CHAPTER-II

HIV/AIDS POLICIES AND PROGRAMMES OF GOVERNMENT OF INDIA
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2.1 Introduction: The Framework of HIV/AIDS Policies

Having discussed the intensity of HIV/AIDS and its implications, a more rigorous analysis to the variables of HIV/AIDS is due. For want of the discussion on policies and programmes, this chapter ought to highlights and devote on the background and historicity of HIV/AIDS, which paved way for the launch of various programmes and policies to deal the HIV/AIDS problems in India.

2.1.1 Objectives of AIDS Policy

The general objectives of HIV/AIDS policies are to prevent the epidemic from spreading further and to reduce its negative impacts, not simply because of infected persons but also the health and socio-economic well being at all the levels of the general population. The specific objectives of the policies are: to reiterate strongly the Government’s firm commitment to prevent the spread of HIV infection; to reduce personal and social impact; as well as to generate a feeling of ownership among all the participants.¹

To make it a truly national effort, the HIV/AIDS policies will run from both the governmental and non-governmental levels, which will include: Central Ministries and its agencies; State Governments and its agencies; city corporations and municipalities; panchayati institutions and local bodies; public and private sector industrial undertakings; business houses and corporations. To prevent and alleviate the AIDS problems, an enlarged community initiatives are mobilise with the support of a large number of NGOs and CBOs, this in turn will promote a more supportive socio-economic environment for the prevention of HIV/AIDS in India. In order to prevent women, children and other

socially weak groups from becoming vulnerable to HIV infection, the government has categorically highlighted in its AIDS policies the need of improving health education, legal status and economic prospects, so as to provide an adequate as well as an equitable provisions of health care to the HIV infected people and their families.2

The HIV/AIDS policies of government of India also includes: drawing of people’s attention to the compelling public health rationale for overcoming stigmatisation and discrimination against people infected by AIDS; promotion of better understanding about HIV infection among the people at large; generation of awareness about the nature of its transmission.

The HIV/AIDS policies also elaborates and includes: the adoption of safe behavioural practices to prevent the disease from spreading further; provision of proper health care and support for the people living with HIV/AIDS both in the hospitals and at homes; as well as to constantly monitor and interact with the international and bilateral agencies for their support and cooperation in the field of research and development, such as: new vaccines; drugs; latest health care technologies and equipments as well as valuable financial and managerial inputs.3

2. 1. 2 Strategy of AIDS Policy

The national AIDS control policy principally aims at the following strategy for the prevention and control of HIV/AIDS in India.

Firstly, the prevention of further spread of the disease by ensuring the availability of prevention tools, such as: availabilities of voluntary counselling and testing centres; availabilities of antenatal care centres; establishment of screening centres; distribution and installation of condom vending machines; administration of safe blood products and hygienic medical implements. Secondly, the launch of awareness programmes such as: educating the masses about the implications of AIDS; discourse on the use of drugs and its efficacy, discourse on the use of contraceptive and its efficacy; discourse on how to

2 Ibid.
control and prevent sexually transmitted diseases as well as opportunistic diseases. Thirdly, the provision of socio-economic milieu, were the families and individuals affected by HIV/AIDS can manage the problems themselves with their family and community support. And lastly, the health care services will be made more conducive and available to the people living with HIV/AIDS in times of their sickness both in hospitals and at homes through community support. These are some of the most important component of AIDS policies preventive strategies in India, which are not just directed at the specific high risk groups but are meant for all the sections of the society.  

2.1.3 National AIDS Committee (NAC) 1986

HIV/AIDS in India was first identified among the commercial sex workers (CSW) in Chennai, Tamil Nadu in 1986. Soon the government of India constituted a high-powered National AIDS committee in 1986.

2.1.4 National AIDS Control Organisation (NACO) 1987

In 1987, the National AIDS Control Programme (NACP) was launched under the ministry of Health and Family Welfare. The national AIDS control program realised the establishment of a number of screening centres throughout the country, which covered the screening of blood products and health education. The focus was initially to screen the foreign students in India. Towards the end of 1987, National AIDS Control Organisation (NACO) started seeding ground with the programme activities that covered the surveillances in the epicenter of the epidemic. Screening of blood and blood products for safe transfusion, health education and the generation of public awareness through mass communication were initiated in all the major urban areas of India. In 1992, with the support of the international agencies such as World Bank, UNAIDS, UNDP and WHO, the ministry formally established the National AIDS Control Organisation with the prime function of policy formulation, prevention and control programmes.  

4 Ibid.
2.1.4.1 National AIDS Control Project Phase I (1992-1999)

Along with the launch of NACO, the government of India had also launched a strategic plan for HIV/AIDS prevention for the period 1992-1999, christened as the National AIDS Control Project Phase-I (NACP-I), that provided a viable platform for the establishment of an awareness and care facilitation centres, and showed due concern about HIV/AIDS in India. On the other hand these establishments meant the facilitation and development of state AIDS societies in all the Indian states. These multi-sectoral strategies for the prevention and control are: programme management; surveillance and research; Information, Education and Communication (IEC); social mobilisation through NGO’s, Control of Sexually Transmitted Diseases (STDs); condom programming; blood safety and reduction of HIV impact.6

The NACP-I has generated a new streams of awareness about HIV/AIDS, especially among the urban and rural literate masses of India. By the end of the NACP-I in 1999, the awareness levels have increased satisfactorily to over 80 per cent in urban areas, but remain low of about 30 per cent in rural India. NACP I met with several challenges in its programmes and registered some success. The achievements included capacity building in management and technical aspects of the programme in all the states and union territories. Many probationary centres were established for the training and management of HIV/AIDS personnels. More than 500 STD clinics and many ANC (Antenatal) clinics along with hundreds of free consultation and testing sites were established. Blood banks and blood transfusion without valid license were made illegal and were terminated. By the end of the NACP-I term in 1999, there were no unlicensed blood banks in India. Around 154 zonal blood testing sites were set up and over 815 public sectors as well as a good number of voluntary blood banks were regulated and

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strengthened. Surveillance systems were established in some 140 centres and 180 sentinel sites across India by the end term of NACP-I.7

National AIDS Control Project phase first was funded by International Development Agency (IDA) with a grant of about US $84 million. It was in fact a start up investment that catalyst into launching an intervention for HIV prevention, with an aim of slowing the further spread of HIV, and to mitigate the consequences and the adverse impact of HIV/AIDS. The launch of NACP-I had ensured and help in many ways in strengthening the various governmental arms to curtail the HIV/AIDS menace such as: the National AIDS Committee; the National AIDS Control Board (SACB); the National AIDS Control Organisation (NACO) and the State AIDS cells.

NACP-I significantly contributed in strengthening the systems for HIV sentinel surveillance, it had installed centres for voluntary counselling and testing in medical colleges, it had covered the national programme on sexually transmittable diseases, which brought about the synergy in STD control programmes. Due to the constant effort of NACP-I, the awareness generation activities were stepped up along with an AIDS advocacy and the NGO’s involvement. NACP-I also ensured the modernisation of blood banks along with the campaigns to increase voluntary blood donation, and lastly the NACP I prominently strengthened the management and treatment of sexually transmitted infections and promoted condom use.8

Though an appreciable progress and achievement were made with the launch of NACP-I, especially the capacity building at state levels, however it had to fight with some significant limitations in the implementation of NACP, such as centralisation of planning and implementation did not facilitate the divergent priority settings, the management across state governments remain a commendable low. The implementation of project activities at state levels remained highly uneven. The sentinel surveillance was not been able to conduct in all the states. These all limitations ultimately lead to a gross inadequacy and discrepancies in disseminating information regarding the curtailment and

8 The World Bank (2005), n.6.
prevention of HIV/AIDS epidemic in India. Vulnerable groups and sections were not all identified, the issues surrounding care and support of people living with HIV/AIDS could not be fully addressed. The IEC (Information, education and communication) remained somewhat limited, and community involvement was inadequate.\(^9\)

2.1.4.2 National AIDS Control Project Phase II (1999-2004)

The second phase of the National AIDS Control Programme (NACP-II), which was drafted for the period 1999-2004, has expanded the purpose and objectives of HIV/AIDS policies in India. NACP-II has also shifted the focus from raising awareness to changing behavior, with the launch of NACP-II, the state AIDS control societies were allocated separate funds through targeted interventions. NACP-II initiated a number of various policies and programmes with a well knitted cooperation among the public, private and voluntary sectors. It aimed at evidence based planning and prevention with a mandate for blood safety, youth campaign, Voluntary Testing and Counselling (VCT), social mobilisation, care and support for the people living with HIV/AIDS. The prevention measures taken up by NACO in the second phase includes: the school AIDS education programme, where teachers and peer educators among students are trained; debates and discussions about HIV/AIDS are made part of the school curriculum; it has also sponsored and formulated various prevention efforts such as, voluntary blood donation day, radio and TV programmes with a popular Indian film star, concerts, TV sports, distribution of posters and placards; moreover, highlights about HIV/AIDS where made to appear in all the major Newspapers and Journals both at local and national level.

Deriving from the experience of NACP-I, the NACP-II has covered the most affected and high risk-groups, such as sex workers, truck drivers, injecting drug users, men who have sex and migrant labours. NACP-II made the prevention programme a multi-sectoral body, priorities were given on setting up of annual sentinel surveillance, behavioural surveillance, mapping of high-risk groups and HIV case detection. State

\(^9\) UNDP/NACO (2004), n.7.
AIDS control societies were given the responsibilities to implement the various policies and programmes.10

Programme implementation and management in the state has become stronger, due to the flexibility and decentralise approach adopted by the NACO in the second phase. The outcomes visualise in the NACP-II were to keep the HIV seroprevalence below 5 per cent in the high prevalence states, below 3 per cent in the moderate prevalence states and below 1 per cent in the low prevalence states.11

Whatever may be the successes of NACP-II, it is still debatable whether there is a sufficient commitment at government levels to deal with the epidemic. Many high profiled public figures time and again refuses to accept that India is facing a severe threat from HIV/AIDS, the tentacles of AIDS is growing rapidly and the battle against the menace seems to have been mired by lack of consensus among the policy makers and programmers. The fund allocated during the NACP-II is only 538.8 million, which is at the lower side given the magnitude of socio-economic implications of HIV/AIDS in India.12

2.1.4.3 National AIDS Control Project Phase III (2004-2009)

The run up phases of NACP-II were matured by the end of March 2006, which was immediately followed by the launch of the third National HIV/AIDS Control Project (NACP-III). NACP-III was helped by the World Bank that provided 250 million dollars, this grant have significantly contributed and supported the Government’s efforts to prevent the further spread of HIV/AIDS and mitigated the impact being brought by the AIDS epidemic in India, which on the other hand have not only helped in assisting the

10 Government of India (2004), n.5
11 The World Bank (2005), n.6
prevention programs, but also gave boost to amplifying care, support and treatment of people living with HIV/AIDS across the country.\textsuperscript{13}

NACP-III was also supported by DFID (British Department for International Development) with a handsome grant of 102 million pounds, Global Fund against AIDS, TB and Malaria (GFATM) has contributed 214 million dollars and USAID gave a grant of 50 million dollars. Although the HIV prevalence rate in India is low, but India remains acutely at risk of both growing as well as harvesting the epidemic.

