five out 11 VCTCs had information regarding HIV/AIDS and sexually transmitted infections (STIs) displayed. Out of the 11 VCTCs, nine had separate space for counselling, either in separate rooms or in curtained areas. In some cases, however, a cupboard was used as the only partition between the two counselling rooms. There was no proper demarcation between the male and female counsellor’s rooms; hence, there was no privacy during counselling.

In two VCTCs, there were no rooms exclusively for the counsellors, and they shared the rooms with the lab technician. Hence, confidentiality of the client was not maintained well.

All of the medical college VCTCs were conducting ELISA tests. Out of the seven non-medical college VCTCs, two had only one Rapid/Simple kit. These seven non-medical college VCTCs were sending their samples for confirmation to the nearest reference laboratory.

For the safe disposal of biomedical waste, all the VCTCs had functional needle cutters. The segregation process, however, was not followed as per the guidelines in four VCTCs. All the 11 VCTCs disposed the infective material after disinfecting/autoclaving, followed by incineration/deep burial as per waste disposal guidelines.

---

**Table 3**

**Infrastructure of the Counselling Rooms within the VCTC**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Available</th>
<th>Not available</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separate room</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Waiting space with display of information</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Waiting area/room</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Counselling room</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Sitting arrangement for counselling</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Space in the counselling room</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>

**Table 4**

**Lab Infrastructure within the VCTC**

<table>
<thead>
<tr>
<th>Availability of testing kits</th>
<th>Available</th>
<th>Not available</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>11</td>
<td>-</td>
<td>11</td>
</tr>
<tr>
<td>B</td>
<td>8</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>ELISA*</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Personal protection devices</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Disinfectant</td>
<td>10</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Proper biomedical waste disposal</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>

Availability of PEP drugs 5 6 11

*District-level VCTCs have not been provided ELISA facilities. One VCTC associated with a blood bank was using the blood bank’s ELISA facility for HIV testing.
As part of infection control measures, seven of the 11 VCTC labs had protective devices such as gloves, masks, and aprons. At two VCTCs, only gloves were available. It was observed that gloves are routinely used by lab technicians, but use of facemasks and aprons is irregular. None of the VCTCs had eye shields.

PEP, according to NACO, has to be provided in all VCTCs. There is a possibility of occupational exposure that may place the worker at risk of HIV infection. NACO has listed standard precautions (universal work precautions) to be taken in case of occupational exposure. The VCTC operating manual includes these guidelines. Despite having budgetary provision for PEP under opportunistic infections, only six had PEP medicines for lab technicians. The rest had to order it from other places.

**External Quality Assessment Programme (EQA)**
According to the EQA programme set up by NACO, all samples testing positive by using three rapid test kits at the district-level VCTCs are retested using three ELISA test kits with different antigens or principles. It is also required that 5 percent of negative samples and all borderline positive samples be sent to the state-level reference labs twice a year for checking the results. It was observed that only one of the MOICs was aware of the exact system or process of EQA. The district-level VCTCs that did not have ELISA testing facilities reported that they send positive samples for confirmation to state reference labs or to the nearest centre where ELISA facilities are available. However, none of the VCTCs sent the 5 percent of negative samples to the state reference labs twice a year for checking the results. Written quality assurance protocols should be made available to the staff. The staff should be oriented regarding quality assurance.

**Internal Quality Maintenance**
For internal quality maintenance, various practices were prevalent, as follows:
- In discordant (ambiguous) results, technicians get the samples tested by a senior lab technician or medical officer.
- Samples are checked for clear serum.
- Twenty positive samples are rechecked every six months.
- If the reagent is not proper, the report is sent to NACO.
- Test kits are checked.
- Expiry dates of the kits are checked.
- Temperature of the kits is maintained.
- Temperature maintenance is cross-checked by the MOIC.
- Instructions by the National Institute of Biologicals (NIB) are followed.
- Suspected negative cases are sent for confirmation.
- Borderline and false negative samples are rechecked.

Quality control and quality assurance (QA) of laboratory activities remain issues. The continued loss of skilled staff is a serious problem. With trained personnel turnover, constant re-training of qualified staff and rebuilding the experience base are needed to support public health needs. Without additional resources, expanding the current workload of existing laboratories to support the additional requirements for CD4 counts and other advance tests would be extremely difficult.
Record Keeping
Maintaining the confidentiality of client records is critical. More or less every record was available except the referral form, which was available at only one VCTC. Lab forms were not available at four VCTCs. The operating procedures manual was not available at three VCTCs. HIV testing protocols, condom records, and post-test forms were not available at two VCTCs.

Monitoring and Supervision
Currently there is no system in place for external monitoring of the work of VCTCs. The additional director of UPSACS has the responsibility of supervising the function of VCTCs. As far as the internal supervision is concerned, the MOIC is responsible.

Supervision of VCTC Counsellors
Supervising the work of counsellors—how they are using skills and information, what problems they encounter, and what their needs are—is important for developing skilled counsellors. It was seen that none of the counsellors were getting any supervision from the heads of institutions, psychiatrists, or senior counsellors. The only supervision was from MOICs. Six counsellors complained that they did not even get supervision from the MOICs. The only person they would clarify their doubts and share their problems with was another counsellor.

Profile of VCTC Staff
The staffing pattern of every VCTC is the same. The medical officer is appointed as the officer in charge of the VCTC. The other staff are two counsellors—one male and one female—and one lab technician.

Recruitment Procedures
According to the recruitment procedures, counsellors are to be appointed preferably through NGOs. Advertisements are published in two local newspapers, and screening is done by a selection committee formed at the district level, comprising the chief medical superintendent, the MOIC, and an NGO representative. The initial contract for counsellors is for a duration of two years with the NGOs. Salaries are paid by the NGO through the VCTC. In two VCTCs, the recruitment and salary were through NGOs.

Staff Pattern
All the VCTCs except one had two counsellors—one male and one female. At one VCTC, where counsellors could not be appointed, the MOIC was doing the counselling. All staff had gone through at least one training related to HIV/AIDS and VCTCs conducted by UPSACS.

Educational Qualifications of VCTC Counsellors
Thirteen counsellors recruited fulfilled educational qualifications as per the UPSACS guidelines. Seven, however, did not meet the requirement.

Previous Experience in Counselling and HIV/AIDS
Only six VCTC counsellors had any previous experience in drug de-addiction, mental health, or family welfare services. Three of the 20 counsellors had initial
exposure to the field of HIV/AIDS; their experience focused on organizing awareness camps.

Profile of Lab Technicians
All 11 lab technicians had completed their diploma in medical lab technology (DMLT). Out of 12 lab technicians, 10 were recruited according to NACO guidelines, fulfilling the educational requirement of a DMLT. One VCTC, Benaras Hindu University, has two lab technicians against the UPSACS guideline of one lab technician per VCTC). They explained that due to heavy client load, they need two lab technicians. In one centre, the lab technician’s age was 64 (more than the NACO recommended age of 62 years).

Five lab technicians had previous experience working in a lab. As NACO recommends hiring lab technicians with experience, it was seen that most VCTCs fulfilled this criterion.

Training of the Staff
All of the 11 MOICs of VCTCs were trained in a three-day training workshop at NIB, Noida. Two of the VCTC in-charges felt that the training they received was much lower in its standards as compared with what they already knew. They found it very basic and not very helpful in their work. One of them commented, “What is the point in teaching us about certain tests and equipment when we do not even have the facility to use it? First provide us with the equipment, and then train us in using it.”

Eleven out of 12 lab technicians were trained in a three-day training workshop at NIB, Noida. Two of the lab technicians found the training inadequate. They felt more time should be allotted for the training.

All the counsellors were trained by UPSACS in a seven-day training programme conducted at Lucknow. Some counsellors had also attended a workshop for three days by UPSACS. Though a majority of the counsellors found the training useful in developing their counselling skills and HIV/AIDS knowledge, some felt it was very basic and not very practical. They felt that rather than teaching about the techniques in a theoretical way, they should be taught how to use them in practice to benefit them in their work.

All the counsellors and lab technicians felt the need for refresher training. Some of them were trained in 2001 when they were appointed for the job and have not received any training since then. They felt their knowledge of recent happenings in the field of HIV/AIDS, legal issues, dealing with HIV-positive clients, and so forth is not up to the mark.

<table>
<thead>
<tr>
<th>Educational qualifications of counsellor</th>
<th>Number of counsellors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctorate</td>
<td>1</td>
</tr>
<tr>
<td>Masters in Social Work</td>
<td>2</td>
</tr>
<tr>
<td>Masters in Psychology</td>
<td>5</td>
</tr>
<tr>
<td>Masters in Sociology</td>
<td>2</td>
</tr>
<tr>
<td>Masters in Political Science</td>
<td>1</td>
</tr>
<tr>
<td>Masters in Sanskrit</td>
<td>1</td>
</tr>
<tr>
<td>Bachelors in Sociology</td>
<td>2</td>
</tr>
<tr>
<td>Bachelor in Psychology</td>
<td>1</td>
</tr>
<tr>
<td>B.Sc</td>
<td>2</td>
</tr>
<tr>
<td>BAMS</td>
<td>1</td>
</tr>
<tr>
<td>Post Graduate in Management</td>
<td>1</td>
</tr>
<tr>
<td>LLB</td>
<td>1</td>
</tr>
</tbody>
</table>
Training Needs

In order to improve the quality of counsellors and lab technicians, open-ended questions were asked about their training needs. Following are the training requirements expressed by them.

