

Sensitisation Workshop on

HIV/AIDS

on

On November 30- December 01, 2004

A Report

Facilitated by:

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Ms. Martha Farrell

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BACKGROUND

In keeping with PRIA's commitment to work against the issue of marginalisation in the society and to sensitize its staff members on the same, a two-day workshop on the issues of HIV/AIDS was organized in PRIA, New Delhi to cover the staff members who had not participated in similar workshop organized earlier. Twenty-five staff members from different field offices and head office (list attached) participated in the workshop. Ms. Gunjan Sharma was the external facilitator of the workshop. Ms. Martha Farrell and Ms. Ranjana Pandey were internal co-facilitators of the programme.

In the introductory session, while sharing the objectives of the workshop the facilitators clarified that though PRIA does not work on issues of HIV/AIDS directly, nor was it planning any intervention on the issue in near future, the value of the workshop was seen in enhancing the sensitivity level of the staff members and in equipping them with a shared understanding on some key developmental concerns related to the issues of marginalisation, especially of women, in dealing with issues of HIV/AIDS. .

PRIA has been hosting these workshops for a period of time now. This workshop was the second one in the series of the two workshops planned for PRIA staff in the year 2004. Learning from the experiences of the previous workshop, it was decided to keep the information and discussions very topical and sensitive as well as keep the "almost first exposure" to the issue in mind while discussion and facilitation.

Two initial planning meetings were organized with the external facilitator before the workshop and the following handouts were prepared/collected for circulation during the workshop: The themes covered in the workshop are– Myths and Misconceptions; Basics of HIV/AIDS; Statistics on HIV; Wildfire; Sexuality circle game; Viewing of movie- Phir Milenge; Discussion on the movie; Demographic Silhouettes and impact of HIV/AIDS on women; Rope exercise (design attached).

OBJECTIVES

The objectives of the workshop were:

- To equip the staff on basic information on HIV which may be clear, concise as well as easy to apply at the grassroots level.
- To help break and dispel myths associated with HIV/AIDS,
- To begin a small discussion some aspects of Sexuality,
- To develop an understanding on issues of People Living With HIV/AIDS (PLWHAs) as well as to strongly address stigma and discrimination issues,
- To see HIV as not just a medical concern

PROCEEDINGS:

DAY I:

The workshop began with a small icebreaker and game, to relax and ease the group. The group was then asked to share their expectations from the workshop and the participants raised the following expectations :

- FACTS ABOUT HIV (PREVENTION) – TECHNICALITY
- MYTHS AND MISCONCEPTIONS

- HIV/AIDS AND WOMEN
- DEALING WITH PATIENTS AND FAMILY TECHNICALLY
- REHABILITATION
- SOCIO-ECONOMIC IMPLICATIONS – ESPECIALLY ON WOMEN
- LEGALISATION OF PROSTITUTION
- HIV/AIDS POLICY
- HOW TO DISSEMINATE INFORMATION ABOUT HIV/AIDS
- ROLE OF CIVIL SOCIETY IN HIV/AIDS ISSUES

To begin the session of the day after clarification on the expectations that the training would try to meet, the participants were invited to share one thing they like about themselves and one secret desire with the person by their right side.

Most of the participants spoke about wanting to be and become “ good, successful development professionals”, and some shared about going on a holiday and some about driving fast on an empty street.

Myths and Misconceptions:

For the first activity of the day the participants were divided into four groups to participate in a quiz. This exercise focused on bringing clarity on the Myths and Misconceptions associated with the issue of HIV/AIDS. Each group was given one statement about HIV, about which the participants had to discuss within their group and justify as accurate or otherwise. This exercise was done in two rounds. Out of the two rounds, the statements of the first round were related to the myths and misconceptions on issues of HIV/AIDS while the statements used in the second round were related to the issues of Sexuality. The statements given to the groups are:

- HIV infects mainly a certain group of people- truck drivers, prostitutes and injecting drug users (IDUs)
- HIV can spread through mosquito and other animal bites
- One can get HIV through shaving razors.
- There is a cure available for HIV
- Homosexuality is abnormal
- Losing one drop of semen is equal to losing 100 drops of blood.
- Having sex with a virgin woman can cure certain infections (sexual).
- A girl can conceive even if she has not got her first periods.

Of all the statements, the one stating that homosexuality is normal elicited the stormiest discussion. With marks and point in question, people often forget that they are discussing taboo issues and easily jump into discussions and conversations, regardless of the issue.

