BRIDGEWATER STATE UNIVERSITY

Journal of International Women's Studies

Volume 18 | Issue 2 Article 16

Jan-2017

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Abstract

In this paper, we examine the role of Voluntary organizations (VO's) in combating the incidence of HIV/AIDS and Sexually Transmitted Diseases among Female Sex Workers in Hyderabad and Secundrabad. These are twin cities in the newly formed state of Telangana state in the southwestern region of India, called the Deccan Plateau. We trace the evolution of VO's towards becoming agents of information and prevention of AIDS in the region. Our focus is on how VOs' interventions impact the prevention of HIV among female sex workers. The activities that contribute towards this aim are sexual health, counseling, medication and continuous health follow-ups. Using purposive sampling methods, we analyze the data quantitatively and qualitatively with the help of case studies with intersectional feminist theory.

Keywords: Voluntary Organizations, AIDS awareness and prevention, Sex Workers, Intersectional feminist theory

Introduction

Women's health, women's empowerment, and AIDS eradication are all global concerns incorporated among the seven Millennium Development Goals (MDGs) propounded by the United Nations [UN Millennium Report 2005]. Goal six of the eight millennium development goals is "to combat AIDS/HIV, Malaria, and other Diseases" and Goal three is "to promote gender equality and empower women." The MDGs have done much to advance progress on the health of women and girls in developing countries and have been "the most successful anti-poverty push in history" [MDG Report 2011]. However, there is still marginalization of women globally when it comes to AIDS awareness, and there is a dearth of awareness programs specifically targeted towards women sex workers, which constitute one of the highest risk groups. Sex workers from the underprivileged sector are not only socio-economically poor but, in the Indian context, they are marginalized by caste and religion making them doubly or triply marginalized under the patriarchal system.

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[2] Bindu A. Bambah (Ph.D.) is the Dean and Professor of Physics and Joint Professor of Women's Studies at the University of Hyderabad. In addition to scientific contributions, Dr. Bambah has written articles and given seminars to Women's Study groups both in India and abroad to devise methods of inducting and training women to assume leadership roles in the physical sciences. Published work on this topic is Women in Physical Sciences from Followers to Leaders Monograph on Women in Science, ISCA publications. Prof. Bambah has also started undergraduate courses on scientific methodology and given lectures to school students on the importance of scientific thinking in all spheres of life. She is also a joint faculty in the Centre for Women's Studies.

We focus on awareness programs for female sex workers (FSW), which are among the highest risk groups for HIV. Sex workers are "female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally" [UNAIDS, 2012].

In India, the first HIV/AIDS case was in Chennai in 1986. Today, HIV is prevalent in 29 of India's 32 states and territories. The epidemic is high (with a prevalence amongst pregnant women attending antenatal clinics being more than 1%) in six states—Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland, and Tamil Nadu. The National AIDS Control Organization of India (NACO) and Andhra Pradesh State AIDS Control Society (APSACS) estimate the number of people with HIV in India at 5.1 million in 2004. India has the second highest population of HIV/AIDS in the world after South Africa. HIV/AIDS is a hurdle for human development, a resurgent infectious virus, a public health crisis, and a major human rights issue as health is a fundamental human right.

We situate our study in Hyderabad and Secundrabad (see map in Figure 1). Globalizationand liberalization are the leading causes of the epidemic spread of HIV/AIDS. Hyderabad had an information technology boom in the 90s which resulted in multinational companies mushrooming in the city. Social media in the form of technological innovation influenced the cultural and the social norms drastically and led to the changes in behaviour and lifestyles. This liberalization has shaped dialogue across cultures globally. A major effect of this was on public health and private lives in the major metropolitan cities of India. Hyderabad is the 5th among the cosmopolitan cities in India. Economic and the cultural shift paved a suitable environment for the spread of infectious disease like HIC/AIDS and other sexually transmitted diseases. Increased job opportunities and as well improved standards of living gave rise to a steep increase in the purchasing power of the people. The financial excess and accessibility resulted in commercializing sex as a source of income in many forms, such as casual sex and commercial sex. Economic liberalization has increased the responsibility and the role of the private sector and at the same time has reduced the control of the government on the financial affairs. A huge gap resulted between private and government welfare policies. Interventions by the voluntary sector were the only way out in executing the less addressed issue of the prevention of the spread of sexually transmitted diseases. To establish a conducive environment economically and also at the community level interventions by VOs into local health concerns at the grassroots level is the only compatible approach. These VOs assess the socio-behavioral factors needed for prevention as well as the primary modes of spread of HIV: sexual contact, mother to child transmission, and through infected blood transfusions and intravenous drug use. As stated rightly by [Chong, 2007], "HIV/AIDS represents a growing and significant health threat to women worldwide. Gender inequities in socio-economic status and patriarchal ideology around sexual practices are among the most important, yet often neglected, reasons for the feminization of this disease".

