CONCLUSION

Policy is major concern to remove any problem faced by any government. In the case of HIV/AIDS its not only problem of any nation but it but it become a global epidemic. So many international agencies like UNAIDS, WHO, UNICEF etc worked at international level. Every nation make national policy to stop prevalence of HIV/AIDS at different level. In over research to analysis the introduction of the problem causes of problem of HIV/AIDS, pattern of transmissions in India and South Africa and Its impact on different aspects of society like as political, social, economic, defenses and all over society as whole. India and South Africa hard hit country in the world so try to evaluate relationship of these nations to fight this problem. South Africa have highest rate of HIV prevalence so they have advance technology to increase awareness about the HIV/AIDS. In this chapter give about conclusion about the research step by step

India is one of the largest and most populated countries in the world, with over one billion inhabitants. Of this number, it's estimated that around 2.3 million people are currently living with HIV. HIV emerged later in India than it did in many other countries. At the beginning of 1986, despite over 20,000 reported AIDS cases worldwide, India had no reported cases of HIV or AIDS. Its activities covered surveillance, blood screening, and health education. By the end of 1987, out of 52,907 who had been tested, around 135 people were found to be HIV positive and 14 had AIDS.

To oversee the formulation of policies, prevention work and control programmes relating to HIV and AIDS. In the same year, the government launched a Strategic Plan for HIV prevention. This plan established the administrative and technical basis for programme management and also set up State AIDS bodies in 25 states and 7 union territories. It was able to make a number of important improvements in HIV prevention such as improving blood safety. In 2006 UNAIDS estimated that there were 5.6 million people
living with HIV in India, which indicated that there were more people with HIV in India than in any other country in the world. In 2007, following the first survey of HIV among the general population, UNAIDS and NACO agreed on a new estimate – between 2 million and 3.1 million people living with HIV.

Goa, a popular tourist destination, is a very small state in the southwest of India (population 1.4 million). In 2007 HIV prevalence among antenatal and STD clinic attendees was 0.18% and 5.6% respectively with HIV has declined from 2.73 million in 2002 to 2.31 million 2007.

Karnataka's "devadasi belt". Devadasi women are a group of women who have historically been dedicated to the service of gods. These days, this has evolved into sanctioned prostitution, and as a result many women from this part of the country are supplied to the sex trade in big cities such as Mumbai. The average HIV prevalence among female sex workers in Karnataka was just over 5% in 2007, and 17.6% of men who have sex with men were found to be infected.

The capital city of Maharashtra - Mumbai (Bombay) - is the most populous city in India, with around 14 million inhabitants. The HIV prevalence at antenatal clinics in Maharashtra was 0.5% in 2007. At 18%, the state has the highest reported rates of HIV prevalence among female sex workers. Similarly high rates were found among injecting drug users (24%) and men who have sex with men (12%)

Manipur borders Myanmar (Burma), one of the world's largest producers of illicit opium. In the early 1980s drug use became popular in northeast India and it wasn't long before HIV was reported among injecting drug users in the region. Although NACO report a state-wise HIV prevalence of 17.9% among IDUs, studies from different areas of the state find prevalence to be as high as 32%.
According to UNAIDS/WHO estimates 23.3 million people are currently living with HIV in Africa which is 70 per cent of the global total over the past year. The continent has lost 2 million people to the disease and some 20 per cent of new infections globally took place in the six countries as per the estimates 25 per cent of today’s practicing doctors by the year 2005.

The epidemic has become one of the most serious challenges face by the country since independence. Ever since the first case was reported in 1986 in Chennai (Tamil Nadu), HIV has spread rapidly from urban to rural areas and from high risk groups to the general population. In India, government has been conducting nationwide sentinel surveillance to assess the spread since 1998. The sentinel sites cover both vulnerable population (Commercial sex workers, MSM, IDU and STD clinics) as well as low risk population such as women attending antenatal clinics. The surveillance data is collected from public sites. The numbers of these sites are regularly increased. These have gone up from 184 in 1998 to 455 in 2003.

UNAIDS estimated there were 5.7 million Indians infected at the end of 2005 against 5.5 million in South Africa. NACO disputed the figure saying there were 5.2 million cases. The explanation by NACO for the difference is that UNAIDS used different methodology and assumptions which changed the population base to entire population cradle to grave.

