
UNIT 9 SOCIAL WORK INTERVENTION FOR THE PREVENTION AND CONTROL OF HIV/AIDS IN THE INDIAN CONTEXT

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Two decades since its inception, the Acquired Immuno-deficiency Syndrome (AIDS) is well accepted to be one of the biggest challenges to the medical profession. No doubt that ongoing research has added to its understanding, but a cure is no where in sight. There have been some achievements, mostly in the use of combination drug therapies, but these have meant nothing more than better management of the, disease, and hence delaying the onset of the syndrome.

As is well known, AIDS is not a disease; it is a set of symptoms that result from the breakdown of the body's defense by the Human Immuno-deficiency Virus or the HIV. The Center for Disease Control (CDC, United States of America) defines AIDS in an adult or adolescent, aged 13 years or older, as the presence of one of 32 conditions indicative of severe immuno-suppression associated with HIV infection. In children younger than 13 years, the definition of AIDS is similar to that in adolescents and adults, except for one feature. The lymphoid interstitial pneumonitis and recurrent bacterial infections are included in the list of AIDS defining conditions (see NIAID Fact Sheet). AIDS marks the end stage of a continuous, progressive pathogenic process. In early stages, the virus enters the human body and silently encroaches the boundaries of the immune system. This period is also called the 'window' period. It is of as short a duration as two weeks and may extend up to two months. It then leads the body progressively to more severe symptoms, profound immuno-deficiency, opportunistic infections, cancers and eventually death.

What has made AIDS a pandemic of global concern? It is generally accepted that the AIDS virus is dynamic, unstable and volatile (Mann and others 1994). Further, it is an ailment that is selective in nature. It infects men and women in their most productive and reproductive years. The Virus that causes AIDS has been known to mutate and change its structure over time. Consequently, it is best recognized as a family of closely related viruses. It is this rapidly changing form of the virus that is making the chances of a cure for AIDS being discovered somewhat difficult. It amounts to stating the obvious that the health of individuals affects the health of entire society. Morbidity, mortality and life expectancy of individuals determine the size and quality of the work force that contributes to the growth and economic development of the country. What future can a country have where families are loosing their bread earners to this scourge?

The AIDS affected suffer in more ways than one. Coping with the shock of their HIV positive status, they suffer from rejection by their near and dear ones. Although the disease has been in existence for nearly twenty years, stigma and discrimination towards people suffering from HIV/AIDS continue in most societies. Goffmann (1998) mentions that HIV/AIDS creates physical stigma (fear of contagion), behavioral stigma (moralistic judgment on homosexual practices and injection drug use) and social stigma (discrimination). Discrimination can be against HIV-afflicted individuals; it can be against the entire family, groups whose one or more members are suffering; or it can be against the entire categories of people (for example, sex-workers, truck drivers, injection drug users, etc.). There are several reported cases of abandonment of the AIDS afflicted

by the spouse and mother. The case of 26 year old Mahesh lying abandoned in a hospital reported by the press bears testimony to this extreme form of discrimination (see Indian Express, December 30, 1999). In Meerut, community wide fear led to the abandonment of the family in which an AIDS afflicted father and daughter had died (Times of India, February 21, 2000). In Mumbai, a truck driver picked up the virus on account of his promiscuous behavior. He passed on the infection to his young wife before he succumbed to the infection. Although the lady was in the family way, she was refused institutional care. Reportedly, the lady lives on with her virus, but the child she gave birth to suffered from several opportunistic infections and died before attaining the age of two years (see Hindustan Times, July 18, 2000).

Not only is AIDS a demographic issue, it has developmental implications too. As a consequence of this ailment, a person may face reduced productivity and a loss of job. His employer may have to put up with work disruption and customer service delays. He may have to handle lowered employee morale, issues of confidentiality and discrimination. In some case, it may mean increased 'costs to the company by way of medical expenses'.

Apart from highlighting the need to upgrade health care service (esp. reproductive health and sexually transmitted disease clinics), the AIDS pandemic has brought forth the inequities that exist in society. With more and more people on anti-retroviral therapy in the developed countries, there is growing concern for those, who are unable to afford this treatment. In India, the division between the rich and the poor is still more manifest. It is estimated that only 2.8 percent of HIV patients can afford combination drug therapy (XII International Conference, 1998). The pandemic has aptly been termed as the medical tragedy of the later half of the twentieth century (World Development Report, (1993).

