REPORT OF THE

NATIONAL WORKSHOP ON WOMEN STDs, HIV and AIDS

Rishikesh, March 1 to 6, 1994

by

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INTRODUCTION

According to recent projections of the World Health Organisation, about eight million women and ten million children will be infected with the HIV virus by the year 2000. The majority of women at risk will not be women working in prostitution, as widely believed, but primarily married women in the reproductive stage of life. The HIV epidemic is a women's epidemic. It affects women in their multiple roles in society.

Therefore, women require special and urgent consideration in response to the HIV epidemic. The epidemic is inextricably linked to the social context, cultural values and economic relations which determine the interaction between individuals and within communities. It differentiates not only in its medical manifestations, but also in its disproportionate impact on those who are socially, sexually, and economically vulnerable.

Women are disproportionately affected by the virus because of their social and sexual subordination. Social and sexual power relations reduce women's ability to protect themselves against sexually transmitted HIV infection, the predominant mode of spread in most countries. Globally, it is estimated that 60% of all cases of infection occur through vaginal intercourse. The efficacy of transmission is increased where women have poor general health and suffer from genital lesions, inflammation, secretions and/or scarifications.

Two general observations need to be made. First, the disease does not strike blindly. Poverty increases the vulnerability to the disease. Secondly, in India where gynaecological ailments including STDs are endemic and diagnostic and treatment facilities are not accessible to poor women, there is a manifold danger to women's lives. It has been proved that untreated STDs increase the danger of infection during sexual contact.

There is a pressing need to explore and understand the gendered dimensions of HIV and AIDS and identify strategies which a woman must have under her control in order to effectively combat the HIV\AIDS epidemic. An effective campaign against its spread amongst women requires empowering every woman affected by the virus - whether she be a wife or a woman working in prostitution.

Few women's groups have taken a critical look at the issue of women and HIV\AIDS. There is a need to create space for a dialogue on this issue, and to evolve a common perspective for influencing existing strategies and formulating new ones. Women's groups have to work jointly with health and human rights groups to develop effective measures to contain the spread of HIV. We also need to understand and link these strategies with other struggles, namely in the area of contraceptive politics and the global campaign on women's human rights.

In light of these concerns, the National AIDS Control Organisation (NACO) approached JAGORI to organise a five day workshop for activists, researchers and professional women on the issue of Women, STDs, HIV and AIDS.

The main objectives of the workshop were:

1. To develop a feminist perspective on the issue of women and STDs, HIV\AIDS.
2. To examine the overall impact of STDs, HIV\AIDS on women's health status and the extent of its pervasiveness amongst women.
3. To share women's experiences of their sexual practices and needs.
4. To strengthen women's strategies to gain control over their bodies and fertility.
5. To help the process of dissemination of information on women and STDs, HIV\AIDS.
6. To evolve legal and health strategies to protect women from HIV infection and women living with HIV\AIDS.

From March 1 to 5, 1994, twenty five women from all over India came together in Rishikesh to learn and speak about the issue of Women, STDs, HIV and AIDS. An ashram was chosen for the workshop because of our feeling that activists in the field need to have a respite from the emotionally intense and politically hectic lives they lead. The ashram offers a space of serenity with its close proximity to the Ganga, and its quiet location at the foothills of the Himalayas.

The participants were drawn from many different fields of activity in the hope that we could bring out the multidimensional aspects of women, STDs, HIV and AIDS. Some have actually been working with people living with AIDS in diverse activities such as counselling, formulating preventive measures, lobbying policy makers, and caring for people living with the virus or syndrome.

For many of us, including the organizers, this was the first time in which we were confronting the issue of HIV\AIDS from women's perspective and experience. We were astonished at the lack of information available about women and the lack of attention given to the gendered dimensions of this syndrome. The workshop provided the space to bring women to the centre of the HIV issue and place it in the socio-economic and cultural context of women's lives in India.

Yet the processes of the workshop were not intended merely to inform ourselves about this subject, but also to challenge our own values, moral positions, prejudices and beliefs. HIV has been difficult to address because it is confronted with so much misinformation and prejudice. In the contexts of women's lives, this is particularly so, for women have been treated as transmitters of the virus and condemned as being immoral. The stigma and resulting ostracism has silenced people living with AIDS, but it has in addition invisibilised women's specific experience of AIDS.

We are hopeful that the processes of the workshop described in this report and the emerging recommendations will provide policy makers and grassroot activists with insights into the complexity of HIV\AIDS in India and how it impacts on women's lives. More specifically, we hope it will give visibility to the women's experience of the virus, and contribute to a more comprehensive policy on HIV\AIDS while simultaneously posing challenges which will help to transform the lives of women as a whole.

- Abha Bhaiya and Ratna Kapur. Co-organizers of the workshop.

NACO WORKSHOP ON WOMEN, STDs, HIV AND AIDS
RISHIKESH, MARCH 1 TO 5, 1994

Introductions

The process of the workshop began with each participant introducing herself by briefly describing her work and how she felt the workshop could be relevant to her activities. In addition, the participants talked about their specific expectations from the workshop.

Most of the participants felt they had inadequate knowledge about HIV and AIDS in general and were unclear as to how women were differently impacted. One participant stated that the AIDS policy was very relevant to understand as she felt it was linked very closely with the current development processes. There was also specific concern with the impact of HIV\AIDS on the family planning program and contraceptive policy. In particular, the current focus on the condom in the context of HIV\AIDS could result in a shift of family planning programs from women to men. In fact, one of the participants from the South India AIDS Action Programme saw this as a positive shift as condoms were safe, cheap, easy to use and placed some responsibility on men for sexual relations. This issue was addressed in greater detail at a later stage in the workshop and has been reported below.

Another participant drew the group's attention to the emotional and mental impact of HIV\AIDS on the people working with those who were HIV positive. She spoke about her personal dilemmas as a health worker and how being female mediated her experience of working with HIV positive people and as well as her male colleagues. She was hopeful that we would address the dichotomies that sometimes exist between our own lives and the work that we do.

Summary

Some of the concerns that emerged from the discussion included:

a. The need to uncover and critique the hidden biases and limitations in existing information.

b. The need to use and recommend terminology which was appropriate for addressing women, STDs, HIV and AIDS. For example, 'target group' was considered an inappropriate term as it singled out people who were thought to be responsible for the spread of the infection. Other terms that needed clarification were `sex workers', prostituted women', and `women in prostitution'. (As there was some controversy over what term was deemed appropriate, we have used the term women working in prostitution and reported the debates that took place on the meaning and use of each term.)

c. The need to make specific recommendations to WHO and NACO as regards policy as well as to NGOs working with women STDs and/or HIV and AIDS.

d. The need for a discussion of the politics of AIDS funding in India and globally. (Unfortunately, it was not possible to address this issue in any depth because of the limited participation of representatives from WHO and NACO in the workshop process. This issue is addressed later in the report.)

In the subsequent session, three women shared their experiences of working in different HIV\AIDS prevention and treatment programmes.

I South Indian AIDS Action Programme - Information and Experiences

The session was conducted by **Shyamala Nataraj** who works with the South Indian AIDS Action Programme. Her focus was to provide basic information about HIV infection and AIDS and clarify any misconceptions or doubts. This session was deemed essential in order to ensure that the remainder of the workshop was built on complete and accurate knowledge of the virus and the syndrome. The participants completed a questionnaire on the night of their arrival in Rishikesh in order for us to assess information base and the knowledge the participants had about HIV and AIDS. A sample of the questionnaire is **Annexure A** to this report. (Note: At the end of the workshop, the participants were of the view that the questionnaire was inadequate. A revised version is being prepared and will be available at Jagori in due course.)

Shyamala shared some basic information about HIV transmission and AIDS and then proceeded to share some of her experiences of working with HIV and AIDS. When she first began her work, she found that sexually transmitted diseases (STDs) were prevalent among the communities where she was working. She stated that though there is a very low chance of HIV being transmitted through unprotected sexual contact, in India, this is the main form of transmission. The reason for this was the presence of STDs or reproductive tract infections (RTIs), lacerations, and breaks in the skin, which greatly increased the chances of getting HIV. SIAAP has therefore focused some of its work on STD treatment. As a strategy, Shyamala stated that treatment and prevention of STDs should be at the forefront of preventive care.

Shyamala clarified that HIV is not easily transmitted. There are several unknown areas about HIV transmission. For example, while it is true that every act of unprotected sex exposes you to the possibility of being infected, no one knows why some people have been having unprotected sex with partners known to be HIV positive, but yet remain uninfected. It is not necessary that HIV is transmitted each time an act of unprotected sex takes place. There is considerable evidence that the presence of STDs greatly increases

this possibility.

The use of the term STD was challenged by some of the participants. It failed to include ailments from which women suffered that were not exclusively STDs, but consisted of innumerable kinds of gynaecological problems. The term 'Reproductory Tract Infection' was also considered inadequate for the same reason. The participants felt that the words 'gynaecological condition' were more appropriate and inclusive of women's health problems. There was also some concern expressed over describing the Clinics as STD clinics, as the term had a certain stigma attached to it and women were thereby inhibited from attending such facilities. Our suggestion was that a broader, more comprehensive 'gynaecological health facility' should be set up, that would also treat STDs, but be described as a gynaecological health care centre.

Testing

Shyamala described the predominant ways in which women discover their HIV status. Women are tested, most often without their consent, at ante-natal clinics, and sometimes these results are not revealed to them. There is no pre or post test counseling.

She informed the group that it can take anywhere upto six weeks after the time of infection for the body to develop antibodies against HIV. Since the preliminary ELISA

test only tests for presence of antibodies (and not for HIV itself), if you take the test in that interim period (called the "Window period"), your test result will be negative even though you are infected. Hence it is important to take a confirmatory test (known as the Western Blot test) after sufficient time has elapsed. Such confirmatory tests are either not easily available or too expensive. (The NACO policy is to do three Elisa tests for confirmation.)

Model of the Phases of the Epidemic

Shyamala pointed out that, to some extent statistics gathering was important for understanding the epidemiology of the epidemic, but they were not sufficient. Statistics had to understood against a framework of analysis. Elizabeth Reid has produced such a framework that Shyamala shared with the group.

a. ORIGIN OF THE VIRUS

The origin of the virus is unknown. And it is also not very relevant. What is more important is that the virus is here and that it should be the main focus of concern rather than its origins.

b. SPREAD

Between the point of origin and the spread of the virus it is critical to focus on developing, promoting and adopting preventive actions. Prevention should be the focus of both policies and strategies.

c. CO-FACTORS

There are a number of co-factors which increase the risk of spread of the virus. These include

(i) poverty **(ii)** commercial activity **(iii)** migration **(iv)** gender **(v)** health status and **(vi)** unemployment.

The spread takes place from **(i)**urban to urban **(ii)** urban to rural and finally **(iii)** rural to rural. Once it has reached the stage of rural to rural spread it has peaked. Shyamala stated that in India it is still possible to concentrate on prevention as the spread of the virus has not peaked.

d. ILLNESS AND DEATH

Once the spread of the virus has peaked, large scale illness and death will occur in the wake of which a number of issues will begin to emerge. These include **(i)** legal issues like discrimination, **(ii)** the demand for other essential interventions such as care, counselling, and family support.

e. SURVIVORS

Death will leave behind orphans and dependents. Many women, who have been

the 'survivors' in other countries have been forced into prostitution as a result of economic need.

f. SOCIO-ECONOMIC IMPACT

The socio-economic impact is in many ways also partly responsible for the spread of virus as well as being a consequence of the spread.

Shyamala stated that it was important to keep in mind this framework when formulating strategies and policies for combatting the virus.

Who is Affected?

The question as to whether targeting was justified with regard to HIV was raised. When SIAAP started work, women working in prostitution were the primary targets of policy makers and strategists. In spite of this, SIAPP started working with this group of women. There were several reasons why : i) it was in many ways easier to work with these women who would not entirely resist such an initiative; ii) as this group had less inhibitions about sex than other women, prevention might be easier; iii) this community already had a developed support system primarily because of the historical discrimination they had experienced. Yet Shyamala stressed that there is no doubt that everyone requires intervention as much as women in prostitution.

(The issue of targeting was discussed in more elaborate detail later in the workshop and those discussions have been reported below.)

Quality of Condoms and Condom Use

Shyamala expressed concern over the fact that the condom had been largely ignored as a form of family planning, and yet it was the cheapest, safest and easiest form of birth control. At the same time it also served as protection from HIV transmission. In fact she was lobbying for an amendment to the Drugs and Cosmetics Act to treat condoms as 'life saving' equipment. **This proposal was endorsed by the workshop and is mentioned in the list of recommendations.**

She further expressed concern over the promotion of condoms through social marketing, which discouraged rather than encouraged the purchase and use of condoms. Social marketing involved making and marketing a product at a low cost with heavy advertising.

An important debate took place on whether condoms were the only form of prevention. Such a focus assumed that penetration constitutes sexual relations. One participant asked, "What about alternatives?" 'Women communicate through various

means with their partners, and intercourse is only one way.'

In addition, in the lives of women who work in prostitution, it may be difficult to insist on condom use. One participant stated that during the course of her work, some of these women had said that the use of a condom for protection against HIV infection had little priority as they were already handling so many serious hazards and risks in their lives. At the same time there was a view that women working in prostitution could negotiate condom use and that we should not generalize their experiences. In countries such as Canada these women had established a `condom only' policy as a condition of their work. In effect, as Shyamala pointed out, women working in prostitution were leading the fight against AIDS and yet they continued to be ignored by women's groups, except perhaps as victims, and oppressed by society.

II Bombay Municipal Corporation AIDS Control Programme- Experiences with Women Working in Prostitution

Alka Gadgil, from the Bombay Municipal Corporation AIDS Control Programme (BMC), shared her work experience in the area of AIDS and STDs. The community with which she has been working are the women of Kamathipura, a red light area in Bombay. She stated that the brothel keepers, madams, women working in prostitution, clients, general practitioners, bar owners, and pimps are all `targetted' for prevention and treatment by the AIDS policy. The focus of her work is to i) reduce STDs ii) increase awareness and iii)promote condom use and safe sex practices.

Alka described the extremely poor living and working conditions of the women in Kamathipura. They have no running water, experience economic exploitation, have to pay `haftas' to policemen and receive inadequate nutrition, as there are no adequate cooking facilities. In 1987, when HIV was detected in Kamathipura, Alka described how women's work was disrupted as a result of the so-called `AIDS interventions'. The area was invaded by NGOs, the media, and academicians. The women felt that they had gained nothing as a result of all this attention, and were merely objects of interest, rather than subjects of concern, with needs and demands.

The `STD Clinics' in the area are not readily used by the women. Whenever they attend the clinic, they are asked intimate details about their lives which they find humiliating. Therefore, they resort to quacks who only further exploit them. At the same time, their other health requirements are not addressed by the system. Their experiences demonstrate that the AIDS campaign cannot be isolated from the other health concerns of these women. The threat of AIDS was not tangible to these women and remained a distant threat. In fact, they did not find the existing HIV\AIDS information useful as it did not

address their other, more immediate, health needs. In light of her experiences with the women in Kamathipura, Alka is beginning to feel that the AIDS campaign should focus its attention on men. In her view, as the customer is treated like a king in Kamathipura, it is ultimately up to him to decide whether or not to use a condom. She felt that the objective of focussing on men, was to make them more conscious of their responsibility.

III AIDS Research Foundation of India - Experiences as a worker with the Foundation

Surekha Garimella, who works with the Foundation, narrated her experiences, bringing into sharp focus the issues and dimensions of a female health worker working with HIV issues and positive people. She discussed the problems she experienced with her family because of her involvement in AIDS prevention work. In the workplace, she had to cope with the use of anti-women swear words by her colleagues, the trauma of advising positive people, the ethics of preaching monogamy, and the irony of asking women in her area of work to negotiate the use of condoms with their husbands when this was not necessarily possible in our own lives. Surekha talked about the human face of AIDS and the economic, psychological and social costs that positive people were forced to bear.

She felt strongly that work on AIDS could not be isolated from other areas of

general health care. HIV prevention and care had to be integrated into a broader health-care programme.

Surekha also discussed the role of the State in terms of the funding available for AIDS research, which has been increased. At the same time, fund allocation for the treatment of many common ailments including tuberculosis has been reduced, even though TB is one of the symptoms of AIDS infection in the Indian context. This is a clear indication of the trend towards privatisation of health care services. She found very little information on the history and impact of AIDS in the Indian context and felt that continuous access and reliance on foreign material was not helpful for those working in the field.

The discussion by participants on the three experiences, raised the following issues-

The group felt that it was important in our discussions not to constantly depict women as victims. Women in different contexts possessed skills that needed to be strengthened to resist discrimination and subordination. The skills available to a middle-class educated housewife were different to those available to a poor rural woman, but neither was powerless.

There was a strong view expressed by the group that regardless of a persons HIV status, there was a pressing need for a gynaecological health care service for women. Women currently received gynaecological care only in their reproductive capacities. In addition, men, who only have access to STD clinics, also required counseling services.

In response to Alka's experiences in the red-light areas, one participant stated that attention should not be entirely diverted from women to men as far as HIV prevention was concerned. Such a strategy would deflect attention away from the broader demand on the State to provide more efficient and wholistic health care services to women.

THE SCOURGE by Shyam Benegal: Reflections on the Film

In the evening, the film "The Scourge" was screened for the participants. The film was strongly criticized by the participants and they urged that it be withdrawn as it was a harmful film. It reinforced the worst myths and fears about HIV infection and AIDS and was replete with misleading information.

Some of the specific criticisms were as follows:

a. The use of colours such as red, and the militant and mechanistic images of HIV and AIDS created a fear psychosis around the issue. This sentiment is reinforced throughout the film by both the narrative and the visuals.

b. The voice used in the film is male and authoritarian.

c. The movie is obsessed with affixing 'blame' on persons who became infected with the virus.

d. The film makes pejorative references to homosexuals, describing them as people with 'unusual' sex appetites. It is also insensitive towards women working in prostitution.

e. Factually incorrect and discriminatory terminology is used throughout the film such as 'full blown AIDS', and 'high risk groups'.

f. The term `unborn child' is used as opposed to `foetus' which is buying into the `right to life' arguments made in the context of abortion.

g. The group was informed that Ford Foundation provided a huge grant for producing this film. This fact raised questions about the accountability of funders as well as filmmakers for disseminating factually incorrect and harmful information.

h. Some group members felt that in producing visual material such as ads or films, the government ought to be obliged to make public its reasons for selecting a particular ad agency or director for creating the visual. A well known name should not constitute the sole criteria for selection.

The group was extremely concerned about the further use or promotion of the film particularly in the context of the National Campaign which is due to be launched in June, 1994. **A strong protest had to be made to the Ethical Committee of NACO through this report against THE SCOURGE together with a demand for its immediate withdrawal.** The next one year was deemed to be a critical period for preventing the spread of the AIDS pandemic. In the context of prevention, images such as those depicted in THE SCOURGE had to be challenged and arrested before they were released in the National Campaign.

DAY TWO MARCH 2, 1994. [1]

I Foundation of the Workshop

This session was conducted by the co-ordinators of the workshop. They addressed the question why it was important to talk about women in the context of HIV and AIDS. They provided relevant statistical information, challenged myths surrounding the epidemic and how these adversely impacted on women, explored women's vulnerability to HIV and AIDS in relation to their health status and the factors reducing their ability to protect themselves from infection. They also examined the existing preventive strategies and their relevance to women's lives.

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[1] The afternoon session was supposed to be conducted by Dr. Rani Bang, a specialist in STDs and gynaecological infections, who was unable to attend at the last minute.

Game

The session began with a word-linked game which involved pairing off, and writing words of hide and seek, of writing words on any portion of one another's body that was associated with 'safe sex'. Thereafter, the group had to search for the word on each of the participants. This game had several effects on the participants which are stated as follows:

* It reduced shyness, reserve and inhibition.
* It was fun to touch each other's bodies
* It was conducted with considerable laughter, which in part, reflected the nervousness of the participants.
* It was conducted consensually and therefore involved respect for one another
* Some had reservations about the game and experienced it as intrusive

The written words that emerged from the game were the following:

1. mutual masturbation
2. masturbation
3. condom
4. non-penetrative sex
5. kissing, hugging, caressing
6. monogamy
7. respect

The last word evoked some discussion. Respect was considered to be very important, but it had never really been addressed in educational materials. The need for respect is particularly important for women whose bodily integrity is violated frequently because they are women.

A further discussion took place on the question of whether monogamy should be recommended as a safe sex practice. There were some divergent views expressed which reflect our moral prejudices and biases. The basic issue was whether monogamy could ensure protection against HIV infection. Those who opposed this position stated:

* The message of monogamy is historical and internalised. It is a norm imposed on women and not on men. The use of such a message in the context of `safe sex' would reinforce it.

* The message of monogamy as a safe sex option was factually incorrect. Since it is impossible to know if a partner is infected unless she/he has been tested, one may be monogamous (and therefore feel safe) with a partner who is infected. Monogamy itself therefore will not protect from infection.

* The message supported a particular type of relationship, namely a marital, heterosexual one. Yet the purpose of a safe sex message should be to help prevent HIV and not about how to live our relationships. Monogamy was about prejudices and not about protection.

One participant expressed some concern over the possibility of a reign of `deviance' being unleashed should we take a stand against asserting monogamous relationships. The group discussed the implications of using terms such as `deviance' and promoting a monogamous norm. In particular, monogamy was a concept associated with a particular type of family structure. All those who resided outside of this structure were considered `deviant', and a threat to the `sanctity' of this institution. The discussion concluded with the recognition by the participants that people can and should be entitled to make choices about their relationships and sexual practices. Our concern should be with the latter insofar as some choices regarding sexual practices can increase the risk of HIV transmission.

The facilitators proceeded to address the epidemiology of AIDS among women. AIDS was initially considered to be a `disease of homosexuals'. Women started becoming visible as women working in prostitution, that is, women who were `bad' and `promiscuous'. Intravenous drug users were also targetted. In effect, the initial response to AIDS resulted in reinforcing prejudices against already discriminated groups who have historically been considered irresponsible and a burden to society. This policy of targetting has proved to be discriminatory and punitive.

Apart from women working in prostitution, women have been rarely addressed by AIDS policies and programmes. And yet it is estimated that by the year 2000, over eight million women and ten million children will be infected with the virus. In 1982, the first woman was diagnosed as HIV positive. Today, over three and a half million women are infected, the vast majority through heterosexual transmission within marriage.

Another trend in recent years is the great incidence of HIV infection among poor people. Almost ninety percent of the total number of people infected globally live in developing countries. It is therefore evident that poor women are the group most

susceptible to infection.[2] Furthermore, research in Africa, North America and Thailand reveals that women are becoming infected at a significantly younger age than men.

In India, there is still no gendered data available on the spread of the infection. According to some estimates nearly four lakh women in India will be infected by the year 2000. More recently women have been addressed by policy makers, but primarily in their capacity as women working in prostitution, or as HIV-positive mothers. The categories are being used as frameworks to identify the risks of HIV infection posed to and by women. In both capacities they receive attention because of the risk they pose rather than as individuals in need of care and support.

Subsequently, the participants divided into smaller groups to discuss the following:

* the biological risk factor of HIV infection for women
* the economic, social and cultural factors that reduce women's ability to protect themselves
* the impact of HIV infection on women in their multiple roles.

[2] See Elizabeth Reid, "Young Women and the HIV Epidemic", Development 1990, Journal of SID and Mabel Bianco, "How HIV\AIDS Changes Development Priorities", Women's Health Journal 4\92, ISIS International.

The groups thereafter presented their analysis:

A. Biological Risks

The participants felt that the biological factors per se did not make women more vulnerable. There are no pure biological factors. Rather, it was the socio-economic and cultural factors that accentuated the impact of these biological risks for women.

Some of the biological risks identified were as follows:

a. There is some suspicion that the concentration of HIV in sperm is much higher than in vaginal fluids.

b. HIV can be transmitted more easily by men to women than the other way around.

c. The vagina is an easy point of entry for the infection.

d. The internal placement of women's genital organs make it more difficult to diagnose gynaecological ailments. Therefore, infections are not easily identifiable unless external symptoms develop.

e. The vagina has a relatively larger area open to infection compared to the penis.

f. Menstruation and metabolic changes during puberty and menopause can accentuate risk in women.[3]

g. Childbirth could require blood transfusions which can increase the risk of infection in women if the blood has not been properly screened.

B. Economic, Cultural and Social factors

Some of the economic, social and cultural factors that influence women's experience of HIV\AIDS are as follows:

a. Early marriages, early and multiple pregnancies leading to a high rate of maternal mortality.

b. Lack of adequate and safe delivery facilities making women susceptible to lacerations and ulcers.

c. Pressure to have a biological child and forced motherhood. Over-emphasis on penetrative sex.

d. Gender insensitive health care services, which dismiss women's experiences. Strong gender and class biases that make poor women more vulnerable.

e. Little access to information on women's bodies and their sexuality leading to alienation of women from their own bodies.

f. Lack of research on health problems specific to women.

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[3] See Reid, ibid.

g. Malnutrition, anaemic conditions, and low resistance.

h. Lack of mobility affects women's ability to seek health care and access to information that is available.

i. Religious practices such as fasting which compound women's poor health condition. These include pollution rites during menstruation or pregnancy which treat women as impure.

j. Other cultural practices such as circumcision, piercing and tattooing, using unsterilised instruments.

k. Pressure of work within and outside of the home. Lack of control over their earnings and the devaluation of their work leads to economic dependency and disempowerment.

l. Sexual abuse and harassment at home as well as in the work place.

All of these factors are indicative of women's low status in society and hence their increased vulnerability to HIV infection. Thus, it is not only women's biological condition, but also their social, economic and cultural circumstances that have a direct influence on the degree of risk to which they are exposed.

C. Other factors

Some other, mainly health, factors which influence the impact of HIV on women's bodies and women's lives were identified during the course of our discussions which included -

* pelvic inflammatory disease (PID)
* eroded conditions of the vagina
* cervical cancer
* vaginal candidiasis and conjunctivitis
* genital lesions, scarification
* white discharge.

In addition, women do not have access to information, and whatever information is accessible is gender biased or insensitive to women's reality and often highly moralistic and judgmental in the manner in which it addresses women.

D. Multiple Roles

The impact of HIV infection on women varies according to the roles they perform such as being a mother, wife, housekeeper, sex partner, carer, sister, daughter, worker, or a woman working in prostitution. The same woman can be and often is involved in many of these roles simultaneously. She will experience intensified discrimination if she

has the infection, or has to bear additional responsibilities in her caring capacity for someone who has the infection. Such a situation will invariably impact on her social and economic status.

Summary

In summary, our discussions were limited because of the lack of information on women and HIV\AIDS. In fact, women have rarely been addressed in either the existing approaches or responses to the pandemic. For example, until recently, the definition of HIV\AIDS issued by the U.S. Center for Disease Control and used worldwide, focused on diseases and illnesses that are characteristic of HIV related illness in (white) men and omitted conditions that often signify the onset of HIV related conditions and AIDS in women. Only under pressure from women's groups internationally were some of the conditions such as pelvic inflammatory disease, vaginal candidiasis, vaginal conjunctivitis and cervical cancer added to the CDC definition. In this respect, it is important to note that women in India experience some of the highest rates of cervical cancer in the world.

Some participants were critical of what they felt was the unquestioning use of the Western Case Definition of AIDS in Indian conditions. The definition of AIDS must be created in the context of Indian women, they felt.

Very limited research has been undertaken to understand how the virus manifests itself in women in ways that are different from men. In fact, diagnostic criteria and policy planning have largely excluded women. If we want to prevent and treat HIV infection in women, then it is critical that more country-specific research be conducted with respect to women. Only then can we formulate strategies that will be effective in mitigating at least the worst features of the infection in women's lives.

II **Prevention Strategies** - The participants once again broke into groups to discuss the different prevention strategies that were being widely promoted and their specific impact on women. The strategies identified were as follows:

* condom use
* blood safety
* prevention and treatment of STDs
* prevention of conception by HIV positive women
* monogamy
* partner reduction
* use of sterilized needles and syringes
* no sex with homosexuals, prostitutes or strangers

Condom Usage

There was a discussion about the promotion of the condom as the only way to ensure protection against HIV infection. Several challenges to this position emerged during the discussion. It was felt by some that such a strategy denies the reality of women's lives where the pressure of motherhood and bearing a son are such strong cultural imperatives. In addition, most women are economically dependent on men, as a result of which they have less agency in insisting on condom use if the man is not willing, and may even experience violence if they refuse to have sexual intercourse without a condom.

On the other hand, some participants expressed concern over linking condom usage with violence. It was important not to reinforce the myth that women were passive in sexual relationships, emptied of all agency and decision-making. Such an understanding conjures up the image of women as helpless victims and in need of protection, which has dangerous implications on women's rights and the construction of women as subjects. Some women also expressed the view that insisting on the use of a condom in the context of every sexual encounter was impractical.

We also discussed the fact that, apart from being relatively accessible and inexpensive, the message of condom usage helped to place some responsibility with men in conducting sexual relations. However, we need to understand that contraception has been a women's responsibility till now because she has to bear the consequences of pregnancy.

Some participants felt that the condom is being promoted in the context of AIDS not out of any intention to impose responsibility on men, nor out of concern for women who may be exposed to the infection. It is being promoted for the protection of men - male lives are at risk. This analysis is substantiated by the fact that policies and strategies dealing with HIV infection which address women, have addressed them primarily as transmitters of the virus rather than recipients in need of protection or treatment.

There was a brief discussion about the female condom. A sample of a female condom and a diaphragm was shown to the participants, the majority of whom had not seen either. Participants were of the view that this condom was not only impractical and expensive, it appeared uncomfortable and would reduce women's sexual pleasure. Simultaneously, there was a critique that the development of the female condom was again placing responsibility on women to prevent the spread of HIV infection. At the same time, it did give women more control over their fertility.

Sexuality and Condom Usage

There was considerable concern expressed over the fact that the emphasis on condom use is based on the assumption that penetrative sex is the primary way in which most people have sex and that it seemed to constitute the definition of sex. In fact the expression 'safe sex' equates 'sex' per se with 'sexual intercourse.' Sex, in fact, is more than just intercourse, and does not necessarily involve intercourse. Petting, kissing, hugging, mutual masturbation, clitoral stimulation and touching erotic zones were identified by the group as forms of sexual enjoyment that were not only safe, but often more pleasurable for women. It is a fact that many women do not enjoy penetrative sex, in the sense of sexual intercourse, or do not equate sexual pleasure exclusively with sexual intercourse.

The group felt that the focus on condom usage viewed sexual pleasure through a myopic lens and was based on the understanding of sexual pleasure in the way most men experience it. **Therefore, participants felt that any message about condom use was incomplete unless it was accompanied with a simultaneous positive message about alternative forms of sexual activity, which were both safe and pleasurable.**

Contraception and HIV

The discussion about the condom also raised a parallel debate about the relationship between the politics of contraception and HIV infection in women. Contraception under women's control confers a degree of power on them over their bodies, fertility, and sexuality. However, the policy promoted by the Indian government denies women such control and poses serious health hazards for Indian women.

The role of WHO in alliance with the Indian government in promoting NORPLANT and several other hormonal and injectible contraceptives such as NET-OEN and DEPO-PROVERA have been sharply criticized. Such forms of contraceptives not only aggravate the already deteriorating health status of many women who are suffering from conditions such as anemia and other common ailments, but have been tested under unethical conditions and without the informed consent of the users.