The predominant mode of spread is through sexual contact (80-85%), while the other 15% is through other means such as blood transfusion and infected needles, as per Indian data [Hyderabad, 2010]. Interventions have three dimensions: creating awareness of the disease, safe sexual practices, and distribution of condoms. Stigma and discrimination towards sex work hamper health interventions for sex workers. Behavioural interventions target risk behaviour reduction, negotiation skills, condom use and promotion of community engagement among the underprivileged or socio-economically marginalized FSWs. "Underprivileged"is an umbrella term for social-economic status, caste, and gender and in the present research, these communities are socio-economically disadvantaged [Planning Commission report, 2013].

In this paper, our aim is to explore issues related to HIV/AIDS through the perspective of VOs and the viewpoint of the beneficiaries.

Research Viewpoint

We use an intersectional feminist framework to examine HIV/AIDS awareness programs in the Indian context where it is utilized to distinguish the experiences of women of lower caste or a minority religion from those of upper caste Hindu women [Nivedita, 2015].

In seeking to adopt a feminist viewpoint for this study, we examined the work done in other countries similar to India on HIV and sex work activism. The criterion for "similarity" is geographic and economic. Geographically, Bangladesh, for example, is a country similarly situated to India which has opened its markets globally.

Sultana, in the paper *Sex worker activism, feminist discourse, and HIV in Bangladesh*, [Sultana 2015] pointed out that HIV programs in Bangladesh have ignored the fact that the 'choices' made by sex workers are due to a range of social factors such as gender norms and notions of bodily purity, which have implications for HIV-related risk.

An added dimension in trying to study VOs' interventions from a feminist point of view is the different perspective on sex work in the many forms of feminism. Thus, we have to delve into multiple branches of feminism in demarcating the feminist conceptualization of sex work. There are two conflicting ideologies. The first ideology that seems to be common among most VOs and certain feminists perceives sex worker as victims of situations, such as economic exploitation and patriarchy [Carpenter 2000]. Victimization is the point of view of radical feminism that seeks to eliminate patriarchy in all social and economic systems. According to positions held by some radical feminists, sex work is the symbol of patriarchy [Anderson 2002] in which women are turned into sex objects to satisfy the desire of men. However, the radical feminist viewpoint is often not shared by sex workers themselves. The feminist position that is more in line with the attitudes of sex workers is the pro-sex-work perspective of liberal feminists which sees sex work as an occupation or profession. Liberal feminism is about choice or women's ability to assert their equality through their actions. In many studies [Kotiswaran 2011], it is argued that sex work is similar to other kinds of labor such as domestic labor. Pro-sex work feminists take the position that sex workers should have the employment rights and better working conditions, such as protection against violence that people in other occupations enjoy [Scott, 2005]. Sex work advocates also argue that sex workers separate their core selves from the labor that they perform [Kotiswaran 2011]. This re-positioning of sex workers allows them recognition in legal contexts and entitles them to work-related benefits such as healthcare.

Thus there are different feminist viewpoints, with which we can study the data relating to sex workers and AIDS awareness. We use an intersectional approach combined with a liberal feminist view. According to human rights sources, "Intersectionality is an analytical tool for studying, understanding and responding to the ways in which gender intersects with other identities and how these intersections contribute to unique experiences of oppression and privilege" [Association for Women's Rights, 2004]. The other identity besides gender that we work with is social marginalization due to caste and religion [Weber, 2003].