The aim and focus of the third phase of the NACP is singularly and squarely remains on the prevention effort, while at the same time it also ensures that those requiring treatment are not denied.\textsuperscript{14}

Government of India has embarked upon an ambitious goal of curtailment, restriction, halting and reversing the HIV/AIDS epidemic by the year 2011, much ahead of the 2015 target of the sixth Millennium Development Goals (MDGs).\textsuperscript{15}

The commitment of NACP-III has yielded and brought many benefits, such as an increased numbers of voluntary counseling and testing centers, establishment and facilitation of clinics to treat sexually transmitted diseases, designated interventions programmes among high risk groups, stringent regulation and support for an effective blood safety program, establishment of prevention of parent to child transmission of HIV, treatment, support and care services for people living with HIV/AIDS.

\textit{Despite these impressive achievements, HIV/AIDS remains a serious threat to India's health gains as well as its economic growth}, said Isabel Guerrero, World Bank Country Director for India. She furthermore points out that the epidemic is concentrated among high-risk groups (sex workers, men who have sex with men and injecting drug users). The increasing HIV prevalence among women in the rural areas points to a generalised


\textsuperscript{14} Mrs. Sujatha Rao, Additional Secretary and Director General, National AIDS Control Organisation, said in New Delhi about the aims and objectives of the third phase of National AIDS Control Programme.

epidemic condition prevailing in some of the Indian states. This NACP-III will therefore significantly help the government to continue scaling up the prevention, care, support and treatment interventions throughout India. Within its five year term period the NACP-III aims to cover 80 per cent of the high-risk group's viz., commercial sex workers, injecting drug users and men who have sex with men. NACP-III is also committed in pursuing and supports the scaling up of interventions in highly vulnerable sub-sections of society, such as national highway truck drivers and seasonal migrant labourers who often carry infection back to their homes in the villages.\textsuperscript{16}

99 Per cent of the Indian population is still uninfected; hence, prevention is the top priority, which is an aim and goal of the National HIV/AIDS policies. Whenever government launches programmes and projects concerning HIV/AIDS, the basic framework of aims and goals highlighted in the National HIV/AIDS policies are always maintain and continually re-shaped to suit the prevailing situation of the AIDS epidemic in India.

India has a significant number of people living with HIV/AIDS. Hence one of the prominent components of the NACP-III is the provision of the treatment, care and support to the people who are living with the HIV/AIDS. It began providing the free Anti-Retroviral Therapy (ART) from April 2004 starting with the high prevalence states of India, by the end of the year 2005, NACP-III has treated more than 80,000 persons under anti-retroviral therapy. During the project period of NACP-III, care and support services were provided to more than 380,000 people living with HIV/AIDS, over 3,40,000 persons were treated under the anti-retroviral therapy of which nearly 40,000 were children.\textsuperscript{17}

NACP-III has strengthen and developed the skills of NACO, the State AIDS Control Societies and the NGOs, which ultimately paved way for shaping the qualitative instrument to curtail the HIV/AIDS problems in India, in doing so the NACP-III has catalyst into scaling the interventions right from the Ministry of Health and Family

\textsuperscript{17} Ibid.
Welfare, government of India. NACP-III has also greatly enhanced the mainstreaming of HIV response through other ministries and the private sectors in India.  

2.1.4.4 National Health Policy 2002

Besides the launch of various HIV/AIDS programmes and projects, there are many vital governmental initiatives to combat the menace. One of the prime health policies 'The National Health Policy 2002' of the government of India, which aims to achieve a zero level growth of HIV/AIDS in India by 2007 and set priority to contain the infection at all level, such as, high-risk groups, women, children and youth. The priorities were focused on public health-related information and the IEC (Information, Education and Communication) for disseminating the curative measures as well as to bring about an overall behavior changes to drive away the menace.

Government’s endeavour to improve health standards in India were partially neutralised by the rapid growth of population. To maximise the socio-economic well-being of the people, it is important to effectively synchronise the population stabilisation measures and general health initiatives. Government of India has separately formulated the National Population Policy (NPP) in 2000. The main commonalities between the National Population Policy-2000 and National Health Policy-2002 are: the prevention and control of communicable diseases: priority to the containment of HIV/AIDS infection; universal immunisation programme for children against all the preventable diseases. Both the National Population Policy-2000 and National Health Policy-2002 address the unmet needs for basic and reproductive health services as well as supplementation of infrastructure. The synchronised implementation of these two policies will be the cornerstone of any national structural plan to improve the health standards in India.

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18 Ibid.
20 Ibid.
2.2 Policy Initiatives

The National AIDS Control Organisation (NACO), under an umbrella of the Ministry of Health and Family welfare, is the prime arm of the government of India; it is created solely to oversee the problems of HIV/AIDS in India. NACO strictly monitors the status of HIV/AIDS prevalence every year since 1998 and formulated a number of AIDS policies and programmes since its inception in 1987-1988. The policies and programmes initiated by NACO are prominently made of the following components (see 2.2.1 to 2.2.14), which are generally design in bringing a paradigm shift in the response to HIV/AIDS at all levels both within and outside the Government.\textsuperscript{21}

2.2.1 Program Management

Since HIV/AIDS is a public health matter, the Ministry of Health and Family Welfare- Government of India, directly takes into account the AIDS epidemic control program. However, because of the strong socio-economic implications and the behavioral nature in India, the HIV/AIDS requires to be treated as a developmental issue which impinges on various economic and social sectors of Governmental and non-Governmental activity. As economically productive sections of the population are the most susceptible to the HIV/AIDS annihilation. Ministries like Railways, Aviation, Heavy Industry, Steel, Coal and other public sector undertakings employ a large number of workforces; hence the active participation and involvement of these forces in AIDS programme are vital components. The organised and unorganised industrial sector needs to be cajoled for taking care of the health and welfare of their workforce. Social Ministries like Welfare, Education, Women and Child Welfare should be devise in such a way that they own up the HIV/AIDS control programs within their own sectoral jurisdiction. These ministries should provide a strong budgetary and managerial support.\textsuperscript{22}


\textsuperscript{22} Ibid.
The state governments should formulate a strong HIV/AIDS prevention and control programme. Since HIV/AIDS prevalence tremendously differs from state to state in India, the respective state governments should design their own strategies and action programmes for solving the HIV/AIDS problems keeping the national aims and objectives in view. In various occasion it has been noted that whenever state governments takes into consideration and implement the programmes and policies, there has been a laudable success. The high prevalence of HIV is somehow linked to the degree of urbanisation, especially in the metropolitan cities; it is common and prominent among the high-risk groups such as, commercial sex workers, drug users, men having sex with men. Due to the high risk behaviour among these communities, the municipal corporations of large metropolitan cities should be encouraged and supported to formulate their own strategies and programmes for prevention and control of HIV/AIDS. The municipal corporations undertakes direct funding of HIV programmes, which can go a long way in reducing the administrative hassle and bottlenecks, this in turn will help in an effective control and prevention of HIV epidemic in India.\(^\text{23}\)

HIV/AIDS is relatively a new disease in India, the sub-district, district or tehsil\(^\text{24}\) does not have an effective HIV control tools and field organisation to tackle the problem. In the case of tuberculosis and leprosy, the district level society receives funds directly from the national programmes. For an effective prevention and control of HIV/AIDS, a similar infrastructure at the district level is urgently needed. This will not only help in quick channelisation of funds, but also bring forth the valuable participation of elected representatives from the 3-tier panchayati raj institution and urban municipalities. The district administration headed by the Deputy Commissioner or District Magistrate or Collector and the Chief Medical Officer of the district hospital as well as the similar setup throughout India would be able to provide the necessary administrative and technical infrastructure for supporting the national HIV/AIDS programmes.