Table 7
Training Needs of Counsellors, MOICs, and Lab Technicians

<table>
<thead>
<tr>
<th>MOICs</th>
<th>Counsellors</th>
<th>Lab Technicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>◆ Organizing publicity campaigns for VCTCs</td>
<td>◆ New trends in HIV/AIDS</td>
<td>◆ ELISA testing and reading-refresher courses</td>
</tr>
<tr>
<td>◆ Knowing more about EQA and quality control process</td>
<td>◆ Information on health</td>
<td>◆ Quality control training</td>
</tr>
<tr>
<td>◆ Western blot, CD4 Count, ELISA test; other diagnostic tests for HIV; establishment and development of Polymerase Chain Reaction; diagnostic methodology; diagnosing HIV in window period; diagnosis of congenital HIV infection</td>
<td>◆ Information on medication</td>
<td>◆ Western blot, CD4 and CD8 counting</td>
</tr>
<tr>
<td></td>
<td>◆ Information on nutrition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ In-depth information on HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ Developing counselling skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ Information on parent-to-child transmission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ Dealing with HIV-positive clients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ Conducting outreach counselling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ Interpersonal communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ Information on maintaining confidentiality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ Information on STI/TB</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ Exposure visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>◆ Dealing with very poor clients</td>
<td></td>
</tr>
</tbody>
</table>

Staff Interaction and Support

Support from NGOs was almost negligible in the VCTCs. There were no proper linkages with the NGOs. Two counsellors who had been appointed by the NGOs had some collaboration with them. The NGOs invited these counsellors to any health camps that they organized. The counsellors used this opportunity to create awareness regarding HIV/AIDS.

Doctors from within the hospitals as well as private practitioners supported the VCTCs mainly by providing professional help. They treat the clients referred from the VCTCs for any STIs and opportunistic infections. Some doctors referred patients from the skin department to the VCTC for testing.

Linking Voluntary Counselling with Care and Support Programmes

HIV-positive individuals have a variety of needs and problems that they face due to their status. The problems may not always be health related. Hence, apart from providing them medications for their symptoms, it is also important to link them to other services that may be offered by NGOs working in the area. Although every medical officer showed concern for linking VCT services with care and support programmes, especially for the benefit of HIV-positive clients, no such linkages were observed. It is important to develop and maintain strong working relationships with care providers and agencies that might be able to provide the needed services.
Counselling, Consent, and Confidentiality

Counselling

Pre-test and post-test counselling was provided in all VCTCs. Follow-up counselling was provided in all except one due to the unavailability of counsellors. In two of the medical college VCTCs, the counsellors said that they did not have enough time for counselling the ward patients as they have a huge case load. Only three VCTCs, in the form of camps or swath melas, did outreach counselling. Counselling without testing was found in rare circumstances where the clients do not agree to get tested after pre-test counselling. Testing without pre-test counselling was found in cases where the patient was referred from a ward. In such cases, the attendants bring the blood sample for testing. In these cases, it was presumed that the doctor had already counselled the patient and taken the informed consent. However, during interaction with the VCTC staff, it was observed that this was not necessarily followed.

Case Load

The graph below presents the average case load for HIV testing per month in the VCTCs visited.

Pre-test Counselling

Most of the counsellors assess the clients’ understanding of HIV/AIDS and their risk assessment. They also give information on the modes of transmission and risk reduction strategies. Very few counsellors discuss the involvement of partners in the testing and follow-up. This is despite the NACO policy, which clearly states the importance of partner involvement. It is seen that few counsellors

Table 8

Number of Clients Tested

<table>
<thead>
<tr>
<th>Name of VCTC</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Year 2002 (Jan.–Sept.)</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>King George Medical College, Lucknow</td>
<td>1,427</td>
<td>1,054</td>
<td>2,481</td>
<td>1,238</td>
<td>1,165</td>
<td>2,403</td>
<td></td>
</tr>
<tr>
<td>District hospital, Fathepur</td>
<td>70</td>
<td>22</td>
<td>92</td>
<td>61</td>
<td>36</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>Motilal Nehru Medical College, Allahabad</td>
<td>161</td>
<td>67</td>
<td>228</td>
<td>81</td>
<td>63</td>
<td>144</td>
<td></td>
</tr>
<tr>
<td>District hospital, Mirzapur</td>
<td>104</td>
<td>59</td>
<td>163</td>
<td>120</td>
<td>79</td>
<td>199</td>
<td></td>
</tr>
<tr>
<td>I.M.S., Benaras Hindu University, Varanasi</td>
<td>2,425</td>
<td>1,613</td>
<td>4,038</td>
<td>2,282</td>
<td>2,191</td>
<td>4,473</td>
<td></td>
</tr>
<tr>
<td>District hospital, Mathura</td>
<td>81</td>
<td>70</td>
<td>151</td>
<td>119</td>
<td>46</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td>S.N. Medical College, Agra</td>
<td>132</td>
<td>79</td>
<td>211</td>
<td>204</td>
<td>95</td>
<td>299</td>
<td></td>
</tr>
<tr>
<td>Central Jalma Institute for Leprosy, Agra</td>
<td>178</td>
<td>106</td>
<td>284</td>
<td>139</td>
<td>79</td>
<td>218</td>
<td></td>
</tr>
<tr>
<td>District hospital, Jalaun (Orai)</td>
<td>154</td>
<td>36</td>
<td>190</td>
<td>158</td>
<td>71</td>
<td>229</td>
<td></td>
</tr>
<tr>
<td>District hospital, Farrukhabad</td>
<td>57</td>
<td>32</td>
<td>89</td>
<td>95</td>
<td>61</td>
<td>156</td>
<td></td>
</tr>
<tr>
<td>District hospital, Faizabad</td>
<td>131</td>
<td>39</td>
<td>170</td>
<td>208</td>
<td>47</td>
<td>225</td>
<td></td>
</tr>
</tbody>
</table>
Table 9

Counsellors Providing Pre-test Counselling

<table>
<thead>
<tr>
<th>Content of pre-test counselling</th>
<th>Percentage of counsellors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients understanding of HIV/AIDS</td>
<td>71</td>
</tr>
<tr>
<td>Nature of HIV/AIDS</td>
<td>47</td>
</tr>
<tr>
<td>Modes of transmission</td>
<td>81</td>
</tr>
<tr>
<td>Misconceptions corrected</td>
<td>19</td>
</tr>
<tr>
<td>Personal risk assessment</td>
<td>76</td>
</tr>
<tr>
<td>Nature of HIV test and testing process</td>
<td>14</td>
</tr>
<tr>
<td>Benefits and consequences of testing</td>
<td>10</td>
</tr>
<tr>
<td>What does a positive result mean</td>
<td>38</td>
</tr>
<tr>
<td>What does a negative result mean</td>
<td>23</td>
</tr>
<tr>
<td>Window period</td>
<td>38</td>
</tr>
<tr>
<td>Client’s emotional readiness for the test result</td>
<td>29</td>
</tr>
<tr>
<td>Importance of post-test counselling explained</td>
<td>10</td>
</tr>
<tr>
<td>Information on living with HIV</td>
<td>14</td>
</tr>
<tr>
<td>Risk-reduction counselling on safer sex practices, condom usage, safe needle use</td>
<td>71</td>
</tr>
<tr>
<td>Condoms distribution and condom demonstration</td>
<td>29</td>
</tr>
<tr>
<td>Willingness to involve partner in follow-up</td>
<td>19</td>
</tr>
<tr>
<td>Referrals discussed and given</td>
<td>0</td>
</tr>
<tr>
<td>Follow up arrangement discussed</td>
<td>33</td>
</tr>
</tbody>
</table>

explain the importance of post-test counselling. This may be one of the barriers to why clients do not come back to collect their reports. Also, because the importance of post-test counselling is not explained in certain centres, spouses or other family members come for report collection rather than the clients themselves. None of the counsellors discussed any referrals with their clients.

Test Results

According to NACO, sero-positive results based on three rapid HIV test kits should be provisionally given by the VCTC and the result should mention “provisionally-detected HIV sero positive, return after 15 days for final result.” However, of the six district VCTCs that did not have the facility for confirming the reactive results, only one provided provisional results to the clients. In two centres, the counsellors explained the possibility of a reactive result to the client. In those VCTCs where only rapid kits were available, the negative results were given in one or two days, but in the case of reactive samples, confirmed results were conveyed to patients in 15 to 45 days.

For confirmation of results, samples are sent to the nearby state reference laboratories by courier or in person. State reference labs explained that the samples
sent by courier, especially during the summer, have the chance of giving false negative results due to the loss of antibodies if the required temperature is not maintained.

**Time Gap between Pre-test and Post-test Counselling**

In the medical college VCTCs, the test reports were given either the same day or within a week to the clients. As many labs did not use the ELISA daily, sometimes it took a week for them to deliver the HIV-positive test results. However, in one centre it was seen that despite having ELISA and rapid test kits, it took four days for the counsellor to deliver even the negative test results. The maximum time that district hospitals took to give their results was 20 days.

**Post-test Counselling**

It was seen that though the window period was explained to the clients, the need for an HIV test after the window period was not given much importance. This may be one of the reasons for low follow-up.

During the post-test period for a negative report, the window period and risk-reduction strategies were discussed. However, very few counsellors addressed the concerns and questions of the clients.

It was observed that though involvement of spouses was not discussed during pre-test counselling, during the post-test sessions, counsellors did discuss partner involvement. Counsellors did not spend much time explaining the report to the clients, and they did not give enough time to see whether the clients understood the reports. Also, risk reduction, which is very important in HIV-positive clients, was not dealt with. Counsellors did not assess the clients’ support systems and their immediate plans. Information on care and support was almost negligible in the counselling sessions.