Basics on HIV/AIDS:

In this session, the participants were again divided into four groups to discuss the basics of HIV. Each group was given a topic to work on and come up with all the information they had on the given topic. The topics given to the four groups are:

- Effects of HIV on the body
- Transmission, ,
- Prevention,

- **Treatments and Testing**

The groups took a while to come up with their presentations. As the group made their presentations, the facilitator filled in the gaps and added other relevant information to the topics. This continued until afternoon and the discussion on Basics had to continue post lunch as well. What is note worthy, however, is that the session on an otherwise “dull” topic, was full of questions and answers and clarifications of all sorts. This greatly enriched the discussions.

Questions on Blood Safety, Testing, Window Period, and life span were certainly most discussed as well as cause of concern.

There was a worry on needle stick injury and one of the participants came up with some farfetched theories on how some positive person could place a needle of blood under a seat in an bus and the pressure of sitting on it would cause it to inject into the blood stream.

...Such conversations are indeed very humorous, for the entire group begins to laugh about the idea, BUT it also shows to the group how impractical this possibility is and how it actually is but a rumor generating out have people’s imagination. The facilitators used this opportunity to push forth this point of baseless rumors as well as dispel the notion that all positive persons were out with a syringe, injecting people, baselessly. So much so that one of the participants said that he had planned a blood transfusion for his mother and was so relieved that he had not gone ahead with it.

Statistics on HIV/AIDS:

In the post lunch session the group was given some national and worldwide statistics around HIV in a power point presentation. After the presentation, the floor was kept open for discussion and clarification of doubts.

Wild fire game:

The last exercise of the day was the well-known “Wildfire” game. In this simulation exercise the participants stood in a circle and closed their eyes. The facilitator touched some of the participants with a pen. The participants were then asked to shake hands with each other. The ones who were touched with the pen were asked to scratch two other person’s hands while shaking hands with them. Later on it was revealed to the group that those who scratched other’s palms were exposed to HIV and might have been infected people and later have infected others also. The ones touched with pen were then made to sit in an inner circle and were asked if they would like to go for an HIV testing. Two of those refused to go for the test while others agreed to go for the test. Later they had to choose one chit of paper to reveal the test results. Some of them were then identified as positive while some were identified as negative. The group was then asked for their feelings (both in the inner circle as infected person and those in the outer circle) on their status. The reactions were very interesting:

- Two people who were exposed to HIV refused to go for the test thinking that what was destined would happen and they do not want to know their status and make their lives miserable. They became selfish and did not bother to think about others whom they might be infecting in turn in lack of awareness of their own status.

- The members, who got a ‘negative’ result, were visibly relieved and rushed back into the main group.
- One of the members, who had a first ‘positive’ result, chose to not get the other one to reconfirm and return to the group. He said he did it for his own safety and would “see what life had in store for him, later”.
- The outside group felt, he must do a test, for his own and their safety, he disagreed.
- The confirmed positive people were certainly tensed and seemed in some sort of trauma. They felt ostracized and even very guilty. They expressed sadness and isolation from the entire group and also that they had no one really to talk to. They even spurned the support of their friends, saying they didn’t have the infection so they didn’t know what it actually felt like.
- Most of them said that they would like to share it with their “friends” making a clear distinction, on those confidantes being the people they themselves choose, as opposed to who the management may want to invest this information with. This led to a discussion on Confidentiality and its importance. The group seemed to agree that Confidentiality was the employees right.
- Issues of Workers Rights, people’s perceptions of people living with HIV, planning a life with HIV, came to the forefront.

Though this was a game, its impact on the group and individuals was very grave. There was some fear, sadness in the group until the end, which remained in spite of repeating that it is but a game. To end the session on a lighter note, the group formed a chain and ended the day with a big group hug.

Video Show:

For the evening the participants were shown a movie on the issue of HIV/AIDS titled “Phir Milenge”. This movie is about discrimination against the HIV positive woman and her struggle against her termination on grounds of non-performance. She filed a case against the employer and in the end won the case and lived a long and healthy life with peer support. The participants saw the movie and shared their reactions the next day.

DAY II:

The next morning, December 1st, was also World AIDS Day. The day began with a feedback round on one thing each person had learned in the previous day. The responses varied from information learning, need to end and address stigma, that positive people have as good a life ahead of them as well as associated issues. The participants also shared their views and learnings from the movie. The discussion brought out the self-discrimination aspects of the infected person also as the woman in the movie herself became conscious of her HIV status and did not allow her own sister to drink water from the same bottle that she was using. The importance of peer support was one of the other important discussions on the movie.

Dr. Rajesh Tandon joined the group and further endorsed the need for such a workshop and how he hoped everyone in PRIA could use this training. He clearly stated that

although PRIA has no direct intervention on HIV, PRIA assumes that when any PRIA colleague or even partner was to see any discrimination or any “injustice” on this score, they would not just stand apart and watch, but would lend active support in addressing the issue in what ever way possible.