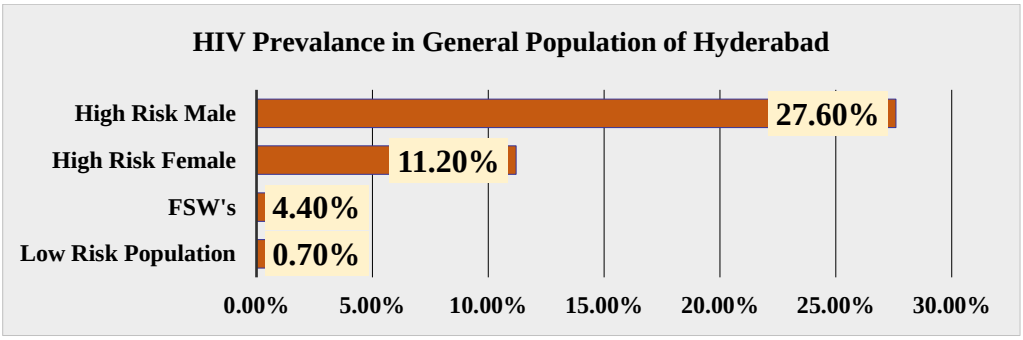
Situating the Study

The study concentrates on the Hyderabad/Secundrabad area in India. Secundrabad and Hyderabad are twin cities geographically located in the Deccan terrain in the Telangana region. Demographically, Hyderabad District has an urban population of 76, 74,689 [Census, 2011]. The sex ratio for Hyderabad District is 955 females per 1000 males. Overall 8.02% of the district population belongs to Scheduled Castes (SC), and 0.90% belongs to Scheduled Tribes (ST). One district hospital, one community health center, and some private medical institutions and VOs serve Hyderabad. Because of globalization there is a floating population in and around the twin cities, making them vulnerable and prone to HIV/AIDS, according to the state-based ministry of health statistics [India Heath Action Trust 2010].

Figure 1: Map Situating Hyderabad (Courtesy Google Maps)

Field work consisted of identifying the VOs actively involved in HIV awareness work. Several visits were done with prior appointment to the project managers of the voluntary agencies. The beneficiaries of the organizations were the female sex workers (FSW) and visits to various categories of sex workers homes, focused (pickup areas) and the catchment areas. Gathering the target group of female sex workers was a difficult task. Stigma, inhibitions, secrecy, and confidentiality were the main hurdles to overcome among the Female Sex Workers and infected women. To overcome these limitations the researcher (Chaya Devi) made several visits to the VOs that advise the sex workers. The counselors in these centers, who held the confidence of the sex workers, introduced them to the researcher. A non-judgmental approach allows the workers could freely exchange their views.

Figure 2: HIV Prevalence rate at Hyderabad in the year 2011



Methodology

Sampling

This study uses purposeful sampling, a technique used in qualitative and quantitative research when the resources are limited [Patton, 2002]. In tune with this type of sampling, we identified individuals who specifically have knowledge or experience related to HIV/AIDS. It is more restrictive than random sampling which allows generality in findings by minimizing the potential for bias in selection [Palinkas, 2013], but useful for many focused studies such as ours. We identified three VOs for the study. The sample for the beneficiaries was taken from the FSWs and the living-with-HIV/AIDS individuals (LHIV) identified by the VOs. Furthermore, we restricted ourselves to the underprivileged women engaged in sex work, who are marginalized by caste and religion.

The three VOs that fitted our sampling criterion were

1. HIV Positive People Efficiency Society (HOPES)
2. Andhra Pradesh State AIDS Control Society (APSACS), Hyderabad which has out-sourced, Hyderabad Leprosy Control Health Society (HLCHS)
3. Manavatha Parivarthan Society

We give a brief description of each of these societies.

1. *HIV of Positive People Efficiency Society (HOPES)*

HOPES is an organization started by a group of seven members who are HIV/AIDS positive, with a mission to spread the awareness of the virus, to educate people to lead a healthy sex life and to prevent the spread of HIV/AIDS in the Hyderabad District. HOPES works under the umbrella of AVAHAN the project started by the Bill and Melinda Gates Foundation for HIV Prevention.

