

# POSITIVE LIVES



## Reach out

She believes: Positive people need to come together to fight for their rights and spread information about HIV and its spread.

She believes: The red ribbon symbol, which is worn by people who believe it can be a sign of hope, has become the fastest each day with no intention to change.

## Resist bias

She believes: HIV affects both rich and poor, high-society women should also come out of the open and fight for their rights.

She believes: Information alone is the strongest tool to stop discrimination meted out to HIV-positive people.

## Uphill task

She believes: Each of us has a role to play in the fight against HIV/AIDS. We must work together to create a society where everyone is treated with respect and dignity.

She believes: Positive people need to come together to fight for their rights and spread information about HIV and its spread.

She believes: The red ribbon symbol, which is worn by people who believe it can be a sign of hope, has become the fastest each day with no intention to change.

## Fight for rights

She believes: HIV affects both rich and poor, high-society women should also come out of the open and fight for their rights.

She believes: Information alone is the strongest tool to stop discrimination meted out to HIV-positive people.

She believes: HIV affects both rich and poor, high-society women should also come out of the open and fight for their rights.

## Heal thyself

She believes: Each of us has a role to play in the fight against HIV/AIDS. We must work together to create a society where everyone is treated with respect and dignity.

## There's hope

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# HIV/AIDS in News – Journalists as Catalysts

She believes: HIV does not mean the end of the world. It is the beginning of another journey.

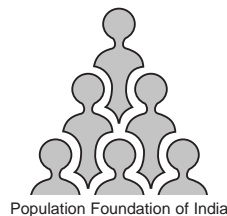
She believes: HIV does not mean the end of the world. It is the beginning of another journey.

## proactive

She believes: Each of us has a role to play in the fight against HIV/AIDS. We must work together to create a society where everyone is treated with respect and dignity.



# HIV/AIDS in News – Journalists as Catalysts



POPULATION FOUNDATION OF INDIA  
B-28, Outub Institutional Area, New Delhi - 110 016  
email: popfound@sify.com  
Phone: 91-11-52899770

*Support Team*

**Usha Rai**

Rimjhim Jain

Swapna Majumdar

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*Designed & Printed by*

Dharana, Tel.: +91-11-24317735, 24318328

email: studiodharana@gmail.com

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# Message

To fight the HIV/AIDS epidemic which has become a major health issue in the country a larger alliance encompassing all sections of society is needed. No one can afford to just sit back, everyone has to be proactive. The media is an important partner in creating awareness about the infection and its management. With the HIV/AIDS epidemic now spreading into remote corners of the country and affecting all sections of society, the fourth estate has to be at the forefront of the fight against the infection and has a special responsibility in informing the public.

I compliment the Population Foundation of India for undertaking a media survey of HIV/AIDS stories in newspapers and TV channels and analysing its impact on stigma and discrimination of those affected. It will help the government and our national and international partners in working better with the media in the fight against the epidemic.

Despite India's deeply religious moorings and a culture that believes that sexuality is a sacred relationship enshrined by wedlock, we now know that it does break the barrier in certain cases. A large number of those infected are extremely young and in the most productive years of their lives.

The awareness generated by media goes beyond the normal official publicity on health issues. Therefore, this endeavour and the manual, is of special value.

**Prasanna Hota**

Secretary, Health and Family Welfare  
Government of India

# Message



The United Nations Development Programme is committed to supporting the national response to the HIV epidemic. The focus of our approach is on supporting Government in advocating for policies that are inclusive and address HIV/AIDS as a development issue.

We believe that HIV/AIDS is not just a health issue; it is a development issue as it affects the economic and social fabric of our society. It is therefore important to build a multistakeholder partnership to address the issue and UNDP plays a lead role in supporting efforts to mainstream HIV into development work of various stakeholders.

The media is an influential and far reaching stakeholder. Not only is it a powerful medium of communication and awareness generation, but it is also a key behaviour change medium as it can influence people's opinions. Journalists can stimulate open and vibrant public debate about issues that underpin the HIV/AIDS pandemic, such as unequal gender relations, social inequalities, stigma and cultural norms, and they are uniquely placed to help break the silence.

To facilitate responsible media reporting with a view to reducing Stigma and Discrimination within societies UNDP has supported the development of researchbased manuals with a state level focus. These manuals build upon the analysis of HIV/AIDS reportage in the print and electronic media in six select states.

The aim is to use these manuals to strengthen media capacity on HIV/AIDS. Two complementary manuals have been developed in partnership with the Population Foundation of India & FAITH Health care Private Ltd with support from UNDP. The Resource book includes information on the various dimensions of HIV/AIDS; the ethics of reporting, appropriate language and guidelines for responsible reporting. The Training Manual is a hands on guide for training journalists.

I would like to thank everyone who has contributed to the development of the resource book and the training manual.

I hope that these manuals will be used effectively for media advocacy.

A handwritten signature in black ink, appearing to read 'Maxine Olson'.

**Maxine Olson**  
Resident Representative UNDP



# Foreword

Would the number of HIV positive people in India have increased from just one in 1986 to 5.1 million in 2005 if the media had played a more pro-active role in the early years of the infection? The media, like others monitoring the epidemic, underestimated its gravity and seriousness.

Would HIV positive people have been thrown into isolation wards as happened with Dominic D'Souza in Goa in 1989 and ten years later with Dhiren Sarkar of West Bengal if the media had presented a more realistic picture of the infection? When Dhiren's wife and family discovered he was HIV positive they walked out on him. Some villagers even bolted the door to his house and tried to set him on fire. The police rescued him and moved him to a hospital in Katwa where he was left in an abandoned room. He was then transferred to Burdwan district hospital. Sarkar died a couple of days later in a dark little corner of the hospital unwanted, deprived of his basic rights as a human being. Afraid of stigma and discrimination, even today a large number of infected people commit suicide.

In most parts of the country there is still an ominous silence around HIV/AIDS. At the intellectual level there is still a debate on why so much money and importance is given to this comparatively new infection as against tuberculosis, malaria and a spate of other ailments.

In May 2005 under a UNDP-funded project, the Population Foundation of India appointed veteran journalist Usha Rai to examine the role of the media in relation to stigma and discrimination faced by HIV affected people. She was supported by journalists Rimjhim Jain and Swapna Majumdar. Research was conducted on media coverage of HIV/AIDS in newspapers in Karnataka, Punjab and Uttar Pradesh and in seven national television news channels.

The six-month survey shows that there is a big gap in what the media has been writing on HIV/AIDS and the expectations of HIV positive people on what they perceive should be the media's role in reporting on the issue. Though there is considerable coverage of HIV/AIDS most of it is often superficial – reporting of events or statements by celebrities.

This manual is an attempt to bridge the communication gap between the media, positive people, NGOs working on the issue and the State AIDS Control Societies. ■

**A R Nanda**

*Executive Director, Population Foundation of India*



# एड्स के निशाने पर ह

जागरण संवाददाता

लखनऊ, 27 मई। मोहनलालगंज सामुदायिक स्वास्थ्य केन्द्र पर बिना स्तनों के ही प्रसव करा दिया जाता है। मरीजों को रक्त चढ़ाने और सीरिज लगाने के लिए भी जैव चिकित्सीय चिकित्सा इंतजाम का प्रयोग नहीं किया जाता। ग्रामीण चिकित्सालयों पर एचआईवी संक्रमण से बचाने के लिए एंजाइम सोसाइटी के संयुक्त निदेशक डा.आरपी माथुर को यह सोसाइटी बताती है कि ग्रामीण चिकित्सालयों में एचआईवी रोग सीधे एड्स के निशाने पर है। भारतीय उद्योग परिसंघ, भारत आस्ट्रेलिया कौंसिल और एड्स नियन्त्रण सोसाइटी द्वारा संयुक्त रूप से होटल ताज में आयोजित कार्यशाला में डा.माथुर ने बताया कि यौन सम्बन्धों के बाद सबसे ज्यादा संक्रमण दूषित रक्त या सूइयों के चुभने से होता है। वह बताते हैं कि जहां यौन सम्बन्धों के चलते 87 फीसदी लोग एचआईवी संक्रमण की चपेट में हैं वहीं के कारण भी तीन फीसदी लोग इस

संक्रमण का शिकार हो जाते बताया कि इस वक्त प्रदेश एचआईवी संक्रमित व्यक्ति एड्स पीड़ित मरीज है। यह है जो स्वैच्छिक जांच केन है। संजय गांधी आयुर्विज्ञान अधीक्षक डा.हेमचन्द्रा अस्पताल में आने वाले मरीज एचआईवी संक्रमित है। यदि कर्मचारियों में एड्स का प्रसारण प्रदेश में 905 एचआईवी संक्रमित और 1614 एड्स मरीजों का प्रसारण करे तो संक्रमण दाखिल हो सक अस्पताल में क भी मरीज का तत्काल साबु उपचार करने मास्क का उपचार के लगेने या अस्पताल

## Section I

## The Media Study





## HIV/AIDS in News: An Overview

The news media is a powerful agent of social and political change and in a country like India where 50% of the population is illiterate or neo-literate, the printed word is taken as gospel truth and the images on television can excite viewers. Both leave a lasting impression. Even an innocuous news story can mould public perceptions and sensibilities.

This is particularly so while addressing a health concern like HIV/AIDS that is comparatively new despite the epidemic being in its 25th year. It is a virus that has many dimensions and inbuilt prejudices associated with it. Its mode of transmission makes it susceptible to be associated with deviant behaviors that have negative perceptions in the public mind. Thus, reporting on HIV/AIDS issues needs to be extremely responsible. Ill-informed reporting can cause repercussions including stigma and discrimination against people affected by HIV/AIDS. It can lead to people losing jobs and being thrown out of homes. On the other hand, stories written with empathy can have them being feted as the champions of a brave new world.

Since this is an epidemic whose dynamics are constantly changing, those covering the issue need to keep themselves abreast of the latest developments. Changes associated with HIV/AIDS are happening not only in medical research but also in the spread of the virus to every section of society.

While the media has started taking active note of the issue and the visibility of HIV/AIDS stories has increased, there is a general feeling that reporting is often insensitive and causes further stigma and discrimination against affected persons. To explore this, a print media review was undertaken in Punjab, Karnataka and Uttar Pradesh with the support of several partner organisations. Seven national television news channels were also reviewed in Delhi. The purpose was to investigate how the news media was handling HIV/AIDS. The study is also a comparative analysis of the differences in qualitative and quantitative coverage between a high HIV/AIDS-prevalence state like Karnataka and low-visibility states such as Uttar Pradesh and Punjab, where the epidemic is in its nascent stage. The study also looked at the differences in approach between the language media and the English press in these states. Basically meant as a resource handbook for journalists, it is hoped that the information in this Manual will also feed into the State AIDS Control Societies



While the media has started taking active note of the issue and the visibility of HIV/AIDS stories has gone up, there was a general feeling that reporting on it was often insensitive and caused further stigma and discrimination against affected persons



What emerged from the study was quite different from the common perception. Most reports were found to be fairly accurate and well informed. But a few bad stories did cause enough damage

strategic planning for information, education and communication (IEC) in the next phase of the NACO country programme.

What emerged from the study was quite different from the common perception. There are many more stories appearing on HIV/AIDS today and most reports were found to be accurate and well informed. But a few bad stories did cause enough damage.

The impact of a story can be gauged from the feeling it leaves readers with. For example, the stories of a beauty pageant for HIV positive women in Kathmandu, Nepal as well as one in Botswana for crowning Ms HIV Stigma-free were inspiring. Eight and twelve women respectively participated in the contests. Newspapers across the country also carried a heartwarming story on positive people putting out matrimonial advertisements and receiving responses. On the other hand, an irresponsible report from Uttaranchal stigmatised HIV positive women by negatively terming them *vish kanyas* (poison women) and alleging they were sent by the enemy to infect the armed forces. Some newspaper headlines also branded a whole community - "Safai karamcharis found HIV positive," and "HIV infection more among non-literate, pregnant women."

Looking at the difference in reporting between three states, the coverage in Karnataka reflected its high prevalence status. Not only did the state have the largest number of stories, the regional language and English press were better informed. The fact that there has been a lot of intervention in Karnataka on HIV/AIDS by NACO, the state government and a range of NGOs and activists is probably why there was more responsible reporting. A cause for concern here was the number of advertisements and stories about 'miracle cures.'

In UP where the regional press covered the issue extensively, the reportage was of poor quality. There were more sensational stories, in Hindi in particular. In Punjab the English press, especially *The Tribune*, the state's leading newspaper, carried some excellent reports on HIV/AIDS. But the stories were of a national and not regional character. The language press in Punjabi, Hindi and Urdu carried fewer stories on the issue. The language press in both states needs a lot more sensitisation on the issue. In both the Punjab and UP press few voices of affected people were heard. The only voices reflected were those of HIV positive persons from other states like Tamil Nadu and Delhi from where the stories emanated.

While journalists need to highlight the HIV/AIDS situation and methods to tackle it, the manner in which it is done should not heighten the fear and stigma associated with the virus.

## HIV/AIDS IN NEWS: THE STUDY

A detailed media tracking and content analysis was carried out for a greater understanding of the issue. Newspapers in English and the regional languages in each of the three selected states were monitored intensively for one month in May/June 2005, with two of the regional language papers in each state being scrutinised for a longer period from January onwards. This was done to bring out clearly the state of the language press that is considered more influential and has greater local readership. National television channels were analysed for coverage on HIV/AIDS for one month in May/June 2005.

The primary objective was to examine whether reportage was enhancing stigma and discrimination.



There was a special look at the language press that is considered more influential and has greater readership

**Table 1a: Newspapers Analysed**

Punjab			
English	Punjabi	Urdu	Hindi
The Tribune	Jagbani	Hind Samachar	Punjab Kesri*
The Indian Express	Ajit		Dainik Ajit
Hindustan Times	Punjabi Tribune*		Dainik Bhaskar
The Times of India	Desh Sewak		Amar Ujala
<b>Total: 13 Publications</b>			
Karnataka			
English	Kannada		
The Deccan Herald	Kannada Prabha		
The Times of India	Prajavani		
The Hindu	Vijaya Karnataka*		
The New Indian Express	Udayavani*		
Vijay Times	Samyuktha Karnataka		
The Economic Times	Suryodaya		
	Sudha (magazine)		
	Taranga (magazine)		
<b>Total: 14 Publications</b>			
Uttar Pradesh			
English	Hindi	Urdu	
Hindustan Times	Dainik Jagran*	Apna Akhbar	
The Pioneer	Rashtriya Sahara		
The Times of India	Hindustan*		
The Indian Express	Swatantra Bharat		
	Jansatta Express		
	Amar Ujala		
	Aaj		
	Rashtriya Swarup		
	Sahara Samay (magazine)		
<b>Total: 14 Publications</b>			

\* These were covered for the period from January to June 2005 while the rest were covered for one month in May/June 2005



A total of 443 articles were found on the subject in 42 newspapers and magazines surveyed in the three states. Sixteen television news stories on HIV/AIDS appeared during one month

**Table 1b: Television News Channels Analysed**

Hindi	English
Aaj Tak	NDTV 24x7
DD News	
NDTV India	
Sahara Samay	
Star News	
Zee News	

These were covered for one month in May/June 2005

A total of 443 articles were found on the subject in 42 newspapers and magazines surveyed in the three states. Sixteen television news stories on HIV/AIDS appeared during the period.

**Table 2a: Language-wise Breakup of HIV/AIDS Related Articles**

Punjab				
English	Punjabi*	Urdu	Hindi	Total
79	9	3	20	111
Karnataka				
English	Kannada*			Total
85	82			167
Uttar Pradesh				
English	Hindi*	Urdu		Total
36	126	3		165
				<b>443</b>

\* Includes two newspapers covered for the period from January to June 2005 while the rest were covered for one month in May/June 2005

**SUMMARY OF STUDY FINDINGS**

**Nature of stories and numbers**

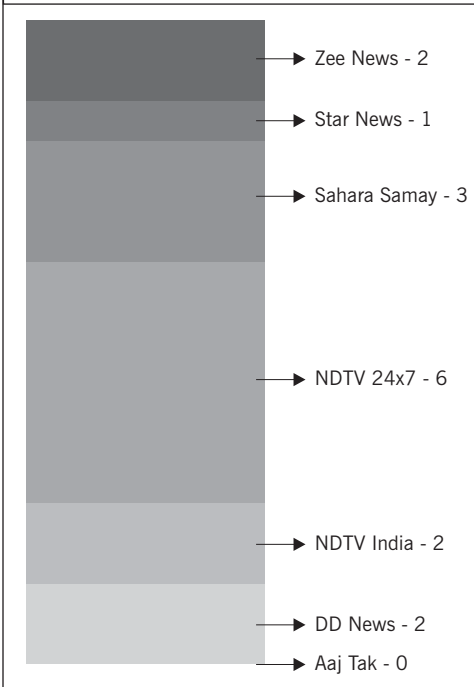
On the whole the number of stories on HIV/AIDS has gone up in recent years. This was brought out by a study in Karnataka indicating a 48% increase in HIV/AIDS stories in three years since 2002 and another by the Centre for Media Studies in Delhi (November 2004

to February 2005) which indicates that within the health sector reporting, half the stories were on HIV/AIDS.

The survey showed that most coverage on HIV/AIDS was in the form of news stories (70%), that is, event-based spot reports. The rest comprised features (15%), photographs (5%) and editorials (3%).

The findings indicate certain differences and some similarities in the coverage between the regional media and the English press. For instance, the English press in Punjab had more articles related to HIV/AIDS. In UP, however, the Hindi newspapers carried a significantly higher number of HIV/AIDS-related stories. In Karnataka the Kannada and English papers carried an almost equal number of stories.

**Table 2b: Total Number of Television Stories on HIV/AIDS**



The Urdu press in Punjab and UP accorded low priority to the subject. In the two states, Urdu newspapers carried just three news items each. The Punjabi press too had just nine stories during the six-month survey. This in itself may be considered as a case of discrimination. A discussion with journalists of the region shows they did not see it as a “prevailing disease.” It was not considered an issue big enough to merit attention at this stage even though they acknowledged the high degree of risk factors, such as endemic drug addiction, a huge migrant workforce and a large number of people involved in the interstate transport sector. There also seemed to be a mental block in Punjab in talking about a virus that is associated with socially taboo subjects such as safe sex, differing sexual orientations and extra-marital relations.

### Space and positioning

Apart from the number of stories, their length and positioning was also analysed. Almost 60% of the stories were single or double column. Most stories in the UP and Karnataka press were single column (40%). In Punjab, however, 60% of stories were spread over 2-3 columns. More specifically, the state’s English newspapers devoted more space (over 4 cols). This was a trend noted in the other states too. In UP, almost 30% of the English stories were carried across four columns.



The Urdu press in Punjab and UP accorded low priority to the subject. In the two states, journalists of the region did not see it as a “prevailing disease”



Several television stories too associate the virus with death and ruin. Stories repeatedly hammer in that the ‘victims’ are at death’s door, though the visuals may show them as healthy, active individuals

Not only did the English press give more space for HIV/AIDS stories, but in all three states it also carried a greater number of editorials (5.5% of total HIV/AIDS stories) as compared to the regional press (1.2%). It also had a marginally larger number of features (18.5%) in relation to the regional press (12.8%).

Front-page stories were few (5.4%). Most coverage appeared on the inside pages (88%). A little over five per cent were in supplements. The English press had a marginally larger number of stories on the front page.

The majority of stories - over 90%, were stand-alone, one-time items. They do not form part of a series or campaign by the press.

### ***Frame of reference***

The frame of reference of most articles has been the national and respective state-level situation of HIV/AIDS. In addition, almost 20% of the stories referred to the global status of the epidemic. Community and individual responses were insufficient.

Several television stories too associate the virus with death and ruin. For example, a sensationalised story on a woman in Mumbai who contracted the infection from her husband/partner who abandoned her was described as ‘roaming free.’ Stories such as this repeatedly hammer in that the ‘victims’ are at death’s door, though the visuals may show them as healthy, active individuals. This association of HIV with ‘living death’ heightens the despair of those infected and the fear of those around, causing infected people to be isolated and rejected.

### ***Issues taken up***

The two major concerns of most stories in the survey have been:

- Raising awareness to prevent spread of the epidemic.
- Stories relating to people affected by HIV/AIDS.

Nearly 40% of the coverage in Karnataka comprised awareness efforts by celebrities and others to control the epidemic. Across the country, the page three culture of glamourising events has been used for sending out messages on HIV/AIDS. Both the print and electronic media have extensively carried photos and statements of celebrities. Even bold pictures of beauty contest winners made a mention about their concern for HIV/AIDS. At the same time the media needs to be careful not to trivialise the issue. A lot of space in the three states was taken up by the release of a music album on the theme of HIV/AIDS within marriage, featuring TV personalities Mandira Bedi and Samir Soni. While some stories were entirely celebrity-focussed, others used it as an opportunity to explore how the virus spreads. Other important political personages like Bill

## Stigma and Discrimination

The primary purpose of this analysis being to look at stigma and discrimination of those affected, certain parameters were devised to be able to cull this from the reports. Articles and TV coverage were analysed to see if they projected a single point of view or had multiple perspectives, if the news item specifically associated the epidemic to certain behaviour or groups of people, and whether the spread of the disease to the general population was adequately addressed. Terminology that could cause panic, accuracy of the information and the confidentiality concerns of infected persons were also examined. The analysis of news stories through these filters brought out the explicit and implicit stigma and discrimination components. It revealed that identification of stigma and discrimination in reportage is often subtle and difficult to pinpoint, yet it does influence the readers/viewers' perceptions on HIV/AIDS.

While the survey showed that 95% of the print articles did not contain any overt stigma and discrimination against people affected by HIV/AIDS, a closer examination of the orientation and slant of stories made it evident that at times the wrong message was being sent out.

For instance, the story titled, "Tamil Nadu school slams doors on HIV positive orphans, says it's risky," is a front-page anchor story in a national daily. An excellent human interest story, the subtitle projects the school's argument that if the children fall on or bump against others they will pass on the infection. This discrimination (refusing them admission) is given the stamp of credibility by the non-committal reporting. It was important to counter the argument of the principal, a person of public stature, by getting a quote from a medical expert or NGO that HIV/AIDS is not transmitted by these means. This is not brought out even in the statement of a medical field worker who says, "An insensitive society and system can kill them sooner." In any case this appeared only in the run-over of the article in an inside page. The news report thus reinforces stigma and discrimination in the reader's mind.

Many good stories are marred by terminology commonly used by the media to describe HIV/AIDS – scourge, dreaded/draconian/deadliest disease/single biggest killer/viral tsunami/even deadlier than the enemy/pestilence/ugly truth. Infected persons are called victims/patients/cases. In Punjabi the word *kauda*, used for those affected by leprosy, is applied in a derogatory manner for the HIV infected. In Kannada, the word *naraka yatane* (deadly disease) is used for describing HIV/AIDS. ■



Many good stories are marred by terminology commonly used by the media to describe HIV/AIDS – scourge, dreaded/draconian/deadliest disease/single biggest killer/viral tsunami



In Punjab, 65% of the articles dealt with people living with HIV/AIDS. Despite the large number of stories, their major concern of facing stigma and discrimination has hardly been addressed directly

Clinton and Kofi Annan added their clout to the concern on the issue in the media.

In Punjab, 65% of the articles dealt with people living with HIV/AIDS. However, further analysis revealed that despite the large number of stories, their major concern of facing stigma and discrimination has hardly been addressed directly. The stories played up 'catchy' themes or those with an unusual human interest angle. The crime aspect is invariably hyped. For instance, several newspapers in Punjab wrote about the acid attack on a woman who left her husband soon after marriage on finding out he was infected. While the media highlighted the criminal charges that both filed against each other, it did not take up other vital issues related to living with the virus. These could have included the woman's right to know of her husband's positive status before marriage and her right for protection.

The other HIV/AIDS issues covered were initiatives by the government and various agencies to tackle the virus, medical research and treatment, and HIV/AIDS impacting the social fabric.

**Absence of multiple perspectives**

As many as 70% of the articles did not have multiple perspectives of various parties involved. This implies that they were one-sided or 'biased.' The voices of people living with HIV/AIDS, caregivers, experts and NGOs were not heard, probably because most stories comprised straightforward reportage.

**Accuracy of information**

About six per cent of the overall coverage was factually incorrect. Some stories were exaggerated and totally false. A story in an Urdu newspaper in Punjab alleged that a new type of condom with a microchip had been developed to prevent HIV/AIDS! Another misleading story in the UP papers says, "Tamatar khao, AIDS bhagao" or 'eat tomatoes - drive away AIDS.' Newspapers also need to take a decision whether items promoting 'cures' for HIV/AIDS should be carried or not. Articles like the use of cow urine as therapy and healing by a 'swami', frequently appearing in the Kannada papers, need to be verified and crosschecked.

A story that raised dubious concerns was a full-page feature in *Hindustan Times* on the theory that the HIV virus does not in fact lead to AIDS. It quoted international scientific authorities to buttress its claim that "AIDS is a non-contagious lifestyle epidemic caused by anti-HIV drugs." Several Indian experts are livid that such a story was carried so prominently even though the page did have a section on dissenting opinions. They say that at this juncture of the epidemic such an article could do extensive harm. This debate has, for instance, set back the response to the epidemic in South Africa.

### Headlines

Of the stories analysed, 11.5% (51 articles) had overtly stigmatising or panic-creating headlines. Seventeen per cent had headlines that did not match the stories. Titles in the Hindi and English newspapers in UP such as, “AIDS being spread by wives who have been bought like goods,” and “247 AIDS patients in the hills and 800 sex workers,” as well as, “From dance bars to prostitution and HIV” make harmful and stigmatising associations. Even headlines like, “India sitting on AIDS Time Bomb?” in major national dailies, are alarmist.

A workshop in Lucknow on medical care-givers was headlined in one English newspaper as, ‘AIDS - paramedics, be careful.’ The story focussed only on “the high danger zone for those who are in charge of patients... for this dreaded, incurable ailment.” It warned that even simple accidents caused immediate infections. Nowhere did it mention that HIV positive patients deserve equal care and treatment or raise the problems they face. The same workshop was reported with greater responsibility by other newspapers.

### Is the copy alarmist?

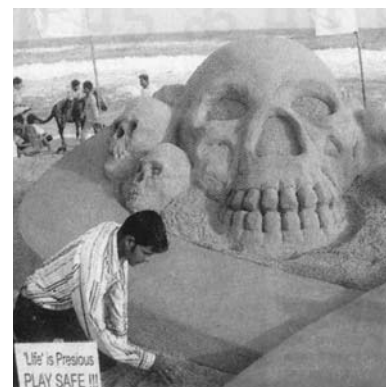
The news stories were analysed for alarmist or panic creating innuendos. It was felt that more English news (15.5%) was alarmist/panic creating as compared to the regional press (7.5%). Overall, 12% of the articles, or 51 items, did contain HIV/AIDS news in a manner that could invoke fear. For instance, a story in a Karnataka English newspaper says, “HIV/AIDS spreading at an alarming rate in State.” Another English article reads, “The pestilence of HIV/AIDS looms large over mankind... the family is under immediate threat from the scourge.”

It may be that the media felt the situation was grave and alarming and adopted this tone. But keeping in view the need to be sensitive to people living with HIV, who might face the backlash of such reporting, greater sensitivity and the proper use of terminology becomes important.

### Photographs/ Illustrations

Almost 30% of all HIV/AIDS stories across the states had an accompanying photograph or illustration. There were also some photo-only items with captions. Of these 142 photos and illustrations, seven were found alarmist. For instance, a supposedly well-meaning awareness campaign by an artist in Orissa displayed a sand sculpture of skulls. This photo was carried by newspapers across the country. There was also a photo caption saying, “AIDS ka danav” or ‘the demon of AIDS.’ The message sent out was of death and doom. There was no attempt to contradict this negative portrayal.

Projecting the virus in this manner is likely to lead not so much to preventive measures against contracting it, but transference of the fear evoked against HIV/AIDS to rejection of



A well-meaning awareness campaign by an artist in Orissa displayed a sand sculpture of skulls, reinforcing the misconception that the HIV infection spells death



A photograph of Sharmila Tagore hugging an HIV positive woman was the best way of sending the right message that the virus was not infectious

the persons infected. Instead, a photograph of Sharmila Tagore hugging an HIV positive woman was the best way of sending the right message that the virus was not infectious.

### **Tone of story**

The overall tone of most stories was neutral (45%) and a few were positive (37%). Seventeen per cent, however, were negative. Positive stories included tales of courage and determination as well as those that expanded the scope of coverage to actively examine the dimensions of the epidemic. For instance, a number of Hindi stories in UP investigated the changing nature of the spread of the epidemic in different regions as well as the treatment of infected persons there in medical and social terms.

Stories that could be termed negative in tone were those that dealt with the virus in sensational or judgemental ways. For instance, a story from Ludhiana by a national TV news channel on a woman and her baby acquiring the infection during her pregnancy merely reported the incident in a dramatised and bleeding heart tone. It did not take up obviously important connected issues such as safeguards to blood transfusion and other legal and medical concerns.

### **Maintaining confidentiality**

Confidentiality is an important right of those affected by HIV/AIDS, particularly in view of the repercussions invited by its violation. Sixty-three news items have not maintained it. It is likely this occurred because a greater number of positive people are coming forward and being open about their status in the media. *The Tribune* carried an entire page of interviews and photographs of ten HIV positive women from across the country. They radiated confidence, speaking of their struggles without self-pity or blame. The Sunday supplement of *The Hindu* also carried a lead story on the voices of Gomathy and Meenakshi, two HIV positive women who travel to villages around Chennai, spreading the message of hope and life beyond the virus. The story was accompanied by a large photograph of the smiling women. Meenakshi did not want TV channels to mask her face when she began her new career as a counselor on HIV/AIDS. *The Sunday Express* too carried the story and photograph of an HIV/AIDS 'survivor', Veena Dhari who has been running the Karavali Positive Women and Children Network in Karnataka since 2000. However, certain stories, particularly those in television, need to be more careful that the identity of those infected is not given away.

### **Blaming high-risk and vulnerable groups**

Fifty-eight news items, or 13% of the articles, laid blame on certain groups considered high risk and vulnerable such as women, sex workers, men having sex with men, blood donors, injecting drug users or truck drivers for spreading the infection. For instance, damning portrayals of women infected with HIV/AIDS, dubbed 'vish kanyas' and

accused of deliberately infecting men, seem to be a recurring thread in some language media. There was also a laudatory curtain raiser in a Hindi newspaper on a movie titled 'Vish-Kanya' being shot in UP. The film is reportedly about "a woman deliberately infecting men with the sole purpose of giving them a ghastly death." Another story from Dehradun in Uttaranchal accuses an HIV positive woman of engaging in prostitution to spread the infection and makes a case for her not to be allowed to roam free. A similar story, based on hardly any facts, was broadcast by a national Hindi news channel some time earlier. The story claimed to investigate rumours about a woman who would arrive in a village and indulge in sex with the men there without taking any money. At the end, she would inform her "victims" - "Welcome to the world of AIDS." The story ends with the question, "Who is this woman?"

### **Association with specific behaviours**

Eleven per cent of the stories link behaviour such as extra-marital sex, multiple partners, different sexual orientations and crime with HIV/AIDS. For instance, a story in a Hindi newspaper on the death of a dreaded dacoit says he experienced an agonising end because of HIV/AIDS, a just punishment for his crimes. The news item also mentioned that the police had found local girls and virility enhancing drugs in his hideout during raids.

Another story carried in an English newspaper in UP traced the life of a bar girl in Mumbai who was said to be infected because her profession brought her in contact with multiple partners. When these girls return to their home state, it was claimed, they passed on the infection to men. Stories like this pass moralistic judgment projecting a certain section as having contracted the virus in well-deserved punishment for doing 'wrong.' The condemnation implicit in these associations with the virus drives the epidemic underground. It also creates false complacency about its spread among those who may consider themselves free from such behaviour.

### **Spread of epidemic into general population**

In the English media, 38.5% stories reflected the spread of the epidemic in the general population, whereas 30% of the regional media reflected it. This implies a larger number of journalists still have preconceived notions that HIV is spread only among certain 'high risk groups'. It gives the wrong notion that those who are not part of these groups are 'safe.' These are personal biases more than facts. The reality is that married women, for instance, with a single partner are equally vulnerable.

### **Linkages with other issues related to HIV/AIDS**

Very few stories - just 17% - dealt with the association of HIV/AIDS with other issues such as gender, trafficking, migration and poverty. Just 10% of stories discuss gender concerns, while 6% analysed its impact on poverty and 4.5% linked it to migration. For



Fifty-eight news items laid blame on certain groups considered high risk and vulnerable such as women, sex workers, men having sex with men, blood donors, injecting drug users or truck drivers for spreading the infection



“Newspapers are already focussing extensively on emerging national issues and HIV/AIDS is seen as important not just from the point of view of health but as a social issue”

instance, a story in Karnataka’s *Vijay Times* titled, “Strange bedfellows: Drought and AIDS,” explored the relationship between the two. However, with most news items being spot stories, such deeper views were evidently lacking. Nevertheless, as HIV has direct and indirect consequences on society, it is important for these perspectives to be reflected in the stories to give an overall understanding of a complicated issue.

### CONCLUSION

The study found few stories actually stigmatised or victimised affected people or gave factually incorrect information. This could be because most stories were ‘passive’ spot news or events or celebrity statements. At the same time, many experts maintain there is a sea change in media reporting since the first incidence of the virus was reported in India in 1986.

In the last couple of years in particular, more stories are being written and they are not all alarmist. As Mr C H Kiron, managing editor of the Telugu daily *Eenadu*, says: “Newspapers are already focussing extensively on emerging national issues and HIV/AIDS is seen as important not just from the point of view of health but as a social issue.”

The fear created by reporting that was not well-informed is being replaced not only by more extensive coverage, but by more sensitive reporting. The fact that positive people are speaking up and many of them don’t mind being photographed has added to the committed journalists’ understanding of HIV/AIDS.

Celina D’Costa, one of the more articulate, public faces of those who are HIV positive, said that 12 years ago when her infected husband died and doctors in Goa told her she was positive, the media carried her picture and story. She was still coping with the death of her husband when her in-laws threw her out. Their excuse ranged from, “Your brother-in-law will not be able to get married if you are in this house,” to “Mosquito bites and shared toilets will lead to others in the family contracting the virus.”

Says Celina: “I wish the media had said something about where I could get medical and legal assistance.” She did not know that she had the right to live in her house or that she had the right to confidentiality. The right to information on HIV/AIDS, she says, should be extended not only to infected people, but to the public at large and in particular the media.

In Kerala, where there was a similar protest against those infected with HIV/AIDS being buried in the church graveyard, the media reported with greater responsibility. The report prominently quoted Sister Dolores who founded the Cancer and AIDS Shelter Society to fight for the rights of infected people. The story also carried a statement of a representative of the Catholic Bishops Conference of India quoting Mother Teresa: “A

person infected or affected with HIV is Jesus among us. The Church won't discriminate on the basis of this as it would go against our faith." It also points out that the Bishops were finalising a policy on HIV/AIDS that would address the issue of stigma and discrimination. The report says Sister Dolores and others broke down the wall that separated the condemned graveyard from the rest of the cemetery.

With more people like Celina speaking up, stories such as the one in *The Tribune* on HIV positive people teaching school children about the infection, are doing much to dispel the negative associations with the virus. An accompanying box item in the story has messages for the children from positive women - "I have absolutely normal children, don't be scared", "I would encourage safe sex or no premarital sex", "HIV people lead a healthy life, they do not simply die" "I was detected with HIV at the age of 19, that is the time for enjoying youth, please take good care."

There are comprehensive websites on HIV/AIDS such as [www.youandaids.org](http://www.youandaids.org), [www.heroeprojectindia.org](http://www.heroeprojectindia.org) and [www.indiangos.com](http://www.indiangos.com). The regional as well as national media have devoted a section of their websites to HIV/AIDS - for instance those of the Women's Feature Service and *Hindustan Times*. In addition there are regular columns in newspapers give expert advice on HIV/AIDS. Readers can write in to them to clarify their doubts on the infection. The weekly column in *The Hindustan Times* devoted to HIV/AIDS is called 'safe-sex' while a column named 'Jagadgala' written by A V Balakrishna Holla in the Kannada paper *Udayavani* frequently takes up HIV among other issues discussed. A Kannada newspaper also reported on a phone-in helpline for those affected. The Government of India's National AIDS Control programme is also quite informative ([www.naonline.com](http://www.naonline.com)) and active at the state and district levels. Also, special media programmes and interactions are regularly held across the country by the government agencies and their partners.

However, there is definitely scope for improvement in coverage by going beyond the spot stories and seeing more than the immediate news. The media can use its influence to demystify or break myths associated with HIV/AIDS. For instance, a Hindi newspaper carried a small story about villagers in Orissa preventing the cremation of an infected couple. The report said they were worried that smoke from the pyre would infect the village. The media should have debunked this belief, as in the story of two infected children in Tamil Nadu denied school admission. Even while reporting about misconceptions among the people about HIV/AIDS, the opinions of experts can be taken to give the correct picture. These provide good opportunities to the media to tell the public how HIV/AIDS actually spreads. Sensitisation of the media on these issues can facilitate recognition of such reporting opportunities. ■



There are regular columns in newspapers giving expert advice on HIV/AIDS. Readers can write in to them to clarify their doubts on the infection



## HIV/AIDS in News: Karnataka

### THE BACKDROP

Karnataka is one of the six HIV/AIDS high prevalence states in India. According to the Karnataka State AIDS Programme (KSAP), the prevalence of infection has been about 20% in the high risk group. The state is estimated to have a 1.5% adult infection rate, with over 5 lakh cases of HIV/AIDS in 2004. There have been 627 deaths reported in relation to HIV/AIDS since 1987. According to the latest estimates, there are 381 HIV positive children below 14 years and 418 between 15 and 19 years.

Karnataka has 78 VCCTC centres where 4062 people have been screened as of June 2005. Presently 1216 people are undergoing treatment. The infection has moved into the general population to the extent that 1.5% of women in antenatal clinics are HIV positive.

### THE STUDY

A media analysis of the coverage and content of HIV/AIDS in Karnataka newspapers was carried out for the period January to June, 2005. It took place in two parts. For six months from January to June two Kannada newspapers were scanned - *Udayavani* and *Vijaya Karnataka*. In the final month from May 8 to June 7, a comprehensive scan of all print media in the state was carried out. This covered 12 daily newspapers in both English and Kannada and two Kannada magazines. All the papers have either originated in the state or are national level dailies editions from Bangalore.

During the overall study period of six months, 167 articles and photographs related to HIV/AIDS were identified. Interestingly, the English newspapers carried a far greater number of stories on the issue. This is evident from the fact that in the one month when six newspapers in each language were intensively reviewed, there were 85 articles in English and just 47 in Kannada. Another 35 articles were identified during the six-month scan of two Kannada papers.

