PREVENTING OF HIV/AIDS IN INDIA –AN ANALYSIS

Dr. CHANDRA SHEKHAR GHANTA*

ABSTRACT :

Acquired Immune Deficiency Syndrome or acquired immunodeficiency syndrome (AIDS) is a disease of human immune system caused by the human immunodeficiency virus (HIV). AIDS is pandemic is a major challenge to development. It is recognized worldwide as one of biggest fatal diseases. It has serious direct and indirect adverse effects on communities. The HIV/AIDS pandemic leads to loss of human capacity. It reduces productive time when caring for family and attending funerals. It also leads to poverty due to diversion of funds for medical expenses, sick leaves, and funeral costs. The nature of the pandemic has made international and national organisations to declare it a disaster that requires urgent action to reduce the magnitude of its effects. Many countries, including India, have developed national strategic frameworks to control the pandemic. The formulation and adoption of the National AIDS Control Programme (NACP) in India, under the Ministry of Health, to coordinate the efforts to combat the spread of HIV/AIDS is one of such strategies. This paper examines the strategies and preventive measures adopted by the Indian government as well as NGO's and the most effective communication tool… the media. The methodology of the paper is descriptive and explorative nature.

Keywords: HIV/AIDS, stigma, discrimination, prevention, control, epidemiology

* Assistant Professor of Mass Communication, Telangana University, Dichpally, Nizamabad. Andhra Pradesh, India, Pin: 503 322.

INTRODUCTION :

Worldwide, rates of sexually transmitted infections (STI) among young people are soaring: one-third of the 340 million new STIs each year occur in people under 25 years of age. Each year, more than one in every 20 adolescents contracts a curable STI. More than half of all new HIV infections occur in people between the ages of 15 to 24 years. The sexual health needs for adolescent girls are generally overlooked, Stigma and vulnerability affects particular groups of men as well as women. Although men generally have more access to information on sexual issues than women, and more decision-making power regarding sexual behavior, Access to information, and treatment for other infections, which facilitate the transmission of HIV and onset of AIDS, including sexually transmitted infections, are limited because of weak public health services, health workers' negative attitudes, and the high cost of treatment. The Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) is the most devastating disease to ever face humankind.

In India, The first HIV/AIDS case was identified in Chennai, the capital of Tamil Nadu state, in 1986. Twenty-five years later, 2.4 million Indians are HIV positive, according to an estimate from the National HIV Sentinel Surveillance (U N General Assembly Special Session - UNGASS 2010). Between 2001 and 2009, however, HIV incidence fell by more than 25 percent, and estimated national prevalence remains below 1 percent. This figure is significantly lower than previous estimates that used only sentinel surveillance data but is considered more accurate because it is based on a national household survey (National Family Health Survey, 2005–2006 - NFHS-3). It is also supported by expanded national surveillance efforts, which estimate a national adult prevalence of 0.29 percent (UNGASS, 2010). According to the 2010 UNGASS HIV country report, India's epidemic is concentrated within most-at-risk- populations (MARPs), with prevalence substantially higher among these populations than in the general population. Prevalence also varies dramatically by district, state, and region, with numerous isolated pockets of high prevalence.

THE WIDE SPREADING VIRUS:

Approximately 60 percent of people living with HIV/AIDS (PLWHA) live in the six high-prevalence states, although prevalence in the general adult population of these states has recently experienced an overall decline. Even in states with low prevalence, there are pockets of high prevalence, and some are seeing increases in new infections. The total number of AIDS cases in 2002 was estimated to be about 550,000. Seven states - Andhra Pradesh, Goa, Karnataka, Maharashtra, Manipur, Mizoram, and Nagaland -already have generalized epidemics, as indicated by a 1 percent or higher prevalence rate among pregnant women in prenatal clinics. These seven states represent 22 percent of the population.

Rising trends among antenatal care (ANC) clinic attendees have been observed in the low- and moderate-prevalence states of Gujarat, Rajasthan, Orissa, Uttar Pradesh, Bihar, and West Bengal. At the national level, trends among ANC clinic attendees and female sex workers (FSWs) appear to be on the decline, although in some parts of southern India, up to 15 percent of FSWs are HIV positive. Trends among injecting drug users (IDUs) vary, with considerable differences between regions. Trends of increasing HIV prevalence among men who have sex with men (MSM) are generating concern, with estimates from the 2008–2009 National HIV Sentinel Surveillance at 7.3 percent in New Delhi, up from 6.4 percent in 2006. Particularly high HIV prevalence among MSM has been reported in parts of southern India (between 7 and 18 percent) and in rural areas of Tamil Nadu state (9 percent).

