

Level of Awareness of HIV/AIDS: High Risk Groups in Manipur and Karnataka

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Abstract: AIDS has emerged as a new and serious public health emergency in Manipur and Karnataka. The State AIDS Policy was adopted by the State Government in both the states. In 1987 a National AIDS Control Programme was launched to co-ordinate national responses. Its activities covered surveillance, blood screening, and health education. Most of these initial cases had occurred through heterosexual sex, but at the end of the 1980s a rapid spread of HIV was observed among injecting drug users (IDUs) and MSM in Manipur, and CSW and MSM in the case of Karnataka. At the beginning of the 1990s, as infection rates continued to rise, responses were strengthened. Specific objectives of the study are: To study about the improvement care for patients with AIDS and investigate the level of awareness of HIV/AIDS among the general population. This study is mostly based on data from secondary sources. There are multiple sources of data analyzed for this research. In addition, qualitative data were gathered through individual interviews with the organizations, to assist in interpretation and clarification of the selected variables in the study. The HIV/AIDS estimates 2008/2009 confirms a slowdown in the AIDS epidemic. There are clear differences in HIV prevalence according to socio-demographic factors. One important finding is that there is a higher prevalence among women who are illiterate in both the states. Comparisons of these cases carried out with mentioning suggestions/recommendations on basis of the analysis to pin-point the pros and cons of the cases and derive learning, and analyse how this can be further improved and replicated to various areas of both the states. One of the major recommendations is that there is need of rapid and progressive scaling up of the study areas.

Keywords: Targeted intervention, preventive measures, counselling, care and support, awareness.

1. INTRODUCTION

AIDS (Acquired Immuno-Deficiency Syndrome) is a disease which is caused by a virus called Human Immunodeficiency Virus or HIV. This virus is fatal and dangerous because it destroys the immune system (the capacity of the body to fight diseases) in the human body and remains in the body for years together without any visible symptoms.

HIV is currently spreading in the world at the rate of new infection every fifty seconds. The HIV/AIDS is not confined to any one caste, community, religion, age-group, sex or profession, though according to the Indian Health Organisation(IHO), women and children are believed to be more prone to AIDS (The Hindustan Times, April 7,1995). According to a recent study in the British Medical Journal, India has an HIV/AIDS population of approximately 1.4-1.6 million people. While it was originally estimated that India might have had as many as 5.5 million people infected in 2005, more accurate estimates put the number at below 2.5 million in 2007. These new figures are supported by the World Health Organisation and UNAIDS. According to the United Nations 2011 AIDS report, there has been a 50% decline in the number of new HIV infections in the last 10 years in India.

The HIV infection is spread over all regions and all groups(including the high HIV prevalence states of Manipur and Karnataka). Enough to show the panic situation set in motion by AIDS. "In the absence at present of a vaccine or cure for

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AIDS, the single most important component of National AIDS Programme is information and education". As the prevalence of HIV is increasing at an alarming rate, the government of both the states has requested the Union ministry of health and family welfare to expedite release of the funds/schemes related with the control of the disease in both the states through National AIDS Control Organisation(NACO).

2. BACKGROUND OF THE STUDY AREA

AIDS has emerged as a new and serious public health emergency in Manipur and Karnataka. The State AIDS Policy was adopted by the State Government in both the states. The Manipur State AIDS Control Society (MACS) and Karnataka State AIDS Prevention Society(KSAPS) was formed and registered to implement the AIDS Control Programme in the States which work under the implementation of National AIDS Control Organisation. Estimated cases of HIV positives among the general population in Manipur are around 38,000(out of 2.4 million) and in Karnataka is around 2,75,000(out of 53 million).

In 1987 a National AIDS Control Programme was launched to co-ordinate national responses. Its activities covered surveillance, blood screening, and health education. Most of these initial cases had occurred through heterosexual sex, but at the end of the 1980s a rapid spread of HIV was observed among injecting drug users (IDUs) and MSM in Manipur, and CSW and MSM in the case of Karnataka. At the beginning of the 1990s, as infection rates continued to rise, responses were strengthened. In 1992 the government set up NACO (the National AIDS Control Organisation), to oversee the formulation of policies, prevention work and control programmes relating to HIV and AIDS. In the same year, the government launched a Strategic Plan, the National AIDS Control Programme (NACP) for HIV prevention. This plan established the administrative and technical basis for programme management and also set up State AIDS Control Societies (SACS). It was able to make a number of important improvements in HIV prevention such as improving blood safety.

By this stage, cases of HIV infection had been reported in every state of the country including Manipur and Karnataka. Throughout the 1990s, it was clear that although individual states and cities had separate epidemics, HIV had spread to the general population. Increasingly, cases of infection were observed among people that had previously been seen as 'low-risk', such as housewives and richer members of society. In 1998, one author wrote:

"HIV infection is now common in India; exactly what the prevalence is, is not really known, but it can be stated without any fear of being wrong that infection is widespread... it is spreading rapidly into those segments that society in India does not recognise as being at risk. AIDS is coming out of the closet."

In 1999, the second phase of the National AIDS Control Programme (NACP II) came into effect with the stated aim of reducing the spread of HIV through promoting behaviour change. During this time, the prevention of mother-to-child transmission (PMTCT) programme and the provision of free antiretroviral treatment were implemented for the first time. In 2001, the government adopted the National AIDS Prevention and Control Policy and former Prime Minister Atal Bihari Vajpayee referred to HIV/AIDS as one of the most serious health challenges facing the country when he addressed parliament. Vajpayee also met the chief ministers of the six high-prevalence states to plan the implementation of strategies for HIV/AIDS prevention.

The third phase (NACP III) began in 2006, with the highest priority placed on reaching 80 percent of high-risk groups including sex workers, men who have sex with men, and injecting drug users with targeted interventions. Targeted interventions are generally carried out by civil society or community organisations in partnership with the State AIDS Control Societies. They include outreach programmes focused on behaviour change through peer education, distribution of condoms and other risk reduction materials, treatment of sexually transmitted diseases, linkages to health services, as well as advocacy and training of local groups. The NACP III also seeks to decentralise the HIV effort to the most local level, i.e. districts, and engage more non-governmental organisations in providing welfare services to those living with HIV/AIDS. The India HIV estimates 2008/2009 confirms a slow down in the AIDS epidemic. National adult HIV prevalence, or the number of adults living with HIV as a proportion of the total population, has declined by over 0.10% points from 2000 to reach an estimated 0.31% in 2009. Manipur(1.4%) shows a declining trend over the past four years whereas Karnataka(0.63%) shows either a plateau or a slightly declining trend over the time period of 2006 to

2009. There are clear differences in HIV prevalence according to socio-demographic factors. One important finding is that there is a higher prevalence among women who are illiterate in both the states.

