CHAPTER – I
INTRODUCTION

There has been a rapid growth in the population of India apart from the
growth of urbanization and modernization. As a result, people are facing socio
cultural problems, among which prostitution is one. A lot of literature is
available related to the various socio-economic political aspects of
prostitution. However, very little information is available on the various
government and non-governmental efforts made to help this section of the
population to lead a dignified life.

An in-depth study of the red light area and the pattern of functioning
reflect the dehumanizing situation that the commercially sexually exploited
women (CSEW) face every day. They are pushed into the trade at a young
age, at times even before they attain puberty and they are not aware of the
trap they are falling into. Once they entered into in the trade, there is no
escape till the brothel keeper has earned well enough through them. Here
they are subjected to physical and mental torture, if they refuse to abide by
the wishes of the keeper. As most women have no formal education, they
have no knowledge of how much they earn. When they are allowed to leave
the set-up, they are most probably a victim of life threatening diseases like
AIDS, and without any place to go to. Thus in all probability, they will continue
in the area and start soliciting and earning. Once trapped in the trade, women
get pulled into a vicious circle from which escape is difficult. They get succor
through the contacts with various organizations working in the area. They
form the bridge for them to develop linkage with the outside world, which also
form the support system to the women, should they choose to move out of the trade. Many organizations work in this area, dealing with various aspects like rescue of minors, dealing with health awareness and treatment with special focus on AIDS and other sexually transmitted diseases, providing counseling services, de-addiction programs, skill development and training etc. Some organizations help in taking care of the children of the CSEWs by providing full-time care, protection and education through the day/night care shelters or residential homes away from the red light area.

Government organization like MDACS (Maharashtra District AIDS Control Society) has played a very prominent role in generating awareness on HIV/AIDS through the assistance provided in providing free literature and organizing various street campaigns. There are many organizations working in this area, they are Navjeevan Centre an undertaking Marthoma Church, CCDT, Prema, Oasis India, Jyothi kailash, SAI, Bombay Teen Challenge, Stop Sex Slavery, Salvation Army, Apne Aap etc. Each organisation has independent specific goals which could be health, education or overall rehabilitation of the CSEW and/ or their children. Normally, female prostitutes are categorized as common prostitutes, singers and dancers, call girls, religious prostitutes (or devadasi), and caged brothel prostitutes. There are no such organization which work on prostitution in India. but there are several NGO which feed on fund for protecting STI/STD’s spread to common population NACO (National AIDS control organization) a govt. agency lead these NGO’s (CNN-IBN, 2008).

The question of sex has confounded man in engaging his attention and concern perhaps since early man. A mystery that it was the primitive man
compared to his civilized counterpart, sex presented the problem of how to
discipline and organize it so as to promote, at least to some extent, cultural
harmony and well being. So, the institution of marriage with an attendant code
of morality evolved into practice. When marriage becomes the rule, sex
outside the matrimonial bonds come to be looked upon as sinful, immoral,
illegal and so on. However, marriage could not completely meet the sexual
needs of men and women in the society they used to commit extra marital
affairs. Especially the female sex workers arose in the society to satisfy the
needs of men at the above situation. While marriage is the product of
civilization, sex work is it's by-product. (Punekar and Rao, 1967).

The Vedas, earliest of the known Indian literature, abound in reference
to prostitution, the present day sex work, as an unorganized and established
institution. This occupation is continuing since the times of Vedas and
Puranas.

Thus neither prostitution nor the sex work is a new phenomenon. They
are as old as the institution of marriage or to say as old as human history/
civilization. In the sense, they have been in existence since society attempted
for societal gains to regulate/ control sexual relationships through the
institution of marriage and family. Though prostitution then did not have the
stigma attached as it now. When sex behavior was institutionalized through
marriage in certain sections of society, usually in the middle and upper
classes, a woman's chastity before marriage, and complete marital fidelity and
strict confinement to the role of housekeeper and mother after marriage, were
over emphasized and valued. Also, the non- adherence to these socio-cultural
norms and conduct by a woman brought her not only severe socio-cultural
disapproval but dire penal site and socio cultural ostracism. On the other hand, concession in sex was granted to men because of the prevalent double standards of sexual morality (Patai and Raphael, 1967, and Ranganayaki, 1958). This inversion of socio-cultural values depended on a strong sense of masculine superiority and on women's oppression, which emphasized that wives are meant only for procreation and looking after the home and family while certain other women are meant for sexual pleasure. And these two almost contradictory and moralities could be maintained only if men were provided with sexual objects outside their own class (Patai op. cit). This gave rise to a special class of women who are supposed to cater sexual companionship and even intellectual need and demands of men, such demands of whose could not be met with in marriage. This contradiction caused the middle upper classes to consider prostitution as an indispensable institution.

It was in the Vedic period that temples are established and religious prostitution started and this increased considerably in Medieval India. During the Medieval period, Muslim rulers recognized prostitution and it was flourished greatly under royal patronage.

Even commercial prostitution or traffic in women is nothing new though its manifestation as the purely commercialized vice it is today is a later development. Not only that, there are references of Hindu shastrakaras such as Manu, Gautam and Brihaspati recommending the suppression of prostitution (Madan, 1983).

In contemporary industrial societies it is condemned mainly because the high degree of sexual promiscuity involved in it fulfils no publicly
recognized societal goal. At the same time there is enough evidence to suggest that even while prostitution in ancient legitimate, it was not widespread and it was only from a small section of aristocracy that its clients were drawn and that only the rich could afford the luxuries of a cultivated courtesan.

In India, the pure commercialization of prostitution picked up speed by the beginning of the 17th century. When both parties exploited women sexually, whether individually by themselves or through someone else, for a purpose not socially acceptable, and having profit motive as the guiding principle of both parties, the one for pleasure and the other for money. From the late 19th century to 21st century, owing to the rapid urbanization and industrialization, development of tourism and other factors prostitution got impetus, and the number of brothels came into existence for the entertainment of foreigners. Most of the women were fallen through various causes like poverty, over sexuality, negligence by the family and society and certain social and cultural institutions like Jogin (Devadasi) system in Karnataka and Andhra Pradesh (Jogan Shankar, 2004).

1.1 Prostitution

Prostitution is sexual intercourse with a person for which payment is made either in kind or in cash (Joardar, 1986). It may be usually regarded as the act of a female who hires her body in exchange of cash payment or payment in kind. It may also be regarded as the act of sexual intercourse with either people of same sex or opposite sex for payment of cash or in kind. Or else it can be regarded as the sexual pleasure given to men by women in
exchange of money. The term ‘sexual relation’ is not a simple one. (Nag, 2001).

From behavioral point of view, prostitution can be defined as the act or practice of person, female or male, who for some kind of reward –monetary otherwise –engage in sexual relations with a number of persons, who may be of the opposite or same sex. Unless otherwise stated, in reality prostitution implies women providing sexual pleasure to men in exchange of cash or kind. ‘Sexual relations’ is not a very precise term. Ordinarily, it means sexual intercourse or more precisely, vaginal and anal intercourse. But other sexual relations may involve exchange of cash or kind- for example, oral sex, masturbation, petting, deep kissing and phone sex. Do they fall under the rubric of prostitution. There is no universally applicable answer to this question. Definition of prostitution in India common parlance is quite narrow. It is regarded as the act of a female who hires her body to a number of males for sexual intercourse in exchange of money.

The existence of prostitution in a society depends upon: (1) The presence of some customary form(s) of marriage, particularly monogamous between a man and a woman, as well as socio cultural structures against marital infidelity of women and (ii) strict observance of pre- marital chastity of women. It might have taken thousands of years for human societies to develop varieties of marriage institutions. There is no evidence of any society in the contemporary world that does not practice any customary form of marriage and also does not have any control over sexual relationship between a man and a woman outside marriage. However, societies may vary considerably in strictures against or toleration of pre- marital and extra-marital
sexual relations between a woman and a man. In general, a so-called tribal society in Africa and Pacific Islands in which pre marital sexual experience has been quite common place. Moreover, in some of these societies, women with such experience are preferred for marriage purpose. In these societies prostitution is reported to have developed only after sailors, traders and other outsiders started hiring native women to become their ‘temporary wives’.

Most societies, being patriarchal in nature customarily exert more control over female sexuality. Violations of marital fidelity and pre marital chastity by men are more tolerated than by women. Hence, although there may not be any difference in basic sex drive of men and women, men are in a more advantageous situation to satisfy their sexual urge outside marital bond. The most convenient and common way for men to do so is to satisfy their urge by having sexual relations with female ‘Prostitutes’.