**Counselling for STI Patients**

NACO has not sanctioned separate counselling centres for STI clinics. The services of VCTCs should be utilized for counselling STI clients. However, it was observed that in only one VCTC, where the

<table>
<thead>
<tr>
<th>Table 10</th>
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</thead>
<tbody>
<tr>
<td><strong>Time Gap between Pre-test and Post-test Counselling</strong></td>
</tr>
<tr>
<td>Same day</td>
</tr>
<tr>
<td>3–4 days</td>
</tr>
<tr>
<td>One week</td>
</tr>
<tr>
<td>Same day for negative, 3–4 days for positive</td>
</tr>
<tr>
<td>Next day for negative, 3–4 days for reactive</td>
</tr>
<tr>
<td>3–4 days for non-reactive, 15 days for reactive</td>
</tr>
<tr>
<td>Same day for non-reactive, more than 20 days for reactive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 11</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Post-test Counselling for an HIV-negative Report</strong></td>
</tr>
<tr>
<td><strong>Content of counselling</strong></td>
</tr>
<tr>
<td>Result given</td>
</tr>
<tr>
<td>Immediate concerns/questions addressed</td>
</tr>
<tr>
<td>Window period explained</td>
</tr>
<tr>
<td>Risk-reduction strategy developed</td>
</tr>
<tr>
<td>Willingness to change behaviour assessed</td>
</tr>
<tr>
<td>Need for HIV test after window period discussed</td>
</tr>
<tr>
<td>Follow-up appointment given</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Post-test Counselling for an HIV-positive Report</strong></td>
</tr>
<tr>
<td><strong>Content of counselling</strong></td>
</tr>
<tr>
<td>Result given</td>
</tr>
<tr>
<td>Meaning of the result for the clients discussed</td>
</tr>
<tr>
<td>Immediate emotional concerns dealt with</td>
</tr>
<tr>
<td>Client able to understand and absorb the result</td>
</tr>
<tr>
<td>Personal, family, and social implications discussed</td>
</tr>
<tr>
<td>Availability of immediate support checked</td>
</tr>
<tr>
<td>Follow-up care and support discussed</td>
</tr>
<tr>
<td>Partner evaluation</td>
</tr>
<tr>
<td>Risk-reduction strategy developed</td>
</tr>
<tr>
<td>Willingness to change behaviour assessed</td>
</tr>
<tr>
<td>Immediate plans, intentions, and actions reviewed</td>
</tr>
<tr>
<td>Symptoms of TB discussed</td>
</tr>
<tr>
<td>Support and referrals given (antenatal care (ANC), TB, STI)</td>
</tr>
<tr>
<td>Rights and responsibilities discussed</td>
</tr>
<tr>
<td>Legal support discussed</td>
</tr>
<tr>
<td>Disclosure discussed</td>
</tr>
<tr>
<td>Bringing spouse for counselling</td>
</tr>
</tbody>
</table>
MOIC himself was holding the charge of the STI clinic, were the clients counselled for STIs. In all other VCTCs, they were only referred to STI doctors.

Consent
Consent forms were available in every VCTC in Hindi. In the case of illiterate clients, the counsellors read the forms and made sure the clients understood what they mean. Only after the client understood the form was his/her written consent taken. Informed consent from the clients was taken by the counsellors prior to the test.

Confidentiality
Confidentiality, according to the NACO guidelines, was maintained in most of the VCTCs. In all 11 VCTCs, clients were given an ID number. In one case, however, patients who were referred from hospital wards were sent to the lab technician with their names.

Regarding keeping the information about the client discrete in any staff interaction, it was observed that only 13 counsellors were able to take proper steps to ensure confidentiality. In a few cases, there were common registers about the client information.

Though the format of test results for positive and negative clients are the same, there are variations in the way they are delivered to the clients. Some lab technicians use red ink to denote positive status whereas negative results are written in blue or black ink. This is discriminatory and should not be encouraged. Also, positive reports are handed over in sealed envelopes to the clients and negative reports are given without any envelope. Uniformity in giving out results should be maintained.

Client files are locked and accessible only to the counsellor in most of the VCTCs. However, in certain cases, either the cabinets were not locked or the keys were shared with other staff as well.

The findings of the test are strictly confidential and under no circumstances are to be divulged to anyone other than the person who has undergone the test. However, in three VCTCs, it was seen that the reports were disclosed to the spouses. The counsellors used to take oral consent from the clients during the pre-test sessions to deliver their reports to their spouses/family members. However, in some cases, reports were given away without any consent. The counsellors explained the test results to the spouses who came to collect the reports. This was observed even in the cases of HIV-positive clients. In such cases, a serious breach of confidentiality was seen. In one VCTC, the reports were sent to the clients by mail. In such situations, there was no post-test counselling. In some centres, the register maintained for HIV-positive people was kept by the MOIC. In one centre, the positive test results were disclosed to the MOIC.

In one of the VCTCs, the MOIC mentioned that the neighbouring prisons and women’s reform centres sent their inmates for testing to the VCTC. These were mandatory tests. Though the counsellors did the pre-test counselling, they were asked to send their reports by mail. This goes against the individual’s right to privacy.
Availability of Condoms
Condoms are one of the effective tools for preventing the spread of HIV. Full information about condoms should be provided by the counsellors, and it should be made available to the persons attending VCTCs. It was observed that counsellors provided condoms to clients upon request only. The counsellors were not distributing condoms upon assessing the client’s level of risk behaviour. This should be noted, as clients may be shy to ask for condoms and may not ask even when they want to. They also may not know that condoms are available from the counsellors in the VCTC. Hence, the counsellors should give condoms when they feel that the clients need them, irrespective of whether or not they ask for it. Only three of the 20 counsellors demonstrate the correct use of condoms to the client. Condom demonstration is necessary to ensure that clients know the correct way of using them to protect themselves.

Client Satisfaction
During the visits to the VCTCs, only four clients could be interviewed. Though the visits were planned during the working hours of the VCTCs, clients were not found in most of the VCTCs. Three out of the four clients were referral cases, and only one was a voluntary client.

While interacting with the clients, it was observed that the clients found the VCTCs accessible. However, as mentioned earlier, as these clients were referred clients from within the hospitals they may have found accessing the VCTC easy.

It was seen that none of the clients knew about the facilities provided in the VCTC. This was seen because there were no proper signboards. Few VCTCs had displayed the correct information of the facilities and services available in the VCTC.

The waiting time for clients to see a counsellor was not long. The clients were satisfied with the information provided during counselling, the attitude of the counsellor, and the quality of the counselling. Some clients expressed that they did not get as much time from the counsellor as expected. In the case of the voluntary client, he mentioned that the counsellor spoke only about HIV/AIDS whereas his need was something else. He wanted the counsellor to discuss his depressive state and suggest how he can overcome his HIV-related anxiety. In yet another case, the counsellor only asked the client about his high-risk behaviour without filling the form. This was due to heavy client load on the counsellor.

Due to the delay in confirmation of HIV-positive reports from the reference labs, the clients felt irritated with the counsellors. They did not feel the motivation to come back again and again for their reports and felt disillusioned. The overall client satisfaction with the VCTC was average with room for improvement.
Recommendations

Infrastructure

- Boards that display the correct address of the VCTCs should be displayed openly in the hospital. They should be in English and Hindi. Uniformity in the design for the display boards is preferred. There should also be boards that have details about the different services offered in the VCTC, such as pre- and post-test counselling, testing, the centres’ hours, and so forth.
- Each VCTC should have its own laboratory and should be equipped with all required equipment for HIV testing.
- Every VCTC should have its own refrigerator. Refrigerators are one of the important and basic requirements of functional VCTCs.
- VCTCs that send their samples to reference labs for confirmation must have carrier boxes with ice packs. Transportation of serum in summer requires maintenance of a cold chain.
- The VCTC counsellor’s room, MOIC’s room, and blood collection room all should be near the OPD, not in the teaching faculty (Lucknow, Varanasi).

Sensitization

- Sensitization of the medical staff—doctors, ward boys, and nurses—should be carried out in every hospital. It was told that when clients express their wish to get a HIV test, the responses from the hospital staff may not be very favourable. Sensitizing them to issues of HIV/AIDS is needed.

Training

- Training sessions that impart new skills and information are important. Refresher training is a must.
- Making the training more practical is important. It is not enough to distribute condoms to the clients; demonstrating how to use them is essential to ensure their use.
- Training the counsellors on issues related to sexuality is important. Most of the counsellors had apprehensions or hesitation to discuss issues related to sexuality.

Information, Education, and Communication (IEC)/Behaviour Change Communication (BCC)

- It was observed that IEC/BCC material was not used by most of the counsellors while counselling clients. Pictorial flip charts can be an excellent teaching tool for literate and illiterate clients. In many centres, IEC was not available. It should be made available in every centre, and counsellors should be trained for its use.

Condom Distribution

- Condom distribution should be encouraged. Records should be maintained. Individuals attending the VCTCs should be made aware about the outlets from where they can get condoms under various schemes.

Outreach Sessions

- In most of the VCTCs, the client load is very low. Counsellors are on duty for four hours, and their services are underutilized. If their services can be utilized
for outreach sessions, it can be useful. If they can go out in the community and hold awareness sessions, it can have a larger impact. Also the counsellor felt that they could do something more in the field. This can also break the monotony in their work and they will not get burnt out so soon.

Financial Support
◆ A budget for carrying out outreach activities is essential. As of now, there is no such provision. This proves a major hindrance in carrying out activities.

Fee Structure
◆ There should be fixed guidelines for charging the patients for HIV testing irrespective of the client being voluntary or a ward patient. Fees should not be taken from poor patients whether voluntary or from wards.

PEP
◆ Charts that explain immediate measures to be taken in the case of a needle prick should be displayed in the lab of the VCTC.
◆ Every technician of VCTC must have the information of the contacting person for availing PEP for HIV.
◆ The MOIC should be directly in charge of providing PEP to VCTC staff.

Referral Services
◆ Referral services with STI departments, TB clinics, and ANC clinics should be strengthened.

Networking
◆ Networking with local NGOs would help to form linkages, which can be helpful for counsellors. NGOs can refer cases to VCTCs; some resource help can also be achieved.
◆ Forming a network of counsellors can help in many ways. Discussing their cases, sharing information, and forming a community is always beneficial.

Support Groups
◆ VCTC services should be expanded to provide care, support, and HIV management also.
◆ Forming support groups of HIV positive people in centres where they have follow up is important. They can have group sessions in home-based care, nutrition, healthy lifestyles, and so forth.
◆ Every VCTC must be linked to the care and support programme for HIV-positive persons. UPSACS should facilitate these linkages.
Background

In the last one and a half decades, HIV/AIDS has emerged as one of the most serious public health problems in India. It, along with tuberculosis (TB) and malaria, is the cause for the maximum morbidity and mortality among Indians today. The lack of political commitment, non-availability of treatment and care options for people living with HIV/AIDS (PLHAs), along with widespread stigma and discrimination prevalent in institutional and community settings make it difficult to address this issue in India. In addition, lack of knowledge and misconceptions regarding the disease are still prevalent among Indians, especially in rural settings.