Moreover, there is a lack of research as to the relationship between hormonal contraceptives and the HIV virus. Other contraceptives, such as IUDs and virucides can also create lesions in the vagina and thus facilitate transmission of the virus. Ironically, some of the safest contraceptives for women, such as the diaphragm, are unavailable in the market. Thus, the argument that the government is promoting choice for women, described as the 'cafeteria approach' by WHO, is unpersuasive and misleading given that some of the safest choices for women are denied to them, while the more detrimental ones

are being promoted. Since diaphragms do not protect against HIV infection, the **workshop called for more research into improving the diaphragm so that it could protect against HIV.**

Blood Safety

The participants were of the view that blood safety was an important prevention message for women. Women were at increased risk to infection from unscreened blood during pregnancy, childbirth, miscarriage, and abortion, which often require blood transfusions. The oft repeated message, "Don't Take Blood from Strangers" is misleading since non-strangers such as family members may well be HIV positive. The assumption that blood donated by close relatives is uncontaminated in thus false and harmful. Messages which target only professional blood donors are therefore not only discriminatory but could prove to be dangerous as well.

It was also felt that the responsibility for ensuring that blood is safe should be on the blood banks, and not on the individual donors who have been targeted by policy makers, or on the recipients.

It was observed that although blood was scarce, and that access to safe blood was the right of all citizens, women had greater difficulty in securing access to safe blood that was available because of their lack of mobility, and their poor socio-economic status.

Prevention and Treatment of STDs

This message was problematic for a number of reasons. First of all, it is easier to detect STDs in men than in women, so treatment is often not provided when it is most necessary. It was also difficult for women to attend STD clinics because of the stigma attached to such visits which constructed the woman as a 'bad' and 'immoral' woman. This factor partly explained why these clinics were overwhelmingly utilised by men and not women.

In addition, STDs are just one of many different kinds of gynaecological ailments that women suffer, but for which there is little if any treatment available. The reason for this is because of the preoccupation of the health care system with women as mothers and not as individuals who have specific health requirements which they experience because they are women. **The workshop supported the suggestion that clinics be referred to as centres for gynaecological health care, and not just STD clinics, and be equipped to deal with women's overall gynaecological health status. A further recommendation that emerged from the group was that the term `sexually transmitted disease' be replaced by the term `gynaecological condition' in order to recognise this situation.**

The participants also strongly recommended that health care facilities be delinked from women's marital, reproductive and familial status as well as from their sexual histories which currently serves as a precondition for determining whether or not they will be entitled to or denied such care. This recommendation is consistent with the provisions of the international Convention for the Elimination of All Forms of Discrimination Against Women, which the government ratified on July 9, 1993.

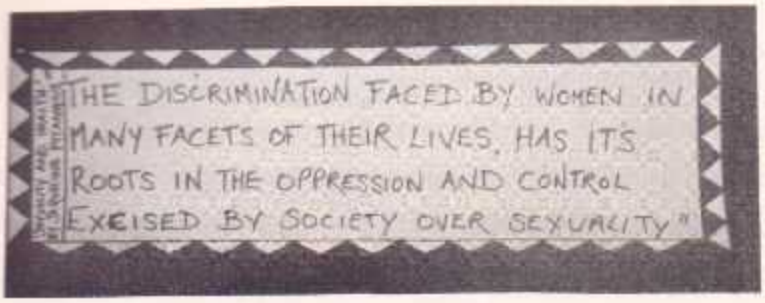
Prevention of Conception by HIV Positive Women

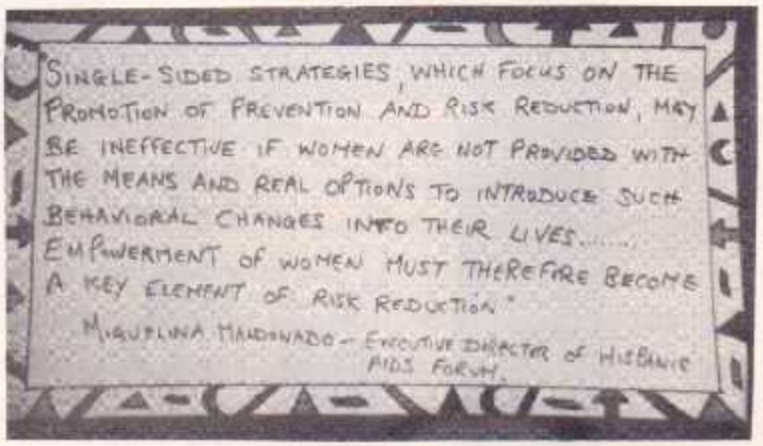
Several issues were raised with reference to this strategy. Apart from assuming that most women get pregnant as a result of consensual sexual relations, the strategy is impractical, misleading and discriminatory. It is impractical, because most women discover that they are HIV positive only after conception, and often at the time of child birth. It is misleading, because evidence indicates that a child has a 70% chance of being born healthy. It is also discriminatory, because it violates a woman's rights to choose if and when to have a child, regardless of her HIV status.

In addition, this message ignores the cultural imperatives that compel women to reproduce as well as the social status that is conferred on a woman who becomes a mother, especially of a son. On the other hand, by refusing to allow HIV women to carry their pregnancy to full term, this strategy relegates them to the category of women who are unfairly denied the right to legitimate motherhood. These women include single women, women in prostitution, lesbian women, and woman who are mentally disabled.

Monogamy

Although the question of monogamy had already been discussed earlier in the workshop, some additional concerns and analysis did emerge from the group discussion. The message of monogamy is moralistic, judgmental and divides women into categories of 'good' and 'bad' women. It is also scientifically inaccurate information because it implies that monogamous people are safe from infection, which is misleading and dangerous as in encourages complacency.





In addition, the group felt it was very important to recognise that monogamy is based on gender inequality - women are intended to promote and sustain this norm. To this extent it also made women responsible for their partner's non-monogamy as the implication of such behaviour was often that she was unable to 'satisfy' him. The responsibility of keeping him happy and content was the woman's. This situation reinforced both her subordination in the normative marital relationship and as well as the double standards of such relationships.

A subtler, but more insidious impact of the message of monogamy is that it denigrates the practices of different ethnic and minority communities, whose culture and value system permit non-monogamous relationships.

Partner Reduction

The debate on partner reduction ran along the same lines as the debate on monogamy. It is a false message as safety cannot be ensured through partner reduction. There was also some concern that a moral message is being promoted through the issue of partner reduction. It reinforced the norm of monogamy, heterosexuality and marriage. It is therefore exclusive and judgmental insofar as it implies that homosexuals, single women and non-marital relationships increase the risk of HIV infection. There is also an assumption that multi-partner sex is irresponsible per se. Rather, responsibility lies in

practicing safe sex rather than in limiting the number of partners.

The group also expressed the view that this strategy reinforced the marital, heterosexual, monogamous norm, thus implying that all other relationship existing outside of this arrangement were 'deviant'.

Discouraging the Use of Unclean Syringes and Needles

This message was often targeted at "drug addicts" without making the distinction that not all drug users use needles and that the activity increases HIV risk only if the needles are shared. According to a participant from Mizoram, in that state, an attempt to promote a needle exchange programme, whereby drug users exchange their used needles for clean ones, has been controversial and seen as promoting drug 'addiction'. She, and another participant active in the area of HIV prevention work in the North-East stated that in the north- east, the government promoted a policy of prohibiting the sale of needles without a prescription. However, far from reducing HIV infection, it has in fact increased.

Sex with Homosexuals, 'Prostitutes' and Strangers

This message targets specific groups rather than activities that are high risk. The participants endorsed the position that HIV infection had nothing to do with who you are, whom you have sex with, but what you do. Targeting groups merely intensifies discrimination against people who were already denied civil rights and rejected by society. The consequence of such a strategy is that it created a complacency in those persons who do not belong to the targeted groups. For example, by targeting women in prostitution, other women live under a false sense of security that they are not at risk. At the same time, if a woman who is not in prostitution discovers that she is infected, she will be very reluctant to speak about her condition because of the fear of being called a 'loose woman'. One participant pointed out the fallacy that 'promiscuity' is a cause of infection by sharing some statistics from Mexico. These indicate that women working in prostitution constitute 0.8% of the HIV cases reported whereas housewives constitute an alarming 9%. Targeting thus silences people, and does not reduce infection. On both counts, it is a very harmful strategy.

As far as strangers are concerned, the message implies that a person is safe if they know their partner. However, statistics from Africa reveal that 60% to 80% of HIV women were only having intercourse with their husbands. (source : Elizabeth Reid)

This message has also intensified discrimination against homosexuals. The group recognised that it is the gay community in the United States and elsewhere that have organised and campaigned around the issue of HIV infection and AIDS and their strategies have become a model for mobilisation for many other communities in different countries. It was also pointed out that gay men are the primary targets of the campaign, and not lesbians. This was partly because of the invisibility of women's sexuality, and

partly because of the assumption that lesbian women are safe. However, it was once again reiterated by the group that the risk lay in the activities persons pursued rather than the group to which they belonged or were seen to belong.

Health Precaution Rules

The rules requiring the use of rubber gloves, and other basic precautions were seen as important for health care workers. However, the risk of exposure to these workers is also very low, and therefore, an alarmist approach is inadvisable. Such an approach has resulted in hospitals and clinics turning away HIV positive people on the grounds that they pose a risk to health care workers and doctors. It also reduces the institution's sense of responsibility to provide safe health care facilities.

The prohibition on the sale of needles without a prescription was considered by the group to be a very harmful policy that would only result in driving drug users underground and facilitating high risk activity. The promotion of disposable needles seemed to be a controversial alternative as they were not biodegradable nor economically viable. Sterilisation of needles after use was therefore deemed to be a more practical and safe approach to reducing exposure to HIV infection.

There was little analysis of this strategy in terms of gender impact. It is unclear whether this omission was the result of lack of information or the view that there is no distinction in terms of gender, although class, and economic dependence (which characterises most women's lives) can influence the increase in high risk activity with respect to needle sharing.

NACO and WHO perspective\policy on Women, HIV and AIDS

This presentation was made by **Prabeen Singh**, who worked for a short time as a consultant with the National AIDS Control Organisation (NACO). It was originally intended that representatives from both NACO and WHO would participate in the workshop and present their respective positions. However, due to last minute bureaucratic demands, neither representative was present for this session despite the terms of agreement which state that NACO would be closely involved in the workshop (although the NACO representative did attend the last two days of the workshop when the educational material was being assessed). The dates and framework were organised in consultation with the WHO and NACO representatives on the understanding that they would be participating. The last minute withdrawal of these representatives caused enormous inconvenience to the organisers and the participants. In addition, the forum was denied the opportunity of questioning WHO and NACO on their position, internationally

denied the opportunity of questioning WHO and NACO on their position, internationally and nationally, on the issue of women, HIV and AIDS. The group was also denied the chance for making WHO and NACO accountable through the process of the workshop for the policy initiatives or lack of initiatives they have taken in this area.

Critique

National AIDS Control Organisation

NACO is a department of the Health Ministry and therefore not autonomous. It consists of two divisions, i.e., the technical division, and the IEC division (Information Education and Communication Section). The Technical Division is in charge of policy statements, testing, blood safety, STD clinics, surveillance, condom availability, and programming. The IEC looks into NGO support, counseling, creation of modules, and research. Below the person heading the IEC are consultants, who have no real power to make or implement decisions.

The resource person stated that there is an urgent need to centralise all policies relating to this infection. However, as the subject of 'Health' is in the Concurrent List, there is no uniformity among the States and therefore any policy initiatives addressing the issue of HIV infection are not likely to be uniformly implemented. Moreover, the personnel in the State AIDS Offices are already handling several other charges and are overburdened. These bureaucratic and administrative limitations pose a real challenge to NACO in fulfilling its task of combating the spread of HIV. NACO should play much more of an advocacy role, the participants felt.

World Health Organisation

The resource person stated that the role of WHO is merely to act as an advisor. At the global level, WHO develops guidelines, training modules and curriculum, which are field tested before being disseminated for potential adoption at the country level. At the country level, WHO functions to assist in programme design and implementation. In India, only limited funds for catalyst activities are available.

In the view of the resource person, the major limitation of the WHO approach was with regard to the modules it was producing. More often than not, there was no follow up, no authentic module testing, and very little cultural sensitivity or understanding. One example that the resource person shared with the participants concerned a module for Counselling in Vellore which was sought to be adopted in Manipur, whose social, historical and cultural context was entirely different.

WHO, NACO Policies and Women

Until October, 1993, there was no mention of women in the WHO and NACO policies. Their priority was confined to reaching women working in prostitution, and to conduct studies on sexual behaviour. Any mention of including women into the HIV/AIDS discourse, was constantly deferred. Thus, the NACO/WHO policy has not been gender-sensitive. There is a lack of consultation with women and with communities, even when it comes to data collection. When data is collected it is not made available to the communities or women who have been the source of the information. Recognising the inadequacies of its policies as regards Women and HIV/AIDS, NACO solicited Jagori to conduct this workshop with support from WHO. The resource woman felt there is an urgent need to ensure that the strategies and policies of WHO and NACO are influenced right away. Although quite recently, NACO has taken some visible action on HIV/AIDS in relation to gender in the Ethical Committee, the issues addressed were primarily concerned with motherhood. The group reemphasised the discussions of the day which stressed the importance of addressing women as individuals and not exclusively in their capacities as reproductive agents. In particular, the socio-economic conditions of women were essential to address when formulating any strategy or policy concerning HIV\AIDS.

The latest WHO Perspective on Women and AIDS can be gauged from the Dec 6-8, 1993 meeting at Geneva. Twenty-two countries were represented at the meeting. Some of the strategies that were developed included:

* The need to promote the adoption of safer sexual practices
* The empowerment of women to be able to negotiate safe sex.
* The development and promotion of female controlled barrier methods and condoms.
* Directing the marketing of condoms at women and not at men.
* Medical research
* The promotion of comprehensive care and support.
* The reduction of the incidence of STDs
* The prevention of transmission through blood
* The countering of discrimination and stigmatisation.

Some of the research priorities that have been identified include:

1. The integration of the HIV campaign into the Family Welfare Programme.
2. As access to hospitals for STD care is limited, it is suggested that MCH Clinics be opened up to include STD care {This has been rejected}
3. A campaign to promote female controlled virucides.

There was a strong feeling expressed by some participants that we must **oppose the inclusion of HIV/AIDS within the Family Welfare Programme**. Instead, the idea that primary health care services be equipped with the infrastructure to take care of a variety of services should be recommended. Some of the other recommendations made by WHO, such as promoting the female condom and targetting women in condom use campaigns, are controversial for the reasons already discussed elsewhere in this report.

Some specific information and clarifications were sought by the participants regarding the role and functioning of WHO and NACO. For the benefit of all the participants, the co-ordinators clarified that NACO asked WHO to support the present workshop after reviewing the proposal. One participant pointed out that frequently the WHO programmes did not reflect the specificity of each country's socio-economic conditions and cultural practices. It was important for WHO to reflect on and be self-critical about its presence and role in developing countries.

THIRD DAY , MARCH 3, 1994

The third day of the workshop was conducted by the co-ordinators and focused on issues of law, the legal rights of persons with HIV\AIDS and the difference gender makes to this analysis.

General Discrimination

The session began by dividing the participants into three groups. Each group was given one of the following documents to understand and critique in terms of the legal approach to persons with HIV\AIDS and the policy promoted by the legislature, the judiciary and members of the public:

i. The AIDS Prevention Bill, 1989 (see **Annexure B**)

ii. The Bhartiya Patita Udhar Sabha petition filed in August 1993 and pending for consideration in the Supreme Court. (see **Annexure C** which is a summary of the petition)

iii. The decision of the High Court of Bombay in Lucy D'Souza and etc. Vs the State of Goa and Others (popularly known as the Dominic D'Souza Case) (see **Annexure D** which is a summary of the decision)

The groups discussed the documents for about one hour and then shared their analysis and thoughts with the rest of the participants in the larger forum.

Group I - The 1989 AIDS Bill

The group was of the view that the only saving grace about the Bill was that it never became an Act. In fact, it was withdrawn as a result of protests from human rights groups and AIDS activists who condemned the Bill for being highly discriminatory and violative of the civil rights and liberties of people living with HIV\AIDS. The group found that most provisions of the bill had fascist undertones and violated many ethical considerations, in particular, the oath of confidentiality that doctors are required to pledge themselves to on becoming qualified.

Furthermore, the Bill was designed to promote a particular way of life and to eliminate those who did not conform to such a pattern, including 'drug addicts', 'high risk groups' such as 'promiscuous people' and 'prostitutes'. It was a moralising piece of legislation that adopted a 'blame the victim' approach to the HIV\AIDS issue.

Some of the provisions considered most disturbing are as follows:

* health authorities were given invasive policing power without even a semblance of reciprocal accountability - Chapter II and III

* registered medical practitioners were required to inform the local health authority of the existence anywhere of any person who is HIV positive or has AIDS or is a `drug addict'(see section 4). The group reiterated the fact that not all drug addicts use needles and many IV users don't share needles. Therefore the two should not be clubbed together as `drug addicts' as was done under the explanation to section 4. It further targeted a group rather than an activity and was therefore discriminatory.

* health authorities can forcibly question, test and isolate an HIV infected person in a hospital "or other place...where the authority considers it necessary to do so in the interests of such person and also to prevent the spread of HIV infection." - s.5. The group noted that no consent of the person detained was required nor was there any obligation on the health authority to provide information about the nature or consequences of test to the person detained. This provision opened up the possibility for anyone to invoke the provisions of section 5, which allows health authorities to act on information provided by medical practitioners or "from any other source" . Such a broad provision could be abused and used to target those individuals or groups thought to be responsible for spreading the infection.

* the bill included no confidentiality provision which could protect an individual's HIV status from public disclosure.

* the policy of confinement and isolation was justified in the bill on grounds that law and order situation in neighbourhood might be affected.

* the provision for the forcible testing of those suspected to be of "greater risk" was misinformed and dangerous. The health authorities had the discretion to decide who was considered to be at `greater risk'. (section 6) According to the Statement of Objects and Reasons of the Bill, such persons belong mainly to "`high risk groups' like sexually promiscuous men and women." The group considered this provision as violative of an individual's fundamental rights.

* section 7 gives health authorities sweeping powers to "take such other precautionary steps to prevent the spread of HIV infection as it may deem necessary". Such a discretion would sanction anything from house arrest to incarceration, to printing someone's name and photograph in the newspaper to sterilisation or even castration.

* the provision for coercive contact-tracing, without the assurance of confidentiality, could only expose the HIV-positive person or a person ill with AIDS and his/her associates to endless harassment. (see section 9)

* health authorities were exempted from any suit or prosecution for "anything which is in good faith done or intended to be done under this Act".

* with respect to blood safety the bill sought to place the entire responsibilityon private citizens, in particular, blood donors who were threatened with prosecution if they knew they were infected and made it their responsibility to get tested every time they gave blood (see section 10 (1) and (2)) The group reacted to the fact that neither, hospitals, blood banks, no large pharmaceutical companies manufacturing blood products, were burdened with any responsibility despite the fact that they were far better equipped to meet the prescribed screening norms and procedures.

The major concern of the participants was that even though the Bill had been withdrawn, **the policy of isolation that it promoted was still being pursued by institutions such as the health care system and prisons, and by decision making bodies such as the judiciary.** (See following discussion of case law).

Group Two - **The Dominic D'Souza Case**

The case concerned the isolation of one of several individuals in Goa on the grounds that he was HIV positive. Dominic was a regular blood donor, who was placed in isolation over an extended period and treated as if he had a contagious disease, by the police and medical personnel. A case was filed in the High Court which challenged certain provisions of the Goa Public Health Act, which permitted the isolation of an HIV infected person, as unconstitutional and violative of the individual's rights to equality, mobility, life and liberty. The Court upheld the policy of isolation reaffirming the assumption that HIV was a contagious disease. Even though the particular provision conferring the power to detain on health authorities was subsequently amended and made discretionary, no guidelines have been laid down for the exercise of this discretionary power.

The group found the judicial language objectionable and insensitive. They challenged the notion that individual rights must be balanced with public interest referred to *p 11 by the judge.(at page 6) There is no indication as to who would determine what constitutes public interest and which particular public's interest was being protected. The decision is also replete with scientifically inaccurate information about HIV,(at pages 3 and 5) which is not a contagious disease, but a virus that can only be communicated if it directly enters the bloodstream. The group also challenged the policy of isolation that was reinforced by this decision (at page 7) and resulted in driving HIV-positive people underground as well as being violative of individual rights and liberties. The decision also states that an HIV positive person cannot receive transplants which amounts to condemning a person to death.(at page 4)

Some of the participants who knew Dominic, shared personal accounts of their interactions with him. Although he demonstrated considerable courage in trying to fight the discrimination he and others experienced because they were positive people, there was a great deal of remorse over the fact that ultimately, that same fear and discrimination by the health care personnel at Beach Candy hospital accelerated his sudden death.

Another participant shared her pain and concern about the countless other HIV positive people who did not have the resources or dynamic personality that Dominic had,

and could not become heroes. They were often confronting their own internal prejudices regarding their infection as well as the fear of the consequences to their lives if their HIV status was exposed.

Group Three - The Bhartiya Patita Udhar Samiti Supreme Court petition

> This petition was filed in the Supreme Court in August 1993 by an organisation claiming to be working for the welfare of prostitutes, seeking directions to the central and state governments to carry out blood tests for the HIV virus on every citizen of the country as well as foreigners resident in India. The petition further seeks directions from the Court to isolate those persons found to be HIV positive and to arrange for their treatment and livelihood.

The group presentation pointed out how this petition was also based on the policy of isolation which had an adverse impact on HIV positive people, for the same reasons pointed out by the other groups, and facilitated the spread of the virus.

The group also called into question the motive and credibility of the organisation who filed the petition. The petition also calls for the legalisation of prostitution, but under conditions that would involve mandatory check ups and other stringent regulations and control. (This approach to prostitution was discussed later in the workshop and is reported below) The remaining critique of the petition follow along the same lines as the critique by the previous groups.

The fact that the petition has been poorly drafted and is based on misinformation about HIV and AIDS, raised the question of the professional accountability of advocates to their clients and to the bench. It also raised the question of the dependency of clients on professionals, denying their own expertise.

The group also recommended that a counter to the petition be filed by one of the organisations present in the workshop as intervenors. **They also recommended the setting up a lawyer-activist cell for HIV and AIDS, in each state.**

Summary

The objective of this exercise was to expose the participants to an understanding of the policy that was being promoted for dealing with HIV and AIDS people by both the legislature and the judiciary. Although the AIDS prevention bill has been withdrawn, it influenced both the public and the judiciary in terms of how to deal with the HIV issue. We summed up the impact of such a policy based on isolation, targeting and denial of the

individual civil rights and liberties of HIV positive people:

a. It is informed by harmful misinformation about HIV infection and how it spreads.

b. It reinforces several myths about HIV infection, including the view that it is groups rather than activities which are at high risk of transmitting the infection.

c. It forces the infection underground as a result of the stigma, persecution and discrimination resulting from exposure. This discrimination is reinforced by judicial decisions and statute law. (i.e. the Goa Public Health Act: see **Annexure E**)

d. It intensifies discrimination against groups that are already (legally) disempowered, such as sex workers, lesbians and homosexuals.

e. It erodes the rights of HIV infected people, whose rights were intact till they were diagnosed HIV-positive. Dominic D'Souza, for example, lost his job. Other consequences have included denial of life insurance benefits and deportation as a result of punitive immigration laws that prevail in many countries.

f. It fails to appreciate that HIV infected people can be productive members of society for many years after being infected.

The isolation policy has been followed in Cuba and at some point, in Romania as well. Cuba was following a policy of testing its entire population, but it has not succeeded partly because of the enormous financial costs involved in pursuing such a policy.

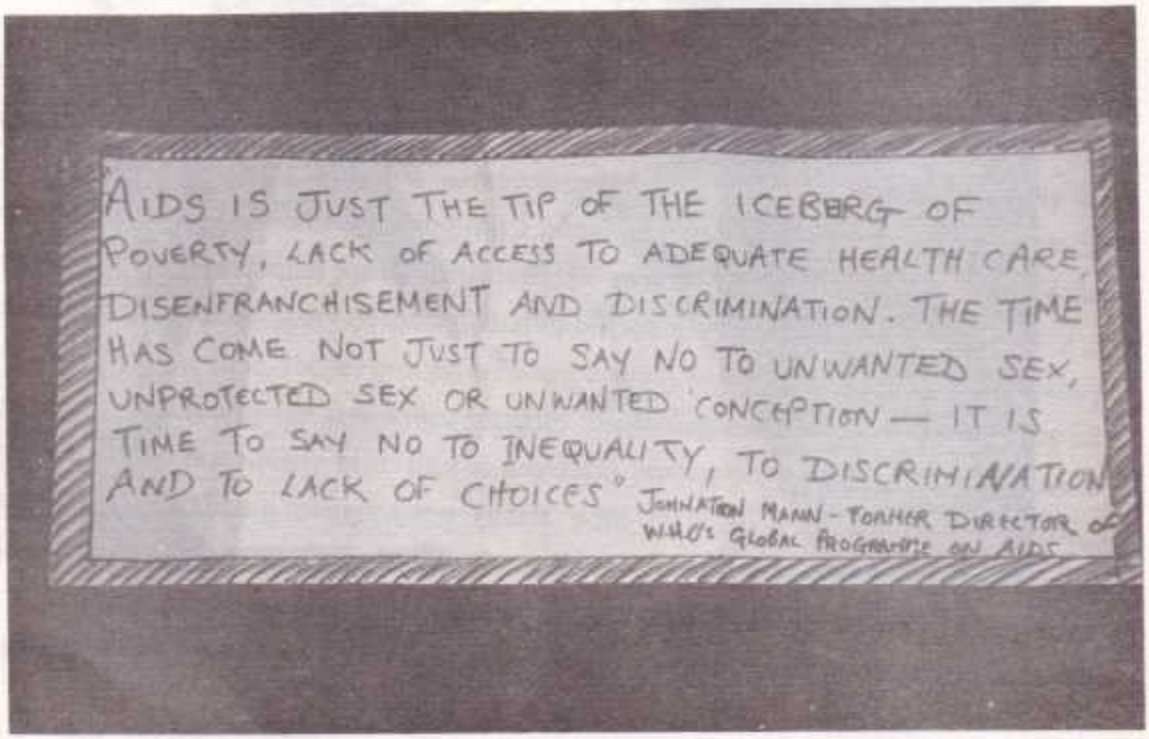
The facilitators shared with the group some understanding about the policy of integration as an alternative to the policy of isolation. The policy of integration has two primary concerns:

* It focuses on education and information
* It encourages those infected with the virus to come out and avail of services available or make themselves available to provide counselling and assist other infected people in securing employment.

In terms of the law, the integrationist approach required that a test only be conducted on a person with their informed consent. Voluntary testing and maintaining confidentiality were essential for bringing the HIV epidemic above ground and ensure the basic human rights and dignity of those found to be positive.

At the same time, those 'groups' who are vulnerable to targeting must immediately be granted protection by the law which includes, conferring certain rights and benefits on people who have historically been denied any legal protection. **Such protection would include decriminalising prostitution (dealt with later in this report); repealing section 377 from the Indian Penal Code which criminalises sodomy; removing discriminatory provisions against women, in particular single women. The latter includes the deletion of all references to chastity, virginity and marital status in all**

legislation relating to divorce, custody, abortion, etc. Application forms for government schemes such as ration cards, children's admission to schools, bank accounts, etc., should not require disclosure of marital status. In addition, the conferment of state benefits should not be made conditional on any of these.


"AIDS IS JUST THE TIP OF THE ICEBERG OF POVERTY, LACK OF ACCESS TO ADEQUATE HEALTH CARE, DISENFRANCHISEMENT AND DISCRIMINATION. THE TIME HAS COME NOT JUST TO SAY NO TO UNWANTED SEX, UNPROTECTED SEX OR UNWANTED CONCEPTION — IT IS TIME TO SAY NO TO INEQUALITY, TO DISCRIMINATION AND TO LACK OF CHOICES" JONATHAN MANN - FORMER DIRECTOR OF WHO's GLOBAL PROGRAMME ON AIDS

Gender Discrimination

The second session once again involved dividing the participants into three groups. Each group was given two stories concerning the lives of different women, which they were to discuss and present in a creative manner. i.e. a play, a song or other medium. The participants were to address the stories at two levels. They were to:

a. identify the accuracy of information in the story concerning HIV infection and AIDS

b. consider the role of gender in either impeding women's access to their rights or contributing to the denial of their legal rights, and how this affected HIV prevention in, or treatment of, women.

The groups worked through the stories for over one hour and presented them to the rest of the participants during the remainder of the afternoon.

Group One -

Malati's Story

> Malati lives in a village about sixty kilometres from Gauhati. Her husband died of TB five years ago and since then, Malati has been responsible for the care and maintenance of her three children, two young daughters and a son who is 17 yrs. old and unemployed. In light of the increase in prices, Malati is unable to support her family on the wages she earns as an agricultural worker.

Rita's Story

> Rita is a housewife in Bangalore. She has been married for one year. Her husband, Arvind, and herself have decided not to have children for another two years. Although Arvind and Rita regularly have sexual intercourse, Rita has not felt sexually satisfied with the relationship. Rita and Arvind have some awareness about HIV and always practice 'safe sex' by using a condom. Even though Arvind wears the condom properly, it frequently tears when he has intercourse. Rita is not aware that Arvind has had a series of sexual relationships with men. Arvind and his male partners have always used condoms in their sexual activity. Rita subsequently discovers that she is HIV positive.

The group presented Malati and Rita's stories together in the form of a play and altered some of the facts. Several issues emerged from their discussion of Malati's story. Firstly, it was important not to view HIV in isolation, but in the context of the reality of

women's lives. Malati was the only earning member of her family. Although the group presenting her story had her commit suicide because of her adverse circumstances, the rest of the participants were of the view that Malati and women like her would not make such a choice. They would and do find ways and means of supporting their children and surviving. In the presentation, Malati slept with the Chowdhury's son to maintain her job. In reality, women are frequently forced into part time prostitution to sustain their families and themselves.

As Malati is an agricultural worker, the issue of minimum wages also came up. Although women are entitled to minimum wages, their work is often categorised as semi-skilled or unskilled, rather than skilled, and thus, they are invariably paid less wages than men.

The fact that sex work or prostitution was not an option for Malati, raised some questions about who chooses to do such work. There were some misconceptions within the group as to how and under what circumstances women enter into prostitution. Some attempt was made to clarify the misconceptions. One important fact stated by a participant, was that women go into prostitution as opposed to other forms of employment, as it provides a readily available opportunity for earning some money. This is partly because women are predominantly valued for their bodies, which is particularly evident in a market economy. In contrast, an activity such a rag picking, is not valued and will therefore not be remunerative nor considered to be an immediate option. However, it was made clear that this did not imply that women get rich in prostitution, but merely helped to explain why prostitution is often a better option, in circumstances where there is little or no choice.

The second story was introduced by Malati's son who goes to Bangalore after her death, and meets Arvind in a sexual encounter. The group discussed the fact of Rita's infection, and agreed that Arvind's bisexuality was notresponsible for the infection, as high risk activity and not groups, facilitate HIV transmission. It was agreed that the source of the infection was not important, and that in fact, such tracing was often used to reinforce the categorisation of the infection by groups rather than by activity. One controversy that arose in the group was whether homosexuality could constitute a ground for divorce. Legally such activity would be criminalised and could be construed as cruelty or adultery if divorce was being sought. Yet it was important to ask whether Rita would bring a case for divorce. The fact is that most women are not revealing their HIV positive status, primarily because of the stigma and discrimination attached to people with HIV infection. Women in particular, do not speak because of social, economic and familial obstacles, but also because of the association of HIV with prostitution and 'loose women'. Arvind, on

the other hand may be in a better position to divorce given the prevailing judicial attitude against HIV positive people. However, his bisexuality might be disclosed in this process, in which case he would receive little sympathy from the judiciary, who is expected to be homophobic, and would also be vulnerable to criminal prosecution under section 377 of the Indian Penal Code.

