UNESCO

A Cultural Approach to HIV/AIDS

Prevention and Care

TOWARDS

A HANDBOOK FOR INDIA

OVERALL ASSESSMENT

CASE STUDIES

STRATEGIES/CONCLUSIONS/RECOMMENDATIONS

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It is my pleasure to present *the building blocks* of a "Handbook for India", carried out within the joint UNESCO/UNAIDS Project "A Cultural Approach to HIV/AIDS Prevention and Care". As such, this document materializes in its first version the expected pilot project.

Actually, after the publication of the overall Handbook on the subject, no consistent set of methodological concepts and tools had been developed at the national level in any region of the world. The choice of India for this première was together fascinating and challenging, to test the validity of the cultural approach.

In this respect, the present achievement is all the more impressive that in India, diversity is the most prominent feature of culture, at the level of the Union as well as in its various regions, states, large cities and societal, linguistic, spiritual and religious communities. It provides further evidence of the fruitfulness of considering culture as the core reality, not only in development generally speaking, but also in responding to an apparently such specific issue as HIV/AIDS. I hope it will be considered both as an example for other countries and the initial phase of a national strategy which calls for a significant follow-up within the project.

In addition, I should like to emphasize that, as a pilot project, this publication reflects fully the Director-General's instructions concerning UNESCO's strategy in HIV/AIDS preventive education, as regards customizing the message and taking cultural factors into account while impinging on social realities. This is the key prerequisite for appropriate, efficient and sustainable effort, in order to ensure that UNESCO's activities are coherent, effective and visible.

In this sense Handbook for India will represent a new step in the implementation of UNESCO's mission in the world mobilization against the epidemic.

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GLOSSARY OF LOCAL TERMS

Arogya	Free from disease
Ayurveda	Indian system of medicine
Babu	Used as a north and east Indian Hindu courtesy title
Charpai	String cot
Dhanda	Business (in this context it means sex work)
Dosti	Friendship
Gotra	Clan
Jati	Caste
Khel	Play
Kismat	Fate
Mahila mandal	Local women's group
Masti	Fun
Mela	Fair
Panchayati raj	Local self governance
Paraya dhan	Someone else's property
Patita	Fallen woman
Pradhan	Community leader
Purdah	The Hindu or Muslim system of keeping women secluded
Sarvodaya	People's movement in mid-twentieth century
Siddha	Indigenous system of medicine
Swasthya	Health
Taluk	Administrative jurisdiction within a district
Unani	Greek system of medicine

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDU	Intravenous Drug User
IUD	Intra Uterine Devices
MSM	Men who have sex with men
NACO	National AIDS Control Organization
NGO	Non-Governmental Organization
PHC	Primary Health Centre
PLWH/A	People living with HIV/AIDS
RMP	Registered Medical Practitioner
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund

I- METHODOLOGICAL BACKGROUND OF THE HANDBOOK

Within the framework of the UNESCO/UNAIDS joint project "A cultural approach to HIV/AIDS prevention and care", and on the basis of the general methodological Handbook drawn up by CLT/CPD/CRM on the subject, the UNESCO Office in New Delhi ensured the elaboration of an Indian Handbook for taking a cultural approach to HIV/AIDS prevention and care. It had to take full consideration of current cultural references and resources which could be identified and mobilized in the various facets of Indian culture, seen in its entirety and rich diversity. The assessment and investigation studies were elaborated on well-differentiated cases and situations. The lessons learnt from this research were shaped into conclusions and recommendations, in order to illustrate the common trends as well as the significant diversities. These were reflected when elaborating the methodological proposals on the topics listed below.

Concerning the objectives and target audience of the Handbook, as stated in the overall terms of reference of the UNESCO/UNAIDS Project, taking a cultural approach in HIV/AIDS prevention and care means that choices in action methods, as well as the overall impulse needed to improve the efficiency, relevance and sustainability of activities carried out - at all levels, and in all types of organized structures – need to be based on the population's cultural references and resources.

The Indian Handbook, as an innovative publication devoted to the cultural approach of HIV/AIDS prevention and care in India provides a critical summary of the results of research already carried out in all related fields and suggests a series of methodological and pedagogical proposals on the topic. It can now serve as a basis for discussion, further reflection and action for different actors: policy makers, researchers, planners and project developers, NGO's, etc. in fields such as medicine and health, social development, population and education policies, IEC, etc.

At a further phase, depending on available financing, a specialized publication for precise target groups as well as training workshops and pilot projects could be developed on the basis of the present overall Handbook.

Beyond documenting the research carried out, developing the Handbook along the cultural approach needed several key issues to be investigated:

- One of the most important aspects of the project was its consideration of people and stakeholders' <u>cultural references,</u> as regards traditions, religious beliefs, conceptions of health and disease, life and death, sexual norms and practices, as interrelated components of their general systems of world representation.

- Special attention was paid to those cultural aspects linked to value systems, knowledge and know-how, which are – or could be - used as resources to motivate people in questioning their sexual and non-sexual behaviours linked to HIV/AIDS prevention and care. This helped them evaluate the risks entailed by

this behaviour in catching and transmitting the virus and, on this basis, recognize the necessity of changing their practices and giving a higher priority to HIV/AIDS, linked to their cultural and daily life conditions.

- Another crucial aspect in the rationale of the project is that the traditional value systems and behaviour norms still active in pilgrimage and worship centres, and rural popular cultures, are increasingly faced with, and more or less destabilized, and disintegrated by the migration flows to big cities. While the rural areas are still living with their own norm and life models, in these urban centres, adolescents and even children are brutally imperilled by the challenges of surviving in a hostile environment, that can be economically and culturally destructive, though apparently permissive and creative. Thus a specific issue like HIV/AIDS has to be understood in the context of dramatic and rapid change. This change often comes in the shape of mutations from the rural, traditional and popular systems, to modern urban structures with sophisticated societal systems that offer destabilizing new conditions of life, based on ruthless, individualistic competition and the loss of spiritual and ethical references.

- It pays specific attention to enlightening the role of the most representative religious belief systems active in India, namely Hinduism, Islam, Jainism, Buddhism, Christianity, in their various aspects, as well as spiritual convergence projects and new syncretic spiritual movements. Other more focused subjects were also researched in depth: role of the family in relation with infected and sick people, in interaction with the health and medical system, differentiated approach to the group refered to as "young people", tribal populations, etc. Contacts and dialogue will be developed to this effect, in order to give an accurate account of their importance and potential influence on peoples inhibited rules and attitudes.

On this basis, the Handbook assesses the present situation in its first part and proposes a set of methodological and pedagogical proposals dealing with the   following activities in its second part:

- Strategy building and project design;
- Culturally-appropriate information, education, communication processes and contents;
- Training curricula and modules for civil service, health and education personnel, media professionals, public authorities at all levels, social and economic associations and movements, including trade unions, business and entrepreneurs associations;
- Sensitizing policy- and decision-makers;
- Building/strengthening partnership with traditional, religious, ethical and cultural stakeholders;
- Collecting and processing data, networking data bases and specialized research centres;

- Formulating more targeted further research needs and general terms of reference for sample pilot projects.

II- STRUCTURE OF THE HANDBOOK

The present report has been defined as a first step towards preparing a National Handbook for care and prevention of HIV/AIDS based on a cultural approach to the problem. Clearly this is a huge task and the current study, as noted above, marks only the beginning of the process. Given the complexity of the cultural scene in India, the report has been conceived as consisting of components at three levels of aggregation.

There are five sections. The first introductory section deals with the background and extent of the epidemic and the rationale for a cultural approach.

Section II provides the macro perspective and an analysis of the general cultural practices and norms of relevance in the Indian society.

Section III presents the insights derived from the field-based studies that covered a spectrum of the population. At one end are the special groups who are particularly vulnerable to HIV infection, i.e. '*women in prostitution*'. Two groups belonging to this category that were studied are the Devadasi community in Karnataka and the Bedia Community in Rajasthan. At the other end are the select mainstream groups, such as adolescent boys, married women and migrant labourers interviewed in Delhi. In between are the groups who do not follow mainstream cultural practices and yet, by their sheer numbers, have large areas of interaction with mainstream population, with implications in the spread of HIV/AIDS. Two examples of such structures reported in this document are MSMs and street children, both from West Bengal. Drug users from Delhi also form a part of the framework.

Section IV draws upon the macro perspective to derive some culturally conditioned beliefs and practices that are of relevance in the care and prevention of HIV/AIDS.

Section V deals with Lessons Learnt and Recommendations including the Conclusion.

III- METHODOLOGICAL CHOICES

1- Objective of the study

This study has been undertaken to provide the basic structure of a handbook for the prevention and care of HIV/AIDS in India, in a manner that is sensitive to the cultural diversities in the country and their crucial significance in formulating institutional preventive and care-giving strategies.

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The study seeks to understand the cultural factors that help or hinder prevention and care of HIV/AIDS within the different vulnerable groups and diverse cultural contexts.

2- Methodology

Various methods of qualitative research have been used for the study. These are:

- **Desk-Based Research** - The study is based on available secondary information on cultural attitudes towards sexual behaviour, gender relations and life-threatening infections.

- **Field Studies** - The desk-based research is supplemented with data collected by the ISST team in relevant cultural practices and norms in specific communities perceived to be at high risk from HIV/AIDS in different parts of India.

Following methods have been followed to collect data from the field:

- Case Studies - Interviews and life histories of individuals have been recorded with a view to understanding the whole process of socialization of individuals in their respective environments with emphasis on their attitudes, way of life, culture of sex, family relations and acceptance within the community.

- Focus Group Discussions - Discussions were held with selected communities and groups with the objective of learning more about their cultural beliefs, attitudes, their treatment-seeking behaviour and their attitudes to life-threatening illness.

- Key Informants Interview - Institutional caregivers, NGO personnel, opinion leaders were interviewed so that more insight could be gained on the behaviour of the community, the types of ongoing prevention programmes and their impact if any on the community.

3- Sample for field studies

In respect of the cultural diversity of the country and the time frame, an attempt has been made to focus on communities from different regions. The sample selected includes both mainstream communities and people outside the popular mainstream culture including culturally distinct ethnic groups. Four locations/communities have been selected from all over the country:

The rationale behind the choice of these groups and their role in the structure of the handbook.

- Selected communities in **Delhi**: local people and the migrants
- Culturally distinct ethnic groups. E.g., Bedias of Bharatpur, **Rajasthan**
- The Men who have Sex with Men (MSM) community and Street Children in **Calcutta**

➢ The Devadasi community of the Bellary district, **Karnataka**

The selection of locations and community groups for the study is indicative but not representative of the culturally diversity present in India. The selection has been made after consultations with the advisory committee and the Delhi office of UNESCO, and after a review of the field conditions and considerations of logistics.

4- Field investigation

In Delhi, discussions were held with adolescent girls and married women from both settled and migrant communities. Focus group discussions were also held with migrant male workers and adolescent boys from the lower-income groups and lower middle-income groups.

In Calcutta, two interviews and a focus group discussion were conducted with the MSM community. Two focus group discussions and three interviews with street children were organized.

Visits were made to the Bedia community in Rajasthan and the Devadasi community in Karnataka for data on sex workers. Two focus groups and several discussions were conducted with sex workers and other members from both Bedia and neighbouring communities in the Bharatpur district of Rajasthan. In the Bellary district of Karnataka, three focus group discussions were held with female members of the Devadasi community. Another FGD was conducted with the non-Devadasi communities in the same area.

In Delhi, one discussion was conducted with ex-drug users and two key informant interviews were held with activists rehabilitating drug users.

I. INTRODUCTION

It is said that in India language changes every five miles. There are eighteen official languages and hundreds of dialects. India is a largely rural country and its economy is still primarily agricultural. Approximately 75 per cent of the population of one billion reside in rural areas. The political entity is divided into 35 states and union territories that are further divided into districts. Some of these states are larger than many European countries. Each state has a different language and script, and includes numerous dialects. The people belong to diverse ethnic groups. India's sprawling landscape ranges from mountains and extended plains to deserts and the peninsular coasts. In addition, India has had a long history of successive waves of settlers and invaders, with an impact on this vast and culturally diverse subcontinent.

A cultural approach to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) care and prevention has to deal with a set of complex issues. It has to take into account the diversity in religion, language, values and social laws that are part of people's lives in India. This handbook takes up some of the issues that are comprised in the cultural matrix and are relevant to the HIV/AIDS epidemic.

1- Background and extent of the epidemic

At the beginning of the millenium, an estimated 3.7 million adults and children were living with HIV in India. With such a huge population, even low prevalence rates mean a huge number of people living with the virus. It is estimated that the largest number of HIV positive individuals reside in India. The first HIV positive case in India was reported in Chennai in 1986. The majority of AIDS cases then gradually extended to 3 states – Maharashtra, Tamil Nadu and later Manipur. The situation at present is worse, with HIV cases spread across all states. At the end of 1999, an estimated 1.3 million women were living with HIV in India. Due to acute under-reporting, and due to the secrecy surrounding the infection, the exact number of HIV cases is not known in many states. States are diversely hit by the epidemic : while some states report few cases of HIV infection, others have reached a high adult HIV prevalence of two per cent and above in the general population.

In India eighty per cent of the cases of infection are said to originate from sexual relations , the rest are due to intravenous drug use, blood transfusions and mother to child transmission. In recent years, the pattern of the spread of HIV has changed. It is no longer confined to urban areas, it has spread to rural areas as well. In the earlier years of the epidemic, HIV was largely prevalent among individuals practicing 'high-risk' behaviour and unsafe sex, with multiple sexual partners, mostly sex workers, truckers,

homosexuals, and intravenous drug users. Now, the epidemic is spreading in the general population. A growing number of orphans and widows live with the virus.

2- Rationale for a cultural approach

The preamble to the Mexico Declaration of Cultural Policies of UNESCO, dated 1982, defines culture as 'a set of distinctive spiritual and material, intellectual and emotional characteristics', which defines a society or social group. 'Culture' in this sense 'encompasses ways of life, the fundamental rights of the person, value systems and beliefs.'

T. Scarlett Epstein defines culture as inclusive of behavioural norms of the society and an inventory of solutions. She suggests that the "success of developmental projects depends on changes in social behaviour that are often deeply rooted in traditional cultural norms, without an understanding of which it is unlikely that necessary and socially desirable behaviour changes can be expected to take place."(Epstein, 1999)

The acknowledgement of the cultural dimensions of development would, therefore, entail basing the theory and practice of development within a cultural approach, at the level of 'strategy, institutional action, programmes, projects or field work.' (UNESCO, 2000).

The two major documents published by UNESCO in this perspective are respectively "Change in Continuity: concepts and tools for a cultural approach to development" (UNESCO, 2000) and the overall publication "Summary of country assessments and project design handbook" based on the cultural approach to HIV/AIDS prevention and care (UNESCO/UNAIDS, 2000).

Recent research: HIV/AIDS and diversity, societal and cultural components

Broad epidemiological patterns of the incidence and prevalence of HIV conceal the considerable local, regional and cultural variety in social practice and sexual behaviour in India. It is quite likely that HIV prevention programmes based on epidemiological patterns have had little impact on the spread of the virus. Current programmes of prevention that are targeted at specific social 'high-risk' groups such as sex workers, truck drivers, intravenous drug users (IDUs) may for these reasons miss out on the vulnerability of others who may be equally at risk.

A recent study conducted by ISST on "*Gender Dimensions of HIV/AIDS*" (2000) also corroborates the fact that the prevailing socio-cultural features have significant implications on the spread of the HIV epidemic in India. Cultural practices and codes play a very significant role in relation to HIV/AIDS in India – both positive and negative. For example, girls'early age of marriage in many parts of India makes them biologically more vulnerable. Cultural restrictions on discussion relating to sex result in perpetuation of ignorance, often leading to avoidable vulnerabilities. Having relations with multiple

sexual partners for men, which leads to high-risk behaviour, is ignored by society and considered as part of maleness and a necessary initiation in sex.

Nevertheless, there is the institution of the family. The Indian family can play a significant role in prevention, and it provides the essential support for HIV positive members, irrespective of the social ostracism they might be facing. Similarly, the traditional value systems could form the basis of more effective methods of prevention and care. Cultural influences on institutional care need to be examined as well. Past experiences of AIDS control and prevention projects highlight that care and prevention efforts are more likely to be sustained if they are integrated into the existing community structures. Programmes need to be updated within their continuum so as to take into account the needs of the target group to better ensure the requisite behaviour change.

II. SOCIO-CULTURAL CONTEXT: ASSESSMENT FROM A MACRO PERSPECTIVE

1- Societal organization

a) Family and Kinship

A discussion on the cultural approaches to prevention and care of HIV/AIDS in India necessarily starts with the family. Family is the basic unit of social organization. This is where the socialization process begins, where behaviour and roles are taught and, gender norms are defined. Moreover, the family provides a support structure for the affected individual and thus assumes greater importance in the absence of state-sponsored welfare. It is also important to examine the family's role with reference to the mode of spread of HIV/AIDS . Sexual activity is the mode of transmission in nearly 75% of the cases and the infection is spreading very rapidly among monogamous single partner married women who have been considered till now as a lower risk category. Hence, it is necessary to examine the family structure in India, and its implications in HIV transmission and care of the infected.

The family in India has to be viewed as part of a wider kinship system . Even the Indian nuclear family exists in a network of formal and informal ties with other families. It needs to be stressed that there is no single model of family and kinship structure in India. Different family structures have emerged from different types of lineage systems, patterns of residence and the types of marriage practised by various communities in the country. They have also been influenced by religious ideology, patterns of production, social divisions in the society, ecology and environment, various behavioural norms and cultural concepts of man and woman. Different family and kinship systems confer different types of rights and entitlements on individuals on the basis of sex, age and marital status. This often determines the right of membership in a family, and access to family resources, division of labour and gender relations.

The most common family structure in India is that of patrilineal descent (succession and inheritance passes from father to son) with patri-virilocal residence (after marriage the woman lives with her husband in his father's house). This system is culturally ideal and has had a strong influence on the values and beliefs, and on gender constructions. Females and males have different status in patrilineal societies. This is reinforced by the fact that men carry the lineage forward, while women move out to become part of their marital homes. Inheritance laws of all religious groups in India are strongly patrilineal where the male members of the family are entitled to inherit property thus excluding the female members partially or completely. Patrilineal joint families are prevalent, mostly among communities engaged in trade and who own land. Joint family may exist without property. Smaller joint families are found among traders, artisans, agriculturists and even urban service classes. In the absence of property the joint family functions collectively to pool resources and labour.

Along with patrilineal descent, matriliny (where inheritance and succession are passed in the female line from mother to daughter) is also practised in some communities. Matriliny is confined to a few areas of the country as compared to the predominance of patriliny across regions and religions. Matrilineal communities are found today in the southwestern part of India and in the northeastern areas. The type of residence in matrilineal communities varies. While some are uxorilocal (when the husband stays in the wife's home), others may be visiting husbands, whereas a few have neo-local residence (the couple sets up a new home) and others follow virilocal residence.

Women in matrilineal communities have a higher status than those in patrilineal communities. An important difference between matrilineal and patrilineal communities in India is that in matrilineal communities, men as well as women, retain their rights to property, while in patrilineal communities women are excluded from rights of property. In terms of the HIV epidemic, women in patrilineal societies have very little access to resources when they themselves or their families are affected. Even those women, whose marital or natal families own property or are engaged in trade, do not have independent access to resources. Theoretically, women in matrilineal communities en joy a better position as they have access to property. However, how much of this translates into actual control over their property is another matter .

b) Caste System

The family has also to be viewed in the context of the caste system in India. The caste system is a distinctive feature of the Hindu society. It refers to the division of society into numerous hierarchically placed hereditary caste groups. The castes are endogamous (marry within the caste group) and accept food cooked only by members of their own castes or those above them in the social hierarchy. Each of these castes is associated with a traditional occupation that is passed down the generations. While the caste system is a social division of Hindu society, similar divisions are also found in other religious groups.