Demographic Silhouettes:

In the exercise called Demographic Silhouettes the participants were divided into four groups and were assigned a task to make the story of well being of a family. All four groups came up with very dramatic stories, one that even had an infected person in it and had learnt to be happy despite the fact that one of them was HIV positive. After all the stories were shared, the group was then asked to identify the characters with both red and blue dots on them. The group was informed that these characters were detected HIV positive and the groups had to discuss the impact of the revealed HIV status on family relations/inter personal relationships. Subsequent to this they were to list the services and support they felt each family would hereby need.

The exercise brought out the following eminent concerns :

- HIV /AIDS is a very key issue to every developmental concern. It is not only a medical problem.
- Inter personal issues of trust; faith and adultery are some key issues people have to confront.
- HIV takes a toll on finances even in well to do families.
- Children living with HIV have a number of issues to deal with, education, stigma, and ostracism.
- Health, nutrition and hygiene are very critical in management to the infection, which may not always be possible in many situations.

To wrap up this workshop, the Rope Exercise was used in which each PRIA employee said what they had learnt or what they would now do to take this work forward, or even how they were feeling at that point of time. The rope went randomly from one to the other person, forming a web, a tight net in which every PRIA employee was now committed to working in some measure on this issue.

An air of touching concern towards the issue hung in the group, seeming as if it had touched a cord in most hearts.

List of Participants

Sl #	Name of Staff	Sex
PRIA, AP		
1	Venkatesham Cheruku	M
2	K Sriram	M
3	K. Srinivas Rao	M
4	K. Mamatha	F
5	Subramanyam Naidu	M
6	Satya Narayan Sharma	M
7	G. Kannaji	M
PRIA, Haryana		
8	Roshni Subhash	F
9	Manish Kumar	M
PRIA, Uttaranchal		
10	Kakul Shelly	F
PRIA, Jharkhand		
11	Sudipto Banerjee	M
12	Sanchita Roy	F
13	Rajendra Singh	M
14	Sajjad Majeed	M
PRIA, Bihar		
15	Mohan Lal Yadav	M
16	Premendra Kumar	M
PRIA, Himachal Pradesh		
17	Vikas Khanna	M
PRIA, New Delhi		
18	Ashok Kumar	M
19	Shabeen Ara	F
20	Varrtika Mudaliar	F
21	Aveek Roy	M
22	Puranjit Banerjee	M
23	SunilKumar	M
24	Pushpita Bandhopadhyay	F
25	Ajit Verma	M
Total	25 participants (7 women and 18 men)	

Handout: 1

What is HIV/AIDS?

AIDS stands for Acquired Immuno Deficiency Syndrome, a cluster of medical conditions caused by HIV, the human immunodeficiency virus, which weakens the body's immune system.

HIV spreads through sexual intercourse without a condom, transfusions of unscreened blood, contaminated needles, most frequently for injecting drug use, and from a woman to her child during pregnancy or breastfeeding.

It is preventable, but not curable. A person who has an established HIV infection has it for life.

HIV is a slow-acting virus. The majority of people with HIV look healthy and feel well for many years after infection; they may not even suspect they have HIV, though they can transmit it to others.

In individuals who do not get antiretroviral therapy, the time between contracting HIV and the development of the serious illnesses that define AIDS is around eight years, and most people do not survive much more than two years after the onset of AIDS.

Treatment with antiretroviral drugs can slow the progression of HIV infection, but these expensive medications are not available to most people in the developing world. Many succumb to serious opportunistic infections caused by the weakening of the immune system.

A laboratory blood or saliva test is the only certain way to determine whether an individual is HIV positive (HIV+). Testing should always be accompanied by pre and post-test counseling.

From UNAIDS Report, 1999

INDIA :

India is one of the largest countries in southern Asia - geographically it is the seventh largest and second most populous nation in the world. Its estimated total population in 2000 was close to one billion, with over half a billion in the 15-49 year-old age group. India shares land borders with Bangladesh, Bhutan, China, Myanmar, Nepal and Pakistan. The shift of population from rural to urban areas is slower in India than in most Myanmar, Nepal and Pakistan. The shift of population from rural to urban areas is slower in India than in most developing countries, but one-fourth of the total population is now urban.

India has a developing mixed economy in which both the public and private sectors participate. India's economic growth, though fairly steady since independence in 1947, has been slow, and its gross national product (GNP) per capita remains among the lowest in the world.

HIV/AIDS situation

HIV infections were likely imported into India in the early to mid-1980s. The first case of AIDS in India was detected in 1986. Since then, HIV infections have been reported in all States and Union Territories.