The discussion revealed that the law was embedded with biases and prejudices, and would not have a constructive role to play in Rita's life, but could in fact harm both Rita and Arvind in different ways.

The participants also raised the possibility of filing a suit under the Consumer Protection Act, against the manufacturers of the defective condom. However, others felt that it was not necessarily the case that the condom was defective. The fact that Rita was sexually dissatisfied, indicates that she is not sufficiently aroused or ready for penetration, and that the condom tears because Arvind attempts penetration while she is still dry and unprepared. It was also suggested that penetrative sex before a woman is ready for intercourse, could cause lesions or lacerations which can also increase the risk of transmission of the virus. Another suggestion was that perhaps Rita does not like sexual intercourse, and that her sexual needs are different from Arvind's. Perhaps, there is no foreplay before intercourse, and Rita does not get sufficiently aroused, or she prefers clitoral stimulation rather that penetration.

Group Two -
Vijaya's Story

> Vijaya is an eighteen year old Brahmin woman who has lived in a joint family in Madras all her life. At the age of five, Vijaya was sexually abused by her Chinnappa, who performed oral sex with her on several occasions. Vijaya has learnt that she is HIV positive. Vijaya's family has arranged her marriage which is to take place in one months time.

The participants discussed the possibility of infection as a result of oral sex, if no condom is used. Although there is some risk involved, it is not as risky as unprotected sexual intercourse. If her Chinnappa performed oral sex on her, it is not likely that he could have transmitted the virus through his saliva. Although traces of the virus have been found in saliva, a considerable amount would be required to prove risky and it would have to enter the bloodstream directly. It is therefore uncertain if Vijaya got the infection from her Chinnappa.

Some participants expressed the view that as Vijaya comes from an orthodox,

Brahmin, joint family, sexual abuse within the family would not be spoken about, nor would a woman be believed if she spoke about it. As a result of the sexual abuse, Vijaya suffers from low self esteem and bouts of depression, and cannot speak out about her abuse let alone challenge some of the biases and guilt she herself has internalised.

The question arose whether she has an obligation to disclose her HIV status to her fiancee. Such disclosure has become a legal requirement in some jurisdictions, and a person can be prosecuted for reckless endangerment for infecting a partner and failing to disclose their HIV status. There is at the same time the possibility of annulment of the marriage if Vijaya's HIV status becomes known to her fiancee only after the marriage. Therefore, disclosure may jeopardise her legitimate status in the joint family set up.

An added dilemma for Vijaya is how to negotiate condom use with her fiance after their marriage without disclosing her HIV status. For a woman in her position, it would be very difficult, especially given the fact that there will be considerable pressure on her to have a child as soon as possible. Thus familial status, religion and caste all operate to influence Vijaya's decisions and her ability to prevent transmission of the virus. If she does have a child, there is every likelihood that her HIV status will become known to her fiance\husband and other family members at that time.

Vijaya's dilemma is difficult to resolve, yet her story and situation are not uncommon and need to be raised when formulating HIV prevention strategies and policies, to bring out the limitations of such approaches when addressing women's lives.

Mary's Story

> Mary is a gynaecologist in Jaslok hospital in Bombay. She has been married to John, an executive in a latex manufacturing corporation, for two years. Mary discovers that one of her patients is HIV infected. During the course of an examination of this patient her latex gloves proved to be defective and tore. Mary later discovers that she is six weeks pregnant and has also contracted HIV.

The group presented Mary's story in the form of a reflection in Mary's mind as to what would different people, such as her mother, her friend and her fiance say, if she were to reveal her HIV status to any of them. In each situation, she fears rejection and blame.

Mary's HIV status will have a direct impact on her professional as well as her personal life. Her husband is unlikely to believe that she contracted the virus as a result of the defective latex gloves and may accuse her of infidelity. Such an association is made by most people because of the misinformation around HIV transmission and AIDS. The

group also questioned whether she could get HIV as a result of the defective gloves. It was again a situation where the likelihood of transmission in this manner was not very high. However, unrealistic fears and misinformation had created a panic amongst health workers in many urban areas, in particular, Bombay, and led to the refusal to admit or treat HIV positive people. While the health care system is preparing to meet the needs of its personnel as regards protection from HIV transmission, there is no reciprocal responsibility on the health care system towards patients who get infected due to hospital services. **The irony is that there is more likelihood of a patient getting infected with HIV by the health care system rather than the health care personnel getting infected by patients.**

Mary may think of suing the latex manufacturing corporations, but it may be difficult to establish a causal connection between the transmission and the defective glove. In fact, through the course of the workshop, there was a gradual realisation by participants that it was difficult to establish a definite causal connection between a particular activity and the infection. An IV drug user may also have used sterilised needles, but got infected through unsafe sex.

By suing the corporation, Mary could jeopardise her husband's job and even their marriage. Such a case would also involve disclosing her HIV status, and facing the consequential discrimination that may result from such disclosure.

The fact that Mary is pregnant, does not mean she needs to abort the foetus as there is a 70% chance that the baby will be healthy. However, if she decides to abort she can resort to the provisions of the Medical Termination of Pregnancy Act. But Mary is also a Christian, and is therefore likely to face opposition from the Church if she chooses to abort the foetus.

Group Three -
Razia's Story

Razia, a lower middle class woman, works in a beauty salon in Delhi. One evening, Rafiq, her husband, wants to have sexual intercourse with Razia. Razia tries to resist him, but Rafiq forces her to have intercourse. Rafiq knows that he is HIV positive. Razia subsequently discovers this fact and also that he has been visiting G.B. Road during the course of the past two years.

Ranibai's Story

Ranibai lives in Dharavi and has recently taken a job in an electronics

factory in the free trade zone in Bombay. She has four daughters between the age of 2 and 12. Her husband has been unemployed for some time. Her husband wants a son.

Sitabai's Story

Sitabai is a sex worker who has been working in prostitution for over ten years. She has been involved with several other sex workers in an AIDS awareness and action programme for five years. Sitabai is keen to set up an AIDS action cell for women in Karol Bagh, a punjabi middle class locality together with activists from some women's organisations.

The group presented all three stories in the form of a song. (**Annexure F**) The issues raised by the song included the following:

a. As regards specific points raised in connection with the issue of HIV\AIDS, the fact that Rafiq has been visiting G.B. Road for two years may give rise to suspicion about where he acquired the virus. However, if his sexual activity was safe, then the fact that he visited women in G.B. Road has nothing to do with how he got infected. It was reiterated by the group that women working in prostitution should not be categorised as 'high risk groups', which is misleading and discriminatory. b. Ranibai and Razia are both lower middle class women which mediates their access to information, health care and education.

c. Ranibai works in the free trade zone in Bombay, which is exempt from protective legislation.

d. Ranibai is probably a casual worker which is the trend of female entry into the labour force which is inexpensive for the employer and carries no security for the labourer.

e. The demand for a son by Ranibai's husband will make it difficult for her to practice safe sexual intercourse.

f. In contrast, Sitabai, who has worked for over ten years as a sex worker would have relatively more control over her income and life in comparison to Ranibai, despite the fact that the latter is the one who is bringing home the income for the family.

g. The issue of religion could also effect each woman in a different way. For example, as Razia is muslim, an attempt on her part to assert her legal rights, say for divorce on grounds of cruelty under the Dissolution of Muslim Marriages Act, could have communal implications. A similar attempt by Shah Bano was taken over by communalists, ultimately resulting in the disempowerment of Shah Bano and the women of the muslim community. The right wing hindu fundamentalists might support Razia's claim, accusing muslim men of discriminating against their women and denying them the same rights that are enjoyed by hindu women (while at the same time denying hindu women the same rights as hindu

men).

h. Sitabai is likely to face strong resistance from the middle class women of Karol Bagh, who will perceive her as a threat. These women will also be inhibited from speaking about sex, let alone HIV, as they are unlikely to have gone through the kind of awareness processes that Sitabai has gone through. At the same time, the fact that Sitabai wants to establish her centre in a middle class locality may be partly influenced by her need for legitimacy and upward mobility.

i. The fact that Sitabai wants to work with women's groups raised some important issues. Experience had demonstrated that most women's groups do not work with women in prostitution. There was some discussion regarding their lack of attention to women in prostitution. Women's groups do not believe in a welfarist reform and rehabilitation approach that some NGOs and government programmes propogate. Yet, organizing 'sex workers' around their rights is not easy either. There has not been much ideological debate among women's groups in India on the issue of women in prostitution. The group agreed that such debate is necessary.

The objective of the story session was to reveal how we have to formulate our strategies for combatting HIV by taking into account the reality of women's lives, and the extent to which HIV-positive women and non-HIV-positive women already experienced considerable discrimination in terms of the law and access to their rights on account of their gender and class, caste, ethnicity, religious background, sexual identity, and marital status. The stories brought out how HIV exacerbates already existing gender inequalities. Currently, women are struggling to hold onto rights that were secured so long ago, but which are being threatened by the impact of structural adjustments and less resource allocation for social services as well as by the onslaught of right wing ideology. For example, the government is currently considering a bill that will withdraw maternity benefits from women who bear a third child, once again punishing the women and remaining oblivious to the circumstances under which and the reasons why women get pregnant and have more children. Women will continue to have these children regardless of such a threat to their rights, but will be made more vulnerable as a result of the withdrawal of these formal rights.

Legal Responses to Women Working in Prostitution

This session addressed the issue of prostitution in terms of the attitudes of the participants as well as law. **Susan Mathews** and **Prabha Kotiswaran**, two law school students who conducted the session, stressed that the issue was being raised because of

the increased attention it has been receiving in the context of the AIDS pandemic. In this context, women working in prostitution have experienced intensified discrimination from being described as a 'high risk group', and have been treated like public property, where even their private lives are subject to scrutiny. However, the increased persecution of women working in prostitution can be treated as a political opportunity to confront social hypocrisies around this issue and provide redressal for a historically disadvantage group of women. Categorisation according to the work these women do should not be used to aggravate the existing legal and social distinctions between 'good' and 'bad' women, but to recognise the historical discrimination they have experienced because of the work they do and to strengthen their position.

The students also challenged the lack of initiative on the part of women's groups to address the issue of prostitution or to work with women in prostitution in a sustained way. They expressed the view that talking and working with these women could initiate an open and much awaited debate on women's sexuality and control over sexuality.

One of the points emphasised by Prabha and Susan was the fact that HIV was just one of many problems that women working in prostitution experienced, and that to exclusively focus on HIV was to ignore the realities of their lives. If they had better living and working conditions, greater access to health care facilities, and their children had access to education, they would be in a stronger position to practice HIV prevention methods

The session proceeded by breaking the participants into three groups and asking them to consider a set of words used to describe or address women who work in prostitution, and how such language influences the way in which they are treated both legally and socially. These terms were as follows:

a. sex worker\ sex trade worker\ commercial sex worker

b. women in prostitution\ prostituted women

c. whore\ hooker\ prostitute\ call-girl

These terms were to be linked to another set of words with which they were associated. The latter set of words were as follows:

a. Sex Trade

b. Sex Industry

c. Profession

d. Work

e. Slavery

f. Crime

Group A

The term sex worker evoked several different responses. Some felt that it stigmatised women working in prostitution and gave the impression that their identity was their sexual role. It also to some extent obscured the oppression and exploitation they experienced. At the same time, the term recognised the agency of these women and their potential to organise and struggle for their rights as workers and against the stigma attached to their work and lives. Some participants felt that the term did not emphasise what they are, but what they do and in this respect was no different from the way in which many of us defined ourselves when referring to our livelihood.

Group B

This group recognised that the term 'prostituted woman' communicated the fact that women were predominantly forced into this work, prompted primarily by poverty. It is a term that makes society as a whole responsible for their situation. On the other hand, the term was problematic because it denied the agency these women had to work and to survive. It was protectionist and promoted a 'victim' image of these women.

The term women in prostitution was preferred by several members of Group B. One participant emphasised that it was more important to recognise and emphasise the

gender identity of these women rather than to refer to their work. However, this view was challenged on two grounds. First of all the use of the term `woman' constructed women as a homogenous group and obscured the differences that do exist amongst and between us. Such differences have been used to disadvantage some women, not all women. For example, our religious and class positions situate us in different relationships to one another, not only in terms of the way in which we are oppressed, but the ways in which by virtue of our class or religious privilege, we do oppress others, including women. Secondly, emphasising the term `women' removes us from our historical and social context and is therefore unhelpful for developing strategies. For example, a woman who is a factory worker is neither exclusively female, nor exclusively a worker. She is a female worker - the two identities are mutually interlinked and influence the way in which she experiences her work place and conditions. The term `women in prostitution' obscures the complicated reality of the lives of women working in prostitution and the fact that they experience discrimination because of the work they do which is selling sex.

Group C

This group felt that the term `whore' had a pejorative meaning. It labelled women as immoral and of `easy virtue' and as having an excessive sexual appetite. The term `hooker' was often used to describe street walkers, that is, women who did not necessarily work in a brothel. The term `prostitute' was associated with a form of slavery. The group also felt that there was an implicit class distinction between the terms `prostitute' and `call girls', the latter often catering, though not necessarily belonging to, higher classes. In addition, there was some element of secrecy and discretion involved in the context of `call girls' which was absent in the work of `prostitutes'. The group alsoassociated the term `call girl' with a `profession' and `prostitute' with `work'.

The participants as a whole agreed that the term used was ultimately the decision of the community of the women to whom it applied. Some of the field experiences shared by the participants suggested that women do not want to be called sex workers. At the same time, one participant stated that it was important to know whether the women referred to, had gone through a consciousness raising or critical awareness process. For example, if the same group wanted to call themselves `bad' women (and experience revealed that women working in prostitution often perceived themselves in this way) would we accept that position unquestioningly? A case in point is the name "Bhartiya Patita Udhar Samiti", in which women working in prostitution are referred to as patitas. The women concerned would necessarily have internalised many of the biases of society

when addressing their own lives.

Another important point raised within the group was that whatever term was used would not necessarily translate easily into the local dialect or language. However, the terms were important for us to understand as they exposed our own biases and prejudices.

Prabha and Susan proceeded to share their experiences of conducting a community based law reform project in Karnataka, under the theme of labour. In this context, they chose to do their project on women working in prostitution. They shared with us the fact that it took ten months of intensive debate to decide upon the terms they used in their final memorandum. Ultimately, they decided to use the terms 'sex worker' and 'prostituted women' to convey both women's agency and victimisation, as both constituted the reality of these women's lives.

Approaches to Prostitution

The law students shared with the group the different approaches to prostitution and the approach that was adopted by them in the context of their law reform project.

The approaches to prostitution can be divided broadly into three categories:

1. Criminalisation
2. Legalisation
3. Decriminalisation

Criminalisation

This approach can take on two different forms, either abolition or toleration. Both versions have a moral basis - they view prostitution as contemptible. They also promote the notion that immoral conduct should be criminalised. The abolitionist approach has been adopted in some states in the U.S.

Toleration This approach is based on the assumption that prostitution is an inevitable social evil and cannot be banned. Legislation which is based on this approach is silent about whether the activity itself is legal or illegal. It criminalises only the outward manifestations of prostitution such as soliciting, brothel keeping and trafficking. This approach does not help women. It is followed in countiries like India, England and Canada. As they are not given any legal rights, they will inevitably refuse to testify against pimps, brothel keepers and traffickers who sustain their livelihood. As a result, the most used provisions of the Act in India are those criminalising soliciting which directly harms women. It is mostly women who are arrested. The Act provides sanction to women being picked up under the Vagrancy, and Police Acts. There is also a provision that permits

anyone who suspects a person of being a prostitute to file a complaint and the magistrate has the power to issue a show cause notice placing an obligation on the person, who is invariably a woman, to prove that she is not a 'prostitute'. This provision can be used against all women, but in particular women who are unescorted by a male, women in non-marital relationships and single women.

Legalisation

This approach is widely misunderstood, and in some ways, the most dangerous. It is based on the assumption that a balance must be drawn between 'public' health and 'public' need [i.e. the man's need]. Its objective is to curb what it defines as the worst side effects of prostitution, such as the spread of STDs, HIV and AIDS. The main features of this approach are:

* zoning - this keeps the women in a 'working women's ghetto'. It segregates them to a separate part of the town or locality. It restricts their private spaces because they are considered to be public women. Even if they venture out of the zone their civil liberties are restricted.
* licensing - which involves the state issuing licenses, registration and the disbursement of health cards to the women. This process often leads to harassment by the agents of the State.
* mandatory check-ups - this has received greater emphasis in light of the HIV pandemic and the myth that women working in prostitution are responsible for transmission of the virus. The woman is compelled to submit herself for check ups or else face imprisonment (this is the law in Germany and Nebraska, U.S.) One participant remarked that it was the state's duty to provide health services and not to force it on individuals. It was also pointed out that a version of this approach is being promoted in the Supreme Court petition filed by the Bhartiya Patita Udhar Samiti.

Decriminalisation

Decriminalisation is based on the assumption that prostitution is a personal choice and that it is therefore a personal matter between consenting adults. It involves the repeal of all specific criminal laws that apply to prostitution and subject it to the realm of general laws.

In 1985, at an international meeting, a Charter of Prostitutes' Rights was formulated by a group of women working in prostitution that advocated this approach. However, there are some serious shortcomings to this approach in so far as it overlooks and does not deal with the exploitative aspects of prostitution and its detrimental impact

on women. The advantage to this approach is that it makes a distinction between the individual in prostitution and the institution of prostitution, which the other approaches obscure, that is, the women is equated with the institution.

Susan and Prabha shared with the group the approach that they had devised during the course of their community based law reform project. They advocated a **Legalisation for Empowerment Approach** to prostitution. This approach is concerned primarily with those women who are already in prostitution. Irrespective of whether she entered the profession by choice or force, this approach emphasised that it was essential to protect her rights. Their proposed Bill ensures that merely because a woman is a sex worker, she cannot be picked up for public nuisance, as her work under the provisions of the Bill is lawful. The Bill addresses the specific abuses that she faces in her workplace and otherwise. The criminal law as it stands either does not recognise, or does not address the specificity of her experience. (For that matter it does not accommodate most women's experiences) The Bill proposes that the civil law be used to address the harms that they experience, rather than depend on criminal remedies which involves relying on the State. It also incorporates some specific health provisions that are for the woman's benefit and makes provision to protect her civil liberties in this context. In particular, she has:

* the right to liberty and not to be kept in quarantine or isolation
* the right not to be forcibly medically examined
* the right not to be denied access to health care facilities

Other rights include the right to retain custody of her child, to minimum remuneration, to social security in the form of a welfare fund and to solicit. Ensuring the last right is particularly important to protect her from police harassment.

The law reform group is hoping to establishment a precedent in the area of law reform for women through this Bill. They have stated that the empowerment of women working in prostitution can initiate empowerment through law reform for all women. (Note: The Bill that has been proposed is purely a student initiative and bears no relation to the institutional initiative prepared by the National Law School which has been requested by the Ministry for Women and Child Welfare).

DAY FOUR, MARCH 4, 1994

The co-ordinators of the workshop divided the participants into three groups to consider three random ads that had been cut out of different magazines. These ads are as follows:

a. A Kohinoor Condom Ad (**Annexure G**)

b. An Ad for Kama Sutra condoms (**Annexure H**)

c. An Ad for Shirts (**Annexure I**)

After a forty-five minute discussion within the small groups, each group presented their responses to the large group.

a. Kohinoor Condom Ad

Some found the ad very positive as it depicted the woman in a sexually assertive position. It did not use the stereotypical image of a man lying supine over a woman. It also hinted at oral sex\ foreplay \ masturbation, and hence was depicting an alternative to penetrative sex. There was some confusion over what the text i.e. "the sweet smell of sex?" was intended to mean. Was it an ad for flavoured condoms, or just about the smell of male semen? The question mark suggests that it isn't sweet.

However, others felt that the depiction presented the woman in a subordinate position. She is kneeling down and in an inferior position. There was also a feeling that the ad was unreal and looked like a representation for a love story rather than a condom. The bodies were also stereotyped, with the male body being tapered and muscular and the female body curved and slim.

b. Ad for Kama Sutra Condoms

The discussion revealed diverse views about this ad. Some participants felt that the portrayal of the female body was sensuous and energetic. There was also a representation of a woman experiencing an orgasm which was a very positive image. Some of the photos also depicted the possibility of sex being mutually pleasurable, and was therefore also positive. The woman was not shown as passive, but as possessing agency in sexual relations. The ad also placed emphasis on giving the woman pleasure. Another positive aspect of the ad is that it suggests that sex is for pleasure not just procreation.

However, other participants felt that the ad was aimed at selling condoms using whatever means possible. They felt that women's bodies were being used as sex objects. They felt that the ad was not meant for female audiences. There was also a difference of opinion regarding the photographs. A number of participants from the smaller group were concerned that there was no picture depicting a nude man. At the same time, the centrality of male sexuality was depicted by the pictures of sperm in every sequence of photos. Some felt that the woman's body was depicted in a subordinate manner through all the sequences, and that one particular picture of a nude woman on a rock was sado-masochistic. Some felt that the message conveyed by these images was that women's bodies are available to men.

c. Ad for Shirts

This ad is aimed at selling shirts using whatever means possible according to the members of the small group. It is trying to sell shirts using a politically correct message, yet it was not clear whether this in itself was a bad thing. Some felt that even though two men were depicted, this ad did not reflect the experience of homosexuals. Whether the purpose of advertising was to reflect reality was questioned. Some felt that the caption in the ad, 'on and off', did not only refer to the casual clothing, but also implied that gay relationships were casual.

However, the entire group supported the fact that the ad did depict an alternative sexual relationship and therefore was very positive. At the same time the relationship was depicted using the heterosexual stereotype of the dominant and submissive relationship.

One participant felt that the ad was intended to have a shock value. However, it was argued that such an ad was unlikely to appear in a mainstream magazine, and would

most probably be produced in a gay magazine. In the latter case, there was no question of shock value. However, such an ad may not promote sales of the shirt even amongst gay men, whose sexual identity may not be open, and who therefore may not buy these shirts for fear of being associated with the ad. This raised a broader issue of homophobia, which the group was unable to address at any length, but raised as a concern that was as significant as sexism, racism or casteism. Homophobia is frequently given less priority than other forms of discrimination yet it isin many ways more insidious as those who are affected by it are often unable to defend themselves out of fear of being exposed and attacked for being lesbian or gay. A further comment was that such an ad could be construed by some members of society as promoting homosexuality. However, it was pointed out that such a response was never made in the case of ads that depicted heterosexual couples selling a product. Such ads were not perceived as promoting heterosexuality, but merely as selling the product.

The purpose of this exercise was to challenge the values, biases and internalised norms of the participants. If we were going to engage in a critique of other people's materials, it was important for us to know our own limitations and prejudices. For some people the ads that were distributed would be considered indecent. It was important to understand that decency was a subjective value and was determined by those who had the power to define what constitutes decency or indecency in a given situation, i.e., the Censor Board. The diversity of views within the group reflected the fact that there could be no one position on this value.

The other important aspect of the exercise had to do with the kind of material we were prepared to produce or show in the communities where we are working. While it is important to be sensitive to the community's norms and values, we must also not act as a censor board for the community on the assumption that they are not ready for such images. Such an approach is often reflective of our own problems in dealing with certain images, rather than our concern for the community's responses.

During the remainder of Day Four, the participants worked on the educational packets they had received on the second day of the workshop. In addition, each group was also given material in the form of (i) jingles (ii) PBS ads (iii) newspaper\media ads and (iv) posters, addressing the issue of HIV\AIDS, which they had to critique both in terms of accuracy of information and gender content, and to produce an alternative jingle, script for a TV ad, newspaper or magazine ad, or a poster that could be used in the AIDS campaign.

DAY FIVE, MARCH 5, 1994

Review and Critique of Information and Educational Materials

The purpose of this session was to present the critiques that the participants had developed of the educational material that they had been given on the first day of the workshop. They were to assess the material for accuracy of information as well as gender sensitivity. The material was divided into three groups as follows:

a. WHO, NACO and UN material
b. Central and State Government material
c. Material produced by non-governmental organisations
d. Articles produced by the autonomous press

A summary of the common critiques and comments is documented below.

a. WHO, NACO and UN Materials

NACO Newsletter , September 1993 (Annexure J)

The group critiqued the newsletter for being very technical and dense. It does not focus on broader social issues, such as the stigma attached to the issue of HIV and AIDS. In fact the document actually perpetuates stigma by categorising HIV and AIDS statistics according to groups. Thus, the term `heterosexual promiscuity' not only reinforces myths about how HIV infection spreads, it is also a dangerous message. It implies that those who are not `promiscuous' are safe. It further reinforces discrimination against those who fall within this category. The newsletter also tended to focus on HIV and AIDS as a disease rather than a virus or syndrome, which are the accurate terms for describing this illness.

On the question of gender sensitivity, the analysis revealed that this document was devoid of any understanding of the gendered dimensions and impact of HIV infection and AIDS.

The group expressed their concern over the lack of any mechanisms for rendering NACO accountable and responsible for the information and material that it produces and disseminates.

AIDS & HIV Infection- Information for U.N. Employees and Their Families- WHO, Geneva, 1991 (Annexure K)

The group questioned the basis for producing this document. It seemed to be concerned with protecting U.N. personnel from `exposure' to the infection from the `third world'. In this respect they found the document very racist in its overtones. The document mentions some geographical areas as risk zones. Although the booklet is informative, it is not well ordered. Another concern was that the understanding of `the family' pervading the

document is the dominant marital, heterosexual, nuclear unit. It is this dominant understanding of 'the family' which is sought to be protected by the information provided. There is no recognition of other types of arrangements. In particular, there is no information at all for UN Employees who are lesbian or gay and the implications that HIV\AIDS may have for them.

The booklet is particularly concerned with assuring U.N. Employees that WHO and National programmes are taking steps to "know when and where rates of HIV infection are increasing."(at p.41). The fact that such information is acquired through sentinel HIV testing, that is "selected groups within a population act as 'sentinel' groups for monitoring health related trends in that population" (at p.41), and that such testing is carried out without informed consent is not mentioned. There is no mention of the fact that UN employees have a special responsibility towards protecting groups whose human rights are violated, and that they must live up to this responsibility.

WHO booklet on mother and child health care & AIDS prevention - 1992 (Annexure L)

This document suffers from some of the same infirmities as the NACO newsletter discussed above. It talks about targeting groups and reinforcing the practice of categorising HIV\AIDS people. The tone of the booklet is also self congratulatory and lauds the effort made by WHO in the area of HIV prevention.

The document is inaccurate in so far as it refers to monogamy as a form of prevention, which is inconsistent with the position of this workshop. (see Day One of this report). Simultaneously, references to 'casual relationships' is moralistic and judgmental and in and of itself, does not increase risk of exposure to HIV infection. The language and tone of the document is also class biased, racist, and reinforces prejudices. For example the term 'drug addict' is used continuously.

As regards, gender sensitivity, by addressing maternal and child health, the document reinforces the role of women as reproductive agents, rather than as individuals. There is no other WHO material which addresses women more generally.

WHO- Global program on AIDS - Consensus statement from the WHO\UNICEF Consultation on HIV Transmission and Breast Feeding, Geneva, 30th April - 1 May, 1992 (Annexure M)

The document is fairly important as it is taking into consideration the realities of 'Third World' countries. Nevertheless, it is again concerned with women in their maternal roles, and also, implies that future generations could become infected because of irresponsible mothers.

b. CENTRAL AND STATE GOVERNMENT MATERIAL

IEC Bureau, Rajasthan [1991] - Booklet- (Annexure N)

The layout and design of this document considered to be both alarmist and discriminatory. It is also full of misinformation, both as regards the origin of the virus and in terms of its statistics, the source of which is never provided.

The document again promotes the policy of targeting and it uses HIV as a stick by which to beat 'deviant' people and behaviour. At the same time it promotes a very conservative morality, without challenging the double standards of that morality.

AIDS: The Deadly HIV, Directorate of Health Services, Assam (undated) (Annexure O)

This document is straightforward in its presentation, yet a considerable amount of the information provided is misleading. Some examples of misleading information are as follows:

* "AIDS is a disease": AIDS is not a disease, but a syndrome of many diseases
* "T Cells of the special glands of the body": T cells are not confined to any special glands in the body
* A lot of terms used in the pamphlet such as WBC, antibody, T-cells, key cells etc., are not self explanatory. This results in creating confusion rather than clarity.

In addition, the pamphlet emphasises the signs and symptoms of AIDS which creates fear and panic as many people may have the symptoms described for reasons other than HIV infection. The pamphlet also gives the impression that all sexual contact is unsafe. This is inaccurate for the reasons already discussed elsewhere in this report. The pamphlet mentions the need for prevention of transmission, but does not describe these preventive methods.

Mr.Condom- A Joint Venture Between the Heart Care Foundation of India and the Government of NCT of Delhi (1993)- (Annexure P)

Although, one participant found this document informative and simple, the majority of the participants were very critical of it. The major limitation of the document is it advocates that 'only' the condom will prevent HIV. There is no simultaneous message about alternatives to penetration, which are both pleasurable and safe, as discussed earlier in the workshop. Penetration focussed on male sexual pleasure and excluded the different

ways in which women experience sexual pleasure. An important ecological concern was raised in connection with promoting condoms which are not bio-degradable and hence, cause environmental destruction.

The participants also found that the messages communicated by the document were moralistic. For example, it spoke strongly against pre-marital sex. The document also gave information that was not altogether useful in our context, such as advising that couples to use water-based condoms, which are not easily available in India.

c. NGO Material

Sathin Ro Kagad , Rajasthan, IDARA STATE UNIT, [1992] - (Annexure Q)

All of the sub-groups were provided a copy of this document as it is one of the few developed for rural poor women and is used extensively within the WDP (Women's Development Programme) of Rajasthan. As this was one of the few documents produced by a women's programme for women, it was considered important to critique it from a feminist perspective.

Similar criticisms were made with reference to this document by all the groups. These are stated as follows:

a. The document was factually incorrect in a number of places.

b. The language, visuals and approach all contributed towards creating a fear psychosis about the illness.

c. The information was communicated in a way that was patronising towards HIV positive people. The references to giving people with HIV love and affection appeared to be superficial given the general discriminatory content of the document.

d. The document lists symptoms of the infection which are common illnesses throughout India, especially in rural areas and urban slums.

e. The document makes a general recommendation to pregnant mothers with HIV to abort the foetus.

f. It advocates monogamy.

g. The document endorses a target oriented approach.

h. There is little emphasis on the preventive measures that can be adopted to protect oneself from HIV.

The document was perceived to be not only discriminatory but also harmful because the information provided was misleading and judgmental. The participants were very concerned about the fact that the newsletter had already been extensively distributed and used and could cause a considerable amount of harm. **There was a general**

consensus that it was essential for the WDP to withdraw this document and issue updated information that was factually accurate and gender sensitive.

Gram Bharati Samiti Pamphlet, (Jaipur) (undated) - (Annexure R)

Once again, this document was found to be alarmist and containing very little useful information. The strategy for containing the spread of the infection was based on targetting. A testing culture is advocated by the document which is highly moralistic in its tone and presentation.

Voluntary Health Association of India :HIV & AIDS Booklet, New Delhi (May, 1993) - (Annexure S)

The language used throughout this booklet was very dense and difficult to comprehend. The visuals were also based on gender stereotypes and the imagery with reference to HIV was violent and militant.

d ARTICLES AND WRITTEN MEDIA MATERIALS

Magazine Article - "I am determined to live as long as I can in order to help others live too." Soutik Biswas. INDIA TODAY (November 30, 1993). **(Annexure T)**

This article uses problematic terms such as 'AIDS carriers' and 'bisexual promiscuity'. There is a suggestion that those who engage in 'bisexual promiscuity' deserve to get the virus. The language in this article is problematic. Terms such as "drug abusers" rather than drug users are used. There is also a constant reference to 'high risk groups'.