The notions of purity and pollution are an integral part of the caste system. This ideology categorises castes, occupations, tasks, food, and bodily emissions as pure or polluting elements. All bodily emissions are considered defiling. Similarly, castes associated with funerals, cleaning toilets, removing carcasses, etc., are also considered unwholesome. As occupations are traditionally associated with certain castes, people of other castes do not like to undertake tasks that are considered polluting. In the past hundred years though, the caste system has changed a lot. Marriage with persons of other castes is becoming acceptable especially in the urban areas and there is a gradual weakening of notions of purity and pollution.

The hierarchical caste system in India has a crucial socio-economic as well as cultural dimension. One of the main features of rural India is the presence of numerous, strong, land-owning castes who enjoy high status and wield power over other castes, in particular (?) secluded castes, landless labourers and numerous small serving castes. Dominant castes also have a tradition of resorting to violence when they find it necessary to enforce

their rights over land or other human beings. According to sociologists that anyone who wants to change or improve living conditions in rural areas in any way has to deal with leaders of the dominant caste as they control access to the people.

c) Marriage

Marriage in India is a universal institution. For Hindus, marriage is an essential religious duty. Marital alliances amongst Hindus is determined by various factors. First of all it has to be as much as possible within the same caste group *(jati)* but outside the lineage and *gotra*.

The Hindu Marriage Act of 1955 made monogamy the rule for all Hindus. Previously every Hindu man was allowed many wives, though in practice only a very small percentage, mostly the very wealthy and powerful traders and warriors practised polygamy. Very often the inability to have a child or to have a son was the reason for taking a second wife. Polyandry is rare except among some communities living in the Himalayas and a few castes in North and South India . Most of these communities practice fraternal polyandry where the husbands are brothers. Monogamy is rapidly becoming a socially preferred norm even among these communities. While Christian men are forbidden to have more than one wife, Muslims men are allowed four wives as long as all are treated equally. However, the actual incidence of polygamy is very low among these two religious groups. Christians and Muslims are also divided into caste-like groups based on perceived racial and cultural differences, region, and the Hindu castes from which they converted. These criteria play an important role in the selection of a spouse.

In northern India, village exogamy is practised. In peninsular India there used to be a preference for cross-cousin marriage where the girl married her father's sister's son. Some communities also practiced marriage with other relatives such as, the maternal uncle.

For all patrilineal families, marriage is an important factor of social security in old age. The son is looked upon as the one who will provide security during old age . A girl is married and sent to her husband's house, while the son brings his wife home and looks after his parents.

In India, marriage is regarded as the destiny of all women . Though there is no religious compulsion to get women married in Islam and Christianity, nor in Hinduism, it is deemed necessary for all women. Though differently, men in India are also under societal pressure to get married Marriage confers on both men and women the status of an adult.

The legal age for marriage for boys is 21 years and for girls 18 years however it is not strictly followed. Even today in rural areas and in urban slums most girls are married at an earlier age . A girl's marriage is related to puberty and a desire to control her sexuality.

Though the age at first marriage is rising consistently many still marry below the legal age.

Mean Age at Marriage

Year	Female	Male
1951	15.4	19.9
1961	16.1	22.3
1971	17.1	22.7
1981	17.9	23.3
1994*	19.4	-
1996*	19.4	-

Source: Figures for 1951, 1961, 1971 and 1981 are from simulate mean age of marriage based on Census data; 1994 and 1996 data are the mean age at effective marriage based on the Sample Registration System. (Manpower Profile India Yearbook, 2000)

Marriage and girls/women's status:

In almost all communities in India, a very high value is placed on the virginity of the bride at first marriage. After attaining puberty, a girl's movements are under constant supervision lest she acquires the reputation of being a 'loose character'. For a woman being married is considered auspicious. Marriage is very closely linked to women's fertility and sexuality. In fact, women's sexuality is expressed through marriage. Subsequently after marriage, there is also a lot of pressure on women to give birth to a son as soon as possible in which case her status rises .

At marriage a woman in the patrilineal system joins the husbands kin. Even if a couple sets up a new residence, it is more a virilocal residence than a neolocal residence. Marriage for a woman does not mean mere incorporation into her husband's family it is a total subordination to the marital family. The bride is under the control of the mother-in-law in matters relating to everyday activities, household chores, mobility and use of resources. Control over resources and authority are in the hands of the males. The clout a woman wields in her marital family is determined by her age, her husband's order of birth in the family, his status within the family, his economic status and also by the status, influence and support of her own natal family. A young married woman, more so if recently married, is constantly under pressure to avoid bringing discredit to her natal family. Women are also under the threat of being sent away to their natal homes, where they may not be welcome. Coupled with this is the socialisation of girls that instils in them the idea that the natal home is only a temporary home and that their future is in their marital home. Most families view a daughter as someone else's property (*paraya dhan*, bringing up a daughter is like watering your neighbour's tree). Women thus live with a great feeling of insecurity in their marital homes.

Girls are brought up to believe that marriage is their destiny and they have to put up with whatever *kismat* (fate) has in store for them. They are under the dictates of the marital family. The daughter-in-law is very often treated as property of the family. In real terms this means that most married women have very little control over resources, mobility, leisure time and even their own body.

These values and related behaviour strengthen gender discrimination in the marital family especially when someone has any serious health problem . The wife has to act as the main caregiver, which is her prime duty, even if she herself is ill. In many cases her marital family deserts her, if she is unable to put in her share of work. A woman is seriously stigmatised as a widow and if the husband dies of AIDS related illness the marital family often sees her as a bad omen. She is often sent back to her natal family and sometimes she is not allowed to take her children.

Widowhood amongst Hindus is strongly associated with inauspiciousness. Common belief was that that widowhood was brought about due to sins committed in a previous life. Divorce and widow remarriage, though traditionally forbidden to patrilineal upper caste women, were practised among lower and some middle castes. Today, however, among upper caste widows, remarriage has gained acceptance to some extent, especially in urban areas. A widower on the other hand faces no such difficulties. He can marry any number of times. He is not considered inauspicious. Widow remarriage is practiced among other religions though it becomes difficult in all cases when the widow has children.

The practice in some parts of Northern India was for the widow to marry her husband's younger brother, though marriage with the husband's elder brother was not unknown. This practice is known as levirate. The children born from such a union are considered as the married couple's children and not as the dead man's children as in some parts of Africa. Marriage of a widower with his wife's younger sister (a sororate) occurs in most parts of the country, .

The institution of marriage with associated defined marriage rules and conventions often results in a situation where individuals have to give in to societal pressure. The rules of marriage such as cross cousin marriage, levirate and sororate sometimes play a negative role in terms of HIV. Despite knowing their HIV status, individuals are forced to marry under social pressure. On the other hand, widows whose husbands have died of HIV related illnesses but are themselves HIV negative, face a lot of social stigma and, in spite of the growing acceptance of widow remarriage they find it very difficult to get married again. This is compounded by the fact that women in strong patrilineal systems such as those in India, have very little access to resources.

As communities and families move up the social hierarchy, they adopt some of the lifestyles of the upper classes and castes. Amongst Hindus, it is manifested by withdrawing women from the workforce, increasing rituals and adopting the practice of giving dowry instead of bride price. Amongst Muslims, *purdah* is a mark of status and upward mobility, whereas in poorer families, necessity prevents segregation. Thus, in certain cases as their family status improves,   women are more segregated. . However amongst both Muslims and Hindus, women with western education and employment opportunities in the urban upper and middle classes are moving out of segregation.

2- Culture and Sexuality

Sexuality has different meanings for different people in different contexts. Sexuality is a comprehensive concept that encompasses the physical capacity for sexual pleasure as well as personalised and shared social meanings attached to both sexual behaviour and the formation of sexual and gender identities. Sexual behaviour and attitudes are constituted within complex political, social, economic and cultural contexts. Sexuality is understood as a complex social construct that has different meanings within different communities and societies, and one that has diverse expressions within and across age, gender and social class.

a) Women

An important aspect of sexuality in patrilineal India is the control exercised over women's sexuality. It becomes most evident at menarche. Here begins segregation of girls . They are withdrawn into the house and a close watch is kept on their movements. Seclusion and segregation are closely linked with ideas of female chastity, modesty and femininity.

As mentioned earlier, a woman's sexuality is mediated through marriage in most communities in India. While there is a premium placed on the virginity of the bride at first marriage, the same is not true for the man. After marriage a woman is expected to be faithful to her husband while digressions by the man are overlooked.

Sexual activity and behaviour is considered to be the man's domain, and a woman is not expected to take the initiative. A woman is not supposed to know about sexual matters or else she is labelled as 'loose' and suspected of infidelity. She should remain 'innocent' and know nothing about her body, contraceptives, and sexuality. Cultural norms do not allow a woman to show desire or question sexual behaviour of her partner. Sexual activity for women is considered a duty for procreation and to fulfil her husband's wishes. A woman who resists or expresses unwillingness to fulfil her husband's desires is threatened with desertion. Thus, a woman is rendered more vulnerable, due to lack of knowledge and lack of control over her body, to sexual violence within marriage and STIs including HIV.

b) Men

While there is strict control over female sexuality the same is not true for males. There is no pressure on men to remain virgins till marriage; neither is there a big stigma attached to pre-marital sex for men. Studies from all over the country reveal that sexual activity is high among adolescent boys. Between 12-25 per cent of patients at sexually transmitted diseases (STD) clinics are in their teens. The first encounters are mostly with sex-workers or with other boys.

At the same time men with other sexual orientations are under very strong social pressure to get married and procreate. This results in a situation where homosexual men are forced

into a heterosexual union through marriage while continuing their homosexual activities.

The socialisation of the man in Indian society takes a different path from a woman's. Here the man has to prove his manliness and sexual desire, otherwise he would not be considered strong. A visit to a sex-worker by a man before marriage is ignored by the society. This acceptance is rooted in a general notion that the man has to be knowledgeable about sex, so as to lead the woman who should be innocent about sex and sexuality. The man is viewed as sexually powerful and a woman as sexually passive.

For any programme to succeed a deeper understanding of sexuality is necessary to pin down people's sexual attitudes and the reasons behind them. The whole gamut of kinship structure, systems of marriage, and ideologies about gender and sexuality shape the concept of sexuality within a society, and should therefore be integrated in this process of understanding. Each of these systems structure sexual relations differently, and the differences are compounded when it involves people of different status and with unequal capacities to negotiate for safer sex. These processes and sexual interactions, therefore, have grave and differing consequences for the vulnerability of different groups to HIV.

3- Culturally conditioned beliefs and their implications

The entire world of sexuality and HIV/AIDS is shrouded in mystery for the average Indian people. To this environment were added hundreds of myths and 'false beliefs' on sexuality and HIV/AIDS that were nurtured by the development of the disease.

Many of the religious and mythological notions in India have been interpreted in different ways at different points of time. Most of the time, texts are interpreted with little knowledge, which may add different dimensions altogether. People often have a tendency to construct social prescriptions for themselves on the basis of these interpretations. Due to the lack of scientific knowledge, people easily derive unscientific, cause and effect equations. Young boys grow up with numerous misconceptions and guilt about masturbation. They believe in the knowledge they acquire from their peers. The absence of clearly-defined, transparent and socially-accountable sexual mores, and the prevalence of fostered myths and secrecy, spell disastrous implications not only for the spread of HIV/AIDS in India, but also in the way it is confronted.

The table below lists a set of culturally conditioned beliefs and myths that have provided fertile ground for the formation of culturally conditioned beliefs regarding HIV/AIDS:

a) Beliefs

General Assessment	Implications
• Sex is a taboo subject (Sex should not be discussed openly across	Misconception on sex, sexuality, lack of knowledge on sexual organs, sexual

genders and age groups)	intercourse and sexual activities • Narrowing down the space for discussion on sex and sex-related matters • Lack of positive language on sex. Sex is within the invisible realm, and very often there are no commonly available appropriate terms to even discuss sex and sexual behaviour in the public arena
• Sex within marriage is perceived as a duty for procreation	Very little inter-spouse discussion on fertility regulation ? Visiting sex workers by men is accepted by the society
• Any woman engaged in any kind of sex outside marriage, is a *patita* (fallen woman)	? Sex workers are regarded as public property. Social hatred for sex workers
• Masturbation leads to impotency and loss of memory.	? Unqualified practitioners flourish ? Guilt feeling leading to depression
• AIDS is not our problem.	? Lack of urgency regarding the epidemic amongst people and policy makers
• Female ignorance of sexual matters is a sign of purity	? Reproductive health of women is not a matter of importance ? A culture of silence and tendency to hide sexual problems

'Masturbation leads to impotency and weakness, because one drop of semen is equivalent to forty drops of blood.. Still, all of us masturbate, knowing that it is bad for health. Masturbation deforms the penis. People who masturbate frequently, suffer a lot in their married life', said an adolescent boy in one of the focus group discussions in Delhi.

b) Myths

- HIV and AIDS are the same thing

- HIV/AIDS can be contracted only through vaginal sex

- Touching and kissing an infected person spreads HIV

- Sharing food spreads HIV, so do mosquito bites

- If your home and environment are clean you will not contract HIV

- People not suffering from any STIs will not contract HIV

- According to the upper and middle classes, HIV/AIDS is prevalent only among slum dwellers and lower classes, as they frequent sex workers. According to the lower class and slum dwellers, HIV/AIDS is contracted by the rich, as they have the money to frequent sex workers

- Sex workers and some women are reservoirs of all sorts of STIs. If one avoids them, then one will not get HIV/AIDS

- There is no need to practise safe sex with known or expensive call girls, as they are clean and safe

- Sex with virgins cures STIs, including HIV

- If you urinate immediately after sex, you won't get any STIs

- Sex is essential to release body heat which accumulates after long hours of driving

- Condoms are unhygienic, because the semen collects in it and touches the penis

- Use of condom reduces sexual pleasure

- Injections are the answer to every illness

- Pure women (loyal to the husband and his family) do not get HIV/AIDS

- A healthy looking person will not have HIV

- HIV can be cured if detected early.

III- SOCIO-ECONOMIC ISSUES

In India as well as at the international level, serious socio-economic unbalance among populations impacts heavily on vulnerability and risk in relation to HIV/AIDS. In this respect, poverty, unemployment and lack of education are crucial aspects of the overall crisis which shapes the factual background to the disease.

1- Poverty and unemployment

Globally the HIV epidemic is most important in Africa, which is one of the poorest regions of the world. However, there is no evidence to suggest any direct correlation

between the epidemic and poverty. Many of the countries affected are the richer countries of sub-Saharan Africa. An examination of the situation in India also does not throw light on any such link. On the other hand, the states of Maharashtra and Tamil Nadu, where the epidemic first spread , are among the more industrialized states.

, While India as a whole has the third highest GNP in Asia (before Corea, Indonesia and Russia) the GNP per capita is only US$ 440, slightly above UN definition of extreme poverty. Thus, high national PNB, rich industry, business and wealthy minorities do not necessarily entail equal distribution of riches but can, on the reverse, aggravate the impoverishment of already underprivileged majorities.

Yet, incidence and patterns of spread do indicate a complex relationship with poverty, and factors closely related to poverty may lead to a kind of risk behaviour or make people more vulnerable as far as HIV/AIDS is concerned.

India has the dubious distinction of being a country with the largest concentration of people living below the poverty line. A broad feature of the Indian labour market that may be of relevance in the present context is the high degree of mobility observed in the lower rungs of the market as a result of a high level of disparity in regional development, manifesting itself in significant regional differences in job opportunities. This has given rise to much rural-to-urban migration, both within and outside state boundaries, much of which is circular migration.

Thousands of young men migrate from rural to urban areas in search of employment. Very often it is the men who migrate leaving their families behind. It has been found all over the world that circular migration has led to increase in the spread of HIV/ AIDS. As these young men leave their wives behind, they often form partnerships and relationships with other women in urban areas, which might even be linked to peer pressure. Unemployment may also lead to other types of risk behaviour such as substance abuse.

Poverty is directly related to nutritional status and health seeking behaviour. This is especially relevant with respect to STIs. The poor in India have low nutritional status that makes them vulnerable to many types of infections and diseases mostly due to deficiency of Vitamin A and iron, which affects the immune system. This makes them more vulnerable to contracting STIs including HIV. The poor also have less access to health care and therefore many of the STIs remain untreated. In this respect, it is worth noting that in the poorest households women have the dice loaded against them in terms of food, access to health care, a heavy workload and various cultural taboos and restrictions. For many poor women, sex work is often the only means of earning a livelihood and maintaining the family. In these situations poor women become vulnerable to HIV/AIDS not only because they have multiple partners but also because they are unable to bargain for safe sex with their clients.

2- Education and literacy: women's inequitable situation

Education is often viewed as the panacea of all social and economic problems affecting the country. It is used as one of the indicators for measuring social development. It is believed that universal education is necessary for the economic development of the country. Education is deemed to have a positive correlation with population control, decrease in maternal mortality, child survival and so on. In the gender debate, education of women also leads to enhancement of women's status.

Education for all is enshrined in the Constitution of India. Article 45 of the Directive Principles of State Policy states, 'the State shall endeavour to provide within a period of ten years from the commencement of the Constitution, free and compulsory education for all children until they complete the age of fourteen years.' Yet, today, India is far from achieving the goal of universal elementary education.

The causes for such high illiteracy are varied. Many of the differences across regions are because education is under the purview of individual states. An important element is the lack of schools in many areas in spite of progress made. According to a survey, in rural areas 94 per cent of the population has a primary school within one kilometre but only 57 per cent of the population has a middle school within one kilometre. Apart from this are the social barriers to access education. Due to seclusion of girls, many parents are unwilling to send their daughters to schools, which are further away. In poor families girls are the first to be withdrawn from school in times of crises.

In all regions, literacy rates are much lower for women than for men. According to the Human Development Report of 1998, only five countries have a female-male literacy gap greater than India: Bhutan, Syria, Togo, Malawi and Mozambique. And no country has a gap larger than the state of Rajasthan.

The other problems faced are lack of infrastructure in schools and lack of basic requirements for running a primary school. The quality of education is abysmal in many government-run schools. A low student teacher ratio, a situation where a single teacher has to handle multiple classes regularly and absconding teachers add to the problem.

A very important issue is that of the content of education and what education is meant to be. For the planners education is meant to enable the population to know the three 'R's' (reading, writing, arithmetic), but what is equally important is the curriculum, especially in view of the HIV/AIDS epidemic. In a study done in Delhi, it was found that years of schooling had a positive correlation with knowledge about HIV/AIDS, partly because it was part of the curriculum, although that did not mean an increase in autonomy or decision making power.

Most schools are still unwilling to take a proactive step in including sex-education. This is because of the stigma attached to 'sex' and unwillingness on the part of the teachers to discuss these issues.

3- Current health care situation

a) Health Infrastructure and access to health care

The concept of health varies from culture to culture. Standards and concepts of health are geographically, culturally and historically variable, as they change over time in response to changing socio-economic and cultural patterns and also to prevailing systems of health care. In the traditional Indian systems of medicine there are two terms used for health: *arogya,* which signifies recovery from ill health and s*wasthya,* which is not a mere absence of diseases, but a positive state of well-being. The latter is a preferred concept. The definition of s*wasthya* is closer to the WHO definition of health.