### Findings

With over 70% of the stories comprising spot reports like the launch of the Integrated Disease Surveillance Project in the state or awareness drives, the survey indicates there is scope for more in-depth and people-oriented reporting on HIV/AIDS. A growing number of HIV positive people are willing to declare their status publicly. While both the



During the overall study period of six months, 167 articles and photographs related to HIV/AIDS were identified. Interestingly, the English newspapers carried a greater number of stories on the issue



The largest number of stories was on awareness-raising efforts, particularly by celebrities. The other topic of media interest was spread of the epidemic, including statistics and data on the number of infections

**Table 1: Number of Publications Tracked for the Study**

English	Kannada
The Deccan Herald	Kannada Prabha
The Times of India	Prajavani
The Hindu	Vijaya Karnataka
The New Indian Express	Udayavani
Vijay Times	Samyuktha Karnataka
The Economic Times	Suryodaya
	Sudha (Magazine)
	Taranga (Magazine)
<b>85 news items</b>	<b>82 news items</b>
* These papers were scanned for a longer period from Jan-June 2005	

English and Kannada press have projected them in the correct manner, actively hunting for more stories of this nature will help to erase the stigma and discrimination they face.

### **Positioning**

Most news items on HIV/AIDS were published in the inside pages of the papers and 12 appeared in supplements. There were 13 items on the front page. These included a report on infections in the BSF and launch of the Integrated Disease Surveillance Project in Karnataka. The largest number of stories related to HIV/AIDS was on awareness-raising efforts, particularly by celebrities. The other topic of media interest was spread of the epidemic, including statistics and data on the number of infections. This was closely followed by human interest stories on people living with HIV/AIDS. They were inspirational personal accounts and articles on the rights of HIV positive people, like stamp scam kingpin Abdul Karim Telgi.

### **Frame of reference**

While the frame of reference of 57% of the stories was national, 41% dealt with the state-level situation of HIV/AIDS, 38% with the global situation, and 16% and 15% stories respectively carried community and individual responses to the epidemic. It follows from this that just 12% of the stories included multiple perspectives of various parties involved, an indicator of subtle discrimination against those actually affected. In the Kannada press in particular people's voices were rarely heard. For instance, an otherwise well-researched feature in *Udayavani* examined the social, economic and legal impact of HIV/AIDS but was devoid of comments from people affected by the virus. The story was generated entirely through data and the author's own understand-

ing of the issue. This was the case with another story too in the newspaper that made a case for 'A healthy society making for a progressive nation'. It cited American efforts at handling the epidemic and included the controversy about HIV/AIDS figures but made no effort to get the perspective of infected persons.

### Overt bias

Apart from this, the Karnataka press has very little overt stigma or victimisation of those affected by HIV/AIDS. Obvious elements of bias were seen in 2.4% of the stories in the survey. Also, almost all the stories were factually correct in their information on the virus. While the issue of maintaining confidentiality did not come up in 56% of the stories, 25% of the remaining proportion of stories did take care not to reveal publicly the identity of people affected by HIV/AIDS while 20% were quite lax in the matter.

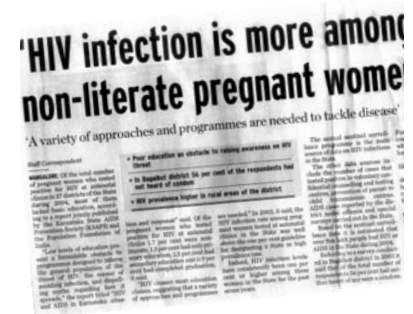
### Headline and story mismatch

In 16% of the cases the headline did not match the rest of the story, as in an article in *The New Indian Express* titled, "NCC cadets to work on HIV front," and another in *Vijay Times* headlined, "Kalam for joint venture to develop anti HIV/AIDS vaccine". In both cases news relating to the virus was little more than a one-line mention in the article while the headline gave it disproportionate attention. In one case, an article in *The Hindu* was titled misleadingly, "HIV infection is more among non-literate pregnant women." It made a judgemental association that was in fact not borne out by the copy. A headline in *Samyuktha Karnataka* titled, "AIDS making India afraid," was also misleading. It was an unnecessary inference, as the story only dealt with the figures of HIV affected people in different states and said that the numbers are increasing because of lack of awareness among uneducated people in particular. It was one of the eight headlines in the Kannada press that did not match the story.

### Creating an alarm

Ten per cent of the stories created a sense of alarm about the epidemic, with the English press having more such cases. An equal proportion of stories had alarmist headlines. These include, "Community efforts keep dreaded virus at bay," and 'HIV/AIDS spreading at an alarming rate in state,' as well as, "Is India sitting on AIDS time bomb?".

The tone of most stories (64%) was neutral. A significant section of stories - 25% - could be classified as positive. These include personal accounts of affected women overcoming prejudice. About eight per cent of the stories did have a negative tone. A number of stories blamed the spread of the virus on sex workers and truck drivers (3% each), classified as the most high-risk groups and reservoirs of infection. A small proportion of stories associated the virus with extramarital sex and multiple partners



The Karnataka press has very little overt stigma or victimisation of those affected by HIV/AIDS. In 16% of the cases the headline did not match the rest of the story



Namakkal district's eligible couples ask for their potential partner's HIV status before marriage. The article mentions that nearly 7% of the town's population is HIV positive and indicates that the virus is an issue of concern for all

(8.4% and 7.8%). Such stories project a lopsided view of the spread of the epidemic and also cause stigma against affected persons who are perceived to have engaged in certain forms of behaviour. It was felt that 14.4% of the stories used terminology that could add to stigma and discrimination.

### **Spread and linkages**

Twenty-seven per cent of the stories accurately reflected spread of the epidemic into the general population. These include a slew of stories on a campaign by television actress Mandira Bedi to highlight married women's vulnerability to the epidemic and another in *The New Indian Express* on Namakkal district's eligible couples ask for their potential partner's HIV status before marriage. Reflecting generalisation of the epidemic, the article mentions that nearly seven per cent of the town's population is HIV positive and indicates that the virus is an issue of concern for all.

Regarding linkages of HIV/AIDS with a wider spectrum of issues, 11% of the stories linked it to gender, and very few spoke of its connection with poverty, employment and migration. These included an article in *Vijay Times* titled, 'Strange Bedfellows - Drought and AIDS,' that brought out the relationship between the two seemingly unrelated issues and the pressures it imposed on women.

### **COMPARISON OF REGIONAL LANGUAGE AND ENGLISH MEDIA**

The analysis also showed up interesting similarities and variations between the English language and regional press. In both cases, events made for easy and routine coverage. The release of a music video on HIV/AIDS by the organisation 'Breakthrough' that featured Mandira Bedi received extensive attention over several days. Similarly, a candlelight march in memory of infected people who died was reported in a routine manner in all the papers. Nevertheless, some of the news items on the launch of the music video sought to highlight married women's vulnerability to the infection.

Statistics were of major media interest, as the extensive coverage of the controversy related to NACO figures of new infections showed. Some of these stories in the English media were well-researched and used the opportunity to bring out in unusual ways the various dimensions of the epidemic. Though the reports were based on data, they carried more than just figures and showed how reporting could go beyond the immediate event or press conference. For instance, the stories brought out how the epidemic criss-crossed rural and urban areas and highlighted preventive efforts in a state like Tamil Nadu that has succeeded in reducing its infection level.

While the Kannada media carried the data released by NACO and also the counter claim by Robert Feacham of the Global Trust Fund, it made no attempt to analyse the contra-

dictory data or put HIV/AIDS related issues in perspective.

The absence of follow-up effort was reflected by the Kannada media in particular as it did not take the opportunity to explore the many social or economic dimensions of HIV/AIDS, leaving wide gaps. For instance, a news item in *Vijay Karnataka* on the death of a prisoner “from HIV/AIDS” made no further attempt to find out if he was given adequate care and attention or if other rights of the prisoner were violated. Similarly, two news reports in *Udayavani* on suicides by people infected with HIV/AIDS received routine coverage that was in fact sensational. There was no effort to balance the negativity of the tragedy with any form of hope-giving message.

Two small reports in *Suryodaya* and *Vijay Karnataka* on the incidence of HIV/AIDS in the police force and BSF made no attempt again to investigate this issue further. Similarly, though there were reports on government efforts to initiate laws to address discrimination at various levels, no attempt was made to explore these initiatives further or find out at what stage of readiness they are.

The survey highlighted that celebrities associated with HIV/AIDS were big newsmakers for the English press in particular. Former American president Bill Clinton’s visit to India on HIV/AIDS work was a major news event. Mandira Bedi and Samir Soni’s association with an awareness campaign was an attention-grabber. Bill Gates comments in Geneva on the epidemic also made news. Miss Universe pledging support and money to HIV/AIDS was covered widely by English newspapers. Another well-known person, the stamp scam kingpin Abdul Karim Telgi, stayed in the news in the English media because of his HIV status.

In the Kannada press however, it was not on the same scale. Bill Clinton’s visit and Mandira Bedi and Samir Soni’s association with the awareness campaign received comparatively less attention. The Miss India contest was not even covered by the regional papers, but for a single mention in connection with HIV/AIDS. Just a colour photo was used, without an accompanying report. The Kannada media also did not make much of Telgi’s HIV positive status. It was mentioned only once in connection with the offer of help from an NGO. Interestingly, in comparison, statements made by politicians had more of an impact on the regional language press. The launch of the Integrated Disease Surveillance Project in Karnataka received extensive coverage (8 items) in Kannada newspapers. There were also large photographs accompanying the reports. However, in these articles HIV/AIDS was mentioned only in passing as part of a larger health effort.

Exceptions to the routine coverage included two well-researched feature stories by *The Hindu* which were prominently placed in its weekend supplement. Titled, “An



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A full-page feature in *The Economic Times* accompanied by photographs, messages and graphics examined the HIV/AIDS epidemic as the country's next human resource issue

Inspiration, a hope" and "Live Positive", the features were accompanied by colour photographs of HIV positive women who had been interviewed and came out openly about their experiences. Another notable article was a full-page feature in *The Economic Times* accompanied by photographs, messages and graphics. It examined the HIV/AIDS epidemic as the country's next human resource issue. A selection of four different articles that focussed on this theme and attractive graphics made it compelling reading. Several newspapers in both languages carried prominently reports on the new trend of declaring one's HIV status before marriage.

Reportage on the impact of HIV/AIDS in rural areas was scant in both languages. One such article in *The Deccan Herald*, titled 'Community efforts keep dreaded virus at bay', did deal with the spread of the epidemic in villages. Though the headline projects an alarmist image, the story was a positive account of village elders taking the initiative in educating the youth on safe sex. Most of the coverage in Kannada appears to have been generated from handouts, such as two stories on a seminar for HIV positive people in Mangalore district.

### **Gender issues**

Women and their concerns in dealing with HIV/AIDS were largely missing from the news, unless it was a feature on HIV positive women's accounts. Other than this, the gender perspective has been excluded from all other coverage by the print media.

### **Tone**

The language used was neutral on the whole. It was not disturbing though a few stories used terminology with insinuations. For instance, terms like *naraka yatane* were used twice in the Kannada papers even when the story was positive. Though none of the reports were disproportionately alarming, the figures reflected the reality of the spread of the infection. There were references in both categories of the media to the AIDS scare/deadly disease/tide of the epidemic/the virus continues to ride/dreaded disease/patients/scourge. Other panic-causing terms included 'time bomb', 'killer/deadly/fatal disease' and 'AIDS is making India shiver.'

Most of the photographs were related to events, such as the one accompanying the candlelight memorial day to honour infected persons who died and photographs relating to Miss Universe. A notable variation was the photo-only news item in *The Deccan Herald* of an infected Mizoram couple with the caption linking their personal story to the HIV/AIDS situation in the state. Features on the lives of positive women describing their experiences were accompanied by prominent photographs of them. The photograph in the *New Indian Express* of a sand-sculpture of skulls as part of an HIV/AIDS awareness campaign was disturbing. It created fear and unease that could result in dis-

criminy behaviour with HIV positive people. Similarly, a photo caption in *The Deccan Herald* on the 'Breakthrough' campaign was negatively titled, "Targeting a scourge." A better alternative, for instance, was the headline to the same story in *The Hindu* - "Do you care for your sweetheart?"

Graphics also need to be used with care. The one accompanying an article in *Udayavani* depicts skulls, an alarmist imagery giving rise to fear against HIV/AIDS. The Kannada media however, made little use of photographs. Those carried were of celebrities or politicians.

## CONCLUSION

The absence of readers' feedback in the form of Letters to the Editor or articles relating to HIV/AIDS – except for one in *Vijay Karnataka* – indicates a general lack of public involvement in the media coverage of HIV/AIDS. Four editorials were carried by the English press, while there were none in the Kannada press.

Several items in the Kannada press featured dubious claims such as cow urine as a possible cure for HIV/AIDS, without adequate supporting data. News of this nature needs to be reported with care and caution. There were also several small news releases on camps held regularly in various parts of the state to cure 'diseases' such as HIV/AIDS. Again, these news items have been carried by the newspapers without verifying the veracity of such claims. Stories and advertisements on "cures" for HIV/AIDS need to be cross-checked by experts before being published. In fact they need to be debunked so that gullible readers are not misled.

There was no coverage relating to HIV/AIDS in the two magazines scanned in May/June. Magazines have an extended shelf life as compared to newspapers and this opportunity needs to be exploited.

Nevertheless, the language media in Karnataka merits special mention for some of its initiatives in covering the issue. These include:

- A regular column in *Udayavani* that emphasises the efforts to stem the spread of HIV/AIDS.
- An investigative report in *Vijay Times* on the negligent and indifferent treatment meted out to visitors at a Voluntary Counselling and Confidential Treatment Centre (VCCTC) at a hospital in Bellary.
- A feature story in *Vijaya Karnataka* giving comprehensive information on a helpline established by the Asha Foundation for those affected by HIV/AIDS. The story was well written, gave a lot of information on the issue, used the Red Ribbon logo to highlight the topic and supplied the helpline numbers.



Several items in the Kannada press featured dubious claims such as cow-urine as a possible cure for HIV/AIDS, without adequate supporting data. News of this nature needs to be reported with care and caution



A small report in *Suryodaya* on the incidence of HIV/AIDS among BSF soldiers appeared on the front page. The infections are played up in a manner that indirectly stigmatises the entire force

### Stigma and Discrimination

Despite such heartening developments, the subtext of media reports reveals stigma and discrimination in overt and covert forms. The orientation and slant of some stories gives a mixed message. This could indirectly lead to the marginalisation, exclusion or discrimination of affected groups who could feel a sense of shame, discredit and psychological trauma.

Most reports are passive and seemingly neutral, but the language used in some cases is negative and loaded. For instance, there are some articles that carry headlines which blame a particular segment of society. The headline of a prominently placed, long article in *The Hindu*, ‘HIV infection is more among non-literate pregnant women,’ clearly blames this group for being carriers of the virus. Moreover, the headline is misleading as the article deals with the fact that the low literacy levels of many of those affected needs to be addressed by designing different approaches to HIV/AIDS prevention. The spin-off effect of such a headline is that it could lead to stigma and discrimination of the “non-literate pregnant woman”.

A report in *The New Indian Express* states: “Of the 1,300 persons registered with ARV therapy centres in the state, the majority are men, mostly those who had been working in other states. Many belong to the middle class and lower middle class.” This again could convey the impression that the virus is present only among a certain segment of society and those who are migrants. The reality however is that the epidemic can be found across all classes of people. In yet another case, the headline reads, ‘Men continue to be in high risk group.’ The article on drought and HIV/AIDS in *Vijay Times* points to families facing poverty but has an extremely negative and judgemental statement saying women are resorting “to prostitution as an easier way of making money rather than working in a legitimate manner.”

In the Kannada press, a small report in *Suryodaya* on the incidence of HIV/AIDS among BSF soldiers appeared on the front page. It stated that 98 of the two lakh soldiers are affected by the virus. The infections are played up in a manner that indirectly stigmatises the entire force. There is no other qualifying statement or balancing opinion. Another news item in *Suryodaya* that pointed to a particular segment of people as carriers of the virus related to the Mumbai police. Carried prominently in the central section of the newspaper, it was based on the growing number of infections in the Mumbai police and that the affected men are allowed to avail of medicines from police hospitals.

A small report in *Vijaya Karnataka* reveals the research findings that Indians and

blacks in South Africa are more prone to HIV/AIDS and that they are not ready to accept this fact. The report does not explain the reasons why these communities are more prone or the wider findings of the study.

On the other hand, there are stories that go a long way in reducing prejudice. A report in *The Hindu* refers to the, “success of networks formed by HIV-infected people. These networks helped in lobbying government for better access to medicines and mobilising popular support for the battle against stigma and discrimination. ....It was only in 2003 that NACO started seeing the networks formed by HIV-infected people as partners in the fight against stigma and discrimination and in the task of providing relevant information to the needy.”

Another positive story in *The Hindu* on an awareness-raising campaign includes useful information on transmission and modes of prevention. By repeatedly conveying such facts, the media can break myths about the mode of spread of the virus and thereby, discriminatory treatment of infected persons.

The coverage on Telgi by *The Times of India* and *Vijay Times* brings out the important issue of human rights of positive people as well as their constitutional rights. The reports highlight that as an infected person he was being meted discriminatory treatment and kept in solitary confinement in contravention of the Supreme Court ruling on the matter.

Interesting reports in *The Times of India* and *The New Indian Express* draw attention to the new custom of asking would-be grooms to produce an all-clear signal on the HIV/AIDS front. One of the reports even goes on to warn: “There is a flip side - there are cases where the alliance has been called off after the family of the girl or the boy sought such a certificate. The stigma attached to AIDS as a sexually transmitted disease still prevails.” Even an editorial was carried on the benefits and impact of such new social norms. Another report in *The New Indian Express* headlined, ‘Now in matrimonial columns: HIV status,’ goes on to say, “Being HIV positive is not as much taboo as it was earlier.”

Noteworthy is the willingness of HIV-positive people to come out about their status. *The Hindu* and *The Deccan Herald* have carried first-hand accounts of HIV positive people leading lives in a wholesome manner, (“I’m HIV positive...if I can lead a normal life, so can you”) bringing out the need for better understanding and sensitivity by society. The features are accompanied by prominent photographs of cheerful women who do not feel the need to hide their positive status. ■



There are stories that go a long way in reducing prejudice. Networks formed by HIV-infected people helped in lobbying with the government for better access to medicines and mobilising popular support for the battle against stigma and discrimination



Human interest stories, done properly, make interesting reading and are able to provide a face to the numbers issue. The accounts of infected people living productive lives convey a hopeful approach in a scenario that is otherwise considered bleak

- *Vijaya Karnataka* also carried a small announcement of an innovative phone-in programme by Akashvani addressing queries on preventing parent to child transmission of the virus. However, the headline did not indicate the nature of the programme, which might have resulted in a lesser number of people tuning in to the programme.
- There was an inspirational story in *Vijaya Karnataka* about a girl named Asha who discovered she was HIV positive within months of her marriage and was now working with an NGO to help other infected people. The story conveyed hope and was well done.

### OVERALL COMMENTS & RECOMMENDATIONS

The survey reveals that the coverage of HIV/AIDS issues is not of high priority in the Karnataka media. The reporting is scanty and sporadic. While one may take comfort in the growing number of stories on the subject, yet most are passive, spot reports that are fairly simplistic and of a routine nature. Qualitative/opinion making/advocacy related coverage is limited.

- Human interest stories, done properly, make interesting reading and are able to provide a face to the numbers issue. The accounts of infected people living productive lives convey a hopeful approach in a scenario that is otherwise considered bleak.
- The focus of coverage needs to be on ‘what next’ and not on ‘how’ the virus was contracted.
- Most news reports look at HIV/AIDS in isolation, without any supporting assessment of the quality of life of those affected. It could in fact be integrated into the general coverage by newspapers on health and quality of life. There was only one such article, in the Kannada daily *Udayavani*.
- News events or stories that have scope for more detailed inquiry into the various dimensions of the epidemic were seldom exploited. These need to be followed up and developed.
- The publishing of so-called “cures” for HIV/AIDS needs to be critically explored. Such items need to be verified and cross-checked, not treated as any other product.
- There was no sharing of information on HIV/AIDS between sister-publications, such as *The Deccan Herald* and *Prajavani*.
- Cartoons or health capsules are a rich source to inform and raise awareness. However, there was not a single cartoon or health capsule which focussed on HIV/AIDS during the survey period.
- The red ribbon logo associated with HIV/AIDS attracts the eye wherever it has been used and needs to be encouraged.
- While it is necessary to report cases of suicides and murders of people living with HIV/AIDS, these also provide the opportunity for social-interest messages to be car-

ried along with the story. This could be in the form of mandatory information carrying helpline numbers or the contacts of VCCTCs, or even messages conveying hope. There was no attempt to do this in any of the stories in Kannada in particular.

- An exposure programme for editors, stringers and local journalists needs to be conducted to strengthen media awareness at the grassroots. It is only when a basic understanding is achieved of a very complex issue, that an understanding of stigma and discrimination can be attempted. For instance, journalists can be oriented on the use of appropriate non-discriminatory language and terminology related to HIV/AIDS. However, concerns about use of discriminatory language and about subtle stigmatising messages sent out by stories require a sound base understanding by the media of HIV/AIDS and its significance. ■

**Shangon Dasgupta**

*(Director, Communication for Development and Learning, Bangalore)*



An exposure programme for editors, stringers and local journalists needs to be conducted to strengthen media awareness at the grassroots. Journalists can be oriented on the use of appropriate non-discriminatory language and terminology related to HIV/AIDS



Punjab has large sections of population that are constantly on the move. Away from their families for long periods, these groups make the state at high risk to the infection

## HIV/AIDS in News: Punjab

### THE BACKDROP

Punjab is not a high HIV/AIDS prevalence state but it is an extremely vulnerable one. According to official data collected till April 2005, there are 2034 people in Punjab who are HIV positive and another 334 people diagnosed with AIDS. There have been 92 virus-related deaths. HIV testing facilities exist in 17 district hospitals and in the four medical colleges of the state.

Punjab has large sections of population that are constantly on the move. Away from families for long periods, these groups make the state at high risk to the infection. Not only does Punjab have a large number of transport sector workers such as truck drivers who travel all over the country, a sizeable section of its population is in the defence services. There is a large and mobile business class and also rural youth seeking employment in other parts of the country as well as abroad. In addition, for some time past Bangladeshis wanting to go to Pakistan have been passing through Punjab. They are all part of the state's shifting population, including its large migrant agricultural workforce.

Another small but growing group is that of terrorists who have either come from Pakistan or visited it. An increasing area of concern is Punjab's notoriously unequal sex ratio that has led to young men looking for and even buying brides from other regions. The state's prosperity has also seen a boom in commercial sex work. A very serious problem in the state is its massive substance abuse which again puts many people at risk of acquiring the infection.

### THE STUDY

To examine how the English and regional language print media in Punjab has been covering the issue, a survey was carried out. Four newspapers each in English, Hindi and Punjabi respectively and one in Urdu newspaper were scanned. The study period covered one month of intensive scanning for all 13 newspapers from May 8-June 10, 2005. In addition, a Punjabi and Hindi newspaper were selected to be scanned for a longer period for six months from January onwards to gain a fuller understanding of the influential language press. In all, 111 stories on HIV/AIDS in all publications tracked were analysed for this study.

From the findings of the six-month survey it was evident that the English press led in

**Table 1: Newspapers Analysed and Number of Stories on HIV/AIDS**

English (Chandigarh editions)	Punjabi	Urdu	Hindi
The Tribune	Jagbani (Jalandhar)	Hind Samachar (Jalandhar)	Punjab Kesri* (Jalandhar)
The Indian Express	Ajit (Jalandhar)		Dainik Ajit (Jalandhar)
Hindustan Times	Punjabi Tribune* (Chandigarh)		Dainik Bhaskar (Chandigarh)
The Times of India	Desh Sewak (Chandigarh)		Amar Ujala (Chandigarh)
<b>No. of Stories – 79</b>	<b>No. of Stories – 9</b>	<b>No. of Stories – 3</b>	<b>No. of Stories – 20</b>

\* These newspapers were scanned for HIV/AIDS stories from January onwards

the publication of HIV/AIDS related news, features and editorials as it had carried 79 of the total identified news items. This forms a huge 71% of the coverage on the issue. Hindi papers were next with 20 news items on the subject comprising 18% of the coverage. This was followed by the Punjabi media that had nine news items forming eight per cent of the overall reportage. The Urdu press had just three items representing three per cent of the coverage.

The maximum number of stories (28%) was carried by the English edition of *The Tribune* published from Chandigarh, followed by *The Times of India* (Chandigarh) 19%, *Hindustan Times* (Chandigarh) 16% and *The Indian Express* with 8% of the stories. *Punjab Kesri* led in the language newspapers with 7.2% of the stories on HIV/AIDS, while *Dainik Bhaskar* and *The Tribune* in Punjabi had 6.3% respectively.

Nearly 40% of the stories were accompanied with photographs or other visuals. They were largely well displayed, most of them being given two columns or more of space. However, only four per cent of the stories were on the front page.

A majority of the news items on HIV/AIDS (44%) were of national complexion, such as release of all-India figures by NACO and celebrity endorsement drives like the release of a music album by Mandira Bedi and Samir Soni, 35% stories were of state level such as reports of an incident in Ludhiana in which a pregnant woman received infected blood from a private nursing home, and 15% were global in nature. Just 15% and 11% stories included individual perspectives and community concerns.



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## AIDS awareness camp

TRIBUNE NEWS SERVICE

MOHALI, MAY 21

Members of the Disabled Persons Welfare Organisation, Punjab organised an AIDS awareness camp in Najagaon village near Chandigarh. More than 250 persons attended the camp. Mr. Paramdeep Singh Bhatia, president of the organisation, said it should be obligatory for a couple to undergo a blood test before

The camp was inaugurated by Mr. Narinder Bhatia and Mr. Sunil Ahuja. They appreciated the move of the organisation. Mr. Dharam Pal Rana, general secretary of the organisation, said parents should feel free to educate their wards about this disease. Mr. Deepak Rohela, vice-president, told that people should use disposable syringes when required. He added that they should insist that barbers use fresh blade for shaving. He pointed out

The press here has begun noticing the epidemic, but confines it to the observation of spot reports of events, seminars, workshops, press conferences and occasional public statements of people living with HIV/AIDS

The subject of these stories related to treatment and care of those affected by the virus in 61% items, spread of the epidemic in 34% cases and 14% dealt with medical research. Only six per cent items referred to stigma against those affected by HIV/AIDS, such as a story from Kerala on the controversy over opposition to infected persons being buried in a church graveyard, and 15% were alarmist in nature. About 20% stories also had alarmist headlines. These include a story titled, "AIDS more dangerous for Assam Rifles than Rebels," and another titled, "All Punjab cops told to take AIDS test." An important finding is that about 49% stories had a positive impact, such as a report on local folk theatre in Mandi, Himachal Pradesh being used as an unusual awareness creating tool and several inspiring reports on the life histories of HIV positive women. Twenty five per cent stories had a negative complexion such as the report of a dubious so-called 'AIDS cure' while 28% were neutral. The latter included a slew of stories on the inauguration of a Care Centre for infected people by the Administrator of the Union Territory.

Some stories seemed to blame a particular section of society for spreading the virus. Nineteen per cent stories blamed women and sex workers, such as a story from Chandigarh titled, "*Commercial sex workaroon ke jaal mein phansi jawani*," 12% blamed injecting drug users and 4 per cent attributed the virus to truck drivers. Related to this are the few stories that associated HIV/AIDS with specific behaviour in a judgemental manner — nine per cent linked it to extra-marital behaviour through statements warning truck drivers for instance against such relationships and three per cent to crime, such as the acid attack story and the one on an attempt to rob HIV positive blood. Another level of analysis revealed that some stories did look at HIV/AIDS in a holistic manner in relation to its impact on gender issue (13%), migration (3%) and human trafficking (3%).

The study makes it clear that the press here has begun noticing the epidemic, but confines it to the observation of spot reports of events, seminars, workshops, press conferences and occasional public statements of people living with HIV/AIDS. At first glance, it may appear that the press has been quite accommodating in covering the subject. But it has a long way to go before complex issues of socio-economic and medical nature are handled.

### COMPOSITION OF PUNJAB PRESS AND ITS IMPLICATIONS

Of relevance is the particular composition and nature of the Punjab press. The Punjab media can be divided into three categories. One is the English language national newspapers headquartered outside Punjab but which have started publishing from this region, like *Hindustan Times*, *The Times of India* and *The Indian Express*. These papers reflect the policies and attitudes of their parent editions though with

some regional variation. They are published mostly from the state capital Chandigarh and Jalandhar, an old centre to which newspapers displaced from Lahore shifted after Partition. Quite a few opinion-making sections of Punjab population are fond of English papers published from outside the state, such as *The Hindu*, *The Telegraph* and *The Asian Age*.

The second category comprises Hindi newspapers that were established outside Punjab but bring out editions from the state, like *Dainik Bhaskar*, *Dainik Jagran* and *Amar Ujala*.

The third category is newspapers of regional origin that are published in Punjabi, Hindi and Urdu. These include *The Tribune*, *Punjab Kesri*, *Ajit*, *Desh Sewak*, *Nawan Zamana*, *Jagbani*, *Hind Samachar* and several other smaller papers. These regional papers are more traditional, conservative and local-oriented. *The Tribune*, in fact, can be taken as a category by itself. It has editions in English, Hindi and Punjabi. The paper tries to maintain its original regional character but takes note of national and global news trends.

Interestingly, the English and Hindi newspapers form the dominating influence, with Punjabi papers coming next. Earlier, the Urdu papers had been most influential, but all of them started Hindi or Punjabi editions after shifting from Lahore. The *Tribune*, that originally started publishing in English, came out with its Hindi and Punjabi editions much later.

Looking at coverage of HIV/AIDS in these distinct groups, it is clear that the English press is active in publishing news of the issue including some analytical articles and those on medical research. However, the Hindi and Punjabi papers of regional origin have yet to take serious notice of the subject. Hardly any space is spared for news or features related to HIV/AIDS. Some papers bring out weekly or occasional one page supplements on health but these are devoted to handling heart disease, asthma, eye problems, digestive disorders, women's ailments and even cancer among others. There is rarely anything on HIV/ AIDS.

While the English newspapers do give space to items concerning awareness and preventive efforts, HIV/AIDS stories that qualify for publication in the regional language press are mostly those that have an unusual human-interest element. The stories that the Hindi and Punjabi language press seems to welcome are of a beauty pageant of HIV positive women even though in distant Kathmandu, the visit of HIV positive women from South India who openly talked of their personal experiences and stories on marital disputes arising out of the situation.



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WHO/V. Pirat

Much of the media indifference in Punjab is because there is little awareness of the immediacy of the epidemic. It is not viewed as prevailing in the state in any significant manner to warrant urgent attention

The Urdu press seems interested only if in its opinion there is an angle that is likely to interest its particular readership. For instance, it completely overlooked several significant news stories relating to HIV/AIDS that broke during the survey period, such as release of national HIV/AIDS figures and the controversy that followed. But it used advice by actress Mandira Bedi on HIV/AIDS, a visit to Kolkata by Pakistani sex workers who discussed with their counterparts the need for greater awareness about the virus and carried a wildly exaggerated feature on the development of a condom with a microchip to prevent the HIV/AIDS infection.

### SUMMING UP

Much of this media indifference in Punjab is because there is little awareness of the immediacy of the epidemic. It is not viewed as prevailing in the state in any significant manner to warrant urgent attention. The study clearly shows that a story on HIV/AIDS will be accommodated if it is easily available, otherwise the press is unlikely to search for stories or even investigate the ones discovered from time to time.

A glaring example is the media coverage of the visit to Chandigarh by a group of HIV positive women from South India to create greater awareness by recounting their experiences. The women came out with relevant and useful information that provided the human interest copy. The event received wide coverage, with several newspapers interviewing the women and their views and photographs received ample space. These were stories of brave women who overcame difficult emotional, physical and economic situations. Some of them faced social discrimination and stigma.

Though several media persons acknowledged that these stories were both inspiring and readable, none tried to look for similar examples in the state itself. There are bound to be stories of social discrimination and stigma in Punjab too and the struggle of people living with HIV/AIDS to overcome this. Most of the time however, the media is satisfied with reproducing official handouts or reporting 'spot stories' of personal experiences. These include the reports of a woman in Nawanshahar district who claimed to have been duped into marrying an HIV positive man or the story from Ludhiana of a pregnant woman being given an infected blood transfusion.

All these stories have been handled as straightforward crime reportage. A number of newspapers reported in detail over a period of time developments in the incident of the couple who filed criminal charges against each other after the woman suffered an acid attack. She claimed that her estranged husband had retaliated after she left him on finding out that he had concealed his HIV positive status from her at the time of marriage. There was no attempt to investigate the background to the story or raise issues

such as the rights of the partner of an infected person. No one was wiser after reading the spate of stories on the incident.

Again, a story on 'safai karamcharis' or cleaning staff in Amritsar being exposed to the HIV infection due to unsafe handling of medical waste was half-baked, carrying incomplete information.

While the language used in reporting is largely innocuous, this could be because most stories are routine and based on handouts or picked up from wires services. Another observation of the survey is that a large number of stories in the English media originate outside Punjab. Not only are few stories from the state written with flair and panache, local journalists also need to look for more stories from the region.

The reason for the regional language media in particular turning a blind eye to the epidemic may lie in the conservative nature of this section of the press and its hesitation to discuss this delicate issue. For instance, while there have been several detailed and well displayed reports about people coping with the infection contracted from suspected blood transfusion as in the case of the pregnant woman in Ludhiana, stories relating to issues such as alternate sexuality, extra marital relationships and drug addiction are completely avoided. While it is known that the reality of drug addiction is a massive problem, the various aspects of the epidemic spreading among injecting drug users are almost never addressed. Again, a very large number of truck drivers originating from Punjab ply all over the country. Instead of taking up issues relating to them the press seems rather to turn a blind eye to such matters.

While generally the worst that can be said about the Punjab media's coverage is its lack of interest in the issue, stories that fuel stigma and discrimination against people affected by the virus are few unlike in other states. However, these need to be pointed out. For example the story in Amar Ujala blames 'loose' women such as commercial sex workers for spreading the virus among middle class youngsters even while absolving the men who are their willing clients.

The article has a bullet point saying, "Prostitution has spread even in the city's prosperous localities." In the worst display of class consciousness, it reports on Chandigarh's well-off 'Sectors' too being in the grip of a vice that makes them vulnerable to the HIV/AIDS infection. Such reporting links the virus with the poor and those segments that are of 'bad character'. The article associates HIV/AIDS as an infection of the 'others', implying that the rich are morally pure and therefore generally immune to it.

Another story that ostracises an entire community is the one headlined, "Safai sewaks



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What needs to be addressed is the media's lack of urgency about the state's HIV/AIDS situation and its many implications

found HIV positive.' Two others say that AIDS has felled more men in the Assam Rifles than the enemy and all Punjab cops being made to test for HIV/AIDS. Not only are these stories misleading as they do not highlight the fact that only a few people in each of these groups have been found infected, but opportunities to raise several pertinent issues associated with the virus are not taken up. These stories could have looked at the individual's right of granting consent before being tested for the virus and if the infected persons' rights to confidentiality and fair treatment by employers was being met or not.

It is also common for almost all stories to use terms like "AIDS patients" to describe HIV positive persons whether they are sick or not, use the ostracising Punjabi word 'kanda' or leper to describe an infected person and say 'AIDS ka danav' or AIDS ka demon' and 'viral tsunami' to point out the threat of the virus. Such terminology adds to the fear and horror against HIV/AIDS, a feeling that can be imperceptibly transferred by some readers to those affected by the virus and influence interactions with them.

However, this can be dealt with by proper motivation and orientation of media-persons. This is evident in the recent performance of the English edition of *The Tribune*. The quantity and quality of its coverage on HIV/AIDS has greatly improved in the past few months with a shift in news focus, direction from top personnel and extra effort at the reporting level. Unfortunately, the Hindi and Punjabi editions of the paper do not reflect the same concern.

### RECOMMENDATIONS

- Routine stories based on speeches, statements and press conferences are not creating an impact. To be noticed, more features and human interest stories must be attempted. What needs to be addressed is the media's lack of urgency about the state's HIV/AIDS situation and its many implications.
- The press can add weight to its stories on HIV/AIDS by taking the comments of public figures such as social activists, spiritual leaders, filmstars and even politicians.
- As far as possible, editorial matter needs to be related to familiar local situations. Even stories emanating from distant places can be reoriented to inject a familiar flavour.
- There is scope for information-based educative news on HIV/AIDS but it needs to be presented in a more interesting manner. This calls for more research-effort and gathering of background material not only by journalists but also by NGO's and official agencies involved.
- Media persons must be motivated enough to chase more stories on HIV/AIDS and consider the issue of significant importance. Media organisations could even con-

sider assigning the work to its specialised staff.

- Instead of mere reporting, a pro-active approach is necessary. More investigative and interpretative stories need to be attempted. A special effort needs to be made to explore elements of stigma and discrimination in stories concerning persons living with HIV/AIDS.
- The media must be vigilant that its reporting does not give rise overtly or covertly to stigma and discrimination against those affected.
- There is scope for more editorials to be written on the subject.
- The eye-catching symbol of the Red Ribbon that symbolises HIV/AIDS should be used more often with the stories.
- A training programme for the media should include building of awareness, take into account motivation levels for covering such stories, help in identifying sources of information and look at the manner of treatment of HIV/AIDS stories. ■

**Prem Kumar**

*Former resident editor, The Indian Express, Chandigarh*



There is scope for more editorials to be written on the subject. The eye-catching symbol of the Red Ribbon that symbolises HIV/AIDS should be used more often with the stories



Uttar Pradesh's large migrant population and low levels of healthcare make it particularly prone to the epidemic. However, the epidemic is low in visibility

## HIV/AIDS in News: Uttar Pradesh

### THE BACKDROP

Uttar Pradesh, the country's most populous state, is a highly vulnerable region with regard to spread of the HIV/AIDS virus. Its large migrant population and low levels of healthcare make it particularly prone to the epidemic. However, the epidemic is low in visibility here, recording 1.4% of the total number of HIV/AIDS cases reported from across the country. In 2004, UP had 10,896 people infected with HIV/AIDS. The prevalence rate is 0.8% in groups considered high-risk and 0.23% in the rest. Districts with high levels of infection include Varanasi, Allahabad, Lucknow, Agra and Gorakhpur.

### THE STUDY

A content analysis of the coverage of HIV/AIDS by newspapers published from UP was carried out from January 1–June 8, 2005, in two parts. For the first five months of the survey from January to May, two Hindi dailies, *Dainik Jagran* and *Hindustan*, were considered. For a month from May 8–June 10, 2005, an intensive scan was carried out of all major print media in the state. This included 13 newspapers and a weekly. All of them have either originated from the state or are national papers with editions from Lucknow. The study revealed that a total of 165 articles related to HIV/AIDS were published in the print media during this period.