With a population of one billion (about half in the 15-49 year-old population), HIV epidemics in India will have a major impact on the overall spread of HIV in Asia and the Pacific as well as globally. The spread of HIV within India is - at least - as diverse as the societal patterns between its different regions, States and metropolitan areas. As a result, tracking HIV patterns, prevalence and trends, and implementing effective programmes, poses a serious challenge to public health programmes. Although HIV prevalence is low in a majority of States, the numbers of HIV infections overall are high. The epidemics vary from States with heterosexually transmitted infections predominating, in Maharashtra and Tamil Nadu, to infections concentrated among injecting drug users (IDU) and their partners in Manipur.

The distribution of HIV/AIDS in India is very heterogeneous. HIV epidemics are focused very sharply in a few southern States, with most of India having extremely low rates of infection. It is noteworthy that 21 of the 31 States only report 4% of the total reported national AIDS cases. The major impact of HIV/AIDS is being felt in Maharashtra in the west, Tamil Nadu in the south with adjacent Pondichery, and Manipur in the north-east. All of these findings highlight the fallacy of considering average national HIV/AIDS figures in India for measuring the HIV/AIDS epidemics. India clearly has areas very severely affected by HIV/AIDS, and yet, as of 2001, major portions of the country still have a very low HIV prevalence. Unless this differential is taken into account for planning interventions, efforts are likely to be inadequate in some areas, and inappropriate in others. With a high prevalence of tuberculosis infection in India, the problem of tuberculosis related to HIV infection also poses a major public health challenge.

Between 1994 and 1997, HIV prevalence among STI clinic attendees in Maharashtra state increased from 6% to 36%, and prevalence among IDU in Manipur increased from 25% to 61%. However, there were insufficient numbers of sentinel surveillance sites to get an adequate picture of the overall HIV situation. There was non-participation of some states, inadequate representation of various risk groups, no representation of the rural population, and a scattered schedule of rounds of collection. In order to obtain better HIV prevalence for India, the National AIDS Control Organization (NACO) instituted a National HIV Sentinel Surveillance (HSS) programme. States were given guidelines on the selection HSS sites to adequately represent the various population subgroups and a regularly scheduled timing for surveillance was instituted.

The 1998 HSS data from antenatal clinics in seven metropolitan cities in the country showed HIV prevalence to be over 2% in Mumbai, more than 1% in Hyderabad and Bangalore, and below 1% in Calcutta, Ahmedabad and Delhi. HIV prevalence levels outside these major urban agglomerations are lower in general, and no infection was found in a number of rural HSS sites.

Based on the analysis of existing sentinel surveillance data, the States and Union Territories can be broadly classified into three groups.

Group I - High HIV prevalence States: includes five States - Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh and Manipur, where HIV prevalence rates were 1% or greater in antenatal women.

Group II - Moderate HIV prevalence States: includes five States - Gujarat, Goa, Kerala, West Bengal and Nagaland, where HIV prevalence rates were 5% or more among high HIV-risk behavior groups but below 1% in antenatal women.

Group III - Low HIV prevalence States: includes the remaining States, where HIV prevalence rates in any of the high HIV-risk behavior groups were still less than 5%.

Estimation of national HIV prevalence

In late 1998, NACO convened a group of national and international experts to review the results of the first round of the expanded HSS with the goal of producing state-specific and national estimates on HIV/AIDS. The new calculations provide greater consistency in making a national estimate of HIV prevalence in India, and the working estimate derived from this consensus meeting - 3.5 million people living with HIV and AIDS in mid-1998 is well within the range of previous estimates. A similar estimation process was held in early 2001 and the national prevalence estimate was increased for 2000 to 3.9 million.

Behavioural surveillance

Realizing the need for behavioural data, behavioural surveillance has figured as an important activity in the AIDS II Project. A protocol on behavioural surveillance has been finalized after intensive consultation with sociologists and behavioural scientists. The protocol has been provided to States and Union Territories for initiating this activity.

Estimated clinical impact of HIV

Based on the HIV prevalence estimate of 3.9 million in 2000 in the 15-49 year-old population, and on the estimated age and general shape of the annual HIV incidence curve, the annual numbers of AIDS cases and deaths can be calculated. For 2000, a total of close to 350 000 AIDS deaths in the 15-49 year-old population is estimated, and the numbers projected for 2005 are close to 500 000. It needs to be fully appreciated that these numbers are national totals and these estimated deaths will be distributed according to the current HIV prevalence that is present in the different States.

The vast majority of these estimated and projected AIDS cases/deaths will be concentrated in the current high HIV prevalence States of Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh and Manipur. There will be few AIDS cases and deaths in the current low HIV prevalence States in the central and northern portions of India. Similarly, the distribution of paediatric AIDS cases and maternal AIDS orphans and HIV-related tuberculosis cases will also be occurring mostly in the five southern States with the highest current HIV prevalence rates.

Source: HIV/AIDS in Asia and the Pacific Region, WHO, 2001,

From: <http://www.hivanddevelopment.org/News/Index.asp>

Handout : 2

Why gender and HIV/AIDS/STDs?