Almost every aspect of the Acquired Immuno-deficiency Syndrome- its diagnosis, prevention and treatment- has human right implications. Controversies begin right from the terminology used against certain categories of persons. Early in the history of the epidemic, the term AIDS victim was rejected by those whom it referred to. The US PWA Coalition at the Second AIDS forum in Denver, in 1983, declared, 'We condemn attempts to label us a victim who implies defeat, and we are only occasionally a patient, which implies passivity, helplessness and dependence upon the care of others. We are the people with AIDS' (Callen, M., 1987). It follows that the AIDS pandemic and issues of human rights are not entirely new.

In the present context, the human rights and HIV/AIDS linkage also emerges from the manner in which prevention programmes are implemented by the public health care system. Mandatory testing without consent, divulging a person's HIV status (principle of confidentiality), and isolation of AIDS patient are some examples where violations of human rights are occurring. In most cases, they go unreported.

In India, those discriminated against fear to attract the limelight. Were they to seek justice, they would have to reveal their HIV- positive status, leading to further discrimination. It is because of this that many persons having risk-behavior keep away from services for AIDS awareness and prevention. Undoubtedly, we need a non discriminating context and support system where people would be able to admit their infection and come forth with their grievances.

HIV/AIDS and the Indian Cultural Context: It goes without saying that risk behaviors do not occur in isolation. They are motivated and given shape by the soico-cultural contexts in which they occur. A major contextual risk factor is the prevalence of HIV itself in the local population which, in turn, influences the impact of risk behaviors.

Social norms define the behaviors of groups, such as the adolescents, youth and women. In most cultures, women occupy a position less than equal to that of men. Often, they are unable to insist on safe-sex practices with the sexual partner (National Institute of Health, 1997). In such societies, the effect of sexually transmitted diseases including HIV is even more debilitating on them. Given their disadvantaged position in conjunction with poverty, they are more often than not, powerless to seek medical care.

Two decades of planned interventions to combat the pandemic have put citizens, medicos, professional social workers and voluntary workers in the thick of hectic activity. Although some success has been achieved, the syndrome has left professionals and governments bewildered. As the epidemic is progressing into the third decade, it is emerging that success in HIV/AIDS prevention demands that interventions be integrated into the community context. Cultural references of any society then assume a pointed significance. In this regard, an understanding of different community groups with regard to traditions, religious beliefs, gender roles, conceptions of health and disease, use of home remedies, sexual norms and practices, is important.

Contextual factors influence behaviors, such as pre-marital and post-marital sex among the younger people. These then get reflected in indicators, such as age at marriage, age at first intercourse and age at first pregnancy. Needless to state, every society defines its own values and norms governing marriage and childbirth. Many tribal groups as also upper echelons of society are reportedly highly permissive in regard to social intermixing, often paving the way of promiscuity and, hence, the transmission of the virus.

Some contextual factors that have an influence on HIV transmissions are individual factors, such as age, sexual identity, self-esteem, untreated sexually transmitted diseases, use of alcohol and drugs, interpersonal factors, such as partner commitment and the practice of safe-sex. Study and identification of these factors that lead to infection, transmission and progression of the disease is important. The need for further research in this area, then, cannot be undermined.

In the Indian context, some cultural traditions seem to have a close linkage with the spread of HIV/AIDS. Males and females have different status in a patrilineal society. For example, the child rearing practices in India often deprive the girl child from attending school. This, followed by an early age at marriage in many parts of the country leads to lack of awareness and higher biological vulnerability, as she enters into woman hood. The woman is the passive partner in sex relationships and this has marked impact upon her sex negotiation skills and assertiveness with sexual partner. This apart, it is the woman who carries the burden of domestic chores. She has the least access to health-care and this problem is aggravated in the rural areas where there are fewer woman doctors. The rural women, then, shy away and resort to home-remedies or other traditional methods. On the other hand, the men are far better off. The stance towards male sexuality is a more permissible one, leading to their high-risk behavior. For example, early initiation into sex and having multiple sex partners is considered to be a part of maleness. Being free from domestic chores and, at times, more mobile in their occupations, such men have a greater likelihood of getting sexually transmitted diseases (STDs) and HIV. In addition, cultural restriction makes conversation on sexual matters taboo and this crosses all sections of society. Needless to state, it perpetuates ignorance and often leads to what could be preventable vulnerabilities.