1.1.1 History of Prostitution in India

Prostitution is an age old institution in India. Mention of courtesans and eunuchs are seen in Vatsyayana’s Kamasutra compiled sometime between 100 to 400A.D. Their livelihood was depended on earning money by providing sexual pleasure to men (Burton and Arbuthnot, 1993). It is mentioned that about 64 qualities are required courtesans for to wooing the high class men. Kautilya’s Arthashastra mentioned that providing sexual entertainment to high class people by trained female sex workers called ‘ganikas’ was controlled by the State (Rangarajan, 1992). The chief controller of entertainment controls the amount that is paid to the ganikas and their State expenses. The ganikas are required to pay one sixth of their income to the State.
Prostitution was an important source of State revenue during the Mughal period. But with the downfall of the Mughal Empire and abolition of the zamindari system, the earlier character of prostitution was reduced. The earlier reputed concubines and prostitutes took to the selling of ordinary sex. During the British period prostitution became famous with the presence of the glamour girls. These glamour girls were present in the port cities as well as in the cantonment areas. The cities of Mumbai, Delhi, Chennai and Kolkata became centers of these glamour girls. Formation of various legislations has abolished the Devadasi system. But yet its practice was prevalent and was known by different names in different areas like Bogam, Jogin and Kalavantulu in Andhra Pradesh, Jagatis and Basvis in Karnataka, Maharis in Kerala, Muralis in Maharashtra, Thevardiya in TamilNadu, etc (Shankar, 1990). Girls dedicated as Devadasis to Yellamma, Hanuman and Khandoba temples in Maharashtra-Karnataka border areas were estimated at 2.5 lacks. The Devadasis in these areas were provided as various materials for local folk tales as well as for movies.

1.1.2 The Devadasi System

The Devadasi was the system where young girls were used to act as servant of the God, sing and dance in the temples. This system was prevalent since 300 A.D. and was fully established in 700 A.D. (Bashma, 1959). The Devadasis were supposed to dance, pray and sing to the Gods as well as to provide sexual pleasure to the temple priests as well as the people who made large donations to the temple. With the passage of time the lower class Devadasis began to provide sexual pleasures to the common visitors of the
temple. This led to the beginning of the ordinary work of the prostitutes. The daughters of these Devadasis were reared up in the temples and took up the same profession. In some regions the lower caste people initiated their daughters at a very young age to the temples to gain spiritual or other forms of favors from the gods or the temple authorities. These dasis were initiated as gods but not allowed to follow celibate lives. Yet their children were not free to choose their own profession, get married and lead a household life. (Eswar, 2002).

Since 10th century onwards, the Devadasis or the temple girls played an important role in the religious and cultural life of the people. The presence of the concept of ‘divine flourish’ is still seen in the present century. The other synonyms of these temple girls gathered from the records of the medieval period were Sanulu, Sani, Sampradayamuvuru, Gadisanulu, Munutisanulu, Pedamunutisanulu and Sani or Munnuri indicating numeric status (South Indian Inscription Vol.IV). They were employed in the temple administration and were given place to stay in the temple complex and carry out various works for the gods. From the inscriptions of Tirumala, Tirupati it is know that temple dancers are referred to as Tiruvidhisani.

Inscriptions in the Tanjore temple dated 1004 A.D. mention the presence of about 400 Devadasis in the temple. They were given free quarters in the temple complex as well as tax free land in the temple. About 20,000 Devadasis were attached to 4000 temples in Gujarat around the medieval times. The Devadasi system existed till the 19th century in Southern India. But it was deteriorated in Northern India due to the destruction of the
temples by the Muslims invaders. In the 20th century the Devadasi system faced a decline in Southern India due to exploitation of the girls from the poor families. The Government legislation in the 1920s and 1930s for abolition of the Devadasi system was a vain effort. A record dated 1390 A.D States that the king Achyuta Raya ordered the daughter of Ranjakam Kuppasani to serve as a dancer in the temple of Sri Venkateswara at Tirumala in the year 1531 (Tirumala Tirupati Devastnam Inscriptions, Vol.III, No.2,Pp.23).These girls represented the hereditary class namely ‘sampradayamuvuru or kanya sampradayamuvuru’. Besides this, the ‘sani’ is portrayed as nartaki (dancer) and the gayika as singer. These artists were followed by the fan-bearing ones in the king’s court. In addition to these sanis there were several girls doing temple work, menial jobs etc who came from the lower section of the society. These people performed the duties like supplying flowers to God and raising the flower gardens. Temple girls were in charge of maintaining these temple gardens and also performed other duties like cleaning the premises, husking paddy, cleaning utensils, cutting vegetables and other sundry jobs. (Raman, 1975).

These temple girls were paid in various forms like giving out the ‘prasada’ given to the deities and a share in the temple property. The ones who make donations to the temples would specify the manner in which various shares were to be given to the temple girls and they also deposited certain amount with the temple authorities for the maintenance of these temple girls. These temple girls acquired a lot of wealth from these donations. There existed a vast difference in the Devadasi system of the past and the Jogin system of the present. The Devadasi system was spread all over and
was not confined to a particular caste nor these Devadasis were treated as untouchables as found in the Jogin system. In Telangana area of Andhra Pradesh Jogin system prevailed for prostitution. Most of the Jogins belong to the Malas and Madigas who were considered as the lowest among the Scheduled Castes. Some Backward Caste communities and Scheduled Caste communities mainly from fishermen, Tenugu and Naikpod castes practice the Jogin system.

The Upper Caste men strengthened their socio-economic relations with the lower caste people by using Dalit women as prostitutes and keeping them under various forms of bondages. A Jogin girl was given money but also made to work in the fields. She used to reside in the village and exploited by all the men including the Dalits. Jogins who entered into prostitution mentioned that the above enumerated factor was one of the deciding factors that had given them the prostitute status. It was the appropriation of the feudal custom by the capitalist market economy and the urbanization process. The regional and village level economic status also added up to preponderant the situation (Das, 1982). Unlike in any other region there was no urban economy and existence of the agrarian system with its hierarchies relate to the increase of the problem.

The Potharajus were the people who had a heavy tuft of hair which had divine power because they did not cut their hair from their childhood. As such the Potharaju bore the power to convert young girl into Jogin. Thus, if any family desired to offer their daughter as Jogin they used to approach the Potharajus. Mostly the village elders also advised on the offering of Jogins to the Potharaju for the well being of the whole village. Here the Potharaju
performs the marriage ceremony of the Jogin with the local village deity by performing the yellow thread (Mangal Suthram) ceremony and adorn leather as a token hailing the holy foot prints of Yellamma, Yellamma Paadalu on her neck. An ordinary girl is transformed into a Jogin in three stages. The first stage is the stage where the girl aged three to six years is married to the God. In the second stage she is offered to the village headman or the Patel or the Patwari after attaining the age of puberty. The last stage is reached when she is treated as the village property and the Potharaju as her Guru. Around 2001-2002 various Government efforts were made to rehabilitate the Potharajus. Smt Kummuden Joshi took an initiative in the year 1988 and married off many Jogins. Around the same time, about 250 Potharajus came to fore, cut off their hair and were rehabilitated under various schemes of the Andhra Pradesh Scheduled Caste Development Scheme and district acts. On 1st August 2002, about 41 Potharajus removed their tuft and another 235 gave up their trinkets, lashes and whips to join the mainstream. Almost all Potharajus have been brought up to the mainstream and their system is wiped out. But the same cannot be said of the Jogin system.

The climate in South India is semi-arid and a lot of draughts are seen every year. This condition results in the large scale poverty of the people. Lower caste people do not own land of their own and are dependent upon the land owners and the money lenders. Utter poverty leads these people to take up sex work. Commercialization of sex work finds its easy victim among such people and they are engaged in such work (Datar, 2003). The main reasons behind conversion of the young girls into Joigins are the recurring death of children in a family, regular occurrence of disease in the house or village,
outbreak of diseases in the village or pure lust of landlords. The nexus between caste system and prostitution are very strong as such they are found in the society. Andhra Pradesh tops the list for trafficking of women among all the States in India. A study on interstate trafficking reported in ‘Shattered Innocence’ by Prajwala, a Non-Government Organization reveals that majority of the women between 12-35 years in red light areas of Delhi, Mumbai, Kolkata and Goa are from Andhra Pradesh. The “catchments” areas for the racketeers include all the 23 districts spread across Costal Andhra, Rayalaseema and Telangana regions. Eighty percent of the victims belong to socially and economically disadvantaged families of which seventy percent are from Backward and draught prone areas and eighty five percent are illiterate (Sirkar, 2003).

1.2 Women Sex Workers

Nearly two out of every five female sex workers (FSWs) in India could be suffering from HIV infection. Those who aren't already infected, however, carry more than 50-times increased risk of getting infected during their lifetime. The region where the risk of HIV infection increased most for a sex worker was Asia (29 times more) compared to a 12-time higher threat in Africa and Latin America (Kounteya Sinha, March 15, 2012, ‘The Times of India’).