To prevent further spread of the epidemic, a large scale mobilisation at the centre, state, district and sub-district levels through organised sections of the community

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\(^{23}\) \textit{Ibid.}

\(^{24}\) Tehsil is an Urdu word used during the British rule in India and Pakistan, it means district in the present day Indian governments administrative unit.
including non-governmental organisations is important for the effective control of the
disease. More numbers of qualified technical and managerial personnel should be made
available at the national and the state levels to strengthen the AIDS control
organisations.25

2.2.2 Social Mobilisation Programmes

One of the most important features of social mobilisation programmes to curb the
HIV/AIDS menace in India is popularly known as IEC (Information, Education and
Communication). Generating awareness about HIV/AIDS through the IEC, and by
providing services such as care, treatment and support to the people infected and affected
by HIV/AIDS has always been a critical endeavour in the effort to prevent the growth
and spread of HIV/AIDS. However, it is increasingly been felt and realise that there is an
earnest need to move beyond awareness generation mechanism to that of a behavioural
change. Information, Education and Communication strategy works well, because it takes
into consideration the sensitivity of Indian cultural and social system. The strategies are
push forwarded by calculating the relativity of the subject to the particular society in
India. In this manner the concerns of the people living with AIDS are also taken care.26

The awareness generation strategy in India is operated through two chambers, one
at the national level and another at the state level. At the national level, the
responsibilities of formulating policy and strategy as well as framing guidelines for
Information, Education and Communication activities are solely carried out by NACO
along with the strong advocacy of elected representatives, medias (including both
regional and vernacular media), as well as press are the special and an important focus at
the national level. At the state level, the state AIDS control societies are the sole
responsible in disseminating the Information, Education and Communication strategies as
per local reality and priorities, it also conducts the Communication Needs Assessment
Studies (CNAS) starting from the grassroots level, which enables them to evolve a state
specific Information, Education and Communication strategies, this strategies not only

25 YouandAIDS (2005), n.20
Communication”, Accessed 9 November 2006, URL:
addresses the local problems and solution but also extend a big help in formulating the overall national strategy and framework to deal with the HIV/AIDS.\textsuperscript{27}

NACO, the prime organisation on HIV/AIDS in India with an array of mechanisms, also undertakes the mass media campaign that provides prototypes and material generation required by the states. The IEC needs of the states are reviewed every two years, a well structured platforms are developed, where Project Directors and IEC officers from the state AIDS control societies come together to participates in the various forums that deals with the HIV/AIDS issues, this in turn facilitates the interstate experience sharing and regional strategy building workshops, where IEC is projected as a means of raising awareness and communication which caters to the need for generating a demand for services as well as behavioural change and a tool for debunking myths and misconceptions. Moreover, IEC helps in breaking the silence on HIV/AIDS as well as dispelling stigma and discrimination. A series of regional and state level workshops were organised so that it can help in providing the readymade materials to the states, which will ensures the capacity building and strengthens them to formulate and develop plausible local and state specific action plans and the IEC material. The New Delhi based research agency Centre for Media Studies, takes the responsibility of assessing and evaluating the contents of the IEC materials developed in the states. The recommendations and outcomes of the evaluation as well as the processes and road map being followed in developing these materials are implementation and feed it to suit the future strategies for IEC at the state and national levels.\textsuperscript{28}

The action plans and the strategies of IEC are also guided by the Computer Management and Information Systems (CMIS), the Communication Needs Assessment Studies (CNAS), the Behavioural Surveillance Survey (BSS) and the annual HIV Sentinel Surveillance. The guidelines for IEC are modified regularly as necessary to suit the changing profile of the HIV/AIDS epidemic in India. It’s been urgently felt that there is an unmet need for information regarding the veracity, misconceptions and common myths, also the information about the four known routes of HIV transmission, modalities

\textsuperscript{27} Ibid.
\textsuperscript{28} Ibid.
for steering clear of susceptibility to HIV, the availability of services such as care, treatment, and support for the people infected and affected by HIV/AIDS. The role of IEC in alleviating stigma and discrimination are pivotal to all communication efforts, which on the other hand had motivated or motivates people to utilise the services being provided through the national AIDS control programme such as anti-retroviral treatment, Nevirapine\textsuperscript{29} for pregnant mothers, medicines for opportunistic infections, STDs/STIs (Sexually Transmitted Diseases/Sexually Transmitted Infections) treatment, free counseling and testing. The initiatives and strategies of IEC should also be focused in mobilising the other sections or sectors of society, which will greatly enhance the integration of HIV/AIDS messages into their existing activities. Likewise, IEC should channelise its activities in the work place across both formal and informal sectors; moreover, it should create a supportive environment for the care and rehabilitation of people living with HIV/AIDS as well as people being affected by the epidemic.\textsuperscript{30}

2.2.3 Media Programmes

Media, which is a staunch social mobilisation programmes is largely and extensively used for disseminating the message at the grassroots level. Song, video and dramas are popularly used for this purpose. This therefore, not only complements the national HIV/AIDS prevention strategies but also supplement the Information, Education and Communication (IEC) strategies. To address the urgent issues surrounding HIV/AIDS, the NACO along with other agencies such as UNAIDS have sensitised the IEC division of the Ministry of Information and Broadcasting. This is a crucial channel of communication, widely relied upon by the AIDS control societies in India.\textsuperscript{31}

Two significant events covering AIDS in India are, the world AIDS day on December 1 and the voluntary blood donation day on October 1. NACO uses these occasions specifically to generate awareness and motivate behaviour changes to dispel the myths and misconception as well as to reduce as much as possible the stigma and discrimination associated to HIV/AIDS.

\textsuperscript{29} A non-nucleoside reverse transcriptase inhibitor (trade name Viramune) used to treat AIDS and HIV.
\textsuperscript{30} Ministry of Health and Family Welfare, Government of India (2004)., n.25.
\textsuperscript{31} Tharoor, Shashi (2004) “Partners in the anti AIDS battle”, The Hindu, New Delhi, 5 December 2004
At the national, state and district levels, NACO sponsors and conducts various campaigns and activities, which are specially design by taking into consideration the local reality. However it needs to further refine the procedural bottlenecks involved in campaigning and educating about HIV/AIDS in India, this can be possibly achieved by strict examination, monitoring and evaluation of available IEC strategies. To capture and enhance the quality of output as well as to ensure that IEC becomes a user friendly tool for learning, planning and management, the Computer Management and Information Systems (CMIS) format for collecting data on IEC has been made operational in India.  

2.2.3.1 Television and Movies

In order to step further the campaigns on AIDS, NACO has produce a high quality television spots which were telecast at prime time over the national news channel. NACO has entered into a partnership with Prasar Bharati of the Ministry of Information and Broadcasting, Government of India and the BBC’s World Services Trust in the late 2001. Two serials titled Jasoos Vijay and Hath Se Hath Mila were produced in the infotainment format and were telecast on prime time slots of Doordarshan, this TV spots were created by some of the best available talent in the country. Jasoos Vijay was a detective thriller and Hath Se Hath Mila was a youth show in a virtual reality format. Jasoos Vijay was awarded the Indian Telly Award while Hath Se Hath Mila received the Commonwealth Broadcasting Association Award. The TV spots campaign became a critical component under the tripartite partnership, Doordarshan has even provided a substantial free airtime for the noble cause. Delhi, Uttar Pradesh and Rajasthan were initially covered under the tripartite partnership. The second phase of the partnership covered most of the North-Eastern India and almost whole of South Indian States.

For the Hindi speaking states of Uttar Pradesh, Madhya Pradesh, Himachal Pradesh, Uttarakhand, Bihar, Jharkhand, Chattisgarh, Arunachal Pradesh and Jammu and Kashmir, NACO has sponsored a TV spot called Kalyani which is telecast through Doordarshan in a magazine format that includes field interviews, success stories, panel

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32 Ibid.
34 Benn, Hilary (2004), “AIDS Threatens India’s Progress”, The Hindu, New Delhi, 29 November 2004
discussions, quiz competitions and contests. The segments on HIV/AIDS focus on rural populations and are produced at the state level Doordarshan Kendras so as to reflect the local priorities, predilection and content. To enlarge the base and curiosity of the audience, NACO has invited celebrities to endorsed messages on HIV/AIDS prevention and control, which were then telecast on Doordarshan and other private television networks.\(^{35}\)

2.2.3.2 Radio

NACO sponsored programmes such as Jiyo aur Jine Do and Let's Talk are broadcasted every week through All India Radio. Jiyo aur Jine Do programme was revamped and launched on the Primary Channel and ‘Vividh Bharati’ stations of All India Radio and re-titled Jeevan Hai Anmol in 2004. Let’s Talk is a FM programme launched in Delhi in 2004. While the FM programme is directed towards the urban audience, Jeevan Hai Anmol is addressed to a mass audience. The state AIDS control societies are roped in to provide field level inputs and to highlight issues of significance relating to HIV/AIDS. These are then woven into these radio programmes. A series of spots have also been produced, which are broadcast on the occasion of Voluntary Blood Donation Day on 1st October and World AIDS Day on 1st December.\(^{36}\)

2.2.3.3 Newspapers, Magazines and Journals

Print materials such as information, posters, booklets, handouts, handbills, flip charts, stickers, flash cards and wall hangings are used by AIDS control societies throughout India, they utilise these print advertising materials with appropriate modification and prototypes being forwarded by NACO. NACO has developed a lot of print material like posters, booklets, folders. These materials are disseminated to all the state AIDS control societies in.\(^{37}\)

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\(^{35}\) Doordarshan, Government of India (2002)., n.32.


A prominent campaign of NACO includes poster series on voluntary blood donation, routes of transmission, stigma, discrimination and care and support. These are done by inserting in the newspapers, magazines and various other available print materials. The Directorate of Advertising and Visual Publicity (DAVP) and other advertising agencies are also used extensively to commemorate events such as World AIDS Day and Voluntary Blood Donation Day. NACO'S initiative also includes the printing of some 1.5 million post cards with messages on HIV/AIDS; this was done with the help and support of the Department of Posts and Telegraphs in 2004. The postcards, which were priced at 25 paisa each, carries an important HIV/AIDS messages in the form of multicolor advertisement. This medium of campaign and strategies has positively enabled NACO to reach out to the lowest economic strata of the Indian population who uses postcards to communicate with their near and dear ones. These postcards have been distributed all over India through states AIDS control societies, NGOs and other AIDS related organisation.38

2.2.3.4 Seminars, Debates and Discussion

The Directorate of Field Publicity (DFP) a media unit of the Ministry of Information and Broadcasting along with State AIDS Control Societies (SACS), were provided a mobile exhibition kits being produced by NACO through DAVP in the appropriate regional languages. For more effective dissemination of this material, NACO has trained and oriented the personnels of the Directorate of Field Publicity regarding the knowhow of mobile exhibition. These mobile exhibition kits were most effectively used in the countrywide Swasthya Jagrutta Mah,39 the month long (15 February to 15 March) integrated health exhibition organised in every parliamentary constituency, which were largely sponsored by the Ministry of Health and family Welfare, Government of India in 2004.40

38 Ibid.
40 YouandAIDS (2004), n.35.
2.2.3.5 Placards, Sign-Boards and Posters

To disseminate the HIV/AIDS awareness more aggressively, NACO has chosen the outdoor media’s such as hoardings, wall writings and establishment of kiosks. In 2003 and 2004, NACO has hired many prime hoarding spaces in Delhi; most of these locations were the prominent road junctions. NACO has used these locations in its Live and Let Live campaign to commemorate the 2003 World AIDS Day.\textsuperscript{41} In another unique initiative, NACO has disseminated key messaging on HIV/AIDS, which were put up on two trains running from Shahdara to Rithala of the Delhi Metro trains in 2004.\textsuperscript{42}

Despite the strong and serious IEC campaign on HIV/AIDS, there is still inadequacy and misunderstanding about the serious implications of HIV/AIDS, the lack of understanding about the diseases persist not just among the common people, but also among the legislators, political and social leaders, bureaucracy and media, leaders of trade and industry and professional agencies such as medical and paramedical personnel engaged in health care delivery system. Hence, there is an urgent need to launch a strong campaign and advocacy targeted at all levels, so that the campaign will make each one of us understandable and feel motivated about the need for an immediate prevention and control of the disease and also for, adopting a human approach towards those who have already been infected with HIV/AIDS. The government emphasis’s the need to start advocacy from the topmost level and spread it down throughout the country.\textsuperscript{43}

Moreover there is still a serious information gap about the cause and spread of HIV/AIDS among a large number of medical and paramedical personnel both within the Government and outside, which occasionally leads to situations of discrimination of people living with or infected by HIV/AIDS in hospitals, dispensaries and workplaces as well as community at large. Such situations of discrimination and overreaction by the public against HIV/AIDS infected people can be eliminated if there is a strong advocacy at all a level.