Two fundamental problems which research in South Africa shares with international efforts are the very limited scope of the research, and the variability of the resulting estimates. With one very limited exception, all direct cost estimates have concentrated exclusively on medical care costs, omitting all other direct costs. These cost estimates have covered only the costs of hospitalisation and, in some cases, the costs of AZT, but have excluded all other direct medical care costs. In addition, all estimates have been limited to the AIDS phase, with no attempt being made at estimating the costs of asymptomatic HIV infection, or of HIV-associated TB. There has also
been no attempt to distinguish between public and private sector utilization of resources, or to model differential use of public sector resources such as economically imposed limits on hospital admissions, or the development of community care arrangements.

HIV / AIDS continue to spread in all regions of the world but at very different rates. The situation' is most dramatic in sub-Saharan Africa, where the highest HIV prevalence rates are found and the number of AIDS cases will continue to rise in the next 5-10 years. An estimated 55% of infected adults in sub-Saharan Africa are women. Meanwhile, the introduction of effective therapies has reduced dramatically the progression to AIDS and death in industrialized countries. In India, government has been conducting nationwide sentinel surveillance to assess the spread since 1998.

In the latter half of the 19th century, the discovery of diamonds and then of gold led to a rapidly growing demand for black mineworkers. During the 19th century, southern African mining industries had a legally enforced migratory black labor system under which many African men were separated from their homes.

Human rights abuses-including those perpetrated within the health sector were common. The apartheid government routinely used violence to exert power. A study conducted by South Africa's Medical Research Council and the London School of Hygiene and Tropical Medicine found that violence remains common in daily life in South Africa and that beating is perceived as normal way of exacting punishment and exerting control.

A recent study in the mining town of Carletonville found an everyday environment characterized by "chaos and danger," as well as high levels of alcohol consumption, poverty, and gang conflict. KwaZulu-Natal has been particularly affected by violence and political conflict between African National Congress and Inkatha Freedom Party supporters, which may play some role in the province's high HIV prevalence. Violence in schools has long
been and continues to remain prevalent. Sixty-five per cent of young South Africans indicate that they are worried about their personal safety and cite crime, violence, and abuse as major concerns.

According to UN estimates for the year 2000, almost 4.2 million of 43 million South Africans were infected with HIV, the largest number of cases of HIV in any country in the world. Although, it is compared to other African countries, best prepared in economic and political terms to cope, it has proven among the least capable of overcoming economic inequality, bitter distrust and social barrier that fund the pandemic. South Africa has the fastest growing HIV/AIDS epidemic in the world. The HIV/AIDS epidemic began to spread in late 80's. The 1990 saw an explosion in HIV prevalence which was estimated at 19.9% at the end of 1999. South Africa's peculiar history has made it fertile ground for the spread of HIV.

In countries heavily affected by HIV, the epidemic affects governance and public service in three main ways: The country loses hard-to-replace political leaders and civil servants; revenues decline and costs rise; and demand for social services increases. Taken together, these factors exert significant pressure on the governments of less developed countries. At the highest levels, AIDS is taking the lives of national leaders—including ministers, parliamentarians, and cabinet members—although most of these are not classified as AIDS deaths because the families fear stigmatization. Nations are losing their leaders and their years of political experience, undermining future national stability and security.

HIV/AIDS has its impact at all levels of society, individuals, household and community as well as the country. In the hardest hit countries, it is erasing decades of health, economic and social progress, reducing life expectancy, slowing economic growth. In some Southern African countries, there are studies which show modest micro economic impact, with some of these countries losing on average between 1-2% of their annual economic growth.
Although very few empirical studies are there on impact, but it gives enough evidence that the impact of HIV/AIDS is limited to micro-level on individuals and households in India. At that level, it is quite server in terms of loss of bread earners resulting in loss of income, low consumption on account of additional burden of medical expenditure, but we do not have evidence of micro-level impact as such evidence is possible with the help of primary surveys, and there are limitations to that. In India, it is clear that there are no macro level impacts yet and may not show for a while. We can say this looking at the performance of the economy in terms of economic growth and various other parameters like, productivity in terms agricultural production, life expectancy etc.