“One of the most striking features of the response to the HIV epidemic to date is how few of the policies and programmes we have developed relate to women’s life situations. The daily lives of women and the complex network of relationships and structures, which shape them, are well known to women and well documented. Despite this, our theories, research agendas, policies and programmes have not been grounded in and informed by these experiences.”

As the HIV/AIDS epidemic and sexually transmitted diseases (STDs) continue to advance worldwide, we are learning ever more about how they affect individuals, households, families, communities, organizations and nations. The individual loss has been enormous, particularly in those countries and regions affected early on. AIDS is increasingly recognized in developing countries as a serious concern for socioeconomic development as a whole. Its impact is seen in family and community structures and relationships and in sectors as varied as education, employment, health care, social welfare, agriculture and the judiciary.

Economic consequences are already apparent. In highly affected countries, the business sector is experiencing increased absenteeism as employees fall ill, care for the sick or attend funerals. Loss of experienced and skilled workers in the formal and informal sectors may lead to lower productivity, savings and investments. In subsistence and small-scale agriculture, loss of labour may result in changes in farming patterns and food shortages.

Strategies to prevent the spread of HIV have focused on the promotion of condom use, reduction of numbers of sexual partners and treatment of STDs [2]. Many of these responses, however, have failed to address social, economic and power relations between women and men, among men and among women. These relationships, together with physiological differences, determine to a great extent women’s and men’s risk of infection, their ability to protect themselves effectively and their respective share of the burdens of the epidemic:

- Women are physiologically more vulnerable to HIV infection than men. Young women are especially at risk and AIDS death rates are highest in women in their 20s.
- Stereotypes related to HIV/AIDS and STDs and their association with marginalized groups (e.g., sex workers) contribute to blaming women for the spread of HIV. Fear of stigmatization inhibits people from taking preventive measures and leads women and men to assess their own risks inadequately. Moreover, many ideas and expectations regarding male and female (sexual) behaviour neither encourage men to act responsibly and protect themselves and their partners from infection nor stimulate women to challenge notions of female inferiority and social structures which keep them vulnerable.

– Low social status and economic dependence prevent many women and young people (e.g., street-children) from controlling their own risk. With little negotiating power, they are often unable to insist on safer sex; disproportionately poor, they may have little choice other than to barter sex for survival.

– As society’s traditional care-givers, women carry the main psychosocial and physical burdens of AIDS care. Yet they have the least control over and access to the resources they need to cope effectively; few men share domestic responsibilities and family care with their partners. Although the necessity of focusing on women’s needs has been highlighted time and again, especially since 1990 when the theme of World AIDS Day was “Women and HIV/AIDS”, women continue to bear the brunt of the epidemic and to be highly vulnerable to infection. Reducing their (and men’s) risk of infection demands gender-based responses that focus on how the different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic.

This involves analysis of gender stereotypes, redefinition of male and female relationships and roles, promotion of cultural beliefs and values supporting mutually responsible behaviour and exploration of ways to reduce inequalities between women and men. A supportive environment can be created thereby, enabling women *and* men to undertake prevention and cope better with the epidemic.

Women and men both have much to gain from increased gender sensitivity in general development policy, planning and programmes, and particularly by national AIDS/STD programmes, AIDS service organizations and related services. At all levels a gender-based focus on problems and solutions is urgently needed.

This publication aims to provide policy-makers, planners and programme implementers with information and ideas to help them incorporate a gender-based approach to HIV/AIDS and STDs into their policies and programmes. It highlights the nature and scale of the epidemic, explores the concepts of gender and a gender-based approach and the ways HIV/AIDS and STDs affect and are affected by gender. Suggestions are made for approaches and strategies to address some of the problems.

It is hoped that the analysis, information, ideas and examples will help stimulate many more gender-sensitive initiatives to help us cope with HIV/AIDS and STDs more successfully.

A gender-based response to HIV/AIDS and STDs focuses on how different social expectations, roles, status and economic power of men and women affect and are affected by the epidemic. It analyses gender stereotypes and explores ways to reduce inequalities between women and men so that a supportive environment can be created, enabling both to undertake prevention and cope better with the epidemic.

Handout : 3

A. FACT SHEET: BASICS ABOUT HIV AND AIDS

● **WHAT ARE HIV AND AIDS?**

HIV (Human Immunodeficiency Virus) is a virus that weakens the body's defence (immune) system until it can no longer fight off illness such as pneumonia, tuberculosis, cancerous tumours and other. HIV kills your CD4 cells (T cells), which direct your body's immune system to defend against infection.

A person is considered to have AIDS (Acquired Immunodeficiency Syndrome) when the immune system is seriously damaged by HIV and symptoms such as weight loss, chronic diarrhoea, fungal infections and respiratory symptoms begin to appear.