SEXUAL INTERCOURSE: THE PRIMARY MODE:

According to the 2010 report of the Joint United Nations Program on HIV/AIDS (UNAIDS), sexual intercourse is the primary mode of HIV transmission in India, accounting for about 90 percent of new HIV infections. More than 90 percent of infected women acquired the virus from their husbands or intimate partners. In most cases, women are at an increased risk not due to their own sexual behavior, but because their partner is an IDU or also has FSWs or MSM as other sex partners. Injecting drug use is the main mode of transmission in the northeastern states, although sexual transmission is increasing. Prevalence rates among IDUs are on the rise in many states, with new regions, such as southern India, also showing upward trends in this group.

Among FSWs, prevalence trends show an overall decline in the south, where targeted program interventions have had a greater reach and achieved broader coverage in terms of raising awareness, testing, and condom use. The 2009 Behavioral Surveillance Survey conducted in five states (Karnataka, Uttar Pradesh, Andhra Pradesh, Tamil Nadu, and Manipur) has shown an increasing trend in consistent condom use among both FSWs and MSM. Similarly, the 2010 UNAIDS report found an increase in condom use at last higher-risk sex among both women and men, at greater than 75 percent. India is a major destination for trafficked girls under age 16 (especially from Bangladesh and Nepal). Trafficked women and girls are particularly vulnerable to HIV infection because they are often unable to negotiate condom use and are often subjected to violent sex. In 2008–2009, FSWs in 47 districts had HIV prevalence rates higher than 5 percent.

POVERTY: THE MAIN REASON

Social powerlessness, poverty and economic dependence contribute to the vulnerability of adolescent girls. The HIV/AIDS epidemic has been fuelled by gender inequality. Unequal power relations, sexual coercion and violence is a widespread phenomenon faced by women of all age-groups, and has an array of negative effects on female sexual, physical and mental health. HIV/AIDS infection reveals the disastrous effects of discrimination against women on human health, and on the socio-economic structure of society.

Usually, girls do not have the same educational and employment opportunities as boys, and they face family and societal forces for early marriage and childbearing. Early marriage and early childbearing are the norm in Bangladesh, although age at marriage is rising in all the countries mentioned. Finally, there is evidence that an increasing proportion of unmarried adolescents are sexually active.

Now a day, age at marriage is increasing, and this raises its own issues and concerns. Sometimes Later marriage increases premarital sex. Sex outside marriage is normally considered immoral and adolescents who engage in it particularly girls are strongly condemned. In many societies, people from groups associated with high incidences of HIV infection – including

injecting drug users, men who have sex with men, and commercial sex workers are subjected to a culture of fear and punishment when their HIV status is suspected.

NATIONAL RESPONSE ON HIV/AIDS:

From the beginning the Government of India keen on eradication of HIV/AIDS and taking various steps to educate people on the panic problem. Shortly after reporting the first AIDS case in 1986, the Government of India established a National AIDS Control Program (NACP), which was managed by a small unit within the Ministry of Health and Family Welfare. The program's principal activity was then limited to monitoring HIV infection rates among risk populations in select urban areas. In 1991, the strategy was revised to focus on blood safety, prevention among high-risk populations, raising awareness in the general population, and improving surveillance. A semi-autonomous body, the National AIDS Control Organization (NACO), was established under the Ministry of Health and Family Welfare to implement this program. This "first phase" of the National AIDS Control Program lasted from 1992 -1999. It focused on initiating a national commitment, increasing awareness and addressing blood safety. It achieved some of its objectives, notably an increased awareness. Law banned professional blood donations. Screening of donated blood became almost universal by the end of this phase.

However, performance across states remained variable. By 1999, the program had also established a decentralized mechanism to facilitate effective state-level responses, although substantial variation continued to exist in the level of commitment and capacity among states. Whereas states such as Tamil Nadu, Andhra Pradesh, and Manipur demonstrated a strong response and high level of political commitment, many other states, such as Bihar and Uttar Pradesh, have yet to reach these levels.

INVOLVEMENT OF NGOs:

The second phase of the NACP began in 1999 and will run until March 2006. Under this phase, India continues to expand the program at the state level. Greater emphasis has been placed on targeted interventions for high-risk groups, preventive interventions among the general population, and involvement of NGOs and other sectors and line departments, such as education,

transport and police. Capacity and accountability at the state level continues to be a major issue and has required sustained support. Interventions need to be scaled up to cover a higher percentage of the population, and monitoring and evaluation need further strengthening. The Government has done away with the classification of states based on prevalence to avoid inducing complacency among states categorized as low prevalence, and has since focused on the vulnerability of states, hence creating a sense of urgency.

