CONCLUSION
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HIV/AIDS came into forefront and entered our consciousness with disturbing elements during the 1980s, and quickly transform itself into an epidemic proportion, the fight against HIV/AIDS since then has gradually mobilised governments, international agencies and non-governmental organisations. However, it became evident that despite massive campaigns and actions to inform the general public about the risks and miseries associated to HIV/AIDS, behavioural changes and individual responses are not occurring the way it is expected. HIV/AIDS continues to expand and spread rapidly beyond the limits, hence a series of serious questions began to emanate as to the efficiency and effectiveness of the efforts being undertaken in combating the epidemic. Experience has demonstrated that HIV/AIDS epidemic is a complex, multifaceted issue that requires close international cooperation and multidimensional strategies.

The establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996 initiated a new approach to the prevention and care of the disease. The programme stressed the need for increased co-ordination and collaboration between institutions for prevention, treatment and care about the people suffering from HIV/AIDS, and at the same time considering the significant social factors involved in it. The declaration of commitment adopted by the UN General Assembly recognised that prevention, care, support and treatment for those infected as well as affected by HIV/AIDS are mutually reinforcing elements of an effective response.

Mortality rate dropped sharply in the developed countries, were most of the HIV/AIDS people having access to the new classes and combinations of antiretroviral therapy. Attention shifted to the complex medical problem of adjusting drug combinations to stay one step ahead of a mutating drug-resistant virus, but progress on prevention fell far behind the expectation. Not to talk about poorer country but nearly every high-income country, the past few years have seen that the epidemic usually make inroads in poorer and more marginalised parts of the society. Coupled with these are the
high-risk groups, were behavioural changes are abysmal and unsafe sex is on the rise, with a corresponding rise in the rate of HIV infection.

Meanwhile, in the developing countries, the slogan \textit{prevention is the only cure} began to sound like the hypocritical justification of a morally bankrupt global divide. Inadequate access to the treatments that have transformed AIDS in rich countries is tantamount to robbing poor ones both of a powerful weapon against the epidemic, and of hope in collective action. Antiretroviral are not magic bullets, but they are an essential component of a comprehensive prevention, treatment and care response. They can motivate individuals to be tested for HIV, support the prevention of mother to child transmission, and help break down barriers of isolation, despair, stigma and discrimination. All this is in addition to their more direct benefit, of providing therapy with the treatment of opportunistic infections and palliative care.

Various research studies carried out under the initiatives of UNAIDS in India, South Africa and many other countries suffering from AIDS have all indicated and proved that: Use of interactive theatre in HIV/AIDS prevention, particularly among the youth; Role of religious leaders and Faith-Based Communities and Organisation (FBO); Association of NGOs and business sectors; Participation of indigenous communities and ethnic groups; Use of arts, literary, personalities and medias; as well as the role of traditional healers have proven very efficient in education, prevention, treatment and care in the fight against HIV/AIDS epidemic. At the same time these factors also help in tackling the miseries of HIV/AIDS such as, stigma, discrimination and prejudice.

The increased political momentum and the prospect of significant increase in the availability of resources have made the need for clarity about the best methods to be used in tackling the HIV epidemic in the world. The global strategy framework on HIV/AIDS, approved by the programme coordinating board of UNAIDS in the year 2000, distilled the lessons learnt in the past 20 years of responding to the epidemic.

The response can be specified as: The requirement of political leadership at all levels to marshal the necessary commitment and resources for the social mobilisation on which the response must be built; The responses to the epidemic need to be
conceptualised as multi-sectoral tasks, and not confined to health sector action, just as the impact of AIDS is felt across all social and economic sectors; The scale and breadth of the response needs to encompass all elements of national planning; Moreover, coordination in the national response is required given the multi-sectoral nature of the crisis; The effectiveness of national responses could be those which are steered right from the offices of prime ministers and presidents; and responses will be successful if people living with HIV/AIDS are always centrally involved along with the participation of communities, NGOs and other organisations, because successful responses to the epidemic have their roots in the communities in the sense that local actors are able to determine the most effective priorities for action and they can act accordingly when they are helped to mobilise the necessary resources. Hence, if these principles are applied to local responses, and when the political leadership show great zeal to proliferate local responses on a national scale, then the epidemic can be reversed and controlled.