The first case of HIV/AIDS in India was detected in 1986. Since then, HIV infection has been reported in all States and Union Territories. At present, it is estimated that there are around 3.82 to 4.58 million people living with HIV/AIDS in India — the second largest number in the world after South Africa. The foremost mode of transmission of HIV is through sexual intercourse, except in the northeast of the country, where injecting drug use (IDU) has been the primary route of transmission. It is also estimated that over 95 percent of the infected do not even know their HIV status. An alarming trend has been observed in the increase in HIV prevalence among antenatal women, indicating the spread of HIV from the high-risk groups to the general population. The spread of HIV within India is as diverse as the societal patterns between its different regions, states, and metropolitan areas. The infection is now spreading among the general population, beyond the groups with high-risk behaviour. This trend is likely to increase over the coming years. Uttar Pradesh is one of the states categorized by the National AIDS Control Organization (NACO) with a low prevalence rate—less than 1 percent among antenatal attendees and less than 5 percent among sexually transmitted infection (STI) clinic attendees. There is concern that the current HIV prevalence levels in Uttar Pradesh do not reflect the reality, as there are insufficient number of sentinel sites, reports of ‘hot spot’ districts with high rates of HIV among STI clinic attendees, poor information levels about STI/HIV especially among women, poor health-seeking behaviour, low condom usage rates, and an inadequate health care delivery system. Complacency at this stage could cause the epidemic to spread rapidly and become out of control in the next five to 10 years.
Care and support for PLHAs, their families, and their communities were until recently neglected components of most HIV/AIDS programmes in non-industrialized countries including in India. Experiences from around the world have shown that improving access to HIV/AIDS care and support services helps destigmatize HIV, improves demand for HIV voluntary counselling and testing services, and allows for early management and prevention of infectious diseases, such as TB and STIs. Providing these services, in turn, creates important opportunities for HIV prevention. Synergetic programming that links prevention with care and support is increasingly part of national and local strategic plans in many countries. Within each community, region, and country, there is an existing level of HIV care and support that needs strengthening. In each setting, however, difficult choices have to be made about the level of care and support that is feasible and affordable in the short term, and what can be attained in the future. Strategies and national standards are needed to guide both the allocation of resources and the implementation of HIV care and support activities at the various levels. Strengthening community, regional, and national capacity to implement comprehensive care and support programmes will make it possible to demonstrate how cost-effective approaches can be replicated, scaled up, and sustained.

This document provides a strategic framework to assist national and local planners, implementers, and donors in setting priorities and outlining the steps necessary to develop comprehensive HIV care and support programmes that meet the medical, psychological and social needs of people affected by HIV. The document contains extracts from the following publications: Key Elements in HIV/AIDS Care and Support (UNAIDS/WHO 2000); HIV Care and Support – A Strategic Framework (FHI 2001).

Goals and Objectives of Care, Treatment, and Support Programmes
The goals of providing care and support for PLHAs are to
- Reduce HIV-related mortality and morbidity
- Improve the quality of life for PLHAs
- Improve the survival of PLHAs

Specific objectives are
- To strengthen HIV prevention
- To expand greater involvement of PLHAs (GIPA)
- To reduce the impact of HIV on TB and HIV-related diseases
- To mitigate the socio-economic and psychologic impact of HIV on individuals, families, communities, countries, and society at large
- To improve HIV care for vulnerable populations such as young people, pregnant mothers, drug users, and orphans, whose access to care is limited

Rationale for Providing Care and Support Services
- Supports basic human right principles—The consensus about the importance of care highlights the fact that health care is a human right.
- Contributes to the prevention of HIV infection—Care provision offers an opportunity to discuss with the client and significant others how they might
prevention of further spread of the infection, and support them in their choices to do so (e.g., by availing access to interventions that reduce mother-to-child transmission of HIV [MTCT], enabling them to increase their safety as sexual partners through safe sex and condom use, and through use of antiretroviral therapy). Prevention and care and support are mutually reinforcing approaches in several ways. Comprehensive care that meets the diverse needs of people living with or affected by HIV builds trust and creates a receptive audience among patients, families, and other community members to enhance prevention efforts. It also paves the way for community acceptance of people living with HIV and decreases stigmatization. Care provision offers opportunities to make prevention interventions more acceptable and available and encourages those who receive care to practise safer behaviours.

- Decreases the spread of other infectious diseases—Care and support for PLHAs decrease the spread of infectious diseases that are common among HIV-infected people, in particular TB and STIs, by early diagnosis and treatment of these conditions.

- Reduce stigma and discrimination—By caring openly and compassionately for HIV-infected people, their caregivers alleviate the fear in their community of HIV infection and alleviate stigma and discrimination.

- Social and economic benefits—Social and economic benefits of care and support for PLHAs arise from recognizing that when PLHAs live longer and healthier, the loss of income for themselves and their families is postponed, and the future of their dependents will be better. Also, the economy will benefit through the better performance of its workforce.

- Builds confidence and hope in PLHAs—If the quality of life of PLHAs improves as a result of care and support, hope will be instilled to the benefit of the individual and the family, and as a result, to the society at large.

- Supports the GIPA principle—Care and support for PLHAs support GIPA in the fight against the epidemic. Beyond opening the possibility of involving PLHAs in policy and decision making, and target action against the epidemic with more precision, GIPA enables the personalization of HIV infection in provision of health care, prevention, peer counselling, community care, and HIV/AIDS advocacy. This makes non-infected people, institutions, and policymakers realize that HIV is also their problem and motivates them to do something about it.

**Key Interventions for HIV/AIDS Care and Support**

It is a widespread belief that the majority of health care needs of PLHAs can be addressed by ensuring access to medication, in particular antiretroviral therapy. However, this idea falls short of effectively meeting their complete range of medical, emotional, social, and economic needs. PLHAs require comprehensive care and support, not just medicine. Care and support must be provided through all stages of HIV infection, from the individual who is concerned about HIV to those who are
infected, to the terminally ill, to those coping with the death of a family member or friend from HIV/AIDS. For a care and support package for HIV to be comprehensive, it should include elements of voluntary counselling and testing for HIV infection, psychosocial support, home and community-based care, and clinical management (including medical, nursing and counselling care). Many of the activities in each of these areas straddle the divide between care and support and prevention. This is one of the reasons why care and support to PLHAs contributes to prevention. Major elements of care and support of PLHAs are described below.

**Voluntary Counselling and Testing for HIV infection**

Voluntary counselling and testing (VCT) for HIV infection is an entry point for HIV/AIDS care and prevention. It needs to be emphasized that availability of testing alone is not enough—testing should be voluntary and confidential, and it should be accompanied by counselling. Counselling is important to prepare clients to come to terms with their HIV status. This includes dealing with fear, guilt, stigma, discrimination, care for a chronic condition, the possibility of early death, and to give them an understanding of what they can and should do about HIV infection, should they be HIV infected. It is also important to help people devise or strengthen ways of staying HIV negative, if they test HIV negative.

In order to be effective, the implementation of VCT services requires many key elements, for example: community awareness, education, and mobilization to ensure those wishing to be tested understand what the test process is and where testing may be undertaken; to ensure that those who are tested and found infected are not discriminated against and supported with their infection; the training of people (health, educational, other staff, and volunteers) in minimum standards of counselling and psychological recognition; acute management and onward referral (and therefore the development of networks of services and resources for taking up onward referrals from counselling); the provision or development of support groups for those affected; the provision of physical facilities suitable for having private, confidential discussions; and monitoring and support for those doing the complex task of counselling.

**Psychosocial support**

A key element in care and support is the provision of psychosocial support. Counselling, spiritual support, support to enable disclosure and risk reduction strategies, medication adherence, and end of life and bereavement support are all part of psychological support. This should be part of the care package at all levels. At its most basic level, this requires the establishment and support of peer-support groups for those found positive, and those affected by HIV. Many good examples of such services—which act as a focus for education, training, and provision of material, basic economic, spiritual and psychosocial support—currently exist in many countries. Those most affected often create such groups through a need for solidarity in the face of broader public stigma and discrimination. GIPA is a vehicle for generation of psychosocial support in communities, and needs to be incorporated and encouraged in designs for care and support.
Home and community-based care
Home and community-based care means any form of care given to PLHAs in their own homes and communities. It can be care activities that a PLHA might do to take care of him or herself or the care given by relatives, friends, or health workers within their homes and communities. HIV/AIDS being a chronic condition, it is essential to recognize that PLHAs do not always require to be hospitalized and care within their families might be more appropriate at some stage of the disease. Discharging PLHAs back to their communities at an early stage or not admitting the person in the first place can be more appropriate provided that the individual’s needs can be addressed outside the institution. There will be times that person will need to consult the health professionals for follow up, but most of the time, PLHAs are well attended in their homes by their families and communities. Home and community care is thus an essential element of comprehensive care for PLHAs in a continuum of care from health institutions to homes and vice versa. For those facing a future of uncertainty and who are fearful of possible consequences of having their status disclosed to others because of stigma and discrimination associated with HIV/AIDS, and for those living far from care and treatment facilities, or without the means to obtain transport to medical and psychosocial support services, provision of care in the home and community-based care are critically important. Such provision requires community-level organization, training, and support to ensure services are being appropriately implemented and used. Nursing care and support to nursing activities in home-based care and elsewhere must be encouraged.

Referral and linkage mechanisms
Effective referral systems are required to ensure that people living with and affected by HIV can benefit from the variety of services comprising comprehensive care and support throughout the course of infection and disease progression. Timely information on where to seek services and strong referral linkages among the various service partners will ensure a continuum of care, avoid duplication of services, and maximize available care and support resources. A good referral network will also make it easier for affected individuals and families to access appropriate care and support, thus saving them time and other costs.

PLHAs and community involvement
Families and communities have cared for and supported ill members for centuries and continue to be the primary service providers and frontline workers of the HIV/AIDS epidemic. In addition, PLHAs need to be involved at all stages of the care and support programme. Community, faith-based organizations (CBOs and FBOs), and PLHA networks have played an important role in mobilizing, involving, and supporting communities to care for and support people and families affected by HIV/AIDS. CBOs and nongovernmental organizations (NGOs) also play an important role in advocating for more effective support and access to care and treatment based on community-identified needs and responses. Effective community responses must be recognized, strengthened, and supported through partnerships designed to develop community members’ capacity to identify, protect, and care for those who are infected, as well as those the most vulnerable to HIV infection. Community members should be involved in the design, implementation, monitoring
and evaluation of care and support projects and strategies to ensure their feasibility, quality, and sustainability.