● **IS THERE A CURE FOR HIV OR AIDS?**

There is still no cure or vaccine for HIV or AIDS. However, there are new drug treatments that can help many people with HIV stay healthy longer and can delay the onset of AIDS. Costs of treatment, however, are expensive and beyond the reach of most people in our country.

● **HOW MIGHT I BECOME INFECTED WITH HIV?**

HIV is transmitted from an HIV positive person through infected body fluids such as semen, pre-ejaculate fluid, blood, and vaginal secretions or breast milk. HIV can also be transmitted through needles contaminated with HIV-infected blood, including needles used for injecting drugs, tattooing or body piercing. HIV is most often transmitted sexually.

● **CAN I GET HIV FROM CASUAL CONTACT WITH AN INFECTED PERSON?**

No! You do not get HIV from an HIV-infected person by working together, playing sports, shaking hands, hugging, closed mouth kissing, sharing drinking glasses, eating utensils or towels, using the same wash water or toilet, swimming in the same pool, or coming in contact with their sneezes, cough, tears or sweat. You also don't get HIV from bug bites or by donating blood.

● **HOW CAN I PROTECT MYSELF FROM HIV?**

You are safest if you do not have sexual intercourse, oral sex or share needles or injection equipment. You are also safe if you are in a relationship in which both you and your partner are monogamous and have been free of HIV for a few months. Whenever you are unsure about the risk of infection, always use a latex barrier when having sex of any kind- vaginal, oral or anal.

● **WHAT IS UNSAFE SEX?**

Unsafe sex—vaginal, oral or anal—is sex without the use of a condom or other protective latex barrier unless you are certain both partners have remained free of HIV for a few months.

● **WHAT IS SAFE SEX?**

Safer sex is sexual activity without penetration or sex using protection, such as a latex condom or, in the case of a oral sex, a latex barrier or plastic wrap. Other safer behaviours include intimate activities such as caressing, hugging, and kissing, massaging etc.

● **WHAT ARE THE SYMPTOMS OF HIV?**

HIV affects each person differently. Because many people with HIV can look and feel healthy for years, you cannot rely on symptoms to know whether you are infected. The only way to know is to be tested.

● **HOW CAN I GET HIV FROM INJECTING DRUGS?**

HIV can be transmitted through shared needles or equipment contaminated with HIV-infected blood. Anyone who injects drugs must either sterilize all equipment or use new, disposable needles and dispose them off carefully.

● **WHAT IF I THINK I MIGHT HAVE HIV?**

If you think you may have been infected with HIV, you should go to a doctor or HIV/AIDS clinic for counselling and testing. Also, many organizations offer testing for HIV.

● **WHY SHOULD I BE TESTED?**

Knowing if you are HIV-positive will allow you to seek early treatment that could help you stay healthy longer.

● **PREVENTING HIV INFECTION**

For people who are not infected with HIV, prevention efforts focus on keeping them from becoming infected.

For the HIV-positive, prevention seeks to keep them from developing opportunistic infections, to prevent their infection from progressing to AIDS, and to keep them from spreading HIV to others.

Three Cardinal Principles of HIV Testing:

Counselling * Consent * Confidentiality

YOU SHOULD NEVER BE TESTED FOR HIV WITHOUT YOUR FULL KNOWLEDGE AND CONSENT

What the test is:

The body produces antibodies in response to infection. If you are infected with HIV, specific HIV antibodies will be present in your blood. The test for HIV looks for sign of these HIV antibodies being present.

Since there are no symptoms of HIV infection, the only way to diagnose HIV infection is through blood tests. There are THREE types of tests that are available for this purpose.

ELISA (Enzyme Linked Immuno Sorbent Assays)
Western Blot
PCR (Polymerase Chain Reaction)

What the results mean:

If your result is negative this means either you do not have HIV or that you have been infected but the HIV antibodies are not yet in high enough numbers to be detected by the HIV test. This is known as '**the window period**' and can last up to about three months from the day of last exposure to any risk behaviour. You may need to have a second test in three months time to confirm the original test result. Talk with your doctor or counsellor about this. Being HIV negative is also referred to as antibody negative or seronegative.

A negative result is an opportunity to you to consider the behaviours or situations, which led you to have an HIV test. *A negative result does not protect you from HIV.* Assess any behaviour that poses a risk to you. If you want to have sex with someone and you are unsure of their present and past sexual practices and/or injecting drug use, then use condoms or safe dams every time you have sex including oral sex, use a new needle every time injecting drugs—**look after yourself.**

If your result is positive this means you have come into contact with HIV and become infected with the virus. A positive test result is also referred to as antibody positive and seropositive. *An HIV positive test result does not mean you have AIDS.*

You will need further tests to determine the state of your health to assess the damage, if any, caused by the virus. It is important at this stage to establish a good relationship with a doctor you trust, who listens to you and in whom you have confidence in treating HIV.