Objectives of the HOPES are:

a) Fight against discrimination towards the HIV/AIDS positive persons.
b) Fight for the legal rights of HIV/AIDS positive individuals and support them and their children with medication.
c) Family and Marriage Counseling

2. *Andhra Pradesh State AIDS Control Society (APSACS), Hyderabad*

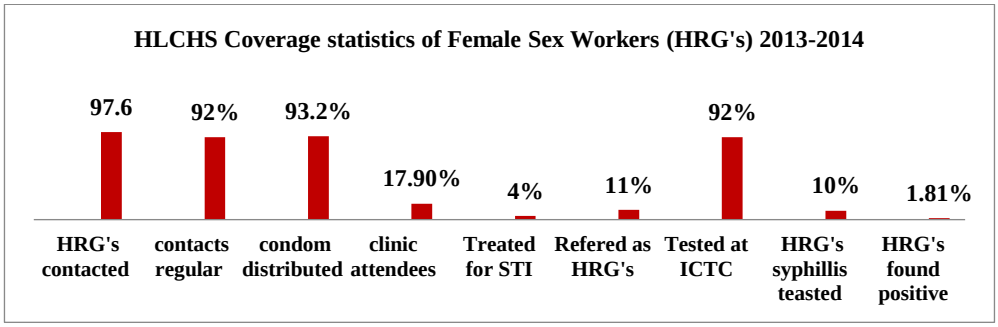
This society is a branch of the Hyderabad Leprosy Control Health Society (HLCHS).A group of philanthropists in the old city of Hyderabad initiated HLCHS. The initial focus was Leprosy interventions in the coordination of Lepra India in 1989 when the incidence of various diseases like leprosy, tuberculosis, and communicable disease was at its highest among the Muslim and underprivileged communities in the old city of Hyderabad. With the lowering of the disease rate it shifted its focus to HIV/AIDS. At present the leprosy rate is low, so the services shifted to HIV/AIDS intervention programs in the slums /underprivileged communities of the old city of Hyderabad. The target interventions are identified and supervised by the project director assisted by project officer and a medical officer. The functionaries are three outreach workers, eight peer educators and two Auxiliary Nurse Midwives. A migrant population of 35,000 is under the catchment area of HLCHS. APSACs provide a list of sectors at risk which are the areas vulnerable to HRG's (High-Risk Groups).

3. *Manavatha Parivarthan Society*

This VO was initiated a decade ago with the objective of serving the underprivileged society with regards to women's health and girl's health education. It conducts training sessions in the form of lectures and focus group discussions on health issues in girls' schools and women's colleges. These help girls and women to gain knowledge of their own bodies. It also does psychological counseling to understand the behavior patterns of the adolescent females. An awareness dialog is designed to make them familiar with sexually transmitted diseases, and their prevention. The serious implications and the repercussions of having HIV/AIDS are emphasized in these health interventions.The beneficiaries are the target group of the various VOs.

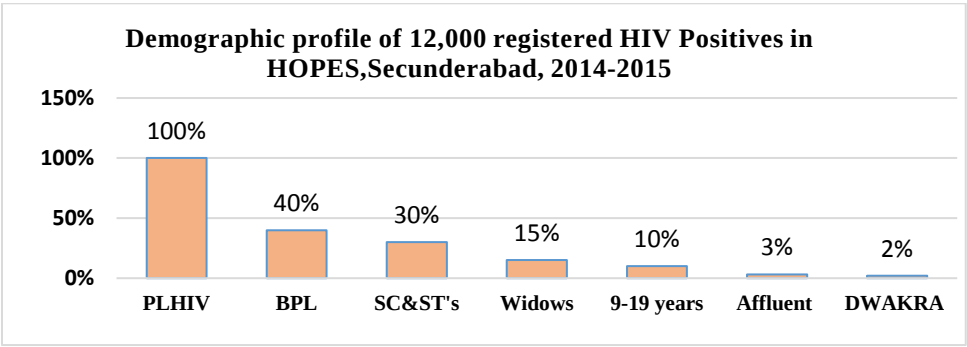
For HLHCS the demography of the FSWs is provided in Figure [3]. The target interventions show that among the 3000 registered, 2,928 high-risk FSW's contacted the HLHCS. 2720 were in regular touch with the HLHCS clinic. Condoms were distributed to 2,796 FSW's and 537 were clinic attendees. 2,760 were tested at an Integrated Counselling Testing Centre (ICTC) and 300 of them tested positive for syphilis, and they also found 54 persons HIV positive.

