HIV/AIDS in News – Journalists as Catalysts

Toolkit for Trainers

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FAITH Healthcare Private Limited
57, Manjusha Building, (5th Floor), Nehru Place, New Delhi - 110 019 (India)
Tel.: 91-11-26292599, 51392300
email: faith@cesinter.com

Support Team
Dilip Jha
Ajeet Prasad
Nandini Datta

Designed & Printed by
Dharana, Tel.: +91-11-24317735, 24318328
email: studiodharana@gmail.com

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India

Message

The United Nations Development Programme is committed to supporting the national response to the HIV epidemic. The focus of our approach is on supporting Government in advocating for policies that are inclusive and address HIV/AIDS as a development issue.

We believe that HIV/AIDS is not just a health issue; it is a development issue as it affects the economic and social fabric of our society. It is therefore important to build a multistakeholder partnership to address the issue and UNDP plays a lead role in supporting efforts to mainstream HIV into development work of various stakeholders.

The media is an influential and far reaching stakeholder. Not only is it a powerful medium of communication and awareness generation, but it is also a key behaviour change medium as it can influence people's opinions. Journalists can stimulate open and vibrant public debate about issues that underpin the HIV/AIDS pandemic, such as unequal gender relations, social inequalities, stigma and cultural norms, and they are uniquely placed to help break the silence.

To facilitate responsible media reporting with a view to reducing Stigma and Discrimination within societies UNDP has supported the development of researchbased manuals with a state level focus. These manuals build upon the analysis of HIV/AIDS reportage in the print and electronic media in six select states.

The aim is to use these manuals to strengthen media capacity on HIV/AIDS. Two complementary manuals have been developed in partnership with the Population Foundation of India & FAITH Health care Private Ltd with support from UNDP. The Resource book includes information on the various dimensions of HIV/AIDS; the ethics of reporting, appropriate language and guidelines for responsible reporting. The Training Manual is a hands on guide for training journalists.

I would like to thank everyone who has contributed to the development of the resource book and the training manual.

I hope that these manuals will be used effectively for media advocacy.

Maxine Olson
Resident Representative UNDP

Acknowledgements

The study on 'HIV/AIDS in news' was conducted in the states of Madhya Pradesh, Haryana and Gujarat and based on the study, the Toolkit for Trainers was developed by FAITH Healthcare Private Limited, New Delhi. Support from State AIDS Control Societies in the three states, Media person, NGOs and PLHAs is greatly acknowledged. We greatly acknowledge the contributions of Mr. Sanjay Dave, Charkha Development Communication Network, Gujarat and Dr. Namrata Sharma, Faculty, Devi Ahilyabai University Indore for the their inputs and support in conducting state level workshops.

Study Team
Dr Salil Basu
Dr C K Basu
Dr Alok Banerjee
Dr Bishwajit Das
Mr Dilip Jha
Mr Ajeet Prasad
Ms Nandini Datta
Ms Alpana Bose

Peer Review Team
Ms Kalpana Jain
Ms Monalisha Mishra
Mr Nobal Thalari
Mr Rajesh Nair
Ms Alka Narang

UNDP Support Team
Dr Ash Pachauri
Mr Anirudha Brahamachari
Ms Malini Mittal

Administrative and Secretarial Support
Ms Pushpa Kala

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organisation
CSW	Commercial Sex Worker
ELISA	Enzyme Linked Immunosorbent Assay
FMS	Financial Management System
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IEC	Information, Education and Communication
NACO	National AIDS Control Organisation
NGO	Non-Government Organisation
OHP	Overhead Projector
PLHA	People Living with HIV/AIDS
SACS	State AIDS Control Society
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
UT	Union Territory
VCTC	Voluntary Counseling and Testing Centre
WHO	World Health Organisation

Introduction to the Toolkit

About the toolkit

This toolkit is a collection of participatory exercises for use in sensitisation of mediapersons involved in HIV/AIDS coverage. It can also be integrated with the existing curriculum of schools of journalism and mass communication. The toolkit has been developed keeping in view the needs of journalists working in remote areas having limited access to experts and resources related to HIV/AIDS. Content of the toolkit has been derived from the research on vernacular media in three states keeping in view the impact of media reports on stigma and discrimination related to HIV/AIDS. It is expected that the workshops conducted according to the toolkit will lead to a better understanding and sensitivity towards issues related to HIV/AIDS stigma and discrimination. Although the toolkit is structured for conducting a "One Day Workshop", the user may customise the content and timing of the workshop as per the local requirements.

Need for the toolkit

Since the early eighties, when AIDS was first recognised, an enormous amount has been learnt about HIV and the forces that drive the epidemic around the world. Now, more than 20 years later, 20 million people have died and 37.8 million people worldwide are living with HIV (UNAIDS Annual Report 2004). Two decades of tackling AIDS have yielded important successes and have taught crucial lessons about which approaches work best, although a cure remains elusive.

Mass media has had a considerable role in creating awareness about the epidemic. The vernacular media especially has a great impact on shaping people's opinions and improving their knowledge of HIV/AIDS. Media coverage of HIV/AIDS and the style and content of writing have been key elements in generating these opinions. However, media reports have also led to creation and reinforcement of various forms of stigma and discrimination. For example one of the articles in a Gujarati newspaper wrote about a woman who indulged in incest due to compelling circumstances and got infected with HIV. In the concluding paragraphs of the article, the woman blames herself for the infection and prays to the god to punish her for her sins. Such portrayals reinforce the existing stigma in the society and leads to a sense of hopelessness. If such reporting is not countered, the fear and panic already surrounding HIV/AIDS is bound to escalate, thereby hampering all efforts to prevent and control its spread.

In this perspective, the understanding and sensitivity of media need to be addressed. In an attempt to enhance the media efforts, in reducing stigma and discrimination related to HIV/AIDS, this toolkit has been developed.

How was the toolkit developed?

In order to understand the gaps in content and style of media reports on HIV/AIDS and its implication on stigma and discrimination, a study was undertaken by FAITH Healthcare Private Limited, a New Delhi based consultancy organisation with support from United Nations Development Programme (UNDP). The study involved content analysis of media reporting on HIV/AIDS in vernacular newspapers and TV channels in the states of Haryana, Gujarat and Madhya Pradesh. Reporting trend, structure, inter-textual relationship and use of language likely impacts were some of areas analysed under the study. Interactions with media persons and other stakeholders also contributed to the study findings.

Salient findings of the media study

- The coverage of HIV/AIDS in vernacular newspaper range from 43 articles in a Gujarati newspaper to 86 in a Hindi newspaper in Haryana during April 2004 – March 2005. However, less than 10% (range 0 –10%) of the articles find their place on the front page.
- A majority of articles were smaller in size, mostly covering events. Features, columns and editorial were only few. Prevalence, deaths and awareness were the main focus areas. Coverage of rights, stigma & discrimination and life of PLHAs were scant.
- Structural deficiencies in terms of poor linkage with headlines, incoherence of the paragraphs/arguments and varying focus of the arguments were observed among all vernacular newspaper. The main reason for structural deficiency was a significant difference in understanding, sensitivity and priority of field reporters and desk editors.
- Misconceptions, incorrect use of terminology and incomplete information were commonly observed in the news articles showing the journalists' lack of clarity about the key concepts of HIV/AIDS.
- Words with negative meanings were frequently used throughout the articles in the context of HIV/AIDS. These include words such as "fatal disease" (jaanleva bimari), "incurable disease" (lailaj bimari), "ill repute" (badnaami), "frightened" (sahme hue), "the fear of AIDS" (AIDS ka khauf) etc. create a sense of hopelessness, panic and fear as well as lead to stigma.
- Instances of association of HIV/AIDS with prostitution, with rape, criminal activities, and immoral activities were observed giving the impression that AIDS is much worse than other stigmatising issues.
- Biases and stereotypes against women and other vulnerable groups existing within the society were usually reflected in the articles.
- PLHAs and other vulnerable groups showed lack of trust in media regarding privacy and confidentiality.

Findings of the study clearly indicated the need for the following:

- Improving the knowledge and understanding of journalists regarding facts and myths related to HIV/AIDS.
- Greater consciousness regarding impact of media on existing stigma and discrimination in the society.
- Conscious efforts for gender sensitive reporting.
- Improving the content and style of reporting to avoid promoting misconception and promote positive attitude towards overcoming the epidemic.
- Better understanding of life and concerns of PLHAs.

Based on the needs arising out of the study, a framework for media sensitisation workshop was developed. Taking into account the time constraints faced by journalists due to their job requirement and working patterns, it was decided to restrict the duration of the workshop to 'One Day'. Documents for training media person and other functionaries especially in the African context were consulted for arriving at various activities/exercises for the workshop. Before finalising this toolkit, a pre-test workshop with select group of journalist was conducted at Ahmedabad. The workshop yielded valuable feedback regarding the applicability of content and processes described in the toolkit. The learning from pre-testing workshop were duly incorporated in this toolkit.

The organisation of the toolkit

The toolkit contains information/instructions for conducting a one-day workshop on "HIV/AIDS in News – Journalists as Catalysts". It consists of the details of the following five sessions:

Session 1: Orientation (participants' introduction, understanding media expectations, introducing the Workshop)

Session 2: Understanding HIV/AIDS (HIV/AIDS scenario, basics of HIV/AIDS, facts & myths)

Session 3: Understanding Stigma & Discrimination (understanding forms of Stigma, causes and effects, mitigation measures)

Session 4: Media & HIV/AIDS (analysing gender & human rights, structure and content of media reports, perspectives of reporter vs. editor)

Session 5: Role of Media (understanding PLHAs perspective & sensitivities, identifying role of media)

The toolkit details objectives, activities, duration, resources needed and

process to be adopted for each session and exercises. Where ever required, further instructions are provided to the facilitator in 'facilitator's note'. Additional information that may be useful to the facilitators is also provided at the end of each exercise. Presentation materials for the facilitator and reading material for the participants are also provided at the end of each exercise.

Who can use this toolkit?

This toolkit is meant for state AIDS control societies, organisations working with HIV/AIDS related issues and any institution involved in media sensitisation.

Target audience

The audience for the workshop is primarily journalists working in print and electronic (TV and radio) media. The workshop content will be valuable to enhance their understanding of HIV/AIDS and improving their sensitivities in reporting.

Journalists identified for the workshop should ideally be those working in vernacular media, and should comprise both field reporters as well as desk editors. They may be employed within a media institution or be free-lance journalists. In addition, the audience may include students of schools of journalism and mass communication and representatives of organisations working in the field of HIV/AIDS.

Preparatory work

- Plan and schedule the workshop three to four weeks in advance.
- In case the workshop is conducted on a periodic basis, a calendar should be prepared and sent to the potential participants.
- In order to have a better turnout at the workshop, participants may be consulted before finalising the date and venue (during interaction, some journalists suggested that second Saturday of each month would be ideal).
- The bureau chief/in-charge of the media organisation should be consulted for preparing the list of participants.
- Identify the suitable venue and check for the available facilities including sitting arrangement, presentation equipments, white board etc.
- Issue invitation letter and follow up with the participant.
- Procure / ensure availability of workshop materials.
- Ensure arrangements for providing tea, snacks, lunch etc. to the participants.
- Participation of PLHAs/ NGO functionaries should be ensured in advance.

Workshop material

- Participants folder/bag containing writing pad, pen, copy of workshop schedule and any promotional material as decided by the organisers.
- Transparencies with overhead projector or computer projector, flip charts, white board.
- photocopies of handouts, note-cards, evaluation questionnaire.