For more information see attached list of Referral/Helplines.

B: FACT SHEET: HIV COUNSELING AND TESTING

Knowing your HIV status is the first step in seeking medical intervention and gaining access to effective treatment and prevention strategies.

WHO SHOULD BE TESTED?

Testing and counselling for early diagnosis of HIV infection are recommended for the following:

- * People who consider themselves at risk for infection
 - * People who have had unprotected sex with a person of uncertain HIV serostatus
 - * Women of childbearing age who are at risk of infection
 - * Pregnant women
 - * Women who plan to become pregnant
 - * People who have sexually transmitted diseases or who have been sexually abused
 - * Spouses, sex partners, and needles-sharing partners of injecting drug users
 - * Tuberculosis and Hepatitis B and C patients
 - * Patients who received blood transfusion between early 1978 and mid 1985
- So if you think you may have been exposed to HIV, it could be time to consider having an HIV test.

There are good reasons for you to consider having an HIV test.

- (a) It gives you the opportunity to assess any behaviours that may have put you at risk; e.g.: sexual and/or drug taking behaviour
- (b) Early diagnosis of the presence of HIV gives you greater treatment options
- (c) You are in a better position to take care of yourself, monitor your health and maintain quality of life.

C: WOMEN- 10 FACTS ON STDs

- Any disease that is passed from one person to another by sexual contact is called a sexually transmitted disease (STD).
- **ONCE IS ALL IT TAKES.** Unprotected vaginal, anal, or oral sex with a single infected partner increases the chance of being exposed to a STD.
- STDs range from mild irritation to diseases that cause infertility and serious illness.
- Women with STDs may not show any early symptoms.
- Women with STDs feel embarrassed, ashamed and isolated but it is important to approach a doctor for treatment, immediately as symptoms begin to show.
- Prevention of STDs:
 - ▶ **ALWAYS use a condom**
 - ▶ do not have sex with partners who have genital rashes, redness, sores, blisters, or a discharge
 - ▶ practice non-penetrative sex.
- A certain amount of clear white discharge in a woman is normal. Itchiness and discharge in the vagina may also be caused by a common yeast infection called 'Thrush' or 'Candida'. This is not a STD and can easily be treated .
- Early treatment is always desirable to prevent complications and further spread of infection. It is important for your partner to also be treated to rule out the chances of re-infection.
- Treatment should not be stopped when symptoms disappear but continued until blood test reports are negative.
- No one is immune to STD's – they affect both sexes – all castes and classes.

Handout : 4

A: Are you affected by HIV/AIDS? Know your RIGHTS

Your Basic Rights

In India, all people are entitled to basic or fundamental rights in the eyes of the law. It does not matter what the religion, race, sex, or place of birth of that person is. Neither do these rights change just because an individual is affected by HIV. It's important to be aware of your basic fundamental rights and to remember that you can do something if they are infringed. Here's a brief idea of three of the most important rights in the HIV scenario.

Right to Informed Consent

Consent is basically agreeing to something. In legal terms, consent is two people agreeing on the same thing in the same sense.

- ⌘ Consent can be 'express', which is verbal or written, or 'implied' through conduct or action, like a nod of the head.
- ⌘ Consent may be general, when it is taken for a lot of things or specific, when it is taken for a specific purpose.
- ⌘ Consent has to be free. It is not free when it is obtained by coercion, mistake, misrepresentation, fraud or undue influence.
- ⌘ Consent also needs to be informed. This is particularly important in a doctor-patient relationship. The doctor knows more and is trusted by the patient. Before any medical procedure, a doctor is supposed to inform the patient of the risks involved and the alternatives available so the person can make an informed decision to undertake the procedure or not.
- ⌘ The implications of HIV are very different from most other illnesses. That's why testing for HIV requires specific and informed consent from the person being tested. Consent to another diagnostic test cannot be taken as implied consent for an HIV test. If informed consent is not taken, your rights may have been violated and you can seek a remedy in court.

Remember to always ask your doctor what tests and medicines you are being asked to take and why. It will help you understand your health problems better. Most doctors will take the time to help you out. After all, that's what they are there for!

Right to Confidentiality

Confidentiality may simply be described as keeping specific information to yourself, just like a secret.