The demand for health care is constantly increasing with development and increasing public awareness. In India, three levels of health problems are prevalent:

- health problems associated with underdevelopment
- the diseases of the affluent
- environmental and behavioural threats among all population groups.

India has a widespread health delivery system. Public, private and voluntary bodies provide health care. Along with the allopathic system, other systems of medicines such as *unani*, *ayurvedic*, homeopathy, *siddha*, etc are practiced. There are 85 hospital beds and 110 doctors per one *lakh*[1] population. However there is a very strong urban bias visible in the delivery of health care. 80 percent of the government health care and two thirds of the private practitioners are in urban areas while 70 per cent of the population reside in rural areas. 80 per cent of the doctors are in the private sector and 60 per cent of them practice systems other than allopathy .

Government health system:

There is a wide spread network of the government health system all over the country. At the centre, the Ministry has three vertical line departments: the department of Family Welfare concerned with population stabilization programmes, reproductive and child health; the department of Health, which deals with medical and public health, drugs control, food adulteration, research and education; and the department of Indian Systems of Medicine and Homeopathy. In rural areas there is one community health centre for every 120,000 , one Primary Health Centre (PHC) for every 30,000 , and a sub-centre for a population of 5000. Each sub-centre has one female and male multi-purpose worker and links the community to the health care system. One trained doctor and a number of paramedics staff the PHCs. While the government health system is present in every district, it is grossly inadequate and unevenly distributed.

It was only after the International Conference on Population and Development (ICPD) in Cairo that reproductive health as a concept and ideology was acknowledged. The government tried to integrate the reproductive health services in the PHCs but most

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[1] Lakh: millions

government programmes have generally ignored the fact that reproduction takes place through sexual relations, which are conditioned by broader gender relations.

On the curative side, there has been marginal growth of hospitals and PHCs across states, and there is an absence of referral services. In majority of the states, there has been no significant increase in hospitals and beds between the mid-1980s and the early 1990s. The marginal increase is inadequate to meet the growing demand for services. Shortage of medicines and drugs is also rampant. A major failure of the public health system has been the insensitive and impersonal attitude of doctors and other caregivers within the system.

Access and demand for health care:

One of the pre-requisites for good health is access to health care. Access to health includes three components: location access, economic access and social access. Even today, a large number of people in India are unable to access health services due to economic, social and location reasons. Access is also integrally related to cost of health care. Health services have been extended to PHCs and sub-centres in rural areas, yet this strategy has had only partial success in reaching adequate health services.

There is meager information on the cost of health care in India and how the extensive public health care delivery system is utilized. The demand for health care is of two types, one for in-hospital treatment and the other for out of hospital treatment. Costs also depend on who provides health care, government or private hospitals. In-patient care requires institutional infrastructure facilities. At the all-India level, 60 per cent of the in-patients get treated at government health care institutions. The proportion is similar in both the urban and rural sectors. Broadly 80 per cent or more of in-patients receive treatment from the public health care system in the less developed states like UP and Orissa while the corresponding proportion is 40-60 per cent in the more developed states like Kerala and Maharashtra. Higher proportion of in-patients being treated by the public care system in the backward states is not an indication of its accessibility or its efficiency. For example, Orissa has 40 beds per lakh population and U.P has 45-50 beds per lakh population. This clearly indicates that government health infrastructure is grossly inadequate in these states. The higher utilization of the public system also reflects the poor development of the private health care system in these states. High levels of poverty and low incomes presumably restrict the demand for private health care. There are some differences in the pattern of utilization of health care facilities between the rural and the urban sectors. A slightly higher number of in-patients are treated in public hospitals in the urban sector, reflecting their urban locations and easier access.

Dominant forces, often caste-based, present in local society may want health care diverted in a certain direction and might even prevent care from reaching others.

The burden of home care has always been on the woman. The woman has the least access to health care, due to her low status in the marital family. This is related to both cultural ideas as well as unavailability of health services. The problem is compounded by the

lack of female doctors whom women can visit. This problem is more acute in rural areas than in urban centres. In the absence of a female doctor, women find it difficult to get physically examined by a male doctor. Most of the time male members accompany her to the doctor, and she is unable to communicate her health problems openly. Most of the time, therefore, she resorts to self-medication or traditional curative methods.

Available studies in India indicate that HIV positive women do not receive the same care and support as men. In many cases, the positive married women, whose husbands have died of HIV related illness were either turned out of their marital homes or denied proper health care.

b) Reproductive health, STI's and HIV/AIDS in India

Reproductive health issues in India and globally have emerged from the women's movement and from a critique of population policies by the women's movement. Reproductive health was brought centre stage by the ICPD in 1994, not just in India but also all over the world when the governments of the world agreed to address issues of women's health including reproductive health, education of girls and empowerment of women.

Reproductive health issues have a special significance for HIV/AIDS in India, as heterosexual transmission is the most common route. It is well established that where heterosexual transmission is the route, HIV spread is more likely from man to women than vice versa. Different estimates show the transmission from man to woman is 1.5 to 4 times more efficient than from woman to man for physiological reasons.
It is also well known that the efficacy of transmission increases when one or both partners are suffering from sexually transmitted infections (STIs). Lesion, inflammation or any other damage caused by STI facilitates the transmission of the virus during sexual intercourse. In this regard, women are at a greater risk for both biological and social reasons.

There is no large-scale data available on the incidence of STIs, even though STIs were the third most important group of diseases in the country, next only to malaria and tuberculosis (TB). The data available from sexually transmitted diseases (STD) clinics, even though from a predominantly male population, shows that the incidence is quite high. Women report less at STD clinics due to cultural taboos, restrictions on mobility, non-availability of user-friendly services, lack of resources, lack of support from the male partner and also because most STIs are asymptomatic in women. The few studies on the incidence of STIs in women that have been carried out by NGOs in small community settings show an alarming scenario. One study showed that up to 70% of the women screened in a community were found to have one or more STI.

Studies also show an interesting difference between patterns of STIs between north and south India. A higher number of men reported sex-workers as the source of infection among male patients visiting STD clinics in the South as compared to the North. This has

been linked to a greater degree of urbanisation in the south. Studies in northern India show a slightly higher percentage of sex with relatives and friends.

Studies also show that between 40 to 60 per cent of patients visiting STD clinics in various parts of India report having picked up the infection from sex-workers. Sex-workers in cities are known to have, on average, about seven partners during the course of a night. Studies also show that sex-workers suffer from one to three STIs. But they lack the knowledge about cure and prevention of STIs and are unable to demand condom use from their clients.

The reasons for such a high incidence of STIs are not difficult to understand. There is ignorance among the general population about the causes, early symptoms and even about STIs. Apart from this is the lack of treatment and diagnostic facilities for STIs. The problem is very acute in the rural areas where the government-run primary health system is the only health care available.

Men:

Patient attendance at STD clinics is predominantly male from the economically low-income strata, while men from middle and upper strata avoid reporting to STD clinics owing to stigma. Most prefer to go to private practitioners who may neither have specialised training nor diagnostic facilities to deal with STIs, and many also end up with unregistered medical practitioners. 30 to 40 per cent of male patients visiting STD clinics are recidivists. Male patients at STD clinics show a great deal of reluctance to bringing their wives or sexual partners for examination. Amongst women patients visiting STD clinics, there is a high percentage of young married women between 14 – 25 years of age. Unmarried adolescent girls are totally left out of any sort of treatment.

Many women suffer silently due to ignorance and also because they feel that it is normal since most women suffer from the same problems. Another important reason is the 'culture of silence' over issues regarding sexuality and reproductive health. There is a strong stigma associated with STIs. The result is that women never speak about these issues for fear of being labelled as 'loose'. The more tangible fear is that of being suspected of infidelity by her husband and marital family if it is known that she suffers from any STI irrespective of the fact that she may have contracted it from her husband.

Women:

Among women, problems of the reproductive tract also aggravate the situations. Inflammation and trauma caused by frequent and difficult deliveries, intra uterine devices (IUDs); induced abortions, etc. are also the cause of many infections of the reproductive tract. Apart from STIs, sexual trauma, forceful penetration and early age of women engaging in sexual activity also lead to damage of the vaginal lining and this increases the possibility of transmission of the HIV infection to women, in the case of an already infected partner .

Among women, due to biological reasons, many STIs, which cause lesions/inflammation, may remain asymptomatic or may cause vague, non-specific symptoms and therefore may go undetected. In addition, for anatomical reasons, diagnosis is a complicated process involving internal examination and laboratory tests, which makes diagnosis difficult. Pre-natal and gynaecological clinics in many public hospitals that are more accessible to women do not have diagnostic facilities for STIs. The problem is most acute in rural areas, which lack any sort of heath care let alone treatment of STIs.

While there is a general lack of health services for the treatment of STIs, the situation is worse in rural parts of the country. It is also especially bad for women who find it very difficult to get access to STI treatment. A lack of female doctors, especially in the rural areas, compounds the problem.

IV- ACTION TAKEN TO DATE

1- Community Organizations

a) Panchayati Raj

The *panchayati raj* institution (PRI) in India is an age-old institution of local self-governance through which people can participate in decisions and activities concerning their own welfare. *Panchayat* literally means an assembly of five elders who lead the administrative, judicial and development activities of their villages. This is the only vehicle for relevant and participatory development. The local structure of governance i.e. the PRI can indeed take on the task of making the health care system at the grassroots more accessible and more transparent. There have been a number of successful attempts at using the *panchayats* as the major channels for health service delivery. However, there have been objections to the functioning of the PR system: the powerless are kept out of the structure, it strengthens the traditional strongholds of power. In spite of this, efforts are engaged to strengthen the system. Decentralized planning is replacing the top-down approach and includes wider involvement of non-governmental and community organizations. The establishment of effective two-way referral systems between the community level and various levels within the health service system is critical for effective implementation of preventive and curative health services. The *panchayati raj* provides an opportunity for mobilizing community leaders, *mahila mandals (*local women's groups), and village health workers to organize themselves for emergency referrals. However, they have yet to define their roles in implementing health programmes and developing links with government and NGO institutions.

b) Non-governmental organizations (NGOs)

The roots of voluntary action in India as a concept can be traced back to the function of social institutions in the medieval period. The earliest NGO efforts were motivated by religious zeal, like the missionary activities in education, health and nutrition, economic

assistance etc. Social reform movements against social prejudices by religious groups also emerged in the early part of the 19th century. The *Sarvodaya* movement in the mid-twentieth century made the maximum impact after independence. Many NGOs started work in different areas with health interventions, tackling issues of employment, education, and agriculture. From the late 70s the idea of people's participation began to emerge, and charity orientation gave way to emphasis on self-reliance. In rural field projects, village health workers were locally selected, trained and employed for health services. During the 80s, the NGO movement became stronger and NGO representatives were given a place at the policy level and the women's movement was at its peak. Empowerment, commitment and participation were the key strategies.

NGO field projects working in the area of health have different orientations and all the projects provide knowledge borne out of actual experiences. An important lesson from most of these NGO experiences is that most of the health problems of the community can be tackled by members of the community itself, if provided the necessary knowledge, encouragement, training of local workers and support. The inter-personal relationships that NGOs maintain with the communities have always been the motivating factor towards effective implementation of development programmes, unlike the impersonal attitude at all levels of the public health system. Sensitivity to cultural and social factors seems to be the key to effective health care. Openness and communication with the community is vital. This includes granting due respect to traditional health practices, and attempting to incorporate folk remedies. Only a person familiar with members of the community, their language, lifestyles, health beliefs and practices, is able to influence health behaviour. NGO experiences also teach that community-level health services need an adequate referral system.

There have been many non-governmental organizations that have had successful health intervention programmes in different areas. These programmes have been successful because they do not view health as an independent parameter but as an integral component of a complex set of socio-economic, cultural and political factors. Participation by the community has been an essential ingredient of NGO programmes.

c) *NGO responses and deficiencies in HIV/AIDS prevention and care*

<u>Responses</u>

With the increasing number of HIV cases in India, the shortcomings of the existing public health structure have been very much in focus. A number of NGOs have started work on providing support to people living with HIV/AIDS along with community outreach prevention programmes. These are organizations that are directly providing care and, counseling to the positive person and the family. A number of existing NGOs have integrated HIV/AIDS prevention programmes within their other development programmes. Several NGOs are attempting to change the negative attitudes of people and their misconceptions about HIV/AIDS in the general public and among injecting drug users, sex-workers, and truck drivers. These programmes aim to promote safer sex through community-based interventions. School children and university students are

reached through extra-curricular activities. University Talks AIDS programme is one such attempt to get across to the youth and promote positive attitudes and healthy lifestyles. NGOs are also reaching out to children in schools through educational sessions on HIV/AIDS and sexuality.

The importance of designing interventions for HIV/AIDS prevention among women in the general population has begun to be recognized only recently. Efforts are being made to raise awareness, provide information, and strengthen women's capacity through empowerment processes. A broad picture of the range of HIV/AIDS interventions focusing on women include: interventions designed to empower women, interventions addressing the problems of HIV/AIDS, interventions employing a need based approach and HIV/AIDS prevention in the context of reproductive health.

<u>Deficiencies</u>

Despite these efforts, the majority of the non-governmental institutions providing health services are located in urban areas, though there are several examples of successful referral systems in the NGO sector. Very few NGOs provide comprehensive programmes and strengthen referral links. The number of STD services and clinics around the country needs to be increased, and problems of STDs have to be integrated into the reproductive health package. Blood screening facilities are not being utilized by many of the hospitals. There is a high demand for provisions of care institutions like care homes, hospices. The state has spoken about hospices, which need to be developed and implemented through NGOs with the involvement of people. There is a need for professional support in care and counselling people living with HIV/AIDS (PLWH/A).

2- Government Support

Soon after reporting the first few HIV/AIDS cases in the country, the seriousness of the problem was recognised and the National AIDS Control Organization (NACO) was set up. Surveillance centres with HIV testing facilities have been set up all over the country to test and report HIV infections. The aim of the NACO is to establish a comprehensive, multisectoral programme in India that would: prevent HIV transmission, decrease morbidity and mortality associated with HIV infection and minimize the socio-economic impact resulting from HIV infection.

The national plan also included improving the level of knowledge amongst medical personnel, to ensure HIV free blood and blood products through blood safety programmes, running public information campaigns on condom promotion and programming, service delivery, STI treatment, counselling and testing centres. NGOs were encouraged to integrate HIV/AIDS activities within their ongoing programmes instead of setting up exclusive AIDS prevention projects. Efforts were also made to promote collaboration with the Department of Youth Affairs and Sports, through the Universities Talk Project, a peer education programme for colleges. HIV/AIDS prevention is one of the services provided under the broad area of reproductive health,

contraception, mother and child health care, safe abortion, reproductive health infections and sexual health.

Facilities and trained manpower for sex counselling were found to be inadequate, particularly for handling counselling for HIV/AIDS. Counselling was essential before and after test results especially in helping infected and affected persons to cope; in changing to safer behaviour by those who were at risk; and for those who had doubts, queries, or fears regarding HIV/AIDS. Some successfully targeted interventions were initiated for the prevention of HIV/AIDS.

Although the strategic plan was comprehensive, implementation was not easy. The programme didn't do as expected and was unable to generate a sense of urgency. It became difficult to reach out to diverse cultural groups in the country. Denial persisted even as the reported number of cases tested positive for HIV exceeded 66,000 which was actually underestimated as per UNAIDS. Denial impeded the implementation of the programme. The conclusions were that infection in surveyed 'risk groups' (sex-workers, MSM, truck drivers, IDUs etc.) was increasing rapidly, which strengthened the prevailing stigma and negative feelings about the risk groups and reinforced the notion that HIV/AIDS is restricted to those 'risk groups'. These countered efforts to make HIV/AIDS everybody's concern. Confronted with this intensified denial, the approach that 'everyone is at risk' did not ring true in the minds of the general public.

Absence of consensus and inadequate supply

Another major difficulty still is that more than a decade into the epidemic and after a number of years of surveillance, there still seems to be no consensus on the epidemic. There are widely different estimates on the magnitude of the problem. Although the creation of awareness about HIV/AIDS was a primary goal, the overall awareness in various sections of the population still remains very low. This was mainly due to the cultural sensitivity and inhibitions that hindered open discussion about sexuality and also limitations of the approach, the methods and materials used for information, education, and communication. Not enough attention has been given to monitoring the quality of material produced and even less to assessing the impact of different materials, media and approaches. Most visual material failed to make the link between what was seen as blood borne disease and the use of condoms. The socio-cultural context, values, customs and social status, socialization process and concept of sexuality were not adequately explored. Programme staff did not understand how all these affect interpersonal communications, sexual decision-making, sexual practices and behaviour.

Various methods have been devised to implement these plans but the goals have not been achieved and there are still wide gaps in knowledge among medical practitioners and a low level of awareness among the public. In populations where awareness is high due to the various intervention programmes there hasn't been much internalisation of this knowledge and therefore, it has not translated to behaviour change. Focus has been more on prevention programmes; interventions and care have not been a priority.

The major problem is one of adequate supply. Institutional care by the public and voluntary sectors is very low and inadequate and does not meet the demands of the people seeking treatment. Small fragments of the population i.e. the organized sector have some sort of security cover under various government acts and provisions. As most of the workforce does not come under the organized sector, government's security services do not reach them. Increasingly materialistic and self-seeking professionals have replaced the breed of professionals who were responsible for the initial achievements in Public Health. A lot has to do with distortion of values and work ethics in these caregivers. The expensive curative medical services provided by the private sector catering to the urban elite is very discriminatory, and more such institutions are needed in the rural settings and in the urban slums.

HIV/AIDS in India is still a hidden infection. Caregivers forget professional ethics and carry their own biases to their workplace. The reaction to HIV among healthcare workers is often dependent not on what they know about the virus, but what they believe they know.

This reaction includes an exaggerated fear of contagion and an instinctive categorization of the infected person. The key role of healthcare workers and all intervention programmes should be to ascertain the nature of the prevailing mythical frameworks and to provide an alternative narrative based upon rational truths and sound ethical principles.

V- SEXUAL SOCIALIZATION, HETEROGENEITY AND POWER EQUATIONS: FIELD DATA

Strategically, HIV/AIDS prevention and control programmes are now principally oriented towards target groups for several reasons. There is evidence that these groups are more vulnerable to the virus than the general population and given the large population of India, target programmes for smaller groups are more viable.

However, it needs to be noted that all the groups and communities studied, whether practicing high-risk behaviour or otherwise, are not isolated groups, but are in constant interaction with each other. Field data indicates that the interaction between the various communities blur the boundaries between low and high-risk groups. Lack of infrastructure in terms of health care, education, and employment combined with patriarchy increases the vulnerability of all sections in the society.

In this study, the data has been collected from groups and communities who are viewed as practicing 'high-risk behaviour' as well as those who are considered at "low risk". From the discussions, it appears that the low risk groups are represented in some low income communities in Delhi. . Traditionally, MSM, sex workers, and intravenous drug users are among those considered as practicing high-risk behaviour. Street children have been included as a highly vulnerable group.

1- Settled and Migrant Communities in Delhi

The "mainstream" community is becoming increasingly vulnerable to HIV/AIDS in India due to a lack of knowledge, awareness and unprotected multi-partner sex. The position of women in society, socialisation of boys and girls, segregation, the culture of silence and the taboo on discussions about sex contribute to the increased vulnerability of the low-risk groups. The ISST study on Gender Dimensions of HIV/AIDS in 2000, reveals that even the single partner married women are vulnerable though generally considered least at risk .

Our field studies with married women, adolescent boys and migrant workers confirm alarming trends of high risk of HIV/AIDS among these mainstream groups. Discussions with workers of an NGO working in the low-income groups in Delhi, further corroborated the appalling state of health care in Delhi slums and the resulting risks of HIV/AIDS.