3. NEED FOR THE STUDY

The task being gigantic and the work that needs to be done for the patients infected with HIV or suffering from AIDS for many years being unprecedented in terms of scale and efforts, government expected to take up the total control programme. Voluntary organisations too, have to be involved in “behaviour change” programme. The World Health Organisation also has emphasized its need. Knowing the origin of HIV infection is related to inadequate health care, subordination of women, illiteracy, poverty and such other traditional problems, the government organisations can surely address themselves to these social realities. Focusing on the social factors influencing the vulnerability of people to HIV infection, the government organisations can provide information, services and other social support systems to people in danger of catching the disease. Before catching the infection, knowledge in the spread of HIV infection can imparted by community-based social workers. The capacity to motivate and sustain the involvement of the vulnerable people will determine the success of these organisations in both the states. After being infected with virus, the need for psychological and social support is as crucial as medical support and non-governmental organisations can easily provide these services. When lakhs of people suffer from a certain disease, total dependence on the medical system will be unwise and will surely result in a failure. There is a simultaneous need to prepare communities to be able to cope with caring for the diseased people and to find resources for this within the community itself (provides comprehensive advice on fighting HIV at a community level). The government organisations can surely make genuine effort towards this support system. Besides helping the patients, the organisations can also help the children, families and other dependents of the sufferers who become victims of isolation and discrimination. The situation assessment in Manipur and Karnataka has highlighted several important issues that will need to be addressed in the study. These include:

1. Widespread HIV Epidemic and Vulnerability – The data clearly shows that all districts of Manipur and Karnataka have been affected, so a broad-based response that reaches every district is required. This will be needed for both the prevention and care and support components.
2. Rural Vulnerability – There is now clear evidence that the epidemic has reached rural areas, and that there is substantial risk and vulnerability in rural areas that could further amplify the epidemic. Therefore, there is an urgent need to develop programme strategies that extend prevention and treatment, care and support programmes and services into rural areas. Without doing this, the overall impact of the programme will be greatly compromised.
3. Reaching Scale with Focused Prevention – There is an urgent need to reach scale with programmes and services to reach the large vulnerable key populations, particularly sex workers and their client’s. In this regard, a strategy is required to reach the high risk networks in rural areas, which, as yet, have not been comprehensively addressed.
4. Growing Care and Support Needs – there will be a growing need to develop a broad-based network of treatment, care and support services that reaches all districts of both the states.

HIV prevention efforts in Manipur and Karnataka are concerned since 2003-04 in both the states has taken a composite approach to intervention with a geographical focus. The approach essentially tries to cover all the target groups within a district through the government organisations covering particular geographical location in a district or the whole district.

It analysed the government supports in both the states where the high prevalence of HIV infection are among the IDUs and sex workers. It identified the best practices in government organisations in regard with the protection and prevention of AIDS and its outcome, and to suggest its adaptation in high prevalence areas of both the states. Comparisons of these cases carried out with mentioning suggestions/recommendations on basis of the analysis to pin-point the pros and cons of the cases and derive learning, and analyse how this can be further improved and replicated to various areas of both the states. One of the major recommendations is that there is need of rapid and progressive scaling up of the study areas.

Infact, mindsets have also been affected to such an extent that AIDS today is still perceived in a moralistic outlook. Rather, categorizing certain groups of people or behaviour has meant more attention on specific groups/behaviour while providing services related to HIV/AIDS prevention or intervention programs. Thus, Karnataka being one of the high incidence of HIV/AIDS cases in India, gives priority to addressing the sexual route of HIV/AIDS transmission while in

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Manipur, more attention is given to sharing of needles and syringes amongst injecting drug users (IDUs). Although the overall awareness level about HIV/AIDS among the youth is fairly high (although individual studies show varying results depending upon study setting), high-risk sexual behaviour without condom use and the presence of certain misconceptions constitute a major area of concern. It aims to review the situational analysis of HIV/AIDS among youths regarding epidemiology, knowledge and behaviour regarding HIV/AIDS, the programmes and policies which address HIV/AIDS in the young, as well as recommend programme strategies to combat the spread of this dreaded epidemic in the state's future productive age group.

OBJECTIVES:

The specific objectives of the study are: To study about the improvement care for patients with AIDS and investigate the level of awareness of HIV/AIDS among the general population.

HYPOTHESES:

In order to empirically achieve in a non – spurious manner the objectives of the study, the following hypotheses were postulated and tested:

1. Awareness/knowledge of HIV/AIDS will significantly influence the practice of precautionary measures against the transmission of the disease.
2. AIDS is not just a health problem; rather, it is a societal problem which threatens the basic social institutions at the individual, family and community levels. AIDS selectively yet definitively, attacks people in their economic and socially most productive years and those responsible for the support and care for others.

4. SOURCES OF DATA

This study is mostly based on data from secondary sources. There are multiple sources of data analysed for this research. In addition, qualitative data were gathered through individual interviews with the organisations, to assist in interpretation and clarification of the selected variables in the study:

- To gain an in-depth understanding of the factors influencing general population willingness to give their knowledge and ideas about HIV/AIDS, and in particular, of locally/socially specific issues that impact HIV/AIDS awareness, and of factors influencing to the staffs, to overview the role of government in respect to prevention and protection of AIDS.

The preliminary hypotheses that had been developed on the basis of the literature review for the study were refined as a result of the information and insight gain during the pilot phase.

5. SAMPLE DESIGN

Qualitative techniques were used to inform the study during the design phase and to aid conceptual and instrumental development, health care access, HIV/AIDS Government policies and initiatives and education/awareness. Selection procedures were based on convenience, but care was taken to ensure that the participants were selected to represent the various dimensions that are important to the study in terms of age, gender, caste, religion, education, etc. To accomplish the above research tasks and questions, implementing the following research steps. First, collected data from various sources, such as articles, reports, survey results, and state official statistics related to HIV/AIDS prevention and protection. Then analysed those pieces of information. Second, we conducted a sociological survey at high risk areas for information to gather information that would later use to form an intervention model of HIV/AIDS transmission protection for the group. The questionnaires addressed their awareness, attitudes, and behaviour towards HIV/AIDS protection. They were collected and analysed based on frequency, and relationship of age, gender, caste, religion, education, occupation and income among the general public. Third, we conducted an in-depth survey of managing people about awareness, attitudes, and behaviour, such as HIV/AIDS prevention and protection high risk.

6. EPIDEMIOLOGY APPRAISAL OF HIV SITUATION IN BOTH THE STATES

Despite being home to the world's second-largest population suffering from HIV/AIDS, the AIDS prevalence rate in India is lower than in many other countries. In 2007, India's AIDS prevalence rate stood at approximately 0.30%—the 89th

highest in the world. The spread of HIV in India is primarily restricted to the southern and north-eastern regions of the country and India has also been praised for its extensive anti-AIDS campaign. The US\$2.5 billion National AIDS Control Plan III was set up by India in 2007 and received support from UNAIDS. The main factors which have contributed to India's large HIV-infected population are extensive labour migration and low literacy levels in certain rural areas resulting in lack of awareness and gender disparity. The Government of India has also raised concerns about the role of intravenous drug use and prostitution in spreading AIDS, especially in north-east India and certain urban pockets. Having a population of around a billion, an increase in 0.1% of HIV prevalence would mean an increase by over half a million in the HIV-infected patients.

According to Mr. Michel Sidibé, Executive Director of UNAIDS, he stated that India's success comes from using an evidence-informed and human rights-based approach that is backed by sustained political leadership and civil society engagement.

Both the states must now strive to achieve access to HIV prevention, treatment, care and support. Both the states experience a generalized epidemic with the virus transmitted from high-risk groups into the general population. A major challenge is to strengthen and decentralize the program to the state and district levels to enhance commitment, coverage and effectiveness.

7. HIGH PREVALENCE AMONG THE VARIOUS GROUP

Operational changes were also made by establishing an effective and structured training programme and institutionalizing a strong monitoring and supervision system. Six states including Karnataka and Manipur with high HIV prevalence account for over two thirds of the HIV burden of the country. While an overall decline in HIV prevalence among antenatal care clinic (ANC) attendees is noted especially in both the states; however, there is an increase in some low and moderate prevalence states.

Table IV(iv): High HIV Prevalence among Different Groups, 2011

State	High HIV prevalence among IDU	High HIV prevalence among MSM	High HIV prevalence among FSW
Karnataka	Below 5%	17.6%	5.3%
Manipur	17.9%	16.4%	13.1%

HIV prevalence at antenatal clinics in Karnataka is lower than Manipur. High HIV prevalence among the MSM in Karnataka more than Manipur. And the prevalence among FSW shows Karnataka is lesser than Manipur. The virus has spread further the female sexual partners of drug users and their children. Although HIV prevalence among IDUs in Manipur has declined over the years, all four IDU sentinel surveillance sites in Manipur still have HIV prevalence of more than 10%.