Facilitator and resource person

Conducting workshop with mediaperson requires a careful handling of various sessions and exercises so as to ensure their active participation. Therefore, the facilitator should have prior experience of conducting interactive workshops. Attempt should be made to involve experts as resource person during various technical sessions. For example, expert on HIV/AIDS programmes and policies could be helpful during second session and a media expert during fourth and fifth session. It is important that the facilitators read through the toolkit and understands the objectives of the workshop, as well as, the individual sessions. This will also allow the facilitator to be aware of situations which require prior preparation.

Session One

Orientation

Objectives

- To welcome the participants and to fecilitate introductions.
- To understand participants' expectations from agencies working on HIV/AIDS.
- To orient the participants to the need, objectives and structure of the workshop.

Duration

60 minutes

Structure

- Exercise one: Participants' Introduction
- Exercise two: Discussion on Media Expectations
- Exercise three: Introduction to the Workshop

Orientation

Exercise 1 — Participants' Introduction

Objectives

- To welcome the participants and to facilitate introductions.

Duration

10 minutes

Structure

Self-introduction by the participants

Process

- First introduce yourself then ask the participants to introduce him/herself one after another.
- The introduction should include participant's name, name of the organisation, designation and nature of work.

Outcome

Participants get familiar with each other.

Facilitator's Note

Ice-breaking game given in the toolkit may be used depending on the requirement and time available. In situations where only few participants have reported and others are expected within a short time, this game could be used to keep them engaged and letting others join.

Exercise 1

Game: Ice-breaker

1. The sun shines on...

The participants sitting in the extreme left in the front row stands and shouts out "the sun shines on..." and names a colour or articles of clothing that someone in the group possess. For example, "the sun shines on all those wearing blue" or "the sun shines on all those wearing socks" or "the sun shines on all those with brown eyes". All the participants who have that attribute must raise their hand quickly. Then everybody should find out the person who was late in responding. This person then stands up and shouts out "the sun shines on..." and names a different colour or type of clothing. The game may go on as long as the time permits.

2. Names and adjectives

Each participant think of an adjective to describe how they are feeling or how they are. The adjective must start with the same letter as their name, for instance, "I'm Henri and I'm happy". Or, "I'm Arun and I'm amazing." As they say this, they can also mime an action that describes the adjective. Each participant takes their turn to describe the adjective.

3. What is the adverb?

One participant leaves the room and the others choose an adverb; for example, 'quickly' or 'sleepily'. When the leaver returns, s/he must find out what the adverb is by commanding people to do various actions 'in that way'. For example, if the leaver says "Talk that way", the group must talk 'quickly' or 'sleepily'. After each command, the participant tries to guess the word. This game could be tried with younger groups like students.

Source: 100 Ways to Energise Groups,The International HIV/AIDS Alliance, 2002.

Orientation

Exercise 2 Discussions on Media Expectations

Objectives

- To understand participants' expectations from agencies working on HIV/AIDS.

Duration

30 minutes

Structure

Discussion

Discussion between participants and officials of various agencies working on HIV/AIDS.

Process

- Ask the participants to share verbally their expectations from the SACS and other agencies working on HIV/AIDS (NGOs, network of positive people etc).
- Initiate a discussion between agencies working on HIV/AIDS and participants regarding how these expectations can be met.
- Discuss the ways to improve co-operation between media and agencies working on HIV/AIDS.

Outcome

At the end of the discussion, participants will have their grievances redressed and will be in a receptive mood to participate in the workshop.

Facilitator's Note

Participants should be allowed to express their grievances especially with regard to cooperation from the agencies. This session should have the participation of officials from SACS and other agencies so that queries of journalists should be adequately responded. The discussion should be guided in such a way that it leads to trust building and an impression of future collaboration. This occasion can also be used to announce initiatives to motivate journalists for increased and improved coverage of HIV/AIDS. In case the discussion goes on for a longer duration, facilitator should intervene and tell the participant that the discussion could be continued during the last session on the role of media.

Orientation

Exercise 3 — Introduction to the Workshop

Objectives

- To orient the participants to the need, objectives and structure of the workshop.

Duration

20 minutes

Materials

OHP/LCD projector, presentation slides, newspaper clippings/TV footage

Structure

Presentation

Presentation on the objectives and structure of the workshop.

Process

- ☐ At the start of this exercise, show or read out news clippings which promote misconceptions and biases and emphasise on its likely impact.
- ☐ Present the findings of the media review.
- ☐ Present the objectives of the workshop linking it with study findings.
- ☐ Present the session plan & duration.

Outcome

Journalists will realise the need for better knowledge and understanding of issues related to HIV/AIDS and understand how workshop sessions will help them.

Facilitator's Note

Before beginning the presentation, the facilitator may ask the participants "Do you think that journalists need to be trained in reporting on HIV/AIDS?" Whatever the answer, show or read out a poorly written article, it should be highlighted that a few poorly written articles may cause more damage than a number of good articles can mitigate. Selection of articles should be done in advance and the identity of newspaper and reporter should be kept confidential.

While explaining the objectives of the workshop, it should be emphasised that the purpose is not to train journalists rather to improve their understanding and enhance their sensitivity in reporting.

Exercise 3

Presentation Slides

Slide 1

Study of media reporting on HIV/AIDS

- The study was conducted on vernacular newspapers and TV channels in the states of Haryana, Gujarat and Madhya Pradesh during March–September 2005.
- The study involved content analysis on reporting trend, structure, inter-textual relationship and use of language.
- Interactions with media persons and other stakeholders such as PLHAs, MSMs, CSWs, NGOs also contributed to the study findings.

Findings

- The coverage of HIV/AIDS ranged from 43 articles in a Gujarati newspaper to 86 in a Hindi newspaper in Haryana during April 2004 – March 2005.
- Less than 10% (range 0-10%) of the articles find their place on the front page.
- A majority of articles were smaller in size, mostly covering events. Features, columns and editorial were only few.
- Prevalence, deaths and awareness were the main focus areas. Coverage of rights, stigma & discrimination and life of PLHAs were scant.

Slide 2

Study of media reporting on HIV/AIDS (contd...)

- Structural deficiencies – poor linkage with headlines, incoherence of the paragraphs/arguments and varying focus of the arguments.
- Main reason for structural deficiency – significant difference in understanding, sensitivity and priority of field reporters and desk editors.
- Misconceptions, incorrect use of terminology and incomplete information – commonly observed in the news articles showing the journalists' lack of clarity about the key concepts of HIV/AIDS.
- Words such as "fatal disease" (jaanleva bimari), "incurable disease" (lailaj bimari), "ill repute" (badnaami), "frightened" (sahme hue) etc. create a sense of hopelessness, panic and fear as well as lead to stigma.
- Instances of association of HIV/AIDS with prostitution, rape, criminal activities, and immoral activities were observed in news reports leading to further stigmatisation.
- Biases and stereotypes against women and other vulnerable groups existing within the society were usually reflected in the articles.
- PLHAs and other vulnerable groups showed lack of trust in media regarding privacy and confidentiality.

Exercise 3

Presentation Slides

Slide 3

Objectives of the workshop

- To orient journalists about the extent of HIV/AIDS problem in regional, national and international contexts.
- To enhance the knowledge and understanding of journalists regarding basic concepts of HIV/AIDS.
- To enhance the journalists' understanding of stigma and discrimination related to HIV/AIDS.
- To promote a balanced and non stereotype gender portrayal in the media.
- To promote the voices of PLHAs by the media.
- To enable journalists to identify their role towards positive and responsible presentation of HIV/AIDS related issues.

Session Two

Understanding HIV/AIDS

Objectives

- To orient the participants on the magnitude of the HIV/AIDS problem and its impact.
- To enhance participants' knowledge about basics of HIV/AIDS.
- To clarify myths and misconceptions related to HIV/AIDS.

Duration

60 minutes

Structure

- ☐ Briefing on session objectives
- ☐ Exercise one: Presentation on HIV/AIDS scenario
- ☐ Exercise two: Presentation on basics of HIV/AIDS
- ☐ Exercise three: Quiz on myths and facts of HIV/AIDS

Orientation

Exercise 1 — Presentation on HIV/AIDS Scenario

Objectives

- To orient the participants on the magnitude of the HIV/AIDS problem and its impact.

Duration

15 minutes

Materials

OHP/LCD projector, presentation slides, reading material

Structure

Presentation

Presentation on country and global scenario of HIV/AIDS epidemic.

Process

- Start the presentation on global scenario highlighting number of PLHAs, new infections, age group, gender and geographical expanse
- Present the Indian and local scenario
- Highlight the impact of the epidemic

Outcome

At the end of the exercise, the participants will understand the magnitude of the AIDS problem worldwide and in local context.

Facilitator's Note

The facilitator should include a presentation slide on the local HIV/AIDS scenario. For this, local resource person could be identified in advance. Further, additional information based on need and time could also be incorporated in the presentation.

In situations where participant show lack of interest in presentation, the facilitator may switch to a more informal setup e.g. changing the sitting arrangement to a circular format and presenting only the highlights, facts and figures of the presentation. Facilitator may think of other ways of doing this.

Exercise 1

Presentation Slides

Slide 1

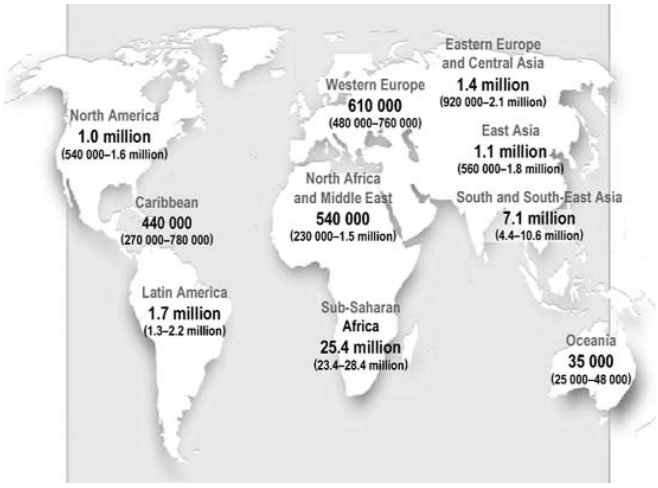
Global scenario

Number of people living with HIV in 2004	**Total 39.4 million (35.9–44.3 million)**
Adults	37.2 million (33.8–41.7 million)
Women	17.6 million (16.3–19.5 million)
Children under 15 years	2 .2 million (2.0–2.6 million)
People newly infected with HIV in 2004	**Total 4.9 million (4.3–6.4 million)**
Adults	4.3 million (3.7–5.7 million)
Children under 15 years	640 000 (570 000–750 000)
AIDS deaths in 2004	**Total 3.1 million (2.8–3.5 million)**
Adults	2.6 million (2.3–2.9 million)
Children under 15 years	510 000 (460 000–600 000)

Source: Global summary of AIDS Epidemic, UNAIDS, December 2004

Slide 2

Adults and children estimated to be living with HIV and AIDS as of end 2004



Source: Report on the Global AIDS Epidemic 2004, UNAIDS

Exercise 1

Presentation Slides

Slide 3

Global scenario

Number of people living with HIV in India (2004)	**Total 5.134 million**
Rural	3.007 million (58.57%)
Urban	2.127 million (41.43%)
Women	39%
People newly infected with HIV in 2004	**28,000**
Overall HIV prevalence	**0.91%**

Source: http://www.nacoonline.org/facts_hivestimates04.htm

- India accounts for 13% of Global HIV prevalence.
- In terms of absolute number, India is second to South Africa with 5.3 million HIV infection (HIV prevalence 21.5%).