- ⌘ Confidentiality arises when in a confidential relationship based on trust, information having the quality of confidentiality is imparted from one person to the other. In such a relationship if confidential information is imported, then it must be kept confidential.
- ⌘ When you tell someone in whom you place trust something in confidence and s/he tells another person about it, that amounts to breach of confidentiality.
- ⌘ A doctor's primary duty is towards the patient and to maintain the confidentiality of information imparted by the patient. If your confidentiality is either likely to or has been breached you have the right to go to court and sue for damages.
- ⌘ People living with HIV/AIDS (PWA) are often afraid to go to court to vindicate their rights for fear of their HIV status becoming public knowledge. However, they can use the tool of 'Suppression of Identity' whereby a person can litigate under a pseudonym (not your real name). This beneficent strategy ensures that PWAs can seek justice without fear of social ostracism or discrimination.

Right Against Discrimination

The right to equal treatment is a fundamental right. However it is available only against state controlled entities, not against private parties. The law provides that a person may not be discriminated against on any grounds of sex, religion, caste, creed, descent or place of birth etc. either socially or professionally by a government-run or controlled institution.

- ⌘ The right to public health is also a fundamental right, something which the state is supposed to provide to all persons. HIV positive persons seeking medical treatment or admission to a hospital cannot be rejected. If they are denied treatment, they have a remedy in law.
- ⌘ Similarly, a person with HIV may not be discriminated against due to his positive status in an employment scenario. A person can be terminated from employment on the grounds of continued ill health. For someone who is HIV+ but otherwise fit to continue the job without posing a substantial risk to others cannot be terminated from employment. Termination in such a situation would give that person an opportunity to seek legal redress.

So whether it's something as simple as using a public well or something more serious like denial of housing, remember you have the right to be treated equally. And you have the support of the legal system to ensure it.

B: Are you affected by HIV/AIDS? Know your rights: EMPLOYMENT

- **Can I be denied employment or be removed from my job if I am HIV+?**

No, if you are fit to perform your job functions, otherwise qualified and do not pose a substantial risk to your fellow workers, a government, public sector employer cannot deny you employment because you are HIV+.

This has been held by the Bombay High Court in *MX v ZY* and arises from your fundamental rights to work, to be treated equally and to earn a livelihood under the Indian Constitution.

Similarly, you cannot be removed from your job by any employer because you are HIV+, provided you are fit to continue to perform your job functions and do not pose a substantial risk to your colleagues.

- **What are the remedies available to me if I am removed from my job due to my HIV+ status?**

You cannot be removed from your job merely due to your HIV+ status. However, if you are, you have different remedies under the law depending on certain variables. Your remedies could include approaching the labour or industrial court for reinstatement and back wages or approaching a civil court for damages or the High Court, if you are in the government/public sector, for setting aside the termination as violative of your fundamental and/or statutory rights.

- **If, due to my medical condition, I am not fit to perform my current job, can I be transferred to a different department with the same organisation?**

If your medical condition does not permit you to perform your job functions, you may be offered an alternate job. But this arrangement should not pose any undue financial or administrative burden on the employer.

- **Can an employer make me undergo a compulsory HIV test as part of a medical examination at the time of recruitment or during the course of my employment?**

No. The purpose of a medical examination is to decide whether a person is fit enough to do a particular job during employment. A medical examination tests a person's functional abilities by examining aspects of her/his health that are relevant to the job s/he performs e.g. tests for the heart, eyesight, breathing etc. An HIV test does not indicate the capacity of the individual to perform her/his job functions.

Government testing policy states that a compulsory HIV test should not be imposed as a pre-condition of employment or for providing health care facilities during employment or as an assessment of fitness to work.

An HIV test can be a voluntary part of a medical examination and should only take place with the specific informed consent of the employee.

However, the above may not apply to a private employer.

- **Do I need to inform my HIV+ status to my employer?**

No, you are not obliged to inform you employer about your HIV+ status unless required by a statutory law because your status is not relevant for the determination of your fitness or capacity to perform your job functions.

- **Can a doctor inform my employer of my HIV status?**

The doctor has an obligation to maintain the confidentiality of his/her patients medical status. However, the doctor may disclose the status if the employee agrees, either expressly or impliedly, to waive his/her right to confidentiality.

- **If I am a spouse of an HIV+ person who has passed away, do I have a right to employment in his/her place?**

If your spouse was working in the government/public sector and the employer has a scheme for compassionate employment, you as the dependant family member can apply for a job on compassionate grounds provided you are fit to perform the job functions and qualified to work in accordance with the scheme.

- **Am I entitled to benefits even if I am HIV+?**

All employees, irrespective of their status, are entitled to terminal benefits. You are entitled to all employment benefits such as pensions, provident funds and housing as well as those relating to spouse, children and/or dependants. However only insured employees i.e. those covered under the Employees State Insurance Act or other insurance schemes, are entitled to medical benefits.

Source: Lawyers Collective

Lawyers Collective HIV/AIDS Unit provides free legal aid and advice to people affected by HIV/AIDS. For more information, contact:

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