While there is a decline in the epidemic among FSW in Karnataka state, declining trends are evident in the Manipur where the epidemic is decreasing both by IDU and sexual transmission. A steady decline in HIV prevalence amongst FSW has been noted, resulting it may be argued, from focused government and stakeholder interventions. HIV prevalence among MSM is stable. However, a varied trend in prevalence has emerged among IDU.

Female Sex Workers:

At the state level, HIV prevalence among FSWs is very high in Manipur (13.1%). In Karnataka, HIV prevalence greater than 5% among FSW. Overall, 48 sites have shown greater than 5% HIV prevalence among FSW all over the country in which includes 3 sites in Manipur and 3 in Karnataka. Among FSW, there is a decline in South Indian States reflecting the impact of interventions, while rising trends are evident in the North East suggesting a dual nature of the epidemic. In the low prevalence states, the trends are stable.

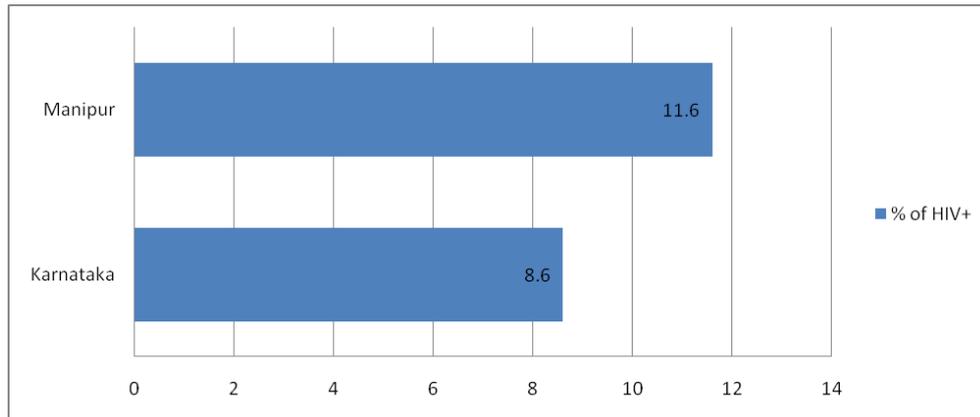


Figure I : HIV prevalence among female sex worker by state, 2006

HIV prevalence in female sex workers was $\geq 5\%$ in 39 of the 123 valid sentinel sites. Manipur, have HIV prevalence $\geq 10\%$ among female sex workers. Whereas in Karnataka, it had HIV prevalence $\leq 10\%$.

Men who have Sex with Men:

Expansion of surveillance among MSM has revealed new pockets of epidemic. Among MSM, high HIV prevalence is recorded in the states of Karnataka (17.6%) and in Manipur (16.4%). All the new MSM sites established in the state of Karnataka have shown high HIV prevalence, suggesting that there may be many pockets of high prevalence among MSM which need to be detected. Moreover, urban areas of the country such as Bangalore, recorded very high HIV prevalence among MSM. Overall, more than 8 districts have shown greater than 5% HIV prevalence among MSM. Among MSM, HIV trends are rising in south Indian states. Rising trends are also noted in Karnataka while trends are stable at the single MSM site in Manipur.

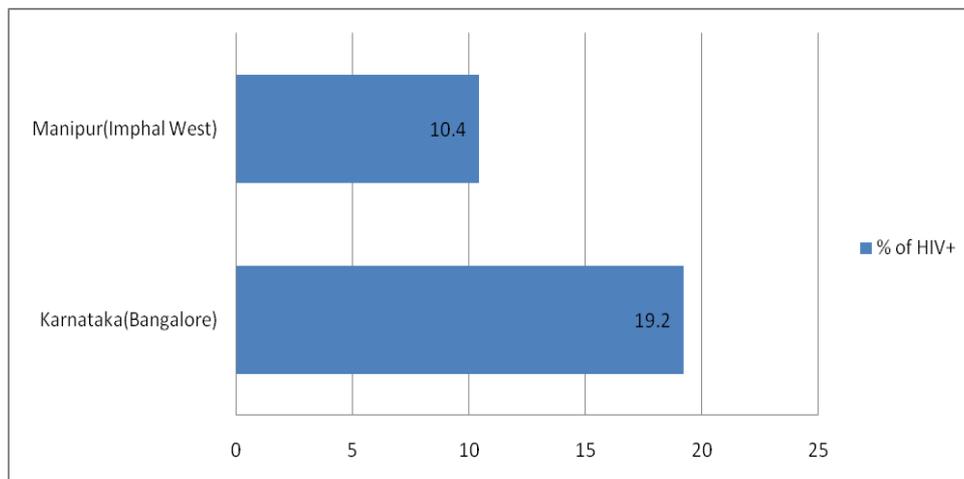


Figure II : HIV prevalence among MSM by sentinel site in both the states, 2006

HIV prevalence among men who have sex with men (MSM) was $\geq 10\%$ in Manipur and in Karnataka was $\geq 15\%$ valid sentinel sites. HIV prevalence among MSM was the higher in Karnataka than in Manipur by $\geq 8\%$.

Injecting Drug Users:

Pockets of HIV Epidemic among IDU identified in 2006 continue to show high HIV prevalence. Manipur (17.90%) high prevalence persists among IDUs and Karnataka (2%) have shown HIV prevalence between 1% and 5% among IDUs. Overall, 22 districts (24 sites) have shown HIV prevalence greater than 5% among IDUs which includes 4 sites in Manipur and no site had been reported in Karnataka. Heterogenous spread of HIV epidemic is evident from the fact that overall, 143 high risk group sites have shown HIV prevalence greater than 5% out of which 39 have shown greater than 15% HIV prevalence in 2007.

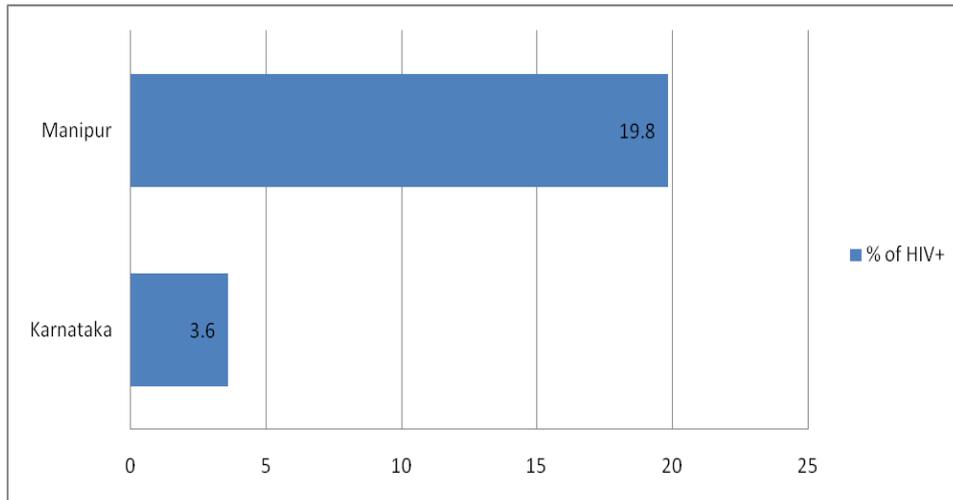


Figure III : HIV prevalence among injecting drug users, by state, India, 2006*

NOTE: Values in parentheses are the number of sentinel sites for each state.