The entire world of sexuality is shrouded in mystery and the young grow up with numerous misconceptions. Peers further fuel their ignorance on various aspects of sexuality. This, in turn, builds up the attitude of people towards those who suffer from STDs and HIV. Oftentimes, this suffering is considered to be their destiny or a consequence of their

past deeds or 'karma' (see also Mane and Maitra, 1992). Beliefs, such as 'evil eye' or black magic, also have an impact on health seeking behavior. Kakkar (2004) has looked into the health behavior of different population groups in Delhi. In a study among drug users and STD clinic attendees, she has shown that culturally conditioned beliefs and practices in Indian households largely influence the patterns of health-care seeking and treatment of disease. Oftentimes respondents have resorted to the use of home remedies for common ailments. It goes without saying that a complete understanding of the cultural constructs - beliefs and attitudes - is important for those who are going to work on HIV/AIDS prevention.

Review of Literature: It goes without saying that HIV/AIDS has, in recent years, generated considerable general and professional interest. Medical practitioners, social workers, psychologists, media persons and functionaries from voluntary organisations have addressed pertinent aspects of the problem. Consequently, a large number of studies have been conducted globally and a large body of knowledge has been built up. Mostly, the attempts have been to understand the epidemic in totality, covering various aspects, such as awareness and information on HIV/AIDS, attitude towards AIDS, and intervention programmes. Let us have a closer look at studies done on HIV/AIDS prevention, intervention strategies and programmes. Surely, findings of these would guide, the nature of interventions by professional social work.

A study conducted on the impact of AIDS in Delhi on 484 men in the age group of 19 to 39 years (Basu and others, 1997) show that a large proportion of these young men have heard of AIDS, yet their understanding of its modes of transmission is at best hazy. It is interesting to note that AIDS awareness is related with the economic status of the respondents, the better off the household, the more likely it is that the respondent has heard of AIDS. Also, more unmarried respondents are informed of HIV/AIDS than those who have entered wedlock. The gap between awareness and information is seen markedly in a study conducted among long-distance truck drivers and their helpers in West Bengal (Rao and others, 1994). Often truck drivers have a number of sexual partners, mainly commercial sex workers. Researchers report that homosexual relationship between the truck drivers and helpers is not uncommon. Rao and others (1994) further report that 39 of the 100 truckers had never heard of AIDS. Among those who knew about it, only 13 knew that it had no cure. Besides, among them, there was no dearth of misconceptions. Singh and Raju (1995) in a study on attitudes and beliefs about AIDS and sexuality among medical and paramedical staff of teaching hospital report of 99 per cent respondents giving the correct viral etiology of AIDS. However, misconceptions regarding HIV transmission prevailed among them and 75 per cent respondents feared contagion while attending patients. This inadequacy in HIV/AIDS knowledge among medicos is as notable, as it is disturbing.

Dental health professionals show good knowledge of HIV/AIDS (Nittayananta and Others, 1996). However, knowledge about oral manifestations associated with HIV infections is low. A large number (77 per cent) are willing to give dental treatment to HIV positive patients, but reveal that they lack confidence to treat oral lesions in them. In a study among sexually active adolescents (n-1379; mean age 13.2 years), Brown and others (1992) report that adolescents were less knowledgeable about HIV, less fearful of HIV, and less tolerant of people with AIDS and had a greater history of risk behavior than their abstinent peers. They suggest special efforts in education and counseling.

During the last two decades, all countries have introduced programmes on information and education on HIV/AIDS. These programmes have addressed several issues,

including discrimination and stigmatization, of the AIDS patient. It is well known that those infected are not only socially stigmatized, but they also suffer from identity crisis, low self-image, guilt and often face family disintegration (see Thomas, 1992). Kegeles and others (1989) have analyzed the social stigma attached to AIDS patients in the USA. They report that 20 per cent of the respondents drawn from the general population think of AIDS patients as offenders getting their due. A number of them (29 per cent) even favored tattooing them, indicating their being sero-positive.