As the term sex worker is devoid of the moral condemnation embedded in the word “prostitute”, it can be applied to any type of discriminate or indiscriminate, effectual or non-effectual commercial sexual transaction short of marriage or other long- term monogamous (or polygamous) relationships.
Sex work is not simply an individual woman selling services; it is highly complex, highly profitable commercial enterprise. Female sex workers are women who enter the prostitution as adults or who, having been forced or non-economically coerced into the prostitution as children or adults, remain female sex workers even when force or non-economic coercion no longer exists. Female sex workers consider themselves to be in charge of their existence of economic coercion. It is true that many women who work voluntarily are still involuntarily subjected to abuse and exploitation by the police, pimps and brothel owners.

It is no accident that countries with a booming sex industry, like India, South Africa, Kenya and Thailand, have, or have had, a major AIDS epidemic. Poverty and commercial sex work go hand in hand. Commercial sex workers play an important role, especially in the early stages of the epidemic, in every country.

Some commercial sex workers do not work in a brothel, but rather in a restaurant or bar where they meet their customers. There women are called “informal” sex workers in India, and it is difficult for public health programs to reach them with prevention messages.

What is the future for a commercial sex worker in India? Most women work an average of only three years, about the same tenure as a professional football players in American’s National Football League. A few save some of their earnings, and use these savings to leave the sex industry for other work. Sex workers may contract HIV/AIDS, the disease that represents another exit route from their occupation.
The essential conditions underpinning the push and pull factor in prostitution are poverty, powerlessness and patriarchy. Abject poverty forces many women into the sex work; however, abject poverty alone is not a sufficient or necessary explanation. Relative poverty and powerlessness also push women into the sex work as the gap between rich and poor increases and people also lose control of their traditional means of subsistence, hence control of their lives and destinies. A large and growing prostitution depends upon the ready availability of poor and powerless women. Patriarchy is also responsible for the growth and sustenance of prostitution. Among the most powerful forces influencing existence and growth of the prostitution in Asia are the myths created by men over time to excuse their predilection for having sex with virgins and young girls. These patriarchal myths serve to justify the adult male rape of young girls and flue the need to bring ever- young girls into the prostitution. The misogynist teaching of the major religions practiced in Asia facilitate the sexual promiscuity and dictating the subjugation of women. The power of religion is so strong that many women believe in the truth of their own inferiority and female sex workers accepted it as their destiny to remain social outcasts. Until the misogynist in cultural and religious beliefs and practices are removed, legal and socio-cultural reforms stand little chance of success in combating the growth of the sex work.

Prostitutes or female sex workers are not homogenous group. There are different types of prostitutes found within the city or region. Carrier (1989) identified nine different types of prostitutes: “Street Walkers; Internet Travelers; Dance Hostesses; Taxi Girls; Professionals Living in Brothels; Semi Professionals; Lovers; Call Girls; and companies for parties or
vacations”. Each of these types of commercial sexual activities offer different types of risk of HIV/AIDS transmission and each require a different form of intervention (Hellman, 2001). In Indian context, the female sex workers can be classified into the following broad categories as Brothel-based Female sex workers in Red-Light areas and elsewhere; Female sex workers of Devadasi Origin; Floating Female sex workers; Call girls; Hijras and Male Female sex workers other than Hijras.

Whatever is known about prostitution or sex work in contemporary India it is based mainly on information gathered from areas known officially or unofficially as red-light areas in cities, towns and villages. The origin and the growth of red-light areas may be partly attributed to the assumption that prostitution is the necessary evil and has to be tolerated as long as it does not create a public nuisance and does not violate the limitations imposed on its practice. Female sex workers of this category do not have a fixed place for meeting and entertaining their clients. They usually roam in the streets, public parks, railway stations, bus stands, shopping areas and areas surrounding cinema halls. Call girls are usually part-time or full-time female sex workers who do not entertain their clients in their own residence. The important distinction is that Call girls are mostly educated, finally better off and they do not have to roam in streets and other public places in search of clients. They generally get their clients through agents who have contacts with potential clients.

Sex work becomes a source of sexually transmitted disease and HIV/AIDS. Half of the people suffering from sexually transmitted diseases have acquired it through promiscuous sex relationships. There is a great
impact on the health of women holding the occupation of sex work. During the past two decades, sexually transmitted diseases have undergone a dramatic transformation. Primarily, the change in name took place from venereal diseases to sexually transmitted diseases. The World Health Organization estimated that over 500 million new cases of sexually transmitted diseases occurred in 2012. Sexually transmitted diseases become a major public health problem in India and most of these diseases are prevalent in high-risk groups like female sex workers. The sexually transmitted diseases play a major role in the transmission of HIV/AIDS. Female sex workers have fallen into diseases because of unsafe sex practices like unprotected sex; not using condom, unaware of the fact that the condom prevents the transmission of sexually transmitted diseases. The sex work and sexually transmitted diseases are closely interlinked (Park and Park, 2000).

Avoidance from all sexual activity is the most effective prevention. However, most people do not choose life time abstinence. The risk of acquiring sexually transmitted diseases including HIV/AIDS is virtually absent, when one has sexual intercourse with a mutually faithful monogamous uninfected partner. In all situations condom should be used for protection against infections. Personal hygiene (washing of genital after intercourse) might also contribute to the prevention of infection, but this is less effective than condom usage (Bhagban Prakash, 1994).

1.2.1 Health of Women Sex Workers

For millions of women today, as in the past, sex work is an occupation: often the only one available to them. While the occupational health of sex
workers varies with the meanings, customs and context of sex work in their local environment, the degree of control they can exercise over their lives is the crucial determinant of their health status. Risks especially of violence and of sexually transmitted diseases, but also of infections and contagious conditions - are mediated not merely through customers but those who manage or orchestrate the circumstances of sex workers: brothel owners, pimps and police amongst them. Repressive legislation may drive the women away from health agencies and health interventions.

There is a great impact on the health of women holding the occupation of sex work. Majority of the diseases suffer from sexually transmitted diseases and HIV/AIDS. The sexually transmitted diseases are a group of communicable diseases that are transmitted predominately by sexual contacts. During the past two decades, sexually transmitted diseases have undergone a dramatic transformation. First, the change in name was changed from venereal diseases to sexually transmitted diseases. Sexually transmitted diseases are Syphilis, Gonorrhea, and Concordia, genital warts and herpes. Sexually transmitted diseases are becoming a major public health problem in India. Most of the sexually transmitted diseases are prevalent in high-risk groups like sex workers. Sex workers fall to it because they have sex with more men in the day. This is a major factor in the spread of the sexually transmitted diseases. The sex worker acts as a reservoir of infection. The sexually transmitted diseases play a major role in the transmission of HIV. They have fallen to them because of unsafe sex practices like unprotect sex, not using condom, unaware of condom and mode of transmission of sexually transmitted disease. Thus sex work and sexually transmitted diseases are
closely interlinked (Park, and Park.J.E, 2000). In India 15 million people become infected with one or more sexually transmitted diseases each year and more than 65 million people are currently living with incurable sexually transmitted diseases.

A woman is a prostitute “only for the limited period of time that [she] engages in the activities, and the woman pursuing this occupation has no more of an identity, fate, or permanence than a man has who is a professional baseball player or soldier”. Most women do not choose prostitution; rather, they are forced into this type of work because of drug addiction, poverty, or lack of education. These factors, in addition to their lives on the streets, expose sex workers to a number of health problems other than, or in addition to, HIV/AIDS and sexually transmitted diseases (STDs). No library and information science (LIS) studies and few in other social sciences have determined the general health problems of women whose occupation is sex work. In addition, little attention has been paid to the health information needs of sex workers, although sources of information about STDs and HIV/AIDS have been identified.

Based on the theory of sense making (discussed above), the research done on medical sciences, and many studies done on female sex workers in the world found that one of the most important sources for spreading HIV/AIDS, a dangerous disease, through sexual intercourse between men and women, between men and men and between women and women. Among all these women sex workers are playing an important role in transmission of HIV/AIDS from one person to other.
1.3 Conceptual Definition of HIV/AIDS

AIDS is a serious illness that slowly attacks and destroys the body's immune system. The result is that the body becomes vulnerable to infections (Opportunistic infections). And concerns, which are not so common in the population. AIDS, i.e. Acquired Immuno Deficiency Syndrome, is not hereditary and is characterized by a number of symptoms occurring to gather. The term syndrome is therefore used for defining AIDS. It is the HIV, that is the Human Immuno Deficiency virus, that finally to a AIDS. All body its presence is particularly high in blood, semen of man, cerebrospinal fluid, and vaginal and cervical secretions of the woman. A person infected with the virus becomes a carrier of HIV and can infect others.