Figure 3: HLCHS Coverage Statistics of FSWs (HRGs) in 2013-2014



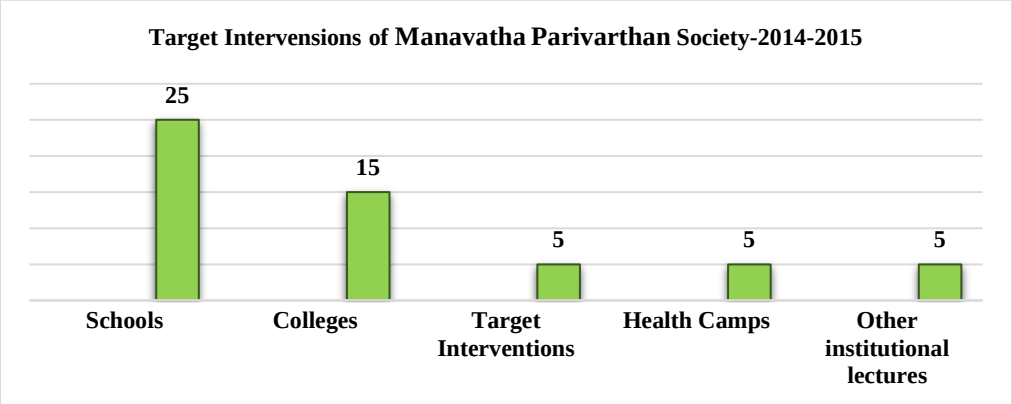
For **HOPES** the demography of the HIV/AIDS positives is given in Figure [4]. 12,000 persons living with HIV are registered with HOPES. Of these, 4,800 were underprivileged categories and were selected for purposive sampling. Among them, we chose 25 persons infected with HIV/AIDS at random for conducting interviews for the study to avoid bias in our sampling. Three thousand, six hundred belong to SC and ST category; 1200 are adolescents of 9 to 19 years of age, 360 are affluent and upper-class, and 240 are from self-help groups (SHGs).

Figure 4: HOPES demographic Profile of registered HIV positives, 2014-2015



For the Manavatha Parivarthan Society, the demography of the Target Interventions is given in Figure 4. Twenty-five schools had adolescent health education courses that include sex education. Fifteen colleges trained in behaviour and attitude changes through lectures and workshops. Five specific target interventions were conducted exclusively to focus on HIV/AIDS awareness programs. Five camps were held for general health issues and awareness among the general population. Added to these, another five lectures addressed in various institutions like Indian Red Cross Society, All India Radio, and NIMSME, etc.

Figure 5: Manavatha Parivarthan Society's Target Interventions 2014-2015



Before getting into the research study, the proposal was submitted to the ethics committee of the University of Hyderabad to get approval to conduct ethnography. The ethics committee framed a code of conduct requiring informed consent of those studied (Female Sex Workers, HIV/AIDS positives) in the research context.

A questionnaire was distributed to the VOs according to the functional hierarchy of the staff and the target groups. For the qualitative or case studies, interviews and focused group discussions were conducted. In the analysis, we present two case studies from HLCHS and two case studies from HOPES, as examples of the larger sample. We used two different set of questions used for the staff and the beneficiaries. Outreach workers, peer educators, and councillors were interviewed to assess the services rendered to the target groups. Beneficiaries who are peer educators, FSW and HIV positives were questioned to know their personal, social and economic status.