The article projects a positive image of all those who have given up drug use and are involved in establishing detoxification and rehabilitation clinics. However, it fails to provide any information about safe drug use practices.

The writer does however stress that HIV positive people should not be socially ostracised.

Newspaper article - "Manipur Prisons Jailing AIDS Hit, Treating Drug Addicts." Indian Express (April 15, 1992). **(Annexure U)**

The article tends to give the impression that the prison is a friendly place. It glorifies the prison as well as the policy of rehabilitation. It emphasises the notion of 'deviance' and talks about the need to bring deviants into the mainstream.

The article is alarmist in its approach and uses judgemental language. For example, instead of using the term 'drug user' it uses the term 'drug addict' and also perceives drug

addiction as synonymous to HIV\AIDS. It also considers prisons as substitutes for families who have 'failed' to control their children. The writer assumes that 48% to 50 % of drug users are HIV positive. However, her own data from Imphal jail indicates that the incidence of HIV among drug users is only 5%. The article is therefore inaccurate and misinformed and displays prejudices that can only result in discouraging individuals from reporting the infection.

The main limitation of this exercise was that the gender analysis of the documents was not very thorough. However, the fact that the documents were predominantly based on so much misinformation and prejudice came out very strongly, and it was assumed in most cases that the material did not address women nor was it gender sensitive.

Critique for Ads, Posters, Jingles, and Film Ads

A Posters (Annexure V)

The participants noted that the imagery, layout and colour scheme in the posters often combine to create fear and panic in those viewing the posters. The use of dramatic images such as a skull also had the same impact. Thus many of the posters were found to be violent and male in their portrayal of AIDS.

Women are depicted in stereotypical roles. For example, the modern, young, 'loose' woman often figures in the visuals, implying that she is responsible for the spread of HIV.

Most posters used harsh images of animals such as snakes. These images do injustice to harmless animals by portraying them to be lethal and dangerous.

The term 'unborn child' is often used instead of foetus, and suggests that there is a high risk of pregnant HIV positive women passing the infection on to the foetus.

The participants found that there were few posters with positive messages and that women were more often than not invisible in whatever message that was being communicated.

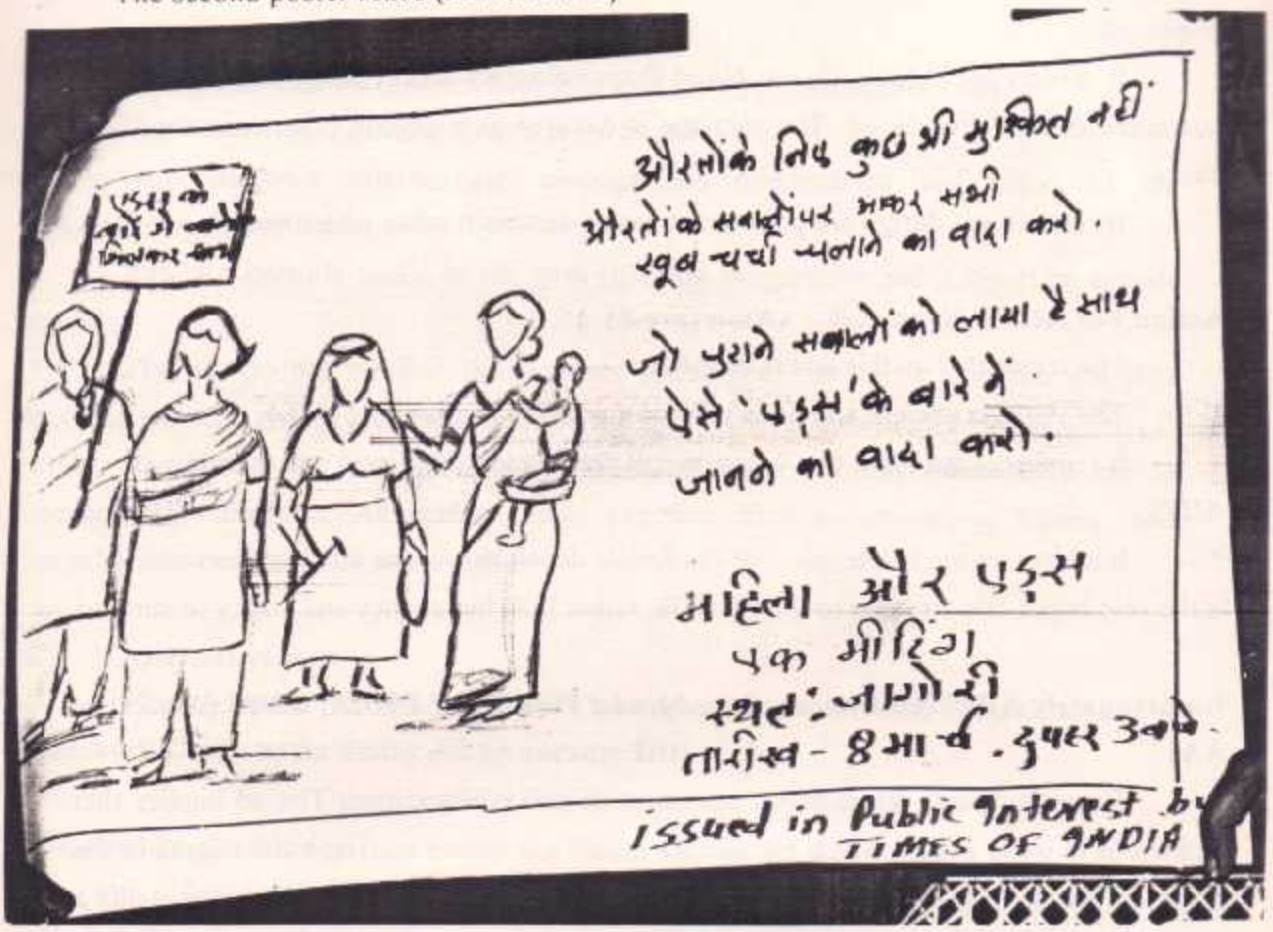
B Alternative Posters

Two alternative posters were created by the group. The first poster **(Annexure W)** depicts women from around the world and contains the following text:

AIDS touches all of us,
Let us share our smiles and our tears,

Let us share our faith and our fears,
That come between us!

The second poster reads **(Annexure X)**



The text is followed by a call for a meeting on AIDS and Women to be held at the Jagori Office on March 8, 1994.

C Advertisements

World AIDS Day 1990: Women and AIDS, TIMES OF INDIA, 1/12/1990 (Annexure Y)

Some of the critique regarding this ad was as follows:

* The ad says nothing about women and AIDS and hence, is misleading
* AIDS is wrongly termed as a disease whereas it is a syndrome.
* It provides obscure information and does not clarify what is meant by the term 'sexual contact'
* It erroneously preaches monogamy whereas the emphasis should be on safe-sex It implies that marriage is the only institution within which legitimate sex can take place

What about single women, especially those who are widowed, separated or divorced?

* There is no information on what constitutes 'safe-sex'.

* The ad makes common people responsible for using unsterilised needles and syringes rather than medical professionals. This is reflected through the language employed.

It directs individuals to use blood from voluntary blood donations which is no guarantee of HIV-free blood. The message is directed at everyone other than the blood banks.

Its layout and design are poor and it has no aesthetic value whatsoever.

Action For AIDS, Newsweek - (Annexure Z)

The comments on this ad are as follows:

* The visual is unclear and of an inferior quality.

* It reinforces the myth that homosexuals are a 'high risk' group and that they spread AIDS.

* It addresses the helplessness of the female dependent in the family if the male, who is the sole bread-winner were to die of AIDS, rather than her agency and ability to survive.

Unfortunately AIDS is a Disease of the Mind , TIMES OF INDIA, 4/2/94 (Annexure AA)

The participants felt that the woman in this ad is objectified. The ad implies that women have weak minds, which encourages unsafe sex before marriage and results in the spread of AIDS. It places responsibility for condom use on the woman. It also presents a distorted view of the 'modern' woman. The text also implies that women mean 'yes' to sex when they say 'no'. The description of the sexual interaction between the man and the woman in the ad suggests that sexual contact was non-consensual.

The overwhelming message of the ad is that condoms are the sole means of preventing HIV infection and that women are completely responsible for ensuring condom use in sexual relations. The message that "condoms can stop AIDS" is erroneous for the reasons already discussed in this report.

How You Can Safeguard Yourself Against AIDS - Glaxo (Annexure BB)

The information provided in this ad is misleading in several respects:

* it gives the impression that all sexual practices are risky. There is a moralistic and misleading message that HIV can be prevented by avoiding multiple partners and 'prostitutes'.

* the ad does not mention alternatives to penetrative intercourse

* the statement that "HIV positive people need TLC to help them live out their life with courage and dignity" is patronising and hides a covert sense of stigma associated with HIV infection.

TODAY , Female Contraceptive -Stardust and Savvy - (Annexure CC)

The comments regarding these ads are as follows:

* they reinforce heterosexual, monogamous relationships and place all the responsibility for birth control on the woman.

* they are patently sexist in the garb of being progressive and supporting gender equality.

* The ads do not mention the fact that spermicides can cause irritation and thus increase women's risk to HIV infection.

The group felt that HIV information must not focus only on condom use to prevent HIV infection. Alternative sexual practices such as embracing, kissing, and masturbation needed to be encouraged.

C Alternative Ads

The ad depicts two women who are having a conversation with one another and is a direct challenge to the Today Ad. **(Annexure DD)**

Open Up a World of Pleasure and Protection

"Do you like spermicides?"

"Ya. And I like spermicide Ads"

"Really? How Come?"

"Because I don't have to use them."

"Ha, Ha! Celibate?"

"Well, polyandrous."

"Ha, Ha, Ha! But you must be doing something for birth control and HIV infection."

"Nope. I don't need to."

"How can that be?"

"Well, we are innovative."

"How, if I am not too inquisitive?"

"Well, firstly, we don't have intercourse."

"What? That's IMPOSSIBLE. What do you do?"

"Well, there are a host of other ways that open up a whole world of excitement."

"Tell me more".

"Well, kissing, cuddling, sucking, petting, masturbating (together and separately), licking ear lobes, and much more!"

"Really? WOW! How inspiring!"

"And all this keeps me and my partners away from HIV. ...And unwanted pregnancies to boot!"

"How wonderful! Nothing's going to stop me now!"

D Jingles (Annexure EE)

In general, the jingles sent out the same distorted and biased messages as the written material critiqued above. The messages are moralistic and delivered by a male, authoritarian voice. They place undue emphasis on penetrative sex. There is no mention of alternatives at all. The messages are misinformed, and factually and scientifically inaccurate. They also unnecessarily aim at creating fear and panic and also contain some class and gender biases. The only persons providing information about AIDS in the jingles are men, women are portrayed as ignorant. Men are serious, while women are flippant. Gender roles are extremely stereotyped. This comes across not only in the dialogues, but also the tone and pitch used. Men are warned to beware of getting HIV, and it is impied that women are spreading it. Also, sexuality is reduced to sexual desire alone, which is portrayed as uncontrollable. There is no questioning of the construction of male and female sexuality, which is accepted as given.

E Alternative Jingles

The group produced two new jingles. In the first jingle two men or one man and woman in equal positions who are lovers, have the following conversation:

A - You hear of safer sex so much these days

B - But what does it mean?

A - MM!! It means a lot of masala!

B - Masala for you or for me?

A - Both. Imagine - kissing, hugging, caressing, masturbating...

B - Oh wow? Lets explore!

The second jingle is as follows :

एच. आई. वी. के लम्बे हाथ

किसी को भी छु सकते है।

सुनो ए दुनिया वालो

सुरक्षित सैक्स अपना लो

बगैर जाँच खून से बच लो

सुई सिरिंज साफ करा लो

फिर एच. आई. वी. से ना डरना यारो।

F Film Ads

The group viewed a series of ads that appear on Doordarshan with messages about AIDS/HIV prevention. Critiques of the ads are as follows:

* Women do not feature in many of the ads - even where they do, they are portrayed in a stereotypical fashion and as primarily responsible for the spread of HIV infection. They are depicted either as caregivers or sex objects.
* Women working in prostitution, homosexuals and `promiscuous' people are continuously depicted as `high risk' groups. Concern is focused on protecting the male clients who visit women working in prostitution. Women's health is not addressed despite the fact that transmission of the virus from males to females is considerably higher than from females to males.
* In addition, the virility of men is constantly celebrated.
* Condoms are described as the only means of preventing HIV infection and also as fool-proof.
* The voice used for these ads is always male and authoritarian.

G Alternative Film Ads

The participants, who prepared the alternative film, ads had difficulty in working with the 20 second time limit, and formulating a non-stereotypical ad for a basically conservative audience.

The framework of the first ad depicts a man and woman in a very understanding, caring relationship, filled with mutual respect. The wife discloses her past relationship with another man which triggers off a process of hurt in her partner's mind. He is upset. He learns that his wife is infected with HIV. He reflects on his own past relationships and wants to share his life with his wife. He says at the end "After all, it could have been me."

The second script shows a man and a woman in a shower, being very intimate with one another. The condom she is about to put on him, slips down the drain. They both feel there is no need for the condom, and instead of penetrative sex, indulge in mutual masturbation.

Some participants' felt that the message of these alternative ads was based on the assumptions of a monogamous, married, heterosexual relationship, which was exclusive and problematic. **The exercise revealed how critical we could be about other's material, but how the very same prejudices that we critique often inform the materials which we produce because we have internalised those prejudices.**

H The `Family'

The co-ordinators were of the view that HIV\AIDS strategies and policies were often based on certain assumptions of `the family'. It was important to understand just what kind of family was being promoted, that is, the marital, primarily hindu, heterosexual, nuclear family. Such an approach did not reflect the reality of many women's lives and ended up being exclusive as well dismissive or judgmental about other types of social arrangements. These alternatives were also very often denied the benefits conferred by the State and even penalised for choosing different lifestyles. The co-ordinators therefore prepared a collage to unfold the multifarious social arrangements in which people live and to expose the exclusivity of the dominant norm.

Amongst some of the arrangements depicted in the collage, were the following:

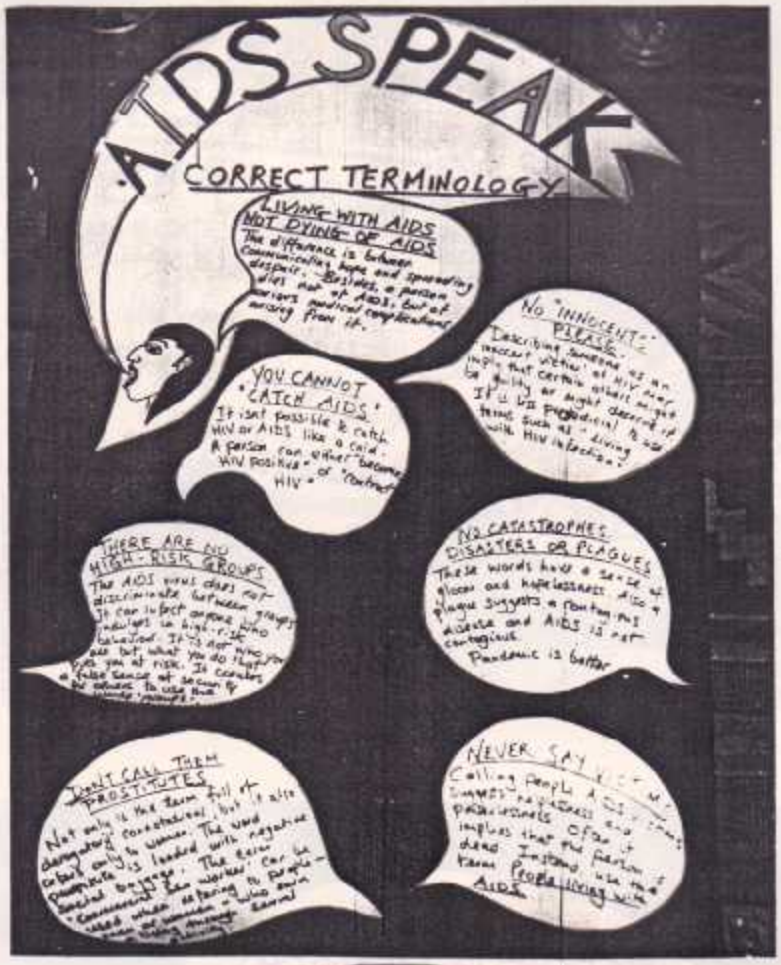
* A single woman working to bring up a physically disadvantaged boy.
* A large joint family as opposed to the increasingly common nuclear family.
* Older women having relationships with younger men.
* Multiracial relationships/families.
* A centrespread model for Debonair and her female partner who strips for a living, working to support a girl child that the former has had from an earlier relationship.
* A woman, who does mujra for a living, working to support a physically disadvantaged female partner.
* Single women living with animals - cats, dogs, birds and so on. This makes us sensitive to the fact that animals can be like members of our families.
* Lesbian and homosexual relationships.

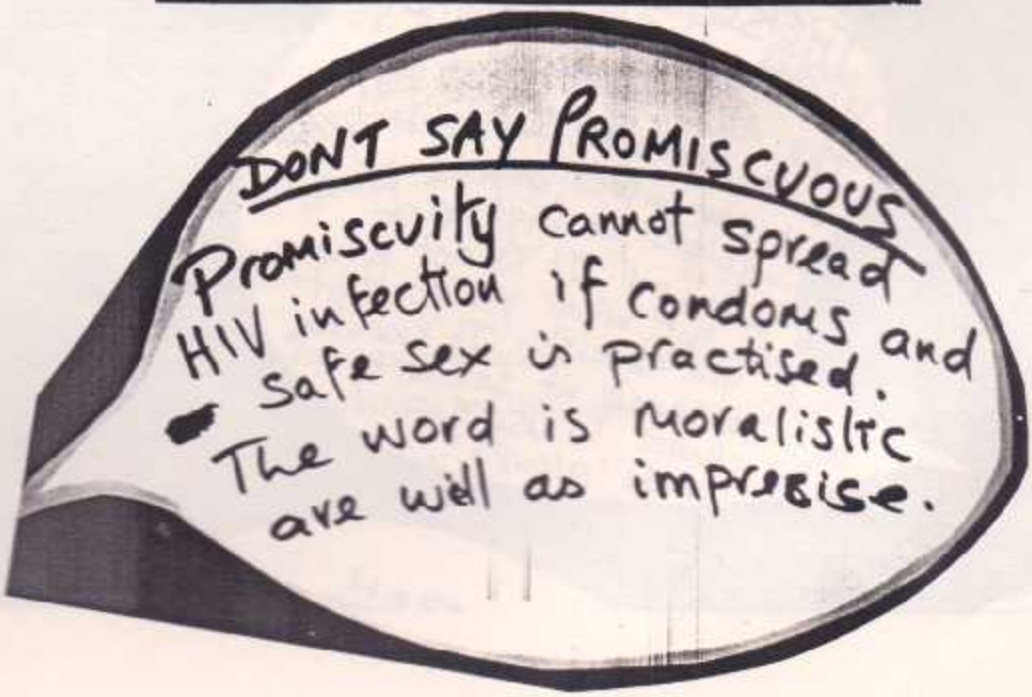
Thus, alternatives to the monogamous, heterosexual, nuclear family do exist all around us. Yet we have internalised the dominant norm which was challenged by the images depicted in the collage.

Language\Terminology

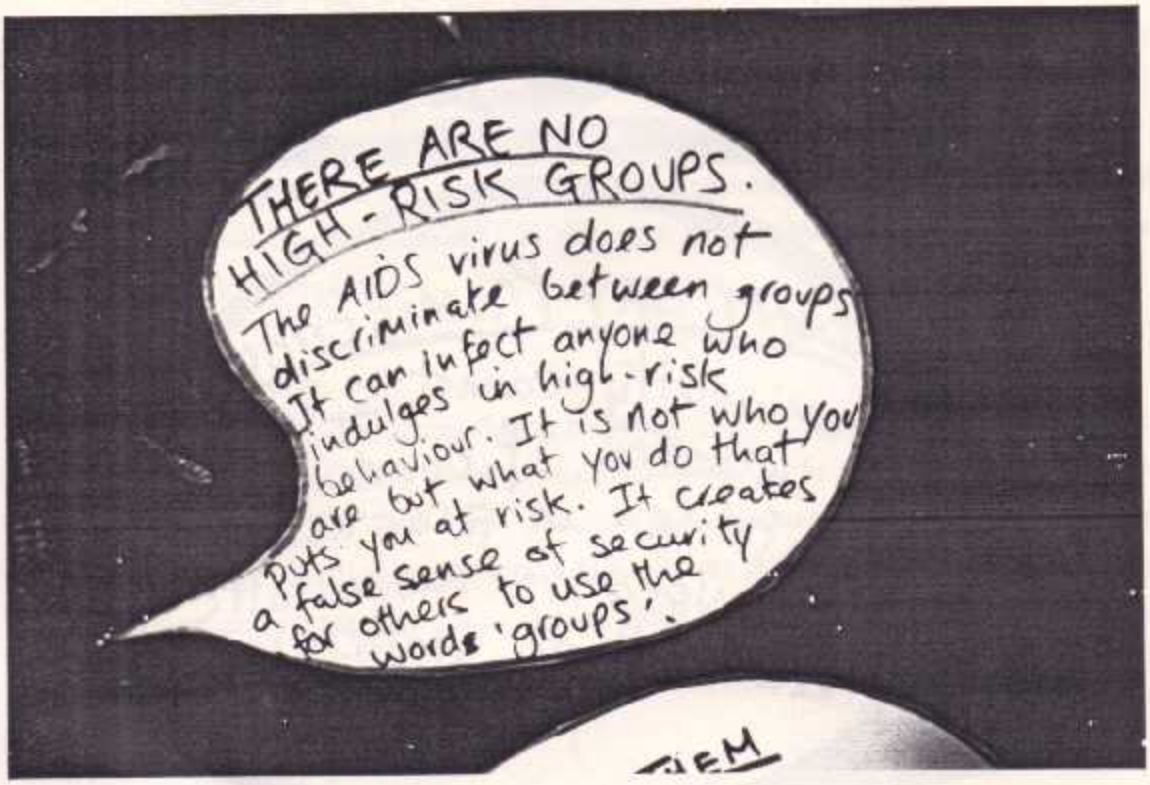
There was some discussion during the workshop on terminology that is used in connection with HIV and AIDS which is often discriminatory or misleading. For example, the group questioned the term `risk' should be used instead of `vulnerability' when addressing women's situation in relation to HIV. It was felt that the word `vulnerability' focused on women as powerless and as victims. Such associations were not made with the term `risk' which was therefore a more appropriate term.

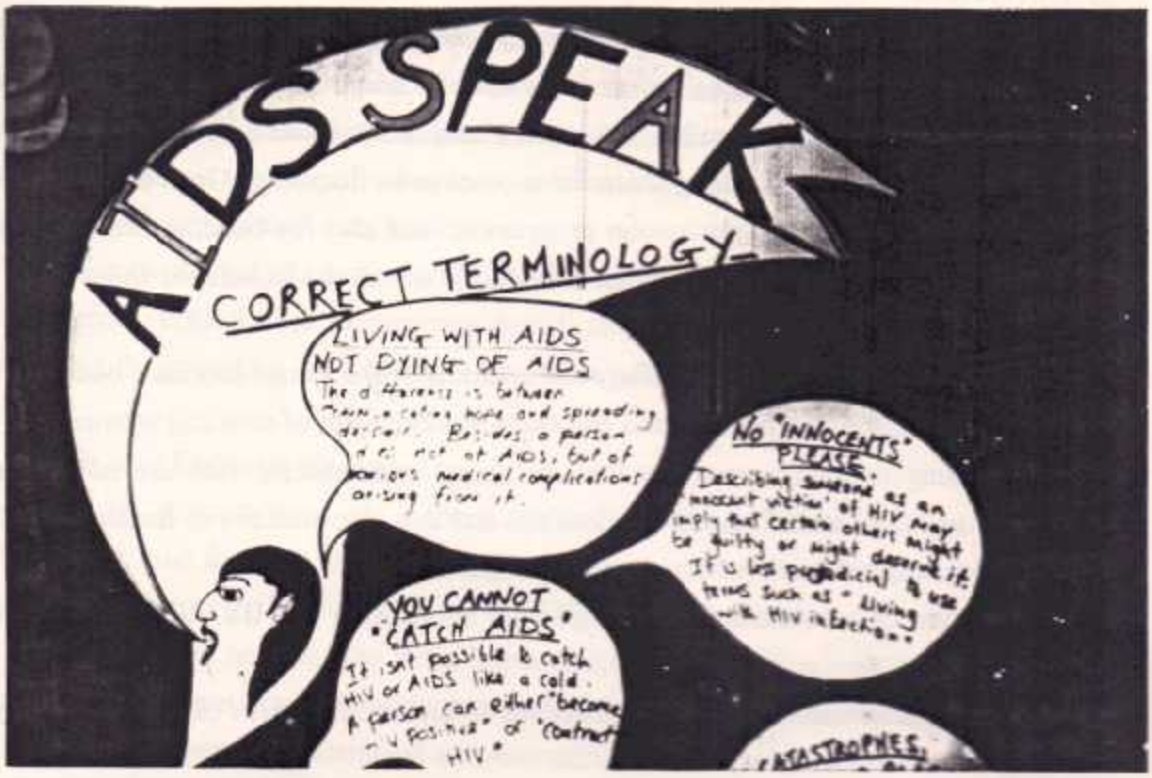
The term "drug addict" was also considered to be inappropriate as it stigmatised the person using drugs and the term drug user was considered to be the more appropriate term. Some other terms that need to be questioned are depicted below:






THERE'S NO SUCH THING AS FULL BLOWN AIDS
People either have AIDS or they haven't. There's no such thing as full blown or half blown AIDS. HIV infection develops into AIDS.


THERE ARE NO HIGH-RISK GROUPS.
The AIDS virus does not discriminate between groups. It can infect anyone who indulges in high-risk behaviour. It is not who you are but what you do that puts you at risk. It creates a false sense of security for others to use the words 'groups'.
FEM



RECOMMENDATIONS

The participants were divided into four groups to propose recommendations on the basis of our discussion under the following themes:

a. Education

b. Health

c. Law

d. Media

Wherever possible, the recommendations were divided into those directed at the government\ international organisations and those directed at national NGOs and feminist groups.

A. Recommendations as to Education:

a. Government

The group strongly endorsed the recommendation that sex education be included in educational curriculum and be described as sex education. The current proposal by the Human Resource Ministry to call it 'adolescent education' would only serve to reinforce the perception of sex as something shameful and not to be discussed. Open discussion was essential as part of the HIV prevention programme, and also for building healthy human relationships. The group emphasised that sex education material include the following:

a. an understanding about the physiology and anatomy of the female and male bodies.
b. an understanding of the physical and emotional development of men and women.
c. incorporating non-judgmental material on sexual relationships, that are not focused exclusively on heterosexual marital relationships and that give visibility to female sexuality.
d. study of the reproductive functions of the human body
e. the provision of accurate and non-judgmental information on HIV/AIDS and safe sex practices
f. all educational materials must be dated as information on HIV\AIDS is constantly changing.

Educational Materials:

It is important to develop IEC materials for different age groups from a feminist perspective. This process could be ensured through regular consultation with feminist groups. The workshop exposed the lack of gender sensitivity in the existing material.

Some of the concrete suggestions that emerged in the form of recommendations for producing material are listed as follows:

1. There should be gender sensitive HIV\AIDS information available in all teacher training colleges.
2. Medical education should include instruction about STDs and all other gynaecological ailments that women experience. The medical curriculum as a whole needs to be made gender sensitive.
3. The administrative courses for the police, military, and the bureaucracy should integrate an understanding of women's overall status and their specific needs.
4. Children's textbooks should be reviewed to eliminate gender, class, caste and heterosexist biases and incorporate material that does not portray women in stereotypical

roles.

5. The IEC material should be made available to all state and central government departments including the offices of the panchayati raj.

6. Sex education should be part of the overall educational process, formal and informal, and should not be included in the family health education as this will result in reinforcing stereotypes about the role of women and men and also invisibilise women's sexuality and focus on their reproductive capacities.

7. A majority of children, particularly girl children, are not exposed to formal education. It is therefore critical that community based educational initiatives be developed and promoted for imparting sex and health education to these children.

b. NGOs and Feminist Groups

1. Feminist groups need to inform themselves about HIV\AIDS prevention and transmission and function as advocacy groups about gender discrimination generally, and as pressure groups in the context of HIV\AIDS issues in particular.

2. Feminist groups need to take more responsibility in networking with NGOs sensitive to women's issues and conduct workshops and training programmes for those groups and individuals who need to understand and internalise feminist perspectives.

3. Feminist groups and NGOs need to work with health workers and other scientific and medical communities to make them gender sensitive to women's health conditions and the treatment they adopt for addressing these conditions.

B Recommendations as to Health:

1. Sanitary towels which promote women's hygiene should not be listed as a luxury item but as an essential commodity. This commodity should be subsidised and produced by the small-scale industry sector.

2. Government health services should be made available to all women, irrespective of their marital status, sexual history, or reproductive capacity.

3. Primary health care centres should provide comprehensive health care services and STD clinics should be converted into gynaecological care clinics and equipped for providing such care.

4. Gynaecological care clinics should also be established in areas where women are working in prostitution.

5. Health personnel who staff the PHCs need to be made gender sensitive and taught how to promote self-help skill among women in the community.

6. A survey of women's sexual practices needs to be conducted and more information

needs to be acquired about the prevalence of STDs amongst women as well as on the specific symptoms that Indian women display at various stages of HIV infection. A list of AIDS-defining diseases/infections must be developed for Indian conditions and this must include the infections specific to women.

7. There must be greater consultation by the government and health ministry with women's groups to ensure that health policies are not gender insensitive or exclusively concerned with women in their reproductive capacity.

8. Sensitive care and counselling facilities need to be provided for HIV positive women.

9. Each state needs to have at least one women's health resource centre which is autonomous.

10. The timings of PHCs need to be reconsidered to address the needs of working women.

11. Blood banks must (i) have stringent screening services and (ii) ensure the availability of blood. The number of blood banks must also increase so as to ensure proper distribution of blood in the rural areas as well as the urban areas.

12. Any policy or programme addressing HIV must not treat it as only a health issue. The socio-economic dimensions of the syndrome in women's lives must also be considered.

13. Forced testing for HIV of prenatal women should cease with immediate effect. Surveillance according to groups must be stopped immediately.

14. Research should be conducted to study the risk of HIV-infection associated with the use of intra-uterine devices, diaphragms, cervical caps and hormonal injectibles and implants.

15. Invasive hormone-based contraceptive technologies (including implants and injectibles) such as Norplant, Net-Oen, and Depo-Provera should be banned in a country like ours where women are already very vulnerable and health care services most inaccessible and inadequate. on how to use them and on alternative sexual practices which are both safe and pleasurable.

16. Good quality condoms also need to be made available with literature on correct use, as well as on alternatives that are both pleasurable and safe.

C Recommendations as to Law:

As far as the law is concerned, there is a great deal of reform that is required in areas of property, marriage, divorce and the criminal law. The existing position of women under the legal system is both formally and substantially inadequate and discriminatory. The Government has recently ratified the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW). According to Article 2, all of our domestic laws must be brought into conformity with the provisions of CEDAW upon ratification.

Some of the specific recommendations made in the area of law are as follows:

1. All laws must be brought into conformity with the provisions with CEDAW and information to this effect be included in the report to be submitted to the CEDAW committee in August 1994.

2. The policy of isolation as a response to those who are HIV positive is violative of the Constitution and the basic human rights of these people. This policy must be abandoned and a policy of integration adopted. There must be no discrimination against those who are HIV positive, particularly HIV positive women, who are already struggling against gender discrimination.

3. Condoms should be considered 'life-saving equipment' under the Drugs & Cosmetics Act thus ensuring their availability and subsidy.