Due to increasing unemployment in rural areas, migrant and/or seasonal workers constitute a large part of the labour force in most Indian cities. This group, though an integral part of the mainstream workforce, happens to be a very high-risk group, due to long separation from their wives and the resultant risk-prone sexual behaviour.

Focus group discussions were conducted in a community with lower middle class population and squatter slum settlements. The local people are the proprietors and let out rooms to the migrant population. The migrant population is mainly composed of rickshaw pullers, small-scale industrial workers, tailors and workers in the informal sector from Haryana, Bihar, U.P. and Rajasthan.

a) Socialization and sexuality

A girl gets married soon after puberty. As soon as a girl starts menstruating , the parents look around for a groom. Most of the girls reported that their mothers had said *you have grown up now and you have to behave yourself*.' Sometimes a girl might be able discuss issues related to sexuality with her elder sister or perhaps a sister-in-law. If she asks too many questions about her body or about sexuality she is ridiculed. Soon she gets to understand the *culture of silence*.

The daughters-in-law in a family never sit on the *charpai* or cot. They sit on the floor, as they are not allowed to sit at the same level as their mothers-in-law. This custom demonstrates the subordinate status of daughters-in-law in the family. They also keep a full or partial veil when they walk in the neighbourhood and cover their faces completely when a man passes by. Mothers-in-law, on the other hand, do not have to be veiled and joke with the men of the neighbourhood.

In most cases, the girl is married to an older boy. This makes the newly wed bride vulnerable, as her older husband might have had premarital sex.

'Men also go to sex workers before marriage. If he does not get married in time, he might take the 'wrong' path', says an aged participant of a focus group discussion in Delhi.

Moreover, it is generally accepted that men in the Indian society have to prove their manliness on the first night of the marriage. In many cases, the man visits sex workers before marriage to gain practical knowledge on sexual intercourse. Due to low condom use, there is an increased risk of getting infections, which could be transmitted to the bride.

Typically, boys are given more freedom than girls, thus adolescent boys may get exposed to sexual risks at an early age. Moreover, sexual outlets are often accepted for growing boys and youth as a necessity. A lot of emphasis is also placed on the boy's "character" as well, and many parents exercise a certain degree of control over their son's actions. Girls are often viewed as evil and responsible for luring boys.

'Adolescent boys might visit sex workers. We can't keep tabs on where they are going. But if we get to know then they'll get a sound thrashing. We keep an eye on the young girls. Girls are equally responsible for luring boys. Why should we always blame boys? Parents should therefore keep an eye on their children...'

'If we feel there is something obscene on the television then we don't allow our children to watch it. Children who are sensible won't watch these programmes'...

'Couples should change their sleeping arrangements. If the children are grown up and are capable of understanding what's happening, then the child should not sleep next to his or her parents.'

Source: Focus Group Discussions with married women in Delhi.

Whether accepted or not, it is a fact that adolescent boys are initiated to sex early in life, mostly through visits to sex workers or friends of the same or different sex.

'Many of our friends visit sex workers. Boys have a curiosity for sex workers as they hear stories from older boys and also want to experience sex... in the peer group, it is related to prestige and status . Friends laugh at the boys who do not have any experience in sex', says a 17 year old boy'.

'Homosexual and bisexual activities are not unknown to boys in our community. Sometimes, older boys and men force younger boys to have sex'.

Source: FGD with adolescent boys in Delhi

Visiting sex-workers is common among migrant labourers. Due to long separations from their wives, they tend to visit sex workers. This is often under peer influence.

'People do visit sex workers, available in the G.B. road area (red light district of Delhi), …even here in our locality, women are available', said a participant in the FGD who is a migrant. *'Otherwise, what can a person do when his wife is not with him?'* says another.
Source: FGD with migrant labourers in Delhi.

b) Women's health

The common illnesses within the community were identified as fever and influenza. For illness women prefer visiting private doctors. There are a number of private doctors across the slum. In contrast they do not like to take advantage of free services from the government dispensaries, mainly because the doctors are impolite and also their medicines are of poor quality and thus, not efficacious. In addition, government doctors do not give enough time to listen to the patients and privacy is not ensured.

People feel more comfortable with private doctors. At times they even get injections when medicines don't work. They said that they prefer going to lady doctors for certain illnesses, which they are unable to discuss with male doctors. For common ailments and illness they don't mind male doctors. They said that the doctors boil the needles before reusing them. At government dispensaries they are not concerned about the mothers' health but place greater emphasis on children's vaccination and family planning. Before, these dispensaries would at least distribute iron tablets but now they no longer hand out tablets.

Women feel their children need more attention and care, *"we don't need to spend unnecessarily by getting ourselves treated. During frequent fever and illnesses we (also husbands) use self-medication.'*

If the woman of the house falls ill she has to do all the housework irrespective of her illness. If she is unable to get up the husband says she is just making a fuss.

No one had ever used oral contraception. A few had used copper -T and a few others had got themselves operated after 4-5 children. Only one woman admitted that her husband was using condoms as a means of contraception because he said she was already weak and contraceptives had side effects. Men think that the use of condom is very inconvenient, and therefore, they don't want to use them. Some women felt that it tears easily hence it is useless.

Another said that *"if men were gentle and loving the condom wouldn't tear so easily"*. It is believed that *"it is always better for the woman to get herself operated. If the man gets himself sterilized and if in spite of it the woman conceives, she gets labeled as having a bad character. Vasectomy isn't always successful"*.

Source: Focus group with married women in Delhi slums.

c) HIV/AIDS awareness among men and women

Women from the selected group had never heard about HIV/AIDS on television. Despite an awareness workshop which was held in the slum for a couple of days, very few were able to tell the modes of transmission. Most said that they didn't know what the preventable measures were. Not much of the awareness-generating programme had been interiorised by the members. Responses like, '*Hum to achchi jagah mein rehte hai. Yahan pe yeh sab bimari nehi hai*' (We all stay in clean places. We don't have these diseases around here) were given by a number of women.

Boys studying in schools know about HIV/AIDS. In many schools, where NGOs have conducted programmes on sex education they are aware of HIV/AIDS. One boy confessed that he had used condoms. The awareness in boys who study in schools where no such programmes have been implemented is very low. They have 'heard of HIV/AIDS, but do not know of the modes of transmission.

During a FGD, migrant labourersmentioned that all of them had heard about HIV/AIDS. They know it is a killer disease, which may be transmitted from sex workers. They also know that a 'used needle' may transmit it because it is 'dirty'. They said that, the doctor should use a new syringe and needle for each injection . When they were asked if they check this when they visit hospitals or private doctors, they said that sometimes they forget to check, and sometimes it is not at all possible to check because the doctor prepares the syringe and the medicine behind a curtain. When the question was asked, *"Did you ever ask the doctor or the pharmacist, if the syringe is new or sterilized?",* one of them said, "Never. The doctor may scold me. Nobody like us (illiterate and poor) dares to ask this question." When people visit a doctor for a serious health problem, it seems they are more concerned about getting the medicine than about knowing whether the syringe has been sterilized.

In the FGD with migrant workers, one person said that, *"people do visit sex workers, sometimes on G.B. road or even here in nearby areas... even in the neighbourhood women are available."* The question was asked, *" Do they use condoms?"* The answer was, *"No I have not heard of condom use by any of our friends. I heard educated people use condoms.* (*Humne suna hai ki pade-likhe log nirodh istamal karte hai. Hum to nehi karte....Bahut dikkat hota hai. Fisal jata hai). I have tried this long ago once with my wife. It is a bit difficult, because it slips".*

They revealed more about their sexual behaviour. While chatting during leisure time, the issue of sex comes up very often. Someone says he knows a woman in a nearby area who is available for sex though she is not a sex worker. Men do not have to use condoms for intercourse with a known woman. The reasons are, (1) they think that, as she is not a brothel based sex worker, she has little chance of contracting HIV; (2) If she has contractedHIV/AIDS, it would show on her face (*Agar koi aisa bhayanak bimari ka shikar ho jaye to dekhne se hi pata chal jayega*). It should be mentioned here that they do not know the difference between HIV and AIDS. One of them said, '*many of our friends*

try to keep relations only with few women. They do not go to an entirely unknown woman at G.B. road (red light area of Delhi) or elsewhere, unless somebody, who knows, takes them."

Sometimes people suffer from STIs, even if these are just a few. Generally, they prefer to go to ayurvedic healers or to private doctors. Somehow, people believe that ayurvedic medicines heal these diseases quickly. They also feel that it is easier to maintain privacy, with an ayurvedic healer. They prefer to go to a private doctor, basically an unregistered medical practitioner because they believe. They think it is easier to talk openly to a private practitioner on these matters . They are not comfortable going to hospitals. That means the loss of a whole day's wage.
Source: FGD with men, women and adolescent boys in Delhi.

A positive woman in her marital family

Asha is a 32-year old HIV positive widow with two children. After her husband died of AIDS-related illness, she was asked to get herself tested. Presently, she is suffering from loss of appetite and weakness.

Asha along with her husband was living in an extended family. After her husband's death, she continues to stay with her in-laws. According to her, she is being treated well by her in-laws. *"They were taking better care of me than they did for their son"*. She feels this might be due to the guilt feeling that their son's wrong doings had brought her to this state. She came to know that her husband had relations with other women outside marriage. She says, *'It's not possible for an ordinary Indian woman like me to leave her husband, so I never thought of it. Moreover, I had to take care of him.'*

During the interview, Asha's mother mentioned that her son-in-law frequently fell ill and her daughter took all the responsibilities of care and treatment. She went on to say that, *'during his last days in the hospital, most expenses were borne by us. I used to carry food for him regularly. From his family only his younger brother and one of his uncle were with him, even his own parents refused to see him when he was on the death bed.'* After his death, Asha was sent back by her in-laws, they didn't want to take up her responsibility and the fear of infection was very high. Then after a lot of discussion with her in-laws the point was driven home that, *'she got the infection from your son, it was no fault of hers, why won't you keep her with you.'*

They accepted that Asha and her children stay with them.

Source: ISST's study on Gender Dimensions of HIV/AIDS, 2000.

d) NGO Effort

The field workers of an NGO in Delhi informed that one essential way for preventing HIV transmission was effective treatment of STIs, which are prevalent in the community. They were involved in mobilising the community to attend the clinic. There were individual counselling and group discussions on reproductive health problems were at the clinic. The number of clients (mainly women) attending the STD clinic is increasing. It is a difficult task to motivate men to attend . Most men are unwilling even to listen. The field workers remarked that sexual activities were quite common among adolescents.

In small group discussions with married women, it emerged that women neither had the courage nor the opportunity to talk about matters related to sex with their husbands . One woman rightly questioned, *'how do we ask our husbands to use condoms?'*

2- Female Prostitution

Prostitution is not always subject to criminalization ; in some cultures the practice may be regarded as a sacred rite. In those societies where prostitution and related behaviour are criminalized, it is typically the prostitute rather than the client, whose behaviour is regulated, reflecting double standards of sexual morality.

In ancient India, this institution was not only recognised but gave access to a certain social status. Prostitutes could wield a great deal of power through their relationships with noblemen and aristocrats. Today, it is an outcaste profession. Yet increasing incidences of prostitution and expansion of red light areas suggest that the profession enjoys the patronage of the society. Growing male dominance, destitution of women, industrialization have led to the commercialization of the traditional institution, sanctioned by social and religious customs for certain castes. Trafficking in girls/women is one of the lowest forms of violation of human rights today, where women and girls are sold like commodities and ironically it is a highly profitable industry. There are new entrants into this profession everyday. These are women who are victims of social oppression and poverty. A large number of sex workers are descendents of old traditional and religious groups – like the Devadasis in North Karnataka and South Maharashtra, Basavis in Andhra Pradesh, temple dancers in Orissa, etc. There are also other communities who have been sending their daughters into prostitution for generations like the Nats and the Bedias of Rajasthan. Women enter into this profession in two ways:

- Voluntary prostitution, where women adopt it voluntarily due to lack of any other means of livelihood, the family may be a party to it;

- Women who are forced into prostitution through religious and customary practices, kidnapping, rape and sale of their bodies through intermediaries.

a) Prostitution and women's overall status

Prostitution should be viewed in the context of the overall situation of the status of women in India. Besides economic reasons, old cultural and religious practices, patriarchy, socialisation processes and superstitions are important factors that need to be understood. There are various other socio-psycho-situational factors and motivations behind a girl or woman wanting to continue with sex work. Women in prostitution have a very low status in most societies, perhaps one of the worst in India. They are labelled as 'randi or "bad women" and the vectors of HIV and other sexually transmitted infections. The police, the pimps and the clients alike, harass them and most of the time they have to give in to the demands of the clients who do not want to use condoms. They have no alternative since their subsistence needs are being met through this profession but the price they have to pay is horrendous.

It is difficult to estimate the number of prostitutes in India. The available estimates of Devadasis are mere conjectures. A survey conducted by Ghosh and Das in the red light areas of Calcutta in 1987 among 6,698 female sex workers found that the average number of clients per worker per day was 2.7, and the rates for both short-time and night visits varied considerably in different areas. About 37 per cent of the sex workers reported that they were either forced by family members or others or had been lured into prostitution with false promises of a job. About 59 per cent were reportedly abandoned by their husbands. 30 per cent were domestic helpers before becoming sex workers.

On the other hand 'call girls' are women who practice prostitution at a hotel or their client's residence. They usually do not identify themselves with the sex workers. Their rates are on the higher side and they have the option of choosing their clients. They are mostly linked to upper class prostitution.

b) Laws regarding prostitution

The objective of the Suppression of Immoral Traffic in women and girls Act (SITA, 1956) was not to do away with prostitutes and prostitution but to inhibit or abolish commercialised vice, namely the traffic in persons for the purpose of prostitution as an organised means of living. An underlying assumption in the SITA is that prostitution is a 'necessary evil' that provides an outlet for uncontrollable male sexuality. Though SITA did not aim to punish prostitutes, it gave enough power to police and other government agencies to terrorise, harass and financially exploit them. The Immoral Traffic Prevention Act (PITA), 1986, is a uniform legislation applicable to the entire country and is an amendment of the SITA (1956). It does not confine prostitution only to the act of a female offering her body for hire, but recognizes sexual exploitation or abuse of a male or a child for commercial purposes. The main thrust of PITA is the enhancement of punishment and creation of new categories of offenses. The objectives of the Act are two-fold: it recognizes the abuse of power by the police during raids and prohibits male police officers from making a search of female sex workers unless accompanied by female police officers; and secondly it seeks to draw women away from prostitution through

their rehabilitation in Protective Homes which should prepare them for gainful employment.

Against this background, two short field studies were conducted in two different communities where women are involved in prostitution. These were the Devadasis of Karnataka and the Bedias of Rajasthan.

c) Devadasis (sacred prostitutes)

The cult of dedicating girls to a deity, called Devadasis, is prevalent in some parts of India. A `Devadasi' means a woman dedicated to, literally a slave of, a deity, whose duties comprise a combination of ritual and community entertainment to assert positive fertility and prosperity.

Religious prostitution has been in practice in several parts of southern India since the third century AD. Pre-puberty girls from poor low-caste homes are dedicated through an initiation rite, to the deity in the local temple during full moon. The system of dedicating women to a temple is a religious act to appease the deity. Sometimes even before menarche she is auctioned for her virginity, "the deflowering ceremony" becoming the privilege of the highest bidder. Yellamma is represented as the principal Goddess who is worshipped, but recent research has shown that other deities such as Meenakshi, Jagannath and Hanuman are also propitiated in this manner. On account of being married to a God or Goddess "Devadasis" are called "Nitya Sumangali" (for ever married).

However, in the areas where the system/cult is prevalent, they call themselves "Basavi" , "Jogati"/ "Jogin", "Devali" , "Naikin" and at times "Sule" (prostitute). All these terms have sexual connotations – either of celibacy (as in Jogin) or of prostitution (as in Sule).

Several factors are said to be responsible for the origin and existence of divine prostitution in India. The fact that temples require whole-time devotees to serve them was a primary factor. This, in turn, led to the belief that women thus dedicated would appease the Gods and would ensure fertility of women belonging to that culture. Hence they developed their own status, roles and rituals, whereby they participated in religious/auspicious ceremonies in the community. Over time, the custom encouraged exploitation of one section of society – especially the poor families in the lower castes – by others, using religious sanctions to gratify male desire.

Some other factors that could have led to this sub-culture may be:

- The custom of dedicating girls to temples emerged as a substitute for human sacrifice, with the aim of appeasing Gods and Goddesses and thus securing their blessings for the community as a whole.

- It is a rite to ensure fertility of the land and an increase of human and animal population.

- It is part of the phallic worship, that has existed in India from early times.

- Probably sacred prostitution sprang from the custom of providing sexual hospitality for strangers; and if the mortal wives of a deity offered such hospitality, prosperity was bound to result.

- The Devadasi cult represents licentious worship offered by a section of society, subservient to the degraded and vested interests of a priestly class.

- The Devadasi system is a custom deliberately created to enable exploitation of lower caste people in India by upper castes and classes as:

  - The upper castes have influenced the establishment of an order of prostitutes who are licensed to carry on their profession under the protective shied of religious belief.

  - The establishment of such system due to poverty ensures that upper class males have access to low caste women to satisfy their carnal desire.

  - The system ensures that powerful people in society are in a position to subordinate lower-caste people out of fear.

There is no evidence of temple prostitution in early times, though it certainly existed in ancient civilization. The earliest reference to girls being dedicated to temples appears in a Tamil inscription dating back to 1004AD. In the Karnataka region, since time immemorial, prostitution has existed and Devadasis have been part of this profession. By the 7th century AD, the Devadasi institution seemed to have taken firm roots in the Indian culture. In the course of two centuries many temples were built in South India and Devadasis were recruited to provide various rituals to Gods and Goddesses. In northern India, the destruction of temples by Muslim invaders led to the decline of Devadasis but it continued unabated in southern parts of India. Even after state governments enacted legislation during the 1920s and 1930s preventing the dedication of girls to temple Gods and Goddesses, the institution survived in some places in different forms and on a smaller scale.

The present study was conducted in the Bellary and Kudligi taluks of Bellary district in Karnataka. Bellary is one of the most backward and drought-prone districts in the country. The available government infrastructure and services are quite inadequate and of low quality. The majority of the population belong to scheduled castes and tribes and other backward communities. Health problems are compounded due to malaria, gastroenteritis, AIDS etc. A number of the Devadasis are living in Kudligi and Bellary taluks along with other sex workers who come from other general communities. The Devadasis are called Basavi in the region. The Basavi does not marry but lives in her parents' house with any man of equal or higher caste whom she may select and her children inherit her father's name. In earlier times it was considered prestigious for a rich landlord to keep young girls. He would bear all expenditure. The present situation is very different : it is a daily sex business. In this district most Devadasis practise from home,

though there is also a large proportion of Devadasis in the red light areas of Chennai and Mumbai.

<u>Family, socialization, sex work and marriage of Devadasis</u>

Most of Devadasi's mothers are also Devadasis. These days, a number of poor families have many daughters and no male member to earn a livelihood. The eldest daughter in such cases is dedicated as a Devadasi even though the mother is not a Devadasi. There are cases where girls lose their virginity before marriage and are forced to become Devadasis. Most of the Devadasis stay with the parental family.

One strong reason for dedicating their daughters to God in the name of Devadasi or Basavi is that the family gets an income and they are taken care of by the man to whom the girl is dedicated. The girls enter prostitution at the age of 12 years or whenever she attains puberty. The practising Devadasis live within the community but in separate areas or streets and are not always found in groups. For example, in Kudligi most of the Devadasis live in an area, which is close to the bus stand and centrally located. In Bellary the Devadasis do not stay in the outskirts like other sex workers. They are scattered and stay amidst the community.

