

The Millennium Development Goals:

A Focus on HIV/AIDS in Indian Women

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Jawaharlal Nehru, the first Prime Minister of Independent India, once said, "You can tell the condition of a nation by looking at the status of its women."¹ India's attitudes toward women range from revering them as the "Divine Form of Strength and Power" to near-inhuman subjugation. The Indian government grants women and men equal rights in its constitution; however, in matters of health and medical care, women live a second-class existence.

Perhaps the biggest threat to Indian women is the escalating HIV/AIDS epidemic. Inadequate healthcare, cultural pressures, ignorance, and many other issues have contributed to a rise in infected women. After examining the social roots of HIV contraction and the status of female medical care in India however, possible solutions can be formed to help curb this situation.

India, as a developing country with a population of over one billion people, faces many economic and social challenges. The HIV/AIDS epidemic seems to be one of the most pernicious threats to India's sustainability due to its rapid contagiousness and its ability to penetrate through diverse layers in Indian society. An alarming effect of this epidemic is the escalating rate at which Indian women are contracting HIV. This epidemic has left an unforgettable imprint on the Indian woman: India suffers from the lowest sex ratios in the South Asia region. The lack of adequate female health care and medical attention for women contributes greatly to this statistic.

Historically speaking, the first HIV case in the South Asia region was reported in Thailand in 1984, just three years after the discovery of the disease. Although HIV was initially transmitted through male homosexual intercourse, it rapidly spread to women in both rural and urban areas in India (see Figure 1). Two decades later, two to five million Indians have been infected with the disease.² What's worse, this statistic may be considerably understated, as HIV/AIDS cases in rural villages and urban cities in India are underdiagnosed, underreported, or even ignored.

Studies have determined that the main method of HIV transmission in India is heterosexual intercourse, which has rapidly infected the female population. On average, men tend to have more sexual partners than women; therefore, a small number of infected men is enough to cause high rates of HIV/AIDS in the female population. Studies have also shown that, on an individual basis, HIV is more easily transmitted from male-to-female rather than female-to-male, resulting in women being infected at greater frequencies.³

Not surprisingly, the highest rate of infection is found in female sex workers (FSW) in the growing urban cities of India. This elevated HIV prevalence has been documented as up to 50 percent or more of the FSW population in Mumbai, India's largest city.² For widespread sexual transmission of HIV to occur, as in Mumbai, the male

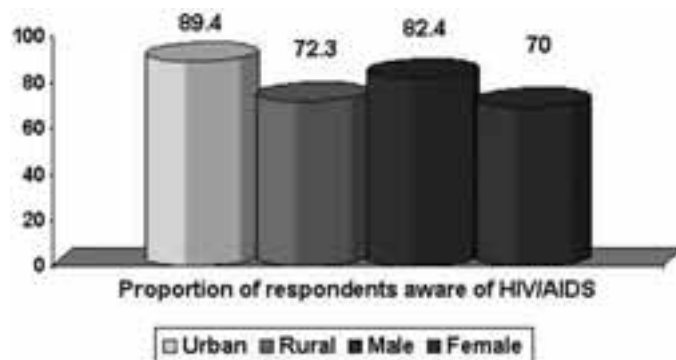


Figure 1. Awareness of HIV/AIDS-all India
Source: National AIDS Control Organization

clients of infected FSW must have followed a pattern of "concurrent or overlapping sex partners and a high frequency of sex partner exchanges along with a high prevalence of such behaviours."⁴ The path of transmission from FSW has led to even higher female infection via the male clients to their regular sex partners.

Furthermore, the issue of female trafficking into FSW has exacerbated the HIV/AIDS epidemic in India. Young women, the majority of whom are under sixteen years of age, are quite vulnerable to sex trafficking and often are forced into this profession. Each year, over 200,000 Nepali and 12,000 Bangladeshi girls are sent India to become sex workers.² Indian social workers have determined that these young women are most likely to be infected with HIV in the first six months of working in the sex trade.⁵

In the initial months spent working in a brothel, these women are extremely vulnerable. They have the least amount of bargaining power, and thus are forced to deal with clients who refuse to wear condoms, which would serve as protection from infection. Many times, these young FSW are also in most need of the money, subjected to violence, and coerced into high-risk and exploitative sexual practices.⁴ In addition, many male clients request virgin sex workers because such workers are perceived as having a low risk of carrying HIV. Unfortunately, this situation contributes to an increase in female infection rates.

A convoluted web of socio-economic and cultural issues affects the vulnerability of these FSW and other HIV-positive Indian women. Poverty, urbanization, ignorance, and gender inequality are all significant factors that shed light on the complexity of halting the HIV/AIDS epidemic in India. Poverty leads many women into the FSW industry either by force or a lack of other employment options. Unable to find other means of employment, this somewhat lucrative business can support basic economic needs for these women.