*The required sample size for each high risk group site was 250. Sites reporting data for less than 75% of this sample size were excluded from the analysis.

HIV prevalence among injecting drug users was $\geq 5\%$ in 17 of the 45 valid sentinel sites. Manipur, had HIV prevalence $\geq 10\%$ among injecting drug users and Karnataka had high prevalence $\leq 5\%$ among injecting drug users. Considerable differences continue to exist in the prevalence rates across different geographical regions. Except certain districts with median HIV prevalence of 1%, all other areas have shown less than 1% median HIV prevalence among ANC clinic attendees. Manipur have shown 0.75% HIV prevalence among ANC clinic attendees while in Karnataka 0.50%.

8. INFORMATION, EDUCATION & COMMUNICATION (IEC)

The focus of IEC activities is on promoting safe behaviours, reduction of stigma and discrimination and demand generation for HIV/AIDS services. Under Phase-II of Red Ribbon Express (RRE) project, the special exhibition train on HIV/AIDS and other health issues completed one year’s journey on 1 December. It disseminated messages on HIV prevention, treatment and care and support, besides information on common diseases, provided free HIV counselling and testing services and general health check-up, and offered training on HIV/AIDS to resource persons. The project received an overwhelming response all across the country making it the world’s largest mass mobilisation programme. Multimedia campaign in Manipur through music and sports, has been very successful in mobilising youth, political and religious leaders and opinion makers for spreading message of HIV/AIDS prevention. Two national workshops were organised in New Delhi covering 16 states including Karnataka and Manipur on dissemination of HIV/AIDS messages through folk media, to develop standardised scripts and folk performances for better and more effective utilization of this medium for HIV/AIDS messaging. Action plans were developed for roll out of folk media campaign.

Voluntary Counselling and Testing Centers (VCTC):

Voluntary Counselling and Testing is now acknowledged as an efficacious and pivotal strategy for prevention and care for HIV/AIDS. Counselling is an important skill and is a necessary part of interventions for several areas within Family Welfare, family planning, safe motherhood, RTI/STI, and in dealing with youth. It is also more cost effective to integrate VCT into sexual and reproductive health services, rather than support them as freestanding sites. Counselling requires specialized skills and attitudes, space to assure confidentiality, laboratory services for testing, adequate reporting systems.

DHFW strategies: While counselling is an important element of several reproductive health services, counsellors are not part of the health provider cadre. ANM, LHV and other providers have been trained in basic motivation, interpersonal skills, but these are not dealt with in any depth, nor are they geared toward attitudinal change. It has thus far formed part of an integrated training package. In some states donors have supported separate training to improve counselling and motivation skills of ANM and LHV (UNFPA through IPD projects, USAID in SIFPSA), but only in selected districts.

NACP strategies: NACO and the SACS have established several VCTCs across the states with about half of them located in high and medium prevalence states. They are primarily located in medical colleges and district hospitals. Each VCTC includes one male and one female counsellor, and one laboratory technician. NACO and SACS supply testing kits for these VCTCs. In the medical colleges, the VCTC are located within the microbiology departments (with counsellors reporting to the HOD, Microbiology) and in charge of the Pathologist in a district hospital. Currently the view of the State AIDS Control Societies is that VCTC utilization is low, particularly in the low prevalence states.

Core Convergence Recommendations for VCTC:

- a. The NACP will manage the VCTC in collaboration with the key staff of the facility in which the VCTC is located. Youth information centers to be established with the VCTC to increase access of young people to information and referral for services for a range of reproductive and sexual health issues.
- b. NACP will support the staff of VCTC and supplies required with DHFW will provide the physical infrastructure.
- c. It is proposed that the district VCTC function as a satellite center to coordinate, support and supervise operations of the VCTCs located in the CHC and 24 hour PHC. This internal coordination is important for several reasons- to maintain quality of services at all sites, to ensure uninterrupted supplies, link with PPTCT at district and CHC levels, and to enable referral linkages of clients that test positive to appropriate centers.
- d. VCTCs will not function as sites for counselling of HIV/AIDS alone. Counsellors in VCTC, particularly at secondary and primary health care levels should be able to counsel for family planning, RTI/STI prevention, safe delivery, and male responsibility. A cadre of counsellors could be established who would serve the RH needs of women and men, including HIV/AIDS, and the RH information and service for young people. It is hoped that this measure will increase utilization of VCTC.
- e. Expand the number of VCTC sites. The expansion should be informed by a rapid assessment of VCTCs in low and high prevalence areas, and identify systems issues, human resource training gaps, and logistics.

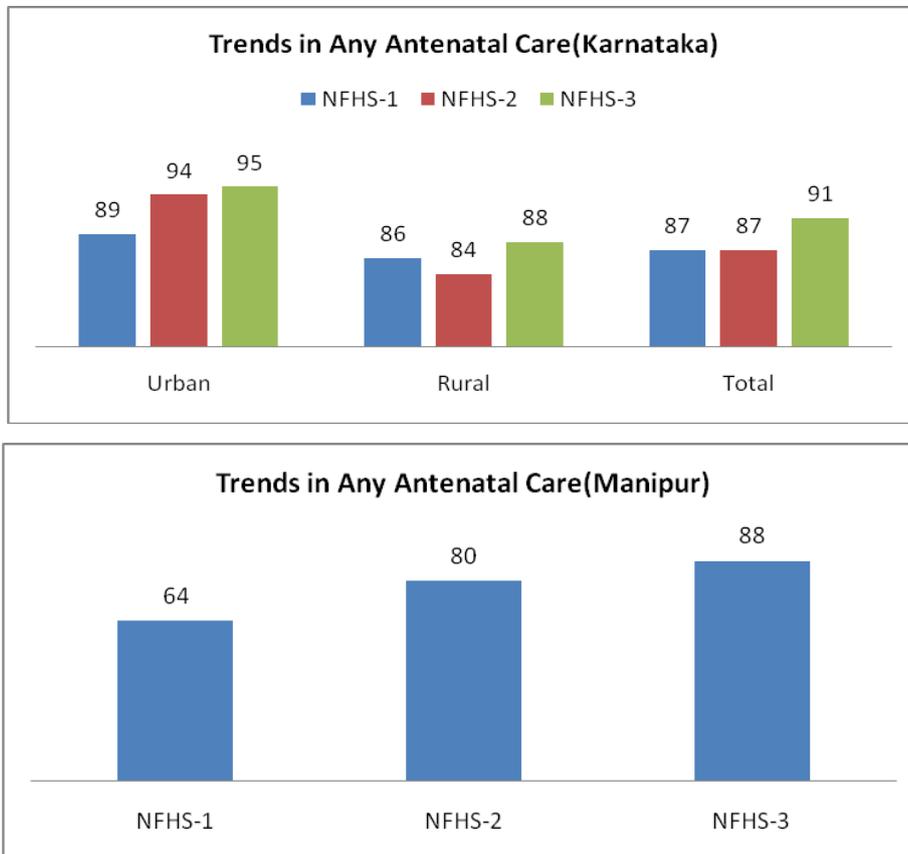


Figure IV: Trends in Any Antenatal Care(Karnataka and Manipur)

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The figure above shows trends in any antenatal care births in the last 3 years in which, Karnataka has increased as well as in Manipur.