Results and Discussion

FSWs between 20-25 years are at high risk of positivity, which correlates with their involvement in more sex work. Prevalence of HIV is 18% more than the older age groups. Among the FSWs, 33% FSWs are between 20-25 years of age and 52% have been in sex work for less than 1-5 years. More than 46% have a client volume less than two per day and 50% are currently married. More than 50% of them reported home based work followed by 20% reported the brothel as the primary place of solicitation. Eighty percent of the FSWs use condoms and peer educators provide these condoms and educate about their usage. More than 50% of them consider sex work as their full-time job for financial support and survival. Fifty percentof the FSWs are married, and

their families supported by their earnings. After the age of 35, these women tend to lose their clients, are left deserted and worn out with disease and infections. Neither government or the VOs nor the family members who depended on them provide support for out of work FSW's. At this stage, they ask for legalization and pension benefits as for any other profession.

Peer Educators (PEs) play a vital role in disseminating the knowledge of the disease, its incidence and also preventive measures under the supervision, training and the guidance of the project co-ordinator. The FSWs get to know the peer educators, who monitor the movements of the other FSWs in the identified areas and streamline the new entry of FSWs for registration with the VOs. Specifically, condom use behaviour is monitored and recorded by FSWs, 85% of the FSWs complained those husbands, and the lovers had never opted for the condom use. Because most of the FSW got into sex work as means of earning at the very young age between 18 to 20 years and continue after they are married, lack of education and have no alternate means of survival, they rely on sex work as their permanent profession.

Case Studies

Case studies have been chosen based on the vulnerability, discrimination and submissive victimization intersecting with poverty, caste, and gender. The "women from scheduled castes and scheduled tribes of India and poor Muslim families are the most vulnerable group for HIV infection. The Scheduled Castes (SCs) and Scheduled Tribes (STs) are various officially designated groups of historically disadvantaged indigenous people in India. The terms are in the Constitution of India, and different low-income groups belong to one or the other of the categories. They belong to families of marginal farmers or landless laborers and must leave the village to make a living. Patriarchal hegemony, sexuality, and sexism intersect with the marginalized socio-economic status of the female sex workers in our study [Sen, 2009]. The traditional work that these castes do was manual labor, and because of globalization, there is not much work for them. Since they mostly work in the unorganized sector, the wages from housework and manual labor are very cheap. The lure of easy money from sex work and their lower status in society make them the victims of confidence tricksters. Hence, they are "triply marginalized" by caste, gender, and poverty. Their experience is very different from the "call girls," who are from an upper caste.

Cased Studies from HOPES

Case Study 1

Monikaisa, 35-year-old HIV-positive woman is a sex worker for ten years. She is married and living in Secundrabad. She and her husband were not aware that they have AIDS, or how they contracted the infectious disease. She financially supports her family through sex work and needs to take care of two primary school kids. She is under the supervision of the Peer Educator of the HOPES clinic. The government, through the VOs, provides free medication and groceries to them. She is doubly affected as an FSW and as AIDS positive. Even though prostitution is illegal in India, the government relaxed the illegality for the AIDS positive cases such as this one. The intervention HOPES provides medical treatment through its intervention programs. Discrimination and psychological trauma have demoralized her, leading into depression. HOPES has rescued her by counseling and strengthened her by recounting success stories of other positives. Thus the voluntary services of HOPES act as a conduit for government interventions, to evade the illegality of the profession. However, such welfare programs do not alleviate the social stigma attached to

the profession. Monika argued that the lucrative nature of the job over others such as housework compels her to stay in business with the supervised use of condoms.

Case Study 2

Shravani is married with two children. She was 25 years old when she tested HIV positive in her second pregnancy. She conjectures that she contracted HIV through the use of infected needles at the hospital. With the intervention of HOPES both her children have been tested and the result is negative. Deserted by her husband and her family and she find taking caring for and raising children difficult tasks to perform. Under the supervision of HOPES, she has access to Anti-Retroviral Treatment (ART). The VO provides a diet consisting of Millet bread (roti), coconut water, and leafy vegetables to keep her immunity levels high and also provides supportive medicines. She is aware of the disease and the severity of its incidence, and the VO helps her in going through the trauma of various stages.

Case Studies of HLCHS

Case Study 1

Our first interviewee was Shantha, the second recorded HIV-positive among the 3000 identified FSWs. She is one the staff and trained as a Peer Educator (PE) at HLCH. She is married with two children and dependent parents to take care of. HLCHS provides her with training, awareness, and medication. In return, she has been monitoring the movements of the sex workers and has registered 120 sex workers into HLCHS. She counsels the other FSWs in implementing safe sex methods such as usage of condoms while teaching the BCC (Behaviour Change Communication). She tracks the condoms used, visits made to the center and blood work of the 120 FSW's that she has registered. She knows that she is infected by the client who visited her. She now prevents the spread of the HIV/AIDS and earns a living. She has turned from a victim to a peer counsellor, thus empowering herself.