Address stigma and discriminatory attitudes and practices

Improving access to HIV/AIDS care and support requires conducive behaviour in all sectors. Health professionals, workplace managers and workers, relatives, and friends need sensitization to avoid stigma or discrimination against PLHAs. Stigma and discrimination constitute obstacles to the development of care service and use, and may jeopardize access to care, openness, adherence to treatment, and the whole quality of care.

Medical Management

Diagnosis and treatment of HIV-related diseases

Worldwide, the main burden of disease in PLHAs arises from a limited number of common infections—and their complications—to which PLHAs are particularly susceptible, namely TB, pneumonia, diarrhoea, and candida infection of the mouth and throat*. Diagnosis of these infections is usually possible at health centres and district hospitals, and they are generally amenable to successful treatment with cheap, affordable, and effective antibiotics. Strengthening of the general health services is crucial to ensuring that PLHAs have access to care for common HIV-related diseases.

In addition to strengthening national TB programmes and harnessing community contributions to ensure that every PLHA with TB has access to effective TB care, increased collaboration is necessary between TB and HIV programmes to provide a coherent response to the dual TB/HIV epidemic. In India, around 50–60 percent of PLHAs will have TB. The government has made provisions for free treatment of all opportunistic infections in public sector hospitals. In addition to these common HIV-related diseases, there is a variety of HIV-related infections and cancers for which treatments are more expensive and, in many parts of the world, not widely available. These HIV-related infections include toxoplasmosis, cryptococcosis, pneumocystis carinii pneumonia, herpes simplex virus, cytomegalovirus, and atypical mycobacteria. HIV-related cancers include Kaposi’s sarcoma and lymphoma.

Ensure adequate nutritional advice to PLHAs

As malnutrition is an important feature of advanced HIV infection, it is important to prevent it. This requires nutritional assessment, nutritional counselling and education that includes food safety, and if possible, the development of a plan of action to prevent weight and muscle mass loss. With some drugs, dietary changes are also needed to prevent side effects and specific symptoms. In some cases, provision of nutritional supplements and the use of anabolic steroids may be useful to prevent or treat wasting.

Palliative care

Palliative care not only includes the management of physical symptoms, such as pain, cough, skin rashes, fever, diarrhoea, but also includes dealing with depression,

suicidal thoughts, and other psychological problems. It also comprises spiritual support and bereavement counselling, and is inclusive of the client and his or her environment. It often requires a multidisciplinary approach.

Prevention of HIV-related diseases
Fortunately, affordable and effective drugs are available to prevent many of the common HIV-related diseases responsible for the main burden of illness and death in high HIV prevalence countries. Cotrimoxazole is effective in protecting against many of the common pathogens (such as pneumococcus and salmonella) responsible for pneumonia and diarrhoea and their complications. The challenge remains to find ways of dramatically increasing access of PLHAs to preventive treatments.

Antiretroviral treatment
Antiretroviral (ARV) treatment usually consists of administering three or four drugs together so that the level of the virus in the body of PLHAs can be suppressed to undetectable levels. While antiretroviral therapy is expensive, it should be recognized that it also represents the present gold standard for the treatment of HIV infection. The introduction of antiretroviral (ARV) therapies in 1996 has dramatically reduced morbidity and mortality in most high-income and some middle-income countries. However, because of their high cost and the complexity of their administration, access to antiretroviral drugs is limited in resource-constrained settings. Regardless of whether governments can afford to subsidize their availability to the general public, there is the need to regulate their use to protect their future usefulness. Also, rather than refusing to deal with these drugs for fear of having to fund them, governments should consider regulating their use and facilitating access to them by supporting human resource development and treatment monitoring infrastructures for antiretroviral therapy, so as to build capacity in the health system to safely and effectively use these drugs. In India, generic drugs are manufactured by Indian pharmaceutical companies like CIPLA, Ranbaxy, and Hetero, and ARV drugs have been exported at a rate of $1 a day. Unfortunately, the imposition of excise and other state taxes has led to ARV drugs being sold in India at Rs. 1,500 per month.

Promotion of safe sex and condom use to clients in HIV care and support programmes
In the care of HIV-infected people the focus is often on drugs, results of viral load tests and CD4 counts, and possible toxicity of the treatments received. Contacts with health services should be used to support preventive behaviour and to promote safe sex or condom use. When doctors perform poorly in this area, the services should be organized in such a manner that HIV-infected people get referred to counsellors or services that make these services available to them.

Diagnosis and treatment of STIs
Diagnosis and treatment of STIs are important not only to prevent HIV but also to prevent complications from STIs. STIs increase HIV transmission, with a factor of 2 to 40. When an STI is treated, this enhancement of HIV transmission disappears. Where STI control is insufficient, it would make sense to strengthen it first in services where known HIV-infected people consult. Indeed, targeting a PLHA with
enhanced STI treatment services has significant benefit beyond that individual, as chances of HIV transmission to sexual partners are reduced.

**Intervention for the prevention of parent to child transmission of HIV (PPTCT)**

Mother-to-child transmission (MTCT) is responsible for more than 90 percent of the infections among children less than 14 years of age. Strategies for PPTCT include primary prevention of HIV infection among women, family planning, antiretroviral therapy, restricted use of invasive obstetric procedures during vaginal delivery, and replacement feeding for the infant. So far, it is known that MTCT prevention has to face many challenges, for example: the weakness of antenatal care infrastructures and services in many developing countries; a lack of awareness of HIV transmission and personal HIV infection in many pregnant women; reluctance to engage in VCT for HIV; relatively weak compliance in taking ARV; and dilemmas in maintaining infant feeding options. In India, the pilot feasibility study for implementation of a PPTCT project was launched in 1999 and then has been expanded to reach all high prevalence district hospitals in the country.

**Post-exposure prophylaxis (PEP) of HIV infection for occupational exposure to HIV**

Interventions to reduce HIV transmission in the health care setting include the use of universal precautions when handling potentially infected material (e.g., wound care and surgical procedures) and ensuring the safety of blood and blood products. While the use of universal precautions is clearly more cost-effective than antiretroviral therapy after an occupational exposure to HIV, PEP is also among the interventions to be considered here. In India, guidelines have been issued by NACO to all public sector hospitals on infection control measures. In addition, the government is making available PEP medication in all public hospitals.

**Socioeconomic support to families and orphans**

PLHAs and their families are confronted with additional challenges throughout the course of the disease, including isolation, loss of income, medical and transport expenses, funeral costs, and the unmet needs of orphaned children for shelter, nutrition, clothing, education and other necessities. Most of these problems are directly or indirectly engendered through the economic impact of HIV/AIDS on the individual, the family, and the community. To mitigate these negative consequences of HIV/AIDS, efforts must be made to build or sustain economic resources for individuals and their households, and to support the creation of community safety nets. Such efforts yield better and longer-lasting results when they are undertaken with an emphasis on supporting the natural social networks of immediate and extended families. With some external support and the involvement of PLHAs, families, community leaders, volunteers, government agencies, nongovernmental and religious organizations, and other community groups, these networks can care for ill family members and adequately support children, spouses, and other relatives within the home environment. Home care programmes are cost effective and can be sustained when there is a strong community support for and involvement in running these services, backed up by quality medical and social services from nearby facilities.
Human rights and legal support
People living with and affected by HIV continue to face stigma, discrimination, and other violations of their human rights. In settings where those infected and affected by HIV suffer from human rights abuses, people are reluctant to learn their HIV serostatus and use existing prevention and care services, thus continuing to fuel HIV transmission. It is fully recognized that protecting human rights and providing legal services to PLHAs and their families are critical components of HIV/AIDS prevention and care. Legal assistance is often needed, for example, to ensure that laws protecting the rights of those infected and affected by HIV are applied, to help people living with HIV write wills, and to safeguard the property and inheritance rights of surviving family members. Involving people living with HIV and their support groups during the planning and design phases, as well throughout the implementation phase of care and support programmes, has been shown to be instrumental in addressing rights and equity issues adequately.

Management of substance using people and vulnerable groups
When present, substance use can greatly complicate the clinical management of HIV infection. Continued IDU might also put others at risk of becoming infected, in particular when needles are shared or when substance users resort to sex work to finance their habit. For both the individual client and society, it is important that care and support services take into account the management of drug addiction in HIV-infected clients. Care provision should be an opportunity to explain and recommend to the clients, particularly vulnerable groups (e.g., youth, sex workers, mobile and migrant groups, injecting drug users, men having sex with men) cost-effective HIV prevention methods that could be used to protect themselves and their entourage.

Structural Elements for Service Delivery
Identification of actors of comprehensive care and support for PLHAs
The provision of comprehensive HIV care and support requires the input of many people, ranging from family members to nurses and doctors, and from community workers to psychologists. These people can be grouped according to their affinity with, and access to training in, different care and support activities. There will be people involved more in clinical care, usually the formal health sector where health professionals offer relief of symptoms and diagnosis and treatment of specific diseases and psychosocial problems, and those more obviously involved in social support provided by community-based organizations, counsellors or support groups, and social sector organizations.

Human resource development
The response to HIV/AIDS requires additional skills and approaches that may not have been characteristic of the health system. This includes not only skills for effective clinical management of PLHAs, but also counselling and psychosocial support skills. These skills are now essential for the response and need to be developed because of the particular PLHA care requirements. There is a need to develop human resource management strategies that take into account the impact of the epidemic on the health system as discussed earlier. Basic training as well as
continuing education will be necessary to produce qualified health personnel in sufficient numbers to cope with the epidemics.

Guidelines and training
National guidelines need to be updated or developed on all essential and enhanced elements of comprehensive care. Curriculum revision of existing basic health cadres training from nursing aides to medical specialist training needs to be undertaken. In-service training on new interventions such as counselling or ARV management needs to be strengthened. Existing guidance from the global level needs to be widely distributed.