The expansion is proposed in a phased manner, and will be governed by the following: prevalence, physical infrastructure, human resources, and community use of facilities. Fortunately both the states also have better infrastructure and increased utilization (higher rates of antenatal coverage, institutional deliveries, and overall increased care seeking behaviour). As a long-term plan, (2012) it is expected that all PHCs will have VCTC facilities that will cover a range of services beyond just HIV/AIDS counselling. The expansion process is proposed as follows:

Phase 1: (2005-2008) In the high prevalence states like Karnataka and Manipur, district hospitals, all CHCs and all 24 hour PHCs will have Voluntary Counselling and Testing Centers, staffed by a full complement of male and female counsellors; separate space and laboratory back up. In the low prevalence centers, VCTC could be located at the district level and at all CHCs. In high prevalence districts within low prevalence states, the choice of whether 24 hour PHCs could offer VCTC could be left to the state.

Phase 2: (2008-2010) All PHCs in both the states and 24 hour PHCs will have VCTC.

Phase 3: (2012): PHCs, all CHCs and district hospitals, will offer VCTC services.

Expansion will be based on review of past experience, utilization and need.

f. Basics of Counselling for all cadres of staff (sub-center to CHC) to be included in training package, so that at the very minimum all staff have the skills to enable clients to understand risk perception, motivate them to seek services, and finally be able to facilitate informed referral.

g. Involvement of private providers and private laboratories, through IMA, FOGSI, and pathologists Association, where testing takes place to ensure that their clients also are counselled and their data is reported at district and state levels.

h. NGOs under HFW programme and NGOs working with High Risk Groups to include information on VCTC functions and sites so that they can carry the message to the community, and increase utilization as appropriate.

Prevention of Parent to Child Transmission (PPTCT):

Core PPTCT interventions need action in the community, and depending on the package of services offered, at the levels of the sub center, Primary Health Center and at the Community Health Center. PPTCT interventions for HIV positive women relate to a range of services provided in the HFW system: antenatal, delivery, and postpartum care, abortion services, VCTC, Management of STIs in pregnancy, Antiretroviral therapy based on current policies- (currently Nevirapine), Family planning counselling and easy access to services, Expansion of well baby clinics, high quality education and information provision on nutrition, breastfeeding, RTI/STI, and HIV/AIDS, male involvement in MCH care, and linkages to community based care and support programs for HIV/AIDS.

DHFW Strategies: DHFW per se does not implement PPTCT interventions. Currently PPTCT interventions are being provided in selected locations through the health facilities of HFW. However, training, supplies and logistics, and drugs are primarily supplied through NACO.

NACP strategies: Currently NACO is providing PPTCT services in units across the states of which are located in high prevalence districts. They are primarily located at the medical colleges of high and low prevalence district. They are located in the Ob/Gyn department. A counsellor, mostly female and one laboratory technician staff each PPTCT. Staff of PPTCT sites (PPTCT team- Ob/Gyn, Microbiologist, Paediatrician, Staff nurse, and one health educator) are trained for five days. Counsellors of PPTCT are trained for a ten-day period. Sensitization training of other staff in the facility where the PPTCT site is located is also conducted.

Core Convergence Recommendations for PPTCT: the management of PPTCT sites should continue to be with the NACP, since all clients of the PPTCT will need to be followed up for care and support. At the institution level, the PPTCT staff will continue to report to the Head of Ob/Gyn. PPTCT at the district level will function as the hub or satellite center to coordinate quality, supplies, reporting and facilitation of referral. NACP will fund the counsellor and laboratory technician in the PPTCT and the supplies required for the PPTCT programme. The PPTCT will be located in the Ob/Gyn department of the CHC and will function through existing staff. PPTCT sites should be expanded in a phased

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manner. Since PPTCT is a function of the obstetric department, and since RCH II is focusing on improving/strengthening access and quality of institutional deliveries, PPTCT can be implemented within the framework proposed for RCH II.

Phase 1 (2005-2008): All district hospitals and CHCs to offer PPTCT, regardless of prevalence.

Phase 2 (2008-2010) In both the states, 24 hour PHCs, should also offer PPTCT.

Phase 3(2012 years): 24 hour PHCs in the states to offer PPTCT services, based on prevalence, utilization, and need.

At the community level, ASHA/ANM will be trained through health education and motivation among women and men for risk perception, risk identification, facilitation in accessing VCTC, and thus identifying positive women in need of PPTCT. Para medical and medial providers at the PHC level will also be trained in similar areas to facilitate referral to PPTCT and enable follow up. Positive women will be followed up through pregnancy by ANM/ASHA and encouraged to opt for institutional delivery in district or CHC/FRU.

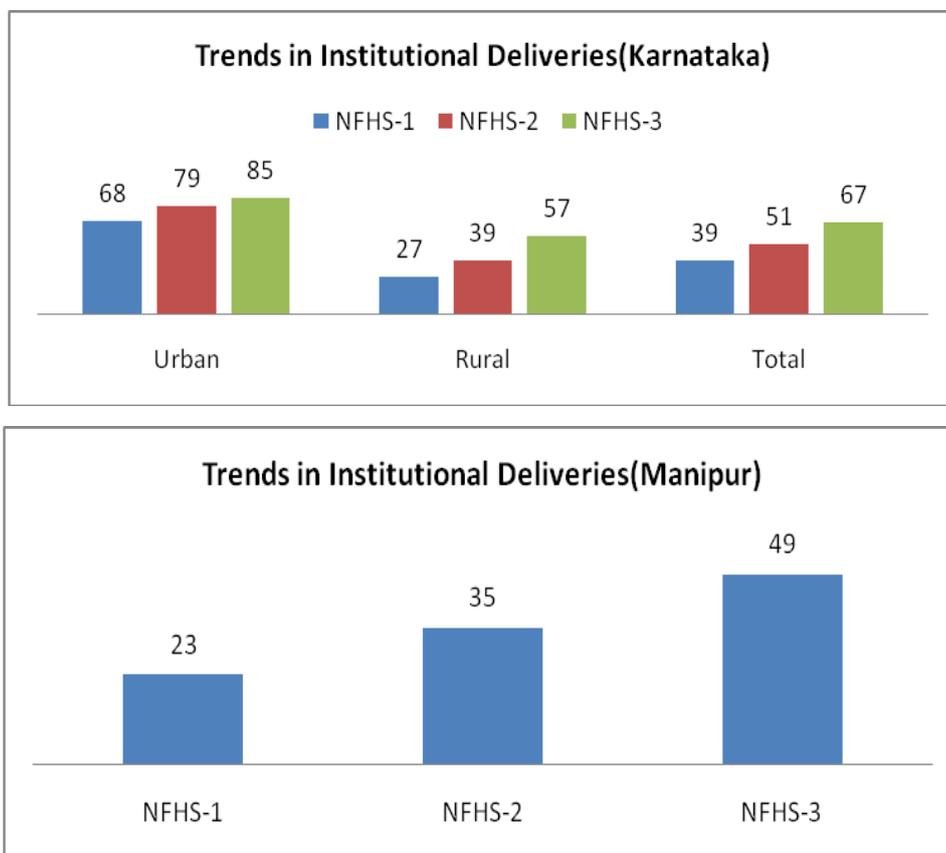


Figure V: Trends in Institutional Deliveries(Karnataka and Manipur)

The figure on the previous page shows trends in institutional deliveries(births in the last 3 years) in which, Karnataka has increased as well as in Manipur.

PPTCT programmes should establish linkages with the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) component of RCH II, to address issues of infant feeding, nutrition, and infections. All providers would need sensitization on issues of stigma and discrimination, so that positive women do not fear institutional deliveries. PPTCT teams should be specially trained in areas of infection prevention, and stigma and discrimination attitudes, as well as the specific technical aspects of PPTCT. Institutions to be strengthened to adopt universal precaution measures and waste management. Delivery kits to be made freely available under the PPTCT programme. Orientation and sensitization of private providers (through IMA, FOGSI, Indian Health Care federation, Hospital forums and associations) and involvement of private hospitals in VCTC and PPTCT as appropriate. NGOs supported by DHW and NGOs working with high-risk groups to be provided with information on location of PPTCT sites and encouraged to facilitate referral and follow up.