Case Study 2

Raabia, 24 years, is an Out Reach Worker (ORW) and a graduate. She belongs to the Dalit caste (lower caste). Acute poverty has led her to sex work. She is self-motivated to protect herself and her family from the infectious disease with the help of HLCHS. She is a regular sex worker as well an efficient ORW who takes the responsibility of 120 sex workers based in the area of Charminar (old city of Hyderabad). She makes door to door visits, talks to them about the hygiene, health and also grooms the young girls who are doing sex work. She motivates them to maintain a clean environment and proper clothing so that they can demand more money from clients. Raabia is well acquainted with many college students and has a huge contact list. She trains them in using the STI prevention methods such as condoms, without which sex is not allowed.

Manavatha Parivarthan Society

The modus operandi of this society is different from the two previous ones. Its main aim is to educate and inform school and college age students, who are between 11 and 20 years old. Motivational programs include health issues related to AIDS awareness and safe sexual practices. The Indian education system introduced sex education into the school curriculum a decade ago, including lessons about changes in body organs, body functions, the reproduction system,

hormonal functions and also psychological implications of sexual changes. When the VO visited the schools, it found that most of the lessons were not taught, but ignored because of "morality" issues: talking about sex is still a taboo in the Indian social context. However, when offered the opportunity, students opened up with various questions related to the body, functions, and sexuality. Myths and mistaken notions about sexuality gleaned through multimedia were clarified. The society sponsored orientation programs, lectures and focus group discussions at the Indian Red Cross Society, at Hyderabad about AIDS/HIV prevention and behaviour change communication.

Theoretical Reflections

Studying AIDS awareness from a radical feminist perspective is often thought of as patronizing to the affected FSW population. In contrast, the liberal feminist framework defends sex work as regular work and posits that FSWs should enjoy all the benefits that regular workers have, such as unions and health care [N Veena 2007]. It is this philosophy, which public health activists and all the VOs that we visited advocated for the decriminalization of the profession and supported the liberal feminist position on sex work [Rogers, 2006]. Hence, in this perspective, sex workers are represented not as victims or vectors, but as fighters or agents and this portrayal relieved them of social stigma.

Discussion

As the result of our study, we find that it is low economic and social status that drives women and girls to depend on sex work for financial support. This notion often means that the use of condoms is not an option when a woman's value is measured by her fertility and her ability to give men pleasure. Focusing on condoms or abstinence as the global response to HIV excludes women whose lives are shaped by these are factors, often beyond their control. Addressing poverty and gender inequality among women is thus an intersectional task [Nivedita, 2015]. There is no recognition in society that women involved in sex work have a human right to education, health, freedom from violence and support. Governmental bodies often treat sex workers as criminals, thus, more often than not; it is VOs that provide support and education to help women sex workers protect themselves from a potentially life-threatening disease.

The data indicates that India has made significant progress in tackling its HIV epidemic, especially in comparison with other countries in the region. For example, while new HIV infections have fallen by more than half since 2001, the number of new HIV cases in neighboring Pakistan has increased eight-fold. The reason for this seems to be two-fold. First, by utilizing the assistance of VOs, the government has avoided the legal aspects of taking on the promotion of awareness of sex workers and high-risk groups, since most of these activities, by law, are illegal [Ahmed, 2011]. Secondly, in most of the AIDS awareness programs for FSWs, the onus of protection against the epidemic lies on the sex worker. Paradoxically, it is the women who are trained and taught about the regular usage of condoms. Moreover, some public health specialists reflecting a liberal feminist perspective, who work for the protection of FSWs in the context of the management and prevention of HIV/AIDS, [Nagaswamy, 2008] argue that sexual labor is not necessarily abusive and violent. [White 1990] has argued "Prostitution is a capitalist social relationship not because capitalism causes prostitution by commoditizing sexual relations but because wage labor is a unique feature of capitalism'.