\textsuperscript{41} Ibid.
\textsuperscript{43} Embassy of India., n.3.
A universal applicability programme on AIDS education should be initiated in schools and the universities throughout the country in order to mobilise large sections of the student community to bring in awareness among themselves and as peer educators to the rest of the community. Such programme should be introduced among the large network of youth organisations, sports clubs and Nehru Yuvak Kendras spread across the country. AIDS prevention education should also be integrated into the programmes of worker education and schemes of social development.44

Various mediums of electronic and print media are available today; it should be used fully to disseminate information on HIV/AIDS, because these mediums have a potential and universal coverage throughout India. In recent year there has been an impressive rise in the levels of awareness about HIV/AIDS among the general community in India, this can be partly attributed to the electronic media, which has taken the AIDS message right up to the village level. Though there is a general awareness about the disease, some specific aspects such as the mode of transmission of AIDS and the method of protecting oneself from getting infected are still not known to a large section of the population. Hence a tailor-made programmes for targeted sections of the populations like students, youth, women, children, truck drivers, sex workers, drug users and migrant workers are urgently needed in India, the only answer in this direction seems to be electronic medias.45

The electronic media should be well equipped with a neatly structured policy for dissemination of information on all aspects of HIV/AIDS, including the reinforcement of positive cultural and social values like love, warmth care and affection within the family. Newspapers, periodicals, magazines and other print media should be used for conducting campaigns for social mobilisation to generate awareness about prevention and for sharing information and expertise. The media should in general play a positive role in generating an enabling environment for AIDS prevention and control as well as support and care of the people living with HIV/AIDS. The best communication talents available in government and private sector should be utilised in designing these media campaigns.

44 Ibid.
45 YouandAIDS (2004), n.35.
which should be developed in local languages and in tune with the local needs and ethos. Media campaigns in rural areas should lay emphasis on local cultural values and should be conducted through popular local mediums like folk dances, jatras and puppet shows.\(^{46}\)

The corporate houses and private enterprises should be seriously encourage to follow the governmental policies and initiate its own mechanism to undertake the HIV/AIDS prevention and control activities, they must formulate its own strategies such as provision of services for their employees both at the workplace and outside as a part of their social responsibility. The large network of Employees State Insurance (ESI) hospitals and dispensaries under the Employees State Insurance Scheme should be effectively used for spreading the message of prevention and control of the disease as well as providing care and support to the workers/employees living with HIV/AIDS and their families.\(^{47}\)

2.2.4 Participation of NGOs and CBOs

Non-Governmental Organisations (NGOs) and Community Based Organisations (CBOs) have made significant and vital contributions in the field of health sector in India, due to their innovative programmes and positive ideas in the areas of health, family welfare and in arresting the spread of communicable diseases, NGOs and CBOs have become an important player for the government for carrying and disseminating the various national plans and policies, hence it is essential to continue to encourage the involvement and participation of the voluntary sector in HIV/AIDS. The National AIDS Control programme has recognised the importance of NGOs participation in the programme for providing community support to the people living with HIV/AIDS and their families, for providing the required care, support and counseling. NGOs and CBOs bring with them their experience and knowledge of community level workmanship. Their approaches are interpersonal and flexible, they know the local reality with sensitiveness, and they exhibit creativity, caring and feasibility by enhancing people’s participation.

\(^{46}\) Embassy of India., n.3.
\(^{47}\) Ibid.
And thus benefit the HIV/AIDS programme tremendously. NACO has formulated specific guidelines for the involvement of NGOs and CBOs in the NACP.\(^{48}\)

Due to the massive population base and the difficulties in imparting viable education on HIV/AIDS in India’s social setting as well as the new challenges posed by the spread of the disease across the country, it is therefore a timely requirement to revise and update the programme guidelines of NGOs. Though there has been a number of successful programmes initiated by NGOs regarding the awareness generation, facilitating counselling and intervention strategies especially among the high-risk group, but there have been occasional failures being encountered by the newly established NGOs due to lack of proper perspective and goal. A handful of grassroots NGOs are willingly coming forward in the battle against HIV/AIDS.\(^{49}\)

NGOs are facing lots of structural and other constraints from the government side, lack of reciprocation and cooperation by government officials at various levels are routinely face by the NGOs. There is a general lack of uniformity in the approach and performance of various state governments as well as the lack of adequate orientation among government officials towards the participation and role played by the NGOs in the National AIDS Control Programme. The file processing of NGOs programme cases are often blocked and delayed causing a red-tapism, the serious flaws in the system of NGO financing such as delay in disbursement of funds and over emphasis on utilisation of finances rather than on impact assessment of the work done by them, which ultimately leads to decline of interest and withdrawal on the part of the NGOs.\(^{50}\)

The flaws and difficulties face by the NGOs are well known to the government, hence NACO has formulated a flexible system and guidelines through which NGOs can operate smoothly. Government commits itself to large scale involvement and participation of NGOs and CBOs in the National AIDS Control Programme, such as:


NGOs and CBOs participation at the policy making level through regular interaction and adequate representation at the National AIDS Committee; involvement of NGOs in the new fields like provision of medical facilities and home-based care, opening of hospices and awareness as well as counseling; greater emphasis are laid by the government to facilitate training and capacity building programmes for the NGOs so that they can be empowered to take up new challenges and additional responsibilities; a periodic revision and updates on NACOs guidelines to NGOs are initiated to reduce the red-tapism and bureaucratic delays in the matter of financing NGO; NACO has encourage a conducive networking among NGOs to avoid duplication and wasted efforts, efforts are tended in this direction to bring in all the nodal NGOs and CBOs under single umbrella working in that area in the same field; governments also need to address the problems being face by its official while dealing with NGOs. Hence to seek a plausible and healthy participation of non-governmental sector in the National AIDS Control Programme, the government must ensure and enhance collaboration between NGOs and CBOs both at the central and state level government.\textsuperscript{51}

Today the Parliamentary Forum has over 300 members who are dedicated to provide leadership to the HIV/AIDS response in India. Its aims are to strengthen and support initiatives on prevention, care and support being implemented by the government, NGOs and others, It also seeks to address stigma and discrimination faced by people living with HIV, enhance the response to HIV at the national, state, district and constituency level, and sensitise other Members of Parliament on HIV/AIDS.\textsuperscript{52}

2.2.5 Sentinel Surveillance Sites

India has established a number of sentinel surveillance sites for different groups of affected people at various places throughout the country. The sentinel site includes; VCT (Voluntary Testing and Counseling) sites, STD (Sexually Transmissible Diseases) clinics, ANC (Antenatal Clinics), Provisions of compulsory blood screening and


Administration of hygienic diagnostic tools. The rate of HIV Prevalence is observed and calculated on the basis of the result obtain from these sentinel sites.

By the end of year 2004, the number of various sentinel sites in India rose to over 760, which includes approximately 171 Sexually Transmitted Diseases (STDs), 401 Antenatal Clinics (ANC), 24 Injecting Drug users (IDUs), 15 Men having Sex with Men (MSM), 42 Female Sex Worker or Commercial Sex Worker (FSW or CSW) and 6 Tuberculosis (TB) sites across India. The percentage HIV prevalence’s in these clinics in some of the states are diagrammatically represented;\textsuperscript{53} see figures 1.2a, 1.2b, 1.2c and 1.2d.


93
Figure 2.1a:

Percentage of HIV prevalence at STD clinics in 2004

Source: National AIDS Control Organisation
Figure 2.1b:
Percentage of HIV prevalence at ANC kiosks in 2004

Source: National AIDS Control Organisation
Figure 2.1c:
Percentage of HIV prevalence among MSM in 2004

Source: National AIDS Control Organisation
Figure 2.1d:
Percentage of HIV prevalence among IDUs in 2004

HIV prevalence among IDUs in 2004

<table>
<thead>
<tr>
<th>State</th>
<th>HIV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tamil Nadu</td>
<td>37.051%</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>26.001%</td>
</tr>
<tr>
<td>Manipur</td>
<td>20.429%</td>
</tr>
<tr>
<td>Mizoram</td>
<td>6.314%</td>
</tr>
<tr>
<td>West Bengal</td>
<td>5.107%</td>
</tr>
<tr>
<td>Nagaland</td>
<td>4.169%</td>
</tr>
<tr>
<td>Meghalaya</td>
<td>0.929%</td>
</tr>
</tbody>
</table>

Source: National AIDS Control Organisation

In the figures values are taken from those states and union territories having more than 3 sites. The HIV prevalence rate were observed from the people having high-risk behaviour for HIV infection, including those who have attended STD clinics, MSM and FSW or CSW, intervention centers, drug de-addiction centers and free HIV/AIDS counselling centers. The antenatal clinics attendees were considered the representative of general population.