Slide 4

Impact of AIDS on people and society

- Household Level:
  - Loss of income and productivity of household member
  - Extraordinary care needs
  - Rise in household expenditure
- Gender:
  - Women face heavy economic, legal, cultural and social disadvantages leading to their vulnerability to the epidemic and its impact
- Employment:
  - Erosion of economic growth, through impact on labour supply and productivity, savings rate, and delivery of essential services
  - Individuals living with HIV lose jobs, incomes and savings
- Children
  - Children orphaned by HIV/AIDS face traumatic circumstances and are often deprived of basic needs

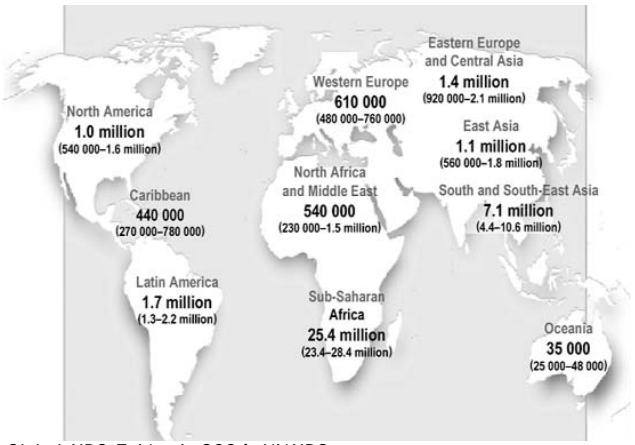
Source: Report on the Global AIDS Epidemic 2004, UNAIDS

Exercise 1

Reading Material

HIV/AIDS global scenario

Adults and children estimated to be living with HIV and AIDS as of end 2004



Source: Report on the Global AIDS Epidemic 2004, UNAIDS

Number of people living with HIV in 2004	
Total 39.4 million (35.9-44.3 million)	
Adults	37.2 million (33.8-41.7 million)
Women	17.6 million (16.3-19.5 million)
Children under 15 years	2.2 million (2.0-2.6 million)

Source: AIDS Epidemic Update 2004, UNAIDS/WHO

People newly infected with HIV in 2004	
Total 4.9 million (4.3-6.4 million)	
Adults	4.3 million (3.7-5.7 million)
Children under 15 years	2.2 million (2.0-2.6 million)

Source: AIDS Epidemic Update 2004, UNAIDS/WHO

AIDS deaths in 2004	
Total 3.1 million (2.8-3.5 million)	
Adults	2.6 million (2.3-2.9 million)
Children under 15 years	510 000 (460 000-600 000)

Source: AIDS Epidemic Update 2004, UNAIDS/WHO

Exercise 1

Reading Material

HIV/AIDS country scenario

India and HIV

With an estimated 5.134 million people living with HIV in the adult population (15-49 years) in 2004, India accounts for almost 13% of the global HIV prevalence. Despite this large number of HIV-infected individuals, because of its large population size, India continues to be in the category of low prevalence countries with an overall prevalence of less than 1%. Though the overall national prevalence is low, six states have reached high prevalence (> 1 %): Manipur, Nagaland, Andhra Pradesh, Tamil Nadu, Karnataka and Maharashtra.

Number of people living with HIV in India in 2004

Male (in millions)	Female (in millions)	Total (in millions)
3.132	2.002	5.134

Source: NACO

AIDS cases in India as per monthly updates on AIDS (31st July, 2005)

Surveillance for AIDS cases in India (Period of report – since 1986 to 31st July, 2005)

AIDS cases in India	Cumulative	This month
Males	79,041	556
Females	32,567	196
Total	**111,608**	**752**

Source: NACO

Number of cases by risk/transmission category as of 31st July 2005

Risk/transmission categories	Number of cases	Percentage
Sexual	95,941	85.96
Perinatal transmission	4,059	3.64
Blood and blood products	2,231	2.00
Injecting drug users	2,672	2.39
Others (not specified)	6,705	6.01
Total	**111,608**	**100.00**

Source: NACO

Exercise 1

Reading Material

Number of cases by age group and sex as of 31st July 2005

Age group	Male	Female	Total
0 – 14 yrs.	2,860	1,994	4,854
15 – 29 yrs.	21,782	14,405	36,187
30 – 49 yrs.	48,342	14,508	62,850
> 50 yrs.	6,057	1,660	7,717
Total	79,041	32,567	111,608

Source: NACO

AIDS cases in India (reported to NACO, as on 31st July, 2005)

S. No.	State/UT	AIDS cases
1	Andhra Pradesh	12,349
2	Assam	225
3	Arunachal Pradesh	0
4	A & N Islands	33
5	Bihar	155
6	Chhattisgarh	0
7	Chandigarh (UT)	1,260
8	Delhi	970
9	Daman & Diu	1
10	Dadra & Nagar Haveli	0
11	Goa	567
12	Gujarat	5,636
13	Haryana	486
14	Himachal Pradesh	252
15	Jharkhand	0
16	Jammu & Kashmir	2
17	Karnataka	2,896
18	Kerala	1,769
19	Lakshadweep	0
20	Madhya Pradesh	1,396
21	Maharashtra	13,747
22	Orissa	467
23	Nagaland	736
24	Manipur	2,866
25	Mizoram	106
26	Meghalaya	8
27	Pondicherry	302
28	Punjab	292
29	Rajasthan	1,153
30	Sikkim	8
31	Tamilnadu	52,036
32	Tripura	5
33	Uttranchal	0
34	Uttar Pradesh	1,383
35	West Bengal	2,397
36	Ahmedabad Mun.Corp.	621
37	Chennai Mun. Corp.	0
38	Mumbai Mun.Corp.	7,484
	Total	**111,608**

Source: http://www.nacoonline.org/facts_reportjuly.htm

Exercise 1

Reading Material

Impact of HIV/AIDS

In all affected countries with either high or low HIV prevalence, AIDS hinders development, causing a devastating toll on individuals and families. In the hardest-hit countries, it is erasing decades of health, economic and social progress – reducing life expectancy by years, deepening poverty, and contributing to and exacerbating food shortages.

Population and workforce

In hard-hit countries, AIDS is likely to reduce the growth rate of the labour force, as it primarily strikes the working-age population. The International Labour Organisation's findings (HIV/AIDS and work: global estimates, impact and response, 2004) indicate that HIV/AIDS has a potential negative impact on economic growth and sustainable development, even in countries which have high populations and low HIV prevalence such as India. The report also states that slow economic growth has serious implications with regards to both job creation as well as employment.

Women

The epidemic's impact is particularly hard on women and girls as the burden of care usually falls on them. Girls drop out of school to care for sick parents or for younger siblings. Older women often take on the burden of caring for ailing adult children and later, when they die, adopt the parental role for the orphaned children. They are often also responsible for producing an income or food crops. Older women caring for orphans and sick children may be isolated socially because of AIDS-related stigma and discrimination. Stigma also means that family support is not a certainty when women become HIV-positive; they are too often rejected, and may have their property seized when their husband dies.

Poverty and hunger

In some of the worst affected countries, the living standards of many poor people were already deteriorating before they experienced the full impact of the epidemic. In general, AIDS-affected households are more likely to suffer severe poverty than non-affected households; this is true for countries with low prevalence as well as those with high rates.

AIDS takes away the income and production capacity of family members that are sick, at the same time as creating extraordinary care needs and rising household expenditure on medical and other costs, such as funeral expenses. On average, AIDS care-related expenses could absorb one-third of a household's monthly income. Families may have to use their savings, sell assets such as land and livestock, borrow money or seek support from their extended family. They also have to reduce

(Contd...)

Exercise 1

Reading Material

spending on housing and clothing. AIDS is intensifying chronic food shortages in many countries where large numbers of people are already undernourished. The epidemic is significantly reducing countries' agricultural workforce and families' income with which to buy food. This is especially damaging for people living with AIDS who need more calories than uninfected individuals.

Agriculture and rural development
A healthy agricultural sector is essential for the well-being and self-sufficiency of developing countries. But the epidemic is attacking the agricultural base of many countries, especially those where the HIV/AIDS estimates are highest.

Education
Globally, AIDS is a significant obstacle to children achieving universal access to primary education by 2015 (a key target of UNESCO's Education for All Initiative and the UN's Millennium Development Goals). An estimated US$1 billion per year is the net additional cost to offset the results of AIDS – the loss and absenteeism of teachers and demand incentives to keep orphans and other vulnerable children in school.

Children, especially girls, from AIDS-affected families are often withdrawn from schools to compensate for loss of income through a parent's sickness and related expenses, to care for sick relatives and look after the home. These families may also take their children out of school because they cannot afford school fees.

Health sector
The epidemic has created a need for robust, flexible health systems at a time when many affected countries have been reducing public service spending to repay debt and conform to international finance institutions' requirements. So already weakened systems are being forced to cope with the extra burden of sickness and the loss of essential staff through sickness and death related to AIDS.

(Source: 2004 Report on the global AIDS epidemic, UNAIDS)

Understanding HIV/AIDs

Exercise 2 — Presentation on Basics of HIV/AIDS

Objectives

- To enhance participants' knowledge about basics of HIV/AIDS.

Duration

20 minutes

Materials

OHP/LCD projector, presentation slides, reading material.

Structure

Presentation

Presentation on basic facts about HIV/AIDS.

Process

- Start the presentation by explaining the term HIV & AIDS and the link between them.
- Highlight the modes of transmission, prevention, testing & treatment.

Outcome

At the end of the exercise, the participants should recognise the need to know more about various aspects of HIV/AIDS.

Facilitator's Note

The facilitator may identify local resource person who is knowledgeable regarding medical and programmatic aspects of HIV/AIDS to provide clarifications on various aspects of HIV transmission, prevention, diagnosis treatment etc. Further, additional information based on need and time could also be incorporated in the presentation.

As mentioned in the earlier exercise, in situations where participant show lack of interest in presentation, the facilitator may switch to a more informal setup.

Exercise 2

Presentation Slides

Slide 1

HIV and AIDS

- HIV stands for Human Immunodeficiency Virus.
- AIDS stands for Acquired Immunodeficiency Syndrome.
- HIV is the virus that causes the syndrome AIDS.
- HIV attacks white blood cells (cells in the blood stream which provide immunity from diseases).
- AIDS is the condition where the immune system is totally destroyed and other infections take over the system.
- These other infections are known as “opportunistic infections”.

Slide 2

Transmission of HIV

- HIV is transmitted through certain (proved) body fluids – blood, semen, vaginal fluid, breast milk, body fluids containing blood, given the condition that the fluid has sufficient viral load and there is a port of entry.
- HIV is transmitted through:
  - Unprotected sexual intercourse
  - Sharing infected syringes / needles
  - Infected blood transfusion
  - Infected parent to child transmission
- The virus is not transmitted through air or water or by casual contact.
- An HIV infected person may develop AIDS symptoms after 8-10 years after infection.

Exercise 2

Presentation Slides

Slide 3

Signs and symptoms

- Major signs
  - Weight loss of over 10% of body weight
  - Fever for longer than one month
  - Diarrhoea for longer than one month
- Minor signs
  - Persistent cough for more than one month
  - General itchy skin diseases
  - Recurring shingles
  - Thrush in the mouth and throat
  - Long lasting, spreading and severe cold sores
  - Long lasting swelling of lymph glands
  - Loss of memory
  - Loss of intellectual capacity
  - Peripheral nerve damage

Note: These symptoms are generic and HIV infection can only be confirmed through HIV test.