In case of India, as mentioned earlier, the impact of AIDS appears only at micro-level. Its data is hard to collect, but the trends of a household survey conducted jointly by National Council of Applied Research, NACO and UNDP suggest that at micro level HIV/AIDS places the households at increased economic and social risk and increase existing gender disparities. HIV households are likely to report loss of income, increased expenditure, lower savings and increased borrowing and liquidation of assets.

The impact to begin with may not appear to be as severe as witnessed in case of South Africa; we can learn lessons from them, from collective world experience and prepare ourselves to act in terms of arresting further spread of disease and mitigating the impact. This is very essential so that we do not end up undoing the achievements made in terms of development so far. The impact can be mitigated by spending resources on preventive measures, care and support programmed and treatment facilities.

AIDS was initially believed to be primarily an urban phenomenon, but it now clearly threatens the lives and livelihoods of rural communities throughout the less developed world. AIDS-related deaths among farm
workers threaten agricultural production and food security, most notably in sub-Saharan Africa where a large segment of society relies on agriculture. The Food and Agriculture Organization (FAO) estimates that 7 million agricultural workers died of AIDS between 1985 and 2000 in the 25 hardest-hit countries in sub-Saharan Africa. FAO projects that 16 million more agricultural workers could die because of AIDS by 2020. The loss of agricultural laborers in southern Africa will cause an estimated 3 per cent loss in grain output.

HIV/AIDS infected individuals and their families, have reduced their agricultural work because

1. Less number of hours put in the work due to illness.
2. Sale of key productive assets like land, tools, cattle
3. Less resources available for tending of land, irrigation better implements
4. Switching to subsistence crops and avoiding high valued crops.

In case of South Africa the negative impact on agriculture could lead to erosion in Gross Domestic product and foreign exchange earnings. The UN Food and Agriculture Organization estimates that AIDS will claim 1/5th or more of agricultural workers in South Africa by 2020.

Twenty five million people have so far died of AIDS and 40 million are people living with AIDS in the world and the number of deaths are certain to rise. At its current level AIDS is the 4th largest cause of mortality. In Africa, it accounted for nearly one fifth of all deaths, making it the leading cause of mortality on that continent. In other areas, the epidemic is rising and yet to acquire such proportions, if not checked.

In India, the impact of HIV/AIDS is not very visible due to the low prevalence rate and large population size. The above mentioned study suggests that long term impact of HIV/AIDS is likely to be severe on the GDP
and livelihoods of people, particularly the poor if current trends are not checked.

This study was done for the first time on such a large scale in India; based on a sample size of almost 8000 households (2,068 HIV HHs) covering 2,385 people living with HIV/AIDS and 6,224 non-HIV Households as a control group spread over the rural and urban areas of the six HIV high prevalence states. The no. of female and male respondents was 1043 and 1342 respectively. The purpose of taking non-HIV household was simply to make comparison with HIV HHs. The observations on the impact are briefly discussed here.

The strategy for awareness generation among the general population is operationalized at two levels. At the national level, NACO is responsible for policy and strategy formulation and for framing guidelines for IEC activities. Advocacy with the elected representatives and with the media, inclusive of the regional media and the vernacular press receives special focus at the national level. At the state level, the state AIDS control societies conduct Communication Needs Assessment Studies.

In order to enhance the awareness levels among the general population, especially in rural areas, Government has decided to use the medium of TV in a more intensive and interactive manner. A television talk show titled “Khamosi Kyon” was launched on the 03rd December 2001 by Hon’ble Union Minister for Health & FW.

Initially the partnership covered only three states i.e. Rajasthan, Delhi and Uttar Pradesh. The second phase of the partnership saw the coverage increase to include South Indian States and most of North and East India. NACO sponsored a health magazine Kalyani which is telecast in the Hindi speaking states of UP, MP, Chattisgarh, Bihar, Jharkhand, Assam, Orissa and Rajasthan.
The segments on HIV/AIDS focus on rural populations and are produced at the state level DoorDarshan Kendras so as to reflect local priorities, predilection and content. The HIV/AIDS chapter in the Kalyani programme is telecast during the months of December and January, in a magazine format that includes field interviews, success stories, panel discussions, quiz competitions, contests etc.

NACO is using the popular FM channel to combine entertainment and education in reaching out to the urban youth. The one hour programme which is titled "NACO Film Hit Parade" is broadcast for one hour every week on the AIR-FM channel in Delhi. The programme has received a wide and positive response from a number of people who respond on the telephone numbers given seeking medical advice and counseling.