India’s HIV/AIDS estimation process is delivered in accordance with the procedures and guidelines issued by the UNAIDS and WHO. India, along with the rest of

54 Ibid.
the world had committed in using the new methodology at the UN general assembly’s special session on HIV/AIDS in 2001. But sporadically India still continues to use the procedures and figures derived from the old methodology. The estimations are carried out by the New Delhi based Institute of Research in Medical Statistics (IRMS) and the National Institute of Health and Family Welfare (NIHFW). The estimations are derived on the basis of HIV prevalence observed in the national sentinel surveillance across India, such as STD, ANC, IDU, MSM and FSW or CSW sites. The governments figures on HIV infections for the year 2004 was 5.134 million, it has been noted that, there were 28,000 HIV infections added in 2004 in comparison to the estimates of 2003. The figures release by NACO in April 2006 puts, India’s HIV count at 5.206 million.

The estimates of prevailing HIV/AIDS statistics in India during the period 1998 – 2004 are vividly represented through the help of Line chart as well its equivalent in percentage in Pie chart respectively, see figure 2.2a and 2.2b.

56 Ibid.
57 NACO (2004), n.52.
Figure 2. 2a:


Source: National AIDS Control Organisation
Figure 2.2b:


Estimates of HIV/AIDS in India during 1998-2004

Source: National AIDS Control Organisation
HIV prevalence in India remains low at 0.91 per cent, which is less than 1 per cent of the population. The trend shows that there is no hyper increase in the epidemic, because there is no tremendous upsurge of HIV prevalence in India. These trends are diagrammatically illustrated, see figure 2.3a and 2.3b.

**Figure 2.3a:**

*Distribution of stages of HIV infection in India*

*Source: National AIDS Control Organisation*
Figure 2.3b:
Distribution of stages of HIV infection in India

Source: National AIDS Control Organisation
The diagrammatic illustration of the distribution of HIV/AIDS among male and female, both in rural and urban India during the year 2004, see figure 2.4.

**Figure 2.4:**

**Distribution of HIV/AIDS in Urban and Rural India in 2004**

Source: National AIDS Control Organisation

The high HIV prevalence noted among both the STD clinics attendees and ANC attendees. The increasing trends are seen among STD clinic attendees in 16 centres and among ANC clinic attendees in 7 sites located in Andhra Pradesh, Maharashtra, Tamil
Nadu, Gujarat, Bihar, Assam, Chattisgarh, Delhi, Haryana, Kerala, Orissa, Gao, Pondicherry and Manipur.\(^{58}\)

As per NACO’s reports, by the end of the year 2005, India continues to remain in the second position in the world with approximately 5.3 million HIV infection and only 0.91 per cent HIV prevalence rate in comparison to South Africa’s 5.5 million HIV infections with more than 21.5 per cent prevalence rate. However, the government of India is shocked to note, when United Nations tenth annual reports on HIV/AIDS was released on 30\(^{th}\) May 2006 in New York, USA. The report says that India has overtaken the Republic of South Africa and it is now home to 5.7 million HIV infections, leaving behind South Africa at its usual numbers of 5.5 million at the end of the year 2005.\(^{59}\) But the government of India refutes the report.\(^{60}\)

I am surprised by the UNAIDS report, I totally disagree with it. The National AIDS Control organisation (NACO) has scientifically arrived at India’s HIV Number of 5.208 million on the basis of sentinel surveillance sites in the country. Even the world Health Organisation (WHO) and UNA IDS has been associated with the process of data collection and approved of it. I don’t know how they have arrived at this number.\(^{61}\)

Hence India’s HIV/AIDS count as per National Family Health Survey (NFHS-3) stands at 2.5 million by the end of the year 2006.\(^{62}\) But whatever may be the facts and figures, HIV/AIDS problems is a reality in India, the implications are already felt. Hence, prevention and control measures should be the main aim and thrust of the governments. It is now an accepted fact that India has a sizable proportion of people living with HIV/AIDS, which are mostly concentrated in 8 states, (see map 2.1) were the HIV prevalence among ante-natal women is more than 1 per cent which is considered to be high prevalence stage.\(^{63}\)

\(^{58}\) Ibid.


\(^{61}\) Dr. Anbumani Ramadose, Union Health Minister, Government of India, commenting on UNAIDS report on possibly inflated HIV/AIDS numbers in India.

\(^{62}\) Kumar, Prasanna .M (2006), n.58.

Map 2.1:
Map of India, showing the most affected states of India

Source: Census of India-2001, Government of India
The regions and states of India as highlighted in the above map of India continue to record high HIV prevalence rate both at ANC and STD clinics, it is in these states that the HIV is rather more rampant and acute, may be because these are the state where HIV/AIDS first began to influx in India. Let us discuss the HIV prevalence’s in these states:

The HIV prevalence rate in Andhra Pradesh is around 2 per cent; it is one of India’s highest HIV prevalence state. Most of the infections in this state is said to have been transmitted through STD, the prevalence rate in STD clinics were recorded over 22.8 per cent in 2005.

In Goa the prevalence rate of HIV was found to be around 1 per cent in antenatal clinics in 2004, which came down to 0 per cent by the end of 2005, the variations may be due to the small number of women who have voluntarily tested themselves in the clinics. However, the prevalence at STD was recorded 14 per cent in 2005. This indicates that Goa is under the stress of HIV/AIDS, importantly among its sexually active people. The proliferation of HIV in Goa is partly blamed for its tourism and partly its drug culture.

The prevalence rate in Karnataka is found to be more than 1 per cent in recent years. It is very high among the Devadasi community in northern Karnataka, historically Devadasi are a group of women who render services to gods, today the community has evolved itself to be a sanctioned prostitutes, Devadasi women are mostly engage in sex trade and ply into various metro cities in India. The average HIV prevalence among sex workers including Devadasis were 18 per cent in 2005.

Mumbai, the capital city of Maharashtra is severely affected by HIV/AIDS. The HIV prevalence rate at ANC is above 1 per cent. Among the sex workers, it is found to

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64 Dev (God) Dasi (slave), it existed since ancient Veda time mostly in Southern Indian temples and the tradition is still vibrant and alive in India. Devadasi used to perform temple rituals and to sing and dance to praise God. For this ritual practice family donated their younger girl child to the temple. Status of Devadasi was high in the society and known as divine girl. As the time passed, system changed and they were used for sex obligation for high caste and class people. Major percentage of low caste and tribal girls are forced to this practice under the cover of religion and some adopt for the reason that family had a history of Devadasi.
be over 20 per cent, the rate of prevalence is also very high among the Injecting Drug Users (IDUs) and homosexual groups.

Tamil Nadu was the first state that recorded the HIV/AIDS cases in India in 1986. By the end of year 2005, it has recorded over 52,000 HIV counts, the highest in India. However, the prevalence rate at ANC has come down from 0.88 per cent in 2002 to 0.5 per cent in 2005.

HIV prevalence in Manipur at ANC is over 1 per cent. It has recorded a high prevalence rate of about 20 per cent among its IDUs. IDUs are the responsible for spreading AIDS to their wives, children and other sexual partners. The prevalence of HIV/AIDS among IDU is primarily because drugs are easily available in this region owing to its nearness to the notorious Golden Triangle as well as Manipur is a major transit junction to South East Asia.

AIDS was first recorded in Mizoram in 1998 among the male IDUs, nearly 10 per cent of the IDU patient has tested HIV positive during 1998 and presently the prevalence is at the lower side of about 5 per cent. Prevalence at ANC has also dropped to around 0.88 per cent in recent years.

Like Manipur and Mizoram, the main cause of HIV/AIDS in Nagaland is also due to drug culture. The prevalence at ANC is over 1.63 per cent, were as among the IDUs it has a prevalence of about 4.51 per cent.

HIV/AIDS is fast spreading in India, the migration and mobility of millions of workers and labourers within and between states in search of better livelihood or the exodus of them from an economically backward areas to more advance regions, have created a difficult situation to tame the already loosen epidemic. Add to this is the millions of cross border migrations to India. Social stigma, low levels of awareness pertaining to low literacy, discriminations and gender disparity, Sexually Transmitted

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65 An area of relatively lawless territory bordering Myanmar, Thailand and Laos. Opium is extensively grown in this region and then illegally exported to other parts of South East Asia, which ultimately lands in the international market. Golden Triangle is responsible for spreading HIV/AIDS in North East India. It has also been suspected that by and large it enhances the international terrorist groups.

66 Government of India (2005), n.61.
Infections (STIs) and Reproductive Tract Infection (RTIs) in men and women, coupled with lack of awareness have all contributed a good hold for HIV/AIDS in India.  

HIV/AIDS is generally mistaken to be a contagious disease, a divine wrath and a sinner’s identification; such beliefs are popular in rural India. An HIV person in India often faces maltreatment and refusal in schools and hospitals whether it is a government or private institutions. Many a time people with HIV/AIDS are quarantine and left in a separate confinement at home or in public institutes. Such situation creates a sense of shuddery feelings among the general population. However, off late NGO’s in India have played a pivotal role by bringing out the public litigation process against such cases of discrimination; various judicial pronouncements in favor of the rights of those sufferers has helped immensely in warding off the miseries of the AIDS patients.

The treatment programmes on HIV/AIDS are still in its nascent stage, drugs are costly and expensive, and vaccination programmes were recently introduced, which is in the experimental stage. The various treatment and therapeutic options are yet to make it within the poor’s reach. HIV is a sensitive virus, it quickly develops resistance to drugs, hence the therapeutic treatment needs an overall perfection in medical procedures, along with strict supervision, without which a fruitful results is least expected.

Though the Supreme Court directives of May 1996 have paved the way for phasing out the unlicensed blood banks as well as the phasing out of professional blood donors by the end of year 1997, but due to the presence of large numbers of blood banks across India, it is difficult to conclude that AIDS is not transmitted through these blood banks, hence a better monitoring and surveillance system is very much required in India.