The greatest number of new infections in a single year since AIDS was first officially recognized as a disease in 1981 (Gottlieb et. al., 1981). The search for the identification and nomenclature of the agent went on till in 1986 (Coffin, et.al., 1986) the international committee on Taxmony of viruses recommended the name a Human Immuno Deficiency Virus" (HIV) to LAV agent identified and named such by Mont gainer and Coworkers (1983) and HTLVIII isolated and identified by Dr. Robert Gallo and associates (1984) and named as such (Gallo, et.al.,1984). So, it was in 1984-83 that the causative virus was isolated from patients of AIDS and was named HIV in 1986.

1.3.1 Definition and Description of HIV/AIDS

Acquired immune deficiency syndrome (AIDS) is an infectious disease caused by the human immunodeficiency virus (HIV). There are two variants of the HIV virus, HIV-1 and HIV-2, both of which ultimately cause AIDS.
AIDS was first recognized in the United States in 1981 in homosexual men. Today it is seen in both homosexual and heterosexual men and women. AIDS is the advanced form of infection with HIV virus. This virus may not cause recognizable symptoms for a long period after the initial exposure (latent period). As of early 2009, no vaccine was available to prevent HIV infection. Until such a vaccine is developed, all forms of HIV/AIDS therapy were focused on improving the quality and length of life for people who were infected by slowing or halting the replication of the virus and treating or preventing infections and cancers that often develop in people with AIDS.

AIDS is one of the most devastating worldwide public health problems in recent history. The United States Centers for Disease Control and Prevention (CDC) estimated that in 2006 944,000 people in the United States had been diagnosed with AIDS since the disease was identified in 1981. In 2006, an additional 1-1.2 million Americans were diagnosed as infected with HIV but not yet showing symptoms (HIV positive). However, in early 2009, the CDC issued a statement that they now thought that earlier the HIV-positive estimates were too low, as many more people than were originally estimated are living with unreported or undiagnosed HIV infection.

According to the August 2008 report issued by the Joint United Nations Programme on HIV/AIDS (UNAIDS), as of 2007, approximately 33 million people worldwide were HIV positive. Over half of the 33 million were women and this statistic has remained stable for several years. The highest number of cases was found in sub-Saharan Africa and Southeast Asia.
More than 70% of HIV infections were transmitted through sexual contact. Traditionally in the United States, the majority of cases were found in homosexual or bisexual men. In 2007, about half of new HIV cases were acquired by men having sex with other men. Fewer than 20% of HIV-positive Americans were women. However, this is not the case worldwide, where transmission by heterosexual individuals is common.

1.3.2 The Risk Factors of HIV/AIDS

AIDS can be transmitted in several ways. The risk factors for HIV transmission vary according to the method of transmission.

**Sexual contact:** People at greatest risk are those who do not practice safer sex by always using a condom, those who have multiple sexual partners, those who participate in anal intercourse, and those who have sex with a partner who has HIV infection and/or other sexually transmitted diseases (STDs). In the United States and Europe, most cases of sexually transmitted HIV infection result from homosexual contact, whereas in Africa, the disease is spread primarily through sexual intercourse among heterosexuals. Most people with AIDS in the United States are between 25 and 44 years of age.

**Transmission in pregnancy:** High-risk mothers include women sexually active with bisexual men, intravenous drug users, and women living in neighborhoods with a high rate of HIV infection among heterosexuals. The chances of transmitting the disease to the child are higher in women in advanced stages of the disease. Breast feeding increases the risk of HIV transmission as HIV passes into breast milk. The rate of pediatric HIV transmission in the United States had decreased substantially because of HIV
testing and improved drug treatment for infected mothers, so fewer than 1% of AIDS cases now occur in children under age 15. In the developing world, mother to infant transmission remains epidemic. In 2006, AIDS was the single most common cause of death in children under age 5 in South Africa, while worldwide children account for about 10% of all AIDS cases.

**Exposure to contaminated blood:** Risk of HIV transmission among intravenous drug users increases with the frequency and duration of intravenous use, frequency of needle sharing, number of people sharing a needle, and the rate of HIV infection in the local population. In 2006, about 19% of men with AIDS and 25% of women with AIDS contracted the disease through sharing needles during intravenous drug injection. With the introduction of new blood product screening in the mid-1980s, HIV transmission through blood transfusions became rare in the developed world. However, contaminated blood is still a significant source of infection in the developing world.

**Needles and body fluid splashes:** Transmission through these sources accounts for fewer than 0.3% of all HIV infections in the United States. This rate reflects the emphasis on universal safety precautions (e.g., use of gloves, face shields, proper disposal of needles) among health care professionals and first responders.

HIV is not transmitted by handshakes or other casual non-sexual contact, coughing or sneezing, or by bloodsucking insects such as mosquitoes. Therefore, it is clear that sex is one of the main reason which causes HIV among people.
HIV/AIDS is one of the top 20 causes of death of all men in the world, and among the top 10 killers for certain groups. Especially in United States, the Black men and men who have sex with men have been hit particularly hard. In one recent study, one out of every five men who have sex with men has HIV — and nearly half of them don’t know they have it. But the good news is that anybody can take steps to protect themselves and their loved ones from HIV.

Women exposed to HIV infection through heterosexual contact are the most rapidly growing risk group in the United States. The percentage of AIDS cases diagnosed in American women has risen from 7% in 1985 to about 25% in 2006. According to the CDC, in 2006 approximately 278,400 women in the United States were living with HIV/AIDS. The rate was highest among black women and lowest among white women. About 75% of these women contracted HIV through high-risk heterosexual activity; almost all of the remainder acquired the infection through needle sharing.

The prevalence of women with HIV in the United States is low compared to the rate in many countries in the developing world. Worldwide about half the people living with HIV are women. According to the United Nations, in 2005 about 59% of women living in sub-Saharan Africa are infected with HIV. The vast majority of them were infected through sex with an infected male partner.

Since AIDS can be transmitted from an infected mother to a fetus during pregnancy or to an infant during the birth process or through breastfeeding, all infants born to HIV-positive mothers are considered a high-
risk group. However, prenatal drug treatment of HIV-positive mothers in developed countries has reduced the number of children born infected with HIV. In the developing world, drug treatment is neither not available nor not affordable. According to the United Nations Children's Fund (UNICEF) worldwide 2.3 million children under age 13 were living with HIV in 2006. The previous year, about 380,000 children died of AIDS and more than half a million children were newly infected. UNICEF estimates that at least 15 million children have lost at least one parent to AIDS.

AIDS is the leading causes of death in children under age five many parts of Africa and Southeast Asia. The interval between exposure to HIV and the development of AIDS is shorter in children than in adults. Infants infected with HIV have a high chance of developing AIDS within one year and dying before age three. In the remainder, AIDS progresses more slowly; the average child patient survives to about seven years of age. Some survive into early adolescence.

1.3.3 Causes and Symptoms of HIV/AIDS

AIDS is a disease that can damage any of the body's major organ systems because HIV destroys immune system cells. HIV attacks the body through three disease processes: immunodeficiency, autoimmunity, and nervous system dysfunction. Immunodeficiency describes the condition in which the body's immune response is damaged, weakened, or is not functioning properly. In AIDS, immunodeficiency results from the way that the virus binds to a protein called CD4, which is primarily found on the surface of certain subtypes of white blood cells. After the virus has attached to the cell's
CD4 receptor, the virus-CD4 complex refolds to uncover another receptor called a chemokine receptor that helps mediate entry of the virus into the cell. One chemokine receptor in particular, CCR5, has been the focus of recent research after studies showed that defects in its structure (caused by genetic mutations) result in a slowing or stopping of the progression of AIDS. Scientists hope that this discovery will lead to the development of drugs that trigger an artificial mutation of the CCR5 gene or target the CCR5 receptor.

Once HIV has entered the cell, it can replicate intracellular and kill the cell in ways that are still not completely understood. In addition to killing some lymphocytes directly, the AIDS virus disrupts the functioning of the remaining immune system cells. Because the immune system cells are destroyed, a wide variety of infections and cancers can take advantage of a person's weakened immune system (opportunistic infections/diseases).

1.3.4 Signs of HIV/AIDS

When a person has been infected with HIV/AIDS he/she will carry the virus many years before any symptoms develop. A person who is already sick (e.g. With T.B) or weak (e.g. during pregnancy) will develop AIDS faster than somebody who is strong and healthy.

The following are the important preliminary signs of HIV/ AIDS

- Heavy loss in weight without any good reason.
- Frequent attacks of fever, diarrhea
- Swelling of glands (especially of throat)
- Sweating at night and body ache.
• Wounds or white patches in the mouth and food pipe.