Strengthening the links among various channels of comprehensive care
To improve the efficiency of service delivery, it is necessary that these people, and the services in which they work, collaborate together, so as to create a continuum of care. The concept of care across a continuum expresses the need for care through all stages of HIV infection, which should be accessible at several points from VCT services, health services (primary health care [PHC], secondary, and tertiary health care), and social services to community-based support and home care. An important feature of the concept is the explicit recognition that community-based activities play a vital role, not only for HIV care and support, but also for HIV prevention, and a formal recognition of the links between care and prevention. Depending on the needs of the patients, they are provided care at the PHC level, the secondary, or tertiary level of health services. The health services may refer the patients to the community-based care organizations that in turn refer the patients to health care services when necessary. Thus, the system needs to strengthen the referral system between different levels of health services and between health services and community-based care.

Infrastructure development
Health care services should be established where necessary. VCT services and laboratories need to be established and adequately staffed and equipped. Where advanced ARV treatment is given, there is a need for basic facilities to monitor the side effects (toxicity) of the drugs and to measure the efficacy of the treatment by CD cell counts and viral loads.

Drugs and medical supplies (commodities, condoms, reagents, needles and syringes, surgical equipment and supplies, gloves, etc.)

- Having human resources and infrastructure is not enough to provide good quality health care. Another important ingredient that the government should secure is drugs and medical supplies. Most people living with HIV/AIDS have very limited access to essential medicine. Essential medicine for HIV/AIDS includes established essential drugs (for pneumonia, TB, diarrhoea, candida, palliative care, STI treatment), drugs to prevent MTCT, and newer high-cost drugs (for opportunistic infections, HIV-related cancers, and highly active antiretroviral therapy [HAART]). In order to increase access to drugs and medical supplies, four strategies are suggested:* Rational selection and use—Drugs

*The UN strategy for increasing access to HIV-related drugs, ITT on access to drugs, 2000.
of choice are identified for specific priority indications based on best evidence on local morbidity patterns and drug efficacy, safety, quality, and cost-effectiveness.

- Affordable prices—“Best prices” for governments, NGOs, and PLHAs will be sought through better price information, negotiation, competition, and reduction of duties, taxes, and distribution costs.
- Sustainable financing—There will be strong advocacy for reallocation of government resources to HIV/AIDS care (taking from outside the health sector, not from HIV prevention or other priority health problems), and expansion of external financing.
- Reliable health care services—Effective use of new HIV-related drugs and prevention of resistance depends on the ability of health care services to diagnose HIV infection, to diagnose associated illnesses, and to monitor treatment adequately.

Financing
Advocacy programmes to get resources mobilized at national and international levels for care should be developed. Financing of health systems for an effective response to HIV/AIDS must achieve two things. First, there must be an overall increase in the amount of funding available in health systems. This is because the magnitude of the HIV/AIDS problem requires a lot more resources to deal with it than what is available in most countries. HIV/AIDS increases the cost of providing health care. The second goal must be to implement measures that offer protection to people living with HIV/AIDS and their families from financial ruin, or reduced access to health services as a result of the increased cost of health care.

Reorganization of service delivery and partnership
The input mentioned above needs to be well planned, equitably distributed, and effectively implemented. Supervision and monitoring and evaluation of the services should be ensured. Comprehensive care for PLHAs should be accessible at all levels along a continuum ranging from formal health and social services to community-based services and home care. Partnerships between communities and institutions within a catchment area should be developed in such a way that an effective referral system between VCT services, basic hospitals and health centers, and home care services is strengthened. Hospitals, NGOs, and CBOs should ensure complementary and discharge planning across the continuum. In view of the large number of actors (stakeholders and partners), there is a need for synergy through effective collaboration among different actors or centres on the continuum of care. There is also a need to harmonize the inputs of different partners so that efforts are complementary and relevant to priority PLHA care and support needs. This synergy is essential for improving the effectiveness of different levels and actors within the continuum of care.

Working environment
Essential care delivery needs not only trained staff but also a conducive working environment. This would include space, privacy, and staff time for VCT in general health services and for particular groups such as young people; antenatal services; operational procedures for patient care; for referrals to home care or enhanced care
to ensure a care continuum; and for universal precautions and monitoring of coping capacity and adherence to standards to be put in place.

Care for the caregivers
Care for caregivers would include activities to prevent burnout of staff and access to PEP at the institutional level, VCT services for health staff, antiretroviral treatment, and institutional policies for HIV infected staff.

Universal precautions and safe blood supplies
Institutional policies for infectious disease control should be developed or updated. These include institutional procedures for the rational prescription of blood transfusions, as well as order and distribution procedures for HIV test kits, gloves, blood collection equipment, and sterilization facilities.

Facilitating community mobilization and action
Health services have been traditionally perceived as possessing the knowledge, expertise, and means to make people healthy. However, this has often led to complete dependency of people on health services and diminished the autonomy of individuals to safeguard their health. Therefore, when health systems experience difficulties or fail to perform well, health outcomes decline significantly. Therefore, the people’s responsiveness is as important as the services. Health systems ought to aim at empowering individuals and communities to identify health challenges and take measures to promote and protect their health and prevent disease. One way of empowering individuals and communities is by providing appropriate, practical, and timely information. The participation of communities and affected individuals is considered essential for a responsive campaign. The more the users participate, the more the services may be made more responsive to the expectations of the people. Broader participation also ensures that there is a multiplicity of efforts and skills that are needed for the scale and complexity of the epidemic. Partnerships need to be developed between health services and communities through mutual influences and support.

Policy development and legislation
Several relevant policies and regulations need to be formulated including HIV testing policies for diagnostic and clinical purposes at the national and institutional levels, including reassessing professional codes to ensure confidentiality and disclosure policies of HIV testing and result provision; prevention of discrimination and stigma against PLHAs in health settings; formalization of counselling as a duty or occupation; formulation of HIV care policies and national standards of essential and comprehensive HIV care; and policies on collaboration between the private and public sector and with NGOs and CBOs to ensure care provision and referrals across a continuum from institution to home. National drug policies and essential drug lists should be updated to reflect the needs for HIV care. Regulation and standardization of use of relevant HIV treatments (e.g., antiretroviral treatments at accredited sites, for MTCT, PEP, and preventive therapies). Policies to protect the rights of people living with HIV/AIDS need to be developed, promoted, and implemented.
Monitoring and evaluation
HIV/AIDS comprehensive care programmes must include a monitoring and evaluation component to refine, adapt, and strengthen existing and new services, and it should be budgeted for and implemented in all HIV/AIDS comprehensive care programmes. Services will only be effective if they are consistently evaluated to measure effectiveness, efficiency, quality, usage, and acceptability in the community. Programmes should seek to collect, analyze, and use data that reflect the extent to which quality care is provided at all levels of the health system, and to identify any problems and potential gaps requiring remedial actions, including participatory assessments and evaluation involving communities. This implies developing indicators and measurement tools appropriate to compare the quality, extent, and coverage of care services at each level with needs, demands, set standards, and norms.

Existing Care, Treatment, and Support Services in Uttar Pradesh
Based on the documents given by the Uttar Pradesh State AIDS Control Society (UPSACS), the current care and support services available for PLHAs in the state are listed below.

Availability of Voluntary Counselling and Testing (VCT) centres
There are around 70 VCT sites in the state and around 19,916 people were counselled between 2000 and 2002.

Availability of clinical care services
- Clinical care services are available in major public sector hospitals in Uttar Pradesh.
- Free treatment of opportunistic infection (OIs) is available in public sector hospitals.
- Financial grants were provided to King George Medical College and eight other medical colleges for providing treatment for OIs in 1999–2000. This grant was extended to all medical college and district hospitals in the state.
- The Government of India provided facility of FACS CD4/CD8 count machine to two medical colleges of the state—King George’s Medical College, Lucknow, and Institute of Medical Sciences, Varanasi. The State AIDS Control Society will cover the expenses towards reagents and chemicals that are required for the machines.
- A special financial grant was also provided to the Chief Medical Officer of Agra for taking care of OIs in women with HIV/AIDS living in the state women’s protection home.
- A total of 1,001 PLHAs were treated for OIs in the state. The most common OI treated was tuberculosis (50–70%), followed by candidiasis (6–30%), and herpes zoster (2%).
- Nodal officers in all medical colleges and all district-level hospitals have been asked to formulate procedures and create a system for proper care of PLHAs.

Availability of PEP facilities
All medical staff working in government hospitals are covered by PEP. Over the years, nine staff members were treated after needle stick injuries and none acquired HIV.
Printing of information, education, and communication (IEC) material
UPSACS has printed booklets on HIV/AIDS care consisting of rights of PLHAs, a listing of all available treatment facilities in the state, and the importance of nutrition.

Prevention of PPTCT
A large number of staff members in the medical colleges have already been trained in PPTCT protocols.

Recommendations for Action
Develop strategic plans for the state
Uttar Pradesh needs to develop strategic plans for quality comprehensive care and support services across a continuum from home and communities to institutions and back. This could be done through technical assistance provided by a technical task force set up for care and support issues within the state, which could include representatives from UPSACS, State Innovations in Family Planning Services Project Agency (SIFPSA), nodal medical officers, the PLHA network, the NGO and CBO community, women’s groups, and bilateral and donor organizations.

Initiate setting up PLHA networks and involvement of PLHAs
In partnership with the Indian Network for PLHA (INP+), there is a need to set up a local PLHA network in Uttar Pradesh. INP+ would provide mentoring and capacity building for PLHA network members to form a society, manage a state secretariat, and provide a platform for PLHAs to advocate for their needs. One of the central planks of the strategy will be the involvement of PLHAs at all levels in planning, participating, and evaluating treatment and care and support services. The active participation of PLHAs as partners will ensure that it achieves its goal. PLHA organizations and networks should be represented at all levels.

Expand access, reach, and quality of HIV voluntary counselling and testing services
This would include designing and establishing more VCT services in all districts of Uttar Pradesh; linking existing VCT to other care and support services in the same geographic area; supporting communication efforts to increase the demand for VCT; providing training in counselling and laboratory diagnosis for counsellors and laboratory personnel on an ongoing basis; and monitoring and evaluating, especially the quality of counselling and testing services.