Crawford and others (1991) in an attitudinal study of clinical psychologists and social workers report that those with no previous AIDS education were more likely to hold negative attitudes towards 'gays' and persons having AIDS. Similarly, studying 178 nurses and medical technology students, Tabet and others (1992) report that 81 per cent of them are fearful of HIV contagion. This kind of fear has a strong correlation with lack of knowledge. Even physicians have not been exempt of these kinds of distorted views (Kelly and others, 1987; Rickleffs 1988; Thomas, 1992). Bruce (1989) reports of hospitals indulging in discriminatory practices. Discrimination has also been reported against the AIDS infected at the workplace (see Harpaz, 1994). Given this range of myths and misconceptions associated with AIDS and AIDS-patients by informed persons and professionals, opinions and attitudes of general population towards them could easily be made out. Discrimination and stigmatization escalate the gravity of the problem. It marginalizes the AIDS afflicted, pushing them further away from the HIV prevention services. Do interventions help bring about a change in attitude?

Intervention strategies: The HIV epidemics are complex in all countries and still more complex in culturally diverse countries. Each population sub-group often has its own sub-epidemic. No doubt, strategic planning for AIDS prevention makes a demand for dependable information on individual and group behavior patterns. In western countries, behavioral sciences have attracted considerable research attention.

A study (Kalichman, 1998) conducted of African American women from an inner city US-community brings out independence effects of intervention component on behavioral outcomes. In the study, four groups of women were given different intervention components (1) Sexual communication skills training; (2) self-management skills training; (3) combination of sexual communication and self-management skills training and (4) HIV education and risk sensitization. Results of this study show that all the four interventions increased AIDS knowledge and intentions to reduce risk behaviors. Authors conclude that a combination of behavioral skills training and communication is most effective for reducing risk among vulnerable women. A study by Kalichman and others (1997) on inner city African-American men stressed that HIV risk reduction should not be assumed to fit all vulnerable populations. Along with negating the use of tailor-made interventions, he also emphasizes the need to re-design responses to the epidemic as fast as it changes. Many researches (see Case, 1992) have emphasized the importance of targeting intervention to the needs of specific population and also to the social and cultural context. This need to be further supported by health and social service infrastructure where, if motivated by a prevention program, an individual can seek help and thereby take action.

Intervention Programmes: For intervention programmes to be effective, it is important that groups are studied, which would be subsequently exposed to these infections. In a cross-sectional survey of 888 heterosexual clients seeking treatment at public alcohol treatment centers, Avin, and others (1994) report that there is substantial prevalence of HIV infection among heterosexual clients, much of which is not associated with injection drug use. As many as 54 per cent of respondents admit having multiple sexual partners

and almost all of them admit not using condoms. Woods and others (1996) have studied the effect of alcohol and non-injection drug use on high-risk sexual behavior. Different interventions aim at drug use reduction or at least reduce the use of non-sterilized needles. In an evaluation study of AIDS education programme, Mc.Cusker and others (1992) report substantial reduction in drug and sex-related risk behaviors among 567 adult drug users. These interventions have drawn upon concepts from behavioral sciences and placed emphasis on experiential learning techniques to enhance participant's self-efficacy. Planned interventions have also shown increased risk reduction behavior related to needle use and condom use (see Siegal and others, 1995).

El-Bassel and Schilling (1992) have shown success in promoting use of condoms among 84 female methadone patients through small group interventions. AIDS knowledge, sexual negotiation skills, safe-sex practices were areas covered in these interventions. Needless to state, a better understanding of sexual behavior and health-seeking behavior among drug users lies at the base of AIDS prevention programmes (see Mulleady, 1992).

In programmes of HIV prevention, there is invariably a component dealing with STD prevention. This involves imparting information on HIV/AIDS, and counseling, especially on safe-sex. A large number of interventions report a change occurring among STD patients after they have participated in prevention programmes. Reportedly, there has been an increase in condom use and a decrease in risk behaviors. This is what is brought out in a study on 186 heterosexual adults (18-66 years) undergoing treatment in an urban STD Clinic in Los Angeles (Wenger and others, 1991). A school based education program has shown a reduction in the number of sexual partners and greater frequency of condom use among school going adolescents (Main, 1994). Consistent condom use with reduced number of sexual partners is the reported outcome of a sexual risk-reduction intervention programme among young African American women (Diclemente, 1995).

Though, not very many, a few risk-reduction interventions are also reported from India. A programme of intervention reducing risk behavior in relation to HIV/AIDS has been conducted among street children through peer education, empowerment and support services (George, 1999). She reports that during a period of twelve months, 1,338 street children have benefited from the mobile medical programme run by a voluntary organisation. A large number of children were given to drug abuse and homosexuality. Many of them suffer from psycho-sexual disorders. A substantial number of children suffer from one form of STDs or the other. What is more disquieting, of the 25 children tested for HIV, one tested positive.