All India Radio broadcasts NACO sponsored programmes, every week. During 2003-4, the erstwhile programme Jiyo aur Jine Do, which was being broadcast on 30 commercial broadcasting stations of AIR in 12 languages since June 1998, was revamped and relaunched on the Primary Channel and Vividh Bharati stations of AIR and re-titled "Jeevan Hai Anmol". Another programme called "Lets Talk" was launched on FM Delhi. While the FM programme is directed towards the urban audience, "Jeevan Hai Anmol" is addressed to a mass audience. The state AIDS control societies are roped in to provide field level inputs and to highlight issues of significance relating to HIV/AIDS. These are then woven into these radio programmes. A series of spots have also been produced, which are broadcast on the occasion of events like Voluntary Blood Donation Day (1st October), World AIDS Day (1st December), at appropriate times.

A toll free National AIDS Telephone Helpline has been set up to provide access to information and counseling on HIV/AIDS related issues. This is a computerized four digit number, 1097, with a voice response system linked with the telephonic hotline. This is a very popular service, since it
maintains the confidentiality of the callers and helps the caller clarify doubts and access personal counseling without revealing their identity. The Telephone Helpline has been extended to 35 cities/towns all over the country.

During 2003-04, NACO hired some hoarding space along prime roads of Delhi, and at prominent road junctions to disseminate messaging on the four known routes of transmission, and on the "Live and Let Live" campaign for the World AIDS Day, 2003. In another unique initiative during 2004, NACO has disseminated key messaging on HIV/AIDS inside two Delhi Metro trains. The messages have been put up on 54 panels of size 50X 21 cms in each of two trains running from Shahdara to Rithala of the Delhi Metro. The total duration of the campaign is six months.

This is extensively used for dissemination of messaging at the grassroots to complement and supplement other forms of IEC, mostly through the Song and Drama Division, Ministry of Information & Broadcasting. This Division of the Ministry of I&B has been thoroughly sensitized by NACO, to address issues surrounding HIV/AIDS. This is a crucial channel of communication, widely relied upon by the AIDS control societies.

The University Talk AIDS Project began in October 1991 and is a collaborative partnership between the National Service Scheme (NSS), Dept. of Youth Affairs & Sports and NACO. The project involves creating awareness among students and the youth on issues related to HIV/AIDS through workshops, seminars and written materials especially designed for them.

Experience to date suggests that educational media can be applied to achieve better health outcomes and is being used in many developing countries and communities to facilitate remote consultation, diagnosis and treatment.

Many European countries developed substantial public education program, making heavy use of mass media, to address the HIV/AIDS epidemic during the1980s and early 1990s. Harvey e t al. (2000) reported that students
viewing the Drama program displayed improvements in knowledge and attitudes about HIV and AIDS compared to those receiving written information only. Bull (2001) observed that internet may facilitate health promotion among men who have sex with men and may not be reached in publicly funded STD prevention setting.

Health related internet use was associated with HIV disease knowledge, active coping, information seeking, and social support among persons who were using the internet. Similarly a report published in Plosmedicine (an open access journal, 2006), advocated that Internet may be a promising strategy to deliver low-cost HIV/AIDS risk reduction interventions in resource limited settings with expanding Internet access.

These observations clearly suggest possibilities of using the educational media for HIV/AIDS related information and health benefits among people. Before suggesting strategies to use educational media for HIV/AIDS prevention it is necessary to understand the reach and potential of key educational media in India. The National Readership Study 2006-20 states that Print, Radio, Television, Mobile telephony and Internet enabled computer are key media in India. Considering the severity of AIDS epidemic, it is high time to adopt innovative strategies to use all these media for imparting HIV/AIDS education and training to school students.

It is a well established fact educational actions on targeted group (in this case school students) are most effective when reinforced by complimentary educational provision aimed at other people who have an influence on the target group (in this case, their teachers and parents). Following this principle, a whole-community approach has been adopted and proposed strategies to use key educational media for HIV/AIDS education are targeted for school students and their parents/teachers.
The Press Information Bureau of the Government of India has organized a number of programmes to sensitize the regional press on the issue of HIV/AIDS. The IEC department of NACO has prepared several packages of materials aimed at various population groups, to be used by the outreach workers, health workers and peer educators working in government as well as non-government organizations. Some of the important packages are as follows:

The other print media developed for awareness were: posters, pamphlet and booklets on general information on HIV/AIDS/STDs, voluntary blood donation, timely treatment of STDs and developing a positive attitude towards those infected with HIV/AIDS.