The problems of Injecting Drug Users (IDUs) has been traditionally confine to some of India’s North Eastern states, but today IDUs are found in various corners of

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70 National AIDS Policy (2004), n.65.
In India, nearly 60 per cent of AIDS cases are reported to be opportunistic TB infection cases. The treatment of TB among the AIDS patient is a serious challenge to the National TB Control Programme. Though the DOTS (Directly Observed Treatment, Short Course) strategy is implemented, but some of the drugs used for the TB treatment under DOTs strategy proved to be serious complications among the HIV patients. Moreover, looking for HIV in TB patient has scared away a large number of TB patients from seeking treatment under the DOTs strategy.72 The opportunistic infections in AIDS case in India is represented in the figure2.5.73

71 Ibid.
Figure 2.5:
Opportunistic infections in AIDS cases in India

<table>
<thead>
<tr>
<th>Cases of opportunistic infections in India</th>
</tr>
</thead>
<tbody>
<tr>
<td>37.660% Tuberculosis</td>
</tr>
<tr>
<td>34.400% Candidiasis</td>
</tr>
<tr>
<td>20.760% Cryptococcus</td>
</tr>
<tr>
<td>4.740% Others</td>
</tr>
<tr>
<td>2.080% PCP</td>
</tr>
<tr>
<td>0.360% Kaposi</td>
</tr>
</tbody>
</table>

Sources: TBC India, National AIDS Policy, Ministry of Health and Family Welfare

(1) TBC India, Directorate General of Health Services, Ministry of Health and Family Welfare

(2) National AIDS Control Organisation (NACO)

(3) National AIDS Policy

Note: PCP (Pneumocystis Carinii Pneumonia).

TB is the most common opportunistic infections among the AIDS patient with nearly 64 per cent affected by it, followed by the oral candidiasic, it kills more adult in India than any other infectious disease, it is reported that the death caused by tuberculosis touches about 1,000 each day. Huge sum of money is invested every year to control the
opportunistic infections.\textsuperscript{74} All these factors have contributed a daunting challenge of HIV infection in India. The large population with low literacy and awareness has galvanised the problems of HIV/AIDS in India.

HIV/AIDS In India is found traditionally amongst certain groups of people, these are classified as high-risk groups, such as: Commercial Sex Workers (CSW); Injecting Drug Users (IDUs); Men Having Sex With Men (MSM); Truck Drivers; migrant labours and among prison inmates. But today, it is no more a valid notion, HIV/AIDS has moved much beyond these classified groups and penetrated into the hitherto unknown regions, it is fast spreading into the general population.\textsuperscript{75} Women and children are rapidly becoming victims of HIV/AIDS mayhem, it has been estimated that 2 in 5 adults living with AIDS are women.\textsuperscript{22} Per cent of HIV/AIDS cases reported have been found among housewives with single partner, which on the other hand have significantly contributed in the increase of HIV/AIDS incidence from mother to child transmission. More than 90 per cent of AIDS cases in India are reported within the sexually active and most economically productive age group of 14 to 44. The predominate mode of transmission are heterosexual contact, followed by injecting drug use and blood transfusion. However, since 1997, the incidence of transmission of HIV through blood transfusion has come down successfully due to government timely intervention and strict safety regulations.\textsuperscript{76}

2.2.6 Testing of HIV/AIDS

There is an active debate in the country on the issue of HIV/AIDS status of an individual, the debate of whither there should be a mandatory testing of the people suspected of carrying HIV infection. Considerable thought has been given to this issue; the Government feels that there is no public health rationale for mandatory testing of a person for HIV/AIDS. On the other hand, such an approach could be counter-productive as it may scare away a large number of suspected cases from getting detected and treated. HIV testing carried out on a voluntary basis with appropriate pre-test and post-test counselling is considered to be a better strategy and is in line with the WHO guidelines.

\textsuperscript{74} TBC India (2006), n.72.
\textsuperscript{75} AVERT (2004), n.12.
\textsuperscript{76} Ibid.
on HIV testing. Government of India has earlier issued a comprehensive HIV testing policy and the following issues are reiterated as: no individual should be made to undergo a mandatory testing for HIV; no mandatory HIV testing should be imposed as a precondition for employment or for providing health care facilities during employment; adequate voluntary testing facilities with pre-test and post-test counselling should be made available throughout the country in a phased manner; there should be at least one HIV testing centre in each district in the country which can be done in a phased manner; in case a person likes to get his HIV status verified through testing, then all the necessary facilities should be given to that person and results should be kept strictly confidential, it should be given out only to the person concern and with his consent to the members of his family; disclosure of HIV status of a person to a spouse or to his or her relatives will entirely depend on the person’s willingness to share the information. However, the person should encourage sharing this information with the spouse and family as it helps the person in getting proper home-based care when he is afflicted with AIDS. In case of marriage, if one of the partners insists on a test to check the HIV status of the other partner, such tests should be carried out by the contracting party to the satisfaction of the person concerned.  

The HIV testing policy adopted by the NACO is found to be an appropriate for the different types of testing that have to be done. At present people are tested for screening in blood banks, epidemiological surveys and confirmatory testing for clinical management and voluntary testing. For screening blood donations, a single test is conducted either through Rapid test or ELISA (Enzyme Linked Immunosorbent Assay) test, which potentially helps in eliminating the possibility of HIV positive blood. In the case of epidemiological surveys, similar procedures are followed with the test series either with ELISA or Rapid or Simple with high sensitivity. In both the above cases the testing is anonymous and the result is not given to the person concerned without validation. People who voluntarily seek the confirmatory testing of HIV status, as well as those who want for the purpose of clinical management, then the samples were tested

with double sessions of ELISA and at least single test each with Rapid or Simple with the preparation of different antigen. The results are given out with the strict scrutiny through pre-test and post-test counselling.\textsuperscript{78}

2.2.7 HIV/AIDS Counselling

Counselling services for suspected cases of HIV infection and for People Living with HIV/AIDS (PLWAs) have been expanded to increase their reach to those who need them. All hospitals, HIV testing centres, blood banks, STD clinics and organisations formed by PLWAs are required to have counselling services manned by trained personnel and professional counsellors. Government of India through its agencies extends all the necessary help in training counsellors and HIV personnel to oversee these counselling centres and also for creating necessary infrastructure for establishment of these centres. Group counselling among PLWAs which has proved to be very effective were encouraged by giving necessary financial and other incentives.\textsuperscript{79}

2.2.8 People Living With HIV/AIDS (PLWAs)

With the spread of the infection across the country, there has been a sharp increase in the number of HIV infected persons in the society. As per India’s society HIV infected people belong to different social strata and from various economic backgrounds. Apart from providing counselling before declaring the HIV status, the Government has tried to ensure the social and economic well being of these people by ensuring protection of their right to privacy and other human rights as well as proper care and support in the hospitals and in the community.\textsuperscript{80}

The HIV positive people were guaranteed equal rights to education and employment as other members of the society. HIV status of a person is kept confidential.


\textsuperscript{79} Ibid.

which will not in any way affect the rights of the person to employment such as: his or her position at the workplace; marital relationship and other fundamental rights.

HIV positive women are having a complete choice and control when it comes to making decisions regarding pregnancy and child birth. Government ensures that there should not be forcible abortion or even sterilisation on the ground of HIV status of women. Pregnant women are given a proper counselling which will enable her to take an appropriate decision either to go ahead with or terminate the pregnancy.\textsuperscript{81}

The Government actively encourages and supports the formation of self-help groups among the HIV infected persons for group counselling, home based care and support of their relatives and their families. Social action through participation of NGOs were encouraged and supported for this purpose. Regarding the treatment, care and support for PLWAs, various policies are tabled and initiated for a comprehensive care that comprises clinical management, nursing care, counselling and socio-economic support through home-based care. Resources from Government and private sectors are massively mobilised for purpose.\textsuperscript{82}

Government has initiated an intensive advocacy and sensitisation among doctors, nurses and other paramedical workers, so that PLWAs are not discriminated, stigmatised or denied of services. Government expresses serious concern at instances of denial of medical treatment by doctors in their clinics, nursing homes and in hospitals which is causing enhanced stigmatisation to the PLWAs. With updated knowledge available on the risks or absence of risk of HIV transmission, such denial of medical care to needy victims is regrettable. The Government has expressed and has expected that the health service sector to come forward and rise to the occasion were they can display necessary concern for the welfare of the community of PLWAs and ensure proper medical care and attention. The professional organisations of medical and paramedical health workers should disseminate information about HIV/AIDS to their members up to the field level. Training of health personnel in diagnosis, rational treatment and for follow up of HIV related illness should continue with greater vigour. Efficient referral systems are

\textsuperscript{81} Ibid.  
\textsuperscript{82} Ibid.
established, starting from testing centres and counseling sites to the hospitals and clinics, as well as community based services and home based care. PLWAs were given adequate information for home care in the form of books and documents to enable them to lead a healthier life and to promote self-help.83

Clinical management of HIV/AIDS requires strict enforcement of bio-safety as well as infection control measures in the hospitals as per the universal safety precaution guidelines. Treatment of AIDS cases do not require any specialised equipment than what is necessary for treatment of the opportunistic infections arising out of HIV/AIDS. Hospitals are required to keep adequate supply of bio-safety equipments to be utilised by medical and paramedical personnel while treating HIV infected persons. Governments on the other hand dose ensure an adequate supply of these equipments and also essential drugs for treatment of the opportunistic infections. Adequate facilities were established for proper disposal of plastic and other wastes and injecting needles used for treatment of HIV infected persons.84

2.2.9 Controlling Sexually Transmitted Diseases (STDs)

The large prevalence of STDs among the general Indian population is a major cause for concern, because the presence of STDs, especially with ulcer or discharge, facilitates transmission of HIV infection. The risk of transmission is 8 to 10 times higher in the case of persons with STDs compared with others. As the risk behaviour of persons with STDs and HIV is the same, Government of India attaches top priority to the prevention and control of STDs as a strategy for controlling the spread of HIV/AIDS in the country.85

The approaches being adopted by the Government for STD control are: Management of STDs through syndromic approach, which has been recently incorporated into the general health service. The positive outcomes of such incorporation

84 Ibid.
is that, once the STD case management is integrated in the peripheral health system, then unnecessary referral will get avoided, leaving the specialised services free for the management of complicated cases and operational research as well as supervision of sites where STD patients are treated. STD among women though highly prevalent, is suppressed because of the social stigma attached to the disease. It has therefore been decided to incorporate services for treatment of Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) at all levels. Department of Family Welfare and the NACO coordinate for an effective implementation of such integration. STD clinics at the FRUs (First Referral Units), district and block level works as a referral centres for treatment of STDs referred from peripheries. STD clinics in all the district hospitals, medical colleges and other centres were strengthened by providing technical equipment, reagents and drugs. Massive orientation training programmes were undertaken to train all the medical and paramedical personnels engaged in providing STD and RTI services through a syndromic approach. All STD clinics also provide the function of counselling services and good quality condoms to the STD patients. Services of NGOs are largely utilised for providing such counselling services at the STD clinics.  