**Table 1: List of UP Newspapers Tracked**

Hindi	English	Urdu
Aaj	The Pioneer	Apna Akhbar
Rashtriya Swaroop	The Times of India	
Sahara Samay (Weekly newspaper)	Hindustan Times	
Swatantra Bharat	The Indian Express	
Amar Ujala		
Hindustan		
Dainik Jagran		
Jansatta Express		
Rashtriya Sahara		
<b>126 news items</b>	<b>36 news items</b>	<b>3 news items</b>

## Findings

The analysis of HIV/AIDS reportage shows that the issue has high visibility with a large number of stories published. Except for a single day, stories on the subject appeared on all the other days of the month-long intensive analysis. The coverage peaked to as many as 14 articles on one particular day. An average of 3-4 articles appeared daily.

Of the 165 articles, 119, or 72 per cent, were news stories, 28, or 17 per cent, were features and four were editorials. Fifty-three stories had accompanying photographs while 11 items were only photographs. Most stories (85%) were placed on the inside pages, with seven stories appearing on the front page. Eleven stories were published in newspaper supplements.

The maximum number of stories appeared on May 27 and 28, (13 and 14 articles respectively) on the following issues:

- Bill Clinton's visit – 6 articles.
- Union Government's report of reduction in HIV infection rate – 4 articles.
- An HIV/AIDS clinical workshop organised by CII in Lucknow – 14 articles.

The frame of reference of the majority of stories was equally divided between national (60 stories) and state-level (58 stories), indicating that local journalists were quite active in reporting on the situation. Thirty stories were about the global HIV/AIDS situation, 25 dealt with the community-level situation and seven looked at individuals affected. Only 24 stories carried multiple perspectives of all affected parties and 19 stories were particular about maintaining the confidentiality of those living with HIV/AIDS.

On the brighter side, a considerable number of stories (48) expanded the scope of their coverage to examine HIV/AIDS linkages with migration, human trafficking, employment, poverty and gender issues. Another positive finding was that 56 stories correctly reflected the spread of the epidemic from high-risk segments to the general population. Nevertheless, some stories (30) still levelled blame for spreading the virus on particular segments of the population, like women and sex workers, men who have sex with men, injecting drug users, blood donors and truck drivers. These stories also carried covert elements of stigma and discrimination. Many of these articles perpetuate the notion that HIV/AIDS is an epidemic of the poor and uneducated. A *Dainik Jagran* article says: "The poor and illiterate people from Purvanchal region who go to other states return with the infection, which is then spread here by them." This falsely distances the virus from other segments, whereas the epidemic does not discriminate between rich and poor.



A considerable number of stories (48) expanded the scope of their coverage to examine HIV/AIDS linkages with migration, human trafficking, employment, poverty and gender issues



The article conveys a warped message that HIV/AIDS is just punishment for criminal action, an association that reflects negatively on others who are infected

Another 16 stories, or 10% of the coverage, served to perpetuate false notions of the epidemic by associating HIV/AIDS with behaviours such as crime, extramarital sex and multiple partners as well as sexually perverted practices. For instance, a story in *Dainik Jagran* headlined, “Dreaded terrorist in Doda dies of AIDS,” opens thus: “There is a saying that those who are cruel, end cruelly,” implying that the criminal deserved to die from the virus. The article conveys a warped message that HIV/AIDS is just punishment for criminal action, an association that reflects negatively on others who are infected. The article also points out that “blue films, local girls and virility boosting potions were found in the terrorist’s hideout during police raids,” indicating that sexually depraved behaviour resulted in the infection. This judgmental attitude intensifies stigma faced by people with HIV/AIDS.

Some stories (25) gave factually incorrect information. For instance, a story in *Jansatta Express* on a scientific breakthrough in treatment raises false hopes without providing any substantial facts to back it. It also has a sub-heading that is misleading and trivialises the infection, “*Tamatar khao-AIDS bhagao*” (“Eat tomatoes and scare away AIDS.”)

### **Creating panic and scare**

Some alarmist news items were part of an ongoing series by their newspaper and served to evoke a feeling of doom around HIV/AIDS. The story on tomatoes and AIDS, for example, says: “Everyone is afraid of death, and to top that if one’s life is taken inch by inch and one has to put up with discrimination at the same time then it becomes dangerous.”

A photograph of a sand sculpture depicting skulls created by an artist, ironically to promote awareness, instead reinforced the fear that life ended with HIV/AIDS. This negative imagery was carried without comment by a number of newspapers.

Headlines in the media (11 stories), like “Hepatitis B not as dangerous as AIDS” and “Four members of a single family have AIDS” or “Entire family in grip of HIV,” and “Youth dies of AIDS”, not only selectively highlight individual infections that would be likely to lead to their ostracism, but are based only on the fact that someone has contracted the virus. They do not carry any information on prevention and control of the infection or go into other dimensions that would give a full picture.

Words commonly used in the context of HIV/AIDS to describe its serious nature are ‘bomb, genocide, dangerous disadvantage, *bhayanak trasadi* or fearsome tragedy’. A popular description to convey the horror of the infection is- *til til kar marna* or dying in slow agony. The terminology expresses the view that HIV/AIDS means agonizing death and the infection is as destructive as a bomb. The fear thus evoked against the virus leads to revulsion against those who have it.

### **Comparison of regional language and English press**

The study shows that there were more articles on HIV/AIDS in the Hindi press in Uttar Pradesh as compared to the English press. While this was partly because more Hindi newspapers are published in the state and were therefore included in the study, the Hindi press did in fact have a greater proportion of stories.

A detailed look at the coverage by the Hindi language media reveals that the two major issues it took up were HIV/AIDS awareness campaigns including those by celebrities and, the spread of the epidemic. Fifty of the 126 articles had a neutral tone since most of the stories were based on press conferences or government releases or were event-oriented reports of workshops, training events or camps. Twenty-one stories had a negative tone. For instance, an article on an infected woman described her as a sex worker and a threat to military personnel in Dehradun; another article attributed an increase in STI and HIV/AIDS infections in Bundelkhand to the growing practice of buying brides from other regions who were blamed for spreading the virus.

The rest were positive reports like the stories in *Jansatta Express* titled, “AIDS spreading from cities to rural areas,” and in *Hindustan* titled, “If Pepsi and Coke can reach villages then why not condoms,” “Health administration lax on HIV epidemic,” deals with a host of issues around the epidemic in UP and the government apathy.

In comparison, the English press in UP carried a significantly smaller proportion of news on HIV/AIDS but it had a larger number of individual and community-based stories. Six of the 36 stories were related to spot events. The proportion of stories with a neutral tone was also smaller compared to the Hindi press. However, a majority of the articles were informative and analytical, providing a perspective. They were also better displayed.

For further analysis of both categories of the state’s print media, their differing manner of reportage of the same news event was studied. Almost all the newspapers had reported on the Union Health Minister announcing a reduction in the transmission rates of HIV/AIDS infections in the country. The reports were carried on May 26 and 27. The Hindi dailies reported it as follows:

- The *Swatantra Bharat* carried a long article on the government’s HIV/AIDS figures, the controversy generated by Global Fund’s contradiction and a reaction by the Vishwa Hindu Parishad to the Global Fund’s claim of differing rates of spread of the virus among Hindu and Muslim populations.
- *Amar Ujala* had a slightly smaller story mentioning the government data and its variance from figures given by the Global Fund.



Twenty-one stories had a negative tone. For instance, an article on an infected woman who was described as a sex worker and a threat to military personnel in Dehradun



Nineteen articles in UP discussed care as being a fundamental right of HIV positive people, many of them debunked wrong notions leading to stigma and discrimination faced by positive people

- The *Jansatta Express* only reported the event from the point of view of the VHP press conference that contradicted the Global Fund report. It also had a colour photograph of VHP supremo Ashok Singhal.
- *Aaj* carried three articles on the same day, one on the government mentioning that infection rates have come down and two others that discussed the VHP’s contentions.

The English dailies covered the same news in the following manner:

- *The Pioneer* had a total of three news items on the topic. A long news story on May 26 was followed with an editorial on May 27 and also a separate photograph. The editorial welcomed the news of reduced infections but suggested caution.
- *The Indian Express* had a four-column story on the government announcement on the front page which carried over to an equally long concluding section on page two.
- *The Hindustan Times* provided an editorial on the HIV/AIDS numbers.

While adequate space was provided to the news in both cases, the English newspapers carried additional editorial comments that gave a balanced view. Significantly, the English press did not make any reference to the claims by the VHP which raised a religion-based controversy on the rate of spread of the virus. This was quite unlike the Hindi papers, where all but one gave prominent coverage to the issue.

Regarding the Urdu press, there were three articles on HIV/AIDS in the one month of intensive media survey. The stories dealt with the state health ministers’ statements and a workshop on the growing number of people in India and UP who are affected, including preventive measures. The articles were largely balanced and neutral in tone.

**Media treatment of people living with HIV/AIDS and stigma and discrimination**

If the issue of stigma has been raised directly in any of the stories, it has been done so with concern in most cases. For instance, 19 articles discussed care as being a fundamental right of HIV positive people, many of them debunked wrong notions leading to stigma and discrimination faced by positive people and provided inspiring life histories. Some of these stories are briefly described:

- English Story on how infected people are getting married after putting out matrimonial advertisements and declaring their status.
- English Very short item on how survival rates after contracting the virus have increased globally.
- English Article describing the isolation and discrimination faced by a young infected

English	girl in Madhya Pradesh Story from Karnataka of a positive woman's efforts to help other infected persons by starting an NGO. Full page story with colour photograph, appearing in a supplement.
Hindi	Three separate stories, two on a beauty pageant in Nepal for positive women and another on a similar pageant in Botswana and the role of diet in ensuring healthy lifespan for positive people.
Hindi	Picture of Miss Universe contestants pledging assistance against the epidemic.
Hindi	Story from Africa of the marriage of an infected couple breaking all social barriers.
Hindi	Three separate media report on an NGO asking for treatment of imprisoned Telgi who is HIV Positive.
Hindi	Two articles on a cultural programme organised in Lucknow to raise funds for those taking ARVs and to spread awareness.
Hindi	Article describing spread of the virus in relation to the vulnerability of the migrant population in eastern UP and preventive efforts by Banaras Hindu University.
Hindi	Discusses the vulnerability of women to the epidemic and the steps being taken by networks of positive women in different states.
Hindi	Launch of a Toolkit by Oxfam relating to prevention and care of positive people.
Hindi & English	Several media reports related to a CII workshop in Lucknow of clinical care of HIV/AIDS affected people.

The workshop on clinical care organised by the CII in Lucknow, with assistance from Australian experts, generated extensive coverage. This could be because most regional-level workshops had only conveyed the threat-perception of the epidemic without giving it the human face that this particular workshop on clinical care did. The different ways in which various newspapers covered this event provides an interesting study.

Five of the news reports, in English and Hindi, took a neutral stance by carrying event-based reports that focussed on who spoke at the inauguration and reported the minister's speech. They did not address the issues that were raised. Four positive reports focussed on what had been said, using the workshop as an event to explore the various dimensions of the virus and its spread. Three stories, however, raised the risk to health-care personnel and their safety concerns in a manner that would add to their fear of treating HIV/AIDS affected persons. In its story titled, "AIDS: Paramedics be careful," *The Times of India* said there is a 'high danger zone for those who are in charge of the patients. Even simple accidents cause immediate infection.'" It highlighted the



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A speculative report on ARVs quotes the instance of a man losing his mental balance after taking the drugs and attempting to murder his wife. Again, the news is one sided, as it does not carry any supportive statements by doctors

statement that in a place like UP in which the condition of health care centres such as that of the one in Mohanlalganj in the capital was pathetic, paramedics were exposed to a higher degree of threat from this “dreaded incurable ailment.” Such a report has the effect of prejudicing caregivers against HIV positive persons.

Similarly, a report in the *Dainik Jagran* headlined, “Medical workers being targeted by AIDS,” warns rural health workers that they are in the direct line of fire from AIDS. Instead of reporting in a responsible manner on precautions to be taken, the item advises that hospital workers who are pregnant, “should not even come near such patients.” Such sensational and factually wrong information can dash hopes for non-discriminatory treatment of infected persons.

A report in *The Indian Express* is an interesting juxtaposition of two articles derived from the same workshop. One focussed entirely on specific incidents of stigmatising and discriminatory treatment meted out by health workers to infected persons. It does not balance this coverage by including comments about why such ostracism is wrong. The other article is a speculative report that quotes the instance of a man losing his mental balance after taking the drugs and attempting to murder his wife. Again, the news is one sided, as it does not carry any supportive statements by doctors. Such a serious charge could inhibit people from taking ARVs.

### **Reporting on HIV and gender issues**

The media has exhibited two extreme ways of reporting on HIV positive individuals, women in particular. A feature in *The Indian Express* on Veena Dhari, a positive woman from Karnataka who spoke of overcoming stigma and discrimination and became an inspiration for others was a sensitive story that helps reduce discriminatory reactions by ill-informed public.

Four stories deal with the launch of a media campaign by Mandira Bedi and others on wives being vulnerable to the infection and the need for even married couples to use condoms. An article in *Sahara Samay* titled, “Earning and bringing home AIDS” focusses on the reasons for spread of the epidemic in eastern UP. It brings out the risks faced by women of the region by discussing the high rate of migration for work. The feature clearly establishes the epidemic’s link to poverty and unemployment, analyses the availability of medical help for infected persons and their treatment by family and society.

A similar positive role is played by an article in *Hindustan* titled: “28 persons have died of AIDS in Kushinagar district in the past two and a half years.” Despite the sensational headline, the story is a meaningful investigation into eastern UP’s infection levels with special mention of the vulnerability of women. One news item deals with the health

impact of the National Commission for Women's contention that sex workers can never be officially recognised, while another informs that female condoms will soon be available. An extremely encouraging photograph carried in *Dainik Jagran* was that of celebrity Sharmila Tagore hugging an HIV positive woman.

However, these are exceptions. Only 12 of the 165 news items discussed concerns of women in relation to the virus. Overall, their concern and greater vulnerability to the virus or how they are coping, has not been reflected in the media. In fact, the study found 21 negative stories that could have a devastating impact on infected women.

A section of the Hindi newspapers repeatedly referred in a derogatory manner to women with the virus as 'vish kanyas' or 'poison women'. The media adds to the stigmatisation by alleging these women were infecting 'innocent victims'. A report in the *Swatantra Bharat* titled "The film *Vish Kanya* to raise public awareness on AIDS", is datelined Gorakhpur and praises the movie for alerting people by its story of "a woman afflicted with AIDS who establishes relationships with people and gives them torturous death in return for just a few moments of pleasure." A three-column story in *Dainik Jagran* titled, "*Vish kanyas* are stinging the jawans," claims that infected women are being sent by terrorists to deliberately infect Indian armed forces. The article insists this is not just hearsay but true reportage and that even the union health ministry was involved in countering this threat.

A series of prominently placed three-column articles in *Hindustan* 'exposes' for the sake of public safety, the designs of an infected woman who has been 'found' in Dehradun and was allegedly spreading the epidemic by engaging in prostitution. The article claims that this woman was left loose or '*khulla choda hua*' with the state administration supposedly being in a flap for letting her go. The newspaper raises questions about the effectiveness of the AIDS control programme pointing out that the infected woman, who was brought to the city for treatment by an NGO, was roaming freely. The article dehumanises the woman into a beast who must be kept chained for public safety.

Articles of this nature always conclude that a HIV/AIDS infected woman must be a prostitute. The same article in *Hindustan* has a box item titled, "247 AIDS patients in the mountains and 800 sex workers." It is such ill informed news reporting that leads to public hatred and fear of infected women and even their being stoned to death. The men involved are projected sympathetically, often as victims.

Another article that similarly reflects this mindset is a story in *Hindustan* that alleges the virus is spread in the Bundelkhand area by brides 'bought' from other parts. It



A section of the Hindi newspapers repeatedly referred in a derogatory manner to women with the virus as 'vish kanyas' or 'poison women'. The media adds to the stigmatisation by alleging these women were infecting 'innocent victims'



HIV/AIDS is no longer a theoretical threat for the state. It is a reality among the hundreds and thousands of men and women who are dependent on earning a livelihood away from home

concludes that these women were infected as they had previously been engaged in prostitution and sympathises with those who married them. The story says that the men were paying the price for sins committed by their wives. Moreover, the article is written in a light-hearted tone, further trivialising the issue.

*Hindustan Times* also carried a story titled, “From dance bars to prostitution and HIV,” that links the three subjects. It traces the life of an infected woman and here again, the blame rests on ‘bad’ women like her who have contracted the infection by their sexual activities and are passing it on to the hapless men. Another story in *The Pioneer* headlined, “CTS Colony fighting against AIDS and no civic amenities,” stigmatises a particular ‘basti’ in Kanpur by making the unsupported charge that over 25% of the female population here was infected. It says the women of the basti “have a fascination towards the flesh trade.”

### SUMMARY & CONCLUSION

While there is considerable visibility of HIV/AIDS related issues in the newspapers from Uttar Pradesh, the reporting needs to be focussed on the nature of the epidemic. Improved reporting and coverage of HIV/AIDS issues is imperative. Some specific findings and recommendations that emerge from the study are:

1. HIV/AIDS is no longer a theoretical threat for the state. It is a reality among the hundreds and thousands of men and women who are dependent on earning a livelihood away from home. Vulnerability factors include poverty, lack of economic opportunity and migration to cities like Mumbai and Surat by thousands of young men particularly from eastern UP. These men need to be forewarned about the epidemic and equipped with better ways to protect themselves from unsafe sex. Creating a fear psychosis about HIV/AIDS is not the best way to do this. The media should inform the youth about the different ways to avoid unprotected sexual intercourse and carry positive stories of men who have dealt with this situation. It need not restrict itself to mere reportage of events and the reportage needs to avoid broad generalisations.
2. HIV/AIDS is often seen as being a virulent infection. This is not the case. The mere presence of the virus in the body does not lead to either disability or death. There are long gaps between the time the infection is contracted to when the immune system is significantly suppressed leading to disease manifestation. Thus, there is life after and beyond infection. Individuals who are HIV positive need gestures of hope and communities need information to help them support such individuals. A responsible media can play a positive role in helping individuals and communities support each other by publishing stories of hope and profiles of courage.
3. At present the health system response to HIV/AIDS is inadequate. Despite the funding by the National AIDS Control Organisation and its state units, the HIV/AIDS

programme in UP is limited. Also, key areas like blood safety have not been addressed. Instead of simply publishing reports of events where officials make big promises, it is necessary to monitor the implementation of the government programme. The fact that many districts exist without safe blood banks needs to be highlighted, as also that the state programme is still obsessed with targeted interventions among sex workers or truckers while the whole population is at risk because of overwhelming poverty and lack of economic opportunity.

4. The vulnerability of women is an issue of grave concern. However, the trivialisation of the risk to women as shown by the 'vish kanya' report shows the lack of seriousness. As sexual partners or as trafficked sex-workers, women are vulnerable to HIV as they have no say in the matter.
5. It is necessary for senior journalists and editors to put in place a clear editorial policy and guidelines for reporting on HIV/AIDS. This policy/guideline can be developed in collaboration with those who are working on the issue as well as with groups of HIV positive persons. Reporters and even stringers should be provided with training.

The media plays a critical role in creating public opinion and in spearheading social change. In the case of HIV/AIDS, a clear understanding of the nuances of the subject, a concern for human rights, capacity building among journalists to understand and report on a such a sensitive issue and clear editorial policy will enable the media to play a key role in facilitating a holistic and effective response to the HIV/AIDS epidemic in Uttar Pradesh. ■

**Dr Abhijit Das**

*(Advisor, Sahayog, Lucknow)*



The vulnerability of women is an issue of grave concern. However, the trivialisation of the risk to women as shown by the 'vish kanya' report shows the lack of seriousness



The electronic media has devoted considerable time and space to HIV/AIDS-related stories. Stories often comprise as much as a third of the total news bulletin

## Review of TV News Coverage of HIV/AIDS

Television brings out the human face of HIV/AIDS more graphically than the print media. It also has a greater responsibility to report with sensitivity so that identities of those infected are not revealed and stories, while being factually correct, are not alarmist. A study of the seven national channels, however, reveals that while much time and prominence is being given to HIV-related reports, barring one or two channels, there is too much hype. Many of the stories are sensationalised and a doomsday scenario projected. To study how the electronic media handles this relatively new infection, CMS Media Labs monitored prime time news for a month from May 8 to June 10, 2005. Only *NDTV 24x7* is in English while *DD News* has some English bulletins. The rest comprise Hindi broadcasts.

A total of 16 items were examined in this month-long scan of seven channels, monitored between 7 pm and 11 pm, with another passing mention in one of the channels. Overall, there had been a general lull in political news, particularly after Parliament adjourned on May 13.

**Table 1: Total Number of Television Stories on HIV/AIDS**

Channel	Aaj Tak	DD News	NDTV India	NDTV 24x7	Sahara Samay	Star News	Zee News	Total
HIV/AIDS Stories	0	2	2	6	3	1	2	16

### SALIENT FINDINGS AND ANALYSIS

The electronic media has devoted considerable time and space to HIV/AIDS-related stories. The issue seems to be high in terms of news-priority. Stories often comprise as much as a third of the total news bulletin. Fourteen stories were 1-3 minutes long each. On two occasions *NDTV 24x7* devoted 7-10 minutes. Of the seven channels reviewed, it had the most coverage on the topic.

The stories appeared mostly in the middle or latter part of bulletins. Only one - the controversy over the official HIV/AIDS figures in India and South Africa - appeared in the first half of the bulletin. The majority comprised event-based reportage. Interestingly, the media's initiative was seen mainly in covering 'sensational' individual cases.

A number of stories were personality and celebrity-driven. While the visit of Bill Clinton to India for HIV/AIDS work represented the positive impact of celebrity involvement, there were stories where the personality was of greater significance than the issue. The Zee News story on the release of a music video by Mandira Bedi and Samir Soni, carried no actual information on the virus or the extent of its spread.

The majority of items (8) had a national frame of reference, such as awareness campaigns and the release of new HIV/AIDS figures by the government. Two stories from Kolkata on a campaign by sex-workers were interesting in that though the reporting was state level, the American Anti-prostitution Bill they were protesting against had global ramifications. The stories represented the global connections of the epidemic. The media also portrayed three individual cases describing the spread of HIV/AIDS among the population.

*Aaj Tak* had no coverage on HIV/AIDS during prime time in the monitoring period. There was only a brief mention during Bill Clinton's visit.

### **The 'questioning' role**

The electronic media played a crucial role in questioning authority. When the government released new data on HIV/AIDS, the credibility of the figures was the focus of an entire bulletin on *NDTV 24x7*, called 'The X Factor.' A debate was held between experts. The 10-minute coverage took up one-third of the bulletin. This was also the only news item in the survey where graphics were used to explain the HIV/AIDS situation. However, the graphics and scroll information used alarmist terminology such as, 'Has India lost the AIDS Battle?' and 'The AIDS Time Bomb'.

Some stories brought out hard facts on HIV/AIDS in a direct and forceful manner that was not panic creating. For instance, a short story on *NDTV 24x7* about the visit of Manchester United's football stars to Malawi, though a celebrity story, sent out a strong message that "Ten people die of AIDS every hour in Malawi, a country clearly in the epicentre of the epidemic in Africa." While images of death and disease are not to be evoked lightly, this single line had tremendous impact.

Three spot stories brought out the many dimensions of the epidemic. A *Star News* story about schoolteachers in Kolkata being trained on sexual health and HIV/AIDS highlighted the need to demystify the infection. The subject of youth and HIV/AIDS is also dealt with in an *NDTV* story on a cross-country awareness-raising marathon. The story was followed by a live discussion with two of the boys. This story got a fourth of the time allotted to the bulletin. The youngsters also discussed the importance of removing stigma and discrimination. *Sahara Samay* reported on the unusual use of the Kuchipudi dance form to create awareness on HIV/AIDS.



The electronic media played a crucial role in questioning authority. When the government released new data on HIV/AIDS, the credibility of the figures was the focus of an entire bulletin



The straightforward association of HIV/AIDS with death continues through the entire script. It even ends saying “The very knowledge of having this life-taking virus in one’s body is enough to break down anyone’s courage”

An NDTV 24x7 story on popular serials trying to integrate HIV/AIDS in normal life began with a live discussion. The story carried clips of the TV shows and had a producer saying, “We wanted to do something different, which is to depict a character with HIV who is living well, as a productive member of society.” By holding live discussions on HIV/AIDS related stories even during prime time the channel serves to emphasise the importance of the issue among the top stories.

### ***The “instigating” role***

While the electronic media took some initiative in highlighting the spread of the infection among all sections, on many occasions the manner of reporting led to fear which could further stigmatise and discriminate against those living with HIV/AIDS. Instead of sensationalising incidences of the virus, it could have played a more positive role in taking up issues that were relevant, such as blood safety or the rebuilding of lives.

A DD News story on a family in Ludhiana dealing with infection of the wife and child through blood transfusion, was developed as a crime story. It seemed anxious to paint the doctor involved as the villain, rather than addressing the issue of blood screening or mother to child transmission of the virus. Nor does the story indicate an understanding of the fact that there is life after HIV infection.

Several such stories were reported in a manner likely to scare those affected by the virus. This is particularly evident in the human interest stories where individual cases have been highlighted.

In the Ludhiana story the theme of life versus death is constantly reinforced. The anchor’s introduction says: “The negligence of a doctor who should have been life-giving, led to a woman and her baby getting caught in the coils of this deadly disease.” The opening voiceover again counterpoints the joy of living with the terror of death by HIV/AIDS. “With this blood transfusion the woman received in her veins not just life but also material which brought her death.” This was said when the woman and her child are alive.

The straightforward association of HIV/AIDS with death continues through the entire script. It even ends saying: “The very knowledge of having this life-taking virus in one’s body is enough to break down anyone’s courage...what of that innocent baby who does not even understand its misfortune.”

A similar engagement with death and personal ruin is reflected in a Zee News story from Mumbai about a woman getting infected from a man who then abandons her. “Her eyes once saw dreams of spending a beautiful life with her lover, the

woman....was instead left in the lurch when he gifted her AIDS.” The woman is shown mourning her dead baby.

In the attempt to heighten the dramatic appeal, life and death are constantly juxtaposed. No mention is made of the infected persons fighting back against injustice or how they are coping with life and probably trying to make it productive. In these reports one who has contracted HIV/AIDS may be considered dead. The visuals reinforce this theme. The affected woman is seen shedding tears, holding up her dead infant's clothes.

The infected persons are always referred to as ‘victims’ or ‘patients’ and pity is constantly evoked. In the Zee News Mumbai-based story, the man who infected his partner is described as the one who got away and is ‘roaming free.’ Rather than imparting the message of awareness in a positive manner, this leaves viewers with the fear that there is someone uncontrolled out there spreading the infection.

A moralistic tone is also evident, particularly in the Mumbai story. The infected woman is described as having ‘given up everything’ to be with her lover and was in return rewarded with AIDS. It is only towards the end that viewers discover he is actually her ‘husband.’ There is even a shot of their wedding photo.

Similarly, a story on medical research advancement is marred by the bleeding heart approach. The *Sahara Samay* report on a medical innovation that would benefit the HIV infected begins with the anchor evoking pity for ‘victims’ by quoting from a mournful Hindi song. This approach once again clubs all those who are HIV positive as helpless people at death’s door.

### **IMPLICATIONS: CARRYING THE STORY FORWARD**

Yet these stories are important. If done well, recounting of individual cases provide TV viewers a face to the virus and brings the issue closer to their lives. The stories bring out the spread of the epidemic to the general population, revealing that HIV/AIDS is no longer restricted to certain traditional high-risk groups but is spreading fast among housewives and infants. This is information worth absorbing, even though the vulnerability of women and children is brought out in a negative manner.

The legal rights of those who are affected could have been pursued in the Mumbai story about the HIV positive woman. There is a sound byte from a lawyer but the information is scanty. The availability of safe blood is taken up in the Ludhiana story but in an inadequate manner, and the obviously wrong treatment of a pregnant woman being given blood transfusion due to ‘*khoon ki kami*’ (her anaemic status) is neither questioned nor investigated. The story has other gaps too.



If done well, recounting of individual cases provide TV viewers a face to the virus and brings the issue closer to their lives. The stories bring out the spread of the epidemic to the general population



In most stories the confidentiality of infected persons has been maintained by superimposing a mosaic on the faces. However, identification is possible through the husband/father whose visuals and soundbyte have been freely used

A story on *NDTV India* about Telgi preparing his will could have taken up the issue of the man being kept in solitary confinement. Is it due to his HIV positive status? This investigation could have led to a discussion on the rights of positive people and the stigma and discrimination they face. Nevertheless, the story maintains a neutral tone with no attempt to associate criminal offences with HIV/AIDS. Media reporting on this issue has overall been refreshing as Telgi has not covered up or denied the infection, and neither has the media misrepresented or dramatised the situation.

In most stories the confidentiality of infected persons has been maintained by superimposing a mosaic on the faces. However, in the *DD News* story from Ludhiana, even though the infected woman and child have been masked their identification is possible through the husband/father whose visuals and soundbyte have been freely used. Similarly, the Mumbai story about the woman contracting the infection from her partner, names the woman even though her face is masked. The story does not mention of a pseudonym. Moreover, the 'husband' who infected her is named and shown through photographs, the implication being that one need not have any qualms about violating his privacy rights.

To sum up, the tracking of TV news brings out the fact that though HIV/AIDS has high visibility, the discussion of the issue and visuals related to it must be more enlightened and sensitive. While the media can pat itself for bringing HIV issues into the limelight, it needs to be more supportive of those living with it. ■

**CMS Media Labs**  
*Centre for Media Studies, Delhi*





## Tracking Changes in the HIV/AIDS Epidemic

While statistics are important as they reflect the gravity of the epidemic, the rapidly changing dimensions of HIV/AIDS also needs to be recognised by the media as they have the power to influence and change public opinion. But to do so, the media must be informed of the various aspects of the epidemic.

The second section of the manual comprises articles by eminent journalists and experts on the changing government policy, the different linkages between HIV/AIDS and issues like productivity, gender, stigma and discrimination.

While highlighting the changing dimensions of the epidemic, articles in this section underline the crucial role the media can play in allaying fears and debunking myths.

Although Manipur has not been included in the overall study, since it was one of the first states where HIV/AIDS was detected, it mirrors the changing face of the infection seen in the rest of the country. The first wave of the epidemic in India in the early nineties was among drug users. In Manipur, addiction to injectible drugs facilitated by the easy availability of heroin, made hundreds of young people highly vulnerable as they often shared needles and thus exposed themselves to the infection.

The infection then changed track when it was transmitted to unsuspecting spouses through the sexual route after desperate parents turned to marriage in an effort to wean them off drugs. When pregnant women unknowingly passed it on to their children, the gender dimension of the epidemic was seen.

Ignorance about the modes of transmission has added to the stigma and discrimination against persons infected and affected by HIV/AIDS. Denial of treatment by doctors, familial and societal ostracism has obfuscated the truth that HIV/AIDS is a manageable infection. Disseminating information that a regulated medical regimen supported by love, care and acceptance can build esteem and confidence, helping them to lead healthy lives.

A majority of HIV positive people depend on their jobs for survival. By drawing attention to little known facts about legal rights of persons infected, which include the right to work, the media can reduce stigma and discrimination. ■



While highlighting the changing dimensions of the epidemic, all the articles in this section underline the crucial role the media can play in allaying fears and debunking myths



It was only through the doctor's register, with the word 'AIDS' emblazoned on it, that he first came to know he was infected with the human immunodeficiency virus (HIV)

## Removing the HIV Stigma

This story dates back to Goa in 1989, of how ignorance compounded by wrong laws stigmatised an HIV positive person and put him through the most terrible humiliation and indignity. Dominic D'Souza fought back and became one of the strongest advocates for the rights of people living with HIV/AIDS.

On the morning of February 14, the police knocked on the doors of Dominic's house and asked him to come to the police station. Thinking one of his friends was in trouble, Dominic rushed to the police station only to find himself being taken off to a hospital under police escort. No reason was given for this or the physical and medical tests that he was put through under the watchful eyes of burly policemen. It was only through the doctor's register, with the word 'AIDS' emblazoned on it, that he first came to know he was infected with the human immunodeficiency virus (HIV).

There was no explanation, no counselling, not a word of sympathy or support to assuage his mounting fear and humiliation. But worse was in store. He was taken to a former TB sanatorium and detained for 64 days. Confined to a small, dirty room, he was not allowed to contact his family or friends....not even to let them know where he was. In his own account of those first 24 hours, Dominic said he survived only because he had no knife or gun to take his life.

Over the next couple of days Dominic learnt the blood that he had donated some months ago had tested positive. Instead of informing him, the hospital tipped off the police. The police detained him under the Public Health Act which was then in force in Goa. Under the Act, detention of all HIV positive persons was indefinite, regardless of whether there was any actual risk of HIV transmission to other members of the public. After a legal battle he was allowed to return home.

Dominic's story does not end here. When he tried to return to work, he found that his job had been given to someone else and his employer asked him to resign because other employees would not want to work with a HIV positive person.

Though the mandatory detention of all HIV positive persons was stopped, detention was left to the discretion of health authorities. Dominic died in May 1992 but he laid the foundations for the rights of positive people in Goa. The stigma, humiliation and

discrimination he suffered were documented in the print and electronic media and became the subject of international conferences on HIV/AIDS.

Stigma is in fact a powerful tool of social control. It can be used to marginalise,

### **Bollywood and HIV/AIDS**

Several films have been made on HIV/AIDS, the stigma attached to the infection and on the rights of HIV positive people. The film *Philadelphia*, starring Tom Hanks, was the first mainstream Hollywood film on homosexuality. It highlighted that unsafe sex between men can make them vulnerable to HIV/AIDS. It brought out the tremendous discrimination that existed against those infected in the United States in the nineties. Though a top executive in an American firm, Tom Hanks is isolated and thrown out of his job when the company gets to know he is HIV positive. After a lot of running around, Hanks is able to find a black lawyer who fights his case of discrimination because of the infection. He wins the case and gets a whopping compensation from the company but dies. Tom Hanks was awarded an Oscar for his performance.

In India, which has the second largest number of HIV positive people after South Africa, two films have been made by Bollywood in 2004 and 2005 on HIV and the stigma and discrimination attached to it. While *Phir Milenge*, was made by actress turned producer Revathy and has Shilpa Shetty, Abhishek Bachchan and Salman Khan in lead roles, *My Brother Nikhil* was produced by Sanjay Suri and was written and directed by Onir. Both are excellent feature films which however did not do well at the box office. *My Brother Nikhil* is a takeoff on the case of activist Dominic D'Souza of Goa, who died in 1992. With a star cast of Juhi Chawla, Sanjay Suri, Victor Banerjee, Lillite Dubey and Purab Kohli, the film tells you the story of a man who suddenly falls from grace and is socially ostracised. His parents, friends and colleagues turn their backs on him. Suddenly his whole world collapses. Then he rallies around.

Even though the Indian films did not have box office coffers jingling, they portrayed in a sensitive manner the trauma of a very real, social issue confronting the nation. In that sense they are landmark films. ■



Two films have been made by Bollywood in 2004 and 2005 on HIV and the stigma and discrimination attached to it



When a newspaper reports that a couple who had died of HIV/AIDS in Orissa was not allowed to be cremated for fear that the smoke from the pyre would pollute the entire village, it does an incomplete job. It allows a myth to go unchallenged

exclude and exercise power over individuals who show certain characteristics. It is a mark of shame or discredit on a person or group. In fact stigma precedes discrimination. Discrimination manifests in denial of rights and in difference in the treatment of affected people.

For centuries there was stigma and discrimination around leprosy. Those infected were not allowed to walk the same streets as others. They had to live in isolation, in clusters, called 'lepers colonies.' In fact the word 'leper' was used to describe someone who was shunned/despised. Then came tuberculosis, another highly contagious disease, and the stigma and discrimination persisted but not to the extent as in leprosy. Now with HIV/AIDS, stigma and discrimination are back.

In HIV there is stigma around a range of issues - all related to sex and sexual preferences. In India, there is also some misunderstanding that it is only the poor, the uneducated who are infected. It is only recently that Subroto Roy of the *Sahara* group of industries came out in the media to deny he was HIV positive. Abdul Karim Telgi of the stamp paper scam, however, announced his positive status and sought special treatment and medical assistance in prison. He is probably the first high profile person in India to have gone public about his infection.

The media in particular, both print and electronic, have an important role to play in reporting on HIV/AIDS stories with sensitivity and understanding. Because of stigma and discrimination of those infected with the virus, they have to maintain their confidentiality and mask their identity. They have to dispel the gloom that surrounds the infection. With the new therapy available, HIV positive people can lead long and active lives. Using words like *vish kanyas* or poison women to describe infected women who supposedly engage in prostitution not only stigmatises them as well as sex workers but provokes negative feelings for this class of people. There are newspapers that have used the word '*kaudi*' (leper) to describe an HIV positive person. Some Hindi newspapers in UP warned pregnant doctors and medical personnel against working with HIV positive patients. They reportedly gathered their information from a training workshop for health personnel on treatment and care of HIV/AIDS infected persons.

Lack of accurate information is an important reason for the stigma and discrimination of those infected. The media has not only to be well informed but has to give correct information. There is still a smoke screen around the mode of transmission of the infection. When a newspaper reports that a couple who had died of HIV/AIDS in Orissa was not allowed to be cremated for fear that the smoke from the pyre would pollute the entire village, it does an incomplete job. It allows a myth to

go unchallenged. It has to counter the fears by giving correct information that the virus can only be transmitted through sexual contact, blood transfusion or using an infected needle.

It is equally important to point out that the children of HIV positive people may not be infected and the mother to child transmission rate is 30%.

Stigma can disintegrate families. In Dharwad, Karnataka, auto driver Prakash Salodagi was declared HIV positive when he went with his wife to a local hospital for his recurring bouts of tiredness and weakness. What is worse, the diagnosis was blatantly wrong. His wife and two children promptly left him. Distraught, Prakash attempted to kill himself twice. Later, some friends took him for a retest to the Karnataka Institute of Medical Sciences, Hubli. After three tests, the hospital confirmed he was free of the infection. Armed with this report he went back to the Dharwad hospital and showed it to the doctors. The hospital again tested him and found he was not infected. A third test at the district hospital too confirmed he was free of the infection. But all this was little consolation to Prakash. He had lost everything—wife, children and his peace of mind. “Can the hospital compensate for the trauma that I was put through because of wrong diagnosis,” he asks.