In brief, while the government's response has scaled up markedly over the last decade, major challenges remain in raising the overall effectiveness of state-level programs, expanding the participation of other sectors, and increasing safe behavior and reducing stigma associated with HIV-positive people among the population.

The Government of India is currently in the early stages of preparing for the third phase of the National AIDS Control Program (NACP 3), for which a multi-disciplinary design team has been constituted to lead the preparation. The design of NACP 3 envisages a complex consultative process including nationwide consultations with various national stakeholders, as well as international development partners.

Non-Governmental Organizations (NGOs): There are numerous NGOs working on HIV/AIDS issues in India at the local, state, and national levels. Projects include targeted interventions with high risk groups; direct care of people living with HIV/AIDS; general awareness campaigns; and care for AIDS orphans. Funding for NGOs comes from a variety of sources: the federal or state governments of India, international donors, and local contributions.

THE GLOBAL MEDIA INITIATION:

Mass Media, the most effective public relations tool in the civil society playing a vital role to create awareness among the people on HIV/AIDS. Media divided as print, electronic and traditional media. The Global Media AIDS Initiative (GMAI) is founded on the principle that media represents a formidable ally in any effort to address HIV/AIDS. Launched in January 2004 at an historic meeting at U.N. headquarters of top media executives from around the globe, the GMAI was conceived and organized by the Kaiser Family Foundation and UNAIDS to mobilize and leverage the vast resources of the world's leading media companies to address

AIDS. In this initiation, the national and the regional media partnership is as much as important role to create awareness in the people. Through large-scale national and regional coalitions of media, a network that includes over 300 media companies, the GMAI unites broadcast companies around a common cause. Supporting member broadcasters pledge to make AIDS a business priority and dedicates airtime, creative talent and production resources to HIV-related programming.

- African Broadcast Media Partnership Against HIV/AIDS
- Asia-Pacific Media AIDS Initiative
- Caribbean Broadcast Media Partnership on HIV/AIDS
- Latin American Media AIDS Initiative
- Russian Media Partnership to Combat HIV/AIDS
- U.S. Entertainment Media Partnerships
- Global Partnerships

GOALS AND OBJECTIVES:

The media is playing a vital role in creating awareness among the people on HIV AIDS. The main objectives of the media initiation in this aspect are to develop media leadership in HIV/AIDS in addressing the pandemic. Apart of this the media should provide strategic and technical support to regional partnerships and also forge strategic alliances between media and leading AIDS organizations and other related sectors; offer tailored skill-building resources, including leadership and content-development workshops, online tutorials, and research and reporting guidelines; and serve as a general communications hub through its Web site: www.thegmai.org

FUNDING TO OVERCOME THE PROBLEM:

India receives technical assistance and funding from a variety of UN partners and bilateral donors. Bilateral donors such as USAID, CIDA, and DFID have been involved since the

early 1990s at the state level in a number of states. USAID has committed more than US$70 million since 1992, CIDA US$11 million, and DFID close to US$200 million. The number of major financers and the amount of funding available has increased significantly in the last year. Since 2004, the Gates Foundation has pledged US$200 million for the next five years, the Global Fund has approved US$26 million for Prevention of Mother-to-Child Transmission (PMTCT) and about US$7 million for TB/HIV co-infection, and is considering another round of proposals, and USAID is considering the inclusion of India as its 15th priority country. DFID has also increased its financing and is considering the inclusion of additional states. Other more recent donors include DANIDA, SIDA, the Clinton Foundation and the European Union.

SUPPORT FROM WORLD BANK:

In 1991, the Government of India and the World Bank expanded their collaboration on infectious disease control programs and by 1992; the first National AIDS Control Project was launched with the World Bank credit of US$84 million. The project helped the government to broaden prevention efforts and to establish institutions and procedures necessary to curb the spread of HIV/AIDS. Building upon lessons learned from the first project, India requested World Bank financing for a follow-on project. With a World Bank credit of US$191 million, the Second National HIV/AIDS Control Project was started and this is increasing the pace of implementation through the use of State AIDS Societies to speed the distribution of funds at the state level.

The Bank has also undertaken analytical work to strengthen the national response, including an analysis of the full array of costs and consequences likely to result from several plausible government policy options regarding funding for anti-retroviral therapy (ART). Currently, the Bank is carrying out sector work on the economic consequences of the HIV/AIDS epidemic on India and is actively supporting the design of the third National AIDS Control Program.