These days, many Devadasis marry one of their partners or clients usually from their own caste (valmiki) and sometimes from an upper caste (lingayat). Some unmarried youngsters also come forward to marry Devadasis as a result of the influence and education dispensed by the local NGOs and government department schemes. They are mostly from the same caste and from the same locality.

Government departments such as, KSWDC (Karnataka State Women's Development Corporation), Women and Child Development Department and local NGOs often organize mass marriages for such women. These initiatives have had limited success and have raised questions about their real outcome on the lives of Devadasis. There are reported cases of men who married Devadasis for certain benefits and who have deserted them .

Some Devadasis in Kudligi (colony) are staying with a single partner without any official marriage. The Devadasis usually stop sex work after marriage. They stay loyal to those whom they marry. These Devadasis may entertain other clients if it is inevitable and if the partners/husbands are not capable of supporting them financially. Few partners/husbands don't live with the Devadasis but visit them frequently, fulfil their demands and support the family with cash, clothing etc. They have their own families staying separately.

In Bellary, the Devadasis practice their sex work from their homes. Generally the Devadasis enjoy a better position in the community than other commercial sex workers because it is a traditional practice. Even if not married, most Devadasis have one or two partners. The income of the practicing Devadasis depend on their age and looks. The

young and beautiful ones get more customers and more money.   Men say that   Devadasis get better treatment than wives because they are always available for the man.

Rajamma's story:

Rajamma is a young 21 years old woman , born in a lower middle class family of Bellary district. She has two younger brothers. Her father was a porter and her mother a housewife. She says, '*When I was 3 months old I had wounds on my head. No treatment could cure me so my maternal grandmother prayed to God that if my wounds healed then I would be dedicated as a* Devadasi. *When I was 12 years my grandmother wanted to make me a* Devadasi, *my mother was against it but my father was not bothered, as he was an alcoholic. I didn't know what was happening. I was young and good-looking, and all clients preferred me. I was practicing sex at my mother's place in a small room. I became fed up of entertaining clients and whenever I saw my friends who had married and were living happily with their husbands, I felt bad. Fortunately, at that time (1996), I learnt about one of the government schemes – promoting* Devadasi *marriage; I decided to benefit from the scheme. I decided to leave the profession of prostitution. I had to face a lot of opposition for this decision of mine. I had already two children by then. However, ultimately with the help of a local NGO I married one of my clients. He was not married yet . I got some financial support also. I bought a goat. At present, both my husband and I work as construction labourers. I have four children now. Two years ago I got a tubectomy operation. The operation has created some complications for which I need to undergo another operation but I do not have the money to get myself treated. My eldest son who is 8 years, also works with us at the construction site and the other three go to school.'*

Rajamma is now a married woman and the community does not see her as a Devadasi anymore. She keeps visiting her parental family during festivals and they too visit her. She performs all the important festivals at her house.

 Health, health care, awareness about STIs/HIV

The Devadasis reported some common ailments as backache and stomachache. They prefer to go to private doctors because in government hospitals and Primary Health Centres (PHCs) there are no doctors, medicines are usually out of stock and in addition, the medicines provided are of poor quality. At the same time, they have to wait for long hours. Some even mentioned that though the services are free, there is no assurance that the doctor gets time to see them.

In all the focus group discussions, awareness levels on STIs and HIV was found to be high. They knew about the modes of transmission of HIV and that unprotected sex is the main mode of transmission. Their source of information was found to be radio, T.V, posters and advertisement in cinema halls. At the Bellary District Health Office (DHO),

they are conducting awareness programmes on HIV/AIDS, which reached only the Bellary taluk population. The Devadasis seemed to believe that HIV is like any other STI that can be cured if detected early. They also said that condom use was a method for preventing transmission. They said that though they insist that their clients wear condoms, most of the time the clients refuse and try to convince the Devadasis by offering more money. One Devadasi mentioned that : *"I would like all my customers to wear condom, not because of STIs including AIDS but only because I do not want to wash my private parts again and again. I don't want a dirty man's semen to remain in my body"*.

This certainly points to the helplessness of women in prostitution.

Health care facilities

A few home caregivers and doctors from the government as well as from private nursing homes and NGO workers were interviewed. The government hospital does not have HIV testing facilities nor do they have beds for treating AIDS patients; however private clinics have HIV testing facilities. The dermatology and STD department refers the cases that show symptoms of AIDS to Bangalore government hospitals. In one of the private hospitals the doctor said that there are 23 new cases of HIV every week. They refer the patients to a NGO in Bangalore that provides care and support . Yet another nursing home mentioned that they come across about 8 to 10 new cases of HIV every month. Whenever married persons are found to be HIV positive their spouse and children are all tested for HIV. Recently, one NGO has started a counselling centre on the campus of a nursing home.

Efforts until now

Some local NGOs have worked towards the rehabilitation of the Devadasis. As mentioned earlier mass marriages have been organised for them. In 1989, NGOs trained them in tailoring, basket making and also supplied the required equipment for gainful employment. Some of them were also provided with houses and micro-credit activities were initiated. It is believed that only a few Devadasis stopped practising sex and settled with single partners.

Now many sew for a living . Some have even become stage artists. Most men and women go for construction work. When women go to work, the aged women (mostly ex-Devadasis) look after the children. In other districts of Bangalore a few organizations are working with Devadasis, providing rehabilitation to those who want to leave sex trade.

c) Bedias (Tribal groups)

The *Bedia* identify themselves with the *Kshatriya Rajputs* and come under the Scheduled Caste category in India. Traditionally, the community formed vagrant gypsy-like groups. Dancing and prostitution have been a female profession for generations as well as the major source of income for the community. Earlier women and girls used to serve as

concubines to   men of the upper castes. They always lived in the villages   where the Bedia women were reportedly   concubines of rich farmers . The community is divided into various clans. They practice community endogamy and clan exogamy.   Most of them live in extended families. Their women, who   make money from prostitution, largely contribute to the family income. According to traditional accounts, a large part of the Bedia earnings came from prostitution and dancing. Now most of them are engaged in agriculture. Traditionally the Bedia women did not entertain people from communities considered lower than their own. In the last few decades, as the practice of concubinage declined in the region, the Bedia women got involved in prostitution.

A large part of the Bedia population resides in the Bharatpur district of Rajasthan. The present study was conducted in two villages in Bharatpur.   From the outset, it is essential to mention that the Bedia community does not identify   itself with sex workers. In fact, they object if they are labeled as sex workers. They prefer to identify themselves as entertainers or dancers. As one   elderly woman remarked with pride   *"My daughter is a dancer in Bombay and often her boss takes her to Dubai for dance performances. There she earns a lot"*.

Historically their relationship   has always been unfriendly with the *Jatavs* and *Gujjars*. The Bedias consider themselves higher than these two communities who have always looked down on them . Due to this reason a number of Bedia families shifted to the neighbouring village, where they are the majority. In the early eighties, the relationship became worse. The *Jatavs* and *Gujjars* repeatedly protested against prostitution of Bedia women inside the village. They felt it was a bad influence on their women folk. This forced many of the Bedia to move to the outskirts of the village. The girls and women in the profession started moving out to metropolitan cities like Delhi and Mumbai and to other towns in North India. They are also functioning in small numbers on the highways. It must be mentioned that a large number of Bedia women who are involved in prostitution in different towns and cities are actually from these villages.

Bedia men prepare country liquor, which they sell during the evening. The people who come to buy liquor are lured to have sex with Bedia girls. In recent years, a number of Bedia families have acquired agricultural land. This has become a slight diversion from their main income source. Men do not work full time on the fields, they employ widows and women from nearby villages to work on the fields. These women labourers get influenced by the Bedia girls and soon realize that there is more money in sex work. So they also get involved in the sex trade .

Family, socialization, sex work and marriage of Bedias

In the Bedia community girls enter the profession as early as 12 . Traditionally only the eldest daughter of the family was dedicated to this profession. But now times have changed and it was observed that any daughter could be sent to this profession. In the case of poor families devoid of land all the girls take to prostitution one after the other to support the family. These girls or women may function from home or are sent to red light areas through   pimps. The pimps and the middlemen are part of the Bedia clan. These girls could be sent to the red light areas of Mumbai, Delhi, Alwar and to other small

towns in and around Rajasthan. From their place of work they send money and maintain their links with the families by visiting them during festivals. From early childhood younger girls are sent to visit their sisters and cousins who are into the *dhanda* (sex work). They observe everything. As a key informant mentioned,

"Young girls get to see the glamorous side of the profession; they see the money involved and experience a better life. By the time they attain puberty they have seen a lot of the profession and are already accustomed to the whole tradition. They are asked to decide whether they want to marry or enter the dhanda. The girl's family is paid twenty to thirty thousand Rupees by the first client for deflowering the girl. By rule the girl can never refuse this man ever in her life and has to be available for him anytime. The girls are then taken to other areas perhaps by a relative who is operating as a pimp. In the first few years the girl is obliged to change her place of work every few months so that she does not develop emotional attachments to any particular client. The major part of her earnings is sent to the family as the family subsistence depends on it. Most of those women and girls visit their home during festivals. During this time the girls bring suitcases loaded with gifts for the family and come in a car. In the Bedia *village, most of these households have colour televisions, music systems and mini generators etc. The man in the family, mostly the father or the brother is the pimp who invites clients and negotiates".*

The girls, who do not get into prostitution, get married with somebody in the community. Marriages are arranged through negotiations at guardian's level. There is also a rule in the community that once a girl is married she can not get into prostitution. But the present situation is different and in a number of cases this rule is not followed.

The *pradhan* (local leader) of Bedia village said:
"A lot of money is coming from prostitution and people get tempted. My own sister in-law is into the business. It is her misfortune. She got married, but her in laws forced her into prostitution. It is completely against the community's law. A married woman cannot step into it. We later brought her to her parent's family. But as she was already in prostitution, nobody could marry her. She cannot live a respectful life. When we asked her to choose whatever she wanted to, she had no option but to choose prostitution. A prostitute can marry if she finds someone".

There are cases where sex workers have married one of their clients. Many a time, the couple then work as pimps. The girls could be their own daughters, could be bought or 'kidnapped'. When the women cannot attract many customers due to their age, they start their own business by bringing their girls into the profession. In one case, a sex worker who had been into the profession for more than fifteen years was very insecure because she didn't have a child, *'I am very worried. I desperately want to have a child but I have problems in conceiving. Who'll look after me in my old age?'*

In the case of Preeti, a local Bedia girl, who was working as an educator with a NGO, the community forced her into prostitution. Although she opposed and refused to join the profession the social pressure was so strong that she had to give in. Presently she is in Delhi and functioning independently, her brother who is with her manages and negotiates with the clients. She is working in a reputed hotel as a beautician from where she gets her clients too.

The Bedias are spread across other districts in Rajasthan. In some other districts, buying and selling of Bedia girls is common. Bedia girls are sold only within the Bedia community. After a few years of work, they are sold again to another pimp.

Health, Health care, Awareness about STIs/HIV

In the Bedia community, awareness about HIV seemed high, they said that they knew about the use of condoms and that they asked their clients to use it, but in some cases their clients refused to use condoms. Upon further probe they said *'No, we can't refuse clients if they insist on not using condoms. After all, this profession is providing for our subsistence needs''.* The sex workers do not go to the PHC for their illnesses. If they fall ill they manage to take care of one another. During illness, most of the time, the Bedia family members take care of their girls. They are taken to private practitioners without delay. In case of older women the situation is different. When a woman is unable to entertain enough customers the family does not take much care of her. She has to look after herself.

A visit to a Bedia household consisting of 9 members highlighted the vulnerabilities of young girls. The eldest daughter of the family was a sex worker in Delhi. The next daughter was reported to be suffering from neuro-syphylis and was apparently still working. The third daughter, Meena entered the profession two years ago. At present she is around 18 years. She reported symptoms of STIs and had not gone for a check up. She said : *'the family is in debt and I have to continue. My elder sister who is in Delhi has already paid her part of the debt (around a lakh).'* Meena has three younger sisters and two brothers. She claimed to earn Rs.300 - 400 per night. Meena said : *'I make it a point that the clients use a condom. If the client does not know how to put it on, I help him do so.'* Most of her clients come from neighbouring villages. She mentioned that she was in love with one of the clients who visits her frequently and is allowed to have sex without a condom.

Meena said a large number of NGO health workers had come to this area and conducted awareness on STIs including AIDS. They talked to girls like her. The NGO workers once took Meena to a health camp but there was no follow up. According to Meena, her parents did not seem interested in taking her to the hospital in the town.

> *The village Pradhan's (Headman) version on AIDS, he said,*
>
> *Yes I've heard about AIDS. It is a dangerous disease. I know one neighbouring village girl who was working in Bahrain and came back very sick with AIDS. Doctors verified that she had AIDS. She was kept in a 'Women's Home' (Nari niketan) in Delhi. No she did not stay with her family. But her family visited her frequently.*

Health care facilities

The nearest Primary Health Centre (PHC) is located at a distance of 2 km from the Bedia village. The doctor at the PHC said that he felt that 70% of the general population suffered from STIs but very few reported to the PHC. He also informed that none of the Bedia people come to the PHC. He said that availability of medicines and trained staff was always a problem. As there was no lady doctor and the auxiliary nurses were not sufficiently trained , very few women came with their problems. Even if a woman came with a STD problem, the auxiliary nurse informed the doctor of the symptoms and he would prescribe medicines without examining the patient. Women are embarrassed to get themselves examined by male doctors. The doctor advises them to bring the husband along but the husband never reports. Once a case of HIV was reported and the officers from the district turned up to isolate him from the community. The doctor said that,

> *"We as doctors are asked to do a lot of things and bring about a change in the mind set of people during our posting in villages but it is always frustrating because they understand nothing. They are very ignorant and I have to run after them for their well being. There is a man who is suffering from silicosis. I have come to know about his symptoms from the workers of an NGO, which is working in this region. I had to run after him, as he himself was not coming to the PHC. People think that I am corrupt. They think I do not distribute the full quantity of medicines. It gets very difficult to drive sense into these people's heads. You know that the facilities at the PHC are not good."*

The doctor further reported that in one of the areas on the highway, where Bedia women sell sex, the government established an STD clinic. Unfortunately, the utilization of services by the Bedia community was so poor that the clinic had to be closed. According to an informant Bedia men do not like to send their girls to the clinics as they feel that outsiders could lure the girls. No HIV testing facilities are available in the district or even the surrounding districts. There are no blood banks in the district. Recently a private blood bank has been set up. Abortion is a common practice among the Bedia prostitutes . They mostly get it done byprivate practitioners.

Efforts until now

Interventions in the Bedia community have not been continuous and sustained, it has mostly been from outsiders who have come and gone. Although the awareness about HIV

among the community is high it has not translated into change of behaviour. Serious efforts have not been made to involve the Bedias in planning interventions.

Successful interventions by NGOs to empower sex workers have taken place in Sonagachi, the red-light areas of Calcutta . At Sonagachi sex workers have formed support groups to educate their peers on how to protect themselves from STIs and HIV. Even the HIV positive sex workers have got their support group to provide emotional, social and practical support to their counterparts.

Four levels of negotiations summarise the range of empowerment strategies in the context of safer sex practices:

Negotiations with oneself – to improve perception of self, self-esteem, articulation of their rights and legitimate social identity.
Negotiations with clients – to include solidarity building within the group of sex workers, male sex workers, clients and permanent partners.

Changing and challenging structures and institutions like the police, legal machinery, educational institutions, medical establishments and other groups such as pimps, madams etc.

Negotiation with ideologies – this includes challenging the construction of the good (wife) and the bad (whore) women.

The sex workers intervention project in Rajasthan aims at reducing the risk of HIV infection among sex workers, their clients and the general population in five districts. The organisation has held training camps and initiated general development activities. They seek to improve the lives of sex workers, address issues such as land rights, health care and access to safe drinking water, electricity and basic education for children. The initial response from the community was a demand for general community services rather than condoms.

Strategies

A number of positive characteristics of the Bedia community come into focus. All spoke about family acceptance of sex work. As mentioned earlier, they do not identify themselves with brothel-based sex workers and feel superior to them. So strategies that are appropriate for brothel based sex workers may not be appropriate for them.

Form the above it is clear that both the Bedia and the Devadasis are knowledgeable about STIs including AIDS, yet they are unable to refuse unsafe sex. Along with knowledge negotiation skills need to be imparted. The entire education has to be geared towards an empowering process. Women have unmet needs these have to be identified and strategies have to evolved around them .

Targeted interventions involving the whole community seems more fit in their situation. The whole communities of Bedias / Devadasis have to be involved in planning and implementing the programmes. Men have to be targeted and involved from the very beginning, because even though women are the earners men decide. Due to education and outside influence, many young men are beginning to realise that sex work is not prestigious and women have to come out to join the mainstream.

Interventions with boys and girls have to start early in life. During the socialization process girls are indoctrinated to the glamour of sex trade. Sexual health education could elaborate on the hazards of the profession, which might well be a turning point.

Quality health care services seem to be lacking in these areas. There has to be a network of trained and sensitive local PHC doctors and Registered Medical Practitioners (RMPs). The need for lady doctors at the PHC was brought up again and again. The attitude of the local PHC doctors was very judgmental and therefore unacceptable.
It should be borne in mind that key cultural variables such as: lifestyle, sexuality norms, marriage, secrecy surrounding STIs including HIV/AIDS and confidentiality and other similar social values of these communities must be made available to and respected by groups that work towards HIV preventive programmes. These could include local NGOs or local doctors and RMPs. In other words, programmes and people that are sensitive to cultural traditions will be acceptable to these communities.

Other groups of people who need to be targeted are the local people around the Bedia community who are the clients of the Bedia sex workers. The Devadasis are comparatively better accepted by the community because of their religious sanction. Different communication strategies for each group will be more effective than a single method of educating people.

Involvement of religious leaders is a key to the success of these interventions.

Health interventions by local PHCs and NGOs functioning in the area have to include education and behaviour change programmes about HIV/AIDS. The messages have to be interactive and participatory.

The doctors and caregivers expressed the need for counselling and care services as an essential component of prevention and care. Accessible and affordable Voluntary Counselling and Testing Centres (VCTC) would enable people to get tested

One of the local NGOs working in and around the Bedia villages has employed the young members of the community to open libraries in the area. Books are being provided for the community. Many adolescents in the village become members of these libraries and have access to books and magazines.

IEC (Information Education and Communication) materials could be made available to the community through these libraries along with other daily magazines and storybooks.

At   the NGO level, women's organizations, community-based organisations need to collaborate to inform their members about life threatening illnesses due to their lifestyles through discussions, slide shows in a very non-judgemental way. To encourage behaviour change, peer educators need to know when to enlarge the basic message, when to listen and when to empathise and how to bring information on HIV/AIDS/STIs into conversations about other issues. Pressure to use condoms needs to be encouraged during these discussions.

Finally, it will be immensely helpful to involve young Bedia/Devdasi boys and girls as peer educators to ensure community participation.

Rehabilitation of women who are   leaving sex work or who want to   leave i has to be integrated within other programmes. Another important task is to lobby political leaders for legislative changes and to improve basic infrastructure like health care and educational facilities in the areas. The law on Immoral Traffic Prevention Act needs a new chapter on rehabilitative process, dealing with medical treatment, monitoring, follow-up, education and mainstreaming. The law is ineffective with regard to upper-class prostitution. There is also no provision in the Act for a competent legal aid service for the victims.