These signs are common in many other diseases too. HIV/AIDS should be suspected when a person has several of them at the same time and they persist for a long time (Manjit Singh, 1991).

1.3.5 Modes of Transmission

HIV/AIDS though an infectious disease is not easily transmitted through the environment, e.g., from air, water, food etc. Thus it is not a communicable disease like common cold, influenza, measles or polio virus and other infectious diseases. Only body fluids with a high concentration of virus cause infections. These fluids are blood, semen, and vaginal secretions. There are no well-documented cases where saliva, urine, tears, or nursing HIV/AIDS infected mothers can also pass HIV/AIDS to their children through breast milk (Rubenson, 1987). The virus enters the body in three major modes of transmission namely sexual intercourse, blood transfusion and infections with infected syringe and needles and during pregnancy and child birth.

Worldwide, sexual intercourse is the least efficient, but most frequent, mode of transmission from man to woman, woman to man, woman to woman. Penetrative vaginal, oral and anal intercourses are the most frequent means of transmission. Risk of male- to- female transmission may be higher than that of female-to-male, but the degrees of risk are not established yet.

Sexual transmission of HIV/AIDS appears to be more efficient when co-factors, assaults on the body that increases susceptibility to HIV/AIDS or stimulates disease which sexually transmitted are present. Although HIV/AIDS
is transmitted in the absence of other sexually transmitted diseases, the possibility of sexually transmitted disease that causes genital ulcer is the risk factor for increased infections or increased susceptibility to HIV/AIDS infection. Anal-rectal ulcers also have been implicated in sexual transmission.

The second most frequent means of spreading HIV/AIDS infection—transmission through exchange of infected blood or blood products is the most efficient. The risk of HIV/AIDS infection through blood appears to be related to size of the inoculums. A recipient of a single unit of HIV/AIDS-infected blood has virtually a 100 percent probability of acquiring the infection. HIV/AIDS is transmitted whenever the blood of an HIV/AIDS-infected person enters the system of another person, through transfusion of contaminated blood or use of contaminated syringes and needles as in case of intravenous drug users or accidental inoculation or other skin piercing instruments. HIV/AIDS can be transmitted through the blood products used by persons with hemophilia.

Transmission of infection from mother to fetus during pregnancy is estimated to have an efficient rate, ranging between 30 and 60 percent. Evidence suggests that 25 to 50 percent of all offspring of infected mothers will be infected. The risk of transmission depends on a variety of factors that include the timing of maternal infection (Carballo, 1998). Infection also may accrue from the infant’s exposure to maternal blood during delivery. During birth, infection may also develop from the genital secretion and from mother’s milk after birth. HIV/AIDS will not be spread through casual contact, such as sneezing, touching or sharing utensils or food, or by the use of toilets or
swimming pools. People in social contact with persons who have AIDS or infected with HIV are not at risk.

**Figure 1.1: Routes of Transmission of HIV, India, 2010-11**

![Pie chart showing routes of HIV transmission]

HIV positive cases detected, mother to child transmission accounts for 5.0%, Infected Syringe and Needle 1.7%, Homosexual 1.5% and contaminated blood and blood products account for 1.0% of HIV infections detected during 2011-12.

**Figure 1.2: Routes of Transmission of HIV, India, 2011-12**

![Pie chart showing routes of HIV transmission]

Source: http://www.medindia.net/health_statistics/general/aidsindia.asp
1.3.6 HIV/AIDS Prevention and Treatment Strategies

Most Governments have implemented programmes that focus on HIV/AIDS prevention. Comprehensive prevention programmes include a range of strategies, such as information, education and communication (IEC) campaigns; programmes to modify sexual behaviour; condom promotion; voluntary counseling and testing; ensuring blood safety; and targeting high-risk groups (sex workers and injecting drug users) and vulnerable groups (young people and pregnant women). In addition, some 60 countries have imposed mandatory AIDS testing for immigrants, which, from a human rights perspective, constitutes one of the most contentious responses (UNAIDS and International Organization for Migration, 2004). The most widespread programmes are IEC campaigns, blood screening, testing and counseling, condom promotion and notification/case reporting. Experience indicates that national programmes are most effective when an appropriate combination of programmatic interventions is tailored to the specific risk factors and situations of a country. In Brazil, Thailand and Uganda, for example, very different but highly effective responses to the epidemic were implemented (United Nations, 2003b). A key issue, however, remains concerning how to ensure that programmes are accessible to those in need. A recent survey revealed that in many countries only a small proportion of those at risk had adequate access to basic prevention services UNAIDS, 2004b).

Better individual knowledge of HIV/AIDS and its prevention can complement and enhance the effectiveness of government policies and programmes. Poorly educated persons, for example, know less about
HIV/AIDS and are less likely to use condoms. Thus, they are more vulnerable to infection (United Nations, 2002b). Furthermore, even when women are knowledgeable about HIV/AIDS, they are frequently powerless to choose abstinence or protected sex. Recognizing this, many Governments are raising public awareness by promoting IEC programmes through various channels, including print media, theatre, radio, direct mailings and other public service messages. Non-governmental organizations, networks of people living with AIDS, religious institutions and international and bilateral donors are essential participants in IEC activities.

Prevention efforts have also targeted mother-to-child transmission of HIV. Activities undertaken to eliminate this channel of transmission include HIV prevention services for women of childbearing age, voluntary counseling and testing for pregnant women, comprehensive reproductive health services and antiretroviral prophylaxis. However, progress in expanding access to antiretroviral prevention has so far been limited, with only 10 per cent of pregnant women being offered this treatment (UNAIDS, 2004b).

Although antiretroviral treatment has significantly prolonged life and reduced the suffering of AIDS victims, access to antiretroviral treatment remains extremely low. While concerned international and national efforts have slashed the price of these medicines, treatment remains beyond the reach of most victims in developing countries. Furthermore, the growing availability of HIV therapies must not lead to a neglect of prevention efforts, which would produce an increase in new HIV infections.
1.3.7 Social Work Interventions

A successful AIDS prevention programme requires appropriate social work response (Thomas, 1994). The most sensitive aspect of this disease is that since acquiring it is associated with sexual behaviour, the patient suffers from various pressures and concerns—psychological, social and ethical. In the absence of a preventive vaccine or a curative drug, prevention by education and counseling is the only major means of reducing or even stopping the spread of HIV infection and learning to live with AIDS and HIV.

Thousands of HIV infected people live in isolation and loneliness, looking towards care and human touch which professional social work methods can offer. Some of the problems faced by the AIDS/HIV victims in India include:

- Identity crisis
- Social denial
- Denial of health care
- Low self image
- Guilt feeling and
- Family disintegration.

The social worker plays a vital role in Information Dissemination. To educate people about AIDS, it is necessary first to overcome denial. Until the fact that there is a problem is acknowledged, modifying risk behaviours is not possible. The role of a social worker in a medical team is as important as, that of a physician (Thomas, 1995). While the medical practitioner’s role is limited
to treatment of a patient, the social worker deals with the social, physical, psychological, economic and environmental aspects of the patient who is under treatment. The social worker is the right person who is professionally trained to understand all these aspects of a patient who needs care and treatment.

The social worker helps in co-ordinating the work of the entire team. He/ She prepares the patient to accept the treatment prescribed by the physician. In certain instances, particularly cases like STD/HIV/AIDS and cancer, the social worker explains to the client the need for undergoing laboratory tests. The very decisions to go for an AIDS test require counseling by a Social worker. In several cases, the social worker may have to receive the result of the test and convey the same to the client. Given the present situation, when no cure is available for AIDS patients, a positive test result is a death sentence. The client, his/her family and relatives need to be psychologically prepared for receiving the test results. It is in fact a stupendous task for a social worker in India to handle AIDS cases because of the taboos attached to some of the means of transmission like sex and drugs.

1.3.8 Treatment of HIV/AIDS

In the early 1980s when the HIV/AIDS epidemic began, people with AIDS were not likely to live longer than a few years. But today, there are 31 antiretroviral drugs (ARVs) approved by the Food and Drug Administration to treat HIV infection. These treatments do not cure people of HIV or AIDS. Rather, they suppress the virus, even to undetectable levels, but they do not completely eliminate HIV from the body. By suppressing the amount of virus
in the body, people infected with HIV can now lead longer and healthier lives. However, they can still transmit the virus and must continuously take antiretroviral drugs in order to maintain their health quality.

At present it is evident that there are three major classes of anti-HIV drugs (NIAID, 2002). These drugs are protease inhibitors, Nucleoside analog Reverse Transcriptase Inhibitors (NRTIs) and Non-Nucleoside analog Reverse Transcriptase Inhibitors (NNRTIs). “Protease inhibitors work by preventing HIV/AIDS virus from being successfully assembled by and released from infected CD4+ cells. NRTIs act by incorporating themselves into the genetic material of the virus, thereby halting the viral building process (Richman, 2001) NNRTs stop HIV/AIDS virus production by binding directly onto reverse transcriptase and preventing the duplication of viral genetic materials” (NIAID, 2002).