Slide 4

Testing and diagnosis

- The first test, called ELISA (Enzyme Linked Immunosorbent Assay), looks for such antibodies in blood which are formed as a result of HIV infection.
- A pre-test counseling is conducted at VCTC for anybody preparing to take a test.
- All positive tests by ELISA need not be accurate and hence another test called Western Blot or Immunoflouroscent Assay (IFA) and repeated tests are necessary to confirm a person's HIV status.
- A post-test counseling is conducted for a person who has undergone a test because of the enormous stress and the multitude of emotions that the infected person could undergo on learning his/her HIV status.

Exercise 2

Presentation Slides

Slide 5

Treatment

- Till today, there is no cure for AIDS.
- However, timely treatment of opportunistic infections can keep one **healthy for many years.**
- During the last decade **Anti-Retroviral** drugs have been developed.
- These drugs check the replication of the virus at various levels.
- These drugs can drastically reduce the viral load in blood.
- They do not permanently cure one of HIV.
- More than a dozen HIV vaccines are currently being tested.

Slide 6

Prevention

- Since there is no effective cure, best way to protect oneself from infection is by prevention.
- HIV transmission can be prevented by avoiding certain risk behaviour.
- Sexual mode of transmission can be prevented by
  - abstinence, non-penetrative sexual practices, use of condoms.
- Parenteral transmission can be prevented by.
  - avoiding sharing of syringe/needle, sterilisation of medical equipment, by screening blood/blood products before transfusion.
- Prevention of infection from HIV infected mother to child by
  - taking medication available which prevents transmission to child, having a hospital delivery and avoiding breast-feeding.

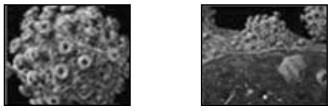
Exercise 2

Reading Material

Basics of HIV/AIDS

What is HIV?

HIV (Human Immunodeficiency Virus) is a virus that causes AIDS (Acquired Immunodeficiency Syndrome), a health condition in which a person is affected by a series of diseases because of poor immunity. HIV by itself is not an illness and does not instantly lead to AIDS. An HIV infected person can lead a healthy life for several years before s/he develops AIDS.
(*UNAIDS definition*)



Human Immunodeficiency Virus

What is AIDS?

As the name, Acquired Immunodeficiency Syndrome indicates, AIDS is a health condition that results from the deficiency in the body's immunity following HIV infection. HIV attacks the human body by breaking down its immune system that is meant to fight diseases. Over a period of time, the immune system weakens and the body loses its natural ability to fight diseases. At this stage, various diseases affect the infected person.
(*UNAIDS definition*)

Does HIV cause AIDS?

Yes. The body of evidence that the underlying cause of AIDS is infection with HIV-1 or HIV-2 is irrefutable. The proof meets the highest demands and standards of science. The process for isolating the virus and linking it to AIDS followed standard systematic scientific steps similar to investigations into other viral diseases such as polio, measles and smallpox. A century ago, the German bacteriologist Robert Koch, devised a test for proving that a disease is caused by a specific microbe. That test, has since become a standard in medicine and is known as "Koch's postulate". Scientists agree that the evidence on the link between HIV and AIDS passes this test. The steps are as follows: first, the microbe must be isolated from a host that has come down with the disease. Then, the microbe is given to a healthy host, where it must cause the same disease. Finally, the microbe must be isolated from this last host. There is a clear correlation of clinical findings of AIDS and the identification of HIV in the blood (although this is usually done by identification of HIV-antibodies, more sophisticated techniques directly identify the presence of HIV gene sequences and/or infectious virus).
(Source: Q&A II: Basic facts about the AIDS epidemic and its impact, UNAIDS Questions & Answers, November 2004)

Exercise 2

Reading Material

How is HIV transmitted?
HIV is transmitted through sexual intercourse (anal or vaginal); blood transfusion; the sharing of contaminated needles in drug injection; and, between mother and infant, during pregnancy, childbirth, and breastfeeding. Sharing of infected blood through blood transfusion or injecting drugs is the most efficient way of transmitting HIV. The virus is not transmitted through air or water or by casual contact.(Sources: Q&A II: Basic facts about the AIDS epidemic and its impact UNAIDS Questions & Answers, November 2004)

Unprotected sex:
If a person engages in sexual intercourse with an infected person without using a condom, s/he can get infected. The sexual act can be both vaginal and anal. Theoretically oral sex without condom (on men) or barriers like dental dam, vaginal dams or plastic wrap (on women) can also transmit the infection.

Sharing of needles:
If a person shares the needle or syringe used by/on an infected person, either for injecting drugs or drawing blood or for any other purpose involving piercing, s/he can get infected. Instruments used for piercing and tattooing also carry a small risk of infection.

Unsafe blood:
A person can get the infection, if he/she is given transfusion of infected blood.

Parent to child:
An HIV positive mother can transmit the virus to child during pregnancy or birth. Breast milk can also act as a transmission-medium.

What is parent to child transmission?
Babies born to mothers infected with HIV may or may not be infected with the virus, but all carry their mothers' antibodies to HIV for several months after birth. If these babies lack symptoms, a definitive diagnosis of HIV infection using standard antibody tests cannot be made until after 15 months of age. By then, the babies are unlikely to still carry their mothers' antibodies and will have produced their own, if they are infected. New technologies to detect HIV itself are being used to more accurately determine HIV infection in infants between ages 3 months and 15 months. A number of blood tests are being evaluated to determine if they can diagnose HIV infection in babies younger than 3 months.
(source: UNAIDS)

Exercise 2

Reading Material

HIV and STDs

Sexually Transmitted Diseases (STDs) caused by unprotected sexual activity enhance the transmission risk of HIV in the general population. STD causes some damage to the genital skin and mucous layer, which facilitates the entry of HIV into the body. The most dangerous STDs are syphilis, chancrold, genital herpes and gonorrhoea. Early treatment of STD reduces the risk of spread to other sexual partners and also reduces the risk of contracting HIV from infected partners. Besides, early treatment of STD also prevents infertility and ectopic pregnancies.

Ways in which HIV is not transmitted

- ☐ Drinking water or eating food from the same utensils used by an infected person.
- ☐ Socialising or casually living with PLHAs.
- ☐ Hugging, touching or kissing.
- ☐ Caring and looking after people with HIV/AIDS.
- ☐ Getting bitten by an infected person.
- ☐ Use of the same toilets as PLHAs.
- ☐ Sharing telephones or computers.
- ☐ Sneezing and coughing.
- ☐ Getting bitten by a mosquito that has already bitten an infected person.
- ☐ Donating blood, if clean equipment is used.
- ☐ Working with people who are HIV positive.

How long after HIV infection do people develop signs of AIDS?

The majority of people infected with HIV, if not treated, develop signs of AIDS within eight to 10 years. Symptoms of AIDS generally appear when the numbers of CD4 white blood cells (critical in mounting immune responses) decreases to 200 per mm3 of blood. Although the length of time between the first detection of HIV antibodies to the onset of symptoms differs between locations.

(Q&A II: Basic facts about the AIDS epidemic & its impact , UNAIDS Questions & Answers, November 2004)

Exercise 2

Reading Material

Is it true that people can be HIV-positive and not develop AIDS?
Speculation that HIV does not cause AIDS has in part been fuelled by the existence of groups of individuals who have been HIV-positive for many years without progressing to AIDS. The course of HIV infection and the development of AIDS do vary among individuals. About five to 10% of HIV-positive individuals develop AIDS symptoms very rapidly during the first years of infection, and about the same proportion remain infected with HIV for 15 years or more without progressing to AIDS. But on average, AIDS symptoms develop approximately eight to 10 years after initial HIV infection in people who do not receive ARV therapy.

(Q&A II: Basic facts about the AIDS epidemic & its impact , UNAIDS Questions & Answers, November 2004)

Stages after being infected with HIV

1) Acute sero-conversion – HIV spreads all over body within weeks of infection
2) Window period – 6 weeks to 6 months for person with HIV to test as positive
3) Asymptomatic stage – Virus replicates itself and begins killing the cells of the immune system
4) Symptomatic stage – HIV attacks and destroys CD4 lymphocytes and the immune system is disabled.

(Source: Resource Manual on HIV/AIDS for training of Education Officers of the Central Board for Workers Education, ILO/VV Giri National Labour Institute)

What are the early symptoms of HIV infection?
Many people do not develop any symptoms when they first become infected with HIV. Some people, however, get a flu-like illness within three to six weeks after exposure to the virus. This illness, called Acute HIV Syndrome, may include fever, headache, tiredness, nausea, diarrhoea and enlarged lymph nodes (organs of the immune system that can be felt in the neck, armpits and groin). These symptoms usually disappear within a week to a month and are often mistaken for another viral infection.

During this period, the quantity of the virus in the body will be high and it spreads to different parts, particularly the lymphoid tissue. At this stage, the infected person is more likely to pass on the infection to others. The viral quantity then drops as the body's immune system launches an orchestrated fight.

More persistent or severe symptoms may not surface for several years, even a decade or more, after HIV first enters the body in adults, or within two years in children born with the virus. This

(Contd...)

Exercise 2

Reading Material

period of asymptomatic infection varies from individual to individual. Some people may begin to have symptoms as soon as a few months, while others may be symptom-free for more than 10 years. However, during the asymptomatic period, the virus will be actively multiplying, infecting, and killing cells of the immune system.

What happens inside the body?
Once HIV enters the human body, it attaches itself to a White Blood Cell (WBC) called CD4. Also, called T4 cells, they are the main disease fighters of the body. Whenever there is an infection, CD4 cells lead the infection-fighting army of the body to protect it from falling sick. Damage of these cells, hence can affect a person's disease-fighting capability and general health.

After making a foothold on the CD4 cell, the virus injects its RNA (ribonucleic acid) into the cell. The RNA then gets attached to the DNA (deoxyribonucleic acid) of the host cell and thus becomes part of the cell's genetic material. It is a virtual takeover of the cell. Using the cell's division mechanism, the virus now replicates and churns out hundreds of thousands of its own copies. These cells then enter the blood stream, get attached to other CD4 cells and continue replicating. As a result, the number of the virus in the blood rises and that of the CD4 cells declines.

Because of this process, immediately after infection, the viral load of an infected individual will be very high and the number of CD4, low. But, after a while, the body's immune system responds vigorously by producing more and more CD4 cells to fight the virus. Much of the virus gets removed from the blood. To fight the fast-replicating virus, as many as a billion CD4 cells are produced every day, but the virus too increases on a similar scale. The battle between the virus and the CD4 cells continues even as the infected person remains symptom-free.

But after a few years, which can last up to a decade or even more, when the virus numbers in the body rise to very high levels, the body's immunity starts getting defeated. The balance shifts in favour of the virus and the person becomes more susceptible to various infections. These infections are called Opportunistic Infections because they swarm the body using the opportunity of its low immunity. At this stage, the number of CD4 cells per millilitre of blood (called CD4 Count), which ranges between 500 to 1,500 in a healthy individual, falls below 200. The Viral Load, the quantity of the virus in the blood, will be very high at this stage.

Opportunistic infections are caused by bacteria, virus, fungi and parasites. Some of the common opportunistic infections that affect HIV positive persons are: Mycobacterium avium complex (MAC),

(Contd...)

Exercise 2

Reading Material

Tuberculosis, Salmonellosis, Bacillary Angiomatosis (all caused by bacteria); Cytomegalovirus (CMV), Viral hepatitis, Herpes, Human papillomavirus (HPV), Progressive multifocal leukoencephalopathy (PML); Candidiasis, Cryptococcal meningitis and Pneumocystis Carinii pneumonia (PCP). Toxoplasmosis. Cryptosporidiosis.