4. The bill produced and promoted by the students of the National Law School which advocates a 'Legalisation for Empowerment' approach towards women working in prostitution is strongly supported by the workshop and needs to be considered seriously by the government and Parliament.

5. The law reform drafted by a Committee constituted by the National Commission on Women in the area of sexual assault needs to be urgently considered by the Commission and introduced into Parliament.

6. No divorce should be allowed on the ground of the spouse being HIV positive, unless a person intentionally infects her or his partner. In this case the grounds for divorce should be 'irretrievable breakdown of marriage' which is currently not available in the law. A legal proposal to this effect needs to be drafted.

7. Immigration and travel policies should not discriminate against foreigners. Such an approach is seen to be a way of blaming outsiders for the spread of the virus and abdicating responsibility for formulating and implementing effective prevention strategies in our domestic contexts.

8. Feminist representatives must have access to and influence in the Ethical Legal Committee of NACO.

9. Testing must be done only with the 'informed consent' of the individual being tested.

10. Public Health laws must be amended to secure civil rights of HIV positive persons. In particular, the arbitrary discretion accorded to public health officials in the Goa Public Health Act must be repealed.

11. Doctors must come under the purview of the Consumer Protection Act, to ensure the confidentiality of HIV patients and protection against discrimination by medical personnel.

12. Human rights, feminist and other non-governmental groups should initiate proceedings in the Human Rights Commission with respect to discrimination experienced by people living with HIV. As the issue of women's human rights has become a global concern, groups should focus on bringing cases concerning women and HIV\AIDS to the Commission.

13. Students of the National Law School will recommend to their institution the following:
(a) To establish an informal information service about HIV/AIDS and the rights of those infected by or exposed to the infection.
(b) To produce a portfolio on the legal aspects of HIV/AIDS.
(c) To inquire about NGOs working in the area of HIV/AIDS in Bangalore and critique their materials.
(d) To conduct a small workshop on HIV/AIDS for women within the National Law School in Bangalore.

D Recommendations as to the Media

a. Legislators, Policy makers and the Judiciary

The media includes all forms of communication including audio visual, print and traditional media. The following recommendations were made with respect to the responsibility and utilisation of the media in the context of HIV\AIDS transmission and prevention.

1. The participants strongly objected to the screening of Shyam Benegal's film, "THE SCOURGE" in any part of India. The film is replete with misinformation and representations that are frightening and designed only to create fear and panic in the

viewer. It also intensifies discrimination against HIV positive people and focuses erroneously on 'high risk' groups rather than high risk activity. The film also reinforces the worst stereotypes of women.

2. NACO should allocate funding for the production of low budget, user friendly, and sensitive films on 'Women and AIDS'. The films should address the relevance of class, gender, caste, sexual preference\orientation, ethnicity, age and disability to HIV transmission and prevention.

3. NACO and the Department of Women & Child Welfare should have a systematic IEC policy on women and conduct a survey and evaluation of all IEC material for its gender content and sensitivity.

4. NACO should have some resource persons on the Ethical Committee to see that the material produced is gender sensitive, practical and informative.

5. All development departments in the State Governments should be gender and class-sensitised through refresher courses or trainings and have a 'year marked' budget for the promotion of IEC material for women.

6. Policy makers should delink women from their familial role and address women's specific needs as individuals. This is a requirement under the provisions of CEDAW.

b. Strategies for NGOs and Feminist Groups

1. Feminists and NGOs must lobby against the promotion and dissemination of such existing IEC material on HIV\AIDS that is based on misinformation and biases, and is anti-women. Groups must monitor material that is produced in different languages and challenge such material that does not promote women's rights and interests.

2. Such groups should also attempt to collect information and produce indigenous resource material on female sexuality and HIV/AIDS.

3. Workshops need to be conducted on sexuality to clarify women's perspectives on the subject and training/learning materials need to be developed on this issue. More specifically, it is recommended that sexuality workshops be conducted by women's groups

all over the country to increase our own understanding on issues related to women's sexuality.

4. Sensitisation workshops need to be conducted with Women's Organisations, NGOs, and grassroot women activists to inform them about HIV/AIDS and enable them to develop counselling and caring skills in relation to HIV-AIDS infected persons that is relevant for the context in which they work.

5. NGOs and feminist groups need to initiate research to assess the overall health status of women living in different socio-economic conditions and publicise their findings to make policy makers aware of women's reality and needs.

6. The Co-ordination Unit for Beijing in Delhi should lobby for ensuring that the issue of Women HIV and AIDS is included in the agenda of the 4th U.N. World Conference for Women to be held in Beijing in September 1995. The issue must be part of both the official conference as well as the NGO forum.

7. Journalists and other media persons, including advertising agencies, must be continuously challenged about their representations of women, especially when such representations reinforce gender stereotypes. This strategy can involve writing to newspapers or producing visual material such as that produced at this workshop that not only challenge stereotypes, but promote alternative depictions of women.

8. Two of the participants from the workshop, namely Alka and Sabala, should be participants in the WHO/NACO Film Makers' Sensitisation Workshop which is scheduled to take place in the near future.

9. A member of the Press Council of India should be a member on the Ethical Committee of NACO.

EVALUATION

On the last day of the workshop, the participants were asked to assess its processes and content. The following are some of the comments made :

* there is a need to conduct similar workshops elsewhere by those who participated in this workshop.
* the workshop was informative, but more importantly it challenged our own beliefs and prejudices. The process of self-critique was most important.
* there is a need to have a separate comprehensive workshop on sexuality. Even though the issue of sexuality did come up everyday while dealing with different aspects of HIV, it was important to have a separate session on sexuality within this workshop.
* those who work with HIV-positive individuals derived a great deal of strength from these interactions.
* there should have been a full session on sexually transmitted diseases.
* the all-India nature of the workshop was very important.
* certain sessions focused more on information giving and sacrificed participatory processes.
* we learned to critique material produced by other groups and organisations. However, the process made us aware of how easily we commit the very same mistakes in producing our own materials that we criticise others for making.

CONCLUSION

How do we conclude a process that has only just begun? The process of scientific, social and sexual inquiry required for understanding and fighting the epidemic is indeed going to be a long and arduous one for women. The workshop was an important beginning. It was more than just an experience of learning about HIV and AIDS - it was a process of self-discovery and unlearning. It challenged the narrow paramaters of our knowledge about health, family, legal rights and sexuality.

We were not surprised to discover gender biases both in the understanding of the virus and the syndrome, as well as in the prevention policy that is currently being pursued. The challenge for the participants and all those engaged in HIV prevention work, is to expose these biases and find ways of eradicating them. The committment demonstrated by the participants is no doubt a source of hope and optimism that this challenge will be effectively confronted.

The immediate struggle will involve publicising the issue and ensuring that it is addressed by policy makers, the health care system, donor agencies, the media, educationalists and activists alike. There is likely to be resistance, as the subject raises so many controversial issues over which little or uninformed public debate has taken place. These include issues of sexuality, population control, gender insensitive laws, and the insitution of the family. We need to develop strategies that can effectively raise these issues in governmental and non-governmental spaces.

As co-ordinators of the workshop we learned a great deal from the participants about how to address sensitive issues as well as about the enormity of the problem that women are confronting in the context of STDs, HIV and AIDs. We would like to acknowledge the trust that the participants reposed in us which was essential to creating a positive environment in which to function and completing the tasks which we had set out to achieve. We would also like to acknowledge the contribution made by other resource women to the workshop. We are indeed hopeful, that the recommendations that have be made by this workshop will be seriously addressed and implemented by NACO and different government departments as well as by feminists, human rights activists and other progressive individuals and organisations.

NATIONAL WORKSHOP ON STD-HIV_AIDS,1st-5th March'94,RISHIKESH

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ANNEXURES

ANNEXURES

A. Jagori Questionnaire

B. The AIDS Prevention Bill 1989

C. Bhartiya Patita Uddhar Samiti Petition (summary)

D. Lucy D'Souza v. State of Goa (A 1990 Bom 355) (summary of decision)

E. Goa, Daman, and Diu Public Health Act, 1985

F. Song produced by one group on three stories concerning women's rights and HIV\AIDS (Hindi)

G. Kohinoor Condom Ad (photo)

H. Kamasutra Condom Ad (photo) I. Ad for Shirts (photo)

J. NACO Newsletter (September, 1993)

K. AIDS and HIV Infection - Information for U.N. Employees and Their Families- WHO, Geneva, 1991

L. WHO booklet on mother and child health care & AIDS prevention - 1992 (this document is missing)

M. WHO- Global program on AIDS - Consensus statement from the WHO\UNICEF Consultation on HIV Transmission and Breast Feeding, Geneva, 30th April - 1 May, 1992

N. IEC Rajasthan Booklet, 1991

O. AIDS: The Deadly HIV, Directorate of Health Services, Assam (undated)

P. Mr.Condom- A Joint Venture Between the Heart Care Foundation of India and the Government of NCT, Delhi (1993)

Q. Sathin Ro Kagad , Rajasthan, IDARA STATE UNIT, [1992]

R. Gram Bharati Samiti Pamphlet, (Jaipur) (undated)

S. VHAI - HIV and AIDS Booklet

T. "I am determined to live as long as I can in order to help others live too." Soutik Biswas, INDIA TODAY,(November 30, 1993).

U. "Manipur Prisons Jailing AIDS Hit , Treating Drug Addicts." - Indian Express (April 15, 1992)

V. Original Posters

W. Alternative Poster I (photo)

X. Alternative Poster II (photo)

Y. World AIDS Day 1990 - 'Women and AIDS', Times of India.

Z. Action for AIDS, Newsweek.

AA. Unfortunately AIDS is a disease of the Mind, Times of India.

BB. How can you safeguard yourself against AIDS, Glaxo.

CC. Today Female Contraceptive Ads, Savvy and Stardust . 1993. (colly.)

DD. Alternative Ads (photo)

EE. Original Jingles (transcribed)

FF. List of Films

FACTS AND FEELINGS

So many years into the AIDS epidemic, there are only a certain limited amount of facts that we know, and even these are changing. There is a lot of misinformation. In addition, the whole issue of HIV/AIDS raises a lot of feelings, confusions, ambiguities, and many many difficult issues.

You see before you a set of questions. The catch to this quiz is that there is no right or wrong answer. You can't pass or fail it - it is not a test. These questions are simply to enable us look at our own attitudes and feelings and to assess the level of our collective knowledge about HIV/AIDS. We will try to find answers to these questions through the course of this workshop Please answer all of the questions in this quiz

In each multiple choice question, you can mark more than one answer In true/false, Yes/No or Agree/Disagree questions, mark only one.

1. AIDS is a disease that cannot be treated : True / False

2. The Human Immunodeficiency Virus (HIV) can only survive in the following body fluids :
   (a) tears (b) saliva (c) urine (d) semen (e) vaginal fluids
   (f) seminal fluid (g) blood (h) menstrual blood
   (i) breastmilk (j) amniotic fluid

3. HIV enters the bloodstream only through .
   (a) mucous membranes
   (b) capillaries
   (c) open wounds
   (d) eyes

4. You can be infected with HIV in the following ways :
   (Against each choice write either Yes/ No / Maybe / No idea)
   (a) hugging
   (b) sharing razors
   (c) a blood transfusion
   (d) insect bites
   (e) care of a person with AIDS
   (f) having an injection
   (g) using drugs
   (h) sex with prostitutes
   (i) oral sex (j) kissing
   (k) breastfeeding (l) masturbation
   (m) sexual intercourse without a condom
   (n) sexual intercourse with a condom

5. Efforts to develop a vaccine against HIV have not proved successful because:
   (a) there are different strains of HIV
   (b) no vaccines have ever been produced against viruses, only against bacteria, etc.
   (c) HIV mutates and changes its form inside blood cells

6. The HIV test actually detects
   (a) presence of HIV in your blood
   (b) presence of antibodies to HIV in your blood
   (c) whether you have AIDS or not

7. If you are test postive for HIV, it means
   (a) you have AIDS (b) you will get AIDS (c) you will die soon
   (d) you need to practice safe sex
   (e) you don't need to practice safe sex since you are already infected
   (f) you can pass on the virus to others

8 If you test negative for HIV, it means that
   (a) you are not infected (b) you don't need to practice safe sex
   (c) you are immune to HIV infection in the future
   (d) you need to take the test again after six weeks

9. There are people with AIDS who have tested HIV-negative. This means that
   (a) HIV is only one factor responsbile for AIDS ; there may be other factors which are not known yet
   (b) AIDS is caused by something else, not HIV. The idea that HIV is responsible for AIDS has been floated by the Medical establishment in the West to create big business.
   (c) The results of the test must have been wrong.

10. The Elisa test works well only in temperate zones. In humid tropical countries, it results in a large number of false positives : True / False

11 How long can HIV (Human Immunodeficiency virus) live outside the body?
   (a) 30 seconds (b) 1 minute (c) 3 minutes
   (d) half an hour (e) do not know.

12. Is it necessary to boil the clothes of an HIV-infected person when washing them ? Yes / No

Smt. LUCY R. D'SOUZA and etc., PETITIONERS, v.
STATE OF GOA and others, RESPONDENTS.

V.A.MOHTA,J. :- Section 53 (1) of the Goa, Daman and Diu Public Health Act, 1985 empowers the State Government to isolate persons found to be positive for Acquired Immuno Deficiency Syndrome (AIDS), for such period and on such conditions as may be considered necessary and in such Institutions or wards there of as may be prescribed. A common point raised in these three petitions is whether the said provision is unreasonable, and therefore, violative of the rights under Articles 14,19 (1) (d) and 21 of the Constitution of India (the rights to equality, mobility and life).

3. The Act was made when Goa was a Union Territory along with Daman and Diu. State of Goa, soon after its formation amended the Act by the Goa Public Health (Amendment) Act,1987, which was published in the Official Gazette on 17.12.1987. Several diseases including AIDS were added in the statutory list of infectious diseases contained in Section 47. Sub-sections (vi) to (xv) were added to Section 53 (i). Sub-section (vi) makes it mandatory not to refuse collection of blood for investigation of AIDS or any other communicable infectious disease if the Health Officer has reasonable grounds to suspect that the person is suffering from any of those diseases. Sub-section (vii) makes it mandatory to isolate persons found to be positive for AIDS by serological tests. Sub-sections (viii) to (xv) enumerate the care and/ or precaution to be taken in the case of patient suffering from AIDS or other infectious disease. The Act was futher amended by the Goa Public Health (Amendment) Act,1989 which was published in the Official Gazette on 15.6.1989. The mandatory requirement of isolation of an AIDS patient contained in sub section (vii) of Section 53 was converted into the discretionary requirement and authority of the Health Officer in the matter was withdrawn and given to the State Government. Further a provision to clause (xv) was added.

4. Section 53 with its face-lifting upto date reads thus:
"53 (1) : If it appears to the Health Officer that any person is suffering from an infectious disease, and that such person-

(i) Is without proper lodging or accommodation, or

(ii) Is without medical supervision directed to the prevention of the spread of the disease, or

(iii) Is lodging in a place occupied by more than one family, or

(iv) Is in a place where his presence is a danger to the people in the neighbourhood; and

20. Safe Sex constitutes :
    (a) being monogamous/ having sex with only partner through the lifetime
    (b) protected vaginal/anal intercourse with an HIV negative person
    (c) avoiding sex
    (d) using condoms
    (e) finding alternatives to penetration
    (f) contact of semen/vaginal fluids with unbroken skin

21. Safer Sex constitutes :
    (a) oral sex on a woman or a man
    (b) reducing number of sexual partners
    (c) asking your partner's sexual history
    (d) having protected sex with a woman when she is menstruating
    (e) sterilizing all sexual toys before and after use

22. Unsafe sex constitutes :
    (a) oral sex
    (b) any sexual activity with an HIV + person
    (c) unprotected anal/vaginal intercourse with a person whose HIV status is unknown
    (d) any sexual practice that involves exchange of body fluids
    (e) having unprotected sex if one or both partners has an STD
    (f) inserting finger/hand into vagina/anus

23. A diagnosis of AIDS if given when :
    (a) the person's immune system has broken down to such an extent that the body can no longer protect itself against opportunistic infections
    (b) certain unusual opportunistic infections and tumours develop and antibodies to HIV are found in the blood

NOTICE BOARD

The Acquired Immuno Deficiency Syndrome (AIDS) Prevention Bill, 1989

Bill No. XX of 1989

A BILL to provide for the prevention and control of the spread of Human Immuno Deficiency Virus (HIV) infection and to provide for specialised medical treatment and social support to, and rehabilitation of, persons suffering from Acquired Immuno Deficiency Syndrome (AIDS) and for matters connected therewith and incidental thereto.

BE it enacted by Parliament in the Fortieth Year of the Republic of India as follows:-

CHAPTER I

PRELIMINARY

1. Short title, extent and commencement

(1) This Act may be called the Acquired Immuno Deficiency Syndrome (AIDS) Prevention Act, 1989.

(2) It shall extend to the whole of India except the State of Jammu and Kashmir.

(3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.

2. Definitions

In this Act, unless the context otherwise requires, —

(a) "AIDS" means Acquired Immuno Deficiency Syndrome in a person resulting from HIV infection;

(b) "designated health authority" means an authority designated as such by a State Government under section 3;

(c) "HIV" means Human Immuno Deficiency Virus;

(d) "HIV infection" means the presence in the body of a person of HIV antibodies or antigens detected on the basis of test;

(e) "prescribed" means prescribed by rules made under this Act;

(f) "registered medical practitioner" means a medical practitioner who possesses any recognised medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956 and whose name has been entered in a State Medical Register;

(g) "surveillance centre" means a surveillance centre established under section 8;

(h) "test" means a serological procedure followed for detection of HIV antibodies or antigens in the body of a person.

CHAPTER II

APPOINTMENT OF DESIGNATED HEALTH AUTHORITIES

3. Appointment of designated health Authorities by State Governments

Every State Government shall, by notification in the Official Gazette, appoint such person or authority as it may deem fit as the designated health authority and define the local limits within which such authority shall exercise the powers and discharge the functions conferred or imposed on it by or under this Act.

4. Registered medical practitioner to give information

Every registered medical practitioner who, in the course of his practice becomes cognizant of the existence of any case of HIV infection in a person, a person suffering from AIDS or a drug addict in any private or public dwelling, hospital, nursing home or any other place, shall give information of such person in such form and manner as may be prescribed and with the least practicable delay to the designated health authority within whose local limits he is practising.

Explanation. — For the purposes of this section, "drug addict" means an addict within the meaning of the Narcotic Drugs and Psychotropic Substances Act, 1985.

5. Power of designated health authority to call for information, etc.

On the receipt of information under section 4 or from any other source, the designated health authority shall have the power to direct the person referred to in section 4 —

(a) to furnish such information as that authority may require from him for initiating action under section 7 and section 9;

(b) to submit himself for test;

(c) to remove himself forthwith to a hospital or other place for special care and medical treatment where the authority considers it necessary so to do in the interests of such person and also to prevent the spread of HIV infection.

Explanation. — For the purposes of this section "drug addict" means an addict within the meaning of the Narcotic Drugs and Psychotropic Substances Act, 1985.

6. Test of persons belonging to certain categories

The designated health authority may, having regard to, the kinds of persons frequenting, or living in, any area or areas within its local limits, who are exposed to greater risk of acquiring or transmitting HIV infection or, any other relevant consideration, provide facilities and make necessary arrangements for such persons to undergo test.

7. Steps to be taken by designated health authority

The designated health authority shall, on receipt of information under section 4 or from any other source, take steps to provide for —

(a) counselling by qualified and specially trained person; (b) health education; (c) specialised medical treatment; (d) periodical clinical and serological follow-up action; (e) social support including rehabilitation;

to the HIV infected persons and persons suffering from AIDS and also take such other precautionary steps to prevent the spread of HIV infection as it may deem necessary.

CHAPTER III

SURVEILLANCE AND REHABILITATION.

8. Establishment of Surveillance Centres

The Central Government, after consultation with a State Government, may, by notification in the Official Gazette, establish one or more surveillance centres in the State for the purposes of this Act.

9. Surveillance centres to conduct survey and to report cases of HIV infection to designated health authority.

(1) Every surveillance centre shall conduct clinical or laboratory tests or shall cause such tests to be conducted for the purposes of detecting, determining or monitoring the rate of HIV infection or for identifying the persons so infected amongst the general public or selected groups of persons.

(2) Where a person has been detected to be having HIV infection or as suffering from AIDS, the designated health authority may require the surveillance centre to take steps to trace the sources from which such person has acquired HIV infection and the sources through which he might have transmitted the infection to others.

CHAPTER IV

MISCELLANEOUS

10. Bar to donation of blood, organ, etc.

(1) No person who knows that he is infected with HIV or is suffering from AIDS shall donate his blood, any organ or semen to any blood bank, hospital, laboratory or any other institution.

(2) No professional blood donor shall give blood to any blood bank, hospital, laboratory or any other institution unless he has got his blood tested every time he gives blood for the presence of HIV antibodies in his blood and such test has proved that it is free from HIV antibodies.

Explanation. — For the purposes of this section, the expression "professional blood donor" means a person who gives his blood more than once within a period of three months and for monetary consideration.

11. Protection of action taken in good faith

No suit, prosecution or other legal proceeding shall lie against the designated health authority or any person for anything which is in good faith done or intended to be done under this Act.

12. Power to make rules

(1) The Central Government may, by notification in the Official Gazette, make rules for carrying out the provisions of this Act.

(2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely: —

(a) the form and manner in which particulars regarding the persons infected with HIV or persons suffering from AIDS or drug addicts may be sent to the designated health authority under section 4;

(b) the qualifications and experience of persons who may be appointed under section 7;

(c) the qualifications and experience of —

(i) doctors and nurses; and (ii) laboratory technicians and other technical personnel, associated with surveillance centres, hospitals or other places meant for the special care and treatment of persons infected with HIV or persons suffering from AIDS;

(d) the facilities and equipments required to be provided at a surveillance centre for the purposes of section 9;

(e) any other matter which is required to be, or may be, prescribed.

(3) Every rule made under this Act shall be laid, as soon as may be after it is made, before each House of Parliament, while it is in session, for a total period of thirty days which may be comprised in one session or in two or more successive sessions and if, before the expiry of the session immediately following the session or the successive sessions aforesaid, both Houses agree in making any

modification in the rule or both Houses agree that the rule should not be made, the rule shall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.

STATEMENT OF OBJECTS AND REASONS

Acquired Immuno Deficiency Syndrome more commonly known as AIDS; has of late assumed proportions of a major health hazard in several parts of the world. No vaccine is presently available for affording immunisation against the virus nor is it possible to cure the disease which invariably results in death. The World Health Organisation estimates that 5-10 million people have already been infected by HIV throughout the world.

2. In India, a surveillance programme on AIDS was initiated in 1985. Till 31st July 1989, 3.33 lakhs persons mainly belonging to "high risk groups" like sexually promiscuous men and women have been screened and 1,392 individuals were found to have HIV infection. The long incubation period (about 8 years) renders identification based on clinical symptoms alone inadequate at the initial stage of infection. Therefore, surveillance based on serology is necessary to prevent the spread of HIV, which causes AIDS.

3. Having regard to the potential of rapid spread of infection and the mode of its transmission, it is necessary to take effective measures to prevent the spread of HIV, by detecting persons infected, preventing transmission by them of infection to others and by providing counselling, health education, and social support to, and rehabilitation of, infected persons.

4. The Bill seeks, *inter alia* —

(a) to appoint designated health authorities to carry out the provisions of the Act, who will be authorised to demand information from infected persons, and provide health education, counselling, treatment, social support to, and rehabilitation of, infected persons;

(b) to require registered medical practitioners to report to the designated health authority cases of HIV infection, drug addicts, and AIDS to enable such authority to initiate preventive action;

(c) to provide for the establishment of surveillance centres after consultation with the State Governments for conducting surveys to detect the presence of HIV infection among high risk groups and the general population.

5. The Bill seeks to achieve the above objects.

Rafique Alam

Minister of State in the Ministry of Health and Family Welfare New Delhi.

The 14th August, 1989

FINANCIAL MEMORANDUM

Clause 5 of the Bill provides that the designated health authority shall have power to direct certain persons for test with respect to detecting HIV infection or AIDS.

2. In order to provide counselling facilities under clause 7, qualified and trained personnel will have to be appointed. On their salaries, etc., Rs. 100 lakhs of recurring expenditure is anticipated. Clause 7 further provides for health education, specialised medical treatment, periodical clinical and serological follow-up action and social support to and rehabilitation of HIV infected persons and persons suffering from AIDS. On all these matters an expenditure of Rs. 530 lakhs of non-recurring nature and Rs. 155 lakhs of recurring nature will be involved.

3. In order to provide test facilities and equipments to surveillance centres, under clause 9, an expenditure of Rs. 775 lakhs would be required, out of which Rs. 180 lakhs will be of the nature of non-recurring and Rs. 595 lakhs will be of recurring nature.

4. Apart from the above, no other expenditure of recurring or non-recurring nature from the Consolidated Fund of India is envisaged.

MEMORANDUM REGARDING DELEGATED LEGISLATION

Clause 12 of the Bill empowers the Central Government to make rules to provide for —

(a) the form and manner in which particulars regarding persons infected with HIV or persons suffering from AIDS may be sent to the designated health authority under clause 4;

(b) the facilities and equipments required to be provided at a surveillance centre for the purposes of clause 9;

(c) the qualifications and experience of —

(i) doctors and nurses; and

(ii) laboratory technicians and other technical personnel, associated with surveillance centres, hospitals or other places meant for the special care and treatment of persons infected with HIV or persons suffering from AIDS.

2. The matters in respect of which rules may be made are of administrative detail. The delegation of legislative power is, therefore, of a normal character.

Petition by the Bhartiya Patita Udhar Sabha (an association for the welfare of 'Prostitutes') versus the Union of India (August 1993) filed in the Supreme Court.

1. The petitioner organisation consists of about 28,00,000 member who are citizens of India and are entitled to seek protection of this Court under Article 32 of the Constitution (which enables a party to move the Supreme Court to address the infringement of a fundamental right) for the violation of their rights under article 14 (equality) and 21 (life and liberty) of the Constitution ...

2. The organisation was formed in 1984

3. The petition is seeking a direction from the Court to the government to take appropriate steps to prevent the spread of AIDS and to isolate AIDS victims from the rest of society and provide them treatment and livelihood.

4. The petition goes on to describe what is HIV/AIDS in accurate terms. Then it states that :

"Every body who is exposed to the risk of infection from people having multiple sexual partners, people having other STDs, prostitutes, people sharing needles, children born to infected mothers, and people exposed to unsterilised instruments, during tattooing, earpiercing, injections, etc. are at higher risk."

5. "According to Prof. Dwyer, as he said in his speech in the 2nd International Congress on AIDS in Asia and the Pacific, there are large numbers of HIV positive people in Asia. He described it as an invisible eqidemic. To quote him:

> "I have had politicians say to me - are you sure this whole HIV thing is not a ghost. Where are all these sick people"

He says it is hard for politicians, who tend to think from one election to the next, to realise the severity of the problem when there is an average nine year incubation period between infection and disease. They just don't realise what these horrendous figures of HIV positivity are going to mean in terms of planning of health care delivery. To quote him further:

> "One of the big things we have to tackle in Asia is to get people to realise that if we say there are 400,000 people infected in India, then in a few years time that is going to mean 400,000 sick people, very sick people. It will disrupt service, it will disrupt families, it will disrupt the community. You have to plan for it, but it is difficult."

6. The petition reproduces statistics in local newspapers regarding the number of AIDS cases that are expected by the end of 1993 which include 208 cases in Delhi. The petition also makes reference to another case pending in the Supreme Court :

"It is further submitted that as per another article reported in a magazine dated 28.5.93 'Madhur' there are 17 prostitutes in the Agra Home who are suffering from AIDS and two other prostitutes who were thus suffering from AIDS have already jumped bail. One of these prostitutes is stated to have said: 'the men have forced us into prostitution and have given us this disease, therefore after getting released on bail we will take revenge from these men by giving them the diseases of AIDS.' By an order dated 4.2.93 passed in W.P. No. 1900/81, this hon'ble court has already passed orders for the tracing of these prostitutes who are having AIDS and who have been released from the Home. By another order dated 9.1.92 passed in the same writ petition this hon'ble court has already passed orders for lodging separately the prostitutes having AIDS."

7. "It is submitted that inspite of the above awareness, the respondents (the government and respective ministries) have taken no steps to prevent the spread of AIDS. The respondents should have by now made some legislation and should have taken stringent steps to prevent spread of AIDS. AIDS should have been met with a strong hand, instead of a lukewarm approach from the respondents, who are primarily responsible in our country as the masses are illiterate, uneducated and unaware. The welfare state is, therefore, under a much higher obligation than their counterparts of the developed world. This is the time when the respondents have to live up to the expectation and the faith imposed in them by the people. The respondents would have by now made the testing for HIV mandatory before any blood is transfused. There should be stringent control of blood banks, screening of those donors and fixing of strict liability on the supplying services in the shape of imprisonment; fine or compensation for infection. Disposable instruments, particularly the instruments coming in contact with blood, semen, and vaginal fluid, should have been compulsorily introduced in the medical profession. Prostitution should have been legalised with stringent regulations and controls, as experience has shown that prostitution cannot be effectively banned. The respondents should have treated it as a ground reality. The educative programmes should have been introducted in the country at its war footing. But nothing has been done inspite of India being a welfare state."

8. The grounds on which the petition has been filed are as follows.

i. for the non-action of the respondents in taking any steps to avoid spread of AIDS, a deadly virus, which has shortened the life expectancy of the Indian residents including the members of the petitioner

association. It amounts to depriving of citizen's life except in accordance with procedure established by law and is arbitrary and unconstitutional and thus is hit by article 14 and 21 of the constitution.

ii. Under Article 47 ... the respondent's primary duty is to raise the level of nutrition and standard of living of its people to improve the public health. However, inspite of the said directive, the respondent are unconcerned about the above said deadly disease and have taken no positive steps to contain the impact of such an epidemic which has threatened the human race itself.

iii. (technical)

9. The petitioners have requested the Supreme Court to order the respondents

a. to take the blood test for AIDS/HIV virus of each and every resident of India as well as those entering India and

b. isolate the persons found to be suffering from HIV and arrange for their treatment and livelihood.

10. The petitioners have also asked to court to pass interim orders directing the respondents to take the blood test for the HIV/AIDS virus from "high risk groups" e.g., prostitutes, professional blood donors, drug addicts; and pass appropriate directions directing the respondent to take care that disposable instruments are used in all medical institutions, which come in contact with the blood, semen and vaginal fluids and ensure that such instruments are safely disposed off after use.

(v) Should be removed to a hospital or other place at which patients suffering from such disease are received for treatment, the Health Officer may remove such person or cause him to be removed to such hospital or place.

(vi) No person including a foreigner shall refuse collection of blood for investigation of Acquired Immuno Deficiency Syndrome or any other communicable infectious diseases if the Health Officer has reasonable ground to expect that such person is suffering from Acquired Immuno Deficiency Syndrome or other infectious disease as defined under the Act;

(vii) In the case of a person who is found to be positive for Acquired Immuno Deficiency Syndrome by serological test, the Government may isolate such person for such period and on such conditions as may be considered necessary and in such Institution or ward there of as may be prescribed.