In conclusion, we find that many HIV preventative measures, such as condom distribution, fail to address what drives people into the vulnerable situation of exposing themselves to unsafe sex in the first place. Ignorance and lack of health awareness are two significant drawbacks in the aspect of public health. The HIV/AIDS epidemic, as well as its control, is socio-economically driven among Indian Sex Workers. Thus, facilitating and training women and girls involved in sex work in the aspects of health and well-being to prevent HIV/AIDS is the only tool which is realistically viable. The VOs that we have explored were able to cater to the requirements of the FSWs; they identified them, counseled them and also taught them condom usages and provided systematic follow-up visits. Decades of seeking to achieve the MDGs and SDGs (2006-2016), resulted local proactive policies of the Indian government and their implementation, in successfully lowering rates of STIs. The positive impact of such strategies adds a glimmer of hope for the eradication of the disease among vulnerable communities. Table 1, substantially gives a statistical global estimate and illustrates the impact of the target interventions and the efforts of the VOs.

Table 1: Figures from UNAIDS 2016 of the Global trends and occurrence of the STDs

People living with HIV in 2015(Global)	36.7 Million
People living with HIV accessing ART in 2015	17 Million
New HIV infections in 2014	2.1 Million
New HIV infections averted in the past 15 years due to scale-up of services	30 Million
AIDS- related deaths in 2015	1.1 Million
AIDS-related deaths prevented in the past 15 years due to scale-up of services	8 Million
Reduction in new HIV infections among children	58%

Conclusion

In conclusion, as above stated, we find that even though awareness drives and condom distribution are preventive measures, these initiatives fail to address what drives people into the vulnerable situation of exposing them to unsafe sex in the first place. Ignorance and lack of health awareness are two significant drawbacks in the aspect of public health. The HIV/AIDS epidemic, as well as its control are related to socio-cultural and socio-economic situations catalyzing a shift to sex work. At this juncture, facilitating and training the women and girls in the aspects of health and well-being in preventing the sexually transmitted disease (HIV/AIDS) is the only tool which is ardently approachable. Voluntary organizations (VO's) examined and analyzed were able to cater to the requirements of the FSW; they identified them, counselled them and also taught them condom usages and follow-up visits systematically and technically.

Also, we have seen from our visits to HOPES and the Manavatha Parivarthan Society that risk behavior patterns are internalized at a very young age, as the adolescent population (22% of the world population) is increasing at an alarming rate. India is home to nearly 225 million adolescents between the ages of 10 and 19 years. Unless we attend these issues at the grassroots level, it will become harder to curtail the epidemic. Unless there is a questioning of the

developmental processes and attention is given to access to healthcare, education and food security for socio-economically vulnerable sections of the population, there is little hope of attacking the roots of the epidemic. A direct emphasis on HIV/AIDS care should be an integral part of healthcare systems that already exist. But in countries that do not ensure primary health care, prioritizing HIV/AIDS care in isolation will not only be met with a lack of success; it may also jeopardize the struggle for basic healthcare by side-lining it and making it appear less relevant. Thus the role played by VOS in bridging the gap between the public health care system and high-risk groups, not only lessens the stigma of HIV but also assists high-risk groups to obtain the preventive measures and information they need, without fear of legal consequences associated with their profession or lifestyle.

These organizations have made the first step in the right direction. Our interaction with the VOs revealed to us that besides prevention and education of high-risk groups, the infected cases have no legal rights and are ineligible for medical insurance. Finally, to have an integrated approach to HIV/AIDS control, it is crucial to adopt a three-point program: Firstly, to control the disease one must create programs that tackle the socio-ecological determinants of health in addition to providing cures and interventions. Secondly, we must strengthen general health services to fill this urgent need. We should provide free access to sexual and reproductive health education, and information has to be increased in various forms, targeted to the different needs of women and men and also to various age categories. And thirdly, we must emphasize the human rights approach and recognize the importance of the context and the complexity of the issue. For long term, effective reform, there are no shortcuts. Minor increases of existing services are not going to solve the problem. What is needed is a radical restructuring of services, placing the people at the center.

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