Dominic had felt so angry and hurt when he was dumped by the police in a dirty TB sanatorium. There are umpteen others like Dominic who, unable to take the shock of the HIV positive diagnosis, have jumped off hospital buildings or laid down their lives on the railway tracks. Over three successive days there were three suicides in Mumbai in April 2005. Two suicides were from the fifth floor of the government run J J Hospital and the third of an unemployed sweeper in Mulund, a suburb of Mumbai. One of the men who jumped off J J Hospital was 28 years old and had tested HIV positive two days earlier.

Dr Shalini Bharat of the Tata Institute of Social Sciences, in an interview to a reporter covering the Mumbai suicides said: “We are assuming these suicides are due to stigma but there may be a host of reasons. Sometimes people lack understanding. They are really on the edge and often find there is no one they can turn to. They despair of their socio-economic conditions or job losses, or when the diagnosis is handed to them in a stigmatising way.”

The main issue, she feels, is psycho-social support and hope of treatment. Well-trained counsellors can play a very central role but, she says, there are not enough counsellors for HIV positive people. “We have to give them hope that they can live and perhaps that’s where there is a great need for value neutral advice,” she adds.



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### Conquering Stigma With Love

Dr Suniti Solomon of the YR Gaitonde Centre for AIDS Research and Education, Chennai, identified the first case of HIV in India 18 years ago. Since then, the number of persons affected by HIV has risen dramatically. However, this only strengthened Dr Solomon's resolve not to let numbers overwhelm her efforts to beat the disease by providing better care and support.

But to do this she has often had to think out of the box. Her novel idea of arranging marriages between infected people has been one such inspiration that has given hope and improved the quality of their lives.

But the most touching moment in her 20 years of working with persons infected and affected by HIV/AIDS, came a couple of months ago when one young woman she was treating came to see her with her boy friend.

"The woman introduced her friend as her former class mate. Both were highly educated. She had brought her friend to my clinic because he was unable to understand why she had turned down his proposal of marriage even though she confessed her love for him. I could see both were deeply troubled," said Dr Solomon.

The girl didn't want to keep him in the dark about her status. However, she knew that her friend would never believe her if she told him she was HIV positive. So she brought him to Dr Solomon's clinic and asked the doctor to disclose her infection to ensure that he understood the situation,

"When I told him about her being HIV positive, the young man became silent and then walked out of the room. Seeing that the young woman was devastated, I took her out for a cup of coffee so that she could regain her composure," said Dr Solomon.

After some time when they returned to her room in the clinic, they found the man sitting there with a huge bouquet of roses. Said Dr Solomon: "He said that his love and respect for his girlfriend had gone up because she had not hidden the infection from him. He didn't want to know how she acquired the infection but only how he could take care of her. Both the girl and I started crying and that was one day that I didn't bother to hide the tears rolling down my face. I really wish there would be more such men." ■

**Swapna Majumdar**

Stigma and discrimination seem to multiply alarmingly when the infected person is a woman. Nearly half of all adults living with HIV today are women, up from a third in 1985. A variety of factors render them more vulnerable. They include social norms which deny women sexual health knowledge and practices that prevent them from controlling their bodies and deciding the terms on which they have sex.

HIV positive women have to suffer the traditional taboos of widowhood as well as cope with the indignity heaped on them because of the infection. Most infected women in rural India have had a single partner—their husband—yet they are thrown out of their marital homes after the death of their husbands. The stigma of the HIV positive daughter-in-law and the greed to grab her husband's hard earned savings propels in-laws to drive them out. With the help of NGOs and the Lawyers Collective, many of these women have managed to get back their property and jewellery.

Dulhari (name changed) from Mainpuri in UP was 13 years old when she was married by her family to Ram Singh (not his real name), an interstate taxi driver. When she was 18 years she had her first daughter. Dulhari had never stepped out of her home and village. Then her husband kept falling ill frequently. He was treated for tuberculosis initially. She took him to Agra where he was diagnosed as HIV positive. So she brought him back to Mainpuri and looked after him. Her husband died. Dulhari is HIV positive and so is one of her two daughters. Dulhari is on ARVs and has been able to rebuild her life as a care giver in a home for HIV positive people in north Delhi. Today she has amazing confidence and is often on All India Radio giving 'talks' on HIV/AIDS and related issues.

In Madhya Pradesh, a young married woman decided not to reveal that her mother has been diagnosed as HIV positive. Her infected father had died earlier. The fear of social boycott or discrimination had compelled the family to pass it off as cancer. Now the mother's ailment would also be disclosed as cancer or some other more 'acceptable' illness. "If I tell the truth, there could be a setback to my marriage as well as the career of my younger brother," she said.

What happened to Dominic, Prakash or the others is reality for many people with HIV, whether in India, America or Africa. Ignorance about the way the virus is transmitted, unjustified fear of infection and prejudice against groups of people perceived to be at risk have transcended national boundaries and differences of race and culture. As Julie Hamblin, who specialises in legal and ethical aspects of health policies, puts it: "HIV threatens human rights as profoundly as it threatens public health."



The fear of social boycott or discrimination had compelled the family to pass it off as cancer. Now the mother's ailment would also be disclosed as cancer or some other more 'acceptable' illness

The myth that conflict is inevitable between individual rights and public health has to be dispelled, says Hamblin\*. “Policies and laws that reduce the stigma attached to the HIV infection and build self esteem of people with HIV or at risk of infection can create the environment of mutual trust, support and collaboration that is critical to bringing about and sustaining behaviour change.” ■

**Usha Rai**

\* UNDP report – People Living With HIV: The Law, Ethics and Discrimination

## India's Response to the HIV Epidemic

Chenamma is middle aged. After her husband died of tuberculosis, she remarried. When she became pregnant she visited the government antenatal clinic where, after undergoing prescribed tests, she discovered she was HIV positive. While the immediate cause of her first husband's death was TB, it had become morbid due to his HIV status. The virus had been transmitted to his wife. She had transmitted it to her second husband. Meanwhile, medical efforts were being taken to protect their unborn child from the virus.

Chenamma's story represents the cycle of HIV infection that is entering people's lives. Like her first husband dying of TB without anyone associating it with the HIV virus, no one dies of AIDS (Acquired Immuno Deficiency Syndrome). Because of this disconnect between AIDS and fatalities, there is a controversy over the number of persons who have died of the infection since the first HIV positive person was identified in Chennai in 1986.

Interestingly, the Union Government has set up a committee to determine the total number of persons who have died from HIV/AIDS related causes, as there is a wide variation between the official estimate of 7000 deaths and 160,000 deaths estimated by international agencies. This is not the only controversy that dogs the country's official HIV/AIDS control programme. There are disagreements over its approach and effectiveness.

The official estimate of the total number of HIV positive persons in 2004 is 5.13 million. This indicates a significant fall in the annual increase in the number of infections. However, this data has been questioned widely. It is felt that the Government is underplaying the spread of the epidemic. Interestingly, the official report for 1999-2000 had a candid disclaimer: "The low numbers and the geographic distribution of HIV/AIDS cases show that these numbers do not reflect the true situation in the country and there is under-reporting." Admitting the difficulties in making exact estimates in the Indian context, the report mentions approximate estimates and trends for arriving at the total HIV/AIDS numbers. Ignoring this caveat, the present managers of the HIV prevention programme swear by the figure of 5.13 million HIV positive people.

### LAUNCH OF NATIONAL AIDS CONTROL PROGRAMME

Soon after the first HIV positive person was identified in 1986, the government appointed a committee to deal with the epidemic and the National AIDS Control



The low numbers and the geographic distribution of HIV/AIDS cases show that these numbers do not reflect the true situation in the country and there is under-reporting



Former US president Bill Clinton mingles with the audience at a meeting by National AIDS Control Organisation (NACO) in New Delhi on Thursday.

Programme (NACP) was launched in 1987. In the early years it tried to generate public awareness about the virus, introduced blood screening for safe transfusion and conducted surveillance activities in what were regarded then as epicentres of the epidemic, that is, areas of high commercial sex work. In 1992 the National AIDS Control Organisation (NACO) was set up to develop a national public health programme for prevention and control of HIV/AIDS. The NACP I was launched from 1992-99. The second phase will end in 2006 and preparations are on for drafting the third phase of the programme.

A goal of NACP II was to achieve zero rate of new infections by 2007. In 1999, when this goal was set, the judgment day seemed far away. It was also not realised that the ground work done during NACP I may not be sufficient for the programme to meet such an ambitious goal. At a NACO meeting in 2005, it emerged that this goal was not expected to be achieved. It was also suggested that the goal of zero rate of infection should be interpreted to mean that it should not exceed the then prevailing rate of infection and in any case not allowed to cross 0.9% infection among the total population.

With a budget of over Rs 2,000 crore for five years, the NACP is one of the largest disease control programmes in the country. In addition, the Global Fund to fight AIDS, TB and Malaria has pledged \$240 million; the Bill and Melinda Gates Foundation another \$200 million, and the Clinton Foundation's HIV/AIDS Initiative has partnered with the Confederation of Indian Industries. Seeking to make strategic interventions, these foundations have taken up specific programme areas. On paper the proposed outlay of Rs 1,425 crore seems huge but in actual practice the government allowed NACO to spend only a little more than half of this amount during the five-year period ending in 2002. NACO claims that it fully utilises the allocations.

### **Unions in Sonagachi Negotiate Safe Sex**

In the land of comrades if you put two of them together, they form a union. This has happened in Sonagachi, one of the largest red light areas of Kolkata, West Bengal. While fighting for their professional rights, the commercial sex workers union here has transformed itself into a unique, self-driven community project. It addresses the problems of sex workers' health through peer education and carries out HIV/AIDS awareness campaigns among its members. They have been taught to negotiate the use of condoms with the clients. The use of the rubber sheath is now 80% and the exposure to HIV infection under control. The Sonagachi project covers 60,000 members and has attracted international funding. ■

The NACP is centrally sponsored and implemented through 38 state societies with the mandate of designing programmes according to the needs of each state.

### **NACP'S TRACK RECORD**

During the first phase, the estimated HIV infection rate among adults (15-49 years) was 0.7 per cent. With World Bank support of \$84 million, an attempt was made during this period to develop infrastructure for HIV/AIDS control based upon the contemporary understanding of the epidemic. These efforts resulted in strengthening of the HIV surveillance system by installing 180 sentinel sites. A beginning was made in setting up voluntary counselling and confidential testing centres in medical college hospitals. The HIV/AIDS control programme was linked to control of sexually transmitted diseases and blood banks were modernised. In addition, campaigns for building public awareness about HIV/AIDS were scaled up and condom use promoted.

In reviewing this phase, official documents clearly admit that while the Central Government's commitment was reasonably high, similar state level commitment was lacking. However, Maharashtra, Tamil Nadu and Manipur, where HIV was spreading rapidly, took full advantage of the programme. This was essentially a learning phase in an environment where large sections of people questioned the priority given to HIV prevention. Some even saw a foreign conspiracy in pushing the programme.

Even the sentinel survey could not be conducted across all states, nor was there any emphasis on providing care and support services to HIV positive people. The important lesson learnt was that a centrally driven programme lacked ownership at the state level. It was found that civil society's participation as a stakeholder had not been factored in adequately and this translated into lack of ownership by the communities. Such weaknesses called for drastic changes in the programme design and implementation.

Nevertheless, even the limited campaigns did improve awareness among urban people. When the Behavioral Surveillance Survey (BSS) was carried out across the country in 2000-01, awareness among adults was 76%, reaching 89% in urban areas. Despite the large gaps in the programme, a beginning was made in the modernisation of blood banks and a policy framework drawn up for modern transfusion services. This brought down HIV infections due to transfusion from eight per cent to four per cent.

### **NACP II**

Building on the lessons learnt, NACP II (1999-2006) set out to reduce the growth rate of HIV infections and strengthen the national capacity for responding to the HIV challenge. Specifically, it defined the maintaining of HIV sero-positive levels below five per cent among adults in the six high prevalence states of Andhra Pradesh, Karnataka,



The important lesson learnt was that a centrally driven programme lacked ownership at the state level. Civil society's participation as a stakeholder had not been factored in



Maharashtra, Manipur, Nagaland and Tamil Nadu; below three per cent in the moderate prevalence states of Gujarat, Goa and Pondicherry; and below one per cent in the rest that were categorised as low prevalence.

NACP II was designed to be vastly different from its predecessor. Both international and national experience showed that action needed to be initiated simultaneously on several fronts, from awareness building among the general population, condom promotion, propagation of safe practices among intravenous drug users and commercial sex workers to research and development for a vaccine against HIV.

### Cocktail Therapy

It was a rare coincidence that the country with the largest number of HIV positive people – South Africa – became the venue, in 2000, for announcing that HIV/AIDS was a treatable disease. This raised the hopes of millions of infected people across continents.

Three powerful drugs - Stavudine, Lamivudine and Nevirapine - administered under expert supervision enable HIV infected people who require medical treatment, to lead normal lives. Nevirapine is used for preventing HIV transmission from pregnant mothers to children. The three drugs are known as antiretrovirals (ARVs). They entered the market as branded drugs and the annual expenditure on the drug per person was about \$10,000. This placed the treatment beyond the reach of most people. When generic formulations of these branded versions were introduced, violating patent laws initially, the drug prices dropped dramatically.

Brazil was one of the first developing countries to make available free ARVs. The Indian pharmaceutical major, CIPLA, offered ARVs at \$370 for a year's treatment to organisations and countries supplying free drugs to infected persons. Ranbaxy then came out with an offer of \$275 for a year's treatment. CIPLA came up with another first when it combined the three drugs into one and greatly simplified the drug regimen.

A major development in India's care and support programme for HIV positive persons was the government's announcement in 2003 making ARV therapy available free at government hospitals. The free treatment was available from April 2004 in the six high prevalence states. However, providing treatment has been an uphill task as an adequate supply of drugs and a large number of specially trained doctors are needed to administer ARVs. While NACO is training hundreds of doctors, the Clinton Foundation has also offered to train thousands of doctors. Close supervision is also required of those on ARVs so that they adhere to the treatment. Any failure in following the strict regimen of ARVs could expose them to drug resistant HIV. ■

This approach translated into cost effective interventions. Since 86% of the infections are through sexual transmission, followed by the blood route, emphasis was given to condom use and its multiple benefits. Reduction in sexual partners was also stressed. As a third of all HIV positive people have TB, a link was forged with the government's TB control programme.

Targetted interventions were intensified for sections like sex workers, termed high-risk groups. For the general population, awareness building on risky behaviour was prioritised and Voluntary Counselling and Confidential HIV Testing Centres (VCCTC) set up. The programme strategy was rejigged to decentralise and empower State AIDS Control Societies and involve the NGO sector in a big way. Government departments like the railways, defence and other organised areas of work were encourage to accept ownership of HIV/AIDS programmes.

### THE CHALLENGES

During NACP I the prevalence rate was 0.7 per cent and NACP II was dealing with a prevalence of close to one per cent of the general population. Experts reckon that if HIV infections cross this critical figure, controlling the epidemic would become harder as technically, the country would then face a generalised epidemic compared to one among specific areas. The major concern was that because of India's large adult population of 720 million, of which 280 million were in the most vulnerable age-group of 15-24 years, a mere 0.1 per cent increase in the prevalence rate would catapult the number of HIV positive people by more than half a million. Moreover, the epidemic was moving into the general population and rural areas and becoming concentrated among marginalised sections. One out of four persons reported to be HIV positive was a woman.

The magnitude and diversity of the spread of the HIV virus makes it extremely difficult to control. Experts say in India there is not one single HIV epidemic but a number of distinct epidemics often co-existing within a state, with different vulnerabilities, stages of maturity and impact. For example, though a state may be classified as a low prevalence one, it could have pockets of high HIV prevalence, which makes those living around these areas more vulnerable.

A focus of the programme for the past five years has been raising awareness about STDs and their treatment, as sexual tract infections make a person eight to ten times more vulnerable to HIV. However, only 20% of those infected avail of the free government medical services because of the suspicion that the confidentiality of tests and diagnosis may be breached. Sexually transmitted diseases carry the burden of stigma. The next phase of the programme should plan to cover most of the groups termed high risk.



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There is a huge challenge facing the national programme that plans to work down to the district and lower levels. The efforts made so far in convincing the states' leadership to take up HIV prevention on a priority basis seem ad hoc and inadequate

### Impact of HIV

About 15 years ago the average life expectancy in India was just over 50 years. Compared to this, a country like Botswana had a life expectancy of over 60 years. That situation has now been reversed.

The average life expectancy in India is presently over 60 years and in Botswana it has declined to 30 years. Botswana has experienced a widespread epidemic of HIV/AIDS, particularly among its younger population. HIV reduces the Disease Altered Life Years (DALY) by about 15 years.

To cope with this sudden loss of trained manpower due to the infection, banks and business houses in Botswana and other severely affected countries, introduced strong work-place HIV/AIDS education campaigns for their personnel. ■

HIV treatment can begin only after tests at the VCCTC confirm infection. The key words are 'voluntary' and 'confidentiality' of tests. VCCTCs are being set up right down to the village level. However, the challenge is to make them user-friendly. NACO is planning to give VCCTCs a separate identity. But with the fear and stigma attached to HIV, this may not be a good move.

The national AIDS control programme has created an extensive infrastructure for dealing with the epidemic. Political commitment for HIV/AIDS prevention is reflected in the manifestos of national political parties. Decentralisation of the national programme by delegating more responsibilities to related central ministries and the state societies is another major step in improving implementation. However, the challenge of reaching out to more than half a million villages and to marginalised sections is a daunting one. Perhaps a programme like NACP has not been implemented anywhere on a scale and diversity as in India, and that too in a democratic and federal setting. This shows up as gaps between the vision and concern of NACO and that of the states. Many states, in fact, do not have the requisite capacity for implementing the programme.

In several states considered 'vulnerable' by NACO, the basic health infrastructure is weak and HIV prevention is not a priority. There are seemingly more pressing issues of poverty and health crying for attention. This is a huge challenge facing the national programme that plans to work down to the district and lower levels. The efforts made so far in convincing the states' leadership to take up HIV prevention on a priority basis seem ad hoc and inadequate. This is evident in a matter as simple as heads of state AIDS prevention programmes being appointed without a fixed tenure.

### A, B, C, D Choices

India's approach to HIV/AIDS prevention has been evolving continuously. Within the government there has been no clarity on which approach to follow. The government has wavered on several occasions. One of the earliest strategies was to emphasise that HIV/AIDS could be prevented by practicing one or all four of the choices known as Abstinence, Be faithful (to your sexual partner), consistent Condom use, and Delaying sexual debut.

The government has had mixed views on the way the ABCD approach should be implemented. Most people feel that the method of HIV/AIDS prevention should be left to individuals instead of being decided by AIDS control organisations.

As far as A or Abstinence is concerned, they feel it is not a practical preventive measure even for adolescents engaging in sexual behaviour at an early age who need to know about HIV, STD infections, unwanted pregnancies and the benefits of condom use.

B (be faithful) has been presented by some sections as the most desirable option for adults but others argue that this would lead to moralistic values being associated with the virus. There is no agreement either on the benefits of promoting C (condom use) through the mass media. Those who believe that condom promotion actually encourages casual sex argue that A and B should be aggressively promoted. Conservative religious groups support this view.

Communication campaigns addressed to adolescents and young people also advocate D or Delaying of sexual debut. There is an opinion that this message is too idealistic and enhances the vulnerability of the very young.

In the United States there is a section of people which feels that excessive condom advocacy and the sexually liberated behaviour of the fifties worked against 'family values', that is, fidelity in marriage. On the other hand, the promotion of condoms among sex workers and their clients imparted to it a negative image, as a protective device to be used in casual sex, particularly its commercial transactions.

In India, the condom has been promoted as a family planning device and only recently has it been promoted as protection against STD and HIV. When the National Democratic Alliance government of Atal Bihari Vajpayee was in power, the condom campaign was put on the back burner. The government wanted a balanced projection of A, B, and C strategies, while favouring A and B. The Congress-led government favours promotion of C and the balance has once again shifted. ■





International AIDS prevention observers are keenly watching India's response. While there may be no overt dissent, an undercurrent of difference exists between them and the Government in perception about the HIV/AIDS challenge and the action taken. Experts believe that at this stage, India can change the course of the epidemic. Given her size and economic importance, the outcome here can critically alter the international HIV/AIDS scenario. ■

**S Narendra**

*Former Principal Information Officer to Government of India  
and presently working with NACO on NACP III*

## The Cost of the HIV Epidemic

Considered as a disease of the young, most persons affected by HIV/AIDS are in their prime years and productive period of their lives. In India, almost 90% of people are in the working population, in the 15-49 year age group. It is estimated that about one per cent of this section is infected. The fallout of so many productive persons getting affected is immense on households, businesses, service sectors and the national economy as a whole.

We have seen the devastating impact of HIV on the economies of poor countries in Africa. The GDP of some of these countries have been eroded a great deal. Several studies have estimated that the rate of economic growth has dropped by two to four per cent in sub-Saharan Africa due to the HIV burden. South Africa's GDP is expected to suffer a 17% set back by the beginning of the next decade. These projections are based on HIV's impact on household incomes, burden on state-run health infrastructure, loss of productive workforce, impact on education etc.

There are over 7.5 million infections in Asia and half a million deaths occur each year due to HIV/AIDS related illnesses. The Asian Development Bank estimated that in 2001 alone, economic losses due to HIV/AIDS in Asia were about \$7 billion. It could rise to \$17 billion by 2010 if present trends continue.

However, in India, there have been few studies to quantify the costs of the HIV epidemic on the national economy. Studies done so far are based on various assumptions and projected scenarios. Given the fact that the major route of HIV transmission in India is sexual, it is clear that it affects people in their most productive ages, and that there could be multiple infections within families. Women - who contribute so much to the economic well being of a rural household - are also getting affected in a big way. Almost 50% of those infected are women.

A 1999 study by the Centre for Community Medicine at the All India Institute of Medical Sciences, New Delhi, has put the economic loss due to HIV to one per cent of GDP in India. The study looked at the ten-year period from 1986 to 1995. The cost of HIV infections included the loss of productivity due to sickness and death; productivity loss due to caregivers of those infected; and cost of management of those ill.



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Based on an assumption of 4.5 million cases, the AIIMS study concluded that the estimated annual cost of HIV/AIDS appears to be about one per cent of India's GDP. This comes to about Rs 28,000 crore

The study did not include use of antiretroviral drugs, cost of retraining of new workforce, strengthening of health care system, research and development, communication activities, prevention of vertical transmission, and the intangible cost of pain and suffering to those ill and their families. Based on an assumption of 4.5 million cases, the AIIMS study concluded that the estimated annual cost of HIV/AIDS appears to be about one per cent of India's GDP. This comes to about Rs 28,000 crore.

However, a Harvard School of Public Health study on the economic impact of HIV in India has concluded that it is unlikely that effects on output due to the epidemic at the all India or even at the state level, will be large in the next 15-20 years. There may be sector level effects, particularly in the health sector in the form of growing use of health services and increased public spending on health. HIV/AIDS will substantially lower the well being of affected households and their members. Female members and households belonging to the poor and less educated groups appear to be especially at high risk.

### **IMPACT ON WORKING POPULATION**

An estimated 400 million people are categorised as working population in India and as many as 93% of them work in the informal, unorganised sectors. The prevalence of HIV is growing, but these workers do not have access to information, testing or treatment. They are not covered under any security net. For them, there is hardly any dividing line between workplace and living place and both male and female members work. A large number of migrants work at construction sites in cities like Delhi and Mumbai as well as in projects such as dams and power stations in remote areas. Their sexual behaviour is often risky. But these workers are not covered under any awareness or intervention programmes nor do they have any treatment facilities.

In terms of agriculture, one of the scenarios predicted is that producers may be faced by shortage of labour and switch from cash crops to lower value-added food crops. This would reduce incomes and result in lower foreign exchange and lower tax yields for the government. In all cases where there is an effective fall in labour supply, attempts such as this will be made to economise on labour.

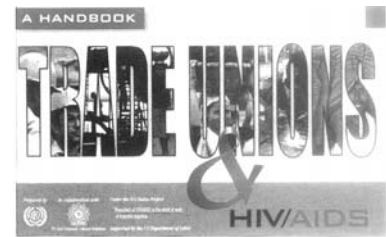
Truckers and transport workers are perhaps the only section of the unorganised sector that is being targeted for awareness and intervention programmes. This could be because they serve large, organised sector companies in oil, cement and other products. Similar efforts need to be made in areas like construction, shipping, urban transport and railways where a large number of casual and contract labour is employed. Here trade unions and sector specific workers' organisations, such as three-wheeler drivers' association or trade unions of railway porters, can play an important role.

Most HIV positive people depend on their jobs for survival. It keeps their households going and helps them buy medicines. A study by the International Labour Organisation (ILO) found that household incomes of HIV positive persons in India are depleted by one third, while the average monthly expenditure on food and treatment increases substantially. As a result, these households have to compromise on their children's education. Nearly 38% of the respondents reported being forced to withdraw children from school.

In view of the gravity of the situation, ILO has begun working with governments, businesses and trade unions to sensitise them on the rights of HIV positive workers. Three key issues identified are non-discrimination, treatment and social security. In collaboration with the National Labour Institute, ILO has developed a training manual for trade unions and has conducted training programmes. It is also working with the Central Board for Workers Education to conduct training courses and integrate HIV/AIDS within the workers' education programme. The National AIDS Control Organisation has also endorsed ILO's Code of Practice for use in workplace interventions throughout India.

### **DISCRIMINATION AT THE WORKPLACE**

In the initial phase, a number of cases of discrimination were reported. Workers were dismissed from their jobs once it was discovered they were HIV positive. This was a



#### **The Case of Badan Singh**

Badan Singh, a head constable in the Border Security Force since 1990, was terminated from service in 1999 after he was found HIV positive during a medical examination. But Singh contended in the Delhi High Court that he was not suffering from any medical problem at the time of his termination.

He appealed that he should either be reinstated or given all retirement benefits as are due to employees with medical disability attributable to service. He also pointed out he would have been due for pension in some years time. But the BSF lawyer argued that if the HIV infection is considered a disability and Singh is given all the benefits, it would "bestow a premium for his sexual deviation or recklessness." The court dismissed this argument, saying "assuming that the petitioner acquired AIDS through extra marital sexual intercourse, it could hardly be presumed that he intended to contract this fatal and stigmatic health disorder, leading immediately to ostracism, so as to become eligible for premature pension." In its final judgment, the court ordered that Singh be given invalid pension with interest from the date of his dismissal. ■



The worst cases of discrimination have been reported from the government sector, particularly the armed forces. Some HIV positive workers challenged their dismissal in the courts. When their numbers started growing, business organisations realised the need for intervention programmes

reflection of the stigma attached to the disease in society. Fearing job loss, many infected persons do not disclose their HIV status to employers. Even big companies did not know how to deal with employees who were infected. They did not have any separate policy nor was the health service equipped to handle HIV positive people. Many companies did not care to take any specific steps, thinking that the problem was not big enough to merit special attention.

Surprisingly, some of the worst cases of discrimination against HIV positive employees have been reported from the government sector, particularly the armed forces.

With growing awareness and cases like that of Badan Singh (See Box), the situation has started changing. Workers, employers, trade unions and governments started becoming aware of the issues involved in HIV at the workplace. Sustained efforts by organisations of HIV positive people, activist lawyers and other civil society groups brought the need for having workplace guidelines and policies into focus. Cases of discrimination at the workplace have been highlighted by the media. Some HIV positive workers challenged their dismissal in the courts. When their numbers started growing, business organisations too sat up and realised the need for intervention programmes.

Still, most efforts are limited to the large, organised corporate sector. The situation in the unorganised sector is quite different.

### **EFFORTS IN ORGANISED SECTOR**

The economic impact of HIV/AIDS on the organised industry can be severe. Besides productive losses, companies have to bear additional expenses of increased medical bills, insurance, ex-gratia in case of death and delays in recruiting skilled employees. There are examples of companies in African countries spending huge sums on such additional expenditures. A major transport company with 11,500 workers in Zimbabwe found that 3,400 of them were HIV positive in 1996. The HIV related costs for the company amounted to over USD 1 million or 20% of its profits.

Replacing skilled, trained professionals is a major problem faced by companies with higher HIV incidences in some African nations. To overcome this problem, a multinational firm in South Africa is said to be hiring three workers for each skilled position to make sure that a replacement is readily available in case an employee dies. It has even been suggested that a pool of unemployed or underemployed workers be kept ready.

The situation in India is not that bad, but widespread appreciation of the problem is still missing. Only large companies are taking note of the epidemic and have begun prevention programmes. Surveys have revealed that their mindsets are still antiquat-

ed. Most businesses do not feel the need to act because the prevalence rate is still low. They also don't feel the need to have written HIV/AIDS policies or run awareness and prevention programmes. It is also a myth that HIV/AIDS is a problem of labour-intensive industries only. Nearly half of India's GDP comes from the service sector that employs millions of young people in vulnerable age groups. These people are mobile and have large disposable incomes. They form a new segment at risk of contracting HIV.

In three large-scale private enterprises in India, absenteeism is projected to double over five years due to HIV/AIDS. The medical expenses of Brihanmumbai Electric Supply and Transport (BEST) Ltd are on the rise because of the cost of providing ARVs to about 130 employees. Similarly, the Railways supports some 500 infected employees.

The Confederation of Indian Industry is encouraging its member companies to adopt non-discriminatory workplace policies and take up advocacy programmes with workers. The guidelines clearly state that it is the responsibility of the management to provide employees with a supportive work environment and ensure non-discrimination; provide a basic code of conduct for all employees towards those infected; and ensure confidentiality. There should be no pre-employment testing for HIV nor should an HIV test be part of the annual medical check-up. Even if found to be HIV positive, the person is to be allowed to continue to in the job unless medical conditions interfere with the work. No employee can refuse to work with an HIV positive colleague. Companies are not to discriminate against any staff member infected by HIV in promotion, training or other privileges.

"Investing in AIDS prevention and care programmes makes excellent business sense," says Tarun Das, chief mentor of CII and managing trustee of the Indian Business Trust for HIV/AIDS. "Such programmes save huge recurring expenses like constant recruitment and training of new staff, increased medical bills, greater insurance premiums and increased management time spent on AIDS-related issues. In the long run they also establish the company as a caring and humane employer," says Das.

Codification of workplace policies is an important step in addressing the problem. For instance, Tata Tea Limited that employs 59,000 workers throughout the country, adopted an HIV policy in 1999. Its highlights are:

**Non discrimination:**

- (1) Employees will not be dismissed on the ground of their HIV status;
- (2) Employees will not be screened for HIV before employment and
- (3) Hiring decisions will not depend on HIV status.



The medical expenses of Brihanmumbai Electric Supply and Transport (BEST) Ltd are on the rise because of the cost of providing ARVs to about 130 employees. Similarly, the Railways supports some 500 infected employees



Newspapers and television are a primary source of information among workers and management. By highlighting issues, the media can create a favourable atmosphere for positive action by companies and trade unions

#### **Confidentially and disclosure:**

- (1) An employee is not required to disclose status;
- (2) If status is disclosed, it cannot be disclosed to others without written consent.

#### **Benefits:**

- (1) Benefits are provided for employees, management, and dependants;
- (2) Benefit packages do not discriminate by HIV status;
- (3) All tea estate workers and dependants have free access to the company health programmes including VCTC (voluntary counseling and testing centres).

#### **Termination:**

- (1) The medical officer of the estate evaluates when an employee is deemed medically incapacitated;
- (2) The employee has the right to appeal against the decision.

The number of companies adopting such policies and taking up awareness and intervention programmes is increasing. Some of these benefits also spill over to other people who interact with the company, such as truckers hired by cement companies, farmers supplying sugarcane to the mills, direct marketing persons working for companies and casual labour hired for specific jobs. Though not on company rolls, such groups often benefit from awareness, counselling and condom programmes run by it.

### **ROLE OF THE MEDIA**

Newspapers and television are a primary source of information among workers and management in both organised and unorganised sectors. By highlighting issues, the media can create a favourable atmosphere for positive action by companies, trade unions, labour departments and workers.

Any discrimination based on workers HIV status is a violation of their basic human rights. Practices like retrenchment, forced testing at the time of appointment and denial of promotions to HIV positive employees need to be covered by the media. They must emphasise that right to health is a basic human right that cannot be denied to workers. Employees have a right to medical care and financial support to the family in case of loss of employment or death related to HIV.

Care should also be taken to protect the confidentiality and identity of workers' involved so as to prevent stigmatisation by co-workers or society. Reporters need to look carefully at HIV workplace policies. They may just be focussing on awareness campaigns, counselling and non-discrimination, while leaving out medical care.

While some companies don't dismiss workers if they are found HIV positive, they have a policy not to employ those found infected at the time of entry. Companies don't take any specific stand on the continuing financial security of a worker if the person is taken seriously ill or dies in harness. Only some workplace policies specifically mention this point. Modicare's policy says:

- (1) HIV/AIDS and related opportunistic infections will be considered like any other disease and the infected person will be entitled to reimbursement for his or her medical bill as per his or her entitlement
- (2) Modicare will consider to sponsor fully or partially the AZT treatment of the employee if s/he is not able to afford the cost of treatment;
- (3) Sponsorship will be done on a case by case basis, with the aim to continue support as long as medically appropriate.

The serious threat of HIV at the workplace can be challenged effectively only when it is considered a matter of right to health of workers. All aspects of HIV/AIDS should be taken care of.

## IMPACT

- **On households:** loss of income due to inability to work, premature death, increased medical expenditure on tests and drugs, impact on children's education, economic loss due to stigma and discrimination.
- **On industry:** higher absenteeism rates, increased medical expenditure, cost of hiring and training new personnel in case of death due to HIV, higher burden of insurance and retirement benefits.
- **On national economy:** additional stress on health infrastructure, higher allocations for HIV, impact on allocations for other diseases, loss of productivity and incomes, drop in savings, depletion of human resources.

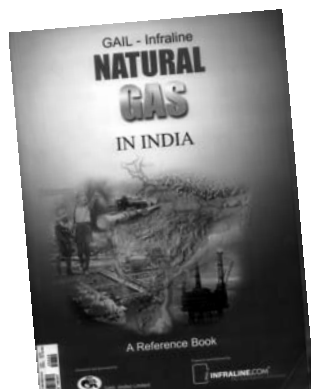
## AGENDA FOR HIV AT WORKPLACE

- **Non-discriminatory workplace policies** for existing employees as well as new recruits needed. No termination or denial of promotions on the basis of HIV status.
- **Confidentiality and disclosure norms** to prevent discrimination and stigma among co-workers and others.
- **Provision of voluntary testing and counselling services** at workplace, as a follow up of awareness and condom promotion campaigns.
- **Provision of antiretroviral therapy** for workers with HIV.
- **Assurance of benefits to affected employees**, no cut-back in benefits, medical coverage and retirement/death benefits. ■

**Dinesh C Sharma**

*Science, Health and Development Journalist*



**RESOURCES:**

Indian Business Trust for HIV/AIDS

Asian Business Coalition on AIDS

International Labour Organization (ILO)

World Economic Forum Global Health Initiative

The Global Business Coalition on HIV/AIDS

Tata Tea's HIV project

[www.indianbusinesstrust.org](http://www.indianbusinesstrust.org)

[www.abcon aids.org](http://www.abcon aids.org)

[www.ilo.org/aids](http://www.ilo.org/aids)

[www.weforum.org/globalhealth](http://www.weforum.org/globalhealth)

[www.businessfightsaids.org](http://www.businessfightsaids.org)

[www.ishima.info](http://www.ishima.info)

## Time for Women to be Seen and Heard

*A doctor and a boy were fishing together. The boy was the doctor's son but the doctor was not the boy's father. Who was the doctor?*

Many people are unable to solve the above riddle because it defies the stereotype. The answer is that the doctor was the boy's mother!

Media reporting from a gender perspective on HIV/AIDS too is more an exception than the rule. There is too much stereotyping in viewing women either as 'victims' or 'transmitters,' as, for example, in their role as sex workers.

This needs to change. Both because gender plays a critical role in prevention, care



### **Gender Inequality is Critical to the HIV/AIDS Epidemic**

The word 'gender' cannot be used interchangeably with the word 'women' or 'sex.' Biological and physiological attributes, such as genitalia and hormones of men and women define their sex. Gender characteristics encompass the whole gamut of socially constructed roles, behaviours, attitudes, beliefs and activities of men and women in a given society.

Gender characteristics greatly influence men and women's access to education, participation in the labour market, division of work within homes and control over productive resources such as property and capital. Sex-defined characteristics are similar across societies but gender-based attributes vary. Equitable or inequitable gender relations can enhance or hamper women's access to prevention, care and treatment of HIV/AIDS.

"Gender inequality is at the heart of the epidemic...we must address power imbalances in every single policy, strategy and programme relating to prevention, treatment and care if we seriously want to tackle this global challenge. It is not simply a matter of justice and fairness. In this case, gender inequality is fatal," says Dr Noeleen Heyzer, Executive Director, UNIFEM. ■



Data from a number of studies suggest that male-to-female transmission during sex is twice as likely to occur as female-to-male transmission

and treatment of HIV/AIDS in men and women and because positive women are survivors, not ‘victims’ and have needs, concerns and desires very similar to sero-negative women.

Leela Banta, President, Manipur People Living with HIV (MNP+), said in 2001, “It is not how long we live that is important but how well we live.” Positive women can live a healthy, fulfilling life. They can work, travel, get married, have children and do almost everything that ‘normal’ women do. If society allows them to be ‘normal.’ This is what the media needs to portray both to reflect the real picture on the ground and to help reduce stigma and discrimination towards positive women.

The media also needs to be aware that women are more vulnerable to HIV both biologically and because of gender inequalities. Data from a number of studies suggest that male-to-female transmission during sex is twice as likely to occur as female-to-male transmission (UNAIDS Report 2004). And what makes women even more vulnerable is their lack of social, economic and political power within their homes and communities. Men and women need appropriate care, prevention and treatment mechanisms. Yet, it is usual for men’s voices and perspectives to dominate in the media; and for stereotypes to be reiterated.

Gender relations affect women more because:

- Most women cannot negotiate safe sex even with their own partners
- Blood transfusions are undertaken often without informed consent
- Most women lack exposure to the media and access to even basic information
- Most women lack the resources to take care of their own needs, and access to even basic health needs

The greater the gender discrimination in societies and lower the position of women, the worse are they affected by HIV. More equitable gender relations and better empowerment of women mitigate the spread of HIV and enable women to cope better.

### ***Women face higher stigma and discrimination***

The downside of all this is that positive women, already a discriminated lot at many levels, face an even higher degree of stigma, shame and marginalisation when their positive status is known.

“My husband, who was also positive, kept me house bound for five years!” says Shobha\* from Chhatisgarh. “He said he was punishing me because it was only after marrying me that he became HIV positive. He said he had gone to other women for years and nothing had happened - till I brought ill-luck upon him.” But Shobha decid-

### Women are Now the Most Affected...

The number of positive women has steadily risen. Initially, positive men vastly outnumbered the women and then their proportion fell. The latest figures are available for December 2003 by when girls and women accounted for half of all people living with HIV; in sub-Saharan Africa, the proportion was 57 %; in India, positive men still outnumber women with a 3:1 ratio but these are official figures. Fear of stigma and discrimination keeps many women from disclosing their status.