HIV positive persons are also prone to cancers like Kaposi's sarcoma and lymphoma. The Center for Disease Control (CDC), Atlanta has listed a series of diseases as AIDS-defining. When these diseases appear, it is a sign that the infected individual has entered the later stage of HIV infection and has started developing AIDS. The progression of HIV positive persons into the AIDS stage is highly individual. Some people can reach the AIDS stage in about five years, while some remain disease free for more than a decade. Measurement of the viral load and the CD4 count helps a doctor in assessing an infected person's health condition.

What are the later symptoms of HIV/AIDS?

- ☐ Lack of energy.
- ☐ Weight loss.
- ☐ Frequent fevers and sweats.
- ☐ A thick, whitish coating of the tongue or mouth (thrush) that is caused by a yeast infection and sometimes accompanied by a sore throat.
- ☐ Severe or recurring vaginal yeast infections.
- ☐ Chronic pelvic inflammatory disease or severe and frequent infections like herpes zoster.
- ☐ Periods of extreme and unexplained fatigue that may be combined with headaches, light-headedness, and/or dizziness.
- ☐ Rapid loss of more than 10 pounds of weight that is not due to increased physical exercise or dieting.
- ☐ Bruising more easily than normal.
- ☐ Long-lasting bouts of diarrhoea.
- ☐ Swelling or hardening of glands located in the throat, armpit, or groin.
- ☐ Periods of continued, deep, dry coughing.
- ☐ Increasing shortness of breath.
- ☐ The appearance of discoloured or purplish growths on the skin or inside the mouth.
- ☐ Unexplained bleeding from growths on the skin, from mucous membranes, or from any opening in the body.
- ☐ An altered state of consciousness, personality change, or mental deterioration.

(source: UNAIDS)

Exercise 2

Reading Material

Testing and Diagnosis

In the early stages of infection, HIV often causes no symptoms and the infection can be diagnosed only by testing a person's blood. Two tests are available to diagnose HIV infection – one that looks for the presence of antibodies produced by the body in response to HIV and the other that looks for the virus itself.

Antibodies are proteins produced by the body whenever a disease threatens it. When the body is infected with HIV, it produces antibodies specific to HIV. The first test, called ELISA (Enzyme Linked Immunosorbent Assay), looks for such antibodies in blood.

If antibodies are present, the test gives a positive result. A positive test has to be confirmed by another test called Western Blot or Immunoflouroscent Assay (IFA). All positive tests by ELISA need not be accurate and hence Western Blot and repeated tests are necessary to confirm a person's HIV status. A person infected with HIV is termed HIV- positive or seropositive.

As ELISA requires specialised equipment, blood samples need to be sent to a laboratory and the result will be available only after several days or weeks. To cut short this waiting period, rapid tests, that give results in 5 to 30 minutes, are increasingly being used the world over. Though rapid tests are more expensive, researchers have found them to be more cost effective in terms of the number of people covered and the time the tests take. If a person is highly likely to be infected with HIV and yet both the tests are negative, a doctor may suggest a repetition of the tests after three months or six months when the antibodies are more likely to have developed.

The second test is called PCR (Polymerase Chain Reaction), which looks for HIV itself in the blood. This test, which recognises the presence of the virus' genetic material in the blood, can detect the virus within a few days of infection.

The process of getting tested for HIV can generate a variety of intense emotional reactions such as fear, anger and denial. Therefore, psychological counseling is essential to prepare individuals undergoing testing for the possible consequences. This is called pre-test counseling and is unavoidable for anybody preparing to take a test.

If the test result is positive, it should not be disclosed without another round of counseling. This post-test counseling is more crucial because of the enormous stress and the multitude of emotions that the infected person could undergo on learning his/her HIV status. A positive test has been linked to increased suicide ideas and attempts and emotional trauma, both at the time of knowing the positive result and also at the emergence of AIDS-defining symptoms.

(source: UNAIDS)

Exercise 2

Reading Material

Is there treatment against HIV and AIDS?

Till today, there is no conclusive treatment to eliminate HIV from the body; however, timely treatment of opportunistic infections can keep one healthy for many years. The commonly available treatment for AIDS is the treatment against opportunistic infections. Normally standard treatment regimens, used against such infections in non-HIV patients, also work well with the HIV-positive persons. If properly treated, almost all the opportunistic infections can be contained.

However, during the last decade, researchers have developed powerful drugs that check the replication of the virus at various levels. Called antiretroviral drugs, they are available in three classes and under various brands. Taken in combinations (called cocktail or combination therapy) under specialised medical advice, these drugs drastically reduce the viral load in blood. However, they do not permanently cure one of HIV. This line of treatment, called HAART (Highly Active Antiretroviral Therapy) has resulted in a huge reduction or AIDS-related deaths. Though many positive persons and caregivers have welcomed these drugs, others have experienced serious side effects. They are also very expensive and are out of reach for a majority of the infected people. But of late, the prices have been steeply falling.

What about vaccines?

More than a dozen HIV vaccines are currently being tested. As of now, there is no vaccine to prevent HIV infection.

Life after HIV

The experience of infected people during the last two decades has shown that HIV is not the "end of the world" and that there is good quality life for several more years. Taking care of one's health, keeping in mind one's vulnerability to diseases, and a positive attitude have been found to be very useful. New drugs and vaccine efforts also offer considerable hope to infected and affected individuals and their families. Several NGOs/CBOs, government organisations, public and private institutions offer ongoing support to people in need.

(source: UNAIDS)

Exercise 2

Reading Material

Prevention

- Since there is no effective cure, best way to protect oneself from infection is by prevention.
- HIV transmission can be prevented by avoiding certain risk behaviour.
- Sexual mode of transmission can be prevented by
  - abstinence
  - non-penetrative sexual practices
  - use of barrier method (e.g. condoms)
- Parenteral transmission can be prevented by
  - avoiding sharing of syringe/needle
  - sterilisation of medical equipment
  - by screening blood/blood products before transfusion
- Prevention of infection from HIV infected mother to child by
  - taking medication available which prevents transmission to child
  - having a hospital delivery and
  - avoiding breast-feeding

(source: UNAIDS)

Understanding HIV/AIDs

Exercise 3 — Quiz on Facts & Myths of HIV/AIDS

Objectives

- To clarify myths and misconceptions related to HIV/AIDS.

Duration

25 minutes

Materials

Quiz questionnaire, timer

Structure

Quiz & Clarifications

Quiz on facts, beliefs and misconceptions related to HIV/AIDS and clarifications on misconceptions.

Process

- ☐ Divide the participants into two groups – A & B.
- ☐ Explain the rules of the 'quiz' i.e. answer the questions in "true" or "false" within 10 seconds. If one group is unable to answer, the question passes to the second group. A total of 20 questions will be asked (10 questions per group), and each correct answer will get one point. Whichever group scores the highest number of points, wins.
- ☐ Start asking questions from the "quiz questionnaire" to each group alternately.
- ☐ At the end of the 'quiz", clarify the doubts and misconceptions.

Outcome

At the end of the exercise, the participants should acknowledge their lack of information leading to myths and misconceptions regarding HIV infection.

Facilitator's Note

As mentioned in the earlier exercise, help from suitable resource person may be taken in providing clarifications on myths and misconceptions.

Sometimes journalists may not like their knowledge to be tested. In such a situation where there is resistance from the participants, the facilitator may quote that such exercise have been carried out with various groups yielding a mixed result i.e. 40-90%. The facilitator may just read out the question and provide answer. In this process the facilitator should explain that misconception regarding each question exists in the society. After this, facilitator may explore possibility of holding quiz with the second set of questionnaire.

Exercise 3

Quiz Questionnaire

Quiz - 1

S. No.	Statements	Group 1	Group 2
1	AIDS is curable.		
2	AIDS is caused by AIDS virus.		
3	HIV and AIDS are the same.		
4	Parents with HIV always have children with HIV.		
5	Partners who are faithful cannot get HIV.		
6	Children who have HIV can attend school.		
7	An AIDS patient may die due to TB.		
8	Women with HIV can have children.		
9	AIDS is not a disease, but it is a condition due to which the person becomes vulnerable to any infection.		
10	HIV affects only High-Risk groups (CSWs, MSMs, IDUs).		
11	A person diagnosed with HIV will die in 10 months.		
12	HIV testing should be mandatory.		
13	PLHAs should be made to wear badges.		
14	HIV Positive persons are attended only by specialist doctors.		
15	AIDS is a sexually transmitted disease (STD).		
16	You can get HIV after being bitten by an infected person.		
17	It takes 6 weeks to 6 months for a person with HIV to test positive through HIV diagnostic tests.		
18	Women are more susceptible to HIV as compared to men.		
19	HIV positive persons have the right to marry.		
20	Herbal remedies have been known to cure AIDS.		

(Note - This questionnaire is not to be distributed to the participants)

Answers:

1. False	6. True	11. False	16. False
2. False	7. True	12. False	17. True
3. False	8. True	13. False	18. True
4. False	9. True	14. False	19. True
5. False	10. False	15. False	20. False

Exercise 3

Quiz Questionnaire

Quiz - 2

S. No.	Statements	Group 1	Group 2
1	Coughing and sneezing do not spread AIDS.		
2	People who have AIDS cannot resist infection.		
3	TB infection in an AIDS patient can be cured.		
4	There is a vaccine to prevent AIDS.		
5	A person with HIV has it for life.		
6	Mosquito bites can spread AIDS.		
7	HIV can spread through needles/syringes.		
8	AIDS is spread only through sex with an infected person.		
9	CSWs are carriers of HIV.		
10	People with HIV always look sick and unwell.		
11	HIV enters the body and in due course weakens and destroys the defence system.		
12	Recently a cure for AIDS has been discovered.		
13	Before blood is given to patients it must be tested for HIV.		
14	AIDS does not concern children.		
15	HIV can spread through urine or faeces.		
16	We should never share the food of a person with HIV.		
17	People with HIV need good food and rest.		
18	It is important to help and support people with HIV.		
19	HIV/AIDS is a social problem.		
20	Donating blood causes AIDS.		

(Note - This questionnaire is not to be distributed to the participants)

Answers:

1. True	6. False	11. True	16. False
2. True	7. True	12. False	17. True
3. True	8. False	13. True	18. True
4. False	9. False	14. False	19. True
5. True	10. False	15. False	20. False

Session

Three

Understanding Stigma & Discrimination

Objectives

- To identify different forms of stigma & discrimination in local contexts.
- To understand causes and effects of stigma & discrimination on HIV infected and affected.
- To allow the participants to share their understanding of stigma & discrimination related to HIV/AIDS.
- To help participants come out with ways to counter stigma & discrimination.

Duration

60 minutes

Structure

- ☐ Briefing on session objectives
- ☐ Exercise One - A: Listing forms of stigma
- ☐ Exercise One - B: Listing causes and effects of stigma
- ☐ Exercise One - C: Participants presentations on their understanding of stigma and discrimination
- ☐ Exercise Two: Participants suggestions to counter stigma and discrimination

Understanding Stigma & Discrimination

Exercise 1A — Listing Forms of Stigma

Objectives

- To identify different forms of stigma & discrimination in local contexts.

Duration

15 minutes

Materials

Note cards, pens, handouts, flip chart

Structure

Brainstorming & listing

Brainstorming and listing of different forms of stigma existing in the local context.

Process

- Brief the participants regarding general concepts of stigma and discrimination in HIV/AIDS context.
- Divide the participants into two groups - A & B.
- Ask each group to brainstorm and list out stigma experiences in the society with the help of given 'guidelines'.
- Help participants to identify general and specific instances of stigma and discrimination experienced/observed by them.