The Global Strategy Framework also shows how to shift the dynamics of the epidemic by lowering risk, vulnerability and impact simultaneously. Most prevention efforts to date have focused on reducing immediate risks by bringing about behaviour change. But behaviour change has been frustratingly difficult to achieve and sustain, because the risks related to HIV exposure are not always easy to control.

Reducing vulnerability is a way of generating a deeper level of change in social structures in order to increase individuals control over risks. It might involve making sexual health services accessible, giving marginalised group’s protection against discrimination, or using schools as a resource to involve whole communities in AIDS responses. The impact of AIDS makes it harder to reduce vulnerability, because it disrupts social structures and depletes resources. Hence reducing impact also has to be part of the core programme such as, by supporting orphans, creating training opportunities and improving access to care and treatment. The common experience of most of the countries suffering from HIV/AIDS is that risks cannot be reduced in isolation. Responses have been successful where it is based on wide community support, their role in designing and delivering change, as well as in changing the social environment. The expanded response to the epidemic has been criticised as insufficiently
prioritised, not focused on outcomes, and lacking in emphasis on sustained behaviour change. But the evidence from those national and local responses to the epidemic in which sustained drops in HIV incidence have been achieved, or in which low incidence has been maintained despite surrounding trends to the contrary, shows that it is precisely when the response to the epidemic is based on a broad social mobilisation, accompanied by clear deliverables, that success were achieved and can always be achieved.

To succeed the prevention, treatment and care programmes of HIV/AIDS, interventions must be targeted and they must be carried out in the right direction with supportive environment. Close examination of the celebrated example of the 100 per cent condom use campaign in Thailand shows its success to have depended on its being part of the package. HIV prevention became part of Thailand's national sense of destiny, emanating right from the desk of the Prime Minister's office. There was a nationwide debate on sexual mores, together with structural solutions such as regulation of the sex industry, intensive education, skills development and peer intervention with sex workers and their clients.

Likewise in India, the red-light district of Sonagachi in Kolkata has a well establishment autonomous and self-sustaining social movement built around the sex industry, it has succeeded in keeping HIV prevalence low, both among sex workers and within the general population. In contrast, in Mumbai, Maharashtra, where many sex workers are bonded labourers, and sustained communitywide interventions have been lacking despite positive results from well-targeted interventions. HIV prevalence among sex workers rose steadily between 1987 and 1997 to the current level of over 70 per cent. Similar attempts to target miners in South Africa have shown that to increase the uptake and success of interventions, workers need to understand them in the social context of their work, recreation, families and communities.

Even in epidemics, which are initially driven by the very specific practice of injecting drug use, there is a simultaneous need for widely diffused intervention. Modelling based on the rapidly growing HIV epidemic in the Russian Federation, have exhibited that early implementation of harm reduction interventions for injecting drug users will have a substantial impact on the size and growth of future HIV/AIDS. Equally,
therefore, it is important to invest in programmes that influence young people, given the relatively low age of injecting drug users, and the future spread of the epidemic, which will be mainly through heterosexual.

The sound economic growth of India and South Africa, increase cooperation among the international communities, active participation of Non-Governmental Organisations, Civil Society Organisations, Business sectors, Medias, Acclaim Personalities and Figures as well as sustainable application of Scientific Developments, such as Anti-Retroviral Therapy, Nevirapine, HAART (Highly Active Antiretroviral Therapy) have all contributed and helped in lessening the HIV/AIDS burden in these two countries in the recent periods. Moreover, the development and initiation of well founded policies and programmes by the respective governments on HIV/AIDS have perceptibly reduced the intensity of HIV/AIDS in India and South Africa.

HIV infections were basically and traditionally concentrated among poor and marginalised groups, including: Commercial Sex Workers; Truck Drivers; Migrant Labourers; Men Having Sex with Men; and Injecting Drug Users in the case of India, as well as Mine Labourers; Armies; and the above groups in the case of South Africa. Transmissions of HIV within and from these groups have driven the epidemic and were behind the spread of HIV in the general population and into the rural areas. On an average and in general, about 90 per cent of the total reported AIDS cases in India and South Africa occur in the sexually active and economically productive age group of 15-44 years. As per India’s NACO and South Africa’s NACOSA, the predominant mode of HIV transmission in these countries are through heterosexual contact, followed by intravenous drug use, blood transfusion and the use of blood product.