Additionally, urbanization not only increases the FSW population and demand, but also exposes non-FSW to the majority of infected males. With more of the rural poor moving to congested cities, there is a rise in unemployment and an increase in women working in the informal sector. An ignorance about the disease and its transmission pervades both rural and urban areas. Many uneducated men and women do not know much about HIV/AIDS and therefore fail to prevent contraction. Estimates show that more than 90% of the infected in rural areas do not know they have contracted HIV.³

In the Indian rural and urban society, sex and its concerns are usually not addressed openly. Therefore, sex education is often non-existent in most school systems. Even when international organizations and governmental establishments allocate funds in an attempt to inform the public about AIDS, their efforts are often ineffective. While handing out pamphlets and displaying informative billboards may alert the literate and concerned minority,

these actions overlook the illiterate or apathetic population that most desperately needs the information.

Furthermore, gender inequality is perhaps the most complicated factor of a woman's vulnerability to this disease. In the urban and rural setting, women have a lack of autonomy in the social and public spheres. Most notably in rural India, many women are married at young ages and have little control over their own affairs. Their male partners may contract HIV through sex workers and in turn infect them. Once infected, these women will often fail to recognize their symptoms, or worse, choose to ignore them completely. All the while, these women continue to care for their families and their multiple responsibilities in society. As such, they have neither the time nor the power to have their condition diagnosed. Even when diagnosed, many Indian women hide their illness, as HIV/AIDS patients continue to be stigmatized in Indian society. In fact, these infected women are often blamed for their situation. Because they fear abandonment and shame, many Indian women conceal their malady.

In light of these issues, the members of the United Nations convened in 2000 to unanimously endorse the Millennium Declaration to improve the general status of developing countries.⁶ From this declaration, they formed the Millennium Development Goals (MDG) as a road map to implement their plan. These goals address the core issues of gender inequality and the AIDS outbreak. In Goal 6, Target 7 of the MDG, the United Nations seeks to "have halted by 2015 and begun to reverse the spread of HIV/AIDS."⁶ Hence in twelve years, with help from the Global AIDS and Health Fund, India must curb this epidemic. The Goals are directed towards effective prevention and treatment programs that will reduce poverty, and in turn, help national economies develop to their full potential.

How can the Indian government refocus its priorities to address the HIV/AIDS concerns? First, there should be an emphasis on education of such infectious diseases in the urban and rural curriculum. Starting from grammar school, the students should be taught about HIV and its impact on society. Teachers should be encouraged to bring up the topic of sexually transmitted diseases in their teaching and to create clear strategies for educating students about safe sex practices and ways of avoiding HIV contraction. Since such topics are taboo in Indian society, it may be difficult to implement such changes. However, once implemented, the population will reap significant benefits, as the population becomes more knowledgeable about HIV/AIDS.

Sex education classes should be made mandatory for high school students because the teenage years are the most vulnerable period for infection via sexual intercourse. Local schools and districts could incorporate counsellors educated about HIV/AIDS, who would encourage concerned students to meet with them. The classroom is not always conducive to discussing private matters, and thus, private question and answer sessions

may prove to be more beneficial. Most importantly, women need to be educated from the beginning about these issues, especially if they have been exposed to some schooling.

Directed marketing on billboards, female magazines, and television commercials should focus on educating women about health issues. Even minor advertisements encouraging proper contraception usage would make a significant difference. Many of these strategies are currently being employed; however, it is not enough (see Figure 2). These policies may address the needs of the literate urban female population, but more is required for the illiterate and rural female populations. For such people, audio advertisements on public radio broadcastings and vocal discussions at religious establishments should be instituted. In addition, AIDS billboards must be made more conducive to the less educated and less literate.

Although it is difficult to change the societal structure and mores, the Indian government can help to empower women through supporting local HIV/AIDS awareness Non-Governmental Organizations (NGOs). Such NGOs are required to set up local support groups where women can come together in the rural areas to discuss such issues. In these rural settings, more village meetings and discussions for females could serve as both educational and supportive forums by women and for women. These meetings should be held frequently and support groups should encourage all local women to attend. These meetings should focus on educating the women about the disease, its modes of contraction, and the availability of treatment. The women should also be encouraged to educate their own children about the risk of HIV.

It may also be useful to educate sex workers in urban areas about their rights to female contraceptives. In addition, blood tests and screenings should be offered, and women should be encouraged to make use of such services. Distributing pamphlets and posting signs in well-known red-light districts will help to alert the FSW. In the long run, an initiative that will move women from the sex industry to microfinanced small businesses could dramatically lower female HIV infection rates, but exploring such an initiative is beyond the scope of this paper. These few but crucial steps, if implemented, would move India a step closer to reaching its MDG.