Studies in the Indian social context bring out that intervention programmes are quite effective. Gangakhedar and others (1995) have studied the impact of HIV counseling on patients attending STD clinic in Pune. Counseling and level of knowledge about AIDS are reported to be associated with risk-reduction. Perception of seriousness of threat and behavior change is aroused mainly on account of suffering from STDs. In a study with drug users in Calcutta, Chattopadhyaya and others (1995) have shown that a sizeable number of them had no knowledge of HIV/AIDS. Of these, who knew about it, 23.3 per cent were misinformed. Nearly 75 per cent reported sharing of injection equipment and felt that this was 'dangerous' and 'infecting their blood'. Kakkar (2004) has shown that although drug users (85 per cent) and STD patients (92.9 per cent) are aware of HIV/AIDS, there prevail among them many misconceptions on its mode of transmission.

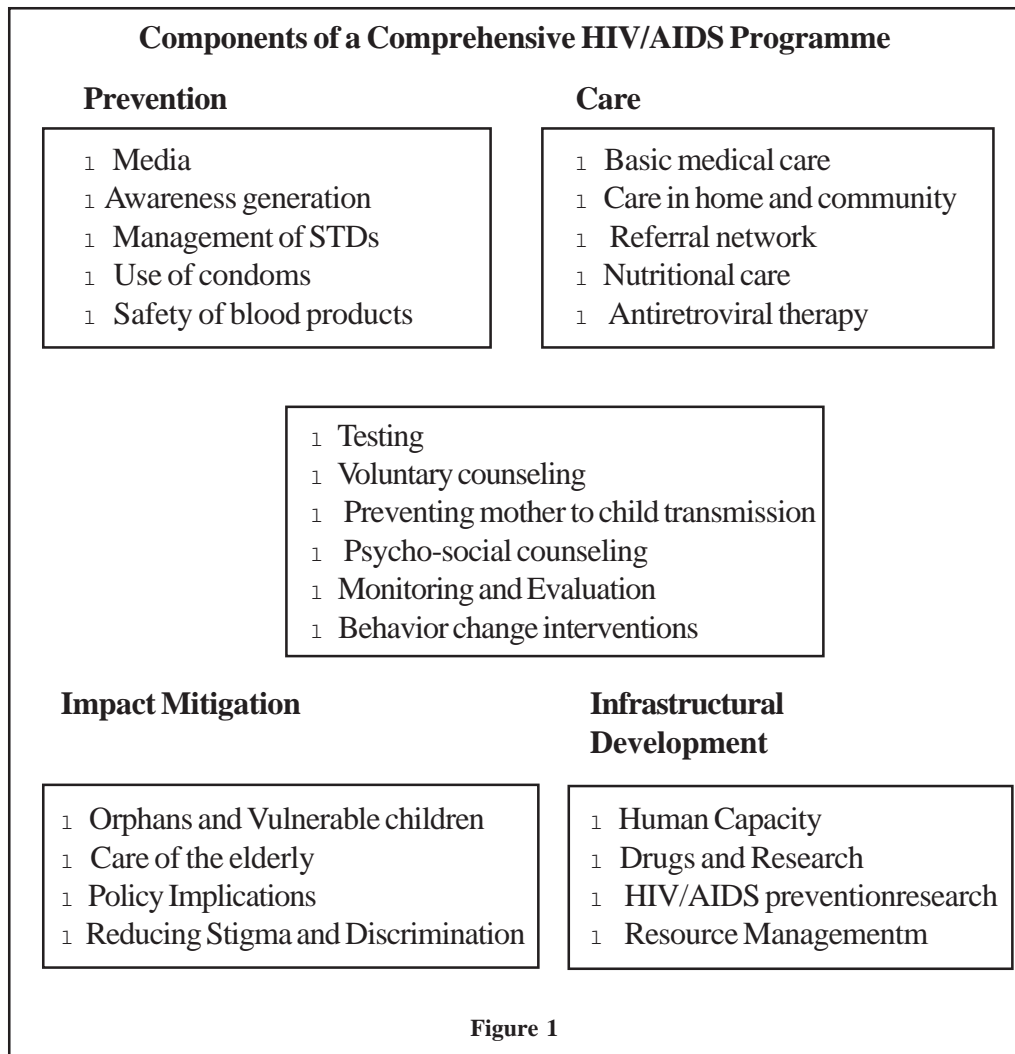
Das (1995) emphasized on the advantage of properly organised interventions. He reports of change among staff members of a voluntary organisation in Orissa. In 1994, the situation of NGO workers towards health care of the HIV/AIDS afflicted was ascertained in terms of knowledge, attitude and practice (KAP). Before the training, 60 per cent of the trainees felt that the AIDS afflicted be ostracized, outcaste, 22 per cent, put them in jail', 86 per cent 'do not marry their son or daughter', and 8 per cent 'treat them at home'. However, nearly a fourth of the NGO workers had a positive attitude; 'accompany them to a hospital' in the post training phase, the trainees showed substantial change in their KAP relating to HIV/AIDS and affirmative predisposition towards the afflicted.