According to UNAIDS, young women in developing countries are twice as likely to be infected as men.

But they are also acting as change agents...

Many are coming forward to disclose their status, to mobilise others like them so that they have a stronger, collective voice and the wisdom to influence decisions regarding their economic and social well-being. Women like Kousalya Periaswamy who was told by her husband about his positive status just a few weeks after marriage, have turned their anguish and angst into positive energies. Widowed now, Kousalya braved social disapproval to speak out and encourage other positive women also to come out. The Positive Women's group of South India is her contribution to the cause. It provides space for women to talk about their trauma and live with it through counselling and various other social services.

"It has to be recognised that women are not just infected/affected by HIV; they are agents of change. Their voices must be heard and their leadership invested in," said Kathleen Cravero, Deputy Director of UNAIDS in 2004. ■



"My husband, who was also positive, kept me house bound for five years! He said he was punishing me because it was only after marrying me that he became HIV positive. He said he had gone to other women for years and nothing had happened"

ed to fight. She managed to run away from her uncaring husband and now works as a daily wager - sweeping the floors in a private office in Bhopal. "I am happy because I am free," she says. "I live with another infected woman and we support each other. At times I'm scared that if she becomes ill and dies, I will have no one. Yet, this is so even for women who lose their husbands. Maybe I too will die quickly. Or maybe I will live and continue to give support to another positive woman."

Anita\*, thrown out by her in-laws after the death of her husband, lives with her elderly parents in Maharashtra. "My in-laws gave me nothing - no money, no share in the land for my four-year-old son and no jewellery for my two-year-old daughter," she says. "I see



Reports about positive women being ostracised, being subjected to physical and mental violence, turned out from homes, being disinherited and even beaten to death abound. What are missing are media stories about how infected and affected women are coping with this epidemic

myself as lucky because both my children are HIV negative. I look after my parents now as both my brothers broke all ties with us on learning of my status. My parents will look after my children if I die earlier,” she says matter-of-factly. Anita has told her children about her positive status and finds that they are empathetic. “They will be more sensitive human beings than their uncles (her brothers),” she says. “That will be my contribution to society.”

Reports about positive women being ostracised, subjected to physical and mental violence, turned out from homes, disinherited and even beaten to death abound. In one instance, people burnt down the homes of sex workers in their neighbourhood, fearing their presence would spread HIV infection in their area! Yet, what are missing are media stories about how infected and affected women are coping with this epidemic, and bringing about behavioural, social or economic change.

#### ***‘Low-risk’ women put to high risk***

Shobha and Anita’s experience point to another chilling fact. ‘Low-risk’ women are at threat because their only fault is that they get married! Women are in no position to ascertain whether their potential partners’ are positive or not.

#### **Changing the Focus of ‘Lifestyle’ Stories**

There are umpteen ‘lifestyle’ stories about wealthy professionals and industrialists buying the services of ‘high class’ call girls; and stories of ‘bored’ housewives taking to this ‘work’ for ‘recreation.’ What does not get written about is that unsafe sex makes this a highly risky behaviour; that education and money are no longer a bar from getting infected; that children often become unintended victims of this unsafe sex.

Current public debate focusses on the morals of extra-marital sexual relationships. The media can inject gender issues into this debate: whether educated and wealthy women are informed about safe sex and able to negotiate it; whether educated and wealthy men are responsible enough to have safe sex with their wives and/or with ‘other’ women; and whether a society that sees an upward trend in this kind of ‘promiscuous’ behaviour can uphold values such as dignity, respect, responsibility and hope if it does not also deal with unsafe sex. Such debates on sexual behaviour in society can help decrease the stigma and discrimination against positive women. ■

### Missing the HIV Link

Crime reporters never talk of the HIV risk when they report on rape. Reports only touch aspects such as mental/physical trauma and economic depravity. Deteriorating law and order situations raise the threat of HIV infection in a city and the health agencies should wake up to this fact.

War/conflict correspondents too ignore stories on HIV. Journalists often receive specialised training in war reporting but this does not include exposure to the risks faced by innocent women. Since the training is often undertaken by the Army, this is perhaps quite understandable! ■

“Two months before my marriage, a relative told my father that I would face problems if I married Ajay,” says Vinita\*. “My father dismissed the remark. He was sure his decision was right as Ajay’s family was well off and Ajay seemed to be successful marketing executive in a shoe firm. We learnt about his positive status three months after marriage and my father has refused to take me back. I do all the housework and look after our year-old child. My husband is too busy travelling and comes to me only when he wants sex. He started wearing a condom after I got pregnant but has never taken me for any test and I’m too scared to undertake it myself. This unknown status is better than knowing that I am positive and being rejected by my larger family! Even if it’s only a matter of time, I’d rather wait than know the truth.”

Vinita’s story points to the new threat that extended families in India face today. How good are our traditional care and support structures? How much do they need to change with the times? Women’s voices are needed to identify gaps, articulate the needs and show the direction of change. The media would do well to pick these up as new ‘stories.’

Married women, cutting across class, are today one of the highest risk groups in India and South Asia even as the National AIDS Control Organisation (NACO), still sees the conventional high-risk groups as sex workers, homosexuals, drug addicts, truck drivers and migrants. Yet, its own 2003 statistics show that more than one per cent of women accessing antenatal services in public health institutions are testing sero-positive. The YR Gaitonde Centre for AIDS Research and Education in Chennai, for instance, has been treating wealthy businessmen’s children who are HIV positive.

Concealment of information regarding one’s HIV status at the time of marriage is a form of violence against women. Another form of violence overlooked by the media is that forced sex is often used as a weapon within homes and communities times of peace and especially during conflict situations. No specific studies have been carried out on



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this cause of the spread of the epidemic. It is reported that the widespread rape of women by soldiers in Uganda in 1986 was a major factor in the spread of HIV in the northern part of the country. The soldiers reportedly had a one in three rate of infection at the time. Forced sex – incest, rape and even marital rape are topics that need to come out of the closet to mitigate the epidemic and remove the stigma and discrimination encountered by women who have faced this violence.

Monika\*, raped by her father's brother from the time she was six-years-old, learnt about her HIV positive status at 16. Fighting back, she got in touch with a counselling centre and has initiated a small network of positive women. "We spread awareness about violence against women and HIV by word of mouth," she says. "It is still very difficult to come out in the open and talk about this."

### ***Vulnerability to HIV/AIDS – A health issue for women***

"A gender perspective is essential in our evaluation of conditions to HIV vulnerability," says Mariamma, an activist working with positive women in Andhra Pradesh. Reproductive tract infections (RTIs) - often the result of poor living conditions, malnutrition and the resultant anaemia - and sexually transmitted diseases (STDs) make women more vulnerable to getting HIV infection. Positive women tend to develop frequent gynaecological problems, cervical cancer and more pregnancy-related complications.

An overwhelming number of women in backward, rural areas and in poor urban slums often suffer from STDs unknowingly because they may not have any outward symptom or they consider some of the symptoms 'normal.' Several micro-level surveys have found that white discharges because of STDs, pelvic inflammatory diseases and cervicitis is so common that up to 80% of the women think of as quite normal and not requiring treatment!

Many women also do not want to talk about their problem for fear of stigma and discrimination - that their husbands will blame them for the diseases and beat them up; or take another woman or even go to a sex worker.

Lack of disaggregated data on women's reproductive health makes it difficult to estimate the potential of HIV infection. Or, when government doctors do not take the responsibility of sharing information and explaining the virus to women in particular, it leads to the spread of infection.

The media can effectively break the gender barrier to raise an informed debate on the needs, concerns and desires of women - along with those of men. The focus of stories can be on women having reproductive and sexual rights. By placing low priority on women's health, policy makers are fuelling the HIV epidemic. This lacuna is being

addressed by the recent Reproductive and Child Health round II and III programme policy frameworks that talk about strengthening RTI/STD services to improve access for vulnerable groups like women and young girls; as also linking it up with the Revised National Tuberculosis Control Programme. These are fertile grounds for media stories to see who is really being reached, where and how much difference these policy frameworks are making in the lives of infected and affected women and girls. As also, how much of the focus is just on treatment and how much also on care and support which are integral to proper treatment.

It is not only in the health sector that women's voices need to be heard and responded to. There is a need to talk to women in other HIV/AIDS-related arenas too – how many women, as compared to men, know that condom prevents infection? How many women - married, unmarried, housewives, working women or sex workers are aware of their bodies? The questions are endless but the bottomline is the same. Girls and women need to come to the fore and be the focus of policy makers, civil society organisations and relevant professionals like doctors, psychiatrists, teachers and academics, so that society can hear what women have to say, what they experience and what they need.

### **Gender and HIV/AIDS – A Development Issue**

Modification of risky behaviour can, theoretically, check the spread of the the HIV virus. This change, however, is influenced by socio-economic and political factors that are beyond an individual's control where gender relations are concerned.

Undernourished, ill and unemployed women are at greater risk of getting infected. Lack of enough women doctors and women teachers hamper women's access to health care and education. Women are also scared of telling their spouses about STDs or RTIs and so cannot avail timely and correct treatment for these.

Media stories can link HIV prevention or spread to women's development. Stories that reflect politics, economics, business, lifestyle, entertainment and development have the potential for integrating the HIV factor.

For example, what are the effects of HIV infection on women workers, especially in the informal sector? How can women care givers be valued for their contribution to the national economy? Which age group of women are being infected more and what does that say for their work life and the national income? Or that Self Help Groups in Karnataka, Orissa and Manipur are taking up projects tha would provide income, care and support to positive women and to widows of positive men. The media can act as the catalyst by flagging such issues. ■



Women - especially an overwhelming number of them in backward, rural areas and in poor urban slums - often suffer from STDs unknowingly because they may not have any outward symptoms or they consider such symptoms 'normal'



The questions are endless but the bottomline is the same. Girls and women need to come to the fore, need to be the focus of policy makers, civil society organisations as well as of relevant professionals

### **Care givers: the double burden**

Besides being the majority of those infected, women and girls are bearing the brunt of the epidemic in other ways too now: as mothers, wives, sisters, grandmothers, daughters and even friends, they increasingly carry the physical and emotional responsibility of tending to loved ones who are infected. These women are coming forward regardless of the resources they may have and giving care under extremely adverse circumstances because there is no alternative.

What is worse, though they may not be sero-positive, even as care givers they face stigma and discrimination. When Vinita, a school teacher in Ahmedabad, shared her husband's positive status with her extended family, her husband's two brothers, living separately, stopped all interactions with her. "I had not contracted the infection. Thank God we came to know about it before I returned from the US where I had gone for a study course. I shared this 'secret' because I thought the family was really close and I need support," she says. "They still talk to my husband though only when there is a real need. I'm completely ignored - as if it is all my fault and had I not gone for the course my husband would not have 'strayed' and been infected!"

Vinita has decided to stay with her husband because she still cares for him. After all, he did share with her his 'secret'. She is grateful for that. If the media could do stories on other such women it would help to spread awareness on one of the most sensitive and complex issues in HIV/AIDS - the need for confidentiality and for notifying the partner of one's status. Discussions on AIDS-India e-group, for instance, have focussed on this issue. In Mumbai, Jaikishan's\* mother now sleeps on the Mumbai pavement because she has had to leave her village to look after her infected son. Maya -ma, as she is called in her village, knows she will never return to her own home. Close to 60 years, she says the village will not accept her after she has 'touched' her infected son. She is clad in her only saree - so faded that it is difficult to identify its original colours. "My life has also faded away," she responds. "In more ways than one. I cannot even die where I was born...."

Maya-ma's role of a care giver needs to be recognised and supported by government services. These are 'stories' that give the media an opportunity to put care givers on the radar of policy makers - these women need special food rations, medical aid, counselling and economic support among other things.

The care provided by these women, including the rising number of nursing professionals, should be recognised and supported. In Orissa, for instance, traditional birth attendants (TBAs) or dais, have been trained by an NGO, in collaboration with the district authority, to identify STDs and RTIs, counsel women and take them for treatment.

Information on HIV, testing and counselling are the next step. Care and support services, including individual and family counselling, are just as important as medical treatment and the media can raise a public and policy-level debate on this critical issue. Care givers, for instance, can bring their experience to decision-making, to shape the kinds of care and support services needed at the village, block, district or state level.

### ***Is science really neutral?***

A major question in HIV prevention is how gender responsive is scientific research and treatment? For instance, it took the medical fraternity some time and a great deal of evidence to accept the idea that HIV was a threat to women (UNAIDS Report 2004)! The proportion of infected women has steadily grown worldwide and this is a dangerous trend requiring scientific solutions as much as socio-economic and political changes.

“We oppose trials on pregnant women with HIV/AIDS if treatment is withdrawn immediately after they have given birth,” Patricia Monica Perez of the International Community of Women Living with HIV/AIDS (ICW) had once said. The discrimination continues in other ways. For instance, there is hardly any research on traditional and other affordable and accessible alternatives to breastfeeding. The focus is on promoting commercial formulae. Similarly, new scientific developments like the female condom and vaginal microbicide products, which are women controlled barriers to HIV infection, have taken a long time to come and are still not widely accessible.

How do the medicines and vaccines impact women's bodies? What are their adverse effects on menstruation and fertility and how can these be mitigated? What about the effects of the virus on women's mental health and well-being? The media's eye on these 'hidden' imperatives would goad the scientific community to focus more on women's needs.

**Aditi Kapoor**

Regional Media Coordinator, South Asia Office, Oxfam (India)

\* Name changed to protect identity

### **Resources**

[www.genderandaids.org](http://www.genderandaids.org)

[www.genderandaids.org/modules.php?name=News&new\\_topic=21](http://www.genderandaids.org/modules.php?name=News&new_topic=21) (for media toolkit)

[www.itrainonline.org/itrainonline/mmtk/mmtk\\_hivaids\\_additional\\_resources.doc](http://www.itrainonline.org/itrainonline/mmtk/mmtk_hivaids_additional_resources.doc)

[www.eldis.org](http://www.eldis.org)

[www.unaids.org](http://www.unaids.org)

[www.unifem.undp.org](http://www.unifem.undp.org)

[http://www.gnpplus.net/gipa\\_in\\_action.html](http://www.gnpplus.net/gipa_in_action.html)

<http://health.groups.yahoo.com/group/AIDS-INDIA/>



Vinita has decided to stay with her husband because she still cares for him. After all, he did share with her his 'secret' on his own. If the media could do stories on more such 'Vinitas', it could spread awareness on one of the most sensitive issues in HIV/AIDS – the need for confidentiality



In Manipur the first wave of the epidemic was among drug users. In the second phase it was transmitted to unsuspecting spouses. From 1995 the spread of the epidemic was more through the sexual route. From 1997 the mother to child transmission of the virus began

## Finding the Way Out of the Needle Maze

The easy availability of heroin in the tiny North Eastern state of Manipur in the early eighties led to hundreds of young people getting addicted to injectible drugs. As they punctured their veins to get a 'high,' several of them sharing the same needle, they exposed themselves to the HIV infection which was still at a nascent stage in the country.

Desperate to get them off drugs, parents pleaded with the jail authorities to take them in and detoxify them. In the social turmoil that the state went through, jails filled with injectible drug users, desperate parents and social workers tied up drug users to electric pole and thrashed them to discourage them from drugs, faith healers in rehabilitation centres also chained them as they chanted their voodoo and the white powder was seized at the border and burnt publicly. But the social sanctions and the hardline 'spoil the rod and spare the child' methods of treatment did not have the desired effect.

It was in 1989 that the first samples of blood of drug users were collected and sent to Pune for testing. In February 1990, the government officially announced 960 cases of HIV/AIDS in Manipur. Close to 50% of the high risk groups had tested positive.

The first wave of the epidemic in the early nineties was among drug users. In the second phase it was transmitted to unsuspecting spouses. From 1995 the spread of the epidemic was more through the sexual route. From 1997 the mother to child transmission of the virus had begun, says Mr Abhiram Mongjam, state coordinator for Population Foundation of India's Global Fund Project on HIV/AIDS.

Mr Mongjam, who was earlier with the Manipur AIDS Control Society, says "desperate to get their sons off drugs, parents turned to marriage as a panacea. But in the process they infected the simple village brides. Many sold off their wife's saris and gold trinkets so that they could continue to buy drugs. Abused and infected many of the girls returned to their parents. The rejection by their spouses enhanced the drug users dependence on drugs.

It was only in October 1996 that Manipur adopted an AIDS policy and the post of district AIDS officer was created. In 1998 the first targetted intervention of injectible drug users and commercial sex workers was initiated by the Manipur State AIDS Control Society.

In June 2005 of the 126036 blood samples tested for HIV, 20297 were positive. Of this number 3917 were women and 3466 were AIDS cases. In fact despite all the interventions the infection rate is a staggering 16% in the high risk groups, which means of every 100 in Manipur, 16 are infected. Among pregnant women, the rate of infection is 1.6%. The reporting of deaths is poor in the State because terminally ill people prefer to come. So the 492 deaths reported are largely from hospital records.

Though in some rehabilitation centres, drug users are still kept in chains for better control and treatment, very clearly HIV infections among drug users in Manipur is coming down. In 1997, close to 77% of the injectible drug users were HIV positive. In 2004 just 21% of the injectible drug users were HIV positive.

Even though the use of drugs continues, sharing of needles has reduced drastically. Because of the intervention of NACO and other groups, health awareness has increased among them. Today if there is an abcess, the drug user does not hesitate to visit a doctor. Since heroin is no longer that easily available and is very expensive, tablets like spasmo proxivon which are non-injectible are being powdered, diluted in water and injected. Peddling of drugs is still lucrative business and in 2003 a former finance minister of the state was caught red handed in a Guwahati hotel.

HIV widows groups have been formed and through the support of UNICEF, women and children are getting treated. The official free supply of ARVs is just 500. Some 1800 people are on the waiting list for ARVs. But several doctors are providing ARVs for those who can afford to pay for it. ■



Even though the use of drugs continues, sharing of needles has reduced. Because of the intervention of NACO and other groups, health awareness has increased. Today if there is an abcess, the drug user does not hesitate to visit a doctor

**Usha Rai**



There are umpteen children like him in Punjab who are HIV positive. Yet people in rural areas in particular are not willing to accept the reality of HIV/AIDS and refuse to take even their children to the doctor for tests

## Children Show the Way

Surinder Singh of a village in Fatehgarh Sahib, Punjab, had not imagined that his one-and-a-half-year old child would be born with a virus called HIV with which he would have to live for the rest of his life. The tragedy struck the family when Surinder took his pregnant wife to a doctor in Ludhiana who told him that she urgently required blood transfusion. Surinder quickly arranged four donors and the blood was given to her without any checks. The result - she contracted the HIV virus.

Surinder's baby is a happy child, oblivious of his parents' sorrow. He is HIV positive - the result of a mother-to-child transmission (MTCT) of the virus. MTCT has an estimated 30% chance of infecting a new-born. No one in the village knows that the two are infected. Surinder's grandfather has been to Kerala in search of an ayurvedic drug and he now plans to go to Nanded in Maharashtra in pursuit of another "miracle cure."

There are umpteen children like him in Punjab who are HIV positive. Yet people in rural areas in particular are not willing to accept the reality of HIV/AIDS and refuse to take even their children to the doctor for tests.

After losing both parents to the virus, Sonu, (name changed) a student of standard three in a village in Ropar district, is being brought up by his uncle, Jassi Motta. But the family is poor and it is not clear how long Sonu will get this support. "Orphaned children whose parents had HIV/AIDS should get assistance from the government till they are 18 years," suggests Manmohan Sharma of the Voluntary Health Association of Punjab.

In Ropar and Rajpura districts, ignorance about HIV/AIDS has resulted in children continuing in school after the death of their parents. The children are not ostracised here. "The old value system of joint families is sustaining those who are HIV positive, including children. But we do not know how long this will continue," says Sharma.

In Iruakalkada village in Koppal district of Karnataka, a group of children are busy enacting plays on the treatment meted out to HIV positive people by family members, the community, schools and the medical fraternity. These children, some of whom are

HIV positive, have been brought together for a consultation on HIV/AIDS by the non-government organisation Samuha-Samraksha with the help of Plan International. Their knowledge levels are high, as Samuha has a school education programme that has succeeded in creating awareness about HIV/AIDS.

The children are vocal in discussing the role of the media in perpetuating stigma and discrimination. Ningamma who was involved in a filmmaking project last year called, *Awareness for Life*, sounds like an adult when she says, “The media is only after sensational stories. They are not interested in highlighting positive stories of care and support.”

When Samuha started work in Koppal district of Karnataka in the nineties, there was little awareness on HIV/AIDS. A rural HIV/AIDS clinic was set up in Kushtagi village with the support of Karnataka State AIDS Prevention Society and work started on a model offering a continuum of care and support. “Our effort was to build the entire community as a resource. We were always fighting off the media in the early days,” recalls Sanghamitra lyengar, project director, Samuha-Samraksha.



### Awareness for Life

*Awareness for Life* is the story of a group of young children who came together to make a film on HIV/AIDS. Among them were two infected children and many HIV-affected children. The youngsters learnt how to do script writing, camera work and research. As they eat, sleep and work together, they realise it is this spirit of camaraderie which has taken them beyond stigma and discrimination. The film captures this transition beautifully.

Ningamma says, “The film is a powerful way of narrating the reality of HIV/AIDS. The project also proved to be a novel method of learning and self-discovery as we had not realised that children with HIV/AIDS were being treated differently. One girl from my village who had HIV/AIDS had been taken out of the school where she studied. I screened the film we had made in the community and the result is she has been taken back by the school.”

The film, which is part of a children’s video project called: ‘*Children have Something to Say*’, changed the life of Jagdish, another boy who was involved in making it. “When we worked on the documentary, we came to know a lot about stigma and discrimination,” he says. Says Shyamala, another girl sensitised to the issue, “We do not know whom we will marry or where we will get married. All this knowledge is very useful.”



The Kushtagi clinic caters to 157 HIV positive children. Samuha's awareness programmes, including candlelight memorials, have helped to remove the stigma of HIV/AIDS as a killer disease

The Kushtagi clinic caters to 157 HIV positive children. Samuha's awareness programmes, including candlelight memorials, have helped to remove the stigma of HIV/AIDS as a killer disease. Many people now know that it is a chronic, manageable illness. The stories about people living with HIV/AIDS are no longer sensational, says Iyengar. "Yes, the media still loves horror stories of stigma and discrimination but it has also played a supportive role. One reason for the change is that HIV/AIDS is no longer viewed as a foreign invasion. Everyone knows someone who has been affected by it."

Her organisation brings out a newsletter featuring stories of care and support to encourage better media reportage on HIV/AIDS issues. It reported on youth groups in a village getting together to reinstate a HIV positive person who was thrown out of job and on people's movements for procuring ARVs and making it available to those who cannot afford it. Iyengar believes that such stories of hope encourage more people to offer care and support to those with the infection. She also feels the media could identify and examine factors like easy access to blue films in rural areas in particular and its impact in encouraging young people to experiment with sex in risky ways. Samuha, for instance, has awareness programmes in the high prevalence Koppal district where it conducts slide shows and interactive sessions in local theatres.

The media impact on people is clear at another children's group in Maharajganj, a district in Uttar Pradesh bordering Nepal from where trafficking is very high. Here, a group of children enthusiastically analyse the positive impact of the Hindi film *Phir Milenge* that captures the reality of HIV/AIDS in daily life and society's attitude towards it. "I like the scene in which the heroine, Shilpa Shetty, accepts the reality of HIV/AIDS in her life," says Jawahar Kumar, a member of Babu Bahini Manch, a children's forum for expression, advocacy and action.

Through the Manch, the children take up a range of social issues, including HIV/AIDS. They want to organise special screenings of *Phir Milenge* in their community. "The press only reports incidents and events. It does not report positive stories," says Ameena, a member of the Manch. Cases of stigma and discrimination are etched in their memory. They recall instances of family members ill-treating infected people. There was a boy in Bijmanganj village whose mother was infected. Her family drove her away from home and a voluntary organisation helped her obtain domestic work. The boy was taken away by his relatives after his mother died.

The children discuss how the positive projection by the media can help dispel myths and reduce the burden of stigma and discrimination. They refer to the positive influence

of the TV series 'Vijay Jasoos,' where the central character is HIV positive and helps others cope with the infection.

Worldwide there are 2 million to 2.6 million children below 15 years who are infected and struggling for survival without the support of parents or guardians. Not only do these children lose the security and safety of their immediate families, but they frequently end up taking on adult responsibilities. They provide care for dying patients, siblings and earn money for basic necessities. Often, they are forced to give up school, have less access to health care, and become vulnerable to malnutrition.

In India, there has been no real study on the impact of HIV/AIDS on children. As per NACO's December 2004 data 1,20,000 children below 15 years are infected by the HIV virus. There is no data on children affected by AIDS. But Karnataka, Punjab and Uttar Pradesh, where the media scan was done, report an increase in the number of HIV/AIDS orphans. Moreover, because of the increasing number of HIV/AIDS patients in the three states, the number of children getting infected is very high. The mother-to-child transmission is as high as 30 % but the government does not have a youth-friendly awareness and prevention programme in place.

While children infected and affected by HIV/AIDS are being taken care of by the community in Punjab, this is more because of the ignorance about the infection than an empathetic response. Simultaneously, there are several myths about HIV/AIDS, especially about it being a "killer disease." This results in people hiding the infection.

Even in Karnataka where awareness is very high, cases of stigma and discrimination come out as sensational media reports. Availability of medicines is another concern. In Karnataka, Samuha has established free seva clinics where people are counselled, diagnosed and given free treatment. To encourage people to come to the clinics without fear of stigma and discrimination, free general check-up is offered.

Samuha runs a chain of women's clinics which deal with all health complaints, including HIV/AIDS and reproductive tract infections. The programme, called *Namma Arogya*, has heightened awareness and increased access, including bringing in infected children.

In Punjab, the only super-speciality hospital for HIV/AIDS is the Post-Graduate Institute for Medical Research, Chandigarh, which also has a children's wing. However, the pressure on the Institute is high and people have to wait for weeks to get attention. Though medicines are free, they are not easily accessible.



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### Memory Books Link Children Orphaned by AIDS to Their Past

“My favourite memories of you go back to the day when you were born, February 20, 1990. This day has become my most precious memory of you. When you came into this world, you were such a nice and lovable baby, admired by all,” says Christine Akuga to her daughter Evelyn Akoth.

Although Christine died of HIV/AIDS related causes, her daughter Evelyn has received more than a few special memories from her mom. Written in English, the Memory Book is a powerful insight into the family life of this 10-year-old girl who, luckily, has not contracted the HIV virus from her parents. The pages, curled and crisp due to thick and heavy pressure writing, tell stories about Evelyn’s mother, father and grandparents.

A great deal of space is dedicated to the mother’s health once she tested positive and to the uneasy relationship she had with her husband’s second wife—her daughter’s step-mother. “This Memory Book was quite revealing for Christine’s parents as well. As they read through it, they learnt many things they were not aware of,” explains Beatrice Muwa, Health Coordinator for Plan in the Ugandan district of Tororo.

The idea of writing a Memory Book comes from terminally ill patients in the United Kingdom. In Uganda, the National Community of Women Living with HIV/AIDS (NACWOLA) began to promote this approach in 1998, and has since encouraged hundreds of women to pass on their family history this way to their children.

NACWOLA came into existence as a result of HIV infected mothers finding it difficult to communicate to their children about their ill health:

“Secrecy wears you down fast,” explains Beatrice Were, Programme Coordinator for NACWOLA as she recalls the moment she disclosed her HIV status to her children. “I was relieved to be able to share my condition with them. In my experience what hurts a child the most is to find out later that you have kept crucial information away from them. But after the sero status is disclosed to children, it is important to involve them in all decisions that will affect them.”

The development of child-friendly IEC material will help communicate issues concerning HIV/AIDS to vulnerable children and adolescents. It can also be used by NGOs to generate awareness about HIV/AIDS while working with people who cannot read or write.

### **Impact of HIV/AIDS on children**

1. Uncertainty about the future
2. Gender difference impacts girl child
3. Vulnerability to infections
4. Economic problems
5. Less access to education
6. Property grabbing
7. Foster care or child headed households
8. Inadequate nutrition/food security
9. Risk of sexual exploitation/abuse
10. Households headed by the elderly
11. Psychological trauma for the infected and affected children

However, under the Indian law consent of parents or guardians is a pre-requisite for providing any kind of care and support for children below 18 years. This is an impediment for preventive programmes on HIV/AIDS. Elders do not even approve of safe sex education. The law needs to be amended so that children above 12 years and especially those who live on the streets or are married very young have confidential access to sexual health information, contraceptives including condoms, STI and HIV/AIDS testing and treatment services.

The response to HIV/AIDS differs from country to country but Uganda's Memory Books are a wonderful way for those infected to communicate with their young ones about their family history.

### **Comics on HIV/AIDS**

In January 2005, children of 8 to 17 years were involved in preparing comics on HIV/AIDS with the support of World Comics and NGOs working on the issue. Sixty street children, orphans, school going and non-school going children from slums, a large number of them infected or affected by HIV participated in the project. After orientation through interactive sessions by a counsellor and infected persons and street plays, the children developed stories on issues such as transmission, prevention, stigma and discrimination and positive living.

With inputs from cartoonists and technical experts on HIV, the children developed comics based on stories they had written. Some 60-70 comics developed by the children were even exhibited. The HIV/AIDS Comics Book, is being distributed to NGOs, HIV/AIDS professionals all over the country and to school children in the Hindi speaking areas.

A helper in a teashop at Chandni Chowk, one of the busiest commercial areas in Delhi,



The HIV/AIDS comics book is being distributed to NGOs, HIV/AIDS professionals all over the country and to school children in the Hindi speaking areas



Amit's melancholy stems from the fact that no one told him not to have multiple partners. "I would not have ventured into such sexual practices if I was warned about the HIV infection"

Amit (name changed) ran away from his home in Bihar and came to Delhi eight years ago. Now 18 and infected with HIV, he is among the many children who have got the infection from the street. "As long as I can remember, I have been involved with girls. I also used to frequent the red light areas of Delhi. My life has been determined by my friends and those who abused me sexually during my early days in Delhi," he recalls. Amit's melancholy stems from the fact that no one told him not to have multiple partners. "I would not have ventured into such sexual practices if I was warned about the HIV infection," he says. There may be many Amits in the country's metros. The new comic book could be their 'life saver.' ■

**Krishnaswamy Kannan & E.K. Vinayakan**

*Plan International (India)*

## Seeking the Right Prescription

### ***Anti-retroviral drugs, vaccines, microbicides and patent issues***

“Make drugs available and you will notice the stigma that surrounds HIV/AIDS receding”, said an NGO representative, to stress that a lot of the silence around HIV/AIDS and peoples’ inability to declare their positive status has also been because they know it will not mean any improvement in their physical situation. In the early days of the epidemic in India, with hardly any AIDS drugs or anti-retrovirals (ARVs) available there seemed little point in declaring one’s HIV status.

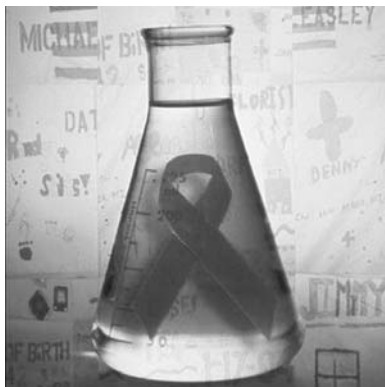
In its annual report of 2002-04, the National AIDS Control Organisation (NACO) made a point: People were not showing up at Voluntary Counselling and Confidential Testing Centres (VCCTCs) because if they were declared HIV-positive, the only tangible follow-up would be for the government to write out a referral. The growing availability of ARVs and their improvement in India and across the world has helped address the stigma associated with HIV/AIDS in the simple sense of treatment options being available. They may not always be suited to individual patients, they are extraordinarily expensive to date, and they may create toxicity, but their availability is helping people living with HIV/AIDS deal with the burden of stigma and discrimination associated with the infection.

Today, we live in a changed India. A little over a year ago, the Central Government launched a free roll-out of ARVs at select centres in the six high HIV prevalence states. It was back in 2001 that the UN General Assembly Special Session on HIV/AIDS pushed for worldwide agreement on the need for ARVs and the Indian government, through NACO, decided on a radical policy change. The National AIDS Control Programme was to give free ARVs to 100,000 people. This initiative was finally launched from April 2004. According to NACO, nearly 7,000 people are receiving free ARVs - a target that is expected to grow to cover one lakh people by 2007. Meanwhile, the government hopes to expand the programme to 100 centres by the end of 2005. The new Patents Bill of 2005 is also a factor for the change. (See Box No 1: India’s New Rules with Patents)

However the reality on the ground is not as promising. (See Box No 2: From *The Indian Express*). People in need of ARVs are queuing up and doctors at government-designated centres are being forced to take some tough decisions on who can be given free



The growing availability of ARVs and their improvement in India and across the world has helped address the stigma associated with HIV/AIDS in the simple sense of treatment options being available



The “3 by 5” initiative launched by the World Health Organisation and UNAIDS in 2003, catalysed treatment in India and other developing countries

ARVs. There are concerns about what line of treatment is being offered in terms of drug choice within the free ARVs programme and about the support infrastructure keeping pace with the roll-out. These are important issues that pose hard challenges. But it is clear that there is global pressure now for science and medicine to deliver. What are the most important scientific breakthroughs? Do they translate into actual improvement in treatment and other options for people living with HIV/AIDS? Is state-of-the-art treatment reaching the needy? But a beginning has been made in widening access to treatment and that is an achievement.

The “3 by 5” initiative (to reach treatment to three million people by the end of 2005), launched by the World Health Organisation (WHO) and UNAIDS in 2003, catalysed treatment in India and other developing countries. Although the programme is unlikely to reach its target by the end of 2005 as per UN data, the last few years have seen overwhelming changes in the approach to ARVs and HIV/AIDS. These were fuelled by the need to expand treatment options in developing countries in particular.

Expanding the reach of treatment options is important. At the Rio conference in July 2005 on HIV pathogenesis and treatment, the focus was on finding innovative means of doing so. HIV/AIDS is an evolving epidemic and the careful monitoring of viral subtypes will be essential to stem its growth. There is urgency now for the world to learn how to lessen the gap between scientific discovery and practice. This is closely linked to finding faster and better ways to treat HIV/AIDS. World leaders repeatedly get

### India's New Rules with Patents

India got a new patents regime in 2005, one that is expected to push forward original research and ensured that processes and products patents are protected. Here's the concern: For several years India has been playing a significant role in the worldwide access to drugs - especially in the developing world - making generic formulations available at affordable prices. It has also been a leader in the global debate at the World Trade Organisation on TRIPS and its impact on public health.

In 2000 Indian pharma companies began manufacturing generic antiretroviral drugs, which impacted positively on the cost of ARVs and allowed wider access to the drugs. According to Medecins Sans Frontieres (MSF), of the 700,000 people who receive ARVs in the developing world, almost half receive Indian generics. In February 2005, MSF said it treated 25,000 people in 27 countries with ARVs and 70 per cent of the patients were on medicines that originated from India. MSF has been a strong advocate for flexibility in the patent regime that will allow wide and free access to ARVs. ■

together to endorse the need for fresh investment and resources to meet the goal of universal access to treatment by 2010.

According to WHO and UNAIDS, 67,000 people are undergoing treatment for HIV/AIDS in India. This means coverage of 4-9% of those infected. The unmet need is 7,35,000. From the Global Fund to Fight AIDS, TB and Malaria, some 4,500 women, their partners and children are to get ARVs. The Round 4 proposal aims to provide 180,000 people with ARVs in the public sector and 200,000 people in the private sector by the fifth year.

In India, the private sector is the most active provider of treatment and the case with HIV/AIDS is no different. The Employees State Insurance Scheme in the Central Government Health Scheme also provide ARVs to employees.

In the overall scenario of providing ARVs to as many people as possible, there is an issue that must be considered. It is established that from among all those who are HIV-positive, only 10-15% really need ARVs. It is very common practice to find that there are several people who are being put onto ARVs but do not really need it - these are people with relatively high CD4 counts (measure of the health of the immune system in an HIV infected person) and no Opportunistic Infections (OIs).

Ideally, ARVs should be prescribed only once immune suppression has really reached an advanced stage and the basic rule for availing free ARVs is that the patient's CD4 counts should be lower than 200. Many health professionals believe that real success will lie in early tracking of infection and looking after newly-positive people so well that their need for ARVs can be pushed as far ahead as possible. Early detection, competent and sensitive counselling, nutrition, social care and support through non-discriminatory employment are vital. Equally important is strict regulation and guidelines in the medical practice of prescribing ARVs, insurance coverage, and addressing the line of regimen available in free ARV centres.

It was in the late eighties that the first ARVs were developed, to interrupt and suppress viral replication and try and restore immune function (See Box No 3: Drugs to Combat HIV/AIDS). From single drugs to coupled combinations to multi-drug combinations now - the upsurge has been rapid, fuelled by quick development of resistance to drugs by HIV within a few years of the first ARVs being used. For less than a dollar ( Rs 48) a day, ARVs are available in India, from generic manufacturers. But shelling out so much per day just for one family member's drug intake is too much for many families. Yet, it is important to value ARV provision because it means not just reduced viral loads but reducing the spread of infection.



It is established that from among all those who are HIV positive, only 10-15% really need ARVs. It is very common practice to find that there are several people who are being put onto ARVs but do not really need it

### From *The Indian Express*

*Indian Express, May 11, 2005, Anuradha Mascarenhas: Free Anti-Retroviral Therapy: Too many patients, too little time*

Pune, May 11: Living with AIDS for three years, Pandurang (name changed), has been ostracised by his parents and given food in separate utensils. Today, as the farmer from Parner waits for free medicines at the Anti-Retroviral (ARV) therapy centre at Sassoon General Hospital, he is scared to reveal that his 30-year-old wife and eight-year-old son are also sero positive.

Neeta lost her husband to HIV two years ago. Last November, she fell sick and started losing weight. Tests revealed that she too had contracted the virus. With just a class X pass certificate, she is unemployed, worries constantly and makes weekly rounds at the ART centre hoping that her name will be considered for the free drugs. Pandurang and Neeta are among the several patients queuing up at the Anti-retroviral (ARV) therapy centre at Sassoon, hoping to be included in the programme that provides free medicines to HIV positive patients. Even as five or six patients are registered every day, the medical worker at the centre is patient with the others, promising to enroll them soon.

An ambitious anti-AIDS initiative by the government aided by the World Bank, the ARV programme aims to provide free medicines - a combination of three drugs (see box) supplied by the National AIDS Control Organisation (NACO) - to HIV patients whose CD4 count is less than 200. There are 33 centres all over the country.