Strengthen medical services for HIV at all stages of infection
The overall goal is to improve the quality of life of people living with HIV by increasing their access to high-quality services for prevention and treatment of HIV-related diseases and, where available, to antiretroviral therapy. Medical services would include TB management, palliative care, preventive therapies, and preparation for ARV interventions using existing national guidelines for management of HIV-related diseases and, where available, on the provision of ARVs. There is also a need to assist local programmes, clinics, and hospitals in the implementation of the guidelines and strengthening the capacity of local health care delivery services to provide diagnosis and treatment of AIDS-related illnesses. Health care staff needs to be trained and
supported to maintain an enabling working environment and positive attitudes toward PLHAs. There is also a need to develop and evaluate the effectiveness, cost-effectiveness, and acceptability of new diagnostic and management strategies for HIV-related diseases.

**Expand TB services to HIV-infected populations and integrate HIV interventions into TB programmes**

It is important to target tuberculosis so as to reduce the burden of TB on HIV-infected individuals and affected communities. This can be achieved through the establishment of HIV services, including voluntary counselling services at TB clinics, periodic screenings of PLHAs for signs and symptoms of TB, and prompt and early treatment of TB.

**Integrate care and support activities in targeted intervention**

There is a need to integrate care and support activities (provision of counselling, linkages to VCT, and referral to care and support services) in existing targeted intervention programmes with vulnerable populations including sex workers, men who have sex with men, migrants, slum youth, and street children.

**Build capacity of NGOs and CBOs to take on care and support activities**

There is a need to provide training to NGOs and CBOs working on health, reproductive health, or HIV prevention projects to undertake basic care and support services for PLHAs. This includes preparation of a resource directory of all organizations’ services.

**Sensitization programmes to reduce stigma and discrimination in the community**

Programmes need to be initiated among the key community stakeholders, religious leaders, political leaders, medical professionals, women, and youth groups to sensitize them on the need to reduce HIV-related stigma and discrimination in institutional and community settings.

**Implement and strengthen PPTCT programme**

Uttar Pradesh needs to implement and strengthen existing PPTCT programmes. There is a need to assess the availability, quality, and use of existing maternal and child health (MCH) services and identify opportunities for integrating PPTCT interventions. In addition, state health services need to develop training plans and provide appropriate training in areas such as counselling, infant feeding, obstetrical practices, and the use of ARV for MCH staff based on the assessment results.

**Initiate home-based and community-based care programmes**

There is a need to initiate care and support systems for the provision of home-based care and community-based care. It also includes improving the well-being and protection of orphans and vulnerable children, and strengthening household security. In addition, referral mechanisms and other linkages with local health centres, clinics, and hospitals need to be strengthened. Also, the capacity of home-based care providers to manage HIV-related illnesses, including TB, and improve their nursing skills, need to be built over a period of time.
**Possible Next Steps**

The steps can be identified as follows:

- **Setting up a task force on HIV/AIDS care and support issues in Uttar Pradesh**—Initial meeting of the task force will define the parameters of the functioning of the group and individual roles and responsibilities of individual members.

- **Conduct situation assessment in the state**—The situation assessment will assess the availability and quality of the essential elements of comprehensive care, the strategies for delivering it, the systems to accommodate these strategies, and the opportunities for strengthening and creating linkages to enhance delivery.

- **Development of a strategic plan**—The situation assessment should inform the development of a strategic plan for the state, which identifies and prioritizes the essential elements of care and support based on the stage of the epidemic, contextual factors, cost, cost-effectiveness, feasibility, and sustainability in a specific setting.

- **Develop standards and guidelines for care and support activities**—The state will need to adopt national standards for care and support and develop or adapt existing tools and guidelines for implementation, and monitoring and evaluation.

- **Capacity building of health care providers, NGOs/CBOs, PLHA network members and other key service providers**—Develop training plans, training tools, and training curricula on the skills necessary to deliver the essential elements of care and support. This could include forging linkages with other technical assistance organizations that can provide skills and experiences to health care providers.

- **Initiate learning sites or centers of excellence for provision of quality care and support services**—Develop, implement, and evaluate learning sites and centres to prepare for scaling up and applying innovative approaches, including the introduction of new and complex interventions such as antiretroviral therapy. Work should be initiated with local partners to plan on going to scale from the outset of programme activities to ensure comprehensive coverage as soon as possible.

- **Monitoring and evaluation framework**—Ensure comprehensive monitoring and evaluation of care and support programmes within a well-developed framework.
HIV/AIDS Prevention Strategies for Uttar Pradesh: Group Discussion
In order to provide a forum for focused discussion on some key aspects of HIV/AIDS situation in Uttar Pradesh, group discussions on four thematic areas were organized. The issues identified by the group, the gaps in the existing situations and the responses/solutions suggested are presented below.

**Group 1: Strengthening the Existing Programmes and Multi-sectoral Approach**

HIV/AIDS is much more than a medical issue; an effective response demands the engagement of institutions and actors not traditionally linked to public health policy. The nature of HIV/AIDS, its modes of transmission, the intense stigma and discrimination associated with people living with HIV/AIDS and vulnerable groups combine to create a complex series of social challenges to the implementation of policy and programmes. An effective response to HIV/AIDS demands that responsibility for prevention, awareness raising, care and support is shared across the widest possible range of sectors as well as by individuals in their everyday lives. A multi-sectoral response means engaging a wide range of sectors including, all government departments, private sector, the media, NGOs, CBOs, academic institutions and faith-based organizations as well as the health sector.

In order to create convergence between sectors and the widest possible coverage, the response to HIV/AIDS in India is framed on policy that promotes the development of a strong and inter-related multi-sectoral approach. HIV/AIDS is a development issue for India, as noted by the National Planning Commission. In the Tenth Plan the Commission has asked ministries to earmark budgets and develop HIV/AIDS programmes. The HIV/AIDS programme in Uttar Pradesh has initiated a series of activities aimed at broadening the State response to the epidemic. Examples of this include sensitizing Panchayati Raj Institutions about HIV/AIDS, NGOs working as partners with the state programme and inclusion of HIV/AIDS into the curriculum by the Education Department. Though a positive start has been made there is a need to expand and institutionalize multi-sectoral approach in Uttar Pradesh. Considering the variety of issues related to prevention, care, support and treatment, there is an urgent need to address in an integrated and systematic manner networking between sectors and the mainstreaming of HIV/AIDS as a development issue. In order to mainstream HIV/AIDS responses, the group reviewed the existing programmes,
identified gaps and developed workable structures and processes that will facilitate sustainable and active multi-sectoral linkages.

**Issues Identified and gaps**
- Multi-sectoral coordination.
- Lack of coordination and supervision for HIV/AIDS activities at the district level.
- Lack of legislation related to human rights and HIV/AIDS.
- Lack of appropriate life-skill education
- Gaps in existing targeted intervention programmes.
- Lack of RTI/STI services in rural areas.
- Low rate of voluntary blood donation.
- Inadequate condom utilization.
- Lack of care and support for PLHAs.

**Suggested Responses/Strategies**
- Expand coordination committee at all levels including civil society representation.
- Post a nodal officer at district level to coordinate and supervise HIV/AIDS activities within the district
- Develop advocacy programme for state legislators and judiciary to develop legislations related to human rights and HIV/AIDS
- Develop and disseminate age-appropriate life-skill educational curricula and materials.
- Review and strengthen existing targeted intervention programmes.
- Make available RTI/STI counseling, diagnostic, and treatment facilities at PHC/CHC level.
- Advocacy and motivation programme for voluntary blood donation, strengthen infrastructure of blood banks, simplify licensing procedures of blood banks and formation of separate cadre for blood bank services.
- Strength behavioural change communication (BCC) related to condoms, improve logistics and use social marketing for promotion of condom use.
- Identify gaps in care and support for PLHAs, advocate for PLHA's access to existing programmes and resources, develop systematic linkages among sectors to address gaps and develop programmes with faith-based organizations for sustained care and support.

**Group 2: Communication Strategies for HIV/AIDS**
Information, education, and communication (IEC) about HIV is a cost effective means of preventing HIV acquisition or transmission. And an effective means of reducing stigma and discrimination. BCC strategies can often be too broad and idealistic to guide practical implementation. These sometimes focus more on message/media design with less attention to the delivery system like how the messages reaches the audiences, how it facilitate exchange of information and how communication can be made responsive to the changing needs. There is a need to reach multiple marginalized audiences and audience segments and this increases the complexity of planning and delivery of communication strategies. BCC tends to be
viewed as small media- posters, leaflets, billboards etc. Focusing on limited forms of media, without due attention to communication needs and objectives, audience segments, how media and where media will be used, appropriate capacity building for communicators and how target groups should be involved in the design and implementation of BCC have to be taken into consideration in the communication strategies.

The Behavioural Surveillance Survey (BSS) conducted by NACO in Uttar Pradesh indicates a very low level of HIV/AIDS awareness among men and women in the state in comparison to the rest of the country. Knowledge regarding the modes of transmission was extremely low and there were many misconceptions and apprehensions about the spread of HIV/AIDS. There are also significant differentials in awareness and knowledge levels among men and women and between districts. The National Readership Survey (NRS) of 2002 shows that the reach of media in both urban and rural Uttar Pradesh is far below the national average. In urban areas of Uttar Pradesh, the reach of the press is 34 percent, TV is around 62 percent and radio is around 8 percent. In rural areas, it was 9 percent for press, 24 percent for TV and 11 percent for radio. In this setting, generating awareness among the general population as well as high-risk groups becomes a key priority of HIV/AIDS interventions. Inadequate knowledge of HIV/AIDS has resulted in violations of human rights, increased gender inequality and stigmatization of people affected.

IEC and BCC strategies have the potential, if inappropriately designed and implemented, to decrease HIV/AIDS related stigma and discrimination, gender inequities and human rights abuses the group discussed the impact of communication strategies in relation to these.