In terms of healthcare administration, women in India tend to receive less medical care than their male counterparts. A study in the Indian state of Punjab shows that medical expenditures for males are almost 2.3 times higher than for females.¹ In a society where males are valued above females, this inattention to women's medical needs must be addressed. Women in this area also tend to wait until their symptoms become intolerable before they seek help. This lack of adequate care, in the context of HIV/AIDS, has led to the high female mortality levels in India.

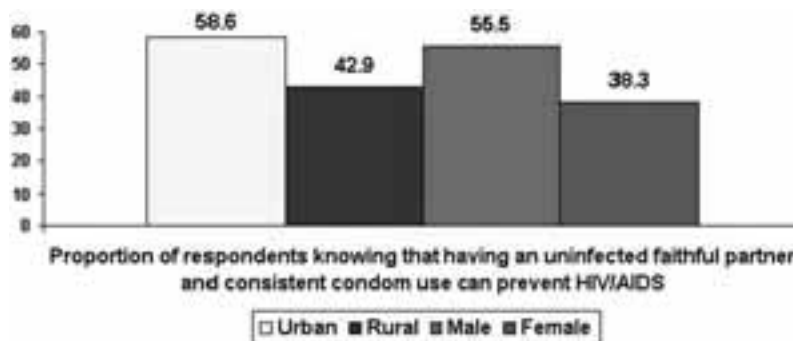


Figure 2. Knowledge of HIV/AIDS prevention methods- all India.

Source: National AIDS Control Organization

In an attempt to decrease this disparity, the Indian government should budget for subsidized female medical care in both rural and urban areas. In particular, blood tests that scan for HIV antibodies should be highly subsidized and such testing should be made free of charge. Women should be encouraged to get tested, and the results must be kept confidential. Furthermore, if a woman is HIV positive, there should be procedures in place for her to purchase affordable medicine, and child-care should be provided for the female patients in every hospital. Frequent scanning and support would not only curb HIV infection rates, but also bring attention to this plight on a regional level. Funding this initiative will involve considerable financial support from the international aid community. In this increasingly interconnected society, it is imperative that global leaders play a role in supporting developing countries suffering from the HIV/AIDS plight.

Another issue that increases the number of HIV positive women is known as vertical transmission. In this path, mothers transmit the virus to their young children. Up to ten percent of antenatal women in South Asia are infected with HIV. Many of the afflicted pregnant women transmit the virus to their infants via several methods. Five percent of these mothers transfer HIV *in utero* during gestation, fifteen percent during the delivery period, and ten percent during postnatal care (most notably through breastfeeding).² Lack of knowledge about HIV transmission among many women in rural and urban India exacerbates this situation.

Vertical transmission could be avoided through proper assessment and care. One of the drugs shown to reduce prenatal HIV transmission by up to sixty percent is zidovudine (ZDV).² With international support through the Global AIDS and Health Fund, ZDV could be highly subsidized and made available to all antenatal HIV positive women. Safer delivery practices could also help reduce the HIV vertical transmission rate. Avoiding episiotomies and premature membrane ruptures during birth and introducing more Caesarean sections would reduce the risk of blood exchange between the infected mother and her child. In addition, the use of formula would prevent transmission via breast-feeding. In order to accomplish this goal, midwives and hospitals through-


out India would have to be trained on how to treat HIV positive women to reduce the risk of vertical transmission.

The growing AIDS epidemic in urban and rural areas in India has made the AIDS issue all the more pertinent in this context. With a population of one billion, with half between the ages of fifteen and forty-nine (the most likely period of HIV infection), India needs to address the AIDS crisis with direct policy implementation. This act in turn will create a major impact on curbing the overall proliferation of HIV in the South Asia region. Currently, the Indian government has established the National AIDS Control Organisation to institute a National HIV Sentinel Surveillance program. This programme collects and analyzes information on those infected with the virus.

Recently, India has taken an even greater stance on HIV/AIDS by demanding that Western pharmaceutical companies reduce the price of HIV/AIDS drugs. As a result, India has suffered a great backlash by developed countries and their pharmaceutical companies. In light of this predicament, global companies are urged to make price cuts in drugs in order to save lives. The Indian government can also allocate more grants to their pharma-

ceutical and research institutions to support domestic innovation. First however, a net reduction of HIV/AIDS drug prices would not only benefit the Indian women afflicted with this disease, but also could be used as an opportunity for the world leader to have a direct impact on the HIV/AIDS epidemic.

In order to reverse the spread of HIV/AIDS by 2015, the Indian government and concerned groups must unite to focus on making HIV/AIDS awareness, testing, and support a concentrated priority. This multi-faceted policy should have a direct impact on women in the urban and rural sectors. Through the strengthening of civil society organizations, medical support, and healthcare education, India can make a step in the direction towards sustainable development.

Only when women truly feel empowered, economically and socially, can their health conditions improve. Different strategies are required for both rural and urban settings, as well as literate and illiterate parts of society. In either case, the goal is still the same: to improve HIV/AIDS education, healthcare, and services for Indian women. 

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