3- Men having sex with men (MSM)

The data presented here is based on a field study in Calcutta.

Homosexuality, or sexual activity between persons of the same biological sex, is a phenomenon which exists universally, but is subject to wide variations in its incidence and in the way that society and the culture   view homosexual acts or relationships. To develop appropriate prevention strategies, it is essential to understand the psycho-cultural frameworks within which sexual behaviour operates, and the context in which they operate in India. A distinction needs to be made between homosexual behaviour, found in most known societies, and homosexuality as a particular role around which individuals construct identities and communities of 'sub-cultures' are framed.

Homosexuality is a matter of strong social disapproval in contemporary India and was a taboo subject in public forums until recently, when some educated and professional men and women took up the question of   recognition and rights of homosexuals. Homosexuals in this country are not given enough space to express themselves, though a number of ancient Hindu texts, including *Kama Sutra* do talk about homosexuality. Even the Vaishnavic notion of worshipping Krishna, where the devotee's body contains the feelings of Radha, can be interpreted as a concept of sexual dualism. In Islamic Sufi literature homosexual eroticism   is a metaphorical expression of the spiritual relationship between God and man.

Along with   societal denial and disapproval, Section 377 of the Indian Penal Code (1860) criminalizes homosexual acts . This statute is based on the British law – Offences against

the Person Act (1861) –, which was subsequently instituted in all colonised countries, including India and Ireland. The law was passed making the act of sodomy illegal, but not homosexuality as such. In independent India, section 377 of the IPC is still in force. Homosexual activists in India think that because of the existence of this law, male homosexuals are 'subjected to systematic harassment, blackmail and extortion at the hand of enforcement agencies and the public. On the other hand, scrapping off this law without an amendment of the existing 'rape-law' would wipe out the last option for lodging a complaint against male rape. It should be mentioned here that rape is quite common in homosexuality.

Indian homosexual movements that have come up recently are strongly westernised and are present among upper middle class and upper class people. Moreover, people from upper income groups with access to resources are more vocal and have more access to western information. But in general, homosexual behaviour is still almost totally unacceptable. Even if it exists in the society, the responses of the community are mostly: '*It does not happen in our community…it is not part of our culture*' or '*our men are not like that*'. Many men, even if inclined to homosexuality , would not be determined or adventurous enough to translate it into homosexual or bisexual behaviour.

However, it should be mentioned here that cultural construction of homosexuality in India is different from that it in the west. First of all, homosexuality is not politicised in this country like in many countries of the west. Secondly, physical proximity among the people of same sex is quite natural here. Some homosexual activists in this country think that the Indian society is not as homophobic as in the west. They think that in some western country , strong anti-gay lobbies also exist side by side with a strong gay lobby. The lobbies are absent where homosexuals are discriminated against mainly in the form of verbal insult and teasing.

In India, MSM can be categorised as follows:

Amongst males-who-have-sex-with-males networks, boys/men are self-defined as *koti* or *dhurani*. They cut across income groups, class, caste, religion and region. They gender themselves through effeminate behaviour in specific spaces. Their exaggerated behaviour makes them visible in several public arenas, this is used as a flirtation mechanism. Males in need of sexual relief irrespective of their sexual choices may often respond to these feminized males for oral sex, masturbation and where space and a measure of privacy permits, anal sex. Significant numbers of *koti*s also sell sex in certain environments.

*Koti*s speak of the 'real man', who is the *panthi,* also known as *giria* or *parikh*. It is not a self-defined term like *koti*. Among the males who exhibit a so-called 'normative' behaviour, some may sexually desire other males, while for many it is simply an act of sexual penetration. The *panthi* visits specific locations where he knows *koti*s are available for sex, for which he may or may not have to pay. MSM have their cruising points and are generally seen at these points (like the lake, certain parks and some public toilets) from seven to ten in the evening.

Sexual relationships between *kotis* and *panthis,* both for commercial and non-commercial purposes are prevalent. Some *kotis* have their fixed *babus* (patrons/clients). Others look for new partners every night. The act of sex does not necessarily depend on monetary transactions as emotional attachment and like or dislike develop a lot in the relationship. *Koti*s have sex with their partners for gifts, money or just for pleasure.

Many of the men stated that they liked anal sex because it was 'tighter' than vaginal sex. They seek *kotis* as sexual partners due to non-availability of women for anal and oral sex. Recent anecdotal evidence indicates that many males see females as vectors of sexual diseases and therefore unsafe for sex. They also feel that vaginal sex is more risky than anal sex.

The majority of *panthis* are invisible. In India, it is a hidden group. They do not want to reveal their sexual identity. Many of them are either married or likely to be married in future.

The third group among homosexuals is known as *dupli*. Duplies believe that there should not be unequal power dynamics in sexual interaction. It is not important for them, who is penetrating who in a sexual act. Hence, they can be both penetrated by their partners or penetrate their partners.

a) Socialisation process of MSM

The socialisation process is a very important phase in the lives of the MSM. The childhood years are important for knowing the self. This is the time when gender notions are yet to be developed. They like dressing up like girls and playing with dolls. They do not face much gibes from their elders during this period. During school years the distinct realisation that they are different dawns on them. This is the time when others easily mark them out due to their effeminate behaviour. Their classmates start teasing them. At the same time, problems also come from friends, neighbours and relatives. They develop low self-esteem. On the other hand, in their sex life, they are subject to rejections from their 'dream men' . A number of *kotis* are also forced to have sex with senior boys. Experiences are not always negative . Few of them start enjoying the sexual act by that time. Persons with a similar attitude and sexual identity come together and a community feeling develops. As a result, a network among the *kotis* forms at the local level.

Manish a twenty-three year old young man shared his own experience:

I was born in a middle-class family of south Calcutta. I clearly remember that I used to play with girls and dolls. I really loved to play with girls. Very often my relatives teased me about this. 'Are you a girl, why are you playing with girls?' Once my aunt asked me, 'Can't you play with boys of your age?' But I felt that I was more comfortable with girls than boys.

At the age of ten when I was in 5th standard my cousin sexually abused me during a marriage gathering. The boy was around twenty years old. This went on for 2 years,

whenever he would visit my home, he would have sex with me. I was scared of that boy. But I never protested against it. Whenever I tried to stop him, he started ridiculing me for my feminised behaviour. He also used to complain to others about my behaviour, and elders in my family got a chance to scold me. But if I allowed him to have sex with me, he did not complain about me to others. This (having sex with him) gradually turned into pleasure and I discovered that I have feminine desires.

At this point in time, I realised that I was different from other boys. Around that time I watched a movie, and was attracted towards a famous cinema star, who acted as the hero in that movie. I felt a strange attraction and desire for that man. I was very embarrassed. I even started questioning myself, 'what is happening to me? How can I tell others that I love him.' My self-esteem was very low during this time. Fortunately, I got a few friends in school, whose ideas and behaviour were similar. My own group members and I used to stick together. We were teased and cornered by other boys but our group used to move together. We were always ready to defend ourselves against any physical abuse on the campus with dividers and compasses from the geometry-boxes against any physical abuses .

When I was in class 7, my friends took me to the lake. The lake has been one of the important cruising grounds for male homosexuals of south Calcutta. Initially, I was teased by the kotis of my age but later they accepted me. I was very happy to meet others whose behaviour was so like mine. I understood that I was not alone. They taught me everything. From them, I came to know that I am a koti. I came to know the terminology used for homosexual and homosexuality, and other words. Gradually, I realized that I could love a 'man' of my choice.

b) Initiation to sex in the life of an homosexual

Young men and boys, usually unmarried, may find themselves sexually aroused through body contact either when playing or sleeping next to each other. Many a time it transcends into a variety of sex acts. Here the sexual act may be mutual masturbation or thigh sex. Male to male sexual acts is very narrow in this context. These sexual acts are not seen as sex but as *masti* or *khel*, a sexual play between boys, which is not considered as serious because it does not involve a woman.

Where there is an age or power hierarchy or both, anal and oral sex may also occur, generally the younger partner acting as the receptive partner. This type of sexual activity can be called 'dosti sex' (friendship sex) and is linked to discharge sex without any construction of sexual identity. Desire may be focused on females. Non-availability of females leads to this. Friendship sex does not prevent marriage and may continue after marriage . Unequal power or age hierarchy may lead to sexual abuse. In hostels or at home, senior boys or elder relatives ranging from cousin brothers to uncles often abuse young boys sexually. Many a time sexual exploitation by seniors and colleagues becomes the initiating factor.

c) Friendship and romance

Romance and friendship in the true sense come in the later years at school. Many of the *koti*s establish relationships with so-called 'straight men' at this stage. The relations are not always stable. Partnerships generally last between a week and three months . Stable and yearlong partnerships are also reported. The emotional attachment is much more intensive for the *koti* than for the other person in the pair. The partner's sexual preference and identity is not known in most cases. He may be a bisexual or a homosexual. Rejection in love comes quite often in life.

Manish narrates, *"in the 9th standard, I joined a gym near the lake. A boy of my age, Vinod, was also a member of that gym. Both of us became good friends and came closer. I developed a soft spot for Vinod. We had sex several times. Later the partnership broke. We parted after some time (after their secondary examination) and we stopped going to the gym. Vinod started going around with girls. Later we met again in the college but the relationship never renewed.*

During the second year in college I had an emotional relationship with a man who was staying with our family as a paying guest. During that time, we were facing several domestic problems. My father had a cerebral attack. Our guest helped us a lot. He almost became a member of our family. We became closer and established an intimate relationship. Even my association with my organisation weakened during this time. Unfortunately, the relationship with the person did not last. I noticed a change in that person. He was not coming back home regularly and was moving around with several girls. He also started avoiding me. I was quite depressed. It took me a long time to get over this episode in life. I had a major depression, lost a year in college. I promised myself that I would never have any emotional relationship in life".

Akhil, a support group member of around twenty years of age, comes from a lower-middle class background in Calcutta. He narrates his own story:

"Presently, I'm attracted to a young businessman who visits me at the lake. I have become emotionally dependent on that man. He comes every evening to meet me. We sit together near the lake and chat for a long time. Recently, a friend of his became attracted to me. My friend introduced this fellow. He meets me whenever my friend is not in town. My friend did not like it and questioned me about it. Anyway, now he plans to marry and settle down. He asked me if I want to stop the relationship. I told him that I would not mind continuing".

d) Male sex workers in Calcutta

A number of *koti*s in Calcutta are engaged in sex work in some form or other. Several dynamics exist in homosexual sex work. One popular form of sex work is gift-sex. It is a form of male sex work, where the service provider receives gifts instead of cash. In Calcutta, the gift ranges from a pair of leather shoes, to an expensive jacket and maybe to a cellular telephone. Gift sex seems to be happening a lot in hotels and guesthouses. Waiters, massage boys are involved in sex-work in these places. There are also a number of youths, who are looked after by their clients, in terms of accommodation, clothing and food. Many male sex workers appear to work in public sex environments, where clients are from across the classes. Sometimes, clients will take them to a guesthouse from the 'pick-up' area. In south Calcutta, the lake area is one of the most interesting cruising joints for homosexuals. By six in the evening they come to this place in search of clients. The monetary transactions start from 50 Rupees per sexual act. It may go up to 200 Rupees per act. The rate varies between good-looking *koti*s and bad-looking ones and also the appearance of the *panthi*. If 'he' is handsome, a *koti* may agree to have sex with him for less money. The sexual act takes place behind a bush in a park, on a deserted platform, in a railway compartment, in one of their houses or in a hotel.

e) HIV/AIDS and risk linked to MSM's sexual behaviour

Homosexuals are extremely vulnerable to STIs and HIV transmission. Discussions with many of them in Calcutta indicated low prevalence of condom use for anal sex. 'It spoils pleasure' is a very common expression. It is also commonly believed that HIV s transmitted only through vaginal sex. Many a time anal sex is seen as '*masti*' by the *panthi,* and is not considered real sex, and so they indulge in unprotected sex.

Emotional involvements are another reason that leads to unprotected sex. If the *panthi* is handsome or a nice man with a gentle disposition, the *koti* may develop an emotional attachment to him. It becomes totally unimportant to use a condom in such cases. Emotional attachments also reduce the bargaining power of the *koti*s. Many a times the relationships do not last long. Moreover, these men are sometimes desperate to get a partner, which further reduces their bargaining power. They do not hesitate to go with a complete stranger.

Akhil, an MSM in Calcutta, narrated a story:

"One night I was returning home at 10 o'clock with a friend of mine – Bappa. Suddenly we noticed that a stranger was following us from a distance. My friend and I took a different route so that we could reach the main road quickly. The route we chose was risky as many thefts and robberies take place there. After crossing the main road near a cinema hall we looked back and found the man standing on the other side of the road. As soon as we looked back the man called my friend. Bappa told me, 'He is calling me'. I asked him whether he was willing to talk to the man. Bappa replied, 'Yes, let him talk to me'. Both of us went to him. The man

> *told me that he wanted to talk to my friend privately. At first I did not agree. I thought that Bappa might be in danger. I had never seen that man before. But I found that Bappa was keen on spending some time with him. They talked for a long time. I was watching them from a distance. The man said that he would come later some day. He also asked my friend if he was available there every evening .*

The location used for a sexual act is another important factor in determining whether a condom will be used or not. Sexual acts, which take place near lake, deserted railway platforms or railway compartments are mostly without condoms. These sexual acts are of short duration. Due to the shortage of time and space, the *koti can* neither bargain with his client nor can he monitor his client for the use of condom. Partners often cheat kotis by taking off the condom before penetration. A support-group member, who is working among the *koti*s in Calcutta, informed that condom use is very low. Although he distributes condoms the *koti*s do not use them.

After a risk assessment programme by an organization in Calcutta, it has been found that condom use in the suburbs is absolutely nil. In south Calcutta few demand condoms and there hasn't been much response among the *koti*s of north Calcutta. North Calcutta is relatively more congested as compared to the southern part; hence there is lack of availability of space and open venues to hold such discussions. A difference in the outlook of the people is observable between the residents of north and south Calcutta. The former are the traditional people with conservative viewpoints and the latter have a relatively modern, indifferent and non-interfering outlook on life.

Anal sex is very common among homosexuals in Calcutta as elsewhere. During anal sex, some *koti*s may end up with ruptures and injuries, though it is not very common. They visit the local practitioners and are unable to explain the situation to them. They generally say that they have piles. The doctor gets to know and threatens the *koti* that his family will be informed if he does not speak the truth. He is operated only when he tells the truth.

Self-esteem is generally low among the *koti*s in Calcutta. Low self-esteem drives people to risky behaviour. In the terminology of male power, the male who is penetrated during sex is considered to be like a female and hence inferior. The simultaneous 'giving up' of male power makes a *koti* a subversive and timid entity in the eyes of the others, and they are marginalised in society. There is little urge to protect oneself from any harm. In a number of cases, *koti*s have got themselves castrated or have tried to join a group of eunuchs in search of an identity. Many *koti*s have a high level of dissatisfaction with their male bodies. This also negatively influences their sense of self-esteem.

*Koti*s at the lake have a strong community feeling. They keep contacts with each other and help each other. At times they discuss their problems and try to figure out the possible solutions.

However, there is a distinct difference between the *koti*s from the low and the high-income groups. The ones from the higher income group have separate cruising venues

and don't interact with other *koti*s. MSM who earn Rs 500 do not interact with those who earn Rs 200. A member termed these people as selfish.

f) NGO efforts

An NGO in Calcutta working on a number of projects has an important project with the MSM community. Back in 1995, few *koti*s had started discussions on their group behaviour, attitudes. The possibilities of establishing an organization were discussed at the lakeside or in their houses. The initiative aimed at developing communities of men who are largely discriminated against by society. The ONG has been trying to present options for the life of MSM and has been working with these men on parallel constructions of masculinity. The organization has a resource centre on male gender studies. It believes in studying male gender as a separate identity while integrating it in the study of both masculinity and femininity. At present, it is conducting a risk assessment among *koti*s in Calcutta. They have several outreach programmes at different cruising venues in Calcutta. Support group members provide counselling and condoms to the MSM.

Very few organisations in Calcutta are making similar efforts to address issues of MSMs. These interventions are taking place at small community levels and need to be integrated in all HIV programmes.

Strategy

HIV/AIDS intervention strategies for MSM should be linked to awareness raising and other wider issues. Space for discussions on gender construction and sexual preferences might change the attitude of society towards homosexuals.

At a broader level, decriminalisation of homosexuality is necessary for providing a cultural space. With the legal reform, there will be more societal acceptance. Negotiation power of the *koti*s will also increase which will lead to reduction of risk behaviour. Preventive actions for HIV transmission cannot be taken care of without these larger reforms.

The myth that anal sex is not 'real sex' and therefore not as risky as vaginal sex, needs to be destroyed. It is rather paradoxical that some MSM do not feel vulnerable to STIs including HIV and continue to have unprotected sex while others are unable to negotiate safe sex. Life skills education and training need to be targeted to enable them to perceive and deal with the risks.

4- Street children

UNICEF has defined street children as, 'those who are of the street and on the street.' 'Of the street' refers to those who live in the street and 'on the street' to those who spend a significant part of the day on the street either for vocational reasons or for a wide range

of other activities like begging, rag picking, car washing or attending to some side street shop. UNICEF has included them under children in difficult circumstances. They are also called 'high-risk children', 'children in need of care and protection', 'abandoned children', etc.

The problem of street children is a global one and exists in both the developed and developing countries, with a difference in size and magnitude. As the countries are becoming more and more urbanized, the number of street children is growing. The following are the categories of street children:

1. Children on the street – these children still have more or less regular family contact . Their focus in life is still the home. Very few attend school, most return home at the end of each working day.

2. Children of the street – this group is smaller but complex. Children in this group see the street as their home and it is there that they seek shelter, food and a sense of family among companions. Family ties exist but are remote and their former home is visited infrequently.

3. Abandoned children – these have severed all ties with the biological family, they are entirely on their own, not for material but also for psychological survival.

Every Indian city has a sizeable number of children who are unaccounted for and who live in shocking inhuman conditions. These children are found on the streets, railway platforms, markets, slums and squatter colonies. Along with other miseries in their lives, these children are exposed to high-risk sexual behaviour in their early years. They have often been subjected to abuse and harassment. Sex is easily available for them. Finding it very hard to make both ends meet, they are driven to a life of precarious survival. Health services, for this marginalised group, are inaccessible and unfriendly. The major focus of the existing HIV/AIDS programmes is on school-going children. The responses to prevent the spread of the infection in out-of-school children are isolated interventions by some NGOs. There are few efforts to link work on prevention of HIV/AIDS with developmental programmes that address poverty, gender, education and access to health care.

a) Running away from home and socialization on the streets

For the present study, discussions with street children were held in Calcutta. Children run away from home early in life at the age of 7-8 years. Most have contacts with their families and visit their family once in a while. They run away from families because of ill treatment from their father and stepmother, lack of space at home, in search of a better life and to seek freedom. Some said that they could not fulfil their parents' wishes and ran away. Some did not like to go to school and study. Many children run away from home because they cannot bear the stress of family problems, especially when the father is alcoholic and beats the wife regularly. They are sometimes motivated by friends who have already run away .