In Pune, the ARV centre was set up in January and according to Dr A L Kakrani, Head, Department of Medicine, Sassoon, 1,011 patients (588 men, 403 women) have been screened. Of these, free medicines are given to 131 patients. "We have written to the Maharashtra State AIDS Control Society who have promised to upscale the programme," Kakrani told *Newsline* when asked about the long queues outside his centre everyday.

Given that Maharashtra with an estimated 7.5 lakh patients has the highest number of infections, making a success of ARV therapy is a daunting task. Also, once started, ARV therapy cannot be stopped midway. Hence the need to ensure that whoever is enrolled is supplied drugs for a lifetime.

Dr V L Kulkarni, Deputy Director, Sexually Transmitted Diseases and in-charge of the ARV programme in Maharashtra, explains the issues. "We are going slow on the ART

programme,” he admits pointing out there should be sufficient stock of drugs to ensure that the lifelong programme is successful. “It is dangerous to discontinue the programme once patients are administered the drugs.”

Dr Mukund Penurkar, Senior Medical Officer with the ARV centre in Pune, agrees. “We feel bad turning away patients. People from as far as Latur, Aurangabad and Ahmednagar come here seeking free ARVs,” he says. Though they have to select their patients carefully, depending upon the CD4 count, wives of HIV patients who have also contracted the virus are admitted on priority. So far, there is one child on ARVs at SGH.

But the government has plans to upscale the ARVs programme. According to New Delhi-based Ajay Khera, Joint Director for Training and ARV, the idea is to have 100 centres across the country by the year-end and treat at least 25,000 HIV infected persons this year.

Apart from ARV centres at Mumbai (1,750 patients), Miraj (350 patients), Pune (131 patients) and Nagpur (140 patients), the other centres will come up at Yavatmal, Akola, Aurangabad, Ambejogai and Kolhapur.

### **THE REGIMEN**

**ARV:** Anti-retroviral therapy is a government programme that aims to provide free drugs to AIDS patients with CD4 count less than 200. In Pune, 131 patients are on ARVs. But there are more who need it.

**Medicines:** The cheapest combination of drugs Stavudine, Lamivudine and Nevirapine comes in a capsule “Tri Omune” costing Rs 1,239 for a month.

The other combination is Duvor-N that includes Zidovudine and Lamivudine. Nevirapine has to be taken separately. This costs Rs 1,350 per month. So far, 10 patients in Pune are on this treatment.

Efavir 600 is the costliest at Rs 2,826 per month. This includes Efavirenz (suitable for patients on anti-TB drugs), Lamivudine and Stavudine.

According to recent media reports the reality of free ARVs and the government’s plans to expand it is wrought with challenges - actual amounts of drugs and making sure treatment goes uninterrupted, once begun, ensuring coverage of those who are the most needy . A lot of patients are turned away in Pune centres for free ARVs and patient selection based on CD4 counts is also difficult. ■



India began its first Phase-I AIDS vaccine trial in early 2005. It hopes to stay engaged with this cutting-edge global endeavour in as close a manner as possible, but a vaccine against AIDS is proving to be one of the scientific and medical community's biggest challenge

Treatment for HIV/AIDS has become centre-stage not only with the political leadership, but with the governmental machinery, medical fraternity and the non-governmental sector. There has been a lot of effort recently to make treatment a part of the comprehensive package to deal with the epidemic. According to UNAIDS and WHO, in December 2003 the focus was on upscaling ARVs in 49 countries under the '3 by 5 initiative.' India is in this select group. In these 49 countries live 87 % of all adults and children infected with HIV/AIDS. Over half the world's infected population that needs treatment lives in six nations - Ethiopia, India, Nigeria, South Africa, Tanzania and Zimbabwe.

Meanwhile, the Indian Government wants to explore other technological options for combatting HIV/AIDS, especially vaccines and microbicides. Several vaccine candidates are being studied in clinical trials worldwide, but the search is still very much in stages of experimentation. Hundreds of clinical trials of more than 30 different vaccine candidates have been completed, but there are no breakthroughs yet.

India began its first Phase-I AIDS vaccine trial in early 2005. It hopes to stay engaged with this cutting-edge global endeavour in as close a manner as possible, but a vaccine against AIDS is proving to be one of the scientific and medical community's biggest challenge. Microbicides — chemical substances that can be used to keep sexually transmitted infections away - are also being tried in various phases, but again, no breakthroughs yet.

It is obvious that these efforts need tremendous political and social support. There are now so many commonalities between advocacy for treatment and novel technologies like microbicides and vaccines that the world has coined for itself a new phrase - MTV - advocacy for Microbicides, Treatment and Vaccines for HIV/AIDS. The idea behind MTV of course, is to be able to combine the strengths of these three complex and active fields to influence and shape worldwide political opinion, and to build the much-needed support and encouragement to continue research to achieve these goals. MTV advocacy is expected to break barriers and allow for strong collaboration that can eventually take the world closer to answers in tackling HIV/AIDS.

So, what lies ahead? Treating HIV/AIDS has just entered a new era - and the immediate focus is a need for drugs that are simpler, offering stronger barriers to resistance, and with minimum side effects. In India, there is now an opportunity to incorporate interventions for prevention in treatment settings. The issue of how involved NGOs can be in the provision of ARVs is being addressed, as well as the question of the extent to which ARVs can be upscaled. The Indian Network of People living with HIV/AIDS is involved in a rapid assessment of the progress of ARV scale up. The Indian government along with WHO has begun a process of monitoring and evaluation of the ARV rollout, starting with a national consultation held in April 2005.

## Drugs to Combat HIV/AIDS

There is yet no cure for HIV/AIDS. ARVs work on disrupting the replication of HIV within the human body but cannot rid the body of the virus. In 1986-87, scientists found a drug that could affect the viral life cycle of HIV by becoming an impediment in its replication. This was a drug designed to act on an enzyme called reverse transcriptase enzyme, thereby blocking the formation of a pro virus DNA. Since then, various drugs acting on reverse transcriptase have been discovered. These drugs generally fall into two groups – Nucleoside Analogue and Non-nucleoside Analogue drugs. In the late nineties, a new line of ARVs that would act on the enzyme protease were discovered. Protease is an enzyme that helps in the maturation of m-RNA to mature virions or viral particles, and these drugs are called protease inhibitors.

According to NACO, though most of these drugs are available in India, these are expensive. They cost Rs. 11,000 - Rs 15,000 per month per patient. The drugs available in India are:

Reverse transcriptase inhibitors

### **Nucleoside analogue**

- AZT (azidothymidine, zidovudine) - 100 mg. each tablet
- DDC (zalcitadine) - 75 mg. each tablet
- Stavudine - 100 mg. each tablet each
- Lamivudine - 150 mg. each tablet

### **Non-nucleoside analogue**

Nevirapine - 200 mg. each tablet

- Protease inhibitors
- Saquinavir
- Ritonavir
- Indinavir

### **Post exposure prophylaxis**

The following drugs are only used for post exposure prophylaxis and supported by the Government of India:

- Zidovudine - 300 mg. twice daily for 4 weeks
- Lamivudine - 150 mg. twice daily for a period of 4 weeks
- Indinavir - 800mg. thrice daily (only when indicated as part of expanded regime)

Detailed guidelines have been issued to all State AIDS Control Societies (SACS) for further dissemination to all hospitals in the public, private and voluntary sectors. The Central Government has provided funds to all the state societies with the direction that the drugs should be made available in all government hospitals. ■

(Source: [www.nacoonline.org](http://www.nacoonline.org))





Recombinant HIV is beginning to complicate matters and calls for better scientific understanding, and some measure of urgency

### ARVs for Children

Without treatment, half the world's HIV positive children will die before their second birthday. Today there are 660,000 children who need ARVs and roughly four million need cotrimoxazole prophylaxis. There isn't sufficient ground knowledge medically regarding the treatment of children and this capacity must be built urgently. ■

There are technical posers too. Recombinant HIV – a variant of HIV that contains genetic materials from more than one subtype of the virus – is beginning to complicate matters and calls for better scientific understanding, and some measure of urgency. How can we make treatment as convenient and efficient as possible and reduce toxicity? In fact, this is an important question being posed to medical science today – can we improve on current HIV drugs and create better drugs that will have less toxicity? Reduction of drug toxicity is a major field of pharmaceutical research. Other questions are – Does interrupted treatment work better?

It is obvious that India has accepted the challenge presented by ARVs and treatment of HIV/AIDS. However it will take some time before the country will be able to use to its advantage indigenous expertise – be it in the pharma sector or from the medical and public health fraternity.

#### **For Further Reading**

1. [www.nacoonline.org](http://www.nacoonline.org)
2. AIDS India e Forum
3. [www.aidslaw.ca](http://www.aidslaw.ca)
4. [www.aidsinfo.nih.gov](http://www.aidsinfo.nih.gov) ■

**Dr Subhadra Menon**  
*Senior Health Journalist*

## Standing Up for Their Rights

Since 2004 there has been significant activity both internationally and in India on garnering a media response to the HIV/AIDS epidemic. In early 2004, the UN Secretary General announced the 'Global AIDS Media Initiative' to fight HIV/AIDS by using the media for public education.

Closer home, in January 2005, a high level meeting chaired by the Prime Minister saw media agencies commit resources including air time, coverage and reporting to address HIV/AIDS. While the news media agreed to encourage 'AIDS journalism', entertainment channels volunteered to weave in HIV/AIDS related themes into popular soaps, serials etc to reach mainstream audiences. Undoubtedly, a heightened media response to HIV/AIDS will help shed misconceptions, ignorance and apathy to HIV/AIDS among the masses.

How differently the 'new, informed' audience will respond to HIV/AIDS and to people affected by it will depend on the nature and manner of HIV/AIDS reportage. To ensure that the audience respond with less prejudice, ridicule and intolerance towards affected people than before, reporters need to be informed of the complex socio-economic and legal factors that underlie the HIV/AIDS epidemic.

This article highlights some of the key legal and human rights concerns that have arisen over the last two decades in the context of HIV/AIDS in India. The essay tracks the defining legal interventions on HIV/AIDS and examines their role in addressing HIV related discrimination. It attempts to foster a better understanding of the interface between human rights, law and HIV/AIDS so as to inform and influence media debates on the epidemic.

### HIV/AIDS AND HUMAN RIGHTS – AN INEXTRICABLE LINK

*“ Paradoxically enough, the only way in which we will deal effectively with the rapid spread of HIV/AIDS is by respecting and protecting the rights of those already exposed to it and those most at risk.”*

Justice Michael Kirby

The incontrovertible public health lesson emerging from the epidemic is that protecting rights of those affected by HIV/AIDS is the best way of protecting the rest of the society.



To ensure that the audience respond with less prejudice, ridicule and intolerance towards affected people than before, reporters need to be informed of the complex socio-economic and legal factors that underlie the HIV/AIDS epidemic



The rationale behind this ‘rights-based’ approach is that HIV prevention, care and treatment will be accessed by the community only if the individual is assured of the right to autonomy and consent, privacy and confidentiality, equality and non-discrimination

This lesson translates into programmes and services that are voluntary, confidential and non-discriminatory in nature. The rationale behind this ‘rights-based’ approach, which is now supported by ample evidence from the ground is that HIV prevention, care and treatment will be accessed by the community only if the individual is assured of the right to autonomy and consent, privacy and confidentiality, equality and non-discrimination. In actual terms, it implies that a sex worker visiting a health clinic is not compelled to undergo an HIV test, merely because her ‘behaviour’ exposes her to HIV infection. Or, that the school is not automatically ‘notified’ of the HIV positive status of a student whose mother dies of HIV/AIDS related illness. And, that a factory worker who tests positive for HIV does not lose his job simply because he is infected. It means that communities, social and state institutions - families, neighbourhoods, schools, hospitals, workplaces treat HIV/AIDS without fear, prejudice and discrimination.

### ***Actualising a ‘rights based’ response***

Fortunately, the National AIDS Control Programme in India is built on a rights based or ‘integrationist’ health model. Preventive education, voluntary and confidential testing, harm reduction interventions for groups at greater risk of infection, non-discriminatory treatment, care and support for positive people constitute the core of the government’s HIV/AIDS programme and are compatible with universally accepted health and human rights standards.

Yet, despite the conceptual indoctrination of rights in policies and programmes, the reality for people affected by HIV/AIDS is very different. It is not uncommon for women attending antenatal clinics to get tested for HIV/AIDS without being informed and to be thrown out after a positive test result. Many hospitals till date publicly identify people living with HIV/AIDS by placing boards with “AIDS Patient” boldly imprinted on the bedside. People testing positive for HIV continue to be refused treatment and inpatient care, lose their jobs and denied other rightful claims. Violence against marginalised and vulnerable communities including sex workers, injecting drug users and gay/transgendered persons is not only condoned but also often approved.

These are a handful of illustrations of rights violations related to one’s actual and/or perceived HIV status. The list is long and encompasses violations in multiple spheres - family, neighbourhood, school, workplace, and hospital.

The two differing approaches described next show that rights have a decisive role to play in preventing the spread of HIV/AIDS and mitigating its effect. Promotion of public health rests on the protection accorded to individual rights. Thus, securing rights of people living with and affected by HIV/AIDS is not only an important end in itself but also serves as a means to a larger end, that is, safeguarding public health.

## Protection of 'individual rights' = Promotion of 'community health'

**1996:** A red light area in Mumbai is raided by the police to eliminate unscrupulous, criminal elements that thrive on prostitution. All 450 sex workers detained and arrested during the operation are forcibly tested for HIV/AIDS. The hospital where the sex workers are tested discloses the results in an attempt to 'warn' the public about the risk that 'breeds' in the red light area. Local municipal authorities consider steps to deal with the hazard that HIV positive sex workers pose to the local public. One suggestion is to imprison those infected with HIV/AIDS. This proposal is turned down, as it may put prison authorities at risk. Another suggestion is to incarcerate them in the infectious disease hospital; but the hospital staff is not prepared to admit AIDS infected sex workers. A third suggestion is to stamp "HIV positive" in indelible ink on the sex workers' faces so that the public is easily able to identify the menace.

Months later, the issue dies down. Meanwhile, some sex workers remain confined to the correctional home without access to medical or other support while others are back on the streets desperately soliciting customers, the risk of HIV/AIDS notwithstanding.

**1999:** HIV prevalence among sex workers in Mumbai over 60%.

**1991:** An STD/HIV survey conducted in a brothel area in Kolkata reveals a high prevalence of STD infection and dismal condom use - conditions 'ripe' for the rapid spread of HIV/AIDS. A public health specialist is summoned to prevent and control the spread of STD/HIV among sex workers and their clients.

The intervention is designed premised on respect, recognition and rights of sex workers. A health centre is started within the area providing check up and treatment for STDs among other health ailments. A core group of sex workers is trained to develop and disseminate information on HIV prevention. Soon, the group begins educating others on correct condom use and protected sex. As the community begins to take control over its own health and life, condom negotiation, which was a daunting task for most, becomes a given, as all sex workers abide by the self-created "no condoms, no sex" rule. Over a span of five years, the prevalence of STD declines while condom use is near universal. Sex workers coalesce to articulate and address concerns of violence, goonda and police harassment, children's education, income and livelihood - the very same factors that underlie risk and vulnerability to HIV/AIDS.

**1998:** HIV prevalence among sex workers in Kolkata is five per cent.





It is in this context that we examine some of the topical legal cases that have set precedence and shaped the legal response to HIV/AIDS till date.

### ***1987: Legal challenge to the ‘isolationist’ response***

Soon after the detection of the first HIV/AIDS case in Chennai, the legislature of Goa enacted the Goa Public Health (Amendment) Act, 1986 to include provisions that allowed health authorities to forcibly test anyone suspected with AIDS. Furthermore, the Act authorised the State to isolate persons with HIV/AIDS. Exercising powers under the Act, Dominic D’Souza, an HIV positive activist, was quarantined in a TB sanatorium for over three months in complete disregard of his fundamental, legal and civil rights. From a public health perspective, the Act set a dangerous precedent of instituting an irrational, fearful and forcible reaction to HIV/AIDS. Dominic’s arrest and confinement as also provisions of the Act that allowed the State to do so were challenged before the Bombay High Court (Goa Bench).<sup>1</sup> Although the Court ordered Dominic’s release, it did not see any infirmity in the impugned legislation. The legal challenge, though unsuccessful in revoking the provisions inimical to rights, prevented the isolationist response as espoused in Goa from being replicated elsewhere in the country.

### ***1997: Affirming the right to work***

In 1993, MX, a casual labourer employed with a public sector corporation was detected with HIV/AIDS during a routine medical check up. Soon after, he received a notice from the employer asking him not to report to work. A writ petition was filed before the Bombay High Court contesting MX’s dismissal on the grounds of his HIV positive status.

The petition contended that MX’s termination was unjust, arbitrary and wrongful since he was physically fit to work. In defense, the Corporation averred that employing a person suffering from a serious disease like HIV/AIDS would pose undue financial and administrative burden and that it cannot be saddled with such responsibility/liability. In a landmark judgment<sup>2</sup> delivered in 1997, the Bombay High Court held that the Corporation’s refusal to employ MX on the grounds of his HIV positive status constituted a violation of his fundamental rights to equality, non-discrimination, life and livelihood. The Court upheld the right to employment of an HIV positive person subject to the condition that such person is otherwise qualified person, medically fit to perform the job functions and does not pose a significant risk to others at work.

The High Court order not only led to MX’s reinstatement but also, on broader note, laid down an affirmative legal principle with regard to employment and HIV/AIDS. Courts in

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1 Lucy v. State of Goa, 1990 Mah LJ 714

2 MX v ZY AIR 1997 Bom 406

India and abroad have, since, followed the *MX v ZY* decision while adjudicating on HIV related employment cases.

### ***Enabling access to justice***

Additionally, *MX v ZY* saw the evolution of a beneficent litigation strategy that enables people living with HIV/AIDS to seek redressal without revealing their identity. HIV positive persons refrained from approaching courts, even in situations of abject infringement of rights, because of potential social ostracism resulting from the disclosure of their status in legal proceedings. Recognising that the stigma associated with HIV/AIDS was a formidable barrier for people with HIV/AIDS in filing claims, the Bombay High Court allowed the petitioner to litigate under a pseudonym. The court accepted that suppression of identity might be allowed in the interest of justice though it impinges on the administration of justice, which demands that trials be open to public scrutiny. Allowing HIV positive litigants to sue without revealing their identity has now become standard practice in most courts.

### ***1998: To marry or not to marry***

In a judgment<sup>3</sup> that came as a setback for people living with HIV/AIDS, AIDS service organisations and rights activists, the Supreme Court, suspended the right to marry of people living with HIV/AIDS in 1998. The facts of the case resulting in this pronouncement were such: - Mr X was engaged to Ms. Y when he tested positive for HIV/AIDS. The hospital authorities did not inform him of his status but instead revealed this information to a third party known to Ms. Y's family. The news spread in the village community like wild fire causing much anguish to Mr X and his family. The social stigma, ridicule and ostracism compelled him to leave the village.

Mr X sued the Hospital for breach of confidentiality of his HIV status. The matter reached the Supreme Court on a technical question of jurisdiction. The court, however, went into the merits of the case rejecting Mr X's claim for damages. The court went further and ruled that persons inflicted with HIV/AIDS could not marry.

The seeming rationale behind the apex court's order precluding positive persons from marrying was that being a sexually transmissible and life-threatening disease, a person with HIV/AIDS cannot be allowed to imperil the right to life of a prospective spouse. The implications of the court order for marriage between two positive persons or even between sero-discordant partners, where such marriage was with full and informed consent, were not clear. A few people however, welcomed the decision believing that it was a sound way of protecting women, who get infected by their husbands and, who in most situations, do not have a say in choosing a partner.



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3 Mr. X v Hospital Z (1998) 8 SCC 296



Following a legal intervention, which saw emphatic arguments dispelling the fallacy behind ‘polarisation of rights’ in the HIV/AIDS context, the Supreme Court restored the right to marry in December 2002.

### ***Awaiting decision***

Other critical legal issues affecting people living with HIV/AIDS that are pending decision from the courts include the right to receive medical care without discrimination, the right to access HIV/AIDS treatment and medication, and the right to continue in military and police service. Besides, there are numerous cases filed by or on behalf of people living with HIV/AIDS for individual relief pending adjudication in family, labour and district courts.

### ***Securing rights but not restitution***

Though legal aid/litigation has enabled HIV affected persons to seek what they are entitled to, there are several limitations to legal redressal. Foremost, Constitutional claims of equality and non-discrimination lie against the State or government bodies only. There are no legal measures that prohibit discrimination in private health care, employment, education and other services. Moreover, rights envisioned and articulated in policy documents do not carry legal force. An HIV positive patient refused treatment by a private doctor cannot take legal action on the basis of a policy provision alone. Furthermore, legal protection for marginalised groups such as sex workers, drug users and sexual minorities is virtually non-existent.

And then there are situations where rights cannot be realised despite a legal intervention. A woman can claim residence in her matrimonial home through a judicial order but the family may continue to avoid her because of HIV/AIDS. A court cannot get co-workers to share a table with an HIV positive colleague even though it may reinstate him in the job. While a court may uphold the right of HIV positive children to receive education, it cannot compel other children in the school to embrace them. A legal framework that protects and promotes rights is imperative to counter AIDS related stigma and dis-

### **A Media Triggered Response**

A few years ago, a national daily published an article over repeated refusal by hospitals to operate on an HIV positive person, who required immediate medical attention. The article caught the attention of a sitting judge in the Delhi High Court, who, suo motto issued notices to the concerned medical authorities to explain this blatant act of discrimination. Additionally, the story evoked an immediate response from the Chief Minister’s office resulting in the provision of prompt medical and surgical care to the HIV infected person.

crimination, as are forces like the media that influence attitudes, opinions and even action.

Clearly then, rights need to be mainstreamed and adopted across the board for a consistent, coordinated and cogent response to HIV/AIDS. ■

**Tripti Tandon**

*Senior Project Officer, Lawyers Collective HIV/AIDS Unit, New Delhi*



Media messages advocating abstinence, single partner sex or faithfulness to the spouse as preventives only end up linking sexual morality with the virus

## Positive Voices

For those living with the virus, the image of HIV positive people as portrayed by the media compounds their problems. The coordinator of the Asia Pacific PLWHA Resource Centre in Delhi, 35-year-old Manoj Pardesi has interacted extensively with journalists. Living with the infection for 13 years now, he says, “In the press we are either made to look like villains spreading infection or as victims grovelling in misery. The media has tremendous reach and influence. It’s high time that it presented a realistic picture of the HIV infection as a manageable health concern.”

Stories of discrimination against HIV positive people make good reading and are easy to report on, but they would have intrinsically more value if linked to real issues, says Manoj. The bigger question in a country that has 5.1 million infections is how to live with the virus? Are people actually getting treatment? These are the dimensions surrounding an infection that can be managed more simply than diabetes, asthma or heart ailments.

### ***Media and morality***

Those infected say that the link of HIV/AIDS with sex has been overpowering. It has diverted media attention from the real concerns that need to be addressed. Media messages advocating abstinence, single partner sex or faithfulness to the spouse as preventives only end up linking sexual morality with the virus, points out Manoj. It imposes a question mark about their character and stigmatises infected persons. It makes it difficult for a man to tell his wife he is HIV positive. It’s a dilemma activist Ram Kumar (name changed) grapples with daily. After losing his factory job in Delhi when his HIV status became public, he returned to his village in Azamgarh district, UP. Five years have lapsed but Ram has not had the courage to inform his wife about his positive status. “Being unemployed and depressed, I joined a support group of affected people in the state and now cycle from village to village everyday spreading awareness. Ironically, I feel my own wife will find it difficult to accept I am infected. I am preparing her by sharing with her experiences of other infected people I meet in the course of my work.”

Manoj does not support the government’s targetted intervention programmes and its focus on select groups like sex workers and homosexuals. The media focus remained on these groups that were seen as having deviant behaviour and this backfired on all those infected by the virus. Awareness, he maintains, must be built around safe sex



**Manoj Pardesi**

rather than unrealistic expectations advocating denial of sex that, in turn, could have other repercussions.

The constant equation of HIV/AIDS with death by newspapers and television channels keeps the virus from being detected. NACO estimates that about 90-95% of the epidemic is undetected and is therefore spreading unknowingly. The fear of the infection stops people from getting tested even if they feel they may be at risk. The language used by the media also conjures up a dreadful image of the infection. HIV/AIDS is often referred to as an “untreatable disease” so even if a person picks up courage to get tested at the Voluntary Counselling and Confidential Testing Centres (VCCTCs), he/she often does not return to pick up the report. The person is unable to overcome the fear of testing positive. The stigma and discrimination caused by the perception of it being incurable is an issue that confronts them.

For those of us living with the infection, says Manoj, the repercussions of this portrayal are multiple. “We are denied our rightful share in property by family members; doctors don’t want to treat us because they consider it a waste of resources and those we live with also feel it is a waste of money looking after us.” A stitch in time saves nine. So it is with HIV positive people. Timely diagnosis and treatment enables them to stay healthy and work with gusto.

The constant equation of HIV/AIDS with death by newspapers and television channels keeps the virus from being detected. NACO estimates that about 90-95% of the epidemic is undetected and is therefore spreading unknowingly

The media's obsession with being the first to break the news and make it salacious, makes it neglect investigation of a whole range of facts related to an event like the suicide of a person who is told he/she is positive. Was the person counselled that it was a health problem that could be handled like any chronic ailment such as diabetes or blood pressure? Counselling is mandatory with an HIV/AIDS test undertaken anywhere. Instead, sections of the media often grab stories on baseless rumours, such as one put out in Chennai in 2003 of an HIV positive man secretly injecting with infected blood motorcyclists from whom he would take lifts. The scare created by a spate of such stories resulted in the lynching to death in Chennai of an anonymous man found with a syringe. Says activist R Elango who was in Chennai at the time for a seminar, "Fear and hatred against infected people like us was running so high because of these media 'reports' that we were afraid to attend the seminar on HIV/AIDS or step out on the streets."

The media giving credence to unfounded information causes incalculable harm, claims Elango. Diagnosed HIV positive in 1988, Elango says he developed diabetes because of harmful 'ayurvedic medicines' from a well-known quack in Kerala whose so-called miracle cure for HIV/AIDS was highlighted by many newspapers and magazines. "Though the quack was later exposed by a consumer rights group, the media rectified its mistake by putting out a small regret notice instead of the full-page features that had been carried on the man earlier." Having helped to set up the Karnataka Network of Positive People, Elango has been tracking reports on the epidemic for over a decade.



*R Elango*

He feels the media must put itself in the shoes of affected people to understand how its coverage can be a matter of life and death for them.

Getting the media's attention is a big challenge. Space constraints, the urgency of news and the need for 'catchy' headlines often result in wrong messages being sent out. Says Ranjit, (name changed) an infected person in Punjab: "I hesitate to reveal my name to the media because I am afraid that my case would be sensationalised and my story twisted. This would hurt my family. As part of civil society, the media too has a responsibility towards us. It must not exploit our situation for pandering to its readers or viewers."

Manoj points out that good programmes and news reports, however, can do marvels for building public awareness on social and medical issues. A BBC World programme, *Haath Se Haath Milao*, is a sensitively prepared series highlighting the infection. Another BBC-produced serial *Vijay Jasoos*, packaged with adventure and suspense is also popular with kids.

### **People not 'victims'**

Loon Gangte, working as Regional Coordinator with the South Asia Collaborative Fund for HIV/AIDS Treatment, is livid with the media's insistence on clubbing HIV positive people as patients. "I am not ill by any yardstick," he fumes. "I probably work harder than many other people and yet every time the press terms a person like me as a 'patient,' 'sufferer' or 'victim.' I am definitely not diseased, helpless or dying." He describes an incident in Kochi where he participated in a rally of 130-odd HIV positive people. "We were shouting slogans at the top of our voices and marched through the city in the heat, yet the next day newspapers reported - 'AIDS patients take out rally!' A patient should be on a wheelchair or in hospital. But this is what happens all the time."

Rather than an obsession with death and dying, there should be stories on HIV positive people laughing, coping, living, says Loon. This can only happen when the media understands the virus and its impact in totality. It must now actively try to educate itself. "There is all-round ignorance here compared to many other countries," says Loon. "When I met a group of 11 Swedish parliamentarians, for instance, I was amazed at how much they knew of HIV/AIDS. They were as knowledgeable as any counsellor. With its huge reach the media can play a very important role in spreading informed awareness of the epidemic."

The key lies in journalists giving 'informed' news rather than allowing baseless prejudices to colour their copy. For this, sustained interaction with HIV positive people is a

The key lies in journalists giving ‘informed’ news rather than allowing baseless prejudices to colour their copy. For this, sustained interaction with HIV positive people is a must



**Loon Gangte**

must. “How can you go to the market and buy clothes for someone you have never met! They will always be ill-fitting. In the same way, journalists must get to know us well if they want to portray us correctly,” says Loon. “They already have the skills to make a story readable. If they have the right understanding then they can sensitise the public in the right direction.” Rather than dramatising single fear-based incidents, macro issues need to be addressed simultaneously.

For instance, has the health system in the states geared up to handle the snowballing epidemic? Thousands of affected people with little idea of what has happened to them travel from villages to cities for medical

treatment. Their experiences find little reflection in media discourses that could shape the formulation of public policy. Soni (name changed) of Ludhiana district in Punjab accompanies her infected husband every month to PGI, Chandigarh, for medical treatment for HIV/AIDS. Looking worn out and harassed, she laments, “Why is the procedure here not simpler? It took two days just to get the card made in PGI - and officials stared and sniggered when I said it was for AIDS. Only on the third day could we meet the doctor who wrote out the tests for my husband.

We stand in line all day for each test, and if our turn comes even one minute after the department’s closing time then the day’s effort goes waste. Reports are to be collected from another part of this huge hospital. My husband cannot stand for too long. We have nowhere to stay when we come from the village. Private treatment is too expensive. We will go back to *jadi-bootis* available in the village instead of going through all this trouble.”

Soni feels there is a lot of difference between those who are ill with HIV/AIDS and those suffering other ailments. “People run away from us. Secondly, our economic stability has been completely destroyed. My husband was a truck driver who cannot work any more. Our savings have finished in his treatment. Our daughter is not going to school anymore. I do part time work when I can to support ourselves, besides taking care of him.”

The fear of not being able to make a living in his prime is also haunting Dharamvir (name changed) of a paramilitary force, who discovered he was infected four years ago. “Though the unit helped me at the time, now they are trying to throw me out. I found out about my infection when I had fever continuously for 26 days and my weight plunged from 75 kg to 35 kg. I was posted in Barmer in Rajasthan and broke down completely when my HIV status was revealed. I did not even tell my family in Gwalior. But gradually I recovered.”

Dharamvir finds that life is being made difficult for him at work. “Many of my seniors and others came to know about the infection because I underwent a lot of mental stress. Also, I am not as strong as I was before and cannot do the same duties. Treatment costs are cut from my salary and the holidays I need because of my treatment are also being deducted from my pay. I took my case to the highest levels of the force and though some people supported me, I am afraid I will soon be out of job. The media must talk about our rights and fair treatment for us.”

If not economic troubles, it is the stigmatising reactions from all around that bother many of those infected. Says Ranjit (name changed), a dealer in spare motor parts, “I required blood transfusion after an accident in 1992. In 2000 I became so sick that my weight went down to 25 kgs and I found out I was infected. But the worst was the suspicious response of my friends and acquaintances. Only my parents, who are well-educated, were supportive. With their help I managed to erase what society was saying and decided to live for my wife and son.” Visiting PGI, Chandigarh and getting medication for the last five years now, Ranjit’s CD count has gone up from a dangerous low of 62 to 280. “These are the things the media should highlight, instead of giving everyone the impression that we are potent weapons of destruction let loose on the public.”

### **A development concern**

An important component of the epidemic is its impact on women. This has hardly been reflected in the media. The hardships women face are double. While infected men are rarely abandoned by their wives or families. Women put up with greater stigma and discrimination. Celina D’Costa who works as an Advocacy Officer with an international NGO cites her personal experience. “When my husband died 12 years ago and I came to know that I too was infected, my first reaction was that there is nothing to hide. I did not conceal my status from family members, neighbours and the church. But with so little information about this new ‘disease’, my in-laws just threw me out of the home. I don’t hold it against them any longer. There was no way they could have known that the infection is not spread by just being in the same house with me, nor is it transmitted by the sharing of bathrooms or through mosquito bites. There was also a lot of social

“Treatment costs are cut from my salary and the holidays I need because of my treatment are also being deducted from my pay. I took my case to the highest levels of the force and though some people supported me, I am afraid I will soon be out of job”

“Women often do not enjoy equality in their marital relationships such as being able to negotiate safe sex or sex on their own terms, or they fear being thrown out of home for no fault of theirs”



**Anandi Yuvaraj**

pressure on them that my brother-in-law would find it difficult to get married if I continued to stay with the family.”

Celina’s openness about her status is not shared by Neera, a seamstress from Chandigarh, who kept her HIV positive status from her husband for eight years. “During pregnancy I came to know I was infected. The doctor warned me that if I told my husband he or his family could blame me. I feel I did the right thing in not revealing my HIV status to my husband who had been suffering from TB.” He came to know of his HIV positive status only when he was admitted to PGI after eight years of frequent illness. Its been a year since her husband died, but his mother refuses to acknowledge he was HIV positive.

Activist Anandi Yuvaraj who has emerged as a role model for other infected women, says it is social attitudes which created a situation where Neera preferred silence. “HIV cannot be tackled in isolation. It has to be linked with the entire process of women’s empowerment. It brings out that women often do not enjoy equality in their marital relationships such as being able to negotiate safe sex or sex on their own terms, or they fear being thrown out of home for no fault of theirs. Empowering women by providing them education, skills and resources would also address their vulnerability to HIV.”

Women’s groups and those working in the development sector need to include HIV/AIDS in their mandate. As Anandi points out, the virus is intimately linked with

social and development indices. Yet few mainstream organisations put it on their agenda. “If the media initiated a debate on these lines then the profile of the virus would change. Currently there is a narrow keyhole view of HIV/AIDS that also informs the strategies meant to counter it. Instead, it needs to be put into the larger development context which should be tackled in a holistic way by everyone.”

Anandi claims she has rarely encountered stigma. Diagnosed as HIV positive in 1997, she subsequently separated from her abusive husband and struck out on her own. “I gained courage from my mother’s reply when I told her of my status. She told me, ‘When you were born did you think you would live forever? Make the best of the time you have.’” Educated upto college and having worked before marriage, Anandi took up a job again. It was with an NGO working on HIV too. Eventually she joined the Positive Women’s Network in Chennai that was involved in educating affected women about their rights and helping to build district level networks of infected women.

Presently working with the India HIV/AIDS Alliance, the 41-year-old Anandi is not on medication. She tours the country and frequently presents the Indian situation at international forums. She says, “Personally I have hardly ever experienced derogatory treatment because of being infected. But I know what many others face. In fact I first publicly revealed my positive status when I stood up for an infected peon in an NGO where I worked. Can you believe it, the head of the organisation that worked for HIV positive people, himself objected to an HIV positive man serving tea. Everyone was shocked when I intervened but they were forced to change their stand. My parents had always pushed me to stand on my own and that really built my self-esteem. How a woman is treated in her own family is how she will be treated later by others.” She says it is her education, independence and upfront attitude that elevated her from a salary of Rs 400 a month to her present job in an international NGO.

### ***Addressing those living with HIV***

The media must go into all issues around an epidemic that is presently discussed by it in the single context of transmission and prevention, a simplistic portrayal of the virus. “In the West, for instance, where HIV has been accepted in society, the media has also mainstreamed the epidemic. Sensitisation issues do not make news any more and neither is there any hype about HIV related stories. Most of the stories are related to resource allocation for the epidemic at the global level,” says Anandi.

However, here the media fuels many of the general misinformed notions. Says Celina, “Like everyone else, I too had the impression that as one who has HIV/AIDS I would soon die. I waited to die...but even 12 years later here I am, completely healthy without needing medication of any kind.”

“The head of the organisation that worked for HIV positive people, himself objected to an HIV positive man serving tea. Everyone was shocked when I intervened but they were forced to change their stand”

Affected people would like to read about the right nutrition and diets for those who are infected. Healthy food can minimise or delay the damage caused by the virus. They want to know how to enjoy a safe married life, more about medication and information about their rights on issues like inheritance and custody of children

Information is given out only about prevention and modes of transmission. There is nothing for those who are living with it. What does one do if you find out you are HIV positive? Whom to contact about more information on the virus? More importantly, how to live and not die with the virus? Celina says affected people would like to read about the right nutrition and diets for those who are infected. Healthy food can minimise or delay the damage caused by the virus. They want to know how to enjoy a safe married life, more about medication and information about their rights on issues like inheritance and custody of children. “Some people argue that it may be damaging to carry news about us. They feel that unless there is the fear of death and illness associated with HIV/AIDS people will be lax in taking precautions or it will encourage promiscuity!”

Wanting to reassure others living in silence with the infection, Celina decided to speak out about herself. But she says the press was just interested in a juicy story. They published her photo and gave out information on where she lived. “The media primarily focussed on how I got the infection. I had ‘come out’ with the intent of raising my voice against fear and discrimination. It turns out this was the last thing on the media’s mind.” She also has a word of caution for those willing to expose themselves to public gaze. Proper counselling is needed about the social and emotional consequences of revealing one’s identity, says Celina.

### **Media wary**

Many of the networks of HIV positive people are wary of interacting with the media. Mike Tonsing has been working for the past six years with the Sahara Care Home in Delhi on its management of information systems. The NGO runs 35 projects all over the country, catering primarily to drug users and people living with HIV/AIDS. Over 25 years old, Sahara was one of the first organisations to start working with those affected by the virus and employs many of them. Says Mike, “The way society looks at us is shaped by what it sees in the media. In the past HIV/AIDS was seen only as a symbol of death. That has changed somewhat now. HIV/AIDS is brought up when incidents of stigma and discrimination come to light. There is still nothing in the media about our living well, taking care of families and contributing to society, which would be very encouraging news to all affected people. It would also alter community perception about us.”

Such stories hardly appear because there is no bond between the press and the networks of HIV positive people. “We have not used the media adequately in sensitising it and putting out our point of view. There is no rapport with the press because we felt it always projected us negatively or twisted the information.” Every year there is a spate of stories around World AIDS Day on December 1, but little after that. “The media



**Mike Tonsing**

knows a little bit about us but not enough to give a full picture. We must change this,” says Mike.