Surveillance and monitoring were strictly followed to adopt the right strategy for prevention and control of HIV, because it is necessary to build up a proper system of monitoring of the epidemic through surveillance activities. The Government have enlarge and refine the sentinel surveillance system for obtaining data on HIV infection rates both in high risk as well as low risk groups of the population and for monitoring the trends. A quality control mechanism through an independent agency were evolved and adopted in order to have a good quality data. Government is also aware of the inadequacy of a comprehensive epidemiological data on the prevalence of HIV/AIDS in India. Such lacunae in information are urgently addressed and filled through a proper sentinel survey mechanism covering both the high risk groups and general population. Special surveys, indicator survey and study of the risk behaviour of targeted groups were undertaken for specified information on the prevalence of HIV/AIDS in the community.  

86 Ibid.  
87 Ibid.
2. 2. 10 Condom Use and the Prevention of HIV/AIDS

In the absence of proper cure or prevention by vaccination, the only effective physical barrier against transmission of HIV is the use of condoms. Condoms have been advocated earlier as a safe method of population control under the Family Welfare Programme. Use of condoms now assumes special significance in the AIDS related scenario as it is the only effective method of prevention of HIV/AIDS through the sexual route apart from total abstinence. Government feels that there should be no moral, ethical or religious inhibition towards propagating the use of condoms amongst sexually active people specially those who practice high risk behavior.\(^8\)

The Government has adopted a conscious policy of use of condoms through the social marketing and community-based distribution system. It has been observed that the social marketing strategy has helped in increasing use of condoms in the country at large. There is greater need to ensure availability of condoms at places and times where they are needed. Hospitals, STD clinics, counseling centres, nursing homes and even private clinics of medical practitioners should have adequate supply of condoms for use of the patients. General availability of condoms in the community drug stores, important road and railway junctions, public places, luxury hotels, etc. should also be ensured for use among sexually active people. This will help in achieving the twin purposes of control and prevention of HIV and as a useful tool for promoting the small family norm. Government would promote development of culturally acceptable information packages about the efficacy of condoms to achieve both these objectives.

While ensuring availability of condoms, it is equally necessary to see that the quality and reliability is also guaranteed. Schedule ‘R’ of the Drugs and Cosmetics Act (DCA) has been amended recently to include condoms for ensuring adequate quality control in their manufacture and distribution. There are adequate numbers of

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manufacturers both in the public and private sectors in the country to take care of the increased demand for condoms among sexually active people.\textsuperscript{89}

\textbf{2. 2. 11 Blood Safety Policy}

Till recently about 6-8 per cent of HIV infections occurred through transfusion of blood and blood products in India. To minimise the risk of transmission of HIV through blood, government has taken a series of measures: testing of all blood units used in the blood banks for HIV, Hepatitis B, Malaria and Syphilis has been made mandatory; under the Supreme Court's directive, a proper licensing system has been introduced for licensing of all blood banks and stopping operation of all unlicensed ones. Government has undertaken a large scale mobilisation effort to increase voluntary blood donation through involvement of governmental and non-governmental agencies. Simultaneously the systems of collecting blood through professional blood donors were phased out by December 1997 under the Supreme Court order. Government has ensured an adequate establishment of blood banking services both at the State and District levels, including the provision of trained manpower. To ensure rational use of blood, more and more blood component separation facilities were established in the country for availability of blood products instead of whole blood. Government has set up National and State Blood Transfusion Councils to oversee blood transfusion services as independent autonomous bodies. The facility of tax exemption for contributions to these councils has also been given. These councils play an important role in augmenting blood transfusion services in the country and to ensure safe blood to the people. To ensure generation of adequate medical and paramedical personnel specialised in blood banks, States were required to open separate departments of Haematology and Transfusion Medicine in the medical colleges.\textsuperscript{90}

With the modernisation of blood bank services, it is expected that the demand for blood will be fully met through the small but more modernised and efficient network of

\textsuperscript{89} Ibid.

blood banks in the public, private and voluntary sectors, thus minimising the risk of HIV transmission through blood.

2.2.12 Research and Development on HIV/AIDS

The research and development efforts in the field of HIV/AIDS have been very limited in the country. With the emergence of vaccination programme by the turn of the century, Government recognises the need to encourage and support research and development; hence government has ventured for collaborative research with scientific groups in the developed countries so as to development vaccines, which will be suitable for the strains of HIV virus prevalent in India. It is also necessary to develop protocols for vaccine trials in the country.91

Research and Development in HIV vaccine was regarded as an expensive proposition but because of the enormity of the problem involved, the effort was worth the investment. Development of anti-retroviral drugs in USA and other developed countries has given hope to the large number of HIV infected persons for greater longevity and a possible cure for the disease. However, these drugs are extremely expensive even by the standard of the developed world. The Government therefore has followed a policy of allowing these drugs to be imported freely into the country to ensure their free availability to those who can afford. Efforts were made to indigenise the manufacturing of these drugs by encouraging the private sector drug industry to get into collaborative arrangements. The efficacy of anti-retroviral like AZT in prevention of prenatal transmission from mother to the child has also raised the hope of saving children from getting the infection from their mothers. Government has sponsored a number of pilot studies to examine these drugs before they were officially introduced for treatment at the pre-natal stage. Government has time and again encourage the indigenisation of the HIV

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related equipment like test kits which will help in reducing the cost of service to a considerable extent.  

2.2.13 Use of Indigenous System of Medicine (ISM)

In a scenario where anti-retroviral drugs are extremely expensive, there is a great need to look into the indigenous system of medicine like Ayurveda, Unani and Siddha apart from Homoeopathy. Some of the medicines in these systems have the potential of reducing the viral load in the body of the patient thus ensuring a healthier and longer life with the infection. The Government has sponsored research projects in Homoeopathic and Siddha systems of medicines and is receiving encouraging response. It will pursue a policy of sponsoring research in ISM and Homoeopathy for development of drugs which can serve the purpose of anti-retroviral, if not for a total cure from the infection.

At the same time it necessary to be vigilant against unscrupulous persons claiming to have invented a cure for HIV/AIDS by magic herbs. Any medicine or system of treatment which cannot stand the test of scrutiny by the professional organisations like the Ayurveda Council or the Homoeopathic Council cannot be accepted as a drug or a system of treatment in the country. The Drugs and Magic Remedies Act requires amendments to stringently deal with cases of unscrupulous persons taking advantage of the misery of HIV infected persons and defrauding them of huge sums of money. A massive awareness campaign has also been launched to make people aware of the dangers of such medication by unqualified persons indulging in quackery.


94 Ibid.
2. 2. 13. 1 Administration of Polyherbal Neem Microbicides Tablets

Research in the field of vaccine development and trials have been initiated in India, most of these are based on polyherbal neem microbicides tablets. The National Institutes of Research on Reproductive Health, Mumbai and PGI-MER (Post Graduate Institute of Medical Education and Research), Chandigarh have conducted clinical trials based on neem microbicides and the products have been found safe to use. The efficacy trials are being conducted by the National AIDS Research Institute, Pune.

Microbicide tablets are potentially lifesaving alternatives to condoms in India, where women lack the power to negotiate safe sex with their husband/partners. A multi stake holder advisory board has been constituted to deliberate the legal, ethical and social - behavioural issues related to vaccine trials in India, several vaccines were tested and reviewed to select the most appropriate for the Indian situations.

Under NACO’s Voluntary Testing and Counseling (VCT) policy, no individual can be made to undergo mandatory testing for HIV; the testing should not be imposed as precondition for employment or provision of health care facilities. NACO has developed several niche guidelines for VCT centers, which deal with consent and confidentiality issues.

2. 2. 13. 2 Administration of Antiretroviral (ARV) Drugs 2004

2. 2. 13. 2. 1 Three by Five Initiatives

"3 By 5" initiatives of the WHO and the UNAIDS, which was launch in India in September have led to the paradigm shift, because until India’s AIDS policy did not

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95 Neem (Azadirachta indica) is a tropical and semi-tropical tree of the mahogany family called Meliaceae; it is indigenous to Indian sub-continent and has a great medicinal values. Indian pharmacist has been using neem since time immemorial.
96 UNDP/NACO (2004)., n.7.
97 Ibid.
98 However this policy does not apply to Armed forces.
99 AVERT (2004)., n.12.
100 The three by five initiatives launched jointly by WHO and UNAIDS in 2003 endeavours to provide antiretroviral treatment (ART) to three million people living with HIV/AIDS in low and middle-income countries by the year end 2005. This was an ambitious noble goal of making universal access of HIV/AIDS prevention and treatment accessible for all who need them as a human right.
support the provision of ARV (Anti-Retroviral) treatments. After The initiation of three by five, the commitment to provide free ARV treatment to AIDS patient began in India at the rate of 10,000 per year. From 1 April 2004, all the government hospitals were notified to provide free ART in all the high prevalence states of India, such as; Tamil Nadu, Maharashtra, Andhra Pradesh, Manipur, Nagaland, Karnataka and Delhi.

The provision of providing the free ART among the high prevalence’s were first ensured among the most three vulnerable groups; viz., HIV positive mothers, HIV positive children below 15 years and adults with full blown AIDS who seek treatment and care in the government hospitals.

Between 2004 and 2005, the government has sought to increase the number of ART centers from eight to twenty five. Pharmaceutical industries have also contributed in the fight against AIDS by reducing the cost of ARV drugs, which on an average cost an approximately ten thousand India Rupee, which is about 222 dollar per patient per year.