The National Institute of Allergy and Infectious Diseases (NIAID) conducts and supports basic and applied research to better understand, treat, and ultimately prevent infectious, immunologic, and allergic diseases. For more than 60 years, NIAID research has led to new therapies, vaccines, diagnostic tests, and other technologies that have improved the health of millions of people in the United States and around the world.

NIAID is one of the 27 Institutes and Centers of the National Institutes of Health (NIH). NIH, like the Centers for Disease Control and Prevention (CDC), is part of the U. S. Department of Health and Human Services (HHS). NIH is the primary federal agency for conducting and supporting basic,
clinical, and translational medical research, and it investigates the causes, treatments, and cures for both common and rare diseases.

NIAID is focused on finding new and more effective therapies, drug classes, and antiretroviral drug combinations that can extend and improve the quality of life for people living with HIV/AIDS. NIAID supports research that advances our understanding of HIV and how it causes disease, thereby unlocking new targets for drug development. Promising medicines are then tested in human clinical trials to determine whether they are safe and effective. This process usually takes several years to complete before a new therapy is available to the public.
Table – 1.1: Progress in Achievement of Physical Targets listed in Outcome Budget of the Department of AIDS Control for 2010-11 and 2011-12.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2010-11</th>
<th>2011-12</th>
<th>Achievement up to January 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Targeted Interventions established</td>
<td>140</td>
<td>188</td>
<td>170</td>
</tr>
<tr>
<td>STI/RTI patients managed as per national protocol</td>
<td>100 lakh</td>
<td>100.1 lakh</td>
<td>120 lakh</td>
</tr>
<tr>
<td>New Blood Component Separation Units established</td>
<td>12</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>New District Level Blood Banks set up</td>
<td>6</td>
<td>7</td>
<td>22</td>
</tr>
<tr>
<td>Districts covered under Link Worker Scheme</td>
<td>186</td>
<td>179</td>
<td>219</td>
</tr>
<tr>
<td>Clients tested for HIV</td>
<td>111.71 lakh</td>
<td>95.45 lakh</td>
<td>120 lakh</td>
</tr>
<tr>
<td>Pregnant Women tested for HIV</td>
<td>86.49 lakh</td>
<td>66.38 lakh</td>
<td>90 lakh</td>
</tr>
<tr>
<td>HIV+ Pregnant Women &amp; Babies receiving ARV prophylaxis</td>
<td>11,350</td>
<td>11,962</td>
<td>17,500</td>
</tr>
<tr>
<td>HIV-TB Cross Referrals</td>
<td>8.5 lakh</td>
<td>10.48 lakh</td>
<td>9.5 lakh</td>
</tr>
<tr>
<td>ART Centres established (Cumulative)</td>
<td>332</td>
<td>300</td>
<td>340</td>
</tr>
<tr>
<td>PLHIV on ART</td>
<td>4,08,815</td>
<td>4,07,361</td>
<td>4,50,000</td>
</tr>
<tr>
<td>Opportunistic Infections treated</td>
<td>2.7 lakh</td>
<td>4.97 lakh</td>
<td>3.1 lakh</td>
</tr>
<tr>
<td>Campaigns released on Mass Media – TV/ Radio</td>
<td>6</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>New Red Ribbon Clubs formed in Colleges</td>
<td>1,200</td>
<td>5,190</td>
<td>1,000</td>
</tr>
<tr>
<td>Persons trained under Mainstreaming training programmes</td>
<td>2,50,000</td>
<td>5,22,337</td>
<td>1,50,000</td>
</tr>
<tr>
<td>Proportion of blood units collected through Voluntary blood donation in NACO supported Blood Banks</td>
<td>80%</td>
<td>79.5%</td>
<td>90%</td>
</tr>
<tr>
<td>Social Marketing of condom by NACO contracted Social Marketing Organisations</td>
<td>22.46 crore pieces</td>
<td>44.72 crore pieces</td>
<td>34.9 crore pieces</td>
</tr>
</tbody>
</table>

**Source:** Avert statistics- 'Annual Report 2010-2011 & NACO Fact Sheet-2012.
1.3.9 Stigma

The stigma of HIV/AIDS is especially pronounced because many of the sufferers, at least in the early stages of the epidemic, were homosexuals, injecting drug users, or the poor. Stigma is prejudice and discrimination against people who are regarded and treated in a negative way. Throughout the world, anti-AIDS stigma is a barrier to the humane treatment of infected individuals. In India, and in many other nations, HIV-positive people are stereotyped as having behaved immorally, and they are punished accordingly.

The people in India, Thailand, South Africa, and other countries who have been fired by their employers and evicted by their landlords, who have been lynched, or committed suicide. The civil rights of HIV-positive people are routinely violated in every nation. People living with HIV/AIDS are beginning to organize for lobby for making anti-retrovirals more widely available, and to seek other policies that benefit people living with HIV/AIDS.

1.4 HIV/AIDS in Global Scenario

At the 2011 United Nations General Assembly High Level Meeting on AIDS that took place in June in New York, Member States adopted a new Political Declaration which contained new targets to effectively respond to the AIDS epidemic. The 2011 Political Declaration mandates UNAIDS to support countries in reporting back on progress made towards achieving the new commitments. It also provides for the UN Secretary-General to report regularly to the General Assembly on progress achieved in realizing these commitments.
Below are the official reports submitted by countries to the UNAIDS Secretariat for the monitoring of progress towards the targets set in the 2011 Political Declaration on HIV/AIDS. Each report is presented exactly as submitted by the country, without editing or other alteration. These submissions will form the basis of the UN Secretary-General’s report to the General Assembly as well as the 2012 End of Year Report on the Global AIDS Epidemic.

According to UNAIDS report (2012), more than 34 million people now live with HIV/AIDS, where 3.3 million of them are under the age of 15. In 2011, an estimated 2.5 million people were newly infected with HIV, among ten 330,000 were under the age of 15. Every day nearly 7,000 people contract HIV and nearly 300 every hour. In this connection during 2011, 1.7 million people died from AIDS, out of which 230,000 were under the age of 15. Since the beginning of the epidemic, more than 60 million people have contracted HIV and nearly 30 million have died of HIV-related causes (UNAIDS World AIDS Day Report 2012).

The regional picture shows that in Sub-Saharan Africa more than two-thirds (69 percent) of all people living with HIV, 23.5 million, live in sub-Saharan Africa—including 91 percent of the world’s HIV-positive children. In 2011, an estimated 1.8 million people in the region became newly infected. An estimated 1.2 million adults and children died of AIDS, accounting for 71 percent of the world’s AIDS deaths in 2011. In Asia and the Pacific, nearly 372,000 people became newly infected in 2011, bringing the total number of people living with HIV/AIDS there to nearly 5 million. AIDS claimed an
estimated 310,000 lives in the region in 2011. More than 13,000 people of Caribbean became newly infected in the Caribbean in 2011, bringing the total number of people living with HIV/AIDS there to more than 230,000. AIDS claimed an estimated 10,000 lives in 2011. In Central and South America there were an estimated 83,000 new HIV/AIDS infections and 54,000 AIDS-related deaths in Central and South America in 2011. This region currently has 1.4 million people living with HIV/AIDS. Approximately 300,000 people in North Africa and the Middle East are living with HIV in this region and an estimated 37,000 people became newly infected in 2011. An estimated 23,000 adults and children died of AIDS. But in Eastern Europe and Central Asia around 140,000 people were newly infected with HIV in 2011, bringing the number of people living with HIV/AIDS to 1.4 million. HIV/AIDS claimed 92,000 lives in 2011. Whereas, during 2011, in Western and Central Europe, there were 30,000 new cases of HIV, bringing the number of people living with HIV in Western and Central Europe to 900,000. An estimated 7,000 people in these regions died of AIDS in 2011.

However, with HIV positive population still expanding the annual number of AIDS deaths can be expected to increase for many years. The overwhelming majority of people with HIV, 95 percent of the globe, live in the developing world. The proportion is set to expand further as infection rates continue to rise in countries, where poverty, poor health care systems and limited resources for prevention led to the spread of virus. The national adult HIV prevalence in India is below one percent although in five states an estimated prevalence of over one percent among adults is reported. The increasing warning signals that serious HIV/AIDS outbreaks occur threatening
several countries. Injecting drug use and sex work is so pervasive in some areas that even countries with currently low infection levels could see epidemics surging suddenly. Statistics prove that both the spread and impact of HIV/AIDS was not random, it disproportionately affects women and adolescent girls who are socially-culturally, biologically and economically more vulnerable.