Activists like Manoj exhort, “I would like to say to the media - be our advocate, join with us to reduce stigma and discrimination, try to spread correct and scientific information on HIV/AIDS by removing myths and misconceptions. Use language that is sensitive to us. Depict it as a manageable disease.” He suggests it should be looked at not just as a health condition but as a development issue affecting the country in many different ways. ■

“Look at HIV/AIDS not just as a health condition but as a development issue affecting the country in many different ways”

**Rimjhim Jain**



### The Importance of the Red Ribbon

Symbols are extremely important in any campaign to create awareness and fight a perceived public threat. India is full of symbols, many of them religious. Political parties have their symbols, so do social movements. The Red Ribbon is an international symbol of HIV/AIDS awareness. It is used to express solidarity with those affected by HIV/AIDS and indicates a commitment to fight its spread.

The Red Ribbon was conceived in 1991 by Visual AIDS, a New York based charity group of art professionals who sought to recognise and honour friends and colleagues who had died or were dying of the infection. Today it is the internationally accepted symbol to publicise the needs of persons with HIV/AIDS and to call for greater funding of services and research.

Inspired by the yellow ribbons honouring American soldiers of the Gulf War, the colour red was chosen for its “connection to blood and the idea of passion - not only anger, but love, like a valentine,” said Frank Moore of Visual AIDS.

However, in India the symbol is not as well known and it is not used that frequently. Ten of the 15 students seeking admission to a course in journalism in Delhi did not know what it stood for. In the general public there is total ignorance about it. Quite obviously it needs to be used much more by newspapers and TV channels when printing or broadcasting stories on HIV/AIDS.

The importance of symbols cannot be overlooked. The Red Triangle, the symbol of the family planning movement in India, is better known. The campaign to fight polio is known by the symbolic two drops. The Indian media needs to engrave the Red Ribbon symbol in the public mind by using it themselves. ■

**Usha Rai**

پنجاب میں نیٹ ورک قائم کرنے کیلئے کوششیں جاری ہیں۔

چند یگرہ 19 مئی (زیریں) ایچ آئی وی

مہلا میں جو کہ مختلف صوبوں سے

ہ میں حصہ لینے آئی تھیں اپنے اپنے

میں جا کر ایڈز مخالف مہم شروع کریں

سلسلہ میں ان کی طرف سے ایک

تیار کیا گیا ہے جس کے تحت وہ

بچوں، نوجوان تنظیموں کو ایڈز

بیداری پیدا کریں گی اور اپنے

لئے آواز بلند کریں گی۔

منی پور، تامل ناڈو، آندھرا

شتر سے کامن ویلتھ یوتھ

کی ورکشاپ کی طرف سے جو قدم اٹھائے گئے ہیں

وہ کافی قابل تعریف ہیں۔

اپنے اپنے صوبوں میں

م کیا ہے۔ جس میں ان

وی پازیٹو مہلاؤں کو

اس نیٹ ورک کے

چار کریں گی۔

میں بھی اپنا نیٹ

اسی سلسلہ میں وہ

لینے آئی تھیں

کے کارن اس

پازیٹو شخص



## Section III

## Useful Information



## Do's and Don'ts:

# The Ethics of Reporting on HIV/AIDS

### WHAT TO LOOK OUT FOR WHEN DOING AN HIV/AIDS STORY

#### ***Do I have the scientific fundamentals right?***

Good coverage of HIV/AIDS is about quality coverage of science, numbers and politics. Reporters essentially discuss one or another of these basics as we present the epidemic to the public through a lens of our choice such as human rights and law, medicine, policy and programme, gender, income, equity, geography or security or even when we prefer to skim the surface once in a while, through a sketchy coverage of functions and announcements. The starting point, however, is empathy for those infected and affected. Then, it is important to know the scientific fundamentals, medical definitions and concepts of the epidemic so that we are equipped to examine, critique or reject them as we interpret the epidemic.

#### ***Am I able to convey these fundamentals to my readers in a simple, accurate fashion?***

A useful way to be comfortable with medical definitions and concepts is to surf reliable websites such as those run by UNAIDS, World Health Organisation or Centre for Disease Control, and discuss them often with qualified medical personnel. It is important to discuss the definitions in simple everyday language that we consider appropriate for readers and check them with experts to ensure that accuracy is not sacrificed.

#### ***Have I developed a system to keep myself updated of major developments and HIV news from other parts of the world, irrespective of my beat?***

As the HIV/AIDS epidemics continue to manifest, they throw up new issues, complicate or negate concepts that we took for granted and often make us rethink our views of society, culture and values. In short, we often find ourselves on a steep learning curve, despite experience in covering the issue for years. Regular updating on global, regional and local developments, keeping abreast of new research and fresh happenings from the field and extensive reading helps insure that we stay in step with HIV/AIDS as it charts its course. All too often, such reading is left to the science/health reporter, if, indeed, a media house has the luxury of that exclusive position.

HIV/AIDS leaves few domains untouched, however, and it is reporters specialising in business, economics, foreign affairs, human rights/law or plain politics who can help





raise the quality of analysis and interpretation of the epidemic. The complex nature of the HIV/AIDS epidemic deserves greater and deeper scrutiny.

Subscriptions to reputed journals and publications from specialist organisations working in HIV, TB, reproductive health, sexuality and drug use are a standard way to remain abreast of new developments. Many of these publications are mailed free to the media on request.

List-serves that deal specifically with HIV/AIDS are another way to follow the latest trends in thinking, the local reactions and controversies in the field and other media coverage on HIV/AIDS. Some useful list-serves include SAATHI (Solidarity and Action Against the HIV epidemic in India) and AIDS-INDIA. To guard the mailbox against a deluge of e-exchanges on these list-serves, it may be helpful to assign an exclusive hotmail or yahoo account to the list-serve which could be accessed on a regular basis.

### ***What are the journalistic ethics when I report on HIV/AIDS?***

After all, HIV/AIDS stories are about people. The task of writing on people living with HIV or their near ones, or on people who seem to be disproportionately infected or vulnerable sometimes appears like negotiating an ethical minefield. Many of the booby traps have to do with expression:

#### **1. Language and prejudice:**

All handbooks on HIV/AIDS reporting usually carry a list of 'offensive' terms that are commonly used in HIV/AIDS reporting with a parallel list of politically correct or sensitive alternatives that we could substitute. Some common ones which have now been popularised by the media and figure in drawing room conversations include sex worker (rather than prostitute), injecting drug user (rather than drug addict) and multiple partner sex (rather than promiscuous).

It's not that the original terms were inaccurate, it's that they come loaded with the baggage of derogatory usage. Several other terms may need similar alteration so that they are reinvested with a new respectability in the age of HIV/AIDS. See how many you can think of.

#### **2. Language and accuracy:**

A second set of terms that are commonly used are inaccurate because they fail to capture adequately the reality. Some common ones include AIDS patient for a person infected with HIV but still healthy. Such people prefer to be addressed as People Living With HIV, a term emphasising life and hope, rather than death and sickness





We also need to be on the alert about the reverse usage of disease as a metaphor. The metaphorical use of medical terms starting with virus, disease, cancer, malignancy, AIDS, pox and diarrhoea, are well worn and continue to tempt the reporter. How justified are we in referring to corruption as the incurable cancer of society, in an age when our understanding of cancer has undergone a sea change and it is no more that monster that eats us inexorably from within? Likewise, can we truthfully refer to HIV/AIDS as a killer or an angel of death, when medicine has already found the tools to make it a chronic manageable disorder, similar to, although vitally different from diabetes or hypertension?

#### 4. Language and translation:

The reporters who work in the local language has a tremendous advantage when it comes to finding a language and set of words to describe our experience with HIV/AIDS. Not for them the need to unlearn the loaded inaccuracies that have peppered coverage of HIV/AIDS over the last 20 years. Working with NGOs, high quality medical information straight from reliable sources and learning to follow the intricacies of the human rights discourse around AIDS can help them embark on a journey of explanatory journalism rather than a style that seeks to impress with its evocative terminology or pre determined views, a weak and distorted translation of English coverage.

There exists in India rich vocabulary on sexuality, illness, home based care, support, responsibility and acceptance. It is up to the local language reporters to uncover the terms in common use and check their appropriateness for HIV/AIDS reporting, relying on explanatory writing as much as possible to ensure that the reader is not misled.

#### ETHICS CHECKLIST:

Here is a beginning of a list of questions concerning ethics, to ask ourselves as we work on covering HIV/AIDS. The list is by no means rigid or complete and we could modify and add/delete as we deem appropriate. While all the questions are relevant, we could begin applying those we need or feel convinced about, depending on the time available and the nature of the report we work on. Over time, the consistent application of these ethical filters would become second nature and would automatically influence the way we conceive of, research and construct the reports. These have been numbered in more or less logical progression.

1. Have I thought about what might be the need for, or goal of my report?
2. Are there specific confidentiality related guidelines/media related policies that exist in the organisations I approach for information/interviews? Or are there HIV/AIDS related media policies available with journalists associations?
3. Have I ensured that my report presents a set of perspectives that are distinct and

help construct a comprehensive picture? Have I given space to views that I don't personally subscribe to?

4. Have I thought about what could be the impact of my report in the near and distant future, on the people I have quoted or covered, on the situations I have described and the conclusions drawn?
5. Who might my report affect and why? Would that be a legitimately desirable impact?
6. What if the roles were reversed and I was not the reporter but the person/organisation covered. How would I feel and what consequences might I face from family, friends, community and at workplace?
7. What strategies might I employ to ensure that the report is accurate and effective at the same time as well as sensitive and minimally destructive or hurtful?
8. Is my approach, reasoning and discussion clearly based on evidence and thorough research? Would it be justifiable in the face of rigorous scrutiny by people living with HIV and stakeholders such as those working in prevention, care or related issues?

### **How does one get a good HIV/AIDS story, one that goes beyond the numbers game?**

When it comes to HIV/AIDS, as in any health reporting, there's no getting away from numbers. Reporters catch the figures flu every year when NACO and UNAIDS release their national estimates on HIV prevalence. The result is a flurry of reportage mostly of the paralysis-by-analysis variety which blows over following well meaning calls from activists and officials entreating us not to 'waste news space on numbers, but to learn to see beyond them.'

Reporters are addicted to numbers whether we understand them or not, the larger the figures, the better. Numbers serve as a tempting opening to any reporting on HIV/AIDS, irrespective of the angle the story explores. Reporters constantly demand to know the 'true numbers' about HIV/AIDS from UN agencies, NGO and others, not realising that only a door to door community prevalence survey that tests every man, woman and child can ever yield the 'truth'. The unique nature of the HIV epidemic, the size of the populations and certainly human rights considerations tell us that such a survey is neither possible nor warranted. We have little choice but to work with estimates that at best offer only an informed guess about the 'truth' and at worst mislead us to jump to the wrong conclusions. This is perhaps one of the best contexts that illustrates the fundamental uncertainties of epidemiology in particular and scientific research in general. We need to get used to asking questions and conveying the tentative quality of what we uncover rather than be obsessed with closing the minds of our readers into a cul-de-sac of dead certainty.

The insensitive use of metaphors and labels distorts the picture. It gives a false





impression when we interpret the numbers with colourful metaphors such as 'scourge'. Ethics demands that we analyse, not simply repeat, the estimates and projections made by local and international agencies. This is important to explain to readers the methods used to arrive at the projections, so that their capacity to respond intelligently to these numbers is enhanced. In short, ethics demands that we convey to readers exactly what these numbers represent and what they do not.

Numbers add shock value and a newsy quality to reports and if presented convincingly and repeated often enough, add a ring of authenticity, deserved or not. One of my favourite stories refers to the 'annual increase in the trafficking of young girls from Nepal to India.' The oft repeated numbers signifying the 'annual increase' vary widely between 5 to 20,000, sometimes more, but at some point simple math intervenes to remind us that these numbers may mean nothing. Nepal would probably have no young girls left, at this rate. A useful question is to ask if a reliable baseline estimate exists in the first place.

A skillful use of numbers ultimately constitutes the substance of quality news and analysis, provided the numbers reflect novelty, proportion, time, context and above all, the human face.

Below is a small list of reminders that help better the quality of commentary on numbers. We could add to this list as our experience grows. The general goal is to strive for a degree of comprehensiveness, no matter how little space we get.

- To help present a fuller picture to readers we could avoid using numbers unnecessarily.
- Explain why we are providing a particular statistic on what that figure means, in simple, accurate language.
- Compare that figure usefully to some other numbers so that the reader can make a reasonable/near realistic inference about proportion, criticality and logic.
- Place statistics on a time scale so that the reader can follow a development over time.
- Indicate what a number means to policy or the public giving concrete examples.

### **Who are the people journalists should contact to get an offbeat story?**

Almost all stories on HIV/AIDS rely on a limited range of sources: reporters contact or are contacted by NGOs and UN agencies and sometimes health ministry officials and people living with HIV. ■

**Dr Jaya Lakshmi Shreedhar**

*Technical Health Advisor, Internews Network*

## Media Guidelines from Consultations

All alarming stories on issues related to HIV/AIDS will carry a public service message which will reiterate that HIV is a manageable infection like any other chronic ailment and will give a helpline number alongside.

This commitment, made by the editor of *Udayavani*, a leading Kannada daily newspaper, was one of the many guidelines that were suggested at the state consultations in Chandigarh, Lucknow and Bangalore to share research findings on the media coverage of HIV/AIDS by the Population Foundation of India.

This study was shared with journalists, NGOs working in this sector, representatives of the state AIDS societies and HIV positive people.

In Chandigarh, while the consultation was able to bring together these four groups on a common platform to discuss the impact of the media on HIV positive people, in Lucknow it facilitated the setting up of a joint group that would work towards more responsible media coverage. In Bangalore, fellowships for English and language media were suggested to motivate more journalists to write on this subject.

Some of the other key suggestions made by the participants to bridge the communication gaps and facilitate accurate media coverage were:

- Access needed to a database to validate information received by journalists on HIV/AIDS and help to understand and analyse data. For example, the difference between HIV and AIDS, projections and actual figures of HIV/AIDS prevalence etc.
- A nodal point, established by either state AIDS societies or NGOs, to serve as a reliable source of information for journalists.
- A style book for media organisations outlining correct terminology for English and regional press. This must be updated periodically to include new terms. Examples of good and bad reporting on the issue needed to clear confusion.
- A code of ethics with regard to confidentiality and informed consent of People Living With HIV/AIDS (PLWHAs) must be included.
- Dissemination of Press Council guidelines on HIV/AIDS coverage only after updating them to include latest developments. There is a need to alert the Press Council on this.
- Policies governing HIV positive media employees by media houses.





- Sensitisation of all media staff including the editor, sub-editors and journalists in district editions and language newspapers to ensure headlines not alarmist or judgmental and retain the spirit of the story. Refresher courses for journalists one good way to help portray HIV positive people sensitively.
- Inclusion of HIV/AIDS as a subject in journalism school curricula.
- Feedback from infected people, field workers and health authorities on media stories to improve quality of coverage.
- Inclusion of gender perspective to reduce stigma and discrimination.
- A resource book with names of health journalists, concerned NGOs and government officials to bridge communication gap.
- Ten story suggestions by NGOs and state AIDS organisations on issues related to HIV/AIDS that may have been missed.
- Field trips organised by NGOs and state AIDS bodies to include voices from grass-roots. ■

## Quiz on Facts and Myths of HIV/AIDS

1. A person can get HIV/AIDS from sitting next to a person who has it.  
 Yes       No
2. A person can get HIV/AIDS by having sex with a commercial sex worker.  
 Yes       No
3. An unborn child can get HIV/AIDS if his/her mother is infected.  
 Yes       No
4. Insects like bedbugs, cockroaches or mosquitoes can be HIV/AIDS carriers and give it to people.  
 Yes       No
5. A person diagnosed with HIV/AIDS will die within 12 months .  
 Yes       No
6. Men with HIV/AIDS may sexually transmit it to women.  
 Yes       No
7. You can get HIV/AIDS by using a phone, which was just used by someone with AIDS.  
 Yes       No
8. You can get HIV/AIDS if a person with HIV/AIDS coughs or sneezes near you or by using the same toilet seat.  
 Yes       No
9. If you kiss a person with HIV/AIDS on the cheek or drink from the same glass, you can get the disease.  
 Yes       No
10. An HIV/AIDS patient may die due to TB.  
 Yes       No
11. HIV/AIDS is not a disease, but a condition making a person vulnerable to infections.  
 Yes       No
12. There is no cure for HIV infected persons.  
 Yes       No
13. If a person with HIV/AIDS cries and his/her tears touch you, you can get HIV/AIDS.  
 Yes       No
14. It is safest to avoid having a blood transfusion.  
 Yes       No
15. Persons who have sex with many different people are at risk of getting HIV/AIDS.  
 Yes       No
16. You can get HIV/AIDS by eating food, which is cooked by someone who has HIV/AIDS.  
 Yes       No
17. You can get HIV/AIDS from swimming pools.  
 Yes       No
18. You are likely to get HIV/AIDS if you sleep in the same bed as someone with HIV/AIDS without having sexual intercourse.  
 Yes       No
19. You can get HIV/AIDS by hugging a person who has it.  
 Yes       No
20. Children can get HIV/AIDS by sitting next to or playing ball with a student, who has HIV/AIDS.  
 Yes       No

21. A person can get HIV/AIDS by having sexual intercourse with an HIV-infected person.  Yes  No
22. Brothers and sisters of children with HIV/AIDS usually also get HIV/AIDS.  Yes  No
23. Doctors and nurses who treat HIV/AIDS patients often get HIV/AIDS as well.  Yes  No
24. Everyone infected by HIV gets AIDS.  Yes  No
25. HIV is the name of the virus, AIDS is the disease caused by HIV.  Yes  No
26. Countries with a high rate of rape cases also have a high HIV/AIDS prevalence.  Yes  No
27. Herbal/Organic food and/or vitamins will shield or cure you from HIV/AIDS.  Yes  No
28. People who suffer from sexually transmitted diseases (STDs) are much more likely to contract HIV/AIDS.  Yes  No
29. Certain sexual practises like “dry sex” supports the spread of HIV/AIDS  Yes  No
30. A HIV positive person has to be treated by specialist doctors.  Yes  No

**Score**

**26-30:** Congratulations! You should start doing seminars on HIV/AIDS!

**25-21:** Very good! You are involved in the HIV/AIDS issue. Keep up that good work!

**20 -16:** Good! You are interested. Find out which questions you answered wrong and get your knowledge updated!

**15 -10:** There are large gaps in your knowledge about HIV/AIDS and you know it! Find out which questions you answered wrong and update your knowledge!

**9-5:** You think you know enough about HIV/AIDS - but you don't! Find out which questions you answered wrong and get your knowledge updated! Repeat the test afterwards!

**Less than 5:** Until now you have not realised that HIV/AIDS is a fatal disease that may also affect you. Find out which questions you answered wrong and update your knowledge! Repeat the test!

**Answers**

- 1  N 2  Y 3  Y 4  N 5  N 6  Y 7  N 8  N 9  N 10  Y 11  Y 12  Y 13  N 14  Y 15  Y 16  N 17  N 18  N 19  N 20  N 21  Y 22  N 23  N 24  N 25  Y 26  Y 27  N 28  Y 29  Y 30  N

## Facts & Myths

**Myth:** HIV/AIDS is mostly an African problem.

**Fact:** Of the 42 million people around the world who live with HIV/AIDS, 70% are in sub-Saharan Africa. But HIV/AIDS is not an African problem alone. It is a worldwide phenomena.

- HIV/AIDS exists and is spreading in Africa.
- HIV/AIDS continues to spread more rapidly in countries or communities within countries where poverty, inequality, and conflict are prevalent. Eastern Europe and Central Asia have the fastest rates of spread, followed by countries in Asia and the Pacific, the Caribbean, and Latin America.

**Myth:** To stop the spread of HIV, people simply need to give up promiscuous sex and drug use.

**Fact:** Socio-economic structures around the world constrain many people's ability to make free choices regarding the behaviours that put them at risk for contracting HIV/AIDS. Economic insecurity, gender and racial inequalities, labour migration, and armed conflict all limit people's ability to avoid exposure to the virus.

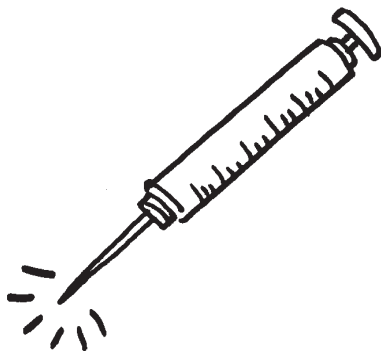
**Myth:** The best way to control HIV/AIDS is through prevention. Costly treatment should wait until prevention programmes have been fully funded and deployed.

**Fact:** Prevention and treatment should have equal roles in the fight against HIV/AIDS:

- Since wealthy individuals have the chance to prolong and improve their lives with ARVs, it contradicts the principles of equity and human rights to allow tens of millions of others to die without treatment.
- Countries in which large numbers of working and parenting age adults die have suffered and will continue to suffer enormous social and economic losses, from which it will be increasingly difficult to recover.
- Efficacy of prevention programmes is limited. Prevention efforts often clash with a socio-economic situation that does not allow people to control their exposure to the virus. Furthermore, even a very successful prevention programme cannot fully stop the spread of the virus in high-prevalence countries.
- Prevention and treatment together have a synergistic effect. Voluntary counselling and testing, a key prevention strategy, is much more successful when tied to a treatment programme for those who test positive.



Illustrations by Priya Nagarajan



**Myth:** HIV/AIDS treatment is impossible because antiretroviral drugs are too expensive and because developing countries lack the sophisticated infrastructure necessary to deliver the drugs. In addition, mishandling of ARVs will lead to increased HIV drug resistance.

**Fact:** ARVs should be a cornerstone in fighting HIV/AIDS in the developing world:

- Treatment for the poor is no longer prohibitively expensive, due to recent sharp drops in drug prices. Both generics and cheaper brand names have become available.
- The enormous economic costs of no treatment outweigh the costs of treatment.
- Evidence shows that treating patients with ARVs can save health systems money.
- Relevant infrastructure is actually present in many regions.
- The delivery of ARVs can be simplified and modified for resource-poor settings
- New partnerships between resource-poor and resource-rich groups are helping to create infrastructure in places it is lacking.
- Drug resistance can be minimised by the creation of locally-appropriate guidelines for treatment. Much of the infrastructure created for national TB programmes can be used to administer ARV therapy.

**Myth:** An HIV vaccine will soon be available, and this will solve the AIDS crisis.

**Fact:** A vaccine will not solve the HIV/AIDS crisis:

- While many advances have been made in vaccine research, significant gaps remain in the scientific knowledge needed to develop an effective vaccine.
- The pace of HIV/AIDS vaccine research is often slow due to lack of financial incentives to develop such a vaccine. Lack of coordination among researching groups exacerbates the problem.
- Due to the difficulties in creating an effective vaccine, the first vaccines deployed will probably be of low efficacy.
- By the time a vaccine has been developed and fully deployed in developing countries, millions and millions of people will have become infected and died of HIV/AIDS if no other steps are taken.

**Myth:** The pharmaceutical industry's drive for high profits, together with its political power, means that pricing policies will never change to benefit poor people with HIV/AIDS.

**Fact:** ARVs are becoming cheaper.

- Generic versions of ARVs are produced in some countries and are exported to other countries.

**Myth:** If you live in a household with a family member who is infected then you may

also be infected.

**Fact:** Just living in the household of an infected family member does not mean you will be too. You can only be infected through sex, sharing needles or exchanging body fluids with somebody who has HIV/AIDS.

**Myth:** Only gay men can be infected with HIV/AIDS.

**Fact:** Straight men, women and children are also susceptible to infection, not only gay men.

**Myth:** Since resources are limited, officials should concentrate on problems that effect large segments of the population, such as nutrition, clean water, maternal and child health, and immunisations, rather than expensive and complex HIV/AIDS treatment that helps only a few.

**Fact:** HIV/AIDS treatment would have far-reaching benefits, since the disease has such devastating social, economic, and general health effects:

- HIV/AIDS kills mainly young adults in their prime working years; these deaths are devastating to economies.
- Agriculture is gravely threatened by HIV/AIDS. As workers die, food production falls, the nutritional status of the population is undermined, and all aspects of health are affected.
- Young children are often left parentless, leading to hunger, poor health, lost educational opportunities, economic and sexual exploitation, and loss of future prospects.
- HIV/AIDS fuels the spread of other infectious diseases, such as tuberculosis.
- HIV/AIDS treatment will help reduce pressure on health facilities by reducing opportunistic infections.

**Myth:** If your child goes to school with someone who has a relative who is ill your child may also be at risk.

**Fact:** This is untrue. There is no way someone can pass the illness on unless they actually have it. If a family member is ill it doesn't mean they are too.

**Myth:** Sharing a cup with someone who is infected with HIV/AIDS will put you at risk of being infected.

**Fact:** There is no proven fact that you will be at risk of getting HIV/AIDS if you share a cup with someone who is sick. It's almost impossible to get sick this way because there would have to be open wounds in your mouth and blood would have to be exchanged. You cannot get HIV/AIDS through saliva. You can kiss someone who is sick and you won't get sick.





### Info Nuggets

- Of the estimated 7.4 m people in Asia living with HIV/AIDS, 5.1 m are in India.
- Out of the people living with HIV/AIDS in India, 36% are women.
- Out of the total number of newly infected individuals in developing countries, 67% are between the age group of 15-24 years.
- Globally, young women and girls are 2.5 times more susceptible to HIV than men and boys.
- In 1985, one third of adults living with HIV/AIDS were women. In 2004, nearly half of the adults living with HIV/AIDS are young women.

### Biological

- During sexual intercourse a larger surface area is exposed in women and therefore it heightens the chances of infection.
- Semen has a higher concentration of virus than vaginal fluid. Therefore, the infection of women by men is twice as likely as infection of men by women.
- The chances of laceration, which provide entry to the virus, are heightened in women because of early and/or forced sexual intercourse as in child marriages.
- Frequent pregnancies lead to reproductive tract infections (RTIs) which increase chances of women being infected because the symptoms are not very visible in women.

### Mode of Transmission



***In India the first case was reported in 1986 in Chennai***

India has the second highest number of people living with HIV/AIDS in the world after South Africa. India accounts for almost 10% of the 40 million people living with HIV/AIDS globally and over 60% of the 7.4 million people living with HIV/AIDS in the Asia and Pacific region.

Heterosexual transmission is driving India's HIV/AIDS epidemic. This route accounts for approximately 85% of the HIV infections in the country. The remaining 15% are accounted to other routes such as blood transfusion and injecting drug use (particularly in India's north eastern states and some metropolitan cities).

Young people in India are among those most vulnerable to HIV. Over 35% of all reported HIV/AIDS cases in India occur among young people in the age group of 15 to 24 years

**High prevalence:** Maharashtra, Tamil Nadu, Manipur, Andhra Pradesh, Karnataka and Nagaland have HIV prevalence rates exceeding five per cent among groups with high-risk behaviour and one per cent among women attending antenatal clinics in public hospitals.

**Concentrated epidemics:** In Gujarat, Pondicherry and Goa where the HIV prevalence rate among populations designated as high-risk has been found to be five per cent or more, but HIV prevalence rates remains below one per cent among women attending ante-natal clinics.

**Low prevalence:** All other States and Union Territories fall into the low prevalence category because HIV prevalence rates among vulnerable population is below five per cent and less than one per cent among women attending antenatal clinics.

The epidemic continues to shift towards women and young people with about 25% of all HIV infections occurring in women, increasing the potential of paediatric HIV in the future.



### ***HIV in India – A fast spreading epidemic***

- **1986:** First case of HIV identified in Chennai.
- **1990:** HIV levels among groups designated high risk like sex workers and STD clinic attendants in Maharashtra and amongst injecting drug users in Manipur reaches over five per cent.
- **1994:** HIV no longer restricted to high risk groups in Maharashtra, but spreading into the general population. HIV also spreading to the states of Gujarat and Tamil Nadu where high risk groups have over five per cent HIV prevalence.
- **1998:** Rapid HIV spread in the four large southern states, not only in groups designated high risk but also in the general population where it has reached over one per cent. Infection rate among antenatal women reaches 3.3% in Namakkal in Tamil Nadu and 5.3% in Churachandpur in Manipur. Among IDUs in Churachandpur it crosses 76% and in Mumbai, 64.4%.
- **1999:** The infection rate in antenatal women in Namakkal rises to 6.5%. About 60% of the sex workers in some areas in Mumbai are infected. Infection rates among STD patients have reached up to 30% in Andhra Pradesh and 14-60% in Maharashtra. About 64.4% IDUs at one of the sites in Mumbai and 68.4% in Churachandpur are infected.
- **2001:** Infection crosses one per cent in six states. These states account for 75% of the country's estimated HIV cases. The Prime Minister addresses the Chief Ministers of high prevalence states and urges them to intensify prevention activities.
- **2003:** Increase of about six lakh infections (4.58 million). This increase noticed primarily in Karnataka, Rajasthan, West Bengal, Tamil Nadu, Gujarat, Bihar, Madhya Pradesh and Rajasthan. There is no significant increase in HIV infections in the country. India continues to be in the category of low prevalence countries with overall prevalence of less than one per cent.
- **2005:** NACO reports 5.13 million infections. ■

# Frequently Asked Questions

## What is HIV?

HIV (human immunodeficiency virus) is the virus that causes AIDS. This virus may be passed from one person to another when infected blood, semen, or vaginal secretions come in contact with an uninfected person's broken skin or mucous membranes. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding.

## What is AIDS?

AIDS stands for Acquired Immunodeficiency Syndrome.

**Acquired** means that the disease is not hereditary but develops after birth from contact with a disease causing agent (in this case, HIV).

**Immunodeficiency** means that the disease is characterised by a weakening of the immune system.

**Syndrome** refers to a group of symptoms that collectively indicate or characterise a disease. In the case of AIDS this can include the development of certain infections and/or cancers, as well as a decrease in the number of certain cells in a person's immune system.

## What causes AIDS?

AIDS is caused by an infection with a virus called human immunodeficiency virus (HIV). This virus is passed from one person to another through blood-to-blood and sexual contact. In addition, infected pregnant women can pass HIV to their babies during pregnancy or delivery, as well as through breast feeding. People with HIV have what is called HIV infection. Some of these people will develop AIDS as a result of their HIV infection.

## How does HIV cause AIDS?

HIV destroys a certain kind of blood cell (CD4+ T cells) which is crucial to the normal function of the human immune system. In fact, loss of these cells in people with HIV is an extremely powerful predictor of the development of AIDS. Studies of thousands of people have revealed that most people infected with HIV carry the virus for years





before enough damage is done to the immune system for AIDS to develop. However, sensitive tests have shown a strong connection between the amount of HIV in the blood and the decline in CD4+T cells and the development of AIDS. Reducing the amount of virus in the body with anti-retroviral therapies can dramatically slow the destruction of a person's immune system. Being HIV positive is not the same as having AIDS. The HIV actually goes inside the white blood cells and lies there quietly. After about 5 to 10 years the HIV virus tricks the cell to start making the viral proteins, this results in the formation of a huge number of viral particles inside the white cells and eventually the cells burst releasing thousands of new viruses in the blood. The released viruses infect new white cells. This cycle goes on and on, and eventually the immune system of the body is overwhelmed and is no longer capable of fighting the infections.

Eventually the infected person may lose weight and become ill with diseases like persistent severe diarrhoea, fever, pneumonia or skin cancer. He or she has now developed AIDS. People with AIDS can be helped with medicines for the different infections. At the moment though, in spite of much research, there is no cure for HIV or for AIDS.

### ***How long does it take for HIV to cause AIDS?***

Prior to 1996, scientists estimated that about half the people with HIV would develop AIDS within 10 years after becoming infected. This time varied greatly from person to person and depended on many factors, including a person's health status and their health-related behaviours.

Since 1996, the introduction of powerful anti-retroviral therapies has dramatically changed the progression time between HIV infection and the development of AIDS. There are also other medical treatments that can prevent or cure some of the illnesses associated with AIDS, though the treatments do not cure AIDS itself. Because of these advances in drug therapies and other medical treatments, estimates of how many people will develop AIDS and how soon are being recalculated, revised, or are currently under study.

As with other diseases, early detection of infection allows for more options for treatment and preventive health care.

### ***Why do some people make statements that HIV does not cause AIDS?***

The epidemic of HIV and AIDS has attracted much attention both within and outside the medical and scientific communities. Much of this attention comes from the many social issues related to this disease such as sexuality, drug use and poverty. Although

the scientific evidence is overwhelming and compelling that HIV is the cause of AIDS, the disease process is still not completely understood. This incomplete understanding has led some persons to make statements that AIDS is not caused by an infectious agent or is caused by a virus that is not HIV. This is not only misleading, but may have dangerous consequences. Before the discovery of HIV, evidence from epidemiological studies involving tracing of patients' sex partners and cases occurring in persons receiving transfusions of blood or blood clotting products had clearly indicated that the underlying cause of the condition was an infectious agent. Infection with HIV has been the sole common factor shared by AIDS cases throughout the world among men who have sex with men, transfusion recipients, persons with haemophilia, sex partners of infected persons, children born to infected women, and occupationally exposed health care workers.

The conclusion after more than 20 years of scientific research is that people, if exposed to HIV through sexual contact or injecting drug use for example, may become infected with HIV. If they become infected, most will eventually develop AIDS.

### ***How well does HIV survive outside the body?***

Scientists and medical authorities agree that HIV does not survive well outside the body, making the possibility of environmental transmission remote. HIV is found in varying concentrations or amounts in blood, semen, vaginal fluid, breast milk, saliva, and tears. To obtain data on the survival of HIV, laboratory studies have required the use of artificially high concentrations of laboratory-grown virus. Although these unnatural concentrations of HIV can be kept alive for days or even weeks under precisely controlled and limited laboratory conditions, Centre for Disease Control (CDC) studies have shown that drying of even these high concentrations of HIV reduces the amount of infectious virus by 90 to 99% within several hours. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other specimens, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to essentially zero. Incorrect interpretations of conclusions drawn from laboratory studies have in some instances caused unnecessary alarm.

Results from laboratory studies should not be used to assess specific personal risk of infection because (1) the amount of virus studied is not found in human specimens or elsewhere in nature, and (2) no one has been identified as infected with HIV due to contact with an environmental surface. Additionally, HIV is unable to reproduce outside its living host (unlike many bacteria or fungi, which may do so under suitable conditions), except under laboratory conditions; therefore, it does not spread or maintain infectiousness outside its host.





### ***How is HIV passed from one person to another?***

HIV transmission can occur when blood, semen, pre-seminal fluid, vaginal fluid, or breast milk from an infected person enters the body of an uninfected person.

HIV can enter the body through a vein (injecting drug use), the lining of the anus or rectum, the lining of the vagina and/or cervix, the opening to the penis, the mouth, other mucous membranes (eyes or inside of the nose), or cuts and sores. Healthy skin is an excellent barrier against HIV and other viruses and bacteria.

These are the most common ways that HIV is transmitted from one person to another:

- by having sex (anal, vaginal or oral) with an HIV-infected person;
- by sharing needles or injection equipment with an injecting drug user who is infected with HIV; or
- from HIV-infected women to their babies before or during birth, or through breastfeeding after birth.

### ***Is there a connection between HIV and other sexually transmitted diseases?***

Yes. Having a sexually transmitted disease (STD) can increase a person's risk of becoming infected with HIV, whether the STD causes open sores or breaks in the skin (like syphilis, herpes, chancroid) or does not cause breaks in the skin (like chlamydia, gonorrhea).

If the STD infection causes irritation of the skin, breaks or sores may make it easier for HIV to enter the body during sexual contact. Even when the STD causes no breaks or open sores, the infection can stimulate an immune response in the genital area that can make HIV transmission more likely.

In addition, if an HIV-infected person is also infected with STD, that person is three to five times more likely than other HIV-infected persons to transmit HIV through sexual contact.

### ***Can I get HIV from getting a tattoo or through body piercing?***

A risk of HIV transmission does exist if instruments contaminated with blood are either not sterilised or disinfected or are used inappropriately between clients.

### ***Can I get HIV from casual contact (shaking hands, hugging, using a toilet, drinking from the same glass, or the sneezing and coughing of an infected person)?***

No. HIV is not transmitted by day-to-day contact in the workplace, schools, or social settings. HIV is not transmitted through shaking hands, hugging, or a casual kiss. You can-

not become infected from a toilet seat, a drinking fountain, a door knob, dishes, drinking glasses, food, or pets.

HIV is not an airborne or food-borne virus, and it does not live long outside the body. HIV can be found in the blood, semen, or vaginal fluid of an infected person.

### ***Are women who have sex with women at risk for HIV?***

Female-to-female transmission of HIV appears to be a rare occurrence. However, there are case reports of female-to-female transmission of HIV. Vaginal secretions and menstrual blood may contain the virus and that mucous membrane (oral, vaginal) exposure to these secretions has the potential to lead to HIV infection.

In order to reduce the risk of HIV transmission, women who have sex with women should do the following:

- Avoid exposure of a mucous membrane, such as the mouth, (especially non-intact tissue) to vaginal secretions and menstrual blood.
- Know your own and your partner's HIV status. This knowledge can help uninfected women begin and maintain behavioural changes that reduce the risk of becoming infected. For women who are found to be infected, it can assist in getting early treatment and avoid infecting others.

### ***Are health care workers at risk of getting HIV on the job?***

The risk of health care workers being exposed to HIV on the job is very low, especially if they carefully follow universal precautions (using protective practices and personal protective equipment to prevent HIV and other blood-borne infections). It is important to remember that casual, everyday contact with an HIV-infected person does not expose health care workers or anyone else to HIV. For health care workers on the job, the main risk of HIV transmission is through accidental injuries from needles and other sharp instruments that may be contaminated with the virus; however this risk is small. Scientists estimate that the risk of infection from a needle-stick is less than one per cent, a figure based on the findings of several studies of health care workers who received punctures from HIV-contaminated needles or were otherwise exposed to HIV-contaminated blood

### ***Which body fluids transmit HIV?***

Fluids with high concentrations of HIV are:

- blood
- semen
- vaginal fluid
- breast milk
- other body fluids containing blood





The following are additional body fluids that may transmit the virus that health care workers may come into contact with:

- fluid surrounding the brain and the spinal cord
- fluid surrounding bone joints
- fluid surrounding an unborn baby

HIV has been found in the saliva and tears of some persons living with HIV, but in very low quantities. It is important to understand that finding a small amount of HIV in a body fluid does not necessarily mean that HIV can be transmitted by that body fluid. HIV has not been recovered from the sweat of HIV-infected persons. Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV.

### ***Can I get HIV from kissing?***

**On the Cheek:** HIV is not transmitted casually, so kissing on the cheek is very safe. Even if the other person has the virus, your unbroken skin is a good barrier. No one has become infected from such ordinary social contact as dry kisses, hugs, and handshakes.

**Open-Mouth Kissing:** Open-mouth kissing is considered a very low-risk activity for the transmission of HIV. However, prolonged open-mouth kissing could damage the mouth or lips and allow HIV to pass from an infected person to a partner and then enter the body through cuts or sores in the mouth. Because of this possible risk, open-mouth kissing with an infected partner is not recommended.