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Behaviour Change Communication:

Changing individual and community behaviour is critical to HIV prevention. In order to impact the epidemic it is necessary to target behaviour change interventions at the individual level to increase knowledge, enhance risk perception, and develop safe sex skills. These are primarily through interpersonal communication and small group discussions and peer education. Such efforts at the individual level need to be reinforced by community level interventions to increase understanding of a supportive environment to reduce risk and vulnerability, and influence societal norms. Messages that are targeted to sexually active individuals include: postponing age of sexual activity, using condoms correctly and consistently, decreasing number of sexual partners, increasing STI and TB treatment seeking and prevention behaviours.

DHFW strategies: HFW has not integrated HIV/AIDS messages in BCC material till date. However, in the past few months, efforts are on to integrate HIV/AIDS prevention messages in some initiatives of the HFW department- wall calendar and diary for 2005 of the MOHFW includes HIV/AIDS messages. Adolescent health education and life skills programmes have included HIV/AIDS content quite substantially, especially in the adolescent friendly health clinics, piloted by MOHFW.

NACP strategies: At the State level, NACO frames guidelines for IEC activities state wide and undertakes multimedia campaigns along with political and media advocacy. NGOs working with high-risk groups for targeted interventions develop their own BCC strategies. SACS in each state have mass media campaigns and other activities for general population- varied across states and school AIDS Education programmes.

Core Convergence Recommendations for BCC:

- Create a mechanism to ensure that the leadership for developing BCC strategies and programmes for DHFW and NACP is vested with one authority.
- Joint (NACO, DFW) behaviour change communication strategy to be developed based on commonality of target groups, and tailored for reach of general as well as high-risk populations. This needs to take place at state level as well between State AIDS Control Societies and State IEC bureaus.

Condom promotion:

Currently the male condom is the most widely available effective protection method against HIV and other STI. Condom distribution can be through free or social marketing channels. They could be through community based distribution systems, depot holders, health facilities, pharmacies, and village stores. For any scaled up prevention response it is important to improve access and availability of condoms to all communities (rural and urban) and groups.

DHFW Strategies: In the family welfare programme, male condoms are promoted as a method of contraception. In order to improve the use of condoms as a contraceptive, several initiatives at social marketing and distribution through government and NGOs are being undertaken. Thus DHFW is the repository of substantial experience in promoting condom use as well as condom procurement and distribution.

NACO strategies: Currently NACO procures and supplies condoms to the NGOs working with HRG. Primarily NACO and the SACS obtain their supplies through the DHFW. NGOs also directly access social marketing agencies. NACO and SACS ensure that there is adequate supply of condoms in STD clinics, VCTC, and Ob/Gyn clinics. SM condoms are made available at outlets situated near state highways and in areas where TI projects are underway. NGOs are encouraged to use a mix of free and SM approaches.

Core Convergence Recommendations for Condom promotion:

- Create a mechanism to ensure that condom programming for NACP and DHFW is managed within a single entity to provide leadership and direction. This integration will greatly facilitate streamlining the condom promotion strategy between the FW and HIV/AIDS programmes.
- Joint development of a strategy on condom procurement and distribution to meet the needs of sexually active women and men as a contraceptive method, as a method of dual protection and to meet the needs of high-risk groups.
- Condom supplies for NGOs involved in TI to be through NACO and SACS.

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- HFW to promote condoms as dual protection method through improved distribution channels.
- Pilots to promote female condom use among general population as well sex workers both as a contraceptive and barrier method.

However the use of condoms as a method of dual protection has not been promoted so far. About 25% of the overall condoms procured are distributed as free supplies with 75% being programmed through social marketing agencies. Of these 25 %, over three quarters are channeled to SACS for distribution to HRG through NGOs.

Safety of blood and blood products:

In addition to ensuring blood safety, other strategies to reduce transmission include: reducing the need for transfusions, educating and motivating low risk individuals to donate blood. The ground reality however, is that the blood transfusion services are plagued by fragmented management, a situation not conducive to blood safety. While our collection of blood demonstrates no absolute shortages, there are occasional and seasonal shortages. WHO recommends that the ratio of the use of blood components and whole blood should be 90:10 since only a limited category of clinical interventions require whole blood. In both the states, 80 per cent of blood is used as whole blood, only and 20 per cent units are utilised as components. Blood banks and blood transfusion centres operate in total isolation; their standards vary from state to state, city to city and from one centre to the other centre within the same city.

DHFW strategies: Currently blood banks are located at state and at district levels. Stringent guidelines for blood banks are in place. In the RCH II programme, DHFW has planned blood storage centers at FRU level. However the procurement of blood will be primarily from the blood banks certified by NACO, so quality control appears to be taken care of.

NACP strategies: NACO has been involved in developing a blood safety policy and guidelines for blood banks. NACO provides state wise details of blood banks supported and strengthened respectively.

Core Convergence Recommendations for Blood Safety:

It is recommended that this policy be continued so that stringent quality controls are maintained at the district levels, and high quality blood is available at secondary levels of care. Most of the blood banks are hospital based and often operate with minimal infrastructure and inadequate / irregular supply of blood. The hospital based decentralised blood banking system has led to a skewed distribution of resources, and makes difficult any implementation of a stringent quality control programme. The purpose of this Action Plan for Blood Safety is to operationalise the priorities and objectives set out in the national blood policy and to address the infirmities in existing systems in terms of quality, structures, linkages and procedures that govern the blood transfusion services in the country.

- A primary objective is to have a well-knit and regionally coordinated blood banking system, with structured blood transfusion services and an inbuilt mandatory Quality Assurance Programme, to be achieved through a series of linked interventions.
- Blood should be meticulously screened for infectious agents, prior to transfusion. To fully operationalise and achieve this objective, we articulate systems for continually imparting appropriate education and training to the concerned staff as well as to the community.
- Blood for transfusion should be obtained only from low risk, voluntary donors. Procedures are specified to promote donor retention.
- Within the national blood transfusion programme, we articulate an effective quality management mechanism so that a commitment to quality enhancement permeates every single regional blood transfusion centre, blood bank and blood storage centre. Individually and collectively each of these entities and structures must become synonymous with safe blood & blood products.
- And finally, in order to ensure the optimal availability of blood for life saving situations, we promote the appropriate clinical use of blood. As a rule of thumb, blood and blood products must be prescribed only when the benefits of transfusion outweigh the risks.

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All of this can be achieved if we link vertically and horizontally all blood banks and blood testing centres with a mandate for quality assurance. The Action Plan for Blood Safety aims to put in place a network of accredited regional blood centres (RBTCs), blood banks (BBs), inclusive of blood storage centres (BSCs) which will make available closer to the people, appropriately screened, safe blood procured through voluntary donation.

Management Information Systems:

DHFW strategies: As part of the RCH II programme a Management Information System is being designed. An Integrated Disease Surveillance Project is also underway. Both these systems will essentially capture data on an ongoing basis at all levels for programme implementation and ongoing monitoring. Small and large scale surveys such as the NFHS and District level HH surveys are also conducted periodically.

NACP strategies: The nationwide sentinel surveillance system captures data on an annual basis from about 455 sites across the country. In addition, VCTC, blood banks and PPTC serve as a reporting base. Programme supported NGOs also report on STI treated, condoms distributed and coverage of high-risk groups.