(viii) All such persons admitted in prescribed wards/hospitals shall be provided with materials, equipment, etc., which shall not be used for any other purpose;

(ix) The parenteral medication of the patents suffering from Acquired Immuno Deficiency Syndrome shall be given through disposable sets/ syringes;

(x) The linen, mattresses, etc., used for the deceased patients who were suffering from Acquired Immuno Deficiency Syndrome shall be immediately destroyed by burning;

(xi) All the staff working for the management of the patient suffering from Acquired Immuno Deficiency Syndrome shall be effectively protected with long rubber gloves, sterilized linen and mask;

(xii) Persons handling the dead bodies of patients who were suffering from Acquired Immuno Deficiency Syndrome shall be instructed to ensure that they do not come into contact with any secretions such as saliva, etc.;

(xiii) The dead body of patient who was suffering from Acquired Immuno Deficiency Syndrome shall be enclosed in a polythene bag and tied with knots at both the ends and sealed before further action for its cremation/burial or despatch abroad as the case may be;

(xiv) No transplant operation of any kind shall be performed unless the donor as well as the receptor is confirmed to be free from Acquired Immuno Deficiency Syndrome through serological investigation;

Provided that in the case of emergency, where blood transfusion is deemed necessary without waiting for the report of ELISA test, written consent of the patient or guardian or relative shall be obtained before such blood transfusion."

5. Mr. Anand Grover, the learned counsel for the petitioners, has raised the following four contentions before us :

(a) provision for isolation is based on wrong scientific material and foundation;
(b) object sought to be achieved from isolation is nullified by provision,
(c) discretion to isolate is unguided and uncontrolled; and
(d) the provision for isolation is procedurally unjust in the absence of the right of hearing.

6. We will take up for consideration points (a) and (b) simultaneously, since they are intertwined. Human Immunodeficiency Virus (HIV) destroys the body's immune system. AIDS is a disease caused by HIV. Some persons affected by HIV may be lucky enough not to suffer from AIDS but that is rare. People with AIDS cannot fight out usual body infections and they usually die. Science, with all its progress, yet does not know the origin of the HIV. At one stage, mystery shrouded the transmission routes of HIV. Present thinking is that HIV is transmitted mainly through (1) sexual contact with an affected person, (2) sharing contaminated needles or syringes, (3) transfusion of infected blood or blood products, (4) contact with body fluids such as tears, saliva, semen, urine, faeces, breastmilk, etc., and (5) infected mother during pregnancy or delivery. The disease is spreading fast and threatening human life despite all efforts at international level. No safe, effective and affordable treatment for the disease is yet found out. AIDS has invaded the human race in a big and rapid way, but there does not appear any chance of its rapid receding. Its impact on human society, economic, social, political, cultural, is increasing. With such devastating effects, no wonder there is a great fear about the disease and inevitably also some degree of prejudice in the society. Research into the causes and cure of the disease is going on and is still incomplete. From time to time, varying and sometimes even conflicting expert reports are published by various organisations including World Health Organisation (WHO). It appears that AIDS still continues to be a subject upon which much remains to be said.

7. Note that there has been no breakthrough at all in the field of prevention and/or cure. There is virtual unanimity among experts that education and counselling of the patient is the most important and effective weapon to be used in the war against AIDS. The basic question is whether isolation of patient under any circumstance is wholly unscientific or counter-productive.

8. Isolation undoubtedly, has several serious consequences. It is an invasion upon the liberty of a person. It can affect a person very adversely in many matters including economic. It can also lead to social ostracisation. But in matters like this individual rights have to be balanced against the public interest. In fact, liberty of an individual and public health are not opposed to each other, but are well in accord. Even if there is a conflict between the right of an individual and public interest, the former must yield to the latter. That apart, isolation is not merely in the interest of society. In a given case, it may also be in the interest of an AIDS patient because he may become desperate, and lose all hopes of survival and therefore has to be saved against himself. Perhaps, bearing in mind all these factors, the experts have considered isolation as one of the preventive measures.

9. In this connection, we extract the following lines from the publication issued by Brown University, "Managing AIDS Patients: The Health Care Professsional's Survival Guide".

"Isolation precautions should be used, however, when AIDS associated conditions such as infectious diarrhoea or tuberculosis are diagnosed or suspected".

Government of India's National Institute of Communicable Diseases, in its publication of July 1986, has also suggested surveillance of certain groups as a preventive measure.

10. Isolation can sometimes be counterproductive, since the patient may go underground, or may not disclose the ailment. Science, and not discrimination, is the ideal way of dealing with the situation, but the 'ideal' is not always 'practical' in life. When such a high risk to the public health exists, erring on the safer side may be permissible. It is pertinent to notice that there is a division of opinion as to whether body fluids such as tears, saliva, semen, faeces, breastmilk, etc., can also be the transmission route of the virus. What is considered definite today may not be so considered tomorrow.

11. It has always to be remembered that matters like this essentially fall in the realm of policy. This policy decision is taken by those who are in charge of advancing public health and who are equipped with the requisite know-how. We find ourselves too ill-equipped to doubt the correctness of Legislative wisdom. Even if there is any doubt about its correctness, its benefit must go in favour of the policy-maker. We are quite conscious that courts are not powerless to examine the correctness of a policy decision. But such power has to be very cautiously exercised, field of exercise being very limited. Settled legal principle is that there is a presumption that the Legislature understands and appreciates the needs of its people. Good faith and knowledge of the

existing conditions has also to be presumed in its favour. There is no weighty evidence - either intrinsic or extrinsic - on the basis of which the above presumption or the presumption of constitutionality of a statute is rebutted.

12. It appears that the State of Goa is the only State which has made a provision like this. This circumstance was sought to be used in support of the contention about the provision being unusual, unreasonable and unscientific. Validity of an enactment cannot be measured by such yardsticks, as rightly submitted by the learned Advocate General. AIDS is many times considered as a foreign invasion. Goa is a well known international tourist spot and is considered to be a high risk for AIDS even in a Government of India publication. If, in the background, the State was obliged to take a lead in the matter, there is nothing surprising or objectionable. We are informed that in the Rajya Sabha, a Bill No XX of 1989 styled as "The Acquired Immuno Deficiency Syndrome (AIDS) Prevention Bill, 1989" has been recently introduced. Section 5 of that Bill provides for removal of a person to a hospital or other place for special care or treatment where the authority considers it necessary to do so in the interests of such person and also to prevent the spread of HIV infection. Section 7 provides for precautionary steps to be taken by the designated authority to prevent the spread of HIV infection.

13. The enormity of the problem can be gauged from the figures of AIDS affected persons given in various publications presented before us and readily relied upon by both parties.

1987 5 to 10 million
1991 50 to 100 million

This demonstrates that present preventive measures have failed to prevent the spread of the disease and there is a necessity to explore fresh areas. It has to be remembered that one of the Directive Principles of State Policy specifies improvement of public health as the primary duty of the State (Article 47).

14. In this background, we find it difficult to accept the submission that there is no scientific basis whatsoever for considering isolation as one of the proper measures for prevention of AIDS or that the object sought to be achieved by isolation is nullified by the impugned provisions of Section 53 (i) (viii).

16. Now, point (c): The Law of this point is also well settled and it is this: In case the legislature lays down a definite policy which inspired it and delegation is in favour of the High authority, such a delegation cannot be said to be uncontrolled or unguided. The legislative policy of Section 53 (i) (vii) of the Act is absolutely clear. It is to prevent the spread of AIDS in public interest. The authority to take a decision in the matter of isolation vests in the highest authority, viz., the State Government itself. Moreover, the State Government

has formulated a policy for its own guidance which is as under :

(i) Foreign national, if found to be HIV-positive, should be isolated at the AIDS Centre, Mapuse, and therefore deported to his parent country;

(ii) In case of any Indian National, if he is from outside this State and found HIV positive, his parent State is to be informed and he should be allowed back to his State or to his place of residence of work.

(iii) In case of a Goan or a local resident of Goa State, he may not be interned, instead he should be allowed to go to his place of work or residence on the condition that he visits the nearest Primary Health Centre for follow-up at least once a month or for taking treatment, if any. A special card be given to the AIDS/H.I.V. person. A laminated card with photo be issued to him, so also a photo of the person be kept for our record.

(iv) In case he fails to report to the Primary Health Centre or nearest Health Care centre, he is liable to be isolated.

17. The possibility of misuse of discretionary power cannot be ruled out for there is no power on earth which is incapable of being misused. But existence of such possibility is not ground for invalidating the source of the power. In case of misuse, the administrative action can be struck down. Discretionary power is not necessarily discriminatory in such cases as held in the leading case of Ram Krishna Dalmia V. Justice Tendulkar, AIR 1958 SC 538, and a host of other cases. We, therefore find no substance in this point.

20. For all these reasons, we repeal the four-pronged attack on the validity of Section 13 (1) (vii) of the Act and hold that the provisions are reasonable and valid substance as well as procedure-wise and are not violative of either Article 14 or Article 19(1)(d) or Article 21.

21. The validity of Section 53 (1) (vii) - as it stood originally - has been questioned before us only by way of abundant precaution because in case the amended provisions are struck down as ultra vires, the original more stringent provision may revive in the absence of such challenge. It is the accepted position before us that the petitioners were isolated before the 1989 amendment and have been released from the isolation wards long before (Under the 1989 amendment, the word "shall" in the provision was replaced with "may").

Petitions dismissed.

III. STATUTE

A Goa Public Health Act (1987 amended) :

* authorities were mandatorily required to isolate a person found to be positive to the serological tests - s. 53 (1) cl. (vii)

* HIV patient shall be provided with materials, equipment etc. which will not be used by any other persons - cl. (viii) thus treating it as a contagious disease.

* linen, mattresses used by deceased AIDS patients shall be destroyed by burning - cl. (x)

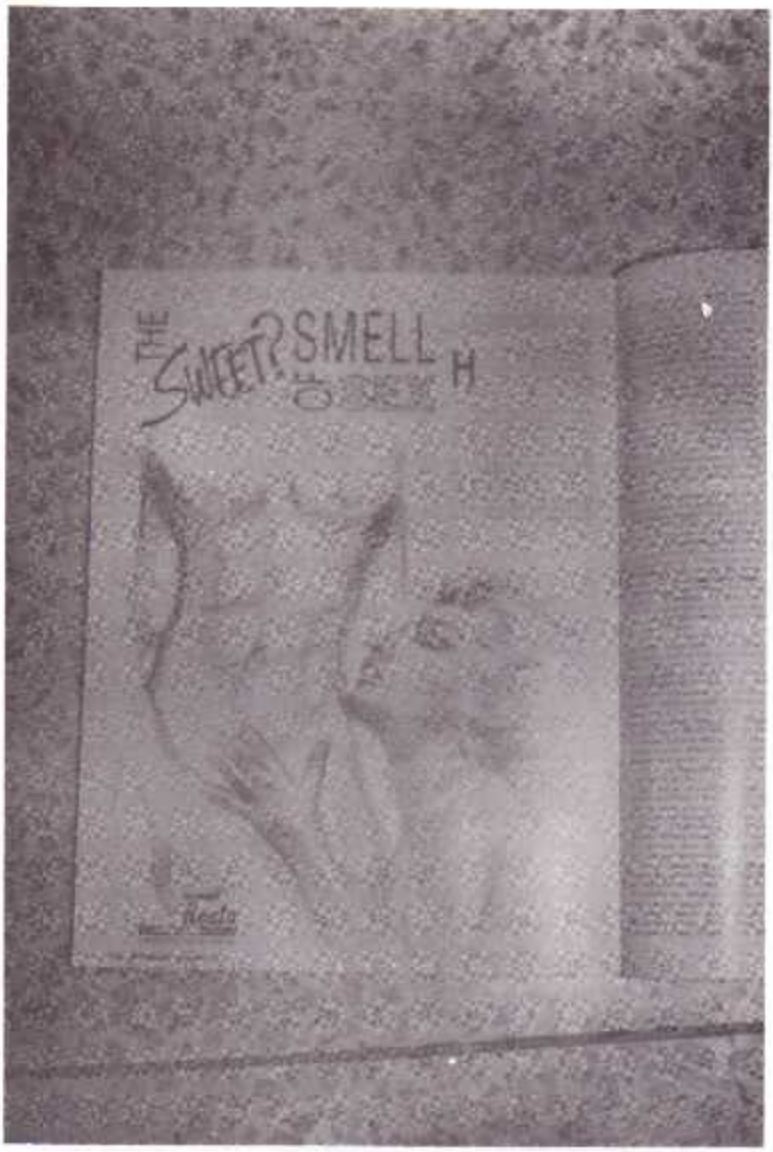
* persons handling dead body of AIDS patients shall ensure that they do not come into contact with secretions such as saliva - cl. (xii)

एक थी रानी एक थी रज़िया
दोनों चाल में रहते थे
है यह कहानी बिल्कुल सच्ची
हम सारे यह कहते है । एक थी रानी एक थी रज़िया
रानीबाई दिनभर काम करके
अपनी बेटियों को पालती थी
लेकिन उसका भाई भी ऐसा
बैठा बैठा खाता था
एक दिन उसने बात करी कि
मुझको बेटा ही चाहिए
पर रानी बाई ने बोला
बेटियाँ मेरी ताकत है-2
मेरे काम में हाथ बटायें
अब न बेटे की आस मुझे है।

शाम को रज़िया मिली अचानक
अपनी परेशानी लेके
जब मैं पार्लर से वापस आई
रफ़ीक घर में बैठा था
मुझे देखकर झट से बोला
चल आ जा झट से बिस्तर में
सुबह शाम की यही कहानी
मैं किसको समझाऊंगी
बुरी बीमारी का डर है मुझे
मेरी बात न सुने कोई
अब मेरी क्या हालत होगी
रफ़ीक को मैं कैसे समझाऊं-2
फिर रानी ने बोला उसको
मेरी कहानी न अलग है कुछ
मर्द भी मेरा पीछे मेरे
बेटा-बेटा रट लगाये-2

एक थी रानी एक थी रज़िया

एक दिन रज़िया को पता चला यह
रफ़ीक वेश्या के पास जाता है
फिर दोनों मिल के चली
नारी मंच की मीटिंग में-2
सीताबाई भी वहीं मिली
जो खुद एक नाकारी औरत थी-2
रज़िया ने पकड़ा सीता को
बोला तू है जिम्मेदार मेरे घर को जलाया है तूने
सीता ने बोला उसको
मुझे आपसे कहना है कुछ
फिर रानी बाहर गई बोली बुरी बीमारी तेरे कारण
सीता ने बोला उसको
तुम भी औरत मैं भी औरत
क्यों आपस में इल्ज़ाम लगाये
मर्दों का ये खेल है सारा-3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AIDS IN INDIA
NEWSLETTER OF THE NATIONAL AIDS CONTROL ORGANIZATION

Editorial *September 1993*

ENSURING PREVENTION : INFECTION CONTROL IN HEALTH CARE SETTINGS INCLUDING BLOOD SAFETY

Emergence of the AIDS epidemic has necessitated quick responses from almost all sections of society. Here was a disease which made silent inroads in our socio-economic structure, and when overt and manifest, resulted in irrational fear and prejudice. This fear has been most often encountered among health care providers as they routinely handle blood and body fluids through which HIV can be transmitted.

One distinctive factor in this disease is that it has no cure or vaccine yet — individual and community responses being based entirely on prevention. Prevention, in fact, is the cornerstone of control of this pandemic. This issue of the newsletter focuses on areas where prevention can be ensured especially in health care settings wherein the earliest effects of the infection occur. By dealing, however, with prevention strategies in health care settings, it is not our intention to minimise the importance of such efforts in other undoubtedly more important fields.

Hospital infection control measures have been targetted for improvement since the beginning of the epidemic. The fear of accidental infection from the Human immuno-deficiency virus (HIV) invariably influences the behaviour of health care workers towards their patients. It is also essential that the patient feels confident that he will not acquire HIV infection from the health care facility. Towards this end, we have made substantial efforts in training, strict enforcement of antisepsis and asepsis and adoption of universal precautions in infection control.

It has been noticed the world over that the attitudes of health care workers influence the adoption of practices that ensure infection control. Re-orientation and training to change attitudes and acquire skills resulting in an improved work culture of health care workers have been taken up on a countrywide scale. We believe that this will make health care settings safer for both health providers and their beneficiaries.

One of the earliest concerns in the health sector was the possibility of blood borne transmission of HIV through blood and blood products. An extensive network of HIV testing facilities have been created throughout the country so that every unit of blood that is transfused is HIV free. This issue of the newsletter is dedicated to highlighting the steps that have been taken to minimise transmission of HIV in health care settings in this country.

— Dr. Shiv Lal

HOSPITAL INFECTION CONTROL AND HIV PREVENTION

By Dr. Prema Ramachandran

Fear of accidental infection with the HIV does exist in all segments of society including patients attending hospitals and health care personnel; this fear influences their behaviour towards individuals known to be infected with HIV. The fact that infection control measures in many hospitals are suboptimal, and hence accidental infection from patient to patient, patient to health care provider and health care provider to patient could occur, has been the major factor responsible for the apprehensions expressed about admission of AIDS patients in hospitals.

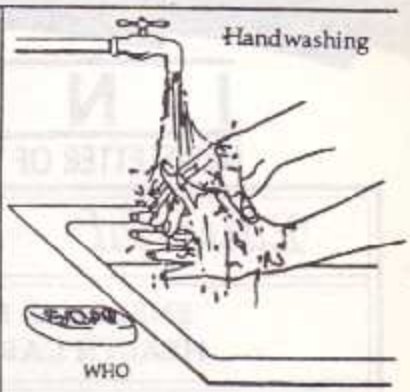
Several questions, often not verbalised, worry the public and policy makers in the context of the HIV epidemic and current efforts to strengthen infection control measures in health care systems. It is essential that these are discussed openly and clarifications provided so that all segments of the population cooperate in infection control measures.

CONTENTS

Why is there a need to strengthen infection control now?

For thousands of years prior to the development and widespread use of antibiotics, health care providers have been treating patients suffering a wide variety of infections. Many of these infections had very high fatality rates.

Before the advent of antibiotics, the problem of accidental transmission from asymptomatic individuals to health care personnel while providing health care has been faced by the latter while treating syphillis. In the pre-antibiotic era, infection control measures received adequate attention: cleanliness, disinfection and antisepsis were the hallmark of any hospital ward. With the advent of antibiotics, the fear of infections faded and the time, effort and mony spent on infection control in health care services dwindled. The rising incidence of hospital acquired infections (HAI) and Hepatitis B infection among the health care providers sounded the warning bell on the need to tighten infection control measures. The advent of HIV infection provides yet another warning and an opportunity to correct the existing lacunae, so that hospitals



can once again become free from the risk of accidental Hospital Acquired Infections (HAI).

What is the magnitude of the problem of HAI in HIV infection?

The magnitude of HAI in the HIV epidemic depends on two factors : the magnitude of HIV infection in India and the risk of accidental infection in the health care set up.

Magnitude of HIV infection in India

Based on the estimate that one to two million people were infected by HIV in India in 1992, the prevalence of HIV infection is quite low, about 1-2 per thousand population. Almost all the infected persons are in the asymptomatic phase and are not aware that they are infected. There are an estimated 10 to 20,000 AIDS patients in India. In most major medical college hospitals, the outpatient load varies between 1000-2000 per day. It is likely that every day, one or more asymptomatic person living with HIV is being treated in these hospitals. Even in the smaller district hospitals with the outpatient load of two to three hundred every day,

ANNEXURE K
WHO/GPA/DIR/91.9
ORIGINAL: English
DISTR.: Limited

A·I·D·S and HIV Infection

Information for United Nations Employees and their Families

World Health Organization
Geneva, 1991

ANNEXURE M

WHO/GPA/INF/92.1
Original: English
Distr.: General

GLOBAL PROGRAMME ON AIDS

CONSENSUS STATEMENT FROM THE WHO/UNICEF CONSULTATION ON HIV TRANSMISSION AND BREAST-FEEDING

GENEVA
30 APRIL – 1 MAY 1992

WORLD HEALTH ORGANIZATION

Consensus statement from the WHO/UNICEF consultation on HIV transmission and breast-feeding

In view of the importance of breast milk and breast-feeding for the health of infants and young children, the increasing prevalence of human immunodeficiency virus (HIV) infection around the world, and recent data concerning HIV transmission through breast milk, a Consultation on HIV Transmission and Breast-feeding was held by WHO and UNICEF from 30 April to 1 May 1992. Its purpose was to review currently available information on the risk of HIV transmission through breast milk and to make recommendations on breast-feeding.

Based on the various studies conducted to date, roughly one-third of the babies born worldwide to HIV-infected women become infected themselves, with this rate varying widely in different populations. Much of this mother-to-infant transmission occurs during pregnancy and delivery, and recent data confirm that some occurs through breast feeding. However, the large majority of babies breast-fed by HIV-infected mothers do not become infected through breast milk. Recent evidence suggests that the risk of HIV transmission through breast-feeding (a) is substantial among women who become infected during the breast-feeding period, and (b) is lower among women already infected at the time of delivery. However, further research is needed to quantify the risk of HIV transmission through breast-feeding and determine the associated risk factors in both of these circumstances.

Studies continue to show that breast-feeding saves lives. It provides impressive nutritional, immunological, psychosocial and child-spacing benefits. Breast-feeding helps protect children from dying of diarrhoeal diseases, pneumonia and other infections. For example, artificial or inappropriate feeding is a major contributing factor in the 1.5 million annual infant deaths from diarrhoeal diseases. Moreover, breast-feeding can prolong the interval between births and thus make a further contribution to child survival, as well as enhancing maternal health.

It is therefore important that the baby's risk of HIV infection through breast-feeding be weighed against its risk of dying of other causes if it is denied breast-feeding. In each country, specific guidelines should be developed to facilitate the assessment of the circumstances of the individual woman.

Recommendations

1. In all populations, irrespective of HIV infection rates, breast-feeding should continue to be protected, promoted and supported.

2. Where the primary causes of infant deaths are infectious diseases and malnutrition, infants who are not breast-fed run a particularly high risk of dying from these conditions. In these settings, breast-feeding should remain the standard advice to pregnant women, including those who are known to be HIV-infected, because their baby's risk of becoming infected through breast milk is likely to be lower than its risk of dying of other causes if deprived of breast-feeding. The higher a baby's risk of dying during infancy, the more protective breast-feeding is and the more important it is that the mother be advised to breast-feed. Women living in these settings whose particular circumstances would make alternative feeding an appropriate option might wish to know their HIV status to help guide their decision about breast-feeding. In such cases, voluntary and confidential HIV

testing accompanied in all cases by pre- and post-test counselling could be made available where feasible and affordable.

3. In settings where infectious diseases are not the primary causes of death during infancy, pregnant women known to be infected with HIV should be advised not to breast-feed but to use a safe feeding alternative for their babies. Women whose infection status is unknown should be advised to breast-feed. In these settings, where feasible and affordable, voluntary and confidential HIV testing should be made available to women along with pre- and post-test counselling, and they should be advised to seek such testing before delivery.

4. When a baby is to be artificially fed, the choice of substitute feeding method and product should not be influenced by commercial pressures. Companies are called on to respect this principle in keeping with the International Code of Marketing of Breast-milk Substitutes and all relevant World Health Assembly resolutions. It is essential that all countries give effect to the principles and aim of the International Code. If donor milk is to be used, it must first be pasteurized and, where possible, donors should be tested for HIV. When wet-nursing is the chosen alternative, care should be taken to select a wet-nurse who is at low risk of HIV infection and, where possible, known to be HIV-negative.

5. HIV-infected women and men have broad concerns, including maintaining their own health and well-being, managing their economic affairs, and making future provision for their children, and therefore require counselling and guidance on a number of important issues. Specific issues to be covered by counselling include infant feeding practices, the risk of HIV transmission to the offspring if the woman becomes pregnant, and the transmission risk from or to others through sexual intercourse or blood. All HIV-infected adults who wish to avoid childbearing should have ready access to family planning information and services.

6. In all countries, the first and overriding priority in preventing HIV transmission from mother to infant is to prevent women of childbearing age from becoming infected with HIV in the first place. Priority activities are (a) educating both women and men about how to avoid HIV infection for their own sake and that of their future children; (b) ensuring their ready access to condoms; (c) providing prevention and appropriate care for sexually transmitted diseases, which increase the risk of HIV transmission; and (d) otherwise supporting women in their efforts to remain uninfected.

Invited participants

Dr Khawaja Abbas, The Children's Hospital, Islamabad Hospital, Islamabad, Pakistan

Dr Deanna Ashley, Ministry of Health, Kingston, Jamaica*

Dr Stéphane Blanche, Paediatrics Department, Necker Sick Children United Hospitals, France*

Dr Wirapong Chatranon, Department of Paediatrics, Siriraj Hospital, Bangkok, Thailand

Dr David Dunn, Department of Paediatric Epidemiology, Institute of Child Health, London, United Kingdom

Mrs Margaret Wambui Gatei, National AIDS Program, Ministry of Health, Nairobi, Kenya

Dr Carlo Giaquinto, Paediatrics Department, University of Padua, Padua, Italy

Dr Jessica Jitta, Department of Paediatrics, Mulago Hospital, Kampala, Uganda

Ms Teresa Kaijange, WAMATA, Dar es Salaam, United Republic of Tanzania

Dr Maureen Law, International Development Research Centre, Ottawa, Canada

Dr Jaime Murahovsky, Breast-feeding Training Centre, Guilherme Alvaro Hospital, Santos, Brazil

Dr Audrey Naylor, WELLSTART, San Diego, California, United States of America

Dr Margaret Oxtoby, Division of HIV/AIDS, Centers for Disease Control, Atlanta, Georgia, United States of America

Ms Gabrielle Palmer, Cambridge, United Kingdom

Dr Jean Claude Pape, National Laboratory and Research Institute, Port-au-Prince, Haiti*

Dr Catherine Peckham, Department of Paediatric Epidemiology, Institute of Child Health, London, United Kingdom

Dr Philippe Van de Perre, AIDS Reference Laboratory, National AIDS Control Program, Kigali, Rwanda

Dr Cesar Victora, Epidemiological Research Group, Department of Social Medicine, Federal University of Pelotas, Pelotas, Brazil

Dr Mamdouh Shaaban, Department of Obstetrics and Gynaecology, Faculty of Medicine, Assiut University, Assiut, Egypt*

Dr David Skegg, Department of Preventive and Social Medicine, University of Otago, Dunedin, New Zealand*

Ms Eka Williams, Department of Biology, University of Calabar, Calabar, Nigeria*

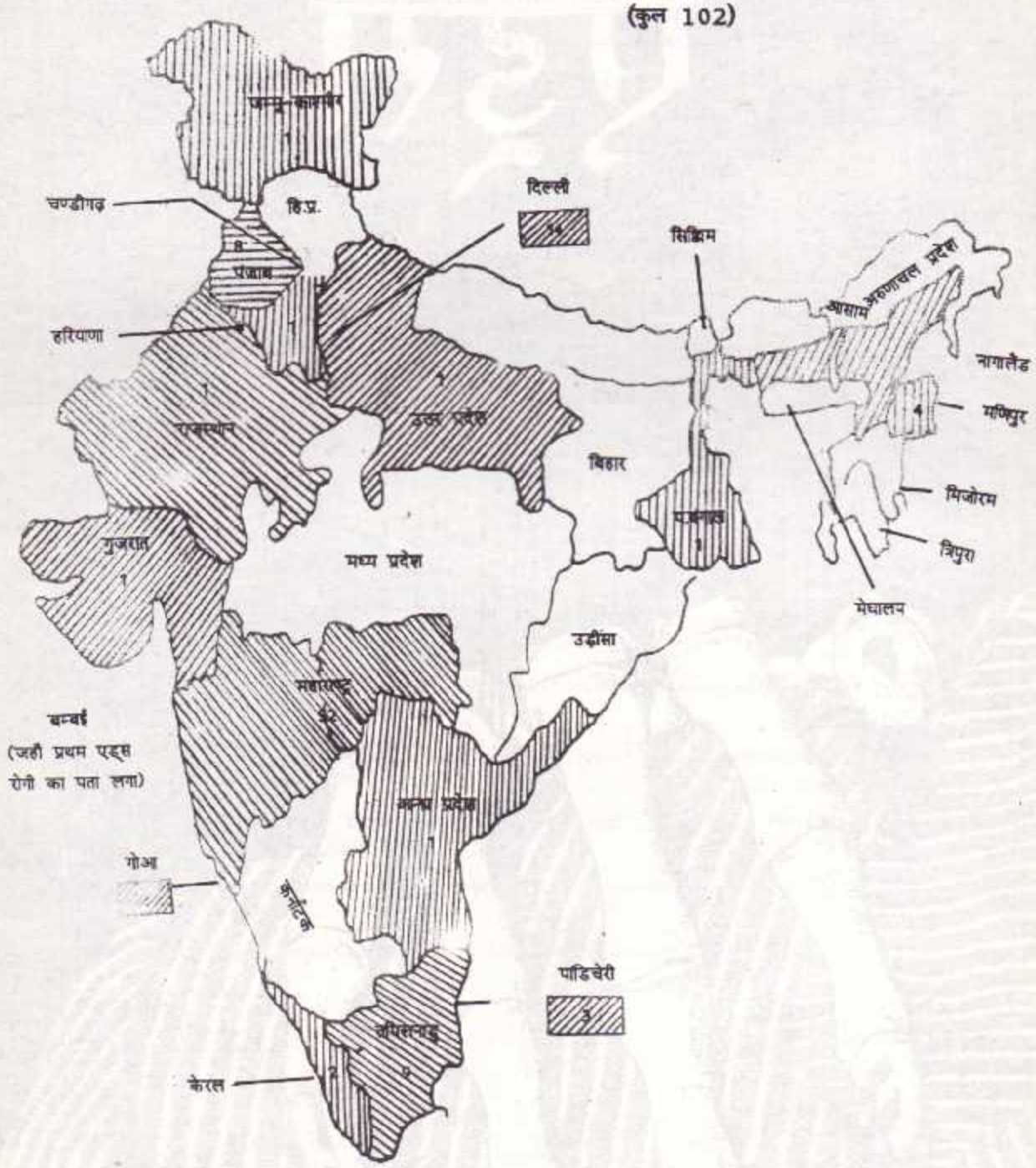
* unable to attend

ANNEXURE N

एड्स

एड्स रोगियों का वितरण (दिसम्बर 1, 1991 तक)

(कुल 102)



एड्स

एक चुनौती

निदेशालय, चिकित्सा, स्वास्थ्य एवं परिवार कल्याण सेवाऐं

जयपुर 302 005

AIDS

THE DEADLY HIV

Directorate of Health Services, Assam Ghy-6

printed by M/S Contemporary Commercial, Ghy-7

এইডছ

AIDS

(Acquired Immuno-Deficiency Syndrome)

WHAT IS AIDS:

AIDS is a disease caused by virus when the cansative organism enters to the body. It breaks down the defence machanism by destroying the T cells of the special glands of the body and there by there will be less amount of Antibody in the circulation. The less amount of antibody will cause less power to the body to fight with other orgonisms resulting to diseases.) The defence system making the body almost defenceless. Due to such condition the body becomes vulnerable to a variety of infections which are always lacking in and around the body.

HIV is caused by virus infeeting the key-cells, which produce the WBC. All HIV cases are not AIDS and HIV positive cases may produce AIDS after a gap of 10 Yrs. We must to precaution not have infection of HIV and there by we can prevent AIDS.

EARLY SIGNS AND SYMPTOMS

(i) Significant and unexplained weight loss.
(ii) Intermittent fever.

iii) Swollen glands.
iv) Persistent watery diarrhoea.
v) Night sweating, body ache, etc.
vi) White patches or ulceration in the mouth or food pipe.

Besides these signs and symptoms, the patient may suffer from lung infections and infections of central nervous system. However, having any of the above signs and symptoms does not necessrily confirm the diagnosis of AIDS. These symptoms may occur in other diseases as well. Diagnosis is to be confirmed by

ransmission.