One case suggests that a woman became infected with HIV from her sex partner through exposure to contaminated blood during open-mouth kissing.

### ***Can I get HIV from anal sex?***

Yes. In fact, unprotected (without a condom) anal sex (intercourse) is considered to be very risky behavior. It is possible for either sex partner to become infected with HIV during anal sex. HIV can be found in the blood, semen, pre-seminal fluid, or vaginal fluid of a person infected with the virus. In general, the person receiving the semen is at greater risk of getting HIV because the lining of the rectum is thin and may allow the virus to enter the body during anal sex. However, a person who inserts his penis into an infected partner also is at risk because HIV can enter through the urethra (the opening at the tip of the penis) or through small cuts, abrasions, or open sores on the penis.

Not having (abstaining from) sex is the most effective way to avoid HIV. If people choose to have anal sex, they should use a condom. Most of the time, condoms work well. However, condoms are more likely to break during anal sex than during vaginal sex.

Thus, even with a condom, anal sex can be risky. A person should use generous amounts of water-based lubricant in addition to the condom to reduce the chances of the condom breaking.

### ***Can I get HIV while playing sports?***

There are no documented cases of HIV being transmitted during participation in sports. The very low risk of transmission during sports participation would involve sports with direct body contact in which bleeding might be expected to occur. There is no risk of HIV transmission through sports activities where bleeding does not occur.

### ***How do people get infected with HIV?***

HIV is transmitted mostly through semen and vaginal fluids during unprotected sex without the use of condoms. Besides sexual intercourse, HIV can also be transmitted during drug injection by the sharing of needles contaminated with infected blood; by the transfusion of infected blood or blood products; and from an infected woman to her baby before birth, during birth or just after delivery.

### ***How can I avoid being infected through sex?***

You can avoid HIV infection by abstaining from sex, by having a mutually faithful monogamous sexual relationship with an uninfected partner or by practicing safer sex. Safer sex involves the correct use of a condom during each sexual encounter and also includes non-penetrative sex.

### ***Is oral sex unsafe?***

Oral sex (one person kissing, licking or sucking the sexual areas of another person) does carry some risk of infection. If a person sucks the penis of an infected man, for example, infected fluid could get into the mouth. The virus could then get into the blood if you have bleeding gums or tiny sores somewhere in the mouth. The same is true if infected sexual fluids from a woman get into the mouth of her partner. But infection from oral sex alone seems to be very rare.

### ***How does HIV affect the body?***

HIV destroys a particular variety of white blood cells that are essential for destroying disease-causing germs. There are several varieties of white blood cells in the body. Of these, lymphocytes form about 25% of the total white blood cell count. They normally increase in number in response to any infection. There are two types of lymphocytes: (a) B cells and (b) T cells. When the B cells come in contact with a disease-causing agent such as bacteria or virus, they secrete large volumes of antibodies - chemical substances that can destroy the disease-causing germs. The main functions of B cells are to search, identify and then bind with the disease causing germs.





Priya Nagarajan

The T cells are lymphocytes that have travelled through a small gland called the thymus gland, which is situated in the middle and upper part of the bony cage of the chest. When a disease-causing germ enters the body, the T cells produce several new copies of itself. Each T cell contains chemical substances that can destroy the specific disease-causing germs. T cells are also called “killer cells” because of their two main actions, which are (a) they secrete chemical substances necessary for destroying the disease-causing germs and (b) they help the B cells in destroying the agents.

### ***How does HIV spread in the body?***

The HIV virus multiplies and affects some cells of the immune system contain a molecule called CD4 on their surface. CD4 molecules are also found on the T cells. When the HIV virus enters the body, it first identifies cells with CD4 and attaches itself to them.

### ***Does HIV/AIDS affect children?***

Yes. Children can be both infected and affected by HIV/AIDS. Over 2.5 million children worldwide are now infected with HIV.

### ***How does a mother transmit HIV to her unborn child?***

An HIV-infected mother can infect the child in her womb through her blood. The baby is more at risk if the mother has been recently infected or is in a late stage of AIDS. Transmission can also occur at the time of birth when the baby is exposed to the mother’s blood and to some extent transmission can occur through breast milk. Transmission from an infected mother to her baby occurs in about 30% of cases.

### ***Can HIV be transmitted through breast-feeding?***

Yes. The virus has been found in breast milk in low concentrations and studies have shown that children of HIV-infected mothers can get HIV infection through breast milk.

### ***Can blood transfusions transmit HIV infection?***

Yes, if the blood contains HIV. In many places blood is now screened for HIV before it is transfused. If you need a transfusion, try to ensure that screened blood is used.

### ***Can injections transmit HIV infection?***

Yes, if the injecting equipment is contaminated with blood containing HIV. Avoid injections unless absolutely necessary. If you must have an injection, make sure the needle and syringe come straight from a sterile package or have been sterilised properly; a needle and syringe that has been cleaned and then boiled for 20 minutes is ready for reuse. Finally, if you inject drugs, of whatever kind, never use anyone else’s injecting equipment.

***Can I get infected with HIV from mosquitoes?***

No. From the start of the HIV epidemic there has been concern about HIV transmission of the virus by biting and bloodsucking insects, such as mosquitoes. However, studies have shown no evidence of HIV transmission through mosquitoes or any other insects — even in areas where there are many cases of HIV/AIDS and large populations of mosquitoes.

When an insect bites a person, it does not inject its own or a previously bitten person's or animal's blood into the next person. Rather, it injects saliva, which acts as a lubricant so the insect can feed efficiently. HIV lives for only a short time inside an insect and, unlike organisms that are transmitted via insect bites, HIV does not reproduce (and does not survive) in insects. Thus, even if the virus enters a mosquito or another insect, the insect does not become infected and cannot transmit HIV to the next human it bites.

***If a person becomes infected with HIV, does that mean they have AIDS?***

No. HIV is an unusual virus because a person can be infected with it for many years and yet appear to be perfectly healthy. But the virus gradually multiplies inside the body and eventually destroys the body's ability to fight off illness.

It is still not certain that everyone with HIV infection will get AIDS. It seems likely that most people with HIV will develop serious problems with their health. But this may be after many years. A person with HIV may not know they are infected but can pass the virus on to other people.

***Is there a vaccine for HIV/AIDS?***

While there is currently no vaccine for HIV/AIDS, research is under way. Many candidate vaccines are presently undergoing either phase I or phase II clinical trials in various countries, including India. Field trials to determine efficacy will take another 3-5 years or more. Hence, a vaccine for general use is unlikely to be available in the near future.

***Is there a treatment for HIV/AIDS?***

All the currently licensed anti-retroviral drugs, namely AZT, ddI and ddC, have effects which last only for a limited duration. In addition, these drugs are very expensive and have severe adverse reactions while the virus tends to develop resistance rather quickly with single-drug therapy. The emphasis is now on giving a combination of drugs including newer drugs called protease inhibitors; but this makes treatment even more expensive.

Better care programmes have been shown to prolong survival and improve the quality of life of people living with HIV/AIDS.





### ***How can I tell if I have HIV infection?***

The only way to know for sure if you have this virus is by taking a blood test called the “HIV Antibody Test.” “The HIV Test” or the “AIDS Test” alone cannot tell you if you have the infection. The HIV test can tell you if you have the virus and can pass it to others in the ways already described. The test is not a part of your regular blood tests—you have to ask for it by name. It is a very accurate test.

If your test result is “positive,” it means you have the HIV infection. Additional tests can tell you how strong your immune system is and whether drug therapy is indicated.

If your test is “negative,” and you have not had any possible risk for HIV for six months prior to taking the test, it means you do not have HIV infection. You can stay free of HIV by following prevention guidelines.

### ***If I am HIV positive, what should I do?***

If you’ve tested positive for HIV, consider the following:

- See a health care professional for a complete medical work-up for HIV infection and advice on treatment and health maintenance. Make sure you are tested for TB and other STDs. For women, this includes a regular gynaecological examination.
- Inform your sexual partner(s) about their possible risk for HIV.
- Protect others from the virus by following precautions.
- Protect yourself from any additional exposure to HIV.
- Avoid drug and alcohol use, practice good nutrition, and avoid fatigue and stress.
- Seek support from trustworthy friends and family when possible, and consider getting professional counselling.
- Find a support group of people who are going through similar experiences.
- Do not donate blood, plasma, semen, body organs or other tissue.

### ***What are the symptoms of HIV/AIDS?***

A person infected with HIV is not likely to have any symptoms for about three to ten years. This period may be longer if the natural defense mechanism of the body is good. Although a person infected with HIV does not have any symptoms, he/she can spread the infection to others. This is why it is recommended that any one who has sex with a partner who is not in a mutually faithful relationship should practice safe sex. This means using a condom.

A person is said to have AIDS if he/she has at least two major signs and at least one minor sign and there is no other cause of poor immune mechanism.

**Major signs:** Diarrhoea is very common in people with HIV/AIDS. It is normally clear

and watery and may be associated with cramp-like pain in the abdomen and vomiting. Chronic diarrhoea with excessive loss of weight is one of the important features of HIV/AIDS. There may also be continuous fever and increased sweating at nights. Weight loss is also one of the signs.

**Minor Signs:** Chronic cough that does not respond to routine treatment, enlargement of the lymph nodes, fungal infection of the mouth called candidiasis, recurrent infections of herpes group of viruses.

### ***What are the opportunistic infections in AIDS?***

Poor defence mechanism of the body allows several disease-causing germs to infect people with HIV/AIDS. One of the common opportunistic infections seen in people with HIV/AIDS is tuberculosis.

**Tuberculosis:** This is a bacterial infection and is normally transmitted when a person with active tuberculosis coughs or sneezes. Common symptoms of tuberculosis include cough, fever, increased sweating at nights, loss of weight and excessive fatigue.

Tuberculosis often occurs in the early stages of HIV infection. Since tuberculosis is already one of the major health problems in India, people with HIV are at a higher risk of getting it. Very often, tuberculosis is the first indication that a person has HIV infection.

Tuberculosis is more common in people with HIV infection who have less than two hundred CD4+ count. ■



## Appropriate Terminology



People Living With HIV/AIDS  
 HIV positive  
 HIV/  
 AIDS  
 Died from HIV/AIDS related illness  
 Multiple sex partners  
 HIV test  
 Contract HIV  
 Transmitting HIV infection  
 Virus/Infection/Epidemic  
 Children orphaned by AIDS  
 Injecting drug users



HIV/AIDS victim/sufferers/carriers  
 HIV patient  
 AIDS virus  
 Full-blown AIDS/ AIDS positive  
 Died of AIDS  
 Promiscuous  
 AIDS test  
 Catch HIV  
 Transferring AIDS  
 Disease  
 AIDS orphans  
 Drug addicts

### AVOID:

#### Term

High risk groups  
 Terminal disease/Deadly/Ticking  
 time bomb/The demon of AIDS/  
 Scourge/Threat/Menace/Halting  
 the march of AIDS/Viral Tsunami/  
 Plague/Death sentence/Jaws of death/  
 Circle of death/World fell apart/  
 Country's AIDS capital/Counting  
 remaining days/Severely afflicted  
 by the curse/Pandemic  
 Innocent victims

#### Why

Everybody is at risk today, not just sexworkers or truck drivers  
 Causes scare and alarm instead of  
 informing  
 It insinuates that the rest deserve it

# NGOs, Networks of HIV Positive People & Websites

## NGOs in Punjab

### Yuvsatta

H.No. 3363, Sec-35D,  
Chandigarh  
Tel.: 0172-614951

### Surya Foundation

(Survival of Young & Adolescent  
Foundation)  
No. 3139, Sector N 28 D,  
Chandigarh  
Tel.: 0172-655661

### All India Women's Conference

Indira Gandhi Bhawan, No. 286,  
Sec-11 A, Chandigarh  
Tel.: 0172-747061

### Progressive Education Society

No. 283, Sec-48 B,  
Kendriya Vihar,  
Chandigarh  
Tel.: 0172-890643

### Indian Council for Social Welfare

Room No. 16, 1st Floor,  
Karuna Sadan Building,  
Sec-11, Chandigarh  
Tel.: 0172-745914

### Servants of the People Society

Lajpat Rai Bhawan,  
Sec-15B,  
Chandigarh  
Tel.: 0172-780611

### Voluntary Health Association of Punjab

SCF 18/1, Sec-10 D,  
Chandigarh,  
Tel.: 0172-743557

### Citizen's Awareness Group

No. 2812, Sec-38 C  
Chandigarh  
Tel.: 0172-604253

### Family Planning Association of India

Kothi No. 637, Phase N II, Mohali  
Tel.: 0172-273791

### Indian Council for Social Welfare

Room No. 16, 1st Floor,  
Karuna Sadan Building  
Sec-11 Chandigarh  
Tel.: 0172 745914

### Society for Service to Voluntary Agencies

Room No. 18-20, 1st Floor,  
Karuna Sadan, Sec-11B  
Chandigarh  
Tel.: 0172-746258

### Jan Shiksha Sansthan

SCO No. 313(FF), Sector-38D,  
Chandigarh  
Tel.: 0172-697740

### Christian Aids

Fatehgarh Sahib, Punjab  
Tel.: 1726-271504

### Arpan Trust

Nangal (Ropar), Punjab  
Tel.: 01887-224741

### Umeed Khanna Foundation

Gaushala Road, Opp,  
Grain Market, Sangrur  
Tel.: 01673-36744, 40663, 32148

### Association for Social & Rural Advancement

VPO Dher-140123 (ASRA)  
District Ropar  
Tel.: No 01882 0 260611, 260211

### Family Planning Association of India

Kothi No 637  
Phase 2, SAS Nagar, Mohali (Ropar)  
Tel.: 0172- 273791

### International Council of Ayurveda Jagraon Sharma Hospital & Nursing Home

Jagraon, Ludhiana  
Tel.: 01624- 23399, 34109

### International Forum for Education and Development

27 Adarsh Nagar, RT Road, Amritsar  
Tel.: 0172-221414

### Malwa Education Society for Social Interventions & Health Activities (MESSIHA)

Natt Road, Talwandi Saboo, Bathinda  
Tel.: 01655- 38486, 20608

**SGN Medical Society**

Shed No. 50, Sector N 3 Talwar  
Township, Hoshiarpur  
Tel.: 01883 37388

**NGOs in Uttar Pradesh**

**Naz Foundation International**

9 Gulzar Colony, New Berry Lane,  
Lucknow 226 001, India  
Tel.: +91 (0)522 205781

**Sarvajan Kalyan Samiti**

275, Katghar, Allahabad- 211003  
Tel.: 0532-2414520, 2416921

**Sukriti Sewa Sansthan**

886 G, Brahmपुरi, Meerut  
Tel.: 1021-613451, 611683

**Pragati Sewa Sansthan**

117/798, N Block ,  
Kakadeo, Kanpur  
Ph: 0512- 50048, 240148

**Nav Jyoti Samaj Kalyan Samiti**

MIG 87, Indra Nagar, Kalyanpur,  
Kanpur Nagar- 208026  
Tel.: 0512 575061

**Global Science Academy**

Malviya Road  
(Near Pikaura Dattu Rai)  
Basti - 272001  
Tel.: 05542 85060

**Sarvahara Kalyan Samiti**

9/35, Ahata Nidhan Singh,  
Guriyabad, Aligarh  
Tel.: 0571 521168

**Gramin Seva Sansthan**

19, 1st Floor , Opp Nurse Hostel,  
Town Hall, Gorakhpur - 273001  
Tel.: 0551-344381, 258880

**Sapna Kalyan Samiti**

Zilla Panchayat Inspection House Road,  
Near D.M. Crossing, Baharaich - 27180  
Tel.: 05252 - 35594

**Swargia Ram Sevak Sewa Samiti**

4/478, Avas Vikas Colony , Near  
Panchayat Bhawan,  
Barabanki - 225001  
Tel.: 05248 - 20111

**Jai Hospital & Research Centre**

Near Shree Talkies Bypass,  
Agra- 282002  
Tel.: 0562 - 520381, 520167

**Deep Jan Kalyan Samiti**

15, Krishnaman Colony,  
Delapir, Bareilly  
Tel.: 0581 - 445087

**FRIENDS**

27, Sheel Nagar Extension,  
Mahmoorganj, Varanasi

**UPVHA**

5/459, Viram Khand  
Gomti Nagar, Lucknow  
Tel.: 2725539

**NGOs in Karnataka**

**Swasti**

No 52, Postal Colony,  
Sanjay Nagar, Bangalore

**Milana**

98, Old Race Course Road,  
Austin Town, Bangalore  
Tel.: 25545691

**Community Health Centre (CHC)**

No 367, Srinivasa Nilaya,  
Jakkasandra 1 Main,  
1 Block, Koramangala,  
Bangalore 560 034  
Tel.: 080 - 2546 1920

**Freedom Foundation**

Site No 30, Survey No 17/2,  
Hennur Village Post,  
Hennur Bande,  
Bangalore 560 043  
Tel.: 080 - 2544 0134/2544 0135

**Samraksha**

No 522, 2nd Floor, Block 5,  
Ranka Park Apartments 4, 5 and 6,  
Lalbaugh Road, Bangalore 560 022  
Tel.: 080-23546965/23546961

**Society for People's Action for  
Development (SPAD)**

Flat No 1-13, Orient Manor,  
15, Highstreet,  
Cooke Town,  
Frazer Town Post,  
Bangalore 560 005,  
Tel.: 080 - 2547 1680

**Vimochana**

No 33/1-9, Thyagaraja Layout,  
Jai Bharat Nagar,  
Maruthi Seva Nagar PO,  
Bangalore 560 033,  
Tel.: 080 - 2549 2781/2549 2783

**ICHAP**

Pisces Building  
#4/13-1, Crescent Road  
High Grounds  
Bangalore - 560 001  
Tel.: 080 - 23562028

**Jagruthi**

Jyothi Complex,  
C3, 2nd Floor, 134/1,  
Infantry Road,  
Bangalore - 560001.  
Tel.: 080 - 22860346

**Odanadi Seva Samsthe**

15/2B, S.R.S Colony,  
Hootagalli Village,  
Belavadi Post,  
Hunsur - Mysore Road,  
Mysore - 571 186.  
Tel.: 0821 - 2402155

**Population Foundation of India's  
Global Trust Fund**

Tel.: 93411 38609  
B-28, Qutab Institutional Area,  
New Delhi-110 016

**Action Aid****(HIV/AIDS Thematic Unit)**

No 3, Rest House Road  
Bangalore - 560001  
Tel.: 080 - 25586682

**Asha Foundation**

No. 58, SBM Colony,  
3rd Main,  
Anand Nagar,  
Bangalore - 560024  
Tel.: 080 - 23332921

**PATH**

11/3-5, 2nd floor, Palace loop road,  
Vasanth Nagar, Bangalore - 560052  
Tel.: 080 - 51518858/57

**Indian Medical Association  
(Karnataka Chapter)**

Katyayini Building, Near CBT, KEB Road,  
Hubli - 580 020  
Tel.: 0 94482 73256

**Karnataka Health Promotion Trust**

Bangalore  
Tel.: 0 94482 39363

**Human Rights Law Network**

Bangalore  
Tel.: 57624757

**Murray Culshaw Consulting**

314/1, 7th Cross Road,  
Bangalore  
Tel.: 080 - 25352003

**Country-wide List of Networks of  
People Living with HIV/AIDS****ANP+ (Assam Network for People living  
with HIV/ AIDS)**

Rangpur Path, Sundarpur,  
Opp. Blue Flame Gas Agency,  
PNDC Building, 2nd Floor  
RG Bodhua Road, Guwahati - 781 005  
Tel: 0361-2585104  
email: anppplus@yahoo.com

**BNP+ (Bengal Network for People  
living with HIV/ AIDS)**

432, Jawpur Road,  
Jagadish Polly,

Kolkata - 700 074

Tel: 033 - 26864466

email: bnpplus\_05@rediffmail.com

**CPK+ (Council of People living with  
HIV/AIDS)**

Ist floor, Noor Mansion,  
St. Albert's High School Road  
Ernakulam - 682 035  
Tel: 0484 - 2367685, 2384462  
email: cpkcpkin@yahoo.co.in

**GSNP+ (Gujarat State Network of  
People Living with HIV/ AIDS)**

No 35, Surat Municipal Medical College  
& Hospital (Simmer)  
Near Sahara Darwaja, Surat  
Tel: 0261- 5594700  
email: gsnppplus@yahoo.co.in

**KNP+ (Karnataka Network of Positive  
People)**

No. 113, 1st floor,  
8th Main Road, 15th Cross,  
Wilson Garden, Bangalore  
Tel: 080- 22120409  
email: knppplus@vsnl.net

**MNP+ (Manipur Network of Positive  
People)**

Yaikul Hiruhanba Leikai Imphal,  
West Imphal, Manipur - 755 001  
Tel: 0385- 2440828, 2440469  
email: mnppplus\_145@hotmail.com

**NMP+ (Network of Maharashtra by  
People living with HIV/AIDS)**

Kashiba Shinda Sabha Graha,  
Waghare Vasti, Pimprigaoan,

Pimpri - 17, Pune  
Tel: 020- 27411020  
email: nmpplus@vsnl.net

**PWN+ (Positive Women's Network)**

9/5, Avenue Road,  
Shanti Apartments,  
Nungambakkam,  
Chennai - 600 034  
Tel: 044 - 28270204, 28203959  
email: poswonet@hotmail.com

**PNP+ (Pondicherry Network of Positive People Welfare Society)**

No.19, Ayyanar Koil Street,  
Raja Nagar,  
Pondicherry - 605 013  
Tel: 0413 - 2200769  
email: pondypositivenet@yahoo.co.in

**RNP+ (Rajasthan Network for Positive People)**

Plot No: 15-B, RSEB Colony  
Vaishali Nagar, Jaipur, Rajasthan  
Tel.: 0141- 2351108, 2358396,  
2348667

email: rnpplus@yahoo.co.in  
**TNP+ (Telugu Network of People Living with HIV/AIDS)**

No.31-12-5, Gopala Krishnaiah  
St. Machavaram,  
Vijayawada - 522 004.  
Tel.: 0866 - 2432306  
email: tnp58ap@indiatimes.com

**UNP+(Utkal Network of People Living with HIV/AIDS)**

'DEVI DAYA' Plot 2983, Anantpur,  
Bes. Chintamaniswarar Temple  
Bhubaneswar 751 006, Orissa  
Tel: 0674-2404238, 2404132

**ZINDAGI GOA**

2nd floor, Behind MPT Ground,  
Uma Shankar Building,  
Patrong, Baina  
Vasco-da-gama 403 802  
Tel: 0832- 3095122, 5645729(PP)  
email: zindagigoa@yahoo.com

**M-PLAS**

C/o Lianvunga Durtlang,

Leitan South, Aizawl,  
Mizoram - 796 005  
Tel: 0389- 2317088  
email: mplas\_mplas@yahoo.co.in

**NNP+ (Network of Naga People Living with HIV/AIDS)**

82, East View, 'D' Block  
Kohima, Nagaland - 797 001  
Tel: 0370 - 2108759  
email: nnpplus@yahoo.co.in

**TNP+ Tamil Nadu Network for People Living with HIV/AIDS**

Kalki Bhawan,  
16, 4th Street,  
Viswasapuram,  
Jnanalivapuram,  
Madurai - 16

**NPH+ Network of People Living with HIV/AIDS in Haryana**

445/23, Opp. Dev High School,  
Hira Nagar, Khansa Road,  
Gurgaon - 112 001  
Tel: 0124- 3952217

**Websites**

www.unicef.org  
www.unaids.org  
www.undp.org  
www.redribbon.com  
www.plwhs.org  
www.indianngo's.com  
www.nfi.net  
www.unifem.org.in  
www.unesco.org  
www.youandaids.org  
www.kaisernetwork.com  
www.icaso.org

www.cdc.gov/hiv/dhap.htm  
www.hsph.harvard.edu/hai/home.html  
www.icrw.org  
www.hivpositive.com  
www.strashope.org  
www.hivtest.org  
www.info.com/hiv  
www.napwa.org  
www.aidsinfo.hih.gov  
www.aegis.com  
www.aids.com  
www.aids-india.org

www.hivanonymous.com  
www.gnpplus.net  
www.ias.se  
www.avert.org/aidsindia.htm  
www.saathii.org/stapp/searchIndia.jsp  
www.aidsalliance.org  
www.whoindia.org/cds/cd/hiv  
www.nacoonline.org  
www.lawyerscollective.org  
www.panos.org.uk  
www.hdnet.org

## Helpline Assistance

### North India

#### AAG

Monday to Saturday 10.00 am - 5.30 pm  
AIDS Awareness Group  
Ms. Elizabeth Vatsyayan  
119, Humayunpur,  
Safdurjung Enclave,  
New Delhi - 110029  
Tel.: 011-26187953  
Fax: 011-51650029  
Email: aagindya@yahoo.co.in

#### Shubhchintak

Monday to Friday 10.00 am - 5.00 pm  
Saturday 10.00 am - 1.00 pm  
AIDS Education & Training Cell,  
Centre for Community Medicine  
Dr. Bir Singh  
All India Institute of Medical Sciences  
(AIIMS),  
New Delhi - 110029  
Tel.: 011-26588333  
Fax: 011-26588663  
Email: birsingh43@hotmail.com  
Website: www.aiims.edu

#### SOFOSH

Monday to Saturday 8.00 am - 10.00  
am and 7.00 pm - 9.00 pm  
Society for Social Health (SOFOSH)  
Dr. Naresh Anand  
H.No. 206/2, Sector-41A  
Chandigarh - 160041  
Tel.: 011-0172-2627310  
Email: sofosh@yahoo.co.in

#### Sparsh

Monday to Saturday 9.00 am - 5.00 pm  
Parivar Seva Sanstha  
Ms. Nirmala Mishra  
C-374, Defence Colony  
New Delhi - 110024  
Tel.: 011-24332524 / 24337712

### South India

#### ACCEPT

Monday to Saturday 10.00 am - 5.30 pm  
245, KRC Road, Near Visthar, Dodda  
Gubbi PO., Bangalore - 562149  
Tel.: 080-22714110 / 56990452  
Email: accept@vsnl.com

#### AIDS Desk, GuruClin

Monday to Friday 9.00 am - 5.00 pm  
National Lutheran Health and  
Medical Board  
Dr. Shiela Shyamprasad  
5 Purasavalkam High Road, Kilpauk,  
Chennai - 600010  
Tel.: 044-26480933  
Email: sheilashyamprasad@yahoo.co.in  
/ guruclin@vsnl.com  
Website: www.aidsdesk.org

#### Asha Foundation HIV/AIDS Helpline

Monday to Friday 9.30 am - 4.30 pm  
Saturday 9.30 am - 1.00 pm  
Dr. Glory Alexander  
No.58, III Main, SBM Colony,  
Anandnagar,  
Bangalore - 560024

Tel.: 080-23543333 / 23545050 /  
23332921  
Fax: 080-23332921  
Email: ashafblr@yahoo.co.in  
Website: www.ashas.org

#### DESH

Monday to Saturday 9.30 am - 5.15 pm  
Deepam Educational Society for Health  
Mr. Sarvannan  
3/655 B Kuppam Road,  
Kaveri Nagar Kottuvakkam,  
Chennai - 600041  
Tel.: 044-24511187 / 2411188  
Fax: 24511112  
Email: desh@vsnl.com  
Website: www.deshhealth.org

#### Divya Disha HIV/AIDS Helpline

All days 8.00 am - 11.00 pm  
Mr. Isadore Philips  
H.No.9-1-103A, Tatachari Compound,  
Secunderabad - 500025  
Email: divyadisha@rediffmail.com /  
isiphil@gmail.com

#### Freedom Foundation (FF) HIV/AIDS Helpline

All days 9.00 am - 5.00 pm  
FF Bangalore Office  
Mr. Ashok K. Rau  
1st Floor Site No.30,  
Survey No.17/2, Hennur Bande,  
Bangalore - 560043  
Tel.: 080-25443101 / 25440135  
Email: freedom\_found@vsnl.net

FF Secunderabad Office  
Mr. Narendran  
21 Carriappa Street, Bolarum,  
Secunderabad - 500010  
Tel: 040-27861023  
Website:  
www.thefreedomfoundation.org

Positive Help  
Monday to Saturday 10.00 am - 5.00 pm  
YRG Care  
Voluntary Health Service,  
Taramani,  
Chennai - 600113  
Tel.: 044-22542929  
Fax: 044-22542939  
Email: info@yrgcare.org

Saadhan Helpline  
Monday to Friday 8.30 am - 7.30 pm  
Saturday 8.30 am - 5.30 pm  
Population Service International  
Chennai  
Mr. J. Joson Mellot  
6/80, Luz Avenue, Mylapore,  
Chennai - 600004  
Tel.: 044-24996131 / 24995808  
Email: chennaihelpline@psi.org.in

Population Service International  
Vishakapatnam  
Monday to Friday 10.00 am - 8.00 pm  
Saturday 10.00 am - 4.00 pm  
Ms. Jessy Choudhury  
Flat no.1, 2nd Floor,  
Satya Sridevi Enclave,  
Third Line, Dwarka Nagar,  
Vishakapatnam - 500016  
Tel.: 0891-5560192  
Email: vizaghelpline@psi.org.in

### **East India**

OSERD  
Monday to Saturday 10.00 am - 5.00 pm  
Organization for Socio-Economic and  
Rural Development  
Mr. S. Pankaj  
144 F Sri Krishna Puri, Boring Road,  
Patna - 800001, Bihar  
Tel.: 0612-2211423  
Email: oserd45@rediffmail.com /  
pankaj55@sancharnet.net

Saadhan  
Monday to Saturday 9.30 am - 8.00 pm  
Population Service International (PSI)  
Ms. Satamita Dutt  
Kolkata, Unit 6 & 7, 4th Floor, Phase 1  
New Alipore, Marketing Complex,  
Block M, New Alipore,  
Kolkata - 700053  
Tel.: 033-243003945 / 243003946

SASO  
Monday to Saturday 9.30 am - 4.00 pm  
Social AIDS Service Organization  
Khwai Lalambung, Makhong,  
Rims Road(s)  
Imphal - 5795001  
Tel.: 0385-2411408  
Email: oharikumar@yahoo.co.in  
Website: www.sasoimphal.org

### **West India**

Asha  
Monday to Friday 9.00 am - 4.00 pm  
Asha Project  
Municipal Eye Hospital, 2nd Floor, M.S.  
Ali Road, Near Two Tank, Grant Road,

Mumbai - 400008  
Tel.: 022-23080486 / 23050796  
Email: asha\_fhi@yahoo.com

FPAI Helpline  
Monday to Friday 10.00 am - 5.00 pm  
Family Planning Association of India  
Dr. Usha Krishna  
5th Floor, Cecil Court, Near Regal  
Cinema, Colaba, Mumbai - 400001  
Tel.: 022-22874689 / 22871856  
Email: fpaimum@hathway.com  
Website: www.fpaidia.com

Glaxo AIDS Helpline  
Monday to Saturday 9.30 am - 7.30 pm  
Ms. Pooja Dave  
Glaxo Smithkline Pharmaceutical Ltd  
Worli, Mumbai - 400025  
Tel.: 022-24983444  
Email: gskhivaidshelpline@yahoo.co.in

Goa State AIDS Control Society  
HIV/AIDS Helpline  
Monday to Saturday 9.30 am - 5.45 pm  
Mr. Jerome Dias  
1st Floor, Dayanand Smruti Building,  
Swami Vivekanand Road,  
Panaji - 403001  
Tel.: 0832-2427286 / 2422518  
Fax: 0832-2422518  
Email: sacs\_goa@nacoindia.org /  
goasacs@sancharnet.in

Positive People  
Monday to Saturday 9.30 am - 7.00 pm  
Mr. John Pinheiro  
Maithili Apts., St. Inez, Panjim  
Tel.: 0832-2431827 / 2424396 /  
2425404

**Prakhakar Helpline**

Monday to Saturday 10.00 am - 4.00 pm

Ms. Anuradha Karegar

Nana Palkar Smruti, Rugna Seva

Sadan, 158 Rugna Seva Sandan Marg,

Off Dr. Ambedkar Road, Parel,

Mumbai - 400020

Tel.: 022-24173233

Email: pkkk\_npss@yahoo.co.in

**Rotary Kripa AIDS Helpline**

Everyday 9.00 am - 9.00 pm

Kripa Foundation

Mr. G.S. Srinivas

81/A, Chapel Road,

Mount Carmel Church,

Near Lilavati Hospital,

Bandra (W),

Mumbai - 400050

Tel.: 022-26429158

Email: kripadarc@vsnl.net

**Saadhan**

Monday to Saturday 9.00 am - 9.00 pm

Sunday 10.00 am - 6.00 pm

Population Service International (PSI)

Dr. Shilpa

18 Kunjai Cooperative Society,

V.P Road, Khotachiwadi,

Girgaun,

Mumbai - 400004

Tel.: 022-23870883 / 39540753 /

30964278

Email: helpline@psi.org.in

**The Salvation Army**

Monday to Friday 10.00 am - 5.00 pm

Manoj Pawar

84, Sankale Street,

Madanpura,

Mumbai - 400008

Tel.: 022-23093566

Email: msal aids@vsnl.net

**SNDT Helpline**

Monday to Friday 2.00 pm - 4.00 pm

SNDT Women's University, Population

Education Resource Centre

Dr. Vandana Chakravathy

SNDT Women's University, 1st Floor,

Above Parkar Hall, New Marine Lines,

Mumbai - 400020

Tel.: 022-22081497 / 22066892

Email: sndtperc@bom3.vsnl.net.in

**UMRC**

Monday to Saturday 10.00 am - 6.00 pm

Unison Medicare and Research Centre

Dr. I.S. Gilada

Maharukh Mansion, Alibhai Premji

Marg, Grant Road (East),

Mumbai - 400007

Tel.: 022-23061616

Email: iho aids@vsnl.com

Website: www.unisonmedicare.com







### शहरों से ग्रामीण क्षेत्रों में पहुंच रहा है एड्स

ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है। शहरों से ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है। शहरों से ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है। शहरों से ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है।

**राज्यों में अक्टूबर से घर-घर जाकर जागसूचक किताबें जायेगा लोगों को**

एड्स का खतरा बढ़ रहा है। शहरों से ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है। शहरों से ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है। शहरों से ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है।

## Strange bedfellows: Drought & AIDS

**D**ROUGHT-stricken villages are adding to the existing figures of HIV/AIDS cases in India. Virender Khanna explores the problem.

Under scrutiny, these areas in a high probability that the number of infections there will rise. HIV/AIDS will increase significantly. These epidemics are leading scientists on the epidemic and they in one such village of Rajasthan reported that about 70 per cent of those women come positive for AIDS and another 20 suffered from many sexually transmitted diseases. The local epidemic of HIV positive partners in work villages could double the number of infected women in the village and spread the local epidemic of HIV/AIDS, outside the village. There are some villages in Rajasthan, Andhra Pradesh, Madhya Pradesh, Chhattisgarh, Orissa, Andhra Pradesh, Karnataka and Tamil Nadu which are drought hit. One

lack of attention and because the susceptibility of people to diseases due to malnourished body. Another indicator that some regions fall prey to various diseases including tuberculosis is rapid and. (epidemiology of women by the rich and powerful, particularly concentrated in villages, upon the available, an easy means of work in a well known fact. Large-scale seasonal work of rural, land and even with of children and women, to create extreme cases, have been reported from various poverty-stricken areas during drought-like conditions. This is a clear indication that drought is leading to increasing incidence of women's sex concentration, the same reason why women who work in such areas are more vulnerable to HIV/AIDS. These are reasons why young, teenage girls have been found more prominently in parents for actual reasons. Involuntarily, they are being sent to work in such areas for work and some of them who stay back on a plough for their wives, daughters, sisters and even mothers and siblings, involuntarily have a hard eye to see the women. More so than in the past, it is now that women are working in the field. More than ever before, they are working in the field. More than ever before, they are working in the field. More than ever before, they are working in the field.

There is also a high likelihood that some of these women who go to work in such areas are taking up prostitution as a traditional means of survival in these regions.

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There is also a high likelihood that some of these women who go to work in such areas are taking up prostitution as a traditional means of survival in these regions.

## कमा कर ला रहे 'एड्स'

एड्स का खतरा बढ़ रहा है। शहरों से ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है। शहरों से ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है। शहरों से ग्रामीण क्षेत्रों में एड्स का खतरा बढ़ रहा है।

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## कमा कर ला रहे...

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## Two-Day Media Workshop Structure

Journalists arrive by 6 p.m. on the day before the workshop and check into hotel.

Participants get to meet and know each other. Film *Phir Milenge* or *My Brother Nikhil* shown followed by dinner.

### Day 1

10 am to 10.15 am	Registration & Coffee
10.15 am to 10.35 am	PFI's presentation on media research findings
10.40 am to 11.15 am	Inauguration by NACO Director – How NACP-II has fared and what is expected of NACP-III
11.15 am to 11.30 am	Q & A
11.30 am to 12 noon	Overview of the HIV/AIDS scenario in the state
12 noon to 12.15 pm	Q & A
12.15 pm to 1.15 pm	Positive people to share their perspectives with the media. Followed by Q&A
1.15 pm to 2 pm	Lunch
2 pm to 3 pm	An interactive session on Facts and Myths on HIV/AIDS
3 pm to 5 pm	Group activity Three or four groups to be formed; will brain storm on subjects allotted to them and work out radio programmes, radio jingles, poster campaigns and do a street play.

**Group 1:** In a district where a network of Positive people has been formed for the first time, several people from the villages of the district join the network. The Ludhiana station of All India Radio organises a panel discussion with three Positive people. It is a 15-minute programme.

**Group 2:** An advertising company has been entrusted by the state AIDS Control Society to conduct a poster campaign on raising HIV/AIDS awareness. The campaign has to promote use of condoms and safe sex. Please prepare a set of four to five posters.

**Group 3:** A young mother discovers late in her pregnancy that she is HIV positive. Do a 20 minutes street play around the issue to bring out the stigma and discrimination that she faces and how she tackles the situation. The entire group participates.

### Day Two

8 am to 2pm	Field trip for journalists to a care and support project
2.30 pm to 5 pm	Group presentations. Awards will be given for the best two presentations.
5 pm to 5.30 pm	A newspaper editor will talk briefly about the media's responsibilities in providing adequate space for HIV/AIDS related stories and an enlightened debate in the media. He/she will present certificates to journalists who have participated in the workshop.

**Peer Review Team:**

Ms Kalpana Jain

Ms Mona Mishra

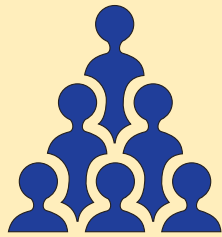
Mr Noble Thalari

Mr Rajesh Nair

Ms Alka Narang

**UNDP Support Team:**

Dr Ash Pachauri, Mr Aniruddha Brahmachari & Ms Malini Mittal



Population Foundation of India