Outcome

At the end of the exercise, the participants will be conscious of various forms of stigma existing in the local context.

Facilitator's Note

The facilitator should orient the participants to also identify forms of stigma and discrimination which may not be directly related to HIV/AIDS but have the potential to be applied to such situations e.g. a mother of a first born girl child faces stigma which may be more severe in case the mother is HIV positive. The stigma should also include those targeted at 1) PLHAs and their families, 2) people assumed to be more vulnerable 3) people assumed to be spreading HIV e.g. CSWs and 4) people working with HIV/AIDS e.g. NGO functionaries.

Exercise 1A

Definition

Stigma

Stigma is described as a quality that 'significantly discredits' an individual in the eyes of others. It also has important consequences for the way in which individuals come to see themselves. Importantly, stigmatisation is a process. Within a particular culture or setting, certain attributes are seized upon and defined by others as discreditable or unworthy.

Much of HIV/AIDS related stigma builds upon and reinforces earlier negative thoughts. People with HIV/AIDS are often believed to have deserved what has happened by doing something wrong. Often these 'wrongdoings' are linked to sex or to illegal and socially frowned-upon activities, such as injecting drug use. Men who become infected may be seen as homosexual, bisexual or as having had sex with prostitutes. Women with HIV/AIDS are viewed as having being 'promiscuous' or as having been sex workers. The family and community often perpetuate stigma and discrimination, partly through fear, partly through ignorance, and partly because it is convenient to blame those who have been affected first. It causes some groups to be devalued and ashamed, and others to feel that they are superior. For example, many women are blamed for the illnesses from which they and their husbands suffer Stigma is also linked to power and domination throughout society as a whole. Ultimately, stigma creates, and is reinforced by social inequality.

Stigma is harmful, both in itself, since it can lead to feelings of shame, guilt and isolation of people living with HIV and also because negative thoughts often lead individuals to do things, or omit to do things, that harm others or deny them services or entitlements. Hospital or prison staff, for example, may deny health services to a person living with HIV/AIDS.

Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group.

Guidelines for Group Work

Group A - Identify stigma related to gossip /name calling /condemnation/self stigma: name calling, scapegoating, finger pointing, teasing, ridicule, labelling, blaming, shaming, judging, back biting, rumour, gossiping, making assumptions, suspecting, abuse, association stigma e.g. whole family or friends also affected by stigma, self-blaming and isolating oneself.

Group B - Identify stigma related to physical & social isolation and loss of rights & decision-making power: Neglecting, rejecting, isolating, separating, not sharing utensils, hiding, staying at a distance, harassment, physical violence, loss of inheritance, loss of family/financial support, loss of decision-making power at family and community level.

Exercise 1A

Definition

Definition of stigma

According to UNAIDS (2002) and (2004), Stigma has been described as a quality that 'significantly discredits' an individual in the eyes of others. It also has important consequences for the way in which individuals come to see themselves.

Importantly, stigmatisation is a process. Within a particular culture or setting, certain attributes are seized upon and defined by others as discreditable or unworthy. Stigmatisation therefore describes a process of devaluation rather than a thing.

Much of HIV/AIDS related stigma builds upon and reinforces earlier negative thoughts. People with HIV/AIDS are often believed to have deserved what has happened by doing something wrong. Often these 'wrongdoings' are linked to sex or to illegal and socially frowned-upon activities, such as injecting drug use. Men who become infected may be seen as homosexual, bisexual or as having had sex with prostitutes. Women with HIV/AIDS are viewed as having being 'promiscuous' or as having been sex workers. The family and community often perpetuate stigma and discrimination, partly through fear, partly through ignorance, and partly because it is convenient to blame those who have been affected first.

Stigma associated with HIV/AIDS is underpinned by many factors, including lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, and prejudice and fears relating to a number of socially sensitive issues including sexuality, serious illness and illicit drug-use. Again, HIV-related stigma is multi-layered, tending to build on and reinforce negative connotations through the association of HIV/AIDS with already marginalised behaviours such as sex work, illicit drug-use, and homosexual and transgender sexual practice. Individuals with HIV/AIDS are often believed to deserve their HIV-positive status by having done something wrong.

According to UNAIDS (2002), stigma is linked to power and domination throughout society as a whole. It plays a key role in producing and reproducing relations of power. Ultimately, stigma creates, and is reinforced by social inequality. It has its origins deep within the structure of society as a whole, and in the norms and values that govern much of everyday life. It causes some groups to be devalued and ashamed, and others to feel that they are superior. For example, many women are blamed for the illnesses from which they and their husbands suffer.

Source: A Conceptual Framework and Basis for Action: HIV/AIDS Stigma and Discrimination, World AIDS Campaign 2002-2003, UNAIDS (November 2002).
Challenging AIDS Stigma and Discrimination in South Asia, Report of An Electronic Discussion Forum, UNAIDS, (February 18 to March 26 2004).

Exercise 1A

Definition

Types of stigma

UNAIDS (2004) and Michigan Department of Community Health (2003) have described eight types of stigma:

1. **Enacted stigma** – A person may experience stigma directly or personally called enacted stigma
2. **Felt stigma** – Stigma may be perceived or presumed to be there in one's environment called felt stigma. Felt stigma is hard to substantiate and is psychologically more damaging.
3. **Overt stigma** – Stigma that is expressed overtly
4. **Subtle stigma** – Much of the time it is conveyed covertly or subtly is called subtle stigma. Like 'felt stigma', subtle form of stigma is difficult to challenge and emotionally more crippling.
5. **Courtesy stigma** – Courtesy stigma is the stigma shared by all those associated with the HIV infected people (health care providers, family members). This form of stigma serves to discourage even the motivated few to serve in this field.
6. **Self stigma** – Self stigma, on the other hand, is the stigma that is accepted and internalised by the person such that the person legitimises others' negative actions and self-restricts own behaviour out of a sense of vulnerability and indulges in self blame/pity. Self stigma reduces people's will to fight and challenge discrimination towards them.
7. **Instrumental stigma** – Instrumental stigma derives from the fear of AIDS as a transmissible and incurable illness and evokes disgust and anxiety. It explains people's avoidance behaviour and the need to protect self from the likelihood of contagion. Because HIV/AIDS is perceived to be fatal, degenerative and known to be transmissible, people may fear contact with those who are infected or perceived to be at risk.
8. **Symbolic stigma** – Symbolic stigma is associated with the social meaning attached to HIV/AIDS and groups perceived to be at risk for HIV/AIDS. Symbolic stigma underlies the 'double stigmatisation' of sex workers, injecting drug users, men who have sex with men, and other marginalised groups.

Source: Executive Summary Findings from Two Surveys of HIV/AIDS - Related Attitudes, HIV/AIDS Prevention and Intervention Section Division of HIV/AIDS - STD, Michigan Department of Community Health, December 2003

Exercise 1A

Definition

Discrimination

Stigma is harmful, both in itself, since it can lead to feelings of shame, guilt and isolation of people living with HIV and also because negative thoughts often lead individuals to do things, or omit to do things, that harm others or deny them services or entitlements. Hospital or prison staff, for example, may deny health services to a person living with HIV/AIDS.

Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group.

Around the world, there have been numerous instances of such HIV/AIDS related discrimination. People with (or believed to have) HIV/AIDS have been:

- Segregated in schools and hospitals
- Refused employment
- Denied the right to marry
- Denied the right to return to their country on suspicion of being HIV positive
- Rejected by their communities
- Killed because of their sero-positive status

HIV/AIDS related discrimination

Young people are disproportionately affected by HIV/AIDS, and people living with HIV/AIDS are disproportionately affected by stigma and discrimination. HIV-related discrimination may occur at various levels. There is discrimination occurring in family and community settings. This is what individuals do either deliberately or by omission so as to harm others and deny them services or entitlements. Examples of this kind of discrimination against people living with HIV/AIDS include ostracism, shunning and avoiding everyday contact, harassment, physical violence and verbal discrediting.

Then there is discrimination occurring in institutional settings, in particular in workplaces, health care services, There are well-documented cases of young people who are known to be (or suspected to be) living with HIV/AIDS, or children who are heavily affected by HIV/AIDS such as orphans, being expelled from school. These all constitute violations of human rights.

Understanding Stigma & Discrimination

Exercise 1B — Listing Causes and Effects of Stigma

Objectives

- To understand causes and effects of stigma & discrimination on HIV infected and affected.

Duration

15 minutes

Materials

Note cards, pens, handouts, flip chart

Structure

Brainstorming & listing

Brainstorming and listing of causes and effects of stigma and discrimination.

Process

- Inform participants to remain in the group and continue working from the earlier exercise.
- Ask each group to brainstorm and list out causes and effects of various forms of stigma listed by the group.
- Help participants to identify causes and effects of stigma and discrimination.

Outcome

At the end of the exercise, the participants will be sensitised towards various forms of stigma its causes and impact. It is expected that the sensitivity will be reflected in their reporting.

Facilitator's Note

The facilitator should help the participants in identifying cause of stigma and discrimination which may be due to lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, and prejudice and fears relating to a number of socially sensitive issues including sexuality, serious illness and illicit drug-use.

Exercise 1B

Handouts

Causes of stigma and discrimination

Stigma associated with HIV/AIDS is underpinned by many factors, including lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, and prejudice and fears relating to a number of socially sensitive issues including sexuality, serious illness and illicit drug-use. Again, HIV-related stigma is multi-layered, tending to build on and reinforce negative connotations through the association of HIV/AIDS with already marginalised behaviours such as sex work, illicit drug-use, and homosexual and transgender sexual practice. Individuals with HIV/AIDS are often believed to deserve their HIV-positive status by having done something wrong.

Effects of stigma and discrimination

Stigma and discrimination have serious negative consequences for young people's sexual and reproductive health. Young people often feel they have little choice but to conceal sexual activity in general and perhaps homosexual relationships in particular, which are especially stigmatised. This secrecy increases their vulnerability to STIs and HIV, by restricting their ability and willingness to access protective resources such as information and condoms, as well as health services – even in settings where these are available to young people. The stigma and discrimination associated with HIV/AIDS are having devastating effects, in particular in the ways in which they silence open discussion of HIV/AIDS, both of its causes and of appropriate responses. Visibility and openness about HIV/AIDS are prerequisites for the successful mobilisation of government and community resources to respond to the epidemic. Concealment may encourage denial that there is a problem, and that urgent action needs to be taken. It can cause people with HIV/AIDS erroneously to be seen as some kind of 'problem', rather than part of the solution to containing and managing the epidemic. A stigmatising social environment poses barriers to HIV prevention and care at many different levels by virtue of being, by definition, a non-supportive environment. HIV-related stigma and discrimination undermine prevention efforts by making people afraid to find out whether or not they are infected, or even to seek out information about how to reduce their risk. Stigma and discrimination also impact on the care and support of people living with HIV/AIDS, undermining capacity to provide support and reassurance to those infected and affected, in the community, in workplaces and in health care settings. Stigmatisation of those affected, but not infected, by HIV/AIDS, such as family care-givers and relatives, can affect the quality of care given to infected people and may deter professional and volunteer care-workers from providing and participating in care.

Understanding Stigma & Discrimination

Exercise 1C Group Presentation on Stigma & Discrimination

Objectives

- To allow the participants to share their understanding of stigma & discrimination related to HIV/AIDS.

Duration

20 minutes

Materials

Note cards, pen, presentation material, flip chart

Structure

Group presentations

Presentation by groups on listed stigma, causes and effects.

Process

- Ask each group to select their presenter.
- Each group will have ten minutes to present their findings from exercise 3A &3B.