Core Convergence Recommendations for Management Information Systems:

- Joint working group to review data needs, assess ongoing sources, and finalize requirements to fit into RCH II MIS, so that all facilities report service performance on RTI/STI, VCTC and PPTCT as part of routine reporting, while maintaining confidentiality.
- State and national level surveys (NFHS III, DLHS) designed to provide information on KAP related to RTI/STI/HIV/AIDS
- Research and prevalence studies to assess nature of STIs to develop suitable management protocols and assess antibiotic resistance patterns. Need to explore linkages with integrated disease surveillance programme.
- Mechanisms to ensure periodic reporting on STI/HIV/AIDS by private providers
- Include NGO reports as part of district level reporting.

Male involvement:

The case to promote male participation in improving reproductive and sexual health for women has been articulated in several documents and is being implemented through several community-based initiatives. However, the reach of programmes of the DHFW to men is low. NACP on the other hand, (given that men are the predominant target group in the general population) has significant experience in approaches to reach men, through condom promotion, STI clinics, and mass media. In RCH II, it is proposed to provide gender sensitization training for all providers. Specific BCC interventions will be implemented to increase demand for male contraceptive methods, male RH services, and to heighten awareness about men responsibility in support of women sexual and reproductive health.

Core Convergence Recommendations to improve male involvement:

Ensure that NACP and DHFW training include male responsibility as a key area

- BCC strategies for both NACP and DHFW to address the area of male responsibility and shared action for improved women
- RH as a major issue- includes partner notification, drug compliance, safe sexual practices and condom promotion.

Strengthening urban health services to improve convergence:

Urban health particularly among the poor presents a special challenge to the DHFW. While overall health indicators in rural areas may be better than in rural areas, they mask significant disparities. The reach of the poor to good health care is limited, and they are often served by the private sector, poorly regulated and offering care of questionable quality. Given the increase of slum populations, migrants, and street children, and that these groups are identified as high risk groups for HIV/AIDS, it is essential that their access to the services such as RTI/STI, VCTC, PPTCT, condom promotion and BCC interventions be improved.

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The NACP supports several targeted interventions in urban areas, primarily through NGOs, and targeted at marginalized, high-risk groups, and not often general population based. NACP also support STI clinics, VCTC and PPTCT in large medical colleges/teaching hospitals. However primary and secondary health care facilities in urban areas are not as clearly structured or organized as in rural areas. RCH II proposes a two-tier facility an urban health center for a population of 50,000- to address primary health care needs of the population, particularly the vulnerable, and a second tier (mix of private and public sector) to serve as referral sites.

Core convergence Recommendations to improve reach of urban health:

- Strengthening urban health infrastructure, including training of urban providers will have benefits for urban RCH and NACP.
- Involvement of urban private sector practitioners in training programmes, through involvement of IMA and FOGSI. .
- Referral information on sites where RTI/STI, VCTC, and PPTCT are available to be widely disseminated to both general and high risk populations through NGOs, private sector, and IEC efforts.
- UHC and Referral sites to offer a range of RCH services without discrimination and in an equitable manner to general populations and populations at risk.

Next steps:

As pointed out initially, this paper is only a broad framework for actions on convergence. The framework needs to be validated at state level to ensure that there is ownership of the issues between the State AIDS Control Societies and the Departments of Health ad Family Welfare. While RCH II is the focus of convergence since it is due to be launched fairly soon, and there has been significant decentralized planning and design, it is emphasized in this document. However there are several other programmes and partners that also need to be viewed through the lens of convergence to ensure appropriate and effective local responses to HIV/AIDS.

Intersectoral convergence activities

As the indicators of health depend as much on drinking water, nutrition, sanitation, female literacy, women's empowerment as they do on functional health facilities, NRHM seeks to adopt a convergent approach for interventions under the umbrella of the district plan which seeks to integrate all the related initiatives at the village, block and district levels. While substantial spending in each of these sectors would be from the concerned departments, the Village Health Plan /District Plan would provide for some catalytic resources through Untied Grants for convergent action.

Also, as reflected in the HIV/AIDS and RCH convergence document, sub-district activities for prevention of HIV/AIDS are also to be planned as an integral component of the DHAPs. Possible demand generation activities for utilizing services offered such as PPTCT, VCT and ART, should be explored. There may be variations across the states in integrating DHAPs with Safe water supply and rural sanitation in the initial years. However eventually district health missions should aim to integrate these programmes also to achieve desired synergy in activities leading to comprehensive response for health determinants.

9. SERVICES FOR PREVENTION

The HIV epidemic in both the states are concentrated among high risk groups (sex workers, men-having-sex-with-men, injecting drug users and clients of sex workers), though there is evidence of the infection spreading to the general population. About one-third of districts in the country have high HIV prevalence.

To contain the infection, NACP-III consolidates efforts in prevention, care, support and treatment of HIV/AIDS. Under the plan all HIV/AIDS linked services are integrated and scaled up to sub-district and community level. However, the services available in any area are based on the prevalence there. This is made necessary as HIV/AIDS in India presents heterogeneous epidemiology with high rate of prevalence, more than one percent in general population in some districts and low prevalence in others.

Awareness raising:

HIV infection is entirely preventable through awareness raising. Therefore, awareness raising about its occurrence and spread is very significant in protecting the people from the epidemic. It is for this reason that the National AIDS Control

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Programme lays maximum emphasis on the widespread reach of information, education and communication on HIV/AIDS prevention. Changing knowledge, attitudes and behaviour as a prevention strategy of HIV/AIDS thus is a key thrust area of the National AIDS Control Programme.

Awareness raising brings behaviour change. Through this route the programme promotes prevention, and aims to reach out to 80 percent of the high risk groups and 95 percent of the young people. In fact, the awareness campaign of NACP implemented on SACS has received a big boost with the formation of National Council on AIDS that has mainstreamed HIV prevention activities in various government institutions and programmes.

HIV/AIDS researchers, specialists and government organizations involved in HIV/AIDS can play a role in providing some of the information or the support required. Capacity building can sometimes take the form of training-of-trainers sessions, where members of community-based NGOs are trained first, and they then use this training to train or educate other stakeholders. As many NGOs working on HIV/AIDS already have existing networks of partner organizations and constituents, NGOs often embrace this task and play an active role in disseminating information to their peers. In some cases, the use of the media is critical. When a trial yields disappointing results, there is need to maintain transparency and hope. Soliciting media support becomes critical in such cases.

10. RESPONSE TO THE CHALLENGES

Based on the experience of both the states, gained along with the evolving trends of the HIV/AIDS epidemic, the focus shifted from raising awareness to changing behaviour, decentralization of programme implementation at the state level and greater involvement of NGOs. The policy and strategic shift was reflected in the two key objectives of NACP implemented on SACS:

- To reduce the spread of HIV infection in India.
- To increase India's capacity to respond to HIV/AIDS on a long-term basis.

The aim was to keep HIV sero-prevalence:

- i. below 5% of the adult population in high prevalence States including Karnataka and Manipur,
- ii. Below 3% in both the States where the prevalence was moderate, and
- iii. Below <1% in Karnataka and >1% in Manipur where the epidemic prevalence was at a nascent stage.

Policy initiatives taken during NACP-II and III include: adoption of National AIDS Prevention and Control Policy (2002) through SACS; National Blood Policy; a strategy for Greater Involvement of People with HIV/AIDS (GIPA); launching of the National Rural Health Mission; launching of National Adolescent Education Programme; provision of anti-retroviral treatment (ART); formation of an inter-ministerial group for mainstreaming; and setting up of the National Council on AIDS, chaired by the Prime Minister/Chief Minister.

At the operational level, SACS and NGOs were involved in the implementation of Targeted Interventions (TIs) among HRGs and setting up Voluntary Counselling and Testing Centres (VCTCs) and STD clinics at the district level. Nation-wide, state level Behaviour Sentinel Surveillance (BSS) surveys were conducted. Prevention of Parent to Child Transmission (PPTCT) programme was expanded across the states.