1.5 HIV/AIDS in India Scenario

The first AIDS case in India was detected in 1986 and since then HIV infection has been reported in all states and union territories. During 2009 2.4 million people living with this condition and in the same year 170,000 HIV/AIDS related deaths happened. The high risk groups with HIV/AIDS are Female Sex Workers (FSW), Men who have Sex with Men (MSM), Transgender (TG), Injecting Drug Users (IDU) and bridge populations like truckers and migrants. According to the records it shows that overall 74.57 lakh STI cases were treated in India during 2011-12.

The country report UNAIDS 2010 indicates that India’s epidemic is concentrated within Most-At-Risk Populations (MARPs), with prevalence substantially higher among these populations than in the general population. Prevalence also varies dramatically by district, state, and region, with numerous isolated pockets of high prevalence. Approximately 60 percent of people living with HIV/AIDS (PLWHA) live in the six high-prevalence states, although prevalence in the general adult population of these states has recently experienced an overall decline. Even in states with low prevalence, there are pockets of high prevalence, and some are seeing an increase in
new infections. Rising trends among Antenatal Care (ANC) clinic attendees have been observed in the low- and moderate prevalence states of Gujarat, Rajasthan, Orissa, Uttar Pradesh, Bihar, and West Bengal. At the national level, trends among ANC clinic attendees and female sex workers (FSWs) appear to be on the decline, although in some parts of southern India, up to 15 percent of FSWs are HIV positive. Trends among injecting drug users (IDUs) vary, with considerable differences between regions. Trends of increasing HIV prevalence among men who have sex with men (MSM) are generating concern, with estimates from the 2008–2009 National HIV Sentinel Surveillance at 7.3 percent in New Delhi, up from 6.4 percent in 2006. Particularly high HIV prevalence among MSM has been reported in parts of southern India (between 7 and 18 percent) and in rural areas of Tamil Nadu state (9 percent). (UNAIDS/India, 2010).
Table – 1.2: India and State-wise HIV Statistics 2010

<table>
<thead>
<tr>
<th>State</th>
<th>Estimated Adult HIV Prevalence</th>
<th>Male (%)</th>
<th>Female (%)</th>
<th>Female sex workers (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andaman &amp; Nicobar Islands</td>
<td>0.29</td>
<td>0.15</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>1.07</td>
<td>0.73</td>
<td>9.74</td>
<td>-</td>
</tr>
<tr>
<td>Arunachal Pradesh</td>
<td>0.2</td>
<td>0.12</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Assam</td>
<td>0.1</td>
<td>0.06</td>
<td>0.44</td>
<td>-</td>
</tr>
<tr>
<td>Bihar</td>
<td>0.26</td>
<td>0.17</td>
<td>3.40</td>
<td>-</td>
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<tr>
<td>Chandigarh</td>
<td>0.46</td>
<td>0.29</td>
<td>0.40</td>
<td>-</td>
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<tr>
<td>Chhattisgarh</td>
<td>0.34</td>
<td>0.22</td>
<td>1.43</td>
<td>-</td>
</tr>
<tr>
<td>Dadra Nagar Haveli</td>
<td>0.17</td>
<td>0.12</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Daman &amp; Diu</td>
<td>0.18</td>
<td>0.13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Delhi</td>
<td>0.35</td>
<td>0.23</td>
<td>3.15</td>
<td>-</td>
</tr>
<tr>
<td>Goa</td>
<td>0.58</td>
<td>0.4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gujarat</td>
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<td>0.3</td>
<td>6.53</td>
<td>-</td>
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<tr>
<td>Haryana</td>
<td>0.17</td>
<td>0.07</td>
<td>0.91</td>
<td>-</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>0.23</td>
<td>0.16</td>
<td>0.87</td>
<td>-</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>0.09</td>
<td>0.06</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Jharkhand</td>
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<td>0.1</td>
<td>1.09</td>
<td>-</td>
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<tr>
<td>Karnataka</td>
<td>0.75</td>
<td>0.51</td>
<td>5.30</td>
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<td>Kerala</td>
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<td>Maharashtra</td>
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<td>Manipur</td>
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<td>0.9</td>
<td>13.07</td>
<td>-</td>
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<td>Meghalaya</td>
<td>0.1</td>
<td>0.07</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
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**INDIA**                         | **0.36**                       | **0.25** |            |                        |

Source: http://pib.nic.in/newsite/PrintRelease.aspx?relid=67292
The Joint United Nations Program on HIV/AIDS (UNAIDS) 2010 report sexual intercourse is the primary mode of HIV transmission in India, accounting for about 90 percent of new HIV infections. More than 90 percent of infected women acquired the virus from their husbands or intimate partners. In most cases, women are at an increased risk not due to their own sexual behavior, but because their partner is an IDU or also has FSWs or MSM as other sex partners. Injecting drug use is the main mode of transmission in the northeastern states, although sexual transmission is increasing. Prevalence rates among IDUs are on the rise in many states, with new regions, such as southern India, also showing upward trends in this group (USAID/India, 2010).

There are various interventions to prevent the HIV/AIDS. Choosing the right mix of interventions is very important in a setting with limited resources and implementation capacity. The researcher had experience in crisis intervention and solving problems from the working experience with people living with HIV/AIDS (Johns Hopkins, 2009). However, it is not clear that which intervention can yield the results they are supposed to yield, especially in the National AIDS Control Organisation work with all the states including Andhra Pradesh State AIDS Control Society, of A.P maintained that there were no statistics or feedback regarding the effect of these intervention programmes on knowledge, attitudes, and behaviour related to HIV/AIDS issues. An appropriate balance among prevention, treatment, care and mitigation should be based on specific epidemiology of HIV/AIDS, including these who are at risk, cost-effectiveness of intervention programmes,
implementation capacity, level of public resources available and extent to which intervention is a "public good".

In all cases, the most important interventions are: behavior change promotion, condoms, STI management, blood safety, VCT, and harm minimization among IDUs. Care, treatment, support and MTCT prevention will have least impact in countries of low prevalence (less than 5% in any high-risk group), be more relevant where the epidemic is concentrated (prevalence over 5% in a high-risk group, but less than 1% in the general population) and become increasingly important in countries with generalized epidemic (population prevalence over 1%) (World Bank, 2010).

1.6 Situation of HIV/AIDS in Andhra Pradesh

While Andhra Pradesh still tops with maximum number of people living with HIV in India, the latest data released by National Aids Control Organisation (NACO) shows HIV dominance in the state has dipped from 0.90% in 2009 to 0.75% in 2011. The National AIDS Control Organisation (NACO), established in 1992, is a division of India's Ministry of Health and Family Welfare that provides leadership to HIV/AIDS control programme in India through 35 HIV/AIDS Prevention and Control Societies, and is "the nodal organisation for formulation of policy and implementation of programs for prevention and control of HIV/AIDS in India" (Nirmala George (2006).

Based on Sentinel Surveillance data, it is estimated by National AIDS Control Organization that (up to April 2010) so far over 4, 50,000 infections are reported in Andhra Pradesh. From 23,905 infections reported during 2009,
the number of new infections dipped to 16,603 during 2011, which is a rare good sign, but overall the case load was still highest with 3.61 lakh to 4.88 lakh cases. Female sex workers are quite high in the State. Coastal districts like Krishna, East and West Godavari, and Guntur registered strong presence of female sex workers and commercial sex trade is quite high in State. Presence of large number of bridge groups (Migrant laborers, Truckers, Construction workers and Street children) are noticed in all these districts and tobacco grading women workers in Prakasam and Guntur. Factors underlying for vulnerability of HIV/AIDS in Andhra Pradesh are high prevalence of paid sex, trafficking of girls and women, vast network of national high ways (4472 km) passing through the state and wide road net work (179980 km) proportionately more number of non-regular sex partners, high incidence of sexually transmitted diseases both among men and women, proportionately lower rates of consistent condom use and high proportion of migrant population.

Finding the status of HIV/AIDS in Andhra Pradesh, involves the government, and nongovernmental organisations (NGOs) particularly established for the people who are living with HIV/AIDS (PLWHAs). NGOs, which are working for controlling of HIV/AIDS have focused on tackling HIV/AIDS infected people, especially women sex workers, from all fronts; social, economic, cultural and medical. Creating network groups and linkages (social capital) takes precedence in NGO approaches to mitigate HIV/AIDS challenges among sex workers in Andhra Pradesh.
1.7 Non-governmental Organization (NGO)

In its most general usage, civil society refers to all voluntarily constituted social relations, institutions, and organisations that are not reducible to the administrative grasp of the state. NGOs are organisations within the civil society that work on the “not-for-profit” approach in the space which exists between the family (household), market and state. It is made up of several types of formal voluntary organisations, where people based on community, neighborhood, workplace and other connections form their association to participate in actions for their own collective interests or for larger social good. Those NGOs which are working at the global arena, across several countries are termed as international NGOs.