**Issue Identified**
- Lack of a comprehensive BCC strategy in UP
- Prioritising audiences: high-low risk behaviour, rural-urban, male-female, hard-easy to reach out
- Reaching the audience
- Designing the message
- Material development
- Capacity of channels to carry communication effectively
- Linkages between communication and service deliveries
- Creating an enabling environment
- Monitoring and evaluation of communication strategy

**Gaps Identified**
- The existing strategy does not address different vulnerable groups and sexual behaviours
- Lack of specific qualitative data; Inadequacy of research
- Difficult to reach due to illiteracy, conservatism, linguistic diversity, issues with invisible population like MSM and physical inaccessibility to interior rural areas
- Need to go beyond information to behaviour change communication. There are too many messages and predominant focus is on preventive message
The messages are too copy heavy and not entertaining
- Inter personal communication channel requires sensitisation, requirement of skills in usage of media material and lack of competent trainers
- Weak linkages between communication and service deliveries
- Lack of political commitment. Policy makers and law enforcement agencies need further sensitisation towards behaviour change, health care providers display attitudinal rigidities and sex workers are not organized
- Insufficient capacity for monitoring and evaluation

**Suggested Responses/Strategies**
- Strategy development process has already begun in Uttar Pradesh. Involvement of NGOs and PLHAs / and other communities (SWs, IDUs, MSM etc.) will be ensured and it will be conducted in a phased manner
- Data from secondary sources-NFHS, BSS etc and data available with TIs will be analysed
- Look beyond mass media to include inter personal communication, strengthen social mobilization through NGOs, youth groups etc.
- Focus on one message – “One message one audience”, personalize the messages, ensure gender sensitivity and pre test concepts and messages
- Partner with professional communication agencies with requisite social sensitivity
- Plan and budget training in communications at all levels from programme managers to frontline workers
- Communication should synchronize with service delivery.
- Use of Parliamentarians Forum for sensitisation, development of advocacy kits, involvement in campaigns, 'give them a face', training of HCPs, use of testimonials from PLHAs, forming collectives, recognition of laudable efforts and sensitisation of PRIs at all levels
- Plan and budget monitoring and evaluation at strategy formulation stage, involve researches as well as community in monitoring and evaluation through participatory approach, use M & E inputs to modify inputs and disseminate and share M & E.

**Group 3: Reaching out to Vulnerable and Marginalized Groups**
A priority of the NACP-II is to targeted interventions aimed at reaching vulnerable groups. Mapping exercise of vulnerable population has been conducted in Uttar Pradesh. The mapping exercise covers all districts in the state and distinguishes core and bridge groups. Core groups include female sex workers, IDUs, MSM and Hijras Street-children, truckers and migrants (in & out) are categorized as bridge groups. The mapping identified 849 sites or locations of core groups and 1,395 locations of bridge groups. The data reveals that there are around 176,000 vulnerable people of which, 14,000 belong to the core groups and the remaining 162,000 to the bridge groups. This is the first and the only mapping exercise to take place in the state.

However the coverage of Target Intervention projects for the vulnerable population is inadequate. Some of the districts with high prevalence of vulnerable population are not covered, so are some of the vulnerable population like MSM, street children and migrants. For TIs to be effective, they need to be developed and implemented in a
manner appropriate to the needs of the community they are designed for. Awareness building and improvement in knowledge levels of the general population should work in tandem with the TIs. These elements were taken into consideration by the group before suggesting a strategic plan of action.

Issues Raised

- Environment (social exclusion, legal and policy, advocacy, sensitization)
  Understanding and knowledge (epidemiology, ethnographic/anthropology, behavioural)
- Services (appropriateness, delivery environment, availability, accessibility).
- Meaningful involvement of the affected populations, group interface, effectiveness and impact assessment cut across these three themes.

Gaps Identified

- Lack of involvement of affected population, inappropriate legal and judicial framework and implementation,
- Inter-ministerial synergy, acceptance of social diversities (sexual, substance use) and mobilization of more stakeholders, services providers, donors, media, men in uniform and faith-based organisations
- Lack of epidemiological data on the prevalence of HIV infection, anthropological/ethnographic data on vulnerable populations, behavioural data of vulnerable population, risk perception/personalisation and treatment seeking behaviours
- No peer-led services, including women’s organizations, lack of need based and appropriate services, lack of minimum essential standards for services

Suggested Responses/Strategies

- Process indicators showing involvement of vulnerable groups to be developed, economic empowerment programmes to be initiated, encourage public debates and conduct advocacy with stakeholders, advocate with the respective ministries, review HIV/AIDS policy and other materials of Education Department, outreach to larger community, advocacy for coalition building
- Peer based research for mapping vulnerable population and sites, for size estimation and BCC development, sensitization of research organisations by vulnerable population, interventions based on operational research, adaptation of good practices
- Collaboration among other interventions, improve STI and TB treatment through referral/linkages, BCC should address all vulnerable groups and sexual practices including anal sex/STI related issues, research/evidence based BCC development, safe spaces for meetings, provision of sublingual oral buprenorphine, NSEP for IDUs, outreach to the larger community, foster sustainability through building community ownership, prison based interventions, condoms/water based lubricants supplies, capacity building of services providers, ensuring quality monitoring and evaluation

Group 4: Treatment, Care and Support

Treatment, care and support for People living with HIV/AIDS (PLHA), their families and communities were until recently neglected components of most
HIV/AIDS programmes in non-industrialized countries including India. Experiences from around the world has shown that improving access to HIV/AIDS care and support services helps de-stigmatize HIV, improves demand for HIV voluntary counseling and testing, and allows for early management and prevention of infectious diseases, such as TB and sexually transmitted infections (STIs). Providing these services, in turn, creates important opportunities for HIV prevention. Synergetic programming that links prevention with care and support is increasingly part of national and local strategic plans in many countries. Within each community, region and country, there is an existing level of HIV care and support that needs strengthening. In each setting, however, difficult choices have to be made about the level of care and support that is feasible and affordable in the short term and what can be attained in the future. Strategies and national standards are needed to guide both the allocation of resources and the implementation of HIV care and support activities at the various levels. Strengthening community, regional and national capacity to implement comprehensive care and support programmes will make it possible to demonstrate how cost-effective approaches can be replicated, scaled up and sustained. This is a component that has crosscutting linkages, as diagnosis of HIV/AIDS brings with it, profound emotional, social and behavioural challenges in addition to medical consequences. Hence, this theme was reviewed along the lines of gender, stigma and discrimination and protection of human rights. Discussion was also done as to link and integrate treatment care and prevention strategies and activities.

**Issues Raised**
- Treatment
- VCTC
- Home/community based care
- Greater Involvement of People Living With HIV/AIDS (GIPA)
- Programme Management
- Research
- Existing public policies
- IEC/BCC
- Resources

**Gaps Identified**
- Improper OI/PEP management at district level, no ARV treatment available, poor network and referral linkages within/outside the institution especially for STI treatment and TB, poor follow-up mechanism of clients, lack of diagnostic facilities
- Shortage of space/inappropriate location, lack of confidentiality, inadequate staffing/ high staff turnover, low utilization of services, quality, lack of coordination with private sector, poor linkages.
- Lack of home and community based interventions which includes psycho-social support, low cost nutrition, spiritual support and facilitating access to government schemes, lack of trained home based & community based counselors
- Lack of conceptual clarity for operationalization, collectivization of PLHAs, no involvement of PLHAs programme/policy at any level
Lack of conceptual clarity with reference to care, lack of decentralization, inadequate monitoring, inadequate system of data collection and analysis, inadequate baseline information on care & support

Lack of adequate data base of HIV/AIDS information, inadequate analysis and poor programmes, lack of qualitative information-on risk behavior patterns

NACO policy does not recognize the differences between the states and is quite inflexible, lack of participation of community in policy making, lack of initiative in mainstreaming HIV/AIDS in all policies of the state

Lack of information material on HIV/AIDS, lack proper dissemination of IEC material

Inadequate skilled manpower, inadequate infrastructure, inadequate utilization of funds and human resources

**Suggested Response/Strategies**

- Guidelines for OI management to be developed to facilitate easy procurement and ensure minimum buffer of PEP, advocacy for ARV treatment at the level of decision makers, collaborative programmes with RCH for STI identification and linkages with rural health institutions for better management of STI and TB, streamlining of monitoring systems and better client management, strengthening of existing diagnostic facilities and creating more facilities up to the CHC level, outsourcing as a mechanism can be thought of.

- Reallocation as per norms and better visibility within the health facility, training/sensitization, fill up vacant positions (contractual can be an option), create better work environment and payment according to market prices, increase visibility and awareness among high risk and general population as well, experiment with different successful models (using NGOs), capacity building, accreditation, explore public-private partnership, build capacity of private sector, develop resource directory and feed-back mechanism for improving effectiveness.

- Adaptation of different models of care in high prevalence districts, replication of successful models, community mobilization- self help groups, panchayati institutions, youth, anganwadis and faith-based groups, building community capacity on basic medical care (symptomatic) , recruitment of community based counselors volunteers from pool of lay counselors.

- Creating enabling environment in community based care and VCTCs for identification, use VCTCs/PPTCTs to motivate HIV+ve persons, advocate at all levels.

- Creating networks and linking them to larger networks, include INP +,etc to create mentor clubs of PLHAs at VCTCs, involve PLHAs as counselors in VCTC/PPTCTs, adopting GIPA principles as policy at all levels.

- Capacity building, exposure visit to other SACS, considering care component in TIs, strengthening at district level hospitals/ administration, district level societies to make district level action plan and implement, monitoring and evaluation framework to be developed, multi-sectoral involvement, capacity building, baseline to be conducted to facilitate in future planning.

- Operational research-collect existing information-analyse, revise policies and programmes, qualitative surveys to complement quantitative studies (BSS).
- Policies need to be more flexible to cater specific needs of state, advocacy with government NACO/SACS, main streaming- UPSACs to take the lead.

- Development of people friendly IEC (prevention to care), develop system for information dissemination. Providers as well as sites periodical evaluation and updating information.

- Community based counselors, adequate training, budget allocation, assessment of existing infrastructure-address gaps, providing adequate and accessible space for VCTCs, capacity building of programme management, setting up systems for efficient management, monitor utilization of funds and human resources.
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