The existing literature on HIV or AIDS shows that there is paucity of information on behavioral patterns and AIDS risk-reduction among different populations, although this dimension is critically important in any prevention strategy. Furthermore, the data brings out that gaps in awareness, fears and phobia, cultural practices, stigma and discrimination, ethical concerns in relation to HIV/AIDS testing, patient rights and care and support are some of the many issues that professional social work can address. Not only this, interventions targeted at special groups, such as women and children need to be looked into.

Social Work Interventions: The AIDS pandemic has spread to all countries of the world. However, the nature of its spread in population groups has been differential. Lampety (1992) attributes the rapid spread of the HIV in poor countries to several factors. Among them, primarily he mentions frequent change of sex-partners, unprotected sexual intercourse, presence of STDs, and poor access to treatment, social vulnerability of women and young people, and economic and political instability. Besides these, social factors beyond the control of individuals are important in the transmission of HIV.

HIV/AIDS interventions are of two types. The first are those that are targeted at the general population. In these, the programmes are designed to improve awareness, knowledge, and attitudes to change social norms, and to create a supportive environment. In the other types of intervention targeted at special groups, such as sex workers, truck drivers and migrant workers, street children and STD patients, the efforts at prevention cover some more aspects to reduce heterosexual transmission of HIV/AIDS. These include early detection and management of sexually transmitted infections, improved behavior in seeking treatment, sexual abstinence or delayed onset of sex, especially in adolescents, fewer sexual partners, safe-sex practices, supportive social environment to sustain behavior change, and reduced stigma and discrimination towards those infected.

For most social workers in contemporary practices, the dilemma is to prepare or not to prepare themselves to work in the field of AIDS prevention and care. 'AIDS is not a problem in my community so why should I prepare? This is what many of them feel. Can Social Work Agencies wait till the first client with HIV/AIDS comes for help? Definitely, their services would be inadequate and lack much required expertise. Social workers need to equip themselves with complete knowledge of HIV/AIDS, have adequate information to be able to assess risk levels, have information on available local resources, and have the skills needed to intervene and help the client. Nearly all aspects of HIV/AIDS prevention and care and support of those infected, need professional social work intervention (see Fig.1).



Professional Social Workers have a major task to accomplish where HIV/AIDS is concerned. Global efforts at HIV/AIDS prevention have, by and large, focused IEC campaigns. There has been extensive use of the print and electronic media. These have had an impact upon awareness generation, but have they been successful in sensitizing individuals? Have they made individuals think 'Am I at risk? The efforts at sensitizing individuals, thereby raising their absolute and comparative risk-perception, have been conspicuously missing in this prevention programme. Social workers can do much to bridge this gap. A range of pro-HIV activities need to be focalized by a **communication programme**. Social workers working at the grass-roots are the best sources of information on norms and traditions, cultural practices and behavioral patterns of their community groups. With their knowledge base, they can use a variety of media to reach out to people with the message of reducing risk. Dance, drama, folk theater, and sports events as well as television, radio, and print media can all be used to spread AIDS awareness.