ISSUES AND CHALLENGES: PRIORITY AREAS:

There are severe institutional capacity constraints, including managerial, at the national and state levels. These are critical factors to address as the program attempts to scale-up the national response. NACO will require a change in its role and responsibilities to provide the necessary leadership and steering role for a stronger multisector response for the next phase in India's fight against HIV/AIDS. The capacity to mount a strong program is weakest in some of the poorest and most populated states with significant vulnerability to the epidemic. There is a need for tailored capacity-building activities and the introduction of some performance-based financing approaches.

PREVENTIVE EFFORTS:

Stigma and discrimination against people living with HIV/AIDS and those considered to be at high risk remain entrenched. A lot of this is a result of inadequate knowledge. For instance, more than 75 percent of Indians mistakenly believed they could contract HIV from sharing a meal with a person who has the disease, according to a recent study. Stigma and denial undermine efforts to increase the coverage of effective interventions among high-risk groups such as men having sex with men, commercial sex workers and injecting drug users. Harassment by police and ostracism by family and community drives the epidemic underground and decreases the reach and effectiveness of prevention efforts. Though there is significant increase in awareness, due to efforts by the government, there is much room for improvement.

Awareness is more important for the process of the prevetion of the wide spreading HIV/AIDS in the society. Sentinel site behavioral surveillance, completed in 2001, showed high HIV/AIDS basic awareness levels (82.4 percent in males and 70 percent in females). However, rural women demonstrated very low rates of awareness in Bihar (21.5 percent), Gujarat (25 percent), and Uttar Pradesh (27.6 percent). New approaches need to be tried to reach rural communities with information about HIV/AIDS, safe sex and how to prevent and treat HIV/AIDS.

CONCLUSION:

"The world we have made as a result of the level of thinking we have done thus far creates problems that we cannot solve at the same level at which we have created them... We shall require a substantially new manner of thinking if humankind is to survive. ."

-Albert Einstein

There is evidence that some prevention strategies have been successful in reducing HIV prevalence among certain groups in India. However, despite these successes, there are still 2.4 million people infected with HIV and many parts of India's epidemic remain unnoticed. The risk of HIV infection among male sex workers, and the role of MSM in the epidemic, is just two largely ignored areas. As well as addressing high prevalence groups, more attention is needed for people perceived to be at low risk, such as married women, as HIV spreads amongst the general population. HIV prevention and intervention strategies need to focus on married, monogamous Indian women whose self-perception of HIV risk may be low, but whose risk is inextricably linked to the behaviour of their husbands. Still there is a need to create awareness among the people in the most of the villages. The Central and State Governments, NGOs and Media should play committed role in creating awareness among the people. Mass media is the best way to reach the target group so that the media should take responsibility to prevent the spreading of the HIV/AIDS in the society.

REFERENCES:

- BBC (2006, 7th July) 'Discounts for Indian sex workers'
- Department of AIDS Control (2010, March) 'National AIDS Control Organisation (NACO) Annual Report 2009-2010'
- Global Health Council (2002) 'Truckers carry dangerous cargo', May 1
- NACO (2010, July) 'Targeted Interventions': National AIDS Control Programme, Phase-III, India'
- NACO (2008) 'Annual Report NACO 2008-09'
- NACO (2007, October) 'Targeted interventions under NACP III: Operational guidelines'. Vol II: Migrants and truckers
- Newmann. S. et al (2000) 'Marriage, monogamy and HIV: a profile of HIV-infected women in south India', International Journal of STD & AIDS 2000; 11:250-253
- Ramesh. B.M. et al (2008) 'Determinants of HIV prevalence among female sex workers in four south Indian states: analysis of cross-sectional surveys in twenty-three districts', AIDS 22(5):35-44
- Shetty, Priya (2010, July 3rd) 'Meena Saraswathi Seshu: tackling HIV for India's sex workers' Lancet 376(9734)
- The World Bank (2008) 'State of the epidemic: India'
- UNAIDS (2008) 'Epidemiological fact sheet on HIV and AIDS'
- UNGASS (2008) 'India - Country progress report'
- UNGASS (2010, March 31st) 'India - Country Progress Report
- UNAIDS (2009, 7th July) 'Landmark Delhi High Court decision recognizes inappropriate criminalization as a barrier to health, human rights and dignity'
- UNGASS (2008) 'India - Country progress report'
- World Bank (2009, February) 'Country Profile: HIV/AIDS in India'
- UNGASS (2008) 'India - Country progress report'
- UNGASS (2008) 'India - Country progress report'