AIDS is usually transmitted through intimate exual contact and not casual contact. The arious methods of transmission are:

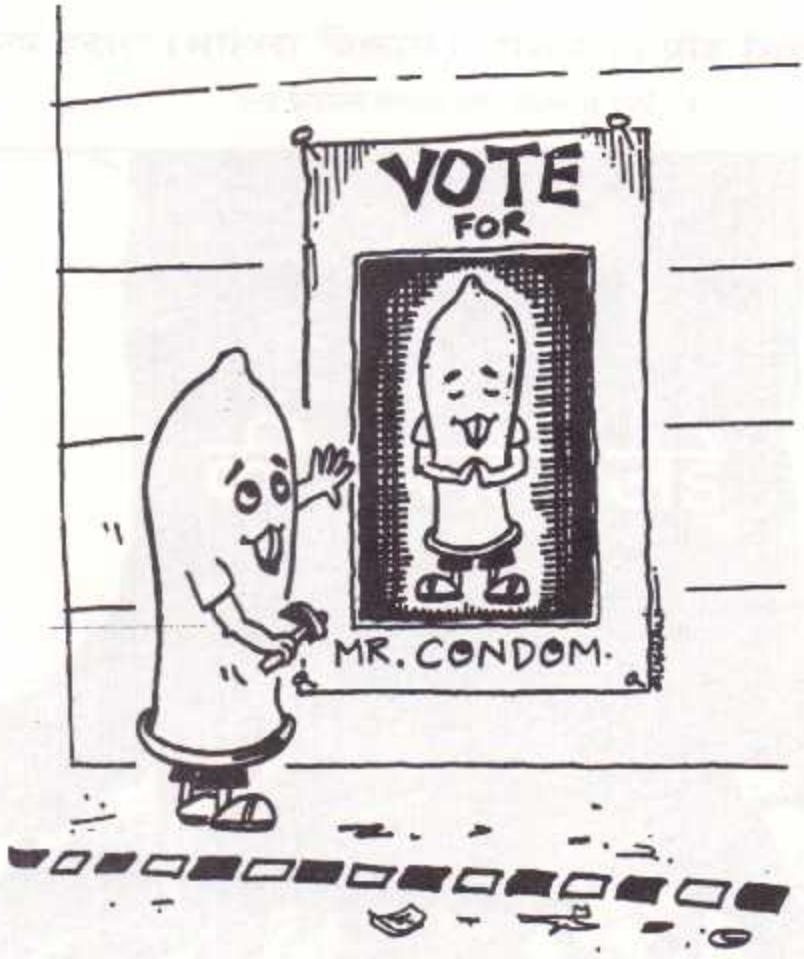
i) Sexual contact.
ii) Sharing contaminated needles and syringes.
iii) Infected blood transmission.
iv) Transmission from infected mother to child before, during or shortly after birth.

PLEASE REMEMBER

—There is no treatment available for AIDS a yet.
—If one gets the disease, it is always fatal.
—There is no vaccine to prevent the disease
—It is difficult to diagnose.
—Its symptoms take a very long time to appear after contracting the infection (6 months to 5 years).
—AIDS patients are prone to get other diseases like pneumonia, cancer etc.
—Whenever in doubt, consult a medical doctor for advice on prevention and diagnosis.

ANNEXURE P

MR. CONDOM



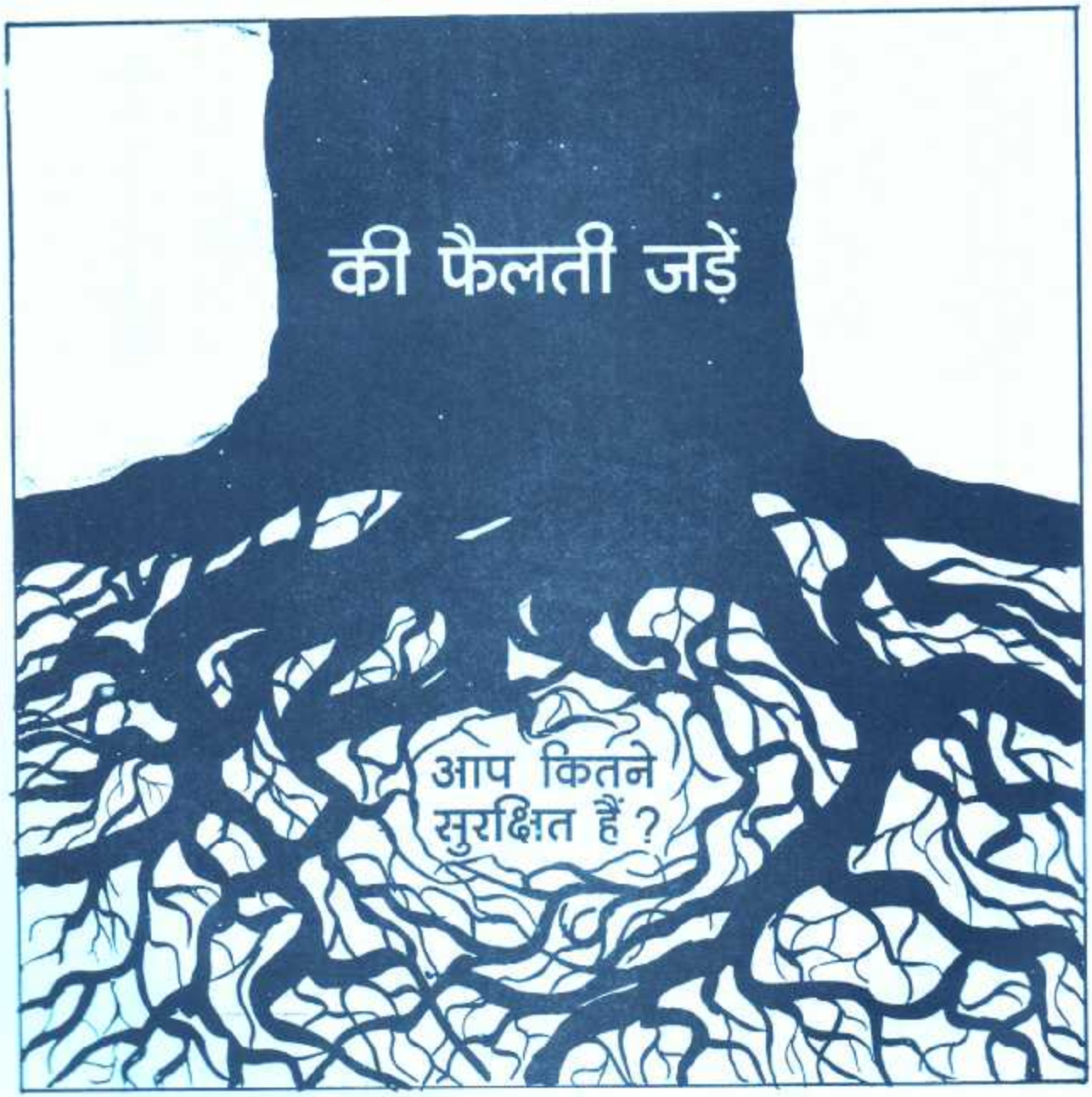
A Joint Venture Between
Heart Care Foundation of India
&
Govt. of NCT of Delhi

ANNEXURE Q

साथिन रो कागद

राज्य इदारा (महिला विकास), राजस्थान प्रौढ़ शिक्षण समिति

7-ए झालाना संस्थान क्षेत्र, जयपुर • मार्च, '93



ANNEXURE R

एड्स खतरे की घण्टी

सामाजिक ढाँचा

यह एक दुखदायी लेकिन तथ्यात्मक पहलू है कि इन परिस्थितियों मे सामाजिक ढाँचा भी उत्पीड़ित महिला के विरोध मे ही खड़ा दिखाई देता है। घटना चाहे दहेज प्रताड़ना, गृह कलह, अपहरण, बलात्कार या असामाजिक तत्त्वो द्वारा किये गये अत्याचार आदि किसी से भी सम्बन्धित हो, हमारा तथाकथित समाज दुर्घटना की शिकार महिला के विरोध मे ही बोलता दिखाई देगा। ऐसे मे उस बेसहारा नारी को एक ही आसरा वेश्यावृत्ति का यह अड्डा दिखाई देता है, जहाँ उसे किसी बदनामी का भय नही रहता।

वेश्यावृत्ति पर सर्वेक्षण

ग्राम भारती समिति ने एड्स शिक्षण परियोजना के प्रथम चरण मे वेश्यावृत्ति पर सर्वेक्षण का कार्य हाथ मे लिया है, जो एड्स संक्रमण का सबसे बड़ा और मुख्य कारण माना जा रहा है। समस्या के वास्तविक स्वरूप की जानकारी के लिए यह आवश्यक है कि तथ्यो के आईने मे उसे देखा जाये। इसके लिए सर्वेक्षण आवश्यक है।

व्यापकता

अभी इतनी जानकारी उपलब्ध है कि राजस्थान के 10 जिलो के 150 गाँव वेश्यावृत्ति से प्रभावित है। क्षेत्र मे जाने से सम्भवतः और भी गाँव इस सूची मे जुड़ जाये

एड्स खतरे की घण्टी

तथा जितनी सख्या मे महिलाओं के इस पेशे मे सलग्न होने की जानकारी है, शायद उससे और बढ़ोत्तरी हो जाए। इसलिए सर्वेक्षण का सही पैमाना क्षेत्र मे जाने से ही बन पायेगा।

रोग की जानकारी

जैसा कि ऊपर इस बारे मे चर्चा की जा चुकी है, किसी व्यक्ति के एड्स का रोगी होने की पुष्टि तत्काल व आसानी से नही की जा सकती। लेबोरेटरी मे रक्त परीक्षण (ELISA TEST) के बाद ही निश्चित रूप से यह कहा जा सकता है कि यह व्यक्ति एड्स से प्रभावित है।

सावधानी व सतर्कता

अभी तक दुनिया मे न तो एड्स का कोई प्रतिरोधात्मक टीका तैयार किया जा सका है और न इसका कोई इलाज है। इसलिए एकमात्र उपाय सावधानी और सतर्कता ही है, जिसके द्वारा एड्स से बचा जा सकता है। और इसके लिए निम्न बातो पर ध्यान देना आवश्यक है—

- अपरिचित स्त्री-पुरुष के साथ यौन सम्बन्ध स्थापित करने से बचे।
- किसी भी प्रकार के सम्भोग के लिए निरोध (कण्डोम) का उपयोग किया जाये।
- अनजान व्यक्ति का रक्त अन्य व्यक्ति को नही चढ़ाया जाये।

एड्स खतरे की घण्टी

- घातक मादक द्रव्यो के लिए प्रयोग की गई दूषित सुई का प्रयोग अन्य व्यक्ति न करे।

शिक्षण और प्रशिक्षण

एड्स से बचाव की दृष्टि से जो सावधानियाँ अपेक्षित है, उनमे जन-साधारण, वेश्यावृत्ति के धन्धे मे लिप्त महिलाओं, पेशेवर रक्तदाताओं तथा नशीली दवाओं के सेवन के आदी व्यक्तियों का शिक्षण अत्यन्त आवश्यक है। वेश्यावृत्ति करने वाली महिलाओं का यदि इस अमानवीय पेशे से मुक्त होना सम्भव न भी हो, तो उन्हे गर्भ-निरोधक उपायों को अपनाने के लिए सहमत किया जाना बहुत जरूरी है। इसी तरह किसी अज्ञात बीमार व्यक्ति का रक्त किसी अन्य बीमार व्यक्ति को देने तथा मादक दवाओं का सेवन करने वाले व्यक्तियो द्वारा प्रयुक्त प्रदूषित सुई के प्रयोग से बचने के लिए लोगों को प्रेरित करना भी अतिआवश्यक है।

इन सब सावधानियों और सतर्कताओं के लिए व्यापक स्तर पर प्रचार-प्रसार और जन शिक्षण किया जाना है और इस कार्य को एक महत्त्वपूर्ण अभियान के रूप मे ग्राम भारती समिति सचालित कर रही है।

आइये, आप हम सब मानव सुरक्षा के इस अभियान मे हाथ बटायें।

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एड्स

खतरे की घण्टी

बचाव

1. निरोध अपनाएँ।
2. अनजान व्यक्ति का रक्त न चढ़ायें।
3. दूषित सुई का उपयोग न करें।

ग्राम भारती समिति
एस-3, गोविन्द नगर (पश्चिम), जयपुर-302 002

पृष्ठ भूमि

एड्स पिछले दो दशक मे दुनिया भर मे फैली अब तक की सबसे भयानक और लाइलाज बीमारी है। शायद ही दुनिया का कोई ऐसा देश हो, जो इससे प्रभावित और इसके खतरे से आतंकित न हो। शाब्दिक अर्थों मे यह रोग प्रतिरोधक शक्ति के अभाव से उत्पन्न एक ऐसी बीमारी है, जिसके कारण मनुष्य की रोगों से लड़ने की शक्ति क्षीण हो जाती है।

हमारे देश में

दुनिया की आबादी का एक बहुत बड़ा हिस्सा आज इसकी चपेट मे है। दक्षिण-पूर्व एशिया के देश एड्स के दुष्प्रभाव से तेजी से ग्रसित होते जा रहे है। हमारे देश के भी कुछ प्रान्त इसकी चपेट मे है। 1991 के अन्त तक के आँकड़ो के अनुसार अकेले बम्बई शहर मे प्रतिमाह लगभग 30 हजार व्यक्ति एच.आई.वी. (ह्यूमन इम्यूनो वायरस) संक्रमित हो रहे है। महाराष्ट्र और तमिलनाडु एड्स के खतरे से सर्वाधिक प्रभावित प्रदेश माने जाते है।

राजस्थान की स्थिति

राजस्थान मे प्रत्यक्षतः एड्स का कोई गम्भीर खतरा नही है। लेकिन एड्स की जानलेवा बीमारी को देश, काल और परिस्थितियों की सीमाओं मे नही बाँधा जा सकता और जो कारण एड्स के लिए आधारभूत माने गये है, वे यहाँ भी मौजूद है। इसलिए राजस्थान भी इसके आसन्न संकट से बचा नही रह सकता।

एड्स के सम्भावित कारण

राजस्थान मे वेश्यावृत्ति के जितने भी अड्डे है, उनमे तो एड्स का खतरा है ही, इसके अलावा पेशेवर खून देने वाले तथा नशीली दवाओं के आदी लोग भी एड्स के संवाहक हैं। एड्स संक्रमण के अन्य कारणो मे दूषित सुई का प्रयोग तथा रोगी व्यक्ति का खून स्वस्थ व्यक्ति को दिया जाना भी शामिल है। पेशेवर खून देने वाले बड़ी संख्या मे जयपुर सहित बड़े शहरो मे है, जो समय-समय पर खून बेचते रहते हैं। इनमे कई एच.आई.वी. से संक्रमित व्यक्ति हो सकते हैं। इसी तरह नशीली दवाओं के आदी लोग हेरोइन, ब्राउन शुगर जैसी मादक दवाये इन्जेक्शन के द्वारा नियमित रूप से लेते है। यदि इस लत के शिकार व्यक्ति एच.आई.वी. से संक्रमित है तो उस सुई का प्रयोग अन्य व्यक्तियो को भी संक्रमित कर सकता है।

वेश्यावृत्ति और उसके कारण

यद्यपि हमारे देश मे वेश्यावृत्ति का इतिहास बहुत पुराना है, लेकिन आज भी बड़ी संख्या मे महिलाओं के इस अमानवीय पेशे मे संलग्न होने के जो कारण सर्वविदित है, उनमे पारम्परिक चलन, गरीबी, दुर्घटना, धोखा, अपहरण, बलात्कार आदि शामिल है। जहाँ तक राजस्थान की बात है, देश के अन्य हिस्सों की तरह यहाँ भी अनेक स्थानो पर देह व्यापार होता है, लेकिन दस जिले— जयपुर, अजमेर, टोंक, कोटा, बूँदी, उदयपुर, डूँगरपुर, बाँसवाड़ा, भरतपुर और धौलपुर वेश्यावृत्ति के घनीभूत केन्द्र बने हुए है। ये केन्द्र बड़ी संख्या मे देशी-विदेशी पर्यटको के निर्बाध आवागमन के कारण एड्स से प्रभावित क्षेत्र माने जा सकते है।

राजस्थान मे वेश्यावृत्ति के निम्न कारण मुख्य माने जाते है-

पारम्परिक पेशा

दक्षिणी राजस्थान के आदिवासी क्षेत्र (उदयपुर, डूँगरपुर, बाँसवाड़ा) तथा धौलपुर, भरतपुर की बेड़िया तथा जयपुर जिले मे राज नट व कंजर जनजाति वर्षों से इस पेशे को परम्परागत रूप मे अपनाये हुए है। राष्ट्रीय राजमार्गों के किनारो पर बसी अस्थाई बस्तियो मे भी इनके केन्द्र है, जहाँ ट्रक ड्राईवर तथा मध्यमवर्गीय शहरी लोग वासनापूर्ति के लिए निरन्तर आते रहते है।

गरीबी और दुर्घटना

गरीबी के कारण अनेक पिछड़ी जातियो के परिवारो की महिलाएँ इस जाल मे फँसी हुई है। धोखा देकर या शादी अथवा नौकरी का लालच देकर लड़कियों के अपहरण, बलात्कार की अनेक घटनाएँ आये दिन होती रहती है। आर्थिक कारणो अथवा आपसी अविश्वास के कारण होने वाली गृह कलह भी इसका एक कारण है। छोटी उम्र की लड़कियों का अपहरण कर बेचे जाने तथा बस अथवा रेल मे अकेले सफर करते समय पेशेवर लोगों द्वारा फुसलाकर ले जाने की घटनाएँ भी कम नही है। एक बार इस तरह की घटना का शिकार होने वाली लड़की कथित समाज की लज्जा के भय से वापस अपने घर को नही लौटती और अन्ततः इसी पेशे मे आकर फँसती है।

पारिवारिक अत्याचार

परिवार जनो द्वारा किये जाने वाले अत्याचारो का भी इसमे बड़ा योगदान है। सास-ससुर, पति अथवा ससुराल पक्ष के अन्य लोगो द्वारा दहेज को लेकर दी जाने वाली प्रताड़ना के कारण महिला को मार देना अथवा उसे आत्महत्या के लिए विवश करने की घटनाएँ तो आये दिन होती ही रहती है। अनेक महिलाएँ सौतेले माता-पिता, पति अथवा अन्य रिश्तेदारों के तानो तथा अत्याचारो से मुक्ति के लिए स्वयं घर छोड़ देती है अथवा कितनी ही असामाजिक तत्त्वों के चंगुल मे फँस जाती है।

के खतरे को टालने के लिए आवश्यक सुरक्षा उपाय अपनाने को तो प्रेरित करना ही है।

त्रिसूत्री कार्यक्रम ➤

लेकिन यह तभी सम्भव है, जब वेश्यावृत्ति में लिप्त इन महिलाओं तथा जन-साधारण को एड्स की भयानकता की जानकारी हो तथा इसके खतरे की गम्भीरता से उन्हें अवगत करा दिया जाए। साराशतः इस परियोजना के 3 चरण है—

1. वेश्यावृत्ति पर सर्वेक्षण,
2. एड्स के बारे में शिक्षण तथा
3. एड्स से बचने के लिए सुरक्षा-प्रयत्न।

वेश्यावृत्ति पर सर्वेक्षण अन्य विषयों की तरह बहुत सहज नहीं है, लेकिन इसे बहुत कठिन भी नही कहा जा सकता। सर्वेक्षण और शिक्षण के इस कार्य में लगने वाले कार्यकर्त्ताओं को साहस, सूझ-बूझ और गम्भीरतापूर्वक काम करना होगा। स्थानीय नागरिकों, सामाजिक कार्यकर्त्ताओं तथा सरकारी अधिकारियों तथा कर्मचारियों का सहयोग भी इसमें आवश्यक है।

चुनौती और प्रयत्न ➤

एड्स एक चुनौती है, जिसका मुकाबला सरकार, समाज और स्वैच्छिक संगठन मिलकर ही कर सकते है। सबके समन्वित प्रयत्नों से ही राजस्थान की मरुभूमि और यहाँ की मानवता को एड्स की जानलेवा बीमारी के खतरे से बचाया जा सकता है।

हम सरकार, आम जनता तथा इस पेशे से सम्बन्धित व्यक्तियों—सभी से इस राष्ट्रीय और मानवीय कार्य में सहयोग की अपेक्षा करते हैं। ग्राम भारती समिति के कार्यकर्त्ता सबके सहयोग से इस चुनौती को स्वीकार कर परियोजना के अपेक्षित लक्ष्यों को प्राप्त करने में सफल होंगे, ऐसा विश्वास है।

श्रीमती कुसुम जैन
परियोजना निदेशक,
एड्स शिक्षण परियोजना तथा
संयुक्त मन्त्री, ग्राम भारती समिति, जयपुर

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AMERICAN FOUNDATION FOR AIDS RESEARCH

एड्स की चुनौती

मानवता की रक्षा के
इस अभियान में
आप सबका सहयोग
अपेक्षित है!

ग्राम भारती समिति
एस-3, गोविन्द नगर (पश्चिम), जयपुर-302 002

एड्स शिक्षण परियोजना के अन्तर्गत राजस्थान में वेश्यावृत्ति : एक सर्वेक्षण

एड्स की भयानकता ➤

बीमारियों की श्रेणी में एड्स एक ऐसा नाम है, जिसके बारे में सुनते ही रोंगटे खड़े हो जाते हैं। एड्स (AIDS) यद्यपि स्वयं अपने आप में कोई बीमारी नहीं है, लेकिन इसके विषाणु शरीर की प्राकृतिक सुरक्षा प्रणाली को नष्ट कर देते हैं, जिसके फलस्वरूप शरीर रोगों से बचाव करने के योग्य नहीं रह जाता। एड्स का रोगी बीमारी से कम, उसके संक्रामक होने की भयग्रस्त मानसिकता के मनोविज्ञान से अधिक प्रभावित होता है।

किसी समय सर्वाधिक अछूत माने जाने वाले कुष्ठरोग से पीड़ित व्यक्ति ने भी आज समाज में अपना समुचित स्थान बना लिया है, लेकिन एड्स का रोगी न केवल स्वजनों से बल्कि समूचे समाज से कट जाता है। बीमारी के दुष्प्रभाव से भी ज्यादा यह एकान्तिकता उसे कचोटती है। और यही इसका खतरनाक, लेकिन वास्तविक पक्ष है।

विश्वव्यापी विस्तार ➤

एड्स की यह भयानक बीमारी यद्यपि दक्षिण अफ्रीका और अमेरिका में अधिक व्यापक है, लेकिन धीरे-धीरे इसका फैलाव पूरी दुनिया में होता जा रहा है। परिणामस्वरूप हमारा देश भी अछूता नहीं रहा। एड्स के संक्रमण के मुख्यत 4 कारण माने गये हैं—

1. अपरिचित स्त्री-पुरुष के साथ यौन सम्बन्ध,
2. एड्स के रोगी का रक्त किसी अन्य रोगी को देना,
3. दूषित सुई का उपयोग तथा
4. संक्रमित माँ से शिशु को।

अब तक पूरी दुनिया में लगभग 15 लाख एड्स के रोगियों के होने का पता चल चुका है। इसकी सर्वाधिक संख्या दक्षिण-अफ्रीका तथा अमेरिका में है। भारत में भी काफी लोगों के एड्स से प्रभावित होने की जानकारी है।

राजस्थान में खतरे के संकेत ➤

राजस्थान में 10 जिले—जयपुर, अजमेर, टोंक, कोटा, बून्दी, उदयपुर, डूंगरपुर, बाँसवाड़ा, भरतपुर, धौलपुर—एड्स के खतरे से प्रभावित माने जा रहे हैं। इसका कारण इन जिलों में होने वाली वेश्यावृत्ति है। कुछ जिलों में पर्यटन स्थल होने के कारण तथा कुछ में आदिवासियों, जन-जातियों में परम्परागत रूप से वेश्यावृत्ति होती है। कुछ जगहों पर सड़कों के किनारे भी ड्राइवरों-राहगीरों की वासना पूर्ति के अस्थाई अड्डे बने हुए हैं। वेश्यावृत्ति के ये अड्डे ही एड्स के आसन्न खतरे के केन्द्र बिन्दु हैं। थोड़े से प्रयत्न और सावधानी से इस खतरे को टाला जा सकता है।

वेश्यावृत्ति पर सर्वेक्षण ➤

ग्राम भारती समिति ने एड्स की इस विकरालता को देखते हुए इस वर्ष के अपने कार्यक्रमों में इसको भी शामिल किया है। इसके अन्तर्गत राजस्थान में एड्स के खतरे की वास्तविक स्थिति का पता लगाने के लिए प्रदेश के 10 जिलों के 150 गाँवों में वेश्यावृत्ति पर एक व्यापक सर्वेक्षण करने का निश्चय किया गया है। एक अनुमान के अनुसार इन 150 गाँवों में बड़ी संख्या में महिलाएँ वेश्यावृत्ति में संलग्न है। सर्वेक्षण में इनकी पारिवारिक पृष्ठभूमि, पेशा अपनाने का कारण, शारीरिक सम्बन्धों के समय सुरक्षा उपाय, एड्स की जानकारी और उसके प्रति सतर्कता-इत्यादि सूचनाएँ एकत्र करनी है।

सुरक्षा उपाय और मानवीय पक्ष ➤

सर्वेक्षण के बाद एड्स से बचने के लिए शिक्षण और चेतना जागरण का अभियान भी चलाना है। यद्यपि इस परियोजना का मानवीय पक्ष अमानवीय कार्य में लिप्त वेश्याओं को वेश्यावृत्ति से मुक्त कर आर्थिक उपार्जन के अन्य स्रोतों से जोड़ना है, लेकिन किसी कारण से इस पेशे से सम्बद्ध रहना उनकी मजबूरी हो, तो भी उनको एड्स

ANNEXURE S

1

एच.आई.वी. और एड्स

सभी को क्या जानना चाहिए

वॉलंटरी हेल्थ एसोसिएशन ऑफ इण्डिया

30/11/94 INDIA TODAY

ANNEXURE T

K.K. SINGH

"I am determined to live as long as I can in order to help others live too."

THE anonymous scribbles on the cell walls of the Sajiwa Central Jail in Manipur speak of the anguish of the inmates. "Don't expect to repent at 10 a.m./ You may die at 9.30 a.m.". Or "Love AIDS/ Live AIDS/ Die soon." Poignant words from the nearly 500 drug addicts dumped by their families in the 108-acre sprawling jail on the outskirts of Imphal.

Last year, 43 tested positive and at least half are thought to have the virus—among them K.K. Singh, who is undergoing intensive counselling. But Manipur's Inspector General of Prisons G.S. Pandher has stopped further tests: "As soon as an inmate knows he is HIV positive, he becomes half-dead. Why scare him?"

Many desperate parents have even registered false charges with the police against their children to have them put into jail, away from drugs. At the old central jail, Mimi Zow runs a high fever, vomits and shivers the whole day. "She was such a pretty and healthy girl," remembers Deputy Superintendent of Police R.K. Memi Devi. Zow had been sharing needles for the past seven years, and has lost more than 10 kg. "I have lost all hope. I want to die," she says.

Khaipu Paite, 19, from Churachandpur, who spends his days at the Sajiwa Central Jail tending to cactus, rose and orange beds, says that when his parents heard he was HIV positive, their attitude changed and he was given food separately in a corner of the home: "I was so depressed that I nearly went mad. Today, I know I can't be saved, but I'm not bothered."

SABAH DAS

In Manipur, jail authorities are making a dent in treating HIV positive drug addicts.

Manipur is acquiring the sad status of the AIDS capital of India. In this north-eastern state, an estimated 1.2 per cent of the total 18-lakh population are intravenous drug abusers. Of them, a frightening 50 per cent are thought to be AIDS carriers.

Waging war on AIDS is not easy in Manipur. Persuading people that the disease is not contagious, so patients should not be ostracised, is difficult. The message being driven home is that there is life after HIV. And it is being spread by the five existing detoxification and rehabilitation clinics in Imphal, some of which have been set up by former addicts.

One of them is Nepram Vikramjit Singh, who heads the Lifeline Foundation, an entirely self-funded rehabilitation centre. Singh should be able to understand a patient's psychology as he used drugs for six years and indulged in bisexual promiscuity although he escaped the virus. Lifeline has already detoxified 110 addicts, half of whom were AIDS carriers. "When we break the news to HIV patients, they are overcome with grief. But it fades as we counsel them and put them into gardening, pisciculture and playing volleyball," he says.

Such counselling is now beginning to show results. K.K. Singh, who is at Lifeline, says: "I want to recover fully and help other victims during the rest of my life. I want to live longer to help others live too." Jail authorities also help by occupying HIV positive inmates in therapeutic activities such as yoga, gardening and exercise. Elsewhere in the state, churches are also counselling patients.

So the bad news from Manipur is that the virus is spreading from high risk groups to the general population. The good news is that a section of those diagnosed as HIV positive are trying to beat the trauma and learning to live again.

—SOUTIK BISWAS
in Imphal and Churachandpur

ANNEXURE U

Indian Express

WEDNESDAY APRIL 15 1992 — Development News — NEW DELHI

Manipur prisons: Jailing AIDS-hit, treating drug addicts

by Usha Rai

THERE is one big blot on the verdant, lush-green landscape of Manipur-heroin addiction. Smuggled across the Burma border, it is freely available in Manipur and the young people—frustrated for want of employment—and the idle rich—seeking a trip to the stars — inject it intravenously.

Like a phantom, chasing the drug addicts are the deadly Acquired Immuno Deficiency Syndrome (AIDS) and the HIV infection. It is estimated that there are 20,000 to 25,000 cases of drug addiction in the state and about 40 to 50 per cent of them are HIV positive. Everyday a new HIV positive case surfaces. With death looming large on the horizon a sense of despondency hangs over the valley.

Anxious parents who have failed to control their moonbeam traipsing youngsters and neighbours, who have tired of losing their clothes (while drying in the sun) and water hoses (stolen by the addicts to buy their magic heroin) are turning these youngsters over to the jail authorities. They are booked under sections 109 and 120 CrPC — the drug laws.

Manipur's jails, especially those in Imphal, are no ordinary prison cells. For the last one-and-half-year they have become reformation centres for the addicts and a place of retreat for the HIV positive cases.

The Imphal jail has 650 drug addicts of which two women and 31 males are HIV positive. The number of women inmates being weaned away from drugs is 27. Ninety five per cent of them are in the 17 to 30 age group. Mr. G.S.Pander, Inspector General of Prisons, Imphal, who is bringing about a mini revolution in the care and rejuvenation of the addicts —albeit from a prison ward— says a staggering 60 per cent of the addicts and HIV positive cases have been sent to jail by their parents, well wishers and neighbours. Initially they are sent for a fortnight which keeps getting extended till they are detoxified and rehabilitated through vocational training. Among the youngsters in jail are children of senior government officials, those in business, politics, academics and even children of the local bards and poets.

In October when the harvesting begins and during Christmas, the parents get them released through a special order of the magistrate. It is the time of feasting and rejoicing and most parents want their children home. By March the rush for the reformation centre begins and by September/October the number of addicts swells to 800.

Mr Pander is keen to point out that it is a jail only in name. The strict regimentation —the 40 minutes of rigorous physical training every morning, eight hours of vocational training, literacy classes for the illiterate and higher levels of learning for those who have finished school, the recreational activities, periodic medical examination and an excellent diet —3100 calories of nutritious food daily—not only wean away the youngsters from their craving for drugs but enables them to put on 2 to 6 kgs in six months. A reformed addict can even put on 12 kgs.

Raghu Rai Express

The first 14 days are extremely tough for the addicts. They are kept in the jail hospital with two persons watching over each addict as they go through the withdrawal syndrome. All bathroom doors have been cut in half so that they can be watched even when they go to the toilet. "There are chances of the youngsters committing suicide when the craving for heroin becomes intolerable," says Mr. Pander.