The number of NGOs operating in the United States is estimated at 1.5 million and in Russia the number of NGOs at present are around 277,000 (Chicago Tribune, 2010). Whereas, in India the estimated NGOs performing their activities are around 3.3 million in 2010, just over one NGO per 400 Indians, and many times the number of primary schools and primary health centres in India (The Indian Express, July 7, 2010).

NGOs are difficult to define and classify, and the term 'NGO' is not used consistently. As a result, there are many different classifications in use. The most common use a framework that includes orientation and level of operation. An NGO’s orientation refers to the type of activities it takes on. These activities might include human rights, environmental, or development work. An NGO's level of operation indicates the scale at which an organization
works, such as local, international or national. One of the earliest mentions of
the acronym "NGO" was in 1945, when the UN was created. The UN, which is
an inter-governmental organization, made it possible for certain approved
specialized international non-state agencies - or non-governmental
organizations - to be awarded observer status at its assemblies and some of
its meetings. Later the term became used more widely. Today, according to
the UN, any kind of private organization that is independent from government
control can be termed an "NGO", provided it is not-profit, non-criminal and not
simply an opposition political party.

Professor Peter Willetts, from the University of London, argues the
definition of NGOs can be interpreted differently by various organizations and
depending on a situation’s context. He defines an NGO as ‘an independent
voluntary association of people acting together on a continuous basis for
some common purpose other than achieving government office, making
money or illegal activities’ (Willetts, Peter, 2012). In this view, two main types
of NGOs are recognized according to the activities they pursue: operational
NGOs that deliver services and campaigning NGOs. Although Willetts
proposes the operational and campaigning NGOs as a tool to differentiate the
main activities of these organizations, he also explains that a single NGO may
often be engaged in both activities. Many NGOs also see them as mutually
reinforcing. Professor Akira Iriye defines NGO as ‘a voluntary non-state, non-
profit, non-religious, and non-military association’ (Iriye, Akira (2009).

NGOs are organizations that work in many different fields, but the term
is generally associated with those seeking social transformation and
improvements in quality of life. Development NGOs are the most highly visible sector, and includes both international and local organizations, as well as those working in humanitarian emergency sector. Many are associated with international aid and voluntary donation, but there are also NGOs that choose not to take funds from donors and try to generate funding in other ways, such as selling handicrafts or charging for services.

1.7.1 The Role of NGOs

Government support and encouragement for NGOs continued in the last few Five-year plans, where a nation-wide network of NGOs was sought to be created. The 11th Five-year plan proposed that NGOs should play a role in development activities in public and private sectors. Also, the social development policies of the government and its implementation mechanisms provide scope and space for NGOs. A case in point is the implementation of control and prevention of HIV/AIDS among the development program, which has led to the growth of NGOs working for development and rehabilitation of women sex workers. This has also been acknowledged in the 12th Five-year Plan Document.

Such proactive state support to NGOs has also brought in the element of reporting and regulations. This is being done through a series of legislative and administrative measures, which are often considered by NGO workers as affecting the performance and efficiency of NGOs. However, the Constitutional provision for right to association ensures that the NGOs enjoy adequate autonomy in terms of their management and governance. In the
words of Prof. Amartya Sen, the relationship between the state and NGOs is one of “cooperative conflict”.

With the increasing role of the NGOs in development activities they are now attracting all sections of people from various communities, and capacities are being built in support areas such as health sector, political sector, social sector to create awareness, motivation, leadership development, governance procedures and practices and institutional development.

1.8 Significance of the Study

From the academic point of view the researcher seeks to examine the demographic characteristics of women sex workers, the influenced factors which put them in this profession and the problems faced by these people. The role of NGOs in prevention of HIV/AIDS spreading through the people especially women sex workers who are professionally participating sexual intercourse with the clients at different levels. It has found that both NGOs and the Government take advantage of each other’s weaknesses and strengths. The Government does not emphasise implementation due to that NGOs constitute a strong group of actors in this field. Still, in formulating HIV/AIDS sensitive policies the Government is active and the Indian political commitment in relation to HIV/AIDS is unique in a Third World perspective. Therefore, NGOs tend to neglect the National Strategic Plan on HIV/AIDS and work after their own agendas. Further NGOs need to improve coordination among themselves and in relation to the Government. There are differences between international NGOs and local NGOs in the sense that international
NGOs have better human resources and more funding but local NGOs have better contextual understanding.

As a well established democracy, the Indian Government has taken number of policies and action of plans to control HIV/AIGS. Still lack of proper implementation to handle the HIV/AIDS epidemic on its own, hundreds of NGOs are working in different areas stretching from humanitarian relief to governmental capacity building. About 100 NGOs work in the health sector and almost all of these are active in HIV/AIDS problematics in some sense (Interviewee). In a context as the East Godavari district in Andhra Pradesh, it becomes important to concentrate on both selected measures and attacking structural conditions that affect and worsen the HIV/AIDS situation. Argues from the previous studies and the history of the district noticed that in some areas and villages connected with National Highways still the prostitution activities are continuing by the women sex workers. It seems like the HIV/AIDS situation in this area (East Godavari) is a certain issue concerning a certain group of people at a certain time.

With an estimated 4.24 to 5.96 lakh HIV positive people, Andhra Pradesh accounts for the highest number of People Living with HIV/Aids (PLHAs) across states in the country. Revealing these grim statistics on the eve of World Aids Day, observed on December 1, experts on Friday rued how the HIV epidemic continues to be a major public health challenge in the state. Within the state, Kadapa stands in the top position owing to the widespread HIV prevalence among pregnant women and is closely followed by East
This is a study about what extent the women sex workers performing their activities in East Godavari district and facing a dangerous threat as the HIV/AIDS epidemic. Further, it is a study about to what extent the active and strong participation of NGOs in prevention of HIV/AIDS among the women sex workers and what are the necessary steps taken for create awareness among these people and took action for their rehabilitation.

Therefore, there is need of prevention of HIV/AIDS among women sex workers in the study area to increase their knowledge and motivate them change present unsafe behavioural practices and reduce their vulnerability care facilities for STI infections to build an enabling environment and advocacy among the important influencers in their lives. The study is also carried out in Andhra Pradesh specifically in East Godavari district due to long spread of National Highway from one corner to the other, functions celebrate in remote villages, and particularly some towns and villages. Still the women sex workers are performing their activities.

The present study is an attempt to draw better understanding of the implications and experience of literature of the experience from intervention Therapy and the new experiential psychotherapies clearly indicates that exposure to another person's deep emotional material tends to shatter psychological defenses and to activate corresponding areas in the unconscious of the persons assisting and witnessing the process, unless they have confronted and worked through these levels in themselves. Since
traditional psychotherapies are limited to work on biographical material, even a professional with full training in analysis is inadequately prepared to deal with powerful experiences of a prenatal and transpersonal nature. The prevailing tendency to put all such experiences into the category of schizophrenia and suppress them in every way reflects not only a lack of understanding, but also a convenient self-defence against the helpers' own unconscious material. Since the study is a part of expanding learning process, the area covered in the study is adequate enough to understand the current conditions of the sample respondents and based on limited sample size too, which forms a major limitation of the study taken from 347 women sex workers.

1.9 Designing of the Study

The study consists with five chapters, where Chapter-1 is introduction and it deals with discusses about theoretical background of HIV/AIDS, causes and remedies were discussed. In this chapter the present situation of HIV/AIDS in the world, in India and in Andhra Pradesh was discussed. The conceptual definition of NGOs, the role of NGOs in preventing HIV/AIDS and the significance of the study was discussed in this chapter. In the Chapter-II the literature review has been discussed where the related studies pertaining to the current study have been analysed and presented. The research methodology of the study has been presented in the Chapter-III. In this chapter the study setting, the need for the study, statement of the problem, objectives, hypothesis, conceptual definitions, tool, method of data collection, sampling, area of the study, statistical treatment and limitations of the study
along with profile of study area have been presented. The Chapter-IV is ‘Data analysis and interpretation’. In this chapter the collected data from the sample respondents has presented in the form of tables, and the analysis and discussion on the tables followed under each table and graphs were drawn wherever necessary. The testing of hypotheses also presented in this chapter in the form of tables, and the results are also discussed with the help of coefficients derived by the statistical tests. The last chapter is ‘summary conclusion and suggestions’. It contains the summary of this study, how the hypotheses lead to the conclusion, some recommendation derived from the findings, and statistical analysis. The chapter also suggests on future studies that can broaden this research, and it also gives the limitations that may have hampered this study.