2.2.14 Cooperation between International, Bilateral and NGOs

More than 600 national and international NGOs are working on HIV/AIDS in India at the local, state and national levels. NGOs programmes includes, support and care to people living with HIV/AIDS, problems of orphanage and general awareness campaign are by far the most effective medium adopted by the NGOs to combat the epidemic. In recent year NGOs have initiated AIDS vaccination programmes in India, around six NGOs came together and formed a National Group on Vaccine Initiatives (NGVI) to develop and test AIDS Vaccines in India, by increasing community understanding and participation in the AIDS vaccine programme. Naz Foundation (India) Trust and Freedom Foundation of New Delhi, YRG CARE, the Indian Network for People Living with HIV/AIDS (INP+) of Chennai, The Guwahati based AIDS Prevention Society (APA) and the SOS Foundation of Nasik, are the members of National Group on

102 Ibid.
Vaccine Initiatives. Most of their funding comes from central/state government, International donors and local contributors.

Most of India's funding and technical helps comes from various UN agencies and bilateral as well as international donors. Some of the prominent bilateral donors such as; UK governments Department of International Development (DFID), Canadian International Development Agency (CIDA) and USAID have been helping Indian government and many Indian states since 1990's, the funds committed by these donors are respectively; 200, 11 and 10 million US dollars.

The number of international financers as well as the amount of funding has been significantly increased in India in recent years. In 2004, the gates foundation has pledged 200 million US dollar; global fund has approved 54 million US dollar. Likewise, there are many international and private funding in India.

The UN bodies, such as WHO, UNAIDS, WB and UNDP are actively engage in India to fight the menace. Hence, the participation and help extended by the international communities, coupled with Indian government relentless policies has at least brought some relief, but there are still a lot more to do to contain the HIV/AIDS in India.

Government notes with satisfaction the active support provided by international agencies of the UN system and bilateral agencies from different countries in the developed world. The World Bank has participated in funding a major part of the national AIDS control programme during the last five years. It has also shown interest in continuing this policy of active participation in future. The organisations which are constituent units of the UNAIDS Theme Group have all done work in India on various sectoral programmes for quite some time. These organisations will have to take a relook at their programmes and priorities in the context of the increase prevalence of HIV/AIDS

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105 AVERT (2004), n.12.
106 Ibid.
among the economically productive and socially exploited sections of the population. The Joint United Nations programme on HIV/AIDS known as UNAIDS will be required to assume a larger role both in terms of providing financial as well as technical expertise to the programme. The theme group of UNAIDS consisting of six UN based organisations will have to play a very effective role in acting as a coordinating agency between the Government and the UN agencies in formulation and implementation of programmes for prevention of HIV/AIDS. Government’s policy is to promote international cooperation to ensure optimal utilisation of resources to avoid unproductive duplication of efforts.108

Bilateral cooperation which has been developed with countries like USA, UK, European Union and others will be extended further to take up specific intervention programmes where the technical and managerial input from these countries can be put to optimum use. Government will promote mutual information sharing with these countries as well as the neighbouring countries in the South Asia region on their national AIDS control plans. Areas of interest which are common to the neighbouring countries like drug use, labour migration, socio-economic status of women and socially handicapped persons, etc. could be the common ground for regional cooperation among the neighbouring countries. Government will be actively looking for technical inputs for development of vaccines, drugs and equipment for prevention and control of HIV/AIDS and would explore bilateral and multilateral collaboration towards this end.109

2.3 Corporate HIV/AIDS policies

As per the fact findings of ILO (International Labour Organisation), more than 26 million workers aged between is 15-49 years, were living with HIV/AIDS at the end of the year 2004. Due to HIV/AIDS, workers are dying or dropping out of labour force at an alarming rate worldwide, more than 13 million labour forces had died of HIV/AIDS by the end of the year 2000. Around 17 African countries are at the threshold of losing more than 10 per cent of their labour forces by the year 2010 because of HIV/AIDS. By

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108 Ibid.
109 Ibid.
the end of the year 2015, countries like South Africa, Lesotho, Botswana, Swaziland, and Zimbabwe are predicted to lose over per cent of their workforce. The impact of HIV/AIDS on businesses are: increase in expenditure on employees' replacement, training, health care and social security cost; reduction in profit level; increase in absenteeism due to illness and bereavement as well as increase in labour misfit due to illness and death. Fall in production due to absenteeism, low labour turnover and the loss of skilled as well as experience workers are the other serious consequences.\textsuperscript{110}

This is true in the case of Indian scenario, though there is a limited data availability but there are strong evidence such as rising costs due to HIV/AIDS in Indian companies: The Singareni Collieries Company Limited in Andhra Pradesh (one of the high HIV prevalence state of India), incurred a whopping expenses of about 65 million Rupees (US$1,44,444) for compensating 29 of its employees who were declared unfit to work by the company medical board due to AIDS related illnesses.

An amount of 1.2 million and 22 thousand Rupees (US$27,155) were incurred by the Employees State Insurance Corporation scheme in providing antiretroviral drugs to around 200 ESIC beneficiaries and employees in the year 2003-2004. Similarly the Indian Railways and BEST (Brihanmumbai Electric Supply and Transport Undertaking Ltd) of Mumbai, have incurred a substantial amount in providing antiretroviral treatment to their employees.\textsuperscript{111}

Besides, the policies and programmes of government and its various organisations, there are many corporate sectors and NGOs that have come forward to fight the HIV/AIDS in India. Corporate sector initiatives on HIV/AIDS in India remained piecemeal till recently, however from 2005, many corporate houses have come forward to shape up the programmes on HIV/AIDS, mainly targeted at work force and the private sector communities.


\textsuperscript{111} Ibid.
A study carried out by the world economic forum in 2005, regarding the Indian companies strategies, awareness and policies to deal with the burgeoning HIV/AIDS problems in India were not appreciable, see figure 2.6.

Figure 2.6:

Levels of strategies and policies on HIV/AIDS among Indian Companies

Source: The Economic Forum

Figure 2.6 highlights the Indian business and corporate response to HIV/AIDS India;\(^\text{112}\) 21.88 per cent of Indian companies claim to have some prevention programs, were as about 19.28 per cent had no treatment programme as such. Nearly 15 per cent did not have any tabled policies to face the expected challenge. Around 13.0 per cent had no facilities to distribute a condom, that means only 5.5 per cent had condom distribution

\(^\text{112}\) UNDP/NACO (2004), n.7.
facilities and about 9 per cent reported having an informal policy. 8.4 per cent had a provision for voluntary testing, and on the other hand about 3.2 per cent of Indian corporate had written policies to combat discrimination in promotion and pay, based on HIV status, 2.9 per cent of them had a provision for anti-retroviral treatment and 2 per cent of Indian companies felt that HIV/AIDS does impact the business plausibility.

In September 2005, CORE-BSCD (Corporate Round table on development of strategies for the environment and sustainable development-Business Council for Sustainable Development) India, a platform of 52 strong companies as well as global Business coalition on HIV/AIDS (GBC) and the Confederation of Indian Industry (CII) has jointly initiated a project engaging corporations involved in Business Process Outsourcing (BPO).\textsuperscript{113}

These conglomerations have initiated an action to deal the HIV epidemic, three core areas have been identified to scale up the awareness to prevent the spread of HIV/AIDS, and these are Communities, Clinical facilities and Work place. The parameter and the inter-link between the three areas are illustrated through the help of a diagrammatic representation, see figure 2.7.\textsuperscript{114}

\textsuperscript{113} Ibid.
\textsuperscript{114} Ibid.
Figure 2.7:
The core areas of HIV/AIDS prevention

Source: National AIDS Control Organisation

India’s HIV/AIDS situation is not very good, and the emerging trends clearly indicates that, if timely actions were not taken by the various businesses and corporate houses, then the cost being inflicted by its inaction will be far greater than what one can normally predict to be. Prevention therefore is the best options and it works best with the most cost effectiveness, provided if the measurements were taken timely and started early.

The corporate or business response to HIV/AIDS should not wait until the problems become obvious. Hence, the right an appropriate time for a company to respond to or take action against HIV/AIDS is when it does not wait to see that it happened to one of its employees. Many Indian corporate and business houses have developed a good
response to HIV/AIDS. The International Labour Organisation has documented around 115 Indian enterprises in that have responded appropriately to the HIV/AIDS menace. The management of these companies quoted the following reasons for developing their HIV/AIDS response:\textsuperscript{115}

Our companies are not in existence just to run our business and to make profits. We are responsible and good corporate citizen over and above our normal operations.\textsuperscript{116}

A healthy workforce is the biggest asset for a company.... A healthy workforce means less absenteeism that translates into more production, which could be ascribed to the success of the programme.\textsuperscript{117}

HIV records do not give the true picture, prevention is better for any company.\textsuperscript{118}

By contributing towards the cause of HIV prevention and control, especially at the workplace, the company enhances the quality of life of its employees, and they in turn, can ensure higher productivity for the organization.\textsuperscript{119}

We believe in the creation of a nurturing, enabling and nondiscriminatory environment for all employees. AIDS related issues are a testing ground for that policy.\textsuperscript{120}

We shall constantly strive to work within our available resources to make our company, our country and this world a safe and healthy place for our future generations.\textsuperscript{121}

Through active involvement of all sections of society in combating the menace of HIV/AIDS, especially at workplace, mutual trust, quality of life and ultimately enhancement of higher productivity are ensured.\textsuperscript{122}

\textsuperscript{115} Afsar, Mohd.S, (2005), n.89.
\textsuperscript{116} Mr. Ratan N. Tata, Chairman Tata Group.
\textsuperscript{117} Mr. Madhur Bajaj, Bajaj Auto Ltd., Pune
\textsuperscript{118} Mr. Vijayakumar, Tata Tea, Munnar.
\textsuperscript{119} Mr. N.Y Sanglikar, Glaxo Smithkline., India.
\textsuperscript{120} Mrs. Anuradha Anand Mahindra, Mahindra and Mahindra Ltd., Mumbai.
\textsuperscript{121} Mr. A.M. Naik, Larsen and Toubro Ltd., Mumbai.
\textsuperscript{122} Mr. Arvind Pandey, Chairman, Steel Authority of India Ltd. (SAIL), New Delhi.