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The gap between rich and poor countries seems to be widening owing to the lack of access to effective therapies and to means for preventing mother-to-child transmission. On the other hand, the success in reducing AIDS mortality and perinatal infections in the industrialized countries cannot mask the failure of preventive programmes in reducing the rate of new infections.

Surveillance of HIV infections and AIDS cases remains an essential tool to monitor the epidemic assess its impact and for planning effective interventions at national level. Collection and analysis of information at regional and global levels enables the close monitoring of the spread of HIV, the assessment of the burden of disease and advocacy for an intensified response to the epidemic.

Just as HIV infection is transcending the boundaries of the high-risk population and spreading into the general populace, prevention and care
programmes have also reached a critical phase. The Indian government is fully committed to preventing HIV/AIDS at the initial stage before it emerges as a catastrophic epidemic. It looks at HIV/AIDS prevention and control as a developmental issue with deep socioeconomic implications and not merely a public health issue.

It touches all sections of the population, both infected and affected, irrespective of their regional, economic or social status. By following a concerted policy, and an action plan that emerges out of it, the government hopes to control the epidemic and slow down its spread in the general population within the shortest possible time. The government hopes that all participating agencies in the governmental or non-governmental sectors, and international and bilateral agencies will adopt policies and programmes in conformity with this national policy in their effort to prevent and control HIV/AIDS in India.

Despite the uncertainties surrounding the spread of HIV infection and AIDS, nonetheless there are conclusions we can draw from these epidemiological trends. The very different approaches to modeling the AIDS epidemic in South Africa have resulted in substantially different projections. However, although these estimates appear to differ widely, they can mainly be grouped into two categories. The first, the 'doomsday' forecasts of economic collapse and large-scale labour shortages, are unlikely to materialize.

The second group converge to a consensus view that if we continue as at present, with no significant interventions being made to alter the course of the epidemic, there is no reason to suppose the impact in South Africa will be any less severe than in the worse-hit African countries. The effect could even be slightly worse. Population growth could level off, but it is unlikely that the population total will actually fall. The situation in South Africa is not hopeless but, makes no mistake; it is potentially very serious indeed; just as it is in other tropical African countries.
South Africa is fortunate in having such sophisticated modeling tools available for planning, which are matched by data of reasonably good quality. However, it would be irresponsible not to caution that all forecasts must be treated with circumspection and that the unpredictability of the AIDS virus as well as unforeseen events could prove these South African analyses wrong, in either direction.

South Africa is also extremely fortunate in being at an early stage in the spread of HIV infection and AIDS. Lessons can be learnt from elsewhere and interventions made which would convert these gloomy projections of the status quo into more optimistic predictions for what the future could hold. Options to reduce the spread of AIDS, and hence reduce pain and suffering, are available if society chooses to pursue them.

South Africa is a unique society, not least because of the disconnected existence of the First and Third Worlds within it, but also because of its diverse cultures, traditions and structural racial inequalities, AIDS will therefore have a unique impact. There is thus an urgent need to analyze the peculiarities of the South African situation and to devise strategies for preventing and controlling AIDS that are uniquely appropriate for its society. The energy and success with which such strategies are devised and pursued will determine the future South African trends and the resulting projections.

Despite nearly five million HIV-positive South Africans, by 2003 state responses to AIDS continued to be characterized by a gap between rhetoric and reality. The lost opportunities, the grandiose yet ineffective initiatives, and endless delays in policy implementation remained even as official statements of determination to fight AIDS intensified and allotted funds grew geometrically. To be fair, there were some promising efforts, notably in AIDS education.
Many African leaders are aware that maintenance of AIDS policies, especially treatment programs, is insecure, and that the tentative nature of AIDS Programs is an immediate problem. Throughout the continent, calls to develop sustainable programs are common within ministries of health. However, African state leaders and donors have often put off addressing the long-term viability of AIDS policies, arguing 'let's do as much as we can today and deal with tomorrow's problems when they come.'