The belief that HIV transmissions are driven by heterosexual exposure is therefore very strong in India and South Africa, this is however no longer tenable. Much larger role for parenteral\(^1\) HIV transmission in medical settings is required. Doctors,

\(^{1}\) Drugs administration other than through the alimentary tract (as by intramuscular or intravenous injection) or Located outside the alimentary tract, e.g. by injection, infusion, or implantation.
including obstetricians and gynaecologists must educate their patients in the dangers of non-sterile injections and ensure that their own practices are beyond reproach. Similar improvements in the sterility of injections in the informal sector are also urgently required, hence patients needs to be protected from their own medical care system in India and South Africa and also other countries with similar epidemiological characteristics.

Epidemiology of HIV shows important differences between developed and developing countries. Therefore, caution should be exercised in extrapolating findings from developed countries to that of developing countries like India and South Africa, especially in the rural areas and among the ethnic groups which usually shows an entirely different pattern in the natural history of HIV infection. Thus, community-based longitudinal studies should be initiated to evaluate the distribution as well as genetic diversity of HIV in this region as a means of facilitating vaccine design and trials. Such studies must also evaluate local cultural, traditional practices and religious belief that may favour or enhance the transmission of HIV/AIDS.

The high prevalence of HIV/AIDS and its co-infections in India and South Africa make it a potential source of an emerging epidemic. Identifying risk factors and routes of transmission is therefore essential for effective intervention. Though India and South Africa has well established policies on blood and blood products, but due to the mushrooming of many private hospital and clinics, the hygienic supply of blood and blood products in these clinics are questionable. Hence, it is required that governments initiate a more stringent regulations and policies, such as monthly reports on blood transactions in each hospitals to be submitted to the ministry of health as well as more stringent testing system to be deployed, whereby all the patients with HIV will be put through comfortable but strict testing process.

India and South Africa are proud to have achieved certain levels of development to tame and control the diseases, these developments include: Institution of HIV workplace policies; Establishment of awareness, prevention, treatment and care programmes; Development of sound surveillances and monitoring systems; Establishment of mandatory screening of blood and blood products; Availability of
clinical and testing facilities such as, VCTs, prenatal and antenatal clinic, STD clinic, ART center and condom dispensing machines; Facilitation of HIV/AIDS information channel; Institutions of rights and empowerment for women and children, Institution of stringent law on discrimination and prejudice; Institutions of right to maintain HIV/AIDS status; Administration of free anti-retroviral drugs under 3 to 5 initiatives of WHO; Development of home and community based care facilities to people living with HIV/AIDS and their families; and lastly the creation and development of states or provincial AIDS control societies in every administrative unit in India and South Africa.

Hence, government’s response to HIV/AIDS in India and South Africa are appreciable since from day one when HIV was first reported in the 1986 and 1982 respectively. The challenges of building a nation-wide AIDS program were immense. The process went normally in India but South Africa was struggling to avoid apartheid system during those periods.

However, over a period of time, various HIV/AIDS policies and programmes were established and initiated in India and South Africa, these policies and programmes were supported by International agencies and are participated by the Non-Governmental Organisations, Civil Society Organisations, Faith Based Organisations, Community Based Organisations and Business Houses of various backgrounds. Five Year Strategic Plans of HIV/AIDS and its equivalent in each administrative unit are implemented; work place HIV/AIDS policies, issues of women and various other programmers on HIV/AIDS are fully established in India and South Africa.

The participation of NGOs or CSOs, business sectors, artist, film and sports personalities and religious institutions in the fight against HIV/AIDS are quite appreciable in these countries. Research and development associated to HIV/AIDS are intelligently pursuit and weightage is given towards the development of indigenous systems of treating the HIV/AIDS.