Because of the high degree of unemployment in the North-East, Mr. Pander says training in skills is crucial for their rehabilitation. Links have to be established with the industry and business houses so that they can earn at least Rs 50 to Rs 75 per day on their release. If they stay unemployed, there is always the danger of their taking to drugs again. People from the rural areas, who have some land are involved in the cultivation of 'jinsing' (the Korean plant that gives energy) ornamental and medicinal plants. Links are being forged with companies like Dabur and Baidnath so that the youngsters can grow the medicinal plants required by these companies. It is so much better than cultivating ganja, says Mr. Pander.

Those from urban areas are taught carpentry – making of cane and bamboo furniture. With the help of the UNDP and WHO one of the biggest workshops for carpentry in the north-east will be set up in Manipur jail. When a detoxified prisoner leaves the jail he will not only know carpentry but will get tools and equipment worth Rs.5,200 and a loan of Rs.4,800 so that he can start his own business.

The secretary, electronics, deputy commissioner for handicrafts (both from the Capital) and Delhi School of Social Work and National Institute of Design , Ahmedabad, have assured assistance in working out the best possible rehabilitation schemes .

Mr Pander, who took over as IG, Prisons, Manipur, just-a-year-and-a-half ago, is confident that with care and concern for the inmates, not just Manipur jail but the 700-odd jails in the country can become mini factories or production units. Manipur jail is spotlessly clean. Last March 46 boys from the jail took the matriculate examination. No wonder there is one post graduate and 26 graduates in the jail.

So far there is only a 10-bed hospital attached to the jail. Just two weeks ago, a 30-bed de-addiction centre was sanctioned for Manipur jail. It will be funded by WHO. Later this month the two doctors, seven nurses and seven pharmacists will be coming to the AIIMS for special training in handling drug addicts and AIDS patients. Mr Pander is also trying to get a counsellor for the jail.

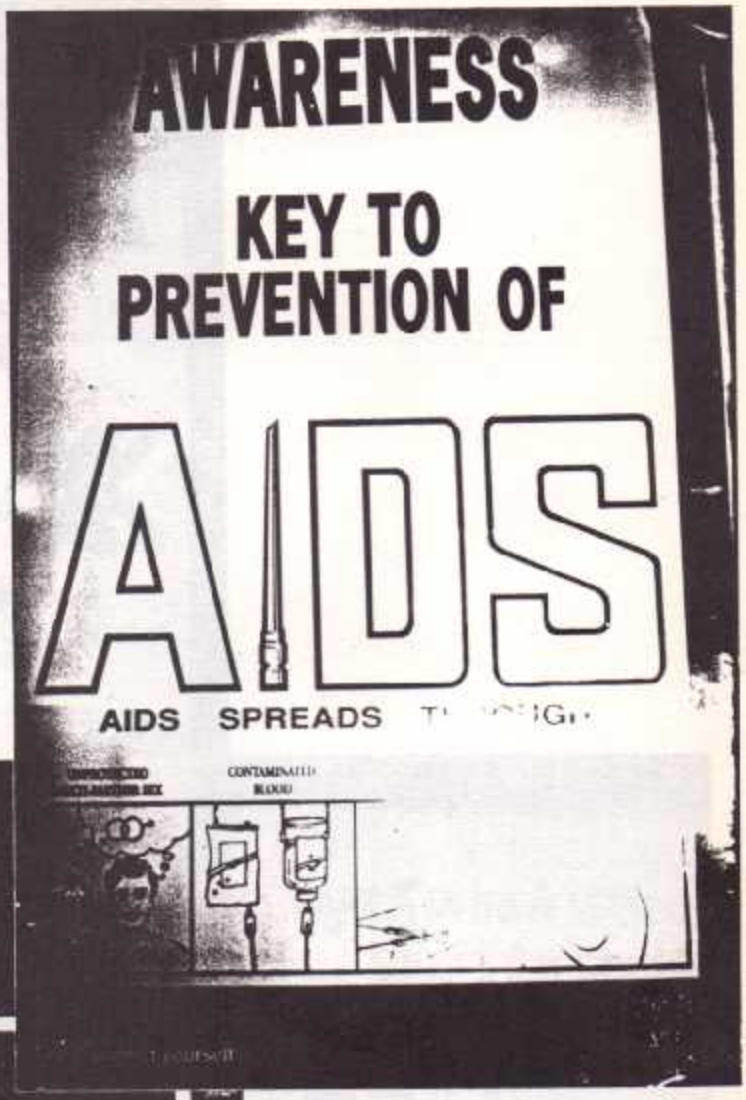
With assistance from Oxfam, a Delhi naturopath, Dr. Bhatia, who claims to have had 90 per cent success in treating an AIDS patient in Calcutta, has been invited to Manipur to provide whatever relief is possible for the HIV positive cases. With the help of magnetic belts, magnetic chairs, and acupressure, Dr Bhatia is believed to have successfully treated cases of arthritis, tuberculosis, diabetes, sciatica and a host of other ailments. The magnetic chair, which costs Rs.5,000, has 64 to 65 high and low-power-magnets and sitting in the chair for 10 minutes every day has therapeutic value. Dr Bhatia has decided to stay as long as needed in Manipur and train parents on use of magnet therapy and acupressure.

In an existing scenario and the most unusual jail reform movement that has been launched at the initiative of a single, committed individual, Mr Pander. But the jail modernisation scheme that would enable the prisons to draw additional funds for planned ventures has come to an end and needs to be extended till the end of the Eighth Plan.

- MARGINALIZING OF
- CRIMINALIZING USERS
- DRUG BY [illegible] INSTEAD OF DRUG ADDICTS


यदि एड्स नहीं चाहते हैं, तो
इनसे बचें
अनेक व अनजान व्यक्तियों से यौन संपर्क
HIV युक्त रक्त
संक्रमित महिला गर्भाधान न करे
नशाखोरी
दूषित सुई
इन्हें अपनायें
एक ही जीवन साथी
HIV जांच किया रक्त
सुरक्षित मातृत्व
नशा रहित जीवन
सुई और उपयोग
सुरक्षा अपनाइये सदा मुस्कराइये
एड्स भगाइये जीवन बचाइये


महिला विकास का है आव्हान
संगठन से ही है पहचान
सब लुगायां रो कैणो है
एको कारके रैणो है


AWARENESS
KEY TO
PREVENTION OF
AIDS
AIDS SPREADS
CONTAMINATED
BLOOD


मौत ही अन्त- इलाज
बचाव ही उपचार है


एड्स
जिन्दगी से मौत


ढाई आखर का मेरा नाम
जिसको डस लूँ ले लूँ जान
एड्स
बचाव के

ANNEXURE W


AIDS TOUCHES ALL OF US
TEARS
LETS SHARE
LETS SHARE
AND BREAK DOWN BARRIERS
THAT COME BETWEEN US!
FEARS

The second poster reads (**Annexure X**)

ANNEXURE Y

WORLD AIDS DAY
1990
WOMEN AND AIDS

TOI 1/12/90

1. AIDS is caused by a virus (HIV)
2. 75% of AIDS infection comes through Sexual contact.
3. Other modes of transmission are
   a) Sharing contaminated needles.
   b) Through blood transfusion of infected person's blood & blood products.
4. There are no obvious signs to tell that someone is infected with HIV.
5. There is no cure for the disease.

PREVENTION:

1. Restrict sex to one faithfully person only. Abstain from sex outside marriage.
2. Use condom to prevent AIDS, STD.
3. Use sterilised needles and syrings.
4. Use blood from voluntary donation for transfusion.
5. In case of suspicion of having infection — get your blood tested. The facilities for blood testing are available at:

   All India Institute of Medical Sciences, Safdarjang Hospital, National Institute of Communicable Diseases (Sham Nath Marg), Hindu Rao Hospital, Guru Teg Bahadur Hospital, Sucheta Kriplani Hospital, Lok Nayak Jai Prakash Hospital, Indian Red Cross Society (Red Cross Road).

DIRECTOR HEALTH SERVICES
DELHI ADMINISTRATION

WORLD AIDS DAY 1990

TOI 1/12/90

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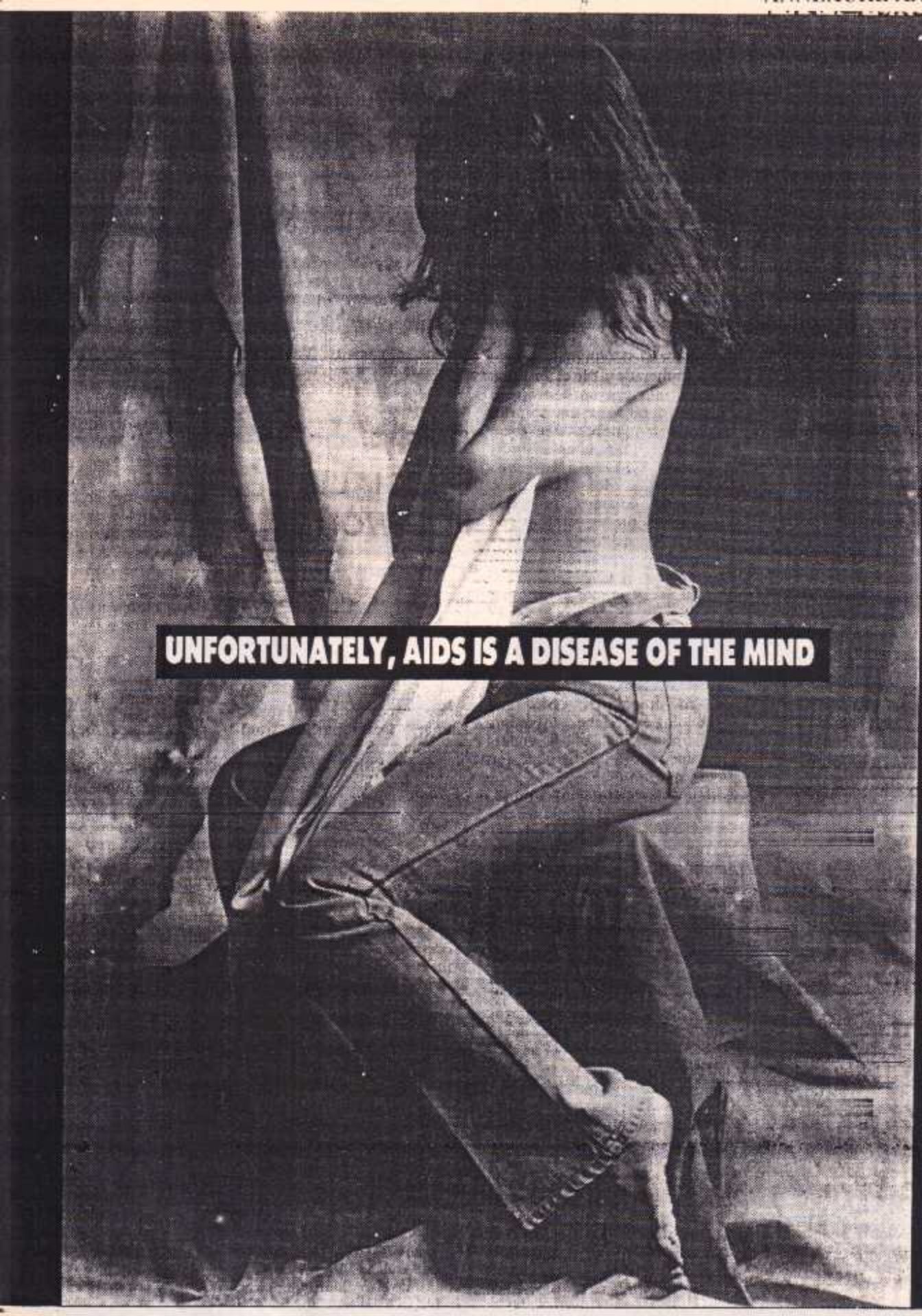
DIRECTOR HEALTH SERVICES
DELHI ADMINISTRATION

ACTION FOR AIDS

He's just started

work as a computer programmer. He has a brother and two sisters. He has had sex just once before with a man. He *didn't think* that there was any point wearing a condom. He has AIDS. He is the boy next door.


UNFORTUNATELY, AIDS IS A DISEASE OF THE MIND

Only a firm mind can prevent AIDS.
It's true.

Let's say a modern young woman has decided she doesn't mind going to bed with a man she likes.

Nothing wrong with that.

She asks him to wear a condom.

He acts surprised. He fusses. He gets angry.

He says it robs him of his pleasure.

He tries emotional blackmail.

Rather than let it get unpleasent she gives in.

He gets his way.

She gets AIDS.

Don't let it happen to you. Only a condom can stop AIDS during Sex.

So keep your mind firm — insist he wears a condom.

Don't give in with an 'OK, never mind.'

Because weak minds spread AIDS.

Never forget that.

AIDS

Weak minds spread it.

ANNEXURE BB

AIDS

Glaxo

How you can safeguard yourself against AIDS

People of all communities, age and sex can be affected by the AIDS virus (HIV). A person who is once infected, will remain infected for life.

AIDS (Acquired Immune Deficiency Syndrome) is caused by a virus called HIV (Human Immunodeficiency Virus). The virus attacks and destroys the cells of the body's immune system, and the body is unable to fight diseases, which ultimately leads to death. Until a drug or vaccine is found to fight the AIDS virus **prevention is the only cure.**

Symptoms

During the earlier stages of HIV infection, the symptoms are vague and often similar to those of common ailments. Some of the symptoms are: fever (more than 3 weeks duration), loss of weight (more than 10% of original weight), skin rash and diarrhoea (more than 3 weeks duration).

AIDS is the end-stage of the HIV infection. It can take many years to reach this stage. The infection at any stage can be passed on to others.

Prevention

The AIDS virus (HIV) can be spread in three ways.

1. **Sexual intercourse (homosexual or heterosexual)**
   - Avoid sexual intercourse with multiple partners, infected partners and prostitutes. The proper use of condoms is necessary.
2. **Blood or blood products**
   - Blood should be tested for HIV antibodies before being used for transfusions.
   - Needles and other skin-piercing instruments should be sterilised before use. It is best to insist on disposable needles and syringes.
   - An HIV carrier should not donate blood or share toothbrushes, razor blades and needles.
3. **From infected mother to baby,** either before, during or after birth.

The AIDS virus does NOT spread through casual contact like shaking hands, touching and hugging. Neither does it spread through food, water, sneezing, coughing, insects, toilets, swimming pools and sharing cups.

There is no need to fear and shun persons who are infected with the AIDS virus. They need a lot of Tender Loving Care (TLC) to help them live out their life with courage and dignity.

1st December is observed every year as World AIDS Day

You can avail of our A V productions (slide-tape and VHS formats) in English, Hindi, Marathi and Gujarati to promote good health.
For a free pamphlet "Your Guide to Good Health" write to the P.R. Department, Glaxo India Limited, Dr. A.B. Road, Worli, Bombay 400 025.

Glaxo **—a concern for health**

RADEUS/G/269-91

Get your nose out of that book now, and come to bed!

Wait. I'm checking out what Vatsyayana

recommends for birth control ...

He recommends a savvy and intelligent wife. Like me.

Well... then you should know I don't like wearing those ...

you know what ...

I won't make you wear them.

"Who needs Kama Sutra when you have Today!"

Are you on the pill or is it a loop?

Neither. Look, why don't you leave it all to me?

Hope you're not planning a long vacation

at your mother's ...

That's neither savvy, nor intelligent.

Hmmm... you're smiling a mysterious smile!

Guess what's behind it?

Wait, let me consult Vatsyayana ...

Grow up! Haven't you heard of Today ?

Today? The woman's very personal contraceptive ?

Right! You sure are well informed.

But are you planning to try it?

Planning to? What do you think has been my protection

during the honeymoon ?

Really? How come I didn't even know !

You don't have to. As long as you are happy,

and I'm happy ...

Hmmm ... Vatsyayana is dead right when he says ...

What ?

That you women can't keep a secret for too long.

Oh shut up !

For a free booklet on Birth Control, send a self-addressed, stamp envelope to Bliss Chemicals Pharmaceuti India Limi Skypak I Annexe, Murol, Andh Bombay 400 0

Today A woman's very personal contraceptive.

You like condoms?

Ya. And I like condom ads.

Really? How come?

Because I don't have to wear them.

Ha, ha! Celibate?

Happily married.

"Birth control? Just leave it to your wife!"

Ha, ha ha! But you must be doing something for birth control?

Nothing.

How can that be?

Well, I do nothing. My wife does it all.

What? If I'm not too inquisitive ...

You are. But I'll tell you. She uses this wonderful thing called Today.

Today? What's that?

A woman's very personal contraceptive.

<u>Then we men must know about it.</u> Tell me more!

Well, it's a small tabule which the woman inserts into her body whenever she needs protection.

I see. Then?

It dissolves completely in about ten minutes, releasing an effective spermicidal action... It can be done in total privacy, and with perfect ease.

<u>The husband need not even know about it.</u>

Interesting! And how effective is it?

Over 99%. And that's an internationally confirmed figure.

I see! Now tell me, you still like condom ads?

Yes. But I like this Today ad more.

Which one?

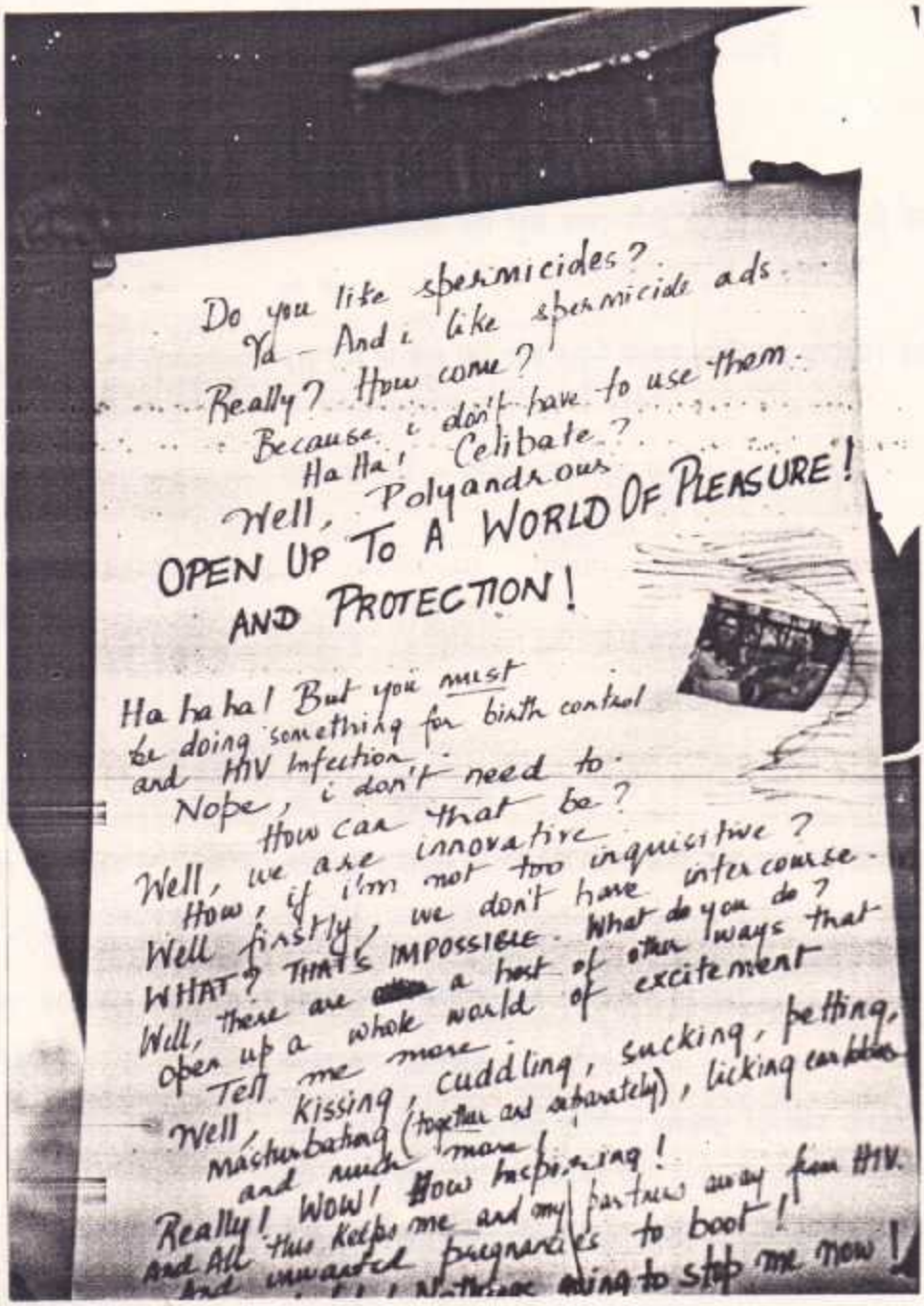
The one we just created!

[illegible]

Conceived.

For a free booklet on Birth Contro[illegible] self addressed stamped envelope to: [illegible] House Annexe [illegible]

Today [illegible] contraceptive


Do you like spermicides?
Ya - And i like spermicide ads.
Really? How come?
Because i don't have to use them.
Ha Ha! Celibate?
Well, Polyandrous
OPEN UP TO A WORLD OF PLEASURE!
AND PROTECTION!
Ha ha ha! But you must be doing something for birth control and HIV infection
Nope, i don't need to.
How can that be?
Well, we are innovative
How, if i'm not too inquisitive?
Well firstly, we don't have intercourse.
WHAT? THAT'S IMPOSSIBLE. What do you do?
Well, there are a host of other ways that open up a whole world of excitement
Tell me more
Well, kissing, cuddling, sucking, petting, masturbating (together and separately), licking earlobes and much more!
Really! WOW! How interesting!
And All this keeps me and my partner away from HIV and unwanted pregnancies to boot!
Nothing going to stop me now!

JINGLE NO. 1
Starts with filmy music

Male Voice	-	रूप तेरा है जवान कितना रंगीन है समाँ
Female Voice	-	भूल कोई न हो जाये जाने जान
Male Voice (authoritative)	-	सावधान! यह भूल कहीं जान लेवा न बन जाये
Female Voice	-	जान लेवा?
Male Voice	-	जी हाँ। क्योंकि यही भूल एड्स जैसी लाइलाज बीमारी भी बन सकती है।
Female Voice	-	तो फिर?
Male Voice	-	इस रोग से खुद को और अपने जीवन साथी को बचाईये। शारीरिक सम्बन्ध के समय कन्डोम इस्तेमाल में लाईये।
Female Voice	-	एड्स से बचें - कन्डोम इस्तेमाल करें।

JINGLE 2
Starts with filmy music

Female Voice	-	आ गये आप?
Male Voice	-	हाँ, कोई खास बात?
Female Voice	-	कब से इन्तज़ार में थी कि आप आयें और आपसे एक बात पूछूँ।
Male Voice	-	क्या ?
Female Voice	-	आज मेरी सहेली कमला आई थी।
Male Voice	-	क्या कह रही थी?
Female Voice	-	कह रही थी कि जिनके शारीरिक सम्बन्ध अनजान या अनेक व्यक्तियों से हो, उन्हें एड्स रोग हो सकता है।
Male Voice	-	बिल्कुल ठीक। यही नहीं, एड्स पीडित महिला से पैदा होने वाले बच्चे को भी एड्स हो सकता है।
Female Voice	-	तभी तो कहते है। . . .
Music	-	Man and Woman singing together पति पत्नि का सच्चा प्यार एड्स से बचने का आधार

JINGLE NO. 3

Starts with music

Female Voice	-	सुनो जी किस फ़िकर में हो?
Male Voice	-	अपना रामू फिर शहर लौट रहा है बहु के बिना और मेरा मन भयभीत है इस नई बिमारी के कारण।
Female Voice	-	नई बीमरी, कैसी बीमारी?
Male Voice	-	एड्स।
Female Voice	-	एड्स क्या ?
Male Voice	-	एड्स एक लाइलाज बीमारी है। धीरे-धीरे इसके वायरस शरीर में फैल जाते हैं और रोगों से लड़ने वाली शक्ति को नष्ट कर देते हैं। फिर रोगी आम बीमारियों का शिकार बन जाता है।
Female Voice	-	पर ये रोग रामू को क्यों लगने लगा?
Male Voice	-	खतरा मुख्य रूप से असुरक्षित सम्भोग से है।
Female Voice	-	हाय राम, क्या इसका कोई उपाय नहीं?
Male Voice	-	अवश्य है। अपने पर काबू रखना, नहीं तो कन्डोम का निश्चित उपयोग करना।
Music	-	Different male voice carrying message शारीरिक सम्बन्ध एक से मुक्ति जाने लेवा एड्स से।

JINGLE 4

Popular filmy music

Male Voice	-	गोरी-गोरी ओ बाँकी छोरी कभी फिर कल आया करो
Second Male Voice	-	यार तू जानता है मेरी जिन्दा दिली का राज ? प्यार-प्यार बिना संकोच के, बिना डर के
Third Male Voice	-	अरे, कुछ तो सोच! मरना है क्या तुझे? एड्स, इसके बारे में कुछ सुना है कि नहीं?
Another Male Voice	-	हाँ भई, एड्स! असुरक्षित सम्भोग द्वारा इसके कीटाणु खून में प्रवेश पाते है।
Third Male Voice	-	साथ ही रोग को सहने वाली शक्ति को भी धीरे-धीरे नष्ट कर देते हैं। नतीजा - मौत।
First Male Voice	-	मौत ? क्या कह रहा है तू ?
Third Male Voice	-	सही कह रहा हूँ। अब तो सिर्फ दो ही रास्ते है - संयम या सुरक्षा।
Male Voice	-	एड्स । बचिये इससे। कन्डोम का इस्तेमाल कीजिये।

JINGLE NO. 5
Starts with music

Male Voice - बम्बई शहर हादसों का शहर

Another Male Voice - बम्बई ही नहीं, आज किसी भी शहर या गाँव में एक हादसा आपके साथ कभी भी हो सकता है - और वो है जानलेवा रोग एड्स के जीवाणु एच. आई. वी. लगने का हादसा।

एड्स के जीवाणु सिर्फ किसी को बाँह में लेने, हाथ मिलाने या किसी के तौलिये, बर्तन या झुठा खाने पीने से कभी नहीं लगता। ये जीवाणु के लगने का ख़तरा सिर्फ तीन हालात में होता है।

एक : असुरक्षित सम्भोग याने बिना कॉन्डोम पहने सम्भोग करने पे।

दो : एच. आइ. वी. प्रदूषित खून या बिना उबाली इन्जेक्शन की सूई और सिरिंज इस्तेमाल करने पे।

तीन : एच. आइ. वी. बाधित गर्भवति द्वारा उसके होने वाले बच्चे को।

एड्स से बचाव पर इन तीन बातों का हमेशा ध्यान रखिये। खास तौर से कॉन्डोम के इस्तेमाल पर, ताकि कहीं आपके साथ न हो जाये ये हादसा।

Music - प्यार का हादसा।

JINGLE 6
Music in male voice

रूप तेरा मस्ताना प्यार मेरा दीवाना
Sound of Laughter of a man and a woman

Male Voice - शीला मैं जानता था तुम ज़रूर मान जाओगी।
आओ आज हम अपने बीच की सारी दूरियाँ मिटा दें।

Female Voice - ज़रा ठहरो, सुनो - पहले ज़रा इसे . . .

Male Voice - ये क्या सुरक्षा ? शीला ये क्या मज़ाक है?

Female Voice - मज़ाक नहीं विनोद, ये तो वक्त की माँग है।

Male Voice - तुम तो ऐसे कह रहीं हो जैसे मुझे एड्स है।

Female Voice - क्या पता ? हो भी सकता है।

Male Voice - ऐसा तो मैं भी सोच सकता हूँ तूम्हारे बारे में।

Female Voice - क्यों नहीं? पर एड्स किसी को भी हो, पर बचाव यही है कॉन्डोम।

Music in Male Voice - भूल कोई हमसे न हो जाये।

लुब्रिकेटेड कॉन्डोम - ये लाईलाज एड्स से सुरक्षा - आपकी और आपके अपने की

7. Begins with the sound of a drum

Male Voice - साहेबान, मेहरबान कद्रदान ज़रा कल्लू मदारी की बातों पर ध्यान दीजिये आज ये आपको लाईलाज बीमारी एड्स की असलियत बतायेगा।

मदारी - जम्बूरे!

जम्बूरा - उस्ताद!

मदारी - एड्स क्या मच्छर के काटने से लगता है?

जम्बूरा - नहीं उस्ताद।

मदारी - हाथ मिलाने से?

जम्बूरा - नहीं उस्ताद।

मदारी - किसी के तौलिये से या झूठा खाने पीने से?

जम्बूरा - नहीं उस्ताद।

मदारी - तो फिर एड्स कैसे फैलता है?

जम्बूरा - एच. आई. वी. जीवाणु से उस्ताद।

मदारी - एच. आई. वी. कैसे लगता है, खुल्लम खुल्ला बतायेगा?

जम्बूरा - यौन सम्बन्ध से उस्ताद।

मदारी - कौन से सम्बन्ध से ?

जम्बूरा - शारीरिक सम्बन्ध से।

मदारी - यहाँ एच. आई. वी. से कौन बाधित है बतायेगा?

जम्बूरा - शकल देखकर बताना सम्भव नहीं उस्ताद।

मदारी - फिर खुद को एच. आई. वी. से कैसे बचायेगा?

जम्बूरा - कॉन्डोम से उस्ताद।

मदारी - क्या कॉन्डोम खरीदने से शरमायेगा?

जम्बूरा - शरमायेगा उस्ताद? तो एड्स से मर जायेगा।

मदारी - तो सुनिये साहेबान एड्स रोगी की कोई नहीं पहचान। इसलिय हमेशा कॉन्डोम अपनाईये और एड्स रोग से अपनी जान बचाईये।

8. DOORDARSHAN AD
A Scene of a med shop

एक आदमी - आज तेरी बारी है। आज तू लेगा कॉन्डोम।

दूसरा आदमी - ठीक है। वो दीजिये .....

दुकानदार - माचिस?

दूसरा आदमी - नहीं।

दुकानदार - साबुन?

दूसरा आदमी - नहीं, नहीं . . . वो वहाँ?

दुकानदार - ओह कॉन्डोम ! बरखुरदार शरमाने से काम नहीं चलेगा। कॉन्डोम कहते हुये अगर झिझकते हो, तो लिख कर भी माँग सकते हो। आखिर सवाल तुम्हारी ज़िन्दगी का है।

लुब्रिकेटेड कॉन्डोम । ये लाईलाज एड्स से सुरक्षा आपकी और आपके आपने की।

LIST OF FILMS ON HIV/AIDS

(Many of these films are available with WHO/NACO. Some you can obtain from Jagori).

S.	*Title*	*Language*	*Duration*	*Director/Producer*
1.	A World United Against Aids	English	21 min.	—
2.	Aids-A Worldwide Effort	English	15 min.	—
3.	Aids film-Talking Aids Stopping Aids	English	21.15 min	CEDAC
4.	Alison	English	20 min.	—
5.	Frontline	English	—	—
6.	Health for All-All for Health	English	—	—
7.	Its Not Easy-The Orphan Generation	English	—	—
8.	Jeevandan	Hindi	10 min.	N.G.O. Aids Cell, All India Institute of Medical Sciences
9.	Karate Khiladi	Hindi	21.15 min.	Street Kids International/The National Film Board of Canada
10.	Karate Kids	English/Hindi	21.15 min	—
11.	Positively Women	English	55 min.	Nalini Singh
12.	Subah Ka Bhoola	Hindi	11 min.	N.G.O. Aids Cell, All India Institute of Medical Sciences
13.	Susie's Story	English/Hindi	21.15 min.	—
14.	Testing To Hound	English	21.15 min.	MCRC Production
15.	The Scourge	—	—	Shyam Benegal
16.	Unmasking Aids	English	43 min.	International Planned Parenthood Federation

PARTICIPANTS AT THE NATIONAL WORKSHOP ON WOMEN STDs, HIV and AIDS

Rishikesh, March 1 to 6, 1994

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