> **The Stories of Babu, Samir and Vijay**
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> Babu (21 years) has been living in the Sealdah Railway Station for the past thirteen years. He narrates his story:
>
> *'I come from a low-income family. My father used to sell sweets at 'melas'. I had an elder brother also. We used to live together. My mother died during delivery when I was a seven-year-old boy. My father remarried. My stepmother was so nasty towards my brother and me that one day my brother left home. He never came back. I too tried to runaway from home. Once I left home but I came back. I was scared. I did not know where to go. My stepmother was beating me up regularly. One of my neighbours advised me to runaway from home. Finally, one day I ran away from home when I was only 8 years old . My aunt dropped me at the railway station. I couldn't locate my elder brother. I started staying on the roads and used to beg and eat leftovers at the station, till one day an unknown person in the station called me and said that he was my friend. He agreed to share his small space in the platform with me.'*
>
> Samir (24 years) comes from a low-income refugee family. His family came from Bangladesh and settled near Calcutta.
>
> *'I ran away from home when I was 7-8 years old. I just felt like running away one day because of the lack of space. I never had any interest in studying. When I came to the station I became a rag picker. I used to move around in the surrounding areas of the station. I was noticed by an NGO and was sent to school.'*
>
> Vijay (11 years old) lives in a congested area of north Calcutta. At present he works in a tea stall as a dishwasher. He shares his experience:
>
> *'I ran away from home when I was 8 years old. My original home is at Bangaon, in 24 Parganas near the India–Bangladesh border. My mother died when I was 6-7 years old. My father is a vendor. He started living with another lady and stayed separately from us. My two younger sisters and I started living with my grandfather. Villagers started teasing us. One day I ran away from home and came to Sealdah station all alone.'*

Boys and girls after reaching the street or railway station find it difficult to obtain food. Soon they start earning through rag picking, working in tea stalls or stealing. Slowly a relationship develops between the older ones and the new comers.

b) *Sexual abuse/sex in life*

For most of them, the first sexual contact in their lives is through sexual abuse or forced sex. A large number of the boys are also repeatedly sexually abused by some men in the station, which lead them to indulge in sex early in life. Some of the boys watch adult

movies with older boys and friends. Later they try to enact the scenes from the movies. Gradually, they start having sex with their peers.

Forced sex is a big problem in children's lives. Children cannot protest . They are threatened by exclusion from the platform. A number of times, little boys are taken to hospital for treatment of injuries caused by forced anal sex. This becomes the initiating factor for the children. The peer educators later found the same boys indulging in sex for pleasure. Kids also agree to have sex for money and food . Sometimes older men show a lot of affection towards a particular young fellow who might be a newcomer to the area. They provide food and a place to sleep and later compel the young boy to have sex with him. Even in the cinema halls, older men have sex with young boys in the darkness.

> Babu relates : *'The man who provided me shelter in the station sexually abused me one day. I was badly injured.'*
>
> Anwar (12 years old) relates : *'An aged person in the station, who lives with his family there, sexually abused me. He did bad things with me.'*

The girls who come to the railway station also indulge in sex in early life. For them too initially it is forced sex. The railway police who patrol the station at night take the girls to vacant train compartments and have sex. Secondly, both these girls and boys steal raw vegetables from the goods trains or the trolleys. If a policeman catches a girl stealing, she is forced to have sex with that policeman or else he threatens to arrest her. The older boys also accompany the girls to steal vegetables. They give the girls protection in exchange of sexual favours. Most of the time, the girls agree to this for survival.

In leisure time, discuss their sexual experiences with their friends. They relate how they went with a girl to have food in a restaurant or to watch a movie. They also share their experience of approaching and persuading girls to have sex. They talk about sexual postures and use their own terminology to identify both male and female sex organs. Most of these boys do not use condoms.

The NGO educators think all these have an impact on the peers. This makes them more inquisitive about sex and sexual activities. Both boys and girls after some time have sex for pleasure. The peer educators counsel these boys on HIV/AIDS, STIs and condom use. They are shown slides of genital infections. Many of them listen to them carefully and now ask for condoms. Some even come to the NGO clinics for condoms. Girls at the station also collect condoms from the girl peer educators. Peer educators told us that cases of STIs have dropped sharply. Now only a few come to the clinics with cases of STIs. The peer educators think that their education works positively among 80 per cent of boys and girls.

Both boys and girls think that girls have not acquired enough power or command to bargain on sex. Boys can apply force on them. Girls are scared of the boys. If a girl does not allow a boy to have sex with her then the boy might injure her with a blade. Finally it is easier for them to offer sexual favour to the boys because they are the persons who can

help them in stealing vegetables from the trolleys and give them other basic information. The girls do not indulge always in sex for money . They like to have sex. Even the girls who know the dark sides of unsafe sex indulge in sexual activities some times for fun . The girl peer educators think that the bargaining power of girls who are not so good-looking is lower than that of the good-looking ones.

c) Love and romance

In comparison girls coming to the station are much fewer than the boys. Whenever a new girl comes to the station, the boys keep an eye on her. She has to depend on some of those boys for her survival. Gradually she becomes intimate with a few or one of them. Sometimes, she becomes close to somebody else outside the station. The peer educators say it is very risky to make friendship with unknown men, as there are some people (both men and women) who are involved in girl trafficking.

The boys have a competition among themselves to take possession of a girl in the station. The girl may be attracted to a particular boy even if his income is less than that of another fellow. The latter who earns more tries to convince the girl. He lures her with a dress or cosmetics . The girl sometimes changes her mind and prefers another guy. The incident may lead to an altercation between the boys. They declare their right on the girl on the basis of their buying power. The overall impact is bad. The boys say that, *'girls are greedy, they change loyalties very easily for money.'*

Young guys may even marry girls living in the station. These marriages do not last longer than a month or two.

> The story of Vijay: *'I fell in love with a girl of my age called Mamoni, at the station. Mamoni was the sister of one of my friends. That friend of mine asked me to marry Mamoni, but I had not thought about marriage before then. Mamoni liked to watch movies; I took her to movies several times. We also had sex several times inside the garden, in the station premises. Later on, Mamoni became too greedy. She started moving with other boys for money and clothes. She even established a relationship with Pavan, a porter. He is a well-built young man. Now I have stopped interacting with Mamoni. Even if we meet, we don't talk to each other.'*

d) Drug/alcohol addiction

The boys spend the money mostly on meals, watching films and also buying 'synthetic solutions', which they are addicted to. They tear off part of a cloth and pour the solution on it and sniff. After some time they feel dizzy, and in this state they either steal things, indulge in sexual activities or just sleep off. A number of boys are also addicted to alcohol and drugs like ganja and charas (hashish).

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e) NGO efforts

Discussions were held with members of one NGO, which is working with socially disadvantaged children in Calcutta through education and social mobilisation They have drop-in-centres, night shelters and a halfway home (24 hours residential centre). The NGO works with the street children at the railway station and other places in Calcutta. In response to the street children's life style, an HIV/AIDS awareness programme was set up. Street children are trained as peer-educators to reach out to their friends and immediate community with information on sex and sexuality with special focus on HIV/AIDS. Three clinics run to respond to the health needs of street children. A counselling programme for the children is integrated with condom distribution.

Strategy

Any intervention programme on HIV/AIDS should be integrated with other existing programmes and the basic needs of the community. There is need to have inter-sectoral links with other development programmes like health, education, and the judiciary.

Provision of adequate resources and other facilities such as, sex education, health camps, and production of educational materials in the local language and role-playing are important. Schemes for vocational training leading to rehabilitation and integrating them into the mainstream have to be part of all intervention programmes. There is also a need for psychosocial interventions including counselling services. In addition, more community centres for children have to be established for providing education, training and shelter. Such centres are essential to get the children together for conducting educational, welfare and recreational activities.

Comprehensive health services are of considerable importance for street children. They should educate and train children about prevention of disease and promotion of health. This can be achieved if one is part of their life in order to understand their lifestyle, their attitude and way of thinking. A planned programme for street children can attempt to change the behaviour of the individual or modify the environment to meet specific needs of the individual.

Peer education methods that have been successful in various parts of the world need to be reviewed and adapted to the Indian context.

5- Drug users

The phenomenon of 'traditional' drug use in Asia has been well documented since the presence of the British in the region. Substances such as cannabinoids and opioids have found their way to Western markets with substantial profit margins which resulted in International pressure for Supply Reduction and crop eradication measures.

Drug users are a highly elusive group in India. Information on the magnitude of the problem among the general population is available from four kinds of sources:

a). research projects, b). data from treatment centres, c). views expressed by key informants such as, ex-addicts, government officials, teachers, parents of addicts, drug peddlers, community leaders and d). addicts themselves. Most recent studies of drug use have shown an escalation in the number of intravenous drug users (IDUs). Those who inject drugs are still an isolated group in our society. The risky behaviour of this group is needle sharing, which is known to be an efficient mode of HIV transmission.

The profile of the IDU in India is diverse and dependent on the location of the user. In the northeastern states of India such as Manipur and Mizoram the IDU cuts across all socio-economic strata. In other regions of India, the lower socio-economic slum communities appear to be more concerned by the phenomenon. Those who indulge in this behaviour mostly share a common syringe within a group. Injecting drugs with non-sterile syringe is one of the key risk factors leading to HIV. The entire system of taking drugs makes them vulnerable to HIV. Another group of people, who actually do not indulge in injecting drugs, are also at high risk because they are the sexual partners of the addicts. The twin epidemics of HIV and substance abuse are fuelled by low awareness levels on the modes of transmission of HIV as well as community marginalization and social policies that prevent and prohibit access to sterile needles and syringes for IDUs.

a) A life dependent on drugs

Many young people start experimenting with drugs during their adolescence. Most of the time they start taking so-called soft drugs like *charas (*hashish*)* or *ganja* (marijuana), later they try hard drugs like heroin or other chemical drugs like ecstasy hallucinogenic drugs. The dose is increased gradually. They take money from their parents, if possible, otherwise they may indulge in stealing or other illegal activities. Peer pressure is high among drug users. Nevertheless, it should also be mentioned that peer pressure is not the only factor triggering their use of drugs. An important number of young people start taking drugs only for fun or experimentation, at times it has nothing to do with depression or peer pressure.

An activist told us that taking hard drugs or hallucinogenic drugs is also due to great exposure to the western society through television and films. It was also reported that many start taking drugs just for the experience . In the process itt does not take much time for many of them to become completely addicted.

Once addicted to a particular type/brand, a drug user first goes in search of his or her drug . If it is not available then any kind of drug is accepted. Anti-epileptic and anti-spasmodic capsules are also swallowed or injected.

According to informants there is a hierarchy among drug users based on the types of drugs used and the way the dose is taken. IDU are rated the lowest and will always be found in separate groups. The upper middle class drug users indulge more in western

drugs and hallucinogenic drugs, which are orally absorbed. Many users also come from the middle class , but according to a psychologist there is a lot of guilt involved.

b) Drugs and sex

Additional risk behaviour is multi-partner sex after taking drugs. Initially, drug use heightens sexual desire. Not only IV drug users, all drug users including alcoholics, are equally vulnerable to HIV if they indulge in multiple partner sex or unsafe sex while under the influence of drugs. A number of intravenous drug users – men, women, and children – sell sex to procure drug money. Frequently, street children who may themselves be peddlers get into drugs, some men get their wives to procure money for their drug habits. These women, in turn, also end up using drugs and selling sex to procure the money.

c) Attitude of family and community

Family bondage is still very powerful in India. There are strong emotional links within families. But as far as HIV/AIDS is concerned, the economic burden is the main problem for the family. Most of the time, a family cannot afford to keep a positive person who has developed AIDS, as medical expenditures are too high. It is not always true that the affected persons are dumped in care-homes. Family members keep track of their loved ones. But there are cases where families need to be motivated. They may be compelled to take back an affected person.

The community looks down upon the addict who is mostly stigmatised, marginalised and alienated from the society.

d) False beliefs about drug use

-   Once a person starts taking drugs, he/she can't stop (proper intervention can help a person to stop drug use).
-   A drug user always lies, cheats, steals (it does happen in a number of cases, but one can't label a drug user a liar/thief).
-   He/she starts taking drugs because of friends or the company he/she is in (at times people who have no friends and are lonely also take drugs).
-   People take drugs only when they are low (drugs are always associated with negative emotions which is not true, at times even the happiest of people take drugs, it adds to the sense of elation).

e) NGO efforts

The Manipur intervention programme has a day care centre and a rehabilitation centre. At the day care centre they have drug users dropping in during the day. Some just drop in because they are curious as to what is going on. During their visit there they are counselled, told about consequences of drug use. The whole programme is non-judgmental and non-threatening. Anyone who enters the day care is accepted. After a

number of such visits, a drug user might decide to go for abstinence and   start a detoxification programme. Once the person is   a bit stable and no longer   dependent on drugs, home visits are made to the family to counsel them and ask them to support the concerned person.

According to one informant's experience who himself was a drug user, '*although family support is there in a number of cases, there is a lot of hesitation in it. Family lacks confidence and faith in the drug user and are always a little wary about the person's drug use status*". The informant said drug addiction is   quite different from alcohol addiction. People with alcohol's problems have more support from the family but the family tends to lose patience with drug users, as it becomes equally traumatic for them.

There are cases where   drug users have stripped their homes of things, cases where they keep threatening their families   to commit suicide if they are not given money. The family finds it very difficult to handle such situations.

Rehabilitation

At one of the NGO rehabilitation centres in Delhi, a drug abstinence programme is proposedtogether with income generation and vocational education. The drug users themselves feel they need to be kept busy or they might have a relapse. They are kept busy with sports, religious, spiritual or recreational activities.

In relapse cases, relapse is manifested before actual drug use. There are signs that make it evident that the person will have a relapse. Lying, stealing, avoiding people are   some of the signs that are well recognised. During this time the NGO tries to bring the person back on to the right track by counselling.

Some of the key informants   interviewed, were ex-drug users and are presently working and providing support to other drug users who are under the care of the NGO . A clinical psychologist who has also been working at the NGO for the past 4 months provided some insight into the lives of drug users.

The informants said that the rehabilitation programme is different from   other rehabilitation programmes run by government or organizations. The NGO puts more emphasis on emotions such as love and patience while handling drug users who come for rehabilitation, unlike other programmes who handle them by giving negative reinforcements. They accept anyone who comes to them without being judgmental. Occasionally they have to be tough but that only helps the person to get back on the right track. The environment is very casual and free with no restrictions imposed on anyone. Only in extreme cases where the individual brings drugs in and supply or molests others, is action taken. Classes are held for people who are illiterate. Musical and sportive activities are frequently held. One of the ex-drug users said that he is still trying hard to stay off drugs now, and on the contrary if he had been punished or sent to prison he would not have stopped taking drugs.

This NGO runs a harm reduction programme in Delhi. Though at times it is hard and frustrating, inmates saw the positive outcome of counselling, which resulted in gradual behaviour changes. Drug users are asked to gradually decrease their doses of drug intake. There are considerable changes in certain cases where individuals have drastically cut down their daily doses and become more functional than before. Their families have been very happy with the changes and have discussed the prognosis with the counsellors. Many of them have gone back to work and bring money home. They said that the percentage of successful cases was small but even if they are able to change the behaviour pattern of 5 in 100, they feel it is worth the work put in. Later, abstinence is even tougher, but there have been successful cases where individuals have stayed clean for years.

In addition the NGO has incorporated HIV/AIDS, Hepatitis awareness in its programme, but feels it does not lead to absolute behavioural change. The high-risk behaviour after drug use is difficult to check. Providing sterile syringes on a regular basis is not always possible. At times, the urgency to fix oneself overpowers one's feeling of personal safety. Among the lower income group, people think that HIV is just another virus, it does not bother them to have it or not. It was stressed that other programmes such as income generation and vocational programmes have to become a part of harm-reduction and rehabilitation programmes. If the drug user is not provided with alternatives, then it becomes difficult to have effective rehabilitation and outreach programmes. It was regretted that most funding agencies provide funds mainly for rehabilitation programmes, and leave out other aspects linked to effective programmes.

Some other organisations have also opted for harm-reduction programmes. They have put most injecting drug users on oral maintenance therapy and few have also abstained from taking drugs so as to reduce the risk of contracting HIV. For this , these organizations have not been provided support from the government and they find it difficult to obtain funds for their programmes.

The Narcotics Act in India treats all drugs (soft and hard) similarly. A person caught carrying 5gm of cocaine, heroin or ganja would be punished equally and the sentences are equally harsh. All agreed that laws have to be modified and need to be milder. A drug user in the Indian context is treated worse than a murderer. The informants spoke from their own personal experiences in prison where they were treated badly by all, the attitude of a prison guard to a sentenced murderer being the same as towards a drug addict. The drug users were given the lowest status and were treated as 'the scum of the earth'. Giving examples of areas where drugs are easily accessible, they spoke about a congested area in Delhi where drug users flock around 4-5pm in the evening to buy their daily doses from a peddler who visits them everyday. The police around the area are well aware of the facts but get their share of money from the peddler.

Strategy

One of the most effective strategies for preventing HIV infection among IDUs is to minimise sharing of injecting equipment by ensuring ready access and utilisation of such equipment. Many models of needle-syringe programmes exist, including dedicated

needle and syringe exchanges, needle and syringe medical prescription, pharmacy provision, secondary needle and syringe exchange, distribution through drug injecting peers, prison exchange programmes, and vending machine dispensing. The largest number of papers presented at the conference on IDU interventions focused on needle and syringe programmes, addressing such issues as models of service delivery, characteristics of clients, effectiveness of interventions and meeting the needs of specific populations.

Outreach, particularly incorporating peer and community-based approaches, is also a common component of many programmes targeting IDUs. Services provided should include: needle-syringe exchange and disposal programme, condom programme , peer education (including current and ex-drug users), care of abscesses and other primary health care, support groups for people living with HIV, referral to detoxification, detoxification camps, family support groups, crisis support shelter and long-term rehabilitation services which must be part of all drug programmes. The interrelationship between sexual behaviour and non-injecting drug use is complex, poorly understood and little studied and further research needs to be done in this area.

V- LESSONS AND RECOMMENDATIONS

The vast cultural diversity of India which includes many culturally fragile communities, does not allow theconduct of exhaustive studies within a limited time span and limited resources. Thus the scope of the study was as broad as wished. Keeping in view these shortcomings the conclusions are more generic in nature.

1- Lessons

a) Established facts

- Culturally defined gender constructions and masculinity may put men and their sexual partners at risk of HIV infection. In India, being predominantly patriarchal, men are the decision makers. They are not supposed to display emotions (they are not supposed to cry, etc.). They can change sexual partners without much opposition. Moreover, it is men who determine when and how often to have sex.

- Girls and women are socialized to assume an inferior position. Pre marital or extra-marital relationships are not culturally accepted or tolerated. There is increasing evidence of domestic violence and sex without consent.

- Cultural tolerance to male-male bonding. From a very early age, a boy is expected to be friendly with other boys but not with girls. So male bonding gets quite strong. It is socially approved for men to hold each other's hand or hug each other. Men often develop strong bonds among themselves and thus, bisexuality goes unnoticed.

- At a time of rapid social change a deeper understanding is needed for culturally accepted behaviour patterns related to courtship and marriage. There is very limited inter-spousal communication in matters related to condom use and fertility, virginity and other matters related to sexuality and sexually transmitted infections (STIs).

- There is very little qualitative data on patterns of sexual risk behaviour of out-of-school male adolescents and unmarried young men. Anecdotal evidence is pointing to widespread sexual networking and prevalence of unsafe sex among this extremely diverse sub population. They are the ones who are creating risk for others and are at high risk themselves.

- Beliefs and perceptions of different groups on seeking treatment for STIs is an interesting area of study. Once again, anecdotal evidence is indicating that most men seek treatment for STIs, but do not necessarily inform their wives / partners . Wives/partners may get infected but majority of them do not have the courage to disclose it to their husbands/partners. Due to the culture of silence, seeking treatment for women is often the last recourse. Moreover, preferred treatment may well be from an unqualified practitioner who provides privacy and confidentiality

to home remedies. Further understanding is needed in the area of treatment regimes that are widely acceptable.