Introduction of a Computerized Management Information System (CMIS) and a Computerized Project Financial Management System (CPFMS) were the other highlights of NACP-II. In addition, a number of organisations and networks were also strengthened; support from bilateral, multilateral and other partner agencies also increased substantially. As a result of all these efforts, the HIV prevalence as indicated by recent studies and analyses seems to be stabilizing, that is in both the states, HIV prevalence have started showing declining trends. The sentinel surveillance results of 2005 also reinforce the stabilization trends indicating that the expected outcomes of NACP-II have broadly been accomplished.

National AIDS Control Organisation is a division of the Ministry of Health and Family Welfare that provides leadership to HIV/AIDS control programme in India through State HIV/AIDS Prevention and Control Societies.

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As the epidemic spread, need was felt for a nationwide programme and an organisation to steer the programme. In 1992 India's first National AIDS Control Programme (1992-1999) was launched, and National AIDS Control Organisation (NACO) was constituted to implement the programme.

The objective of NACP-I (1992-1999) was to control the spread of HIV infection. During this period a major expansion of infrastructure of blood banks was undertaken with the establishment of blood banks and blood component separation. Infrastructure for treatment of sexually transmitted diseases in district hospitals and medical colleges was created with the establishment of STD clinics. HIV sentinel surveillance system was also initiated. NGOs were involved in the prevention interventions with the focus on awareness generation. The programme led to capacity development at the state level with the creation of State AIDS Cells in the Directorate of Health Services in states and union territories.

During NACP-II (1999-2006) a number of new initiatives were undertaken and the programme expanded in new areas. Targeted Interventions were started through NGOs, with a focus on High Risk Groups (HRGs) viz. commercial sex workers (CSWs), men who have sex with men (MSM), injecting drug users (IDUs), and bridge populations (truckers and migrants). The package of services in these interventions includes Behaviour Change Communication, management of STDs and condom promotion. The School AIDS Education Programme was conceptualised to build up life skills of adolescents and address issues relating to growing up. All channels of communication were engaged to spread awareness about HIV/AIDS, promote safe behaviours and increase condom usage. Voluntary counselling and testing facilities were established in healthcare facilities to promote access to HIV counselling and testing. The interventions for prevention of parent to child transmission were also started. Free antiretroviral therapy was initiated in selected hospitals in the country. Development of indigenous vaccine and research on microbicides are some initiatives in HIV research. Apart from this, some policy initiatives during NACP-II included National AIDS Prevention and Control Policy, National Blood Policy, a strategy for Greater Involvement of People with HIV/AIDS and National Rural Health Mission.

A National Council on AIDS chaired by the Prime Minister and consisting of state ministries, chief ministers, civil society representatives, positive people's network and private sector organisations was constituted with the following objectives:

- To mainstream HIV/AIDS issue in all ministries and departments by treating it as a development challenge and not merely a public health problem.
- To provide leadership to mount multi-sectoral response to combat HIV/AIDS in the country with special reference to youth, women and the workforce. Under NACP-II,III responses to the vulnerable groups were fragmented and patchy. Under the composite targeted interventions, IDUs and CSWs were "included" in high risk groups. There are much evaluations on the impact of the interventions with children and women on the epidemic. Regarding youth, substantial work has been done under the Adolescent Education Programme by training teachers and students of all high schools but there were limited interventions for either the out of school or university youth. Whatever was done for youth and young women groups was on account of the initiatives of some SACS and development partners – be it the ASHA programme in both the states that focussed on harnessing the energies of the SHGs in the state which sought to mobilize college youth into committing themselves to promoting healthy living among their peers.

It should be noted that educational initiatives can be organised by NGOs, researchers, other stakeholders, or a combination. As well, it is sometimes necessary to ensure that educational initiatives target audiences other than the – for example, health care workers and the media. In some instances, educational initiatives may be combined with attempts to directly recruit volunteers for the trials.

Vulnerability can be defined as the degree to which an individual or a section of population has control over their risk of acquiring HIV, or the degree to which those people who are infected and affected by HIV are able to access appropriate care and support⁹. Various contextual and structural factors prevailing in India are generally favourable to an increased incidence of HIV/STIs across the country. Increasing pace of urbanization, high internal population mobility, unbalanced male-female ratio (leading to an excess of men in cities), geographical and economic disparities, illiteracy, lack of preventive knowledge and skills, rural-urban differentials in knowledge, poverty, gender roles, spectrum of high-risk sexual behaviour (initiation of sexual activity at younger ages, engaging in sexual intercourse without using a condom) are the documented risk factors. Thus, the risk perception and behaviour of the young people are likely to determine the

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future direction of HIV/AIDS in the country. Under NACP-III, women, youth and children in special settings viz., young people in high prevalence districts, school drop-outs, especially girls, working children, children of sex workers, orphans of HIV/AIDS infected and affected shall be focused targets for specific interventions.

11. RECOMMENDATIONS

The actual number of staffs in SACS vary from Karnataka to Manipur depending on local priorities and requirements. Suggesting a minimum staff strength for all SACS, as states generally seek guidance from NACO on their organization structures. States should define additional staff requirements based on programme content.

- The government needs to promote open and healthy dialogue of the HIV/AIDS epidemic, safe sexual practices, and provide more comprehensive and readily available education classes concerning the epidemic.

- Providing care and support- All workers, including workers with HIV, are entitled to affordable health care services: It is therefore recommended that a District AIDS Control Unit (DACU) be established within the district health administration and brought under the purview of the NRHM. The Unit should be headed by a district programme officer who will be the nodal officer and focal point for all HIV related activities in the district. The DACU reporting to the NRHM District Health Society and its supervisory structures through the district health administration and will be accountable to them for its performance. However, it is recommended that SACS and NGOs can work in partnership with researchers to help overcome initial suspicions and create opportunities for dialog across the high-risk groups involved.

- One to one discussion(consultations) must happen locally as well as nationally. It is important to consider when reaching out to almost all the general population and where the HIV prevalence are low and which is likely to increase the infection due to the ignorance and lack of awareness programmes.

- The behaviour change education programme for most at risk young people in high prevalence districts of both the states.

It is against this backdrop that the researcher recommends the HIV/AIDS education to craft and put in place national policies on enhanced social support for children and women. These policies would guarantee the continued consolidated food, health and education support. Therefore follows that financing responses to HIV should be a shared responsibility-financing and implementing the programmes to deliver effective prevention, treatment, care and support services to all the people in both the states.

12. CONCLUSION

It should be noted that educational initiatives can be organised by NGOs, researchers, other stakeholders, or a combination. As well, it is sometimes necessary to ensure that educational initiatives target audiences other than health care workers and the media. In some instances, educational initiatives may be combined with attempts to directly recruit volunteers for the trials. Vulnerability can be defined as the degree to which an individual or a section of population has control over their risk of acquiring HIV, or the degree to which those people who are infected and affected by HIV are able to access appropriate care and support⁹. Various contextual and structural factors prevailing in India are generally favourable to an increased incidence of HIV/STIs across the country. Increasing pace of urbanization, high internal population mobility, unbalanced male-female ratio (leading to an excess of men in cities), geographical and economic disparities, illiteracy, lack of preventive knowledge and skills, rural-urban differentials in knowledge, poverty, gender roles, spectrum of high-risk sexual behaviour (initiation of sexual activity at younger ages, engaging in sexual intercourse without using a condom) are the documented risk factors. Thus, the risk perception and behaviour of the young people are likely to determine the future direction of HIV/AIDS in the country.

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