Earlier, it was believed that AIDS afflicted those who are given to deviant forms of behavior. They were categorized as 'high risk groups'. Today the thinking is somewhat different. Men, women and children are all 'at risk'. Ellerbrock and others (1991) have shown that a review of the epidemiology of AIDS shows that HIV infection and AIDS cases are growing among women. A look at the yearly incidence rate of AIDS cases worldwide shows that in 1981, women comprised three per cent of individuals diagnosed with AIDS, 6.6 per cent in 1985, 12.5 per cent in 1990-91 (Centre for Disease Control, 1991). The risk of becoming infected with HIV during unprotected sex is two to four times greater for women than for a man (see UNAIDS, 1999). In

addition to the biological make-up, women are more vulnerable to HIV infection because of cultural factors prevailing in many societies. Placed subordinate to the male partner, women often find themselves powerless and in situations where they are incapable of protecting themselves. For example, in Kenya, 40 per cent of sexually active female secondary school students said that they were forced or tricked into sex (see AMRF, 1994). As many women from Cameroon reported that they had been forced into having sex (Rwenge 2000). Reportedly, wife abuse is widespread and gender based violence is linked to HIV/AIDS (Maman and others, 2000). In India, data from antenatal clinics indicate that in the states of Maharashtra, Karnataka, Andhra Pradesh, Tamil Nadu, and Manipur, one in every hundred women attending the clinic was HIV positive (UNAIDS, 1998). Kant and others (1995) report of growing prevalence of HIV among slum women in Delhi. Given their low socio-economic status and low level of literacy, Indian women often do not seek medical treatment for their ailments and resort to do with home-remedies and advice from midwives (see Veeraraghavan and Singh), 1999 and Mane and Maitra 1992).

Gender issues and imbalances, as are depicted in the spread of HIV/AIDS, are undoubtedly of concern to professional social workers. They can help develop interventions to reduce the vulnerability of **women** to HIV in multiple ways.

- 1 Primarily, the efforts should be directed towards combating ignorance. Access to schooling, understanding, and their own biological system, learning about AIDS and other STDs, and developing skills to say no to unwanted or unsafe sex, sexual assertiveness and communication on sex matters with sex-partner are all important aspects of HIV prevention.
- 1 Providing women and girls with a better health-care system and HIV/STD prevention services that are easily approachable (often women find no one to accompany them), making available STD services with women doctors, so that women can approach the clinic without any embarrassment. Wherever possible, such clinics could be equipped with counselors. Voluntary testing and counseling services would help in early detection of HIV/AIDS and also help prevent mother to child transmission of HIV.
- 1 Working with women through various community groups, e.g. group of women in a sewing center. The attempt should be to build among them an approach towards better health-care seeking, taking responsibility for their health (e.g. asking questions to the doctor) and recognizing early symptoms of STDs.
- 1 Working towards women's economic independence, so as to reduce their vulnerability. Indirectly, it would help reduce probability of women trading sex for money.

As is well known, the HIV is selective in nature. It has penetrated some regions, some groups and some economic classes more than others. It has emerged as an ailment of men and women in their most productive and reproductive years. Physical, biological and psychological attributes of the young make them more vulnerable to HIV and other STDs. Also peer pressures influence them often in ways that increase their risk. However, the young do not perceive themselves so much at risk. Reportedly, many of them are unaware of what constitutes risky behavior (Underwood. 2001). Many also consider trials with alcohol, tobacco and drugs a part of growing up. George (1999) has reported of drug use, homosexuality, and HIV prevalence among street children in Delhi.

It goes without saying that in working with adolescents, school social workers and community level workers have a significant role to play. Although it is well accepted that there is a need to make all aware about the HIV, such interventions with adolescents meet with resistance. Infact, in a study conducted by Population Research Bureau, 2000, it is reported that 44 of the 1076 countries reviewed did not include AIDS education in their school curricula. It is well known that modernization has weakened the social bonds and traditions that used to shape young people's behavior and help them in their transmission to adulthood. Opportunities to tell the **young people** about sex emerge less frequently within the family.

- 1 In HIV/AIDS education of the young people, the approach of using peer educators has met with success. When trained peer educators develop social and group norms that protect against HIV infection, they become role models for bringing about desired behavior change. They also appear to the youth as better communicators and help the young acquire skills, such as sexual negotiation and assertiveness. Peer educators, in turn, need professionals for guidance and support.
- 1 Professional social workers, already working with school children, street children, child laborers, children in slums, can do much towards sensitizing them towards better health and HIV/AIDS risk reduction strategies.
- 1 Social workers, working with adolescents, should keep in mind that they should focus on specific risky behaviors.
- 1 They should be able to provide basic information about the risks of adolescent sexual activity and about the methods of protecting them against risky sexual acts.
- 1 Social workers need to know how to help adolescents deal with peer pressure and other social pressures on young people to be sexually active.
- 1 They should provide them with modeling and practice of communication, negotiation and refusal skills.
- 1 HIV/AIDS education should be made age appropriate for different groups of adolescents, i.e. delaying sex for younger adolescents and use of condoms and sexual negotiation skills for the older ones, along with urging abstinence (Kirby and others, 1994).