Outcome

At the end of the exercise, participants of each group will be benefited from the brain storming exercise of the other group.

Facilitator's Note

The facilitator should help the participants in preparing the presentation using flip chart, OHP etc. depending on the availability.

The facilitator should also collect the note cards on which group work has been written. This list will help in future workshops.

Understanding Stigma & Discrimination

Exercise 2 — Countering Stigma & Discrimination

Objectives

- To help participants come out with ways to counter stigma & discrimination.

Duration

10 minutes

Materials

Flip chart

Structure

Discussion & summary

Open discussion on ways to counter existing stigma and discrimination.

Process

- Seek suggestions of participants on ways to counter stigma.
- Allow participants to give their views and counter views regarding various suggestions.
- Summarise major recommendations.

Outcome

At the end of the exercise, participants will be aware of the ways to counter stigma which is expected to be reflected in their future reporting.

Facilitator's Note

Ensure that the discussion does not focus on "who will do it", instead of "how it will be done".

Session Four

Media and HIV/AIDS

Objectives

- To understand the difference between gender and sex.
- To recognise gender inequality and stereotyping in journalistic writing.
- To promote ways to integrate gender and rights perspective into HIV/AIDS reportage.
- To analyse and understand the gaps in journalistic reporting and discuss ways for improvement.
- To understand the difference in perspectives of reporters and editors and find ways to bridge the gap.

Duration

120 minutes

Structure

- ☐ Briefing on session objective
- ☐ Exercise One A: Gender quiz
- ☐ Exercise One B: Analysing gender and human rights in newspaper articles
- ☐ Exercise One C: Discussion on gender and human rights
- ☐ Exercise Two A: Analysing HIV/AIDS story
- ☐ Exercise Two B: Discussion on gaps in HIV/AIDS story
- ☐ Exercise Three: Role play – reporter versus editor

Media and HIV/AIDS

Exercise 1A — Gender Quiz

Objectives

- To understand the difference between gender and sex.

Duration

10 minutes

Materials

Quiz questionnaire

Structure

Quiz

Quiz on difference between sex and gender.

Process

- ☐ Read the quiz statement to the participants and let them say whether it is about gender or sex.
- ☐ In case of disagreement, allow participants to justify their opinion.
- ☐ At the end read out the definitions of sex and gender and distribute the handouts.

Outcome

At the end of the exercise, participants will have understanding of difference between sex and gender.

Exercise 1A

Gender Quiz

Sex or Gender

S. No.	Statements
1.	Women give birth to babies; men don't.
2.	Little girls are gentle and timid; boys are tough and adventuresome.
3.	In many countries, women earn 70 percent of what men earn.
4.	Women can breast-feed babies; men use a bottle for feeding babies.
5.	Women are in charge of raising children.
6.	Men are decision makers.
7.	In ancient Egypt, men stayed at home and did weaving. Women handled the family business. Women inherited property and men did not.
8.	Boys' voices break at puberty; girls' do not.
9.	Women are forbidden from working in dangerous jobs such as underground mining; men work at their own risk.

Adapted from Local Action, Global Change, Learning About the Human Rights of Women and Girls, 1999

Definitions

Sex denotes the biological differences between men and women. These differences are natural because they are given from birth.

Gender denotes the social relationships between men and women and the way that relationship is made by society. In other words, gender is how we are shaped after we are born into society.

While biological attributes can sometimes be altered, biological sex is essentially fixed. In contrast, gender definitions are in a constant state of flux in response to changing social and economic conditions. For example, in situations of war, migration of men, women may take on traditional male roles e.g. heads of families, soldiers. Because gender is constructed by society and not fixed, stereotypical constructed notions of male and female roles can be challenged.

When we say that men and women are not the same, we refer not only to their biological sex differences, but also to the different gender roles that have been created by society. Women and men

(Contd...)

Exercise 1A

have different needs, because of their sex and gender differences. Human rights and development concepts that recognise gender differences seek to address these needs in a way that promotes women's and men's full participation in community and political life.
A gender approach looks not only at the roles and activities that women and men do, but also at the relationship between women and men.

Source: Gender, HIV/AIDS & Rights, Training Manual for Media, Inter Press Services

Media and HIV/AIDS

Exercise 1B — Analysing Gender & Human Rights

Objectives

- To recognise gender inequality and stereotyping in journalistic writing.

Duration

20 minutes

Materials

Newspaper clippings, note cards, analysis framework questionnaire

Preparation

- Identify recent articles from vernacular newspaper for analysis of gender and human rights presentation.
- Visual clippings from local TV channels may also be used for the purpose.

Structure

Analysis

Analysis of gender and human rights dimensions in media reports.

Process

- ☐ Brief the participants regarding the framework for analysis.
- ☐ Divide the participants into two groups – A & B.
- ☐ Give each group the same article to analyse using the framework of questions.

Outcome

At the end of the exercise, participants will be able to recognise the gender weakness and human rights concerns in media coverage.

Facilitator's Note

The analysis should emphasise on identifying words, phrases or meanings that reflect gender bias and stereotypical portrayal. Participants should also be asked to determine why they are not 'sensitive' and how they can be changed so that the stereotypes are not promoted.

Exercise 1B

Analysis Framework

Note–While analysing the report, participants should discuss and record supportive arguments for their findings.

Gender representation in a story

1. **Count the women and the subject areas in which they appear**. Are they evenly distributed, or is the balanced skewed?
2. **Women speaking**. Are they represented in a way that allows them to speak with dignity and authority? What is the sex of the spokesperson or voice of authority?
3. **Gender roles**. Are traditional gender roles reinforced – for example in relation to portrayal of family life or occupation outside the home – or avoided?
4. **Superwoman stereotype**. Are active, independent women represented as if they are 'superwomen?
5. **Natural woman stereotype**. Does the content reinforce the stereotype of women as innately docile, emotional, non-analytical, technically, inept, etc?
6. **Sex-object stereotype**. Are women represented primarily as objects of male desire?
7. **The beauty myth**. What physical attributes apply to male and female participants – for example in relation to age, body weight, skin tone, clothes?
8. **Violence against women**. Does the material normalise violence? Does it suggest that women accept or enjoy violent treatment? How are female survivors of violence portrayed?
9. **Multi-dimensionality**. Does the representation encourage readers to understand women's many dimensions in terms of personality, capabilities, tastes, preferences, etc?
10. **Diversity**. Does the material reflect the diversity of age groups, social classes, ethnic groups, physical characteristics of women and men in the community as a whole?

Human rights issues

11. **Freedom from discrimination is a fundamental human right**: Does representation encourage discrimination based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status?
12. **Privacy & confidentiality**: Does the article portray confidentiality of HIV test results? Does it lead to suggesting mandatory or compulsory testing?
13. **Freedom from inhuman, degrading treatment**: Does it show that association with HIV will downgrade individual's position in the society? Does it suggest automatic isolation of HIV-positive?
14. What are the rights issues highlighted but not specifically stated as rights?

Source: 'Gender representation in a story' adapted from Gender, HIV/AIDS & Rights, Training Manual for Media, Inter Press Services

Exercise 1B

Sample Media Clipping for Analysis

वह फैला गई 25 लोगों में एड्स की सनसनी

- मुजफ्फरनगर में दक्षिण की महिला ने मचाया हड़कंप
- लोगों से सेक्स संबंध बना कर कहा, मुझे तो एड्स है

मुजफ्फरनगर।• वो कौन थी? कहां से आई? उसने सच बोला या झूठ? यह तो किसी को पता नहीं, पर उसके कहने के मुताबिक, 25 लोग खुद को लाइलाज एड्स का शिकार मान कर बुरी तरह सहमे हुए हैं। ये वो लोग हैं जिन्होंने उस महिला से सेक्स संबंध बनाए, वह भी बिना पैसा खर्च किए।

यही उनके डरने की वजह है, क्योंकि जाते-जाते महिला यह कहकर गई है कि उसे एड्स है और इस लाइलाज बीमारी को दूसरों के बीच बांटने के लिए वह अपना शरीर इतनी आसानी से किसी को भी सौंप देती है। ऐसा ही मामला कुछ दिन पूर्व बरेली के एक अस्पताल में आया था जहां पर एक महिला ने पहले तो अस्पताल के कर्मियों से संबंध बना लिए और बाद में कहा कि उसे एड्स है।

यह मामला चरथावल इलाके के गांव का है। बदनामी के डर से पूरे गांव की गुजारिश है कि मेडिकल में एड्स की पुष्टि होने तक गांव का नाम अखबार में न छापा जाए। इसकी वजह है कि इससे पहले गांव जलालाबाद में बिलकुल ऐसे ही मामले एक साल तक किसी की बारात नहीं आई थी। उस समय महिला दक्षिण भारत की बताई गई थी और इस बार भी महिला दक्षिण भारत की रहने वाली बताई गई है। 2 अप्रैल को यह महिला ट्रक में सवार होकर आई थी। वह चाय की दुकान पर चाय पी रही थी। उसे अजनबी जानकर करीब दर्जन भर लोग उसे अपने साथ ले गए। इन लोगों ने उससे जबरदस्ती करनी चाही, तो उसने कह दिया कि जबरदस्ती की जरूरत नहीं है। महिला ने न तो किसी से पैसे लिए और न ही किसी को कंडोम इस्तेमाल करने दिया। इसके बाद यह क्रम उस समय दोहराया गया जब वह गांव के बाहर एक ट्यूबवेल पर नहा रही थी। इस बार भी उसे एक दर्जन से अधिक मुफ्त के ग्राहक मिले। महिला जाते वक्त गांव में एक युवक से कह गई कि उसे एड्स है।

Exercise 1B

Reading Material

Sex and gender

Sex denotes the biological differences between men and women. These differences are natural because they are given from birth.

Gender denotes the social relationships between men and women and the way that relationship is made by society. In other words, gender is how we are shaped after we are born into society.

While biological attributes can sometimes be altered, biological sex is essentially fixed. In contrast, gender definitions are in a constant state of flux in response to changing social and economic conditions. For example, in situations of war, migration of men, women may take on traditional male roles e.g. heads of families, soldiers. Because gender is constructed by society and not fixed, stereotypical constructed notions of male and female roles can be challenged.

When we say that men and women are not the same, we refer not only to their biological sex differences, but also to the different gender roles that have been created by society. Women and men have different needs, because of their sex and gender differences. Human rights and development concepts that recognise gender differences seek to address these needs in a way that promotes women's and men's full participation in community and political life. A gender approach looks not only at the roles and activities that women and men do, but also at the relationship between women and men.

Gender relations involves the way women and men relate to each other in their individual relationships and in groups. The issue here is: does either one have more power and authority than the other? If the answer is yes, then this creates Inequality in the relationships between men and women. The use of gender relations as a toll of analysis shifts the focus from viewing women in isolation from men.

Gender stereotypes are socially constructed beliefs about men and women. They are constructed through sayings, songs, proverbs, the media, religion, culture, custom, education, drama, etc.

Communicating gender requires journalists and other media practitioners to observe the ways people may be marginalised because of their gender (their defined social role in society) as well as race/ethnicity, class/caste, age and other such factors. Who gets coverage? From what perspective? Through which lens? Reflecting which stereotypes about people from different gender, race/ethnics, class/caste and other groups? Are stories helping to advance gender equality and

contd...

Exercise 1B

Reading Material

equity in society or are they angled in a way that upholds traditional attitudes and values? Are women's or men's concerns being separated from the concerns of society in general?