- In India, the family plays a crucial role in the life of an individual. It provides emotional support and acts as a buffer. Family bonds are very strong and most families feel that it is their duty to take care of the infected person, especially if the person happens to be the male breadwinner. Most often stigmatising diseases like leprosy and TB are closely guarded secrets within the family. It is often a matter of shared confidentiality.

- Societal attitude towards individuals and families living with HIV and AIDS (PLWA) is yet to be understood in the Indian context. Media reports of social exclusion and violence against families affected are frequent. As mentioned earlier the enabling environment for PLWA to live with dignity is yet to evolve.

- The magnitude of stigma and discrimination at the corporate level,, in health care centres and even at community level is being reported from various parts of the country. Little or no information is available on the nature of discrimination at the workplace. Enabling legislation and policies are yet to be put in place.

- The social system and functioning of brothels are subject areas that are much less understood. Women and girls are often sold into the sex trade. Brothel owners, Madams and pimps dominate this complex system. Sex workers are totally powerless and this jeopardizes their right to self- protection.

- The sub-culture, group dynamics and social cohesion of injecting drug users are critical aspects for understanding vulnerabilities. At the same time, it is being reported that the rate of partner change among drug users is high. In addition, utilization of health and other services is poor.

- Rapid urbanization is giving rise to the phenomena of 'street and working children'. These children run away from homes for better life, but are paradoxically at an increased risk of sexual violence from older peers and other adults.

- The phenomena of seasonal migration and the risk associated with it require a deeper analysis. Young men (both married and unmarried) from poorer states migrate to bigger cities and towns for employment, leaving their families behind. Once in an alien environment, far away from prying eyes and with some money in the pocket, many of them indulge in unsafe sex and take the infection back home.

- Many cultural minorities (Viz. Nut and Bedia communities, Devdasis, groups practising caste and religious prostitution, tribal populations, etc.) are exposed to the risk of HIV; their existence appears fragile. With rapid social change their

motivations to adopt alternate occupation and coping mechanisms are to be explored.

- With the erosion of their traditional occupation more and more of the 'Hijras' (mostly castrated males) are in the business of prostitution. Their clients are men who have anal intercourse with them, though paradoxically, such men (the clients) do not identify themselves as homosexuals/bisexuals.

- Cultural and linguistic terminology that predisposes vulnerability. Terms such as, 'Gupt rog' (means hidden disease), 'mahila rog' (AIDS-woman's disease), 'swapan dosh' (fault during sleep), 'gandi baat' (sex) are part of common vocabulary, which have implications on HIV prevention programmes.

- Each culture has defined coping, bereavement and ritual cleansing mechanisms. Coping processes of individuals and families living with the virus need to be studied empirically. In view of the enormous psychological stress that AIDS, as a condition, has on individuals and families a deeper understanding of social support mechanisms available will prove beneficial for management and care of PLWA.

- In the past, most IEC efforts have been general and information based. They have not been culturally sensitive, as a result such campaigns have often succeeded in further stigmatizing and criminalizing certain groups (sex workers, truck drivers, MSM etc). Moreover, though they have contributed to raise awareness IEC campaigns have not succeeded in making people feel vulnerable. The gap between "Us and Them" has been widened.

- Most of IEC efforts are urban oriented and generic in nature. Rural and remote communities have yet to be reached. Messages have further stigmatised certain groups. The efforts have not been sustained through proper media planning. Culturally appropriate campaigns need to be targeted using every channel of communication.

- The attitude of health care personnel towards infected people needs a closer scrutiny. HIV/AIDS is viewed primarily as a sexually transmitted disease by society at large and is therefore, associated with immorality. There is also a fear that it could be passed on through ordinary social contact and nursing care.

- Voluntary Counselling and Testing Centers (VCTC) are being established all over the country. Is there enough data on the patterns of utilization of HIV-related services such as access to anti-retroviral services, availability of drugs that reduce pain and suffering caused by AIDS-related illnesses?

- Within the context of HIV/AIDS human rights are less observed not only by the service providers but also by PLWA. Are service providers / PLWA aware of the human rights issues? Are there violations and if so, what forms of redress are

available? In addition, there is little adherence to ethical principles such as confidentiality and informed consent in diverse settings.

b) Societal and cultural impact of socio-economic change: an aggravating factor in the expansion of the epidemic

In India, large-scale migration from rural to urban areas is a seasonal phenomenon. This is due to population pressure on the agrarian land and to some extent due to the glamour of city life. Economic migration is a common feature that attracts young people. Migration has its own health implications.

Culturally Indian society is at a threshold, traditional values are still held with pride, alongside modernization. There is often a conflict between modern and traditional values.

Literacy levels especially women's literacy levels have increased significantly. The overall total literacy rate is 65.38%, 75.85% for males and 54.16% for females, nevertheless, the status of women remains low. The overall sex ratio is 933, but some prosperous states are depicting a disturbing trend of gender imbalance. The sex ratio in some states is as low as 821.

c) Socio-economic, societal and cultural impact of HIV/AIDS: the vicious cycle

AIDS and poverty are closely linked. HIV targets poor and marginalized populations disproportionately. Poverty underlies much sexual behaviour. Poverty increases vulnerability because of migration, commercial sex, failure to use condoms, needle sharing among injecting drug users and poor treatment of STIs.

AIDS leads to decreased productivity, resulting in loss of jobs and an increased expenditure on health care services. As a consequence, household income decreases, which aggravates the already poor nutrition status especially for children. Ill health and poor income lower school enrolment.

In other words, AIDS is a condition resulting from destitution, disempowerment and discrimination.

On the other hand HIV and AIDS lead to social exclusion, rejection from the group, and breaking of the family.

d) Cultural references and resources.

<u>Cultural Traditions and habits</u>

They not only bind communities together but also define statuses and roles. Some cultural traditions are health promoting while many others enhance risk, for instance:

- it is generally acceptable for men to have sex before marriage and if one is a 'real man' then he can also have extra-marital relations, but the same is not the case with women who must be virgins at the time of marriage;

- adolescent girls and young women are often not given information about their 'body' with the belief that their innocence will be ruined. An innocent girl should not know about her body or contraception. This often puts her at risk because she is unable to protect herself.

- often sex between men or boys is termed as 'masti' (fooling around); it is not real sex, because real sex is virginal sex. This makes young men vulnerable.

- sexual violence towards one's spouse/partner is normal for 'macho men'. Such men do not use condoms, because condoms are only for birth control and therefore, could be used with one's spouse but not with the 'other' woman.

- most STIs are a result of heat generated inside the body due to excessive consumption of "hot food". This may result in blisters in the genital area. The treatment, therefore, is to consume "cold food" and wait and watch.

- a cultural belief that is still prevalent in most parts of India is that having unprotected sex with virgins cures STIs.

- many men believe that washing one's penis with one's own urine after unprotected sex gives full protection from STIs.

Culture and health

As explained earlier, the diversity of Indian culture is so vast that almost all systems of medicine and their practitioners practice in perfect tandem. The options are immense and the belief system is intertwined with cultural pluralism.

Choice available ranges from simple home remedies to traditional healers including folk practitioners, ayurvedic, unani, homeopathic and modern allopathic practitioners. These options compel people to undertake what may be described as "Doctor shopping". An average villager would go to a snake charmer for a snake bite, rush to a primary health center for rigor and chills presumably for malaria, go to a herbal medical practitioner for suspected symptoms of STI, or take the child to a magico-religious healer for measles. Certain ritual cleansing mechanisms must be evaluated carefully in this respect.

traditional healers know the pulse of the community and people have implicit faith in them. In addition, these practitioners are good counsellors and their services are generally confidential.

<u>Religious beliefs</u>

To mitigate the impact of HIV and AIDS on individuals and families a multi-sectoral response will be inevitable. Religion plays an important role in understanding values and attitudes, sacred and profane, compassion and care. India practices all the major religious of the world. Peace and tolerance is the corner stone of society. In the past, various religious groups and leaders have played significant roles in wiping out social evils such as dowry, sati, caste-based discrimination etc. Religious leaders have been at the forefront of the fight against diseases such as Leprosy, Tuberculosis that were and are still surrounded by stigma etc.

Since religious leaders shape people's feelings and vision, their involvement and participation in HIV and AIDS prevention and care programmes becomes absolutely essential. They could show the path of tolerance, enhanced self-esteem and dying with dignity. At the same time, they could provide much needed social support and counselling. Like many others, people who are infected often take to spirituality for building inner strength. Many religious sects are known to provide therapeutic solace. Death and dying are both a religious and cultural phenomenon. Religious counselling for bereavement and ritual purity can give the families the needed succour.

e) Social sciences not sufficiently involved

Social Science researchers and Institutions are not yet fully convinced of the need for intensive action research to understand the behavioural dimensions of HIV and AIDS within the wider cultural ethos. This could be due to various reasons among which:

- Inadequate understanding of the course and probable impact of the epidemic;

- Issues related to AIDS prevention and care are still viewed from a health perspective and not from a development perspective, where cultural constructs play an important role;

- Research tools and methodology are too technical and resource intensive;

- Coordination and collaboration between social researchers, NGOs and other health sector partners are weak.

2- Recommendations

A wide range of recommendations are suggested for further elaboration of the project based on the country research. They are summarized under two headings: In depth and long term issues to be addressed and methodological recommendations:

a) In-depth and long term issues to be addressed

In order to fill this breach and make intervention strategies more culturally sound and thus acceptable, it would be necessary to mobilize academic departments and other institutions to undertake action research studies so that interventions could be intensified. A few important areas where action research would be desirable for more effective programming are mentioned below:

- Multi-centric studies to understand the impact of AIDS on cultural minorities and targeted intervention to reduce their vulnerability along with prevention efforts;

- Developing more in depth data on behaviour patterns in specific cultural groups such as the "Hijra Community", specially on their sexual networking and perpetration of violence by their clients;

- Further exploration of culturally accepted behaviour patterns related to courtship and marriage within the context of vulnerability;

- Better understanding of peoples semantic stock on sexuality for appropriate prevention programmes;

- Intensive research on the subculture group dynamics and social cohesion of injecting drug users;

- Research on the reasons and patterns of migration in order to reach migrants in their workplace for preventive education;

- Further exploration of the impact of AIDS on household income and its effects on children education particularly on girls and possible restoration of the family role in this matter;

- Identification of factors that contribute to stigmatisation, social exclusion and violence against affected families , with special emphasis on stigma and discrimination at workplace, in order to identify relevant strategies, possibly with the participation of PLWA;

- Content analysis of IEC messages aimed at rural and remote communities;

- Document concerns and violations of HIV/AIDS Human Rights;

- Survey and improved accessibility of out-of-school male adolescents and married young people, in order to develop appropriate contacts and messages with them;

- Develop and customize information in order to secure community participation in care programmes carried out by Voluntary Counselling and Testing Centres;

- Facilitate an expanded response to the epidemic through involving traditional practitioners and systems of medicine. This will play an important role in HIV and AIDS prevention and care.

- Capacity building of social scientists both in terms of methodology and research tools is an urgent need. Such studies would be extremely helpful in designing culturally relevant intervention programmes that would have people's support and approval.

b) *Methodological recommendations*

The basic principles are as follows:

- Expanded response;
- Decentralization;
- Inter-sectoral and trans-disciplinary approach;
- Building coalitions;
- Realistic time-frame for wider out-reach;
- Participatory planning and programme design;
- Involvement of PLWA in programmes.
- Adaptation and tailoring of projects taking into account the cultural, religious and ethical factors;
- Customizing messages;

Contextualizing HIV/AIDS

The study indicates the relevance of going beyond the medical/ public health model and contextualizing HIV into broader development paradigm. HIV and AIDS related issues are ingrained in traditions, values and the thought processes. They cannot be viewed in isolation. Community's beliefs on very intimate personal matters, such as sex and sexual behaviour are entrenched in societal norms. Even a discussion on such matters is a taboo. Therefore, it is essential to examine the cultural, social and economic context of the epidemic and the situation.

Special attention must be accorded to the culturally fragile sub-cultures. A deeper understanding of the structure and functioning of brothel based prostitution, religious prostitution and caste-based prostitution or for that matter group dynamics of street children will throw insights for more effective targeted interventions.

Is AIDS posing a threat to the sacred institution of marriage, particularly with respect to partner notification and confidentiality? How vulnerable are arranged marriages where the partners are almost strangers to one another?

A cultural approach to HIV prevention and care activities will give a holistic dimension to the understanding of the situation. An analysis of cultural factors will go a long way in refining policies and programmes.

<u>Policy, project design and implementation</u>

The basic recommendation is of course to tailor policies and programmes to situations, cultural sub-groups with specific cultural references and resources. For instance, interventions that are meaningful for brothel based sex workers in the red light area of Delhi are not relevant to floating sex workers or the Bedia community. Similarly, an intervention targeted at men who have sex with men will not be appropriate for 'Hijras'. The cultural contexts are very different, and so are the risks.

Therefore, in order to design interventions, a deeper understanding of the situations remains indispensable; some of them are enumerated as follows:

- Mainstreaming of issues related to HIV and AIDS in other development programmes. For instance, into the education programmes together with life skills, both at the formal and informal levels. Similarly into women's development programmes, workplace programmes etc. HIV and AIDS prevention and care actions could be meaningfully dovetailed into wider programmes;

- In-depth ethnographic studies are needed on the determinants of risk within the cultural context particularly of underprivileged and marginalized communities. In addition, more data is needed on unmet needs of various risk behaviour groups (young people, girl children among sex workers, injecting drug users etc.). The strategies for mobilizing the communities to minimize stigma and discrimination as well as to provide care and support to infected and affected need to be studied in detail;

- Multi-sectoral initiative at community level. For instance, to reduce vulnerability of women and adolescent girls, an empowering strategy encompassing education and vocational training to enhance decision making skills would be imperative, along with affordable and accessible reproductive heath services including counselling. At the same time, efforts will have to be made to involve men in these programmes.

- Networking with various partners and stakeholders for an engagement to fight the epidemic. Coordination at the national, state, district and community levels between NGOs, CBOs, Government departments, institutions, Associations of PWA and Unions would facilitate effective partnership for an expanded response.

<u>Customizing messages – Information, Education and Communication</u>

Today it is not effective to target generic messages. Messages have to be culturally sensitive and should appeal to the target group. For example a message saying, *"Sex is fun, but have it with one"* raised many questions. A group of parents and teachers

revolted as they felt it was against the Indian culture. A similar message depicted, *"AIDS kills but condom saves"*, was apt for people practicing high risk behaviour but certainly not appropriate for school children within the cultural context. In the Indian cultural ambience, an open discussion on condom with young people is a taboo and could be best done in small group discussions.

Moreover, in order to internalise messages, it is necessary to depict positive images. AIDS is not a 'monster' and certainly not a 'demon'. While designing campaigns it must be remembered that in every society there are PLWA and they too would look at such messages. Their feelings have to be respected and messages should not further stigmatise them. Campaigns should be such that an enabling environment is created where PLWA could live with dignity and self-esteem.

It is now a well-documented fact that IEC campaigns generate awareness, but insufficiently to change behaviour. This is why researchers are now moving towards behaviour change communication (BCC) interventions where people are trained to learn life skills (the ability to communicate effectively, the ability to pre-empt a risk situation, the ability to say 'no' to unsafe sex or inject drugs, in other words the ability to take sound decisions about their lives) and develop positive attitudes.

Behaviour change communication interventions are empowering, they engage the target group through simulation exercises, games, role-play, case methods etc. People are able to perceive risk and practice skills.

Training and capacity building

During the course of this research study, it became evident that social scientists and social science Institutions were not yet sensitized to undertake studies on the social, cultural and behavioural dimensions of AIDS. As mentioned earlier, an understanding of the cultural approach to HIV and AIDS prevention and care was not a priority concern for researchers.

Advocacy efforts with social scientist and academic Institutions will be required for an effective and long-term engagement against the AIDS epidemic.

This leads to the related concern of lack of competence and inadequate understanding of the country scenario. Social science researchers would need training in research methodology and documentation of research data. Training for conduction of action research that will lead to programme refinement.

Training is essential at all levels and with different target groups involved in interventions. Tailoring training of different target groups would enhance the capacities for an expanded response. Policy makers need orientation in the cultural approach. Similarly, religious leaders need additional training for providing care programmes.

Capacity building should be an ongoing process and needs to be initiated / strengthened/ at all levels from civil society to policy makers.

<u>Research</u>

A large number of research areas have already been elaborated in the earlier sections. However, a compendium of cultural traditions enhancing HIV/AIDS prevention and care could be documented. Efforts should be made to distribute such documents and other relevant data (such as country profiles, behavioural surveillance findings etc). Academic Institutions and researchers should ensure commitment to HIV/AIDS research.

VI- CONCLUSIONS

This handbook presents the widespread cultural practices and attitudes in the context of HIV/AIDS prevention and care, and focuses on some groups and communities that show focused and specific manifestations of Indian culture. It also broadly covers the socio-cultural background of Indian society in the context of HIV/AIDS, and depicts an enormous variety of cultural practices and beliefs all over the country. Such a discussion highlights the importance of adopting a culturally specific and culturally appropriate HIV/AIDS intervention strategy in this country. A common general strategy can be developed at the broader level, but for specific cultures and communities the intervention programmes should follow an appropriate culturally sensitive policy.

Mainstream Indian culture and traditions are firmly based on the values of patriarchy. The widespread impact of patriarchy is found at all levels of social institutions starting from family and kinship to marriage and sexuality. . The values of patriarchy are so strong that although women take greater responsibility within the family, males maintain their superior status. .

Here lies the importance of adopting a cultural approach to HIV/AIDS prevention and care, mainly to reach every corner of our society and to make the intervention programme successful. One possibility is to highlight that the main focus of patriarchy is male responsibility. In the present context of a cultural approach to HIV, intervention strategies need to identify and strengthen positive characteristics in the culture where the male assumes responsibility as the patriarchal head.

Field studies have revealed how patriarchy institutionalises values and practices within the different cultural groups of population. The present study shows that though the Bedia women take greater responsibility in family sustenance through the profession of entertainment, the whole system is institutionalised and directed by the men and is supported by the female members of the family. Among the MSM in Kolkotta (Calcutta), the relationships between '*kotis*' and '*giriyas*' are similar to heterosexual types of relationships. Negotiating safe sex becomes difficult for the *koti*. Most of the time they get emotionally involved with their partners and they say that they do not like to be demanding, as they might lose their partner to someone else.

Under the strong influence of culture, discussions on sex have become a taboo subject. It narrows down the space to talk about sex and sexuality and therefore hinders sex education. Lack of positive language on sex makes sex a more hidden and obscure subject for the adolescent population. Due to the absence of proper sex education, sex becomes an issue of uninformed discussion among peers, which, in turn, results in unscientific and incorrect information among young boys and girls. The lack of knowledge on sex continues even in later phases of life. A lot of myths are generated due to the lack of latitude for gaining knowledge. The influence of societal norms on one hand and myths and misconceptions on the other make a large section of Indian men and women vulnerable to HIV/AIDS, as unprotected sex is the most important route of HIV transmission.

Prevention of HIV/AIDS is crucially dependent on social and sexual behaviour of the population, aside from factors such as level of awareness, availability and accessibility of services. An intervention programme oriented by the cultural aspects of the society would help to understand the intricacies of the sexual behaviour of a community. Sexual behaviour and social interaction patterns are culture-specific. No uniform strategy package can be designed that will uniformly address all cultural groups.

Any intervention programme on HIV/AIDS should be integrated into other existing development programmes and must meet the basic needs of a community. There is need to have inter-sectoral links with other development programmes such as the health, education, and judiciary programmes.

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