But, whatever may be the effort and Excellencies delivered to curtail the HIV/AIDS menace in India and South Africa or in the world, HIV/AIDS is a reality and is the toughest disease humans have ever encountered. It has shaken the very foundation
of human civilisation and has threatened the existence of human race on this planet. Moreover, the morphology of HIV virus is the most complicated among the viruses to be comprehended, coupled with this is its nature, which is dynamic and difficult to ascertain, therefore it poses a big hurdle and an obstacle in the development of AIDS vaccine and medicine, because the nature and morphology of HIV virus is such that it changes from one host to another host, given such complicated nature of HIV, it is therefore nearly impossible to develop AIDS medicine for every single infections and thus it poses the most daunting challenges to human wisdom. Hence, HIV/AIDS is going to stay for an aeon\(^2\) time and continuously haunt the human civilisation.

Every month millions are added in India, high birth rate along with a huge in-flux of people in search of better livelihood throughout India, added to this internal migration is the international migrations of large numbers of people from across its neighbours. Similar kinds of migration also take place in the Republic of South Africa. In such scenario AIDS occurs and spread more randomly, because the HIV/AIDS infrastructure becomes limited and resource allocation gets diluted.

HIV/AIDS as of now have transcended the boundaries of high-risk groups and entered into the general population. Prevention, treatment and care programmes have already reached at a critical phase. The prevention of HIV/AIDS and its control is therefore become a developmental issue with deep socio-economic implications in India and South Africa. It touches all sections of the population, both infected and affected, irrespective of their regional, economic or social status. By following a concerted policy and an action plan that emerges out of it, Government of India and South Africa are confident to control the epidemic and slow down its spread in the general population within the shortest possible time. All participating agencies such as, Non-Governmental sectors, International and Bilateral Agencies in India and South Africa adopts the policies and programmes in conformity with the respective governments national policy in their effort to prevent and control the HIV/AIDS epidemics. Hence, government of India and South Africa are fully committed and hopeful of preventing the further spread of HIV/AIDS and reduce its implications.

\(^2\) The longest division of geological time periods or an immeasurably long period of time.
Although the situation in India and South Africa merits the scaling up of their policies, prevention and care services as well as scientific applications, but resource constraints, population burdens and unstoppable migrations in India and South Africa makes it imperative for the respective governments, international donors and NGOs to unite and explore more sustainable programmes to fight the HIV/AIDS epidemic.

Whatever may be the progress and development, India and South Africa continuously and critically faces a major challenges of HIV/AIDS epidemic, it has threaten the decades of painstaking progresses made in the health and development. A mature AIDS epidemic reduces life expectancy, increases the demand for medical care, worsens other illnesses such as tuberculosis, and exacerbates poverty and inequality. HIV has risen to high levels among those practicing the riskiest behaviors and is set to spread even more widely in the rest of the population.

India and South Africa needs to build on the lessons learned over the past two decades; the respective governments along with international cooperation and NGOs participation have to develop the scale and reach of its national response to HIV/AIDS. There is in fact no alternative if India and South Africa are to have any chance of changing the course of the epidemic and saving countless thousands, if not millions, of lives. Scaling up of strategies, policies and programmes on HIV/AIDS are clear and well perceived. Policymakers in the government must act swiftly and effectively to prevent the spread of HIV/AIDS, and to treat those who are living with and affected by HIV/AIDS.

Hence, India and South Africa further needs to develop a strong leadership and policy makers at all levels; they need to change the mindset from trying to control strategy to that of facilitating, listening and involving. Governments of India and South Africa continuously needs to challenge the discrimination, prejudice and stigma at every level, they need to bring in stringent and tough laws on discrimination. Involvement of all and varied actors, through a truly inclusive, multi-sectoral approach is what it all take to restrict the advancement of HIV/AIDS. Decentralisation without fragmentation of national AIDS control policies and programmes must be initiated and made it as the protocol of HIV/AIDS prevention, treatment and care services. Community involvement
and empowerment, mobilisation of resources through donors as well as reallocation of
government’s budgets and debt relief would pave way for the restriction of HIV/AIDS
and its implications.

The road is clear and wide, maps and charts are in the hand. The governments
must not wait how soon the journeys take place, rather should show green signal and flag
off from every junction to fight and restrict the HIV/AIDS pandemic. There are millions
waiting to catch back their lost smiles and millions expecting and hoping for better and
sustainable future tomorrow.