As already mentioned, every aspect of AIDS – its diagnosis, prevention, and treatment — has human right implications. Voluntary counseling, testing, and referral, care and support, employment of the AIDS afflicted, and research with those afflicted or affected by AIDS, raise many ethical issues. Many situations, such as safe-sex counseling, and HIV testing demand skilful social work practitioners. Questions asked of a client in relation to his/her sexuality or sexual behavior outside of marriage may raise feelings of relief or anger. If the client's expression of anger is accepted, explored and not judged by the worker, it would result in a climate of increased comfort and trust. A bridge would develop where further discussions of more personal issues would be possible. Not many clients open up with such personal issues until they have tested the worker and needless to state, maturity, experience and acceptance on part of the worker are important elements of this relationship. He should be able to handle the emotions that emerge and individuals in each case.

To work with the HIV/AIDS afflicted, the social worker needs to know of the places where anonymous and confidential **HIV testing** facilities are available at a nearby place. The social worker must educate himself on all the situations when he may need

to raise the issue of HIV testing with a client. Surely, this suggestion will result in shock and anger, raise the anxiety of the client and the worker should be able to deal with it. Also, he needs to remember that the final decision whether or not to be tested is of the client. Once a decision is made to undergo the test, the worker has to plan out the schedule, help seek appointments and counsel the client before and after the test. In case of a positive result, he should be aware of referral services for the treatment of the HIV afflicted.

Although the social work practitioner does a lot of liaison work for his client, in working with such a client, who is suffering from a life threatening illness, he needs to have invaluable clinical skills. In preparing for serious illness and the eventuality that follows, the social worker is involved not only with the AIDS afflicted, but also with his loved ones. The conversations about sexuality, about spirituality, about dying and death are all a reality. The social worker's understanding of his own strengths and weaknesses, his level of comfort in dealing with a person who is in pain and suffering, are important to the success of his intervention.

No other ailment probably has aroused the kind of emotions that HIV/AIDS has done. Stigma is not against individuals, but against entire categories of people. Social workers can work in different ways to help reduce **stigma and discrimination**.

- 1 Raise HIV/AIDS awareness among communities.
- 1 Promote counseling to help people develop the right attitude towards the afflicted.
- 1 Efforts are needed to counter prejudice and misunderstanding to protect the human rights of commercial sex workers, men who have sex with men, and other groups.
- 1 Ensure that individuals can access comprehensive and confidential testing services. Enable the afflicted to share their positive status with their loved ones, if they so desire.

In the area of HIV/AIDS practice, social workers have to adopt a multi-pronged approach. On the one hand, they have to continuously strive towards developing programmes for behavior change, and on the other, they have to influence social norms and empower communities to address the epidemic. It is now well accepted that individual behavior is more likely to change in the context of a supportive community (see UNAIDS, 1999). Social workers can then play an active role in addressing the AIDS epidemic as a development issue. Advocacy efforts are specially needed to bring forth community mobilization, collaboration among policy makers, programme implementers, professionals from different fields and voluntary workers at all levels.

It emerges that Social Work Practice is linked to all stages and programmes of AIDS intervention. Social work intervention is helping many client groups, such as drug users, STD patients, commercial sex workers, etc. to perceive their risks to HIV/AIDS infection and take appropriate measures towards risk-reduction. Understanding group dynamics and human behavior, in many organisations, social workers are successfully carrying out awareness generation programmes. With this view, many Schools of Social Work have incorporated HIV/AIDS in their curricula and many among them carry out workshops to sensitize student social workers to the epidemic. AIDS research (as doctoral research or projects) is also being carried out in some Schools of Social Work. Although much work is being done by social workers towards HIV/AIDS prevention, considerable ground remains to be covered. Professional social work needs to respond to the challenge by addressing not only issues of awareness generation and AIDS education, but also the concerns of those who are silently suffering from the virus.

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