Source: Gender Mainstreaming in Information and Communications, Joan Ross Frankson, Commonwealth Secretariat, May 2000

Gender equality – equality under the law, equality of opportunity (including equality of rewards for work and equality in access to human capital and other productive resources that enable opportunity), and equality of voice (the ability to influence and contribute to the development process).

Source: Engendering Development, A World Bank Policy Research Report, 2001

This definition stops short of defining gender equality as equality of outcomes, because:

- different cultures and societies can follow different paths in their pursuit of gender equality; and
- equality implies that women and men are free to choose different (or similar) roles and different (or similar) outcomes in accordance with their preferences and goals.

Feminism – advocates the social, economic and political equality of women and men. It is concerned with eliminating all forms of discrimination and gender-based violation against women.

A gender-specific story can be characterised as those stories on the media's agenda which deal with the power relations between men and women, gender equality or inequality between women and men or vice versa, the human rights of women in relation to men or vice versa, and stories which deal with access to resources and/or voice by women and men. Some of the media coverage that falls into this area are: gender violence, HIV/AIDS, civil vs. customary laws, cultural norms and traditions, women's entrance into politics, the private sector and fields previously dominated by men or women.

Adding a gender perspective to a story refers to the fact that there is no issue covered by the media which does not in some way affect men and women, boys and girls in a society. In other works, a gender perspective – i.e. the impact of the issue, event or policy being reported on women and men, and the analysis of this impact through the voices of both men and women in the story as sources, gender disaggregated data, which also can tell how issues or policies impact differently on men and women – begins to mainstream gender into all issues and areas covered by the media.

Exercise 1B

Reading Material

Gender dimensions of HIV/AIDS

In India, the six high prevalent states (Maharashtra, Tamil Nadu, Andhra Pradesh, Karnataka, Manipur and Nagaland) the ratio of infected male:female is almost equal.

- Many women experience sexual and economic subordination in their marriages or relationships and are therefore unable to negotiate safe sex or refuse unsafe sex.
- The power imbalance in the workplace exposes women to the threat of sexual harassment.
- Poverty is a noted contributing factor to AIDS vulnerability.
- Women's access to prevention messages is hampered by illiteracy, a state affecting more women than men worldwide.
- Studies show the heightened vulnerability of women, compared to men, to the social stigma and ostracism associated with AIDS, particularly in rural settings.

Why are women more vulnerable?

Socio-cultural reasons:

- Unequal access to education and economic resources.
- They enjoy less power than men in social and sexual relations.
- Women are more likely to experience rape, sexual coercion, sometimes forced to sell or exchange sex for their economic survival.
- Gender-related discrimination is often supported by law and policies that prevent women from owning land, property and other productive resources. This promotes women's economic vulnerability to HIV infection, limiting their ability to seek and receive care and support.
- Women with HIV infection also often experience more social blame and stigma than men in the same position.
- In addition to their own increased risk of HIV, women also carry the social burden of the epidemic, in terms of proving care of relatives with AIDS.

Exercise 1B

Reading Material

Women: more vulnerable to HIV than men

The impact of AIDS on women is severe, particularly in areas of the world where heterosexual sex is the dominant mode of HIV transmission. In sub-Saharan Africa, women are 30% more likely to be HIV-positive than men. The difference in infection levels between women and men is even more pronounced among young people. Population-based studies say that 15-24-year-old African women, on average, are 3.4 times more likely to be infected than their male counterparts.

Risk from husbands and lovers

Marriage and other long-term, monogamous relationships do not protect women from HIV. In Cambodia, recent studies found 13% of urban and 10% of rural men reported having sex with both a sex worker and their wife or steady girlfriend. (Cambodian National Institute of Statistics/Orc International, 2000).

The risk of this behaviour to wives and girlfriends is clear. In Thailand, a 1999 study found 75% of HIV-infected women were likely to be infected by their husbands. Nearly half of these women reported heterosexual sex with their husbands as their only HIV-risk factor (Xu et al., 2000).

Violence and the virus

HIV-transmission risk increases during violent or forced-sex situations. The abrasions caused by forced vaginal or anal penetration facilitate entry of the virus – a fact that is especially true for adolescent girls. Moreover, condoms are rarely used in such situations. In some countries, one in five women report sexual violence by an intimate partner, and up to 33% of girls report forced sexual initiation (WHO, 2001).

Impact of HIV on women and girls in the community and at home

Women may hesitate to seek HIV testing or fail to return for their results because they are afraid that disclosing their HIV-positive status may result in physical violence, expulsion from their home or social ostracism. Studies from many countries, especially in sub-Saharan Africa, have found these are well-founded fears (Human Rights Watch, 2003). In Tanzania, a study of voluntary counseling and testing services in the capital found, after disclosure, only 57% of women who tested HIV-positive reported receiving support and understanding from partners (Maman et al., 2002).

Young girls may drop out of school to tend to ailing parents, look after household duties or care for younger siblings. After a spouse's death, a mother is more likely than a father to continue caring

contd...

Exercise 1B

Reading Material

for his/her children, and a woman is more willing to take in orphans. AIDS-related stigma and discrimination often lead to the social isolation of older women caring for orphans and ill children, and deny them psychosocial and economic support.

When their partners or fathers die of AIDS, women may be left without land, housing or other assets. For example, in a Ugandan survey, one in four widows reported their property was seized after their partner died (UNICEF, 2003). A woman may also be prevented from using her property or inheritance for her family's benefit, which in turn hurts her ability to qualify for loans or agricultural grants. The denial of these basic human rights increases women's and girls' vulnerability to sexual exploitation, abuse and HIV.

Exercise 1B

Reading Material

Human rights & rights of HIV positive people

International human rights norms provide a coherent, normative framework for analysis of the HIV/AIDS problem. They also provide a legally binding foundation with procedural, institutional and other accountability mechanism to address the societal basis of vulnerability and implement change

According UNAIDS (2002), Freedom from discrimination is a fundamental human right founded on principles of natural justice that are universal and perpetual. Human rights inhere in individuals because they are human, and they apply to all people everywhere. The principle of non-discrimination is central to the human rights thinking and practice. The core international human rights instruments prohibit discrimination based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

According to UNAIDS (2004), a lack of human rights protection fuels the epidemic in at least three ways:

- Discrimination increases the impact of the epidemic on people living with HIV/AIDS and those presumed to be infected, as well as their families and associates. For example, a person who is sacked from his or her job because of being HIV-positive is faced with many problems, including the extra economic burdens of healthcare, as well as providing for any dependent family;
- People are more vulnerable to infection when their economic, social or cultural rights are not respected. For example, a refugee may be separated from former sources of support (such as family), and more likely to engage in activities which place his or her health at risk (such as unsafe sex); and
- Where civil and political rights are not respected, and freedom of speech and association is curtailed, it is difficult or impossible for civil society to respond effectively to the epidemic.

Exercise 1B

Reading Material

Important human rights, in the HIV/AIDS context are:

- **non-discrimination and equality before the law**, e.g. eliminating discrimination against people living with HIV/AIDS in the areas of health care, employment, education, immigration international travel, housing and social security;
- **health**, e.g. ensuring equal and adequate access to the means of prevention, treatment and care, such as for vulnerable populations with lower social and legal status, (e.g. women and children);
- **privacy**, both informational and physical, e.g. ensuring confidentiality of HIV test results, and prohibiting mandatory or compulsory testing;
- **education and information**, e.g. ensuring equal and adequate access to prevention education and information, such as targeted material for ethnic minorities;
- **freedom from inhuman, degrading treatment or punishment**, e.g. prohibiting automatic isolation of HIV-positive prisoners;
- **autonomy, liberty and security of the person**, e.g. prohibiting HIV testing or research without informed consent, and prohibiting detention or quarantine solely on the basis of HIV status;
- **sharing in scientific advancement and its benefits**, e.g. ensuring equal and adequate access to a safe blood supply and universal infection control protocols or treatment drugs;
- **work**, e.g. prohibiting dismissal of staff solely on the basis of their HIV status;
- **freedom of expression, assembly and association**, e.g. ensuring availability of registration for groups of people living with HIV/AIDS, such as sex workers or men who have sex with men;
- **participation in political and cultural life**, e.g. ensuring the participation of persons living with HIV/IADS in the formulation, implementation and evaluation of policy;
- **marry and found a family**, e.g. prohibiting mandatory premarital testing, and coerced abortions or sterilisations.

Media and HIV/AIDS

Exercise 1C — Discussion on Gender & Human Rights

Objectives

- To promote ways to integrate gender and rights perspective into HIV/AIDS reportage.

Duration

15 minutes

Materials

Flip chart, note cards

Structure

Group presentation and discussion

Group presentation on analysis of gender and human rights dimensions in media reports, discussion and summary.

Process

- Allow each group to present their findings from the analysis.
- Initiate a discussion on how gender and rights can be mainstreamed into HIV/AIDS related articles.
- Summarise the discussion.

Outcome

At the end of the exercise, participants will be knowledgeable regarding ways to integrate gender and rights perspective into media reports on HIV/AIDS.

Facilitator's Note

Facilitator may try and adjust duration of exercise 1A & 1B, so that there is enough time for discussion during exercise 1C. The emphasis for discussion should be on 'what could have been incorporated in the media reports.

Media and HIV/AIDS

Exercise 2A — Analysing HIV/AIDS Story

Objectives

- To analyse and understand the gaps in journalistic reporting.

Duration
25 minutes

Materials

Note cards, analysis framework, selected newspaper clippings

Preparation

- Identify recent articles from vernacular newspaper for analysis of data presentation, structure & language.
- In case of non-availability of suitable article, the sample article may be translated.

Structure

Analysis
Analysis of media report with respect to data presentation, structure of report and use of language

Process

- ☐ Brief the participants regarding the framework for analysis.
- ☐ Divide the participants into two groups – A & B.
- ☐ Give a set of two articles to each group. One article will be for data presentation and the other for structure and language analysis. The same set of articles should be given to each group.

Outcome

At the end of the exercise, participants will be knowledgeable regarding identifying gaps in media reports with regard to data presentation, structure of report and use of language.

Facilitator's Note
The facilitator may use an alternate exercise on 'data presentation': provide each participant with a set of statistics on HIV/AIDS prevalence from the most recent UNAIDS or any other available report which presents the figures disaggregated by sex, gender and other groups. Ask each group to write a short three paragraph story using the data provided. Allow enough time for the participants to write the short stories and to share them with the other group. The participants together with the facilitator can correct and discuss the stories presented for accuracy and comprehension of the data provided.

Exercise 2A

Analysis Framework

Note - While analysing the report, participants should discuss and record supportive arguments for their findings.

1. Analysing data presentation in a story

i. **Context**: Does the story explain the context in which data is presented?
ii. **Meaning**: Does the data provide precisely meaning?
iii. **Significance**: Is the data significant for the story?
iv. **Source**: Has the source been quoted? Is it reliable?
v. **Discrepancies**: Is there any discrepancies in the data (e.g. contradictory figures)? Has such discrepancies been explained?
vi. **Data collection**: has the data collection process & duration been explained ?
vii. **Applicability**: whether the findings apply to specific or general population/situation has been explained?

2. Analysing structure of the story

i. **Linkage with headlines**: Whether the content is linked to the headlines?
ii. **Linkage of arguments**: Whether the arguments in the story are linked to the key underlying conception or proposition?
iii. **Logical sequence & flow**: Does the arguments in the story have a logical sequence and flow?
iv. **Sources & voices**: Is there diversity of sources and voices? What is missing?
v. **Impac**t: What will be the impact (on readers) due to this structure?

3. Analysing the use of language in the story

- **Complexity**: Is the language complex for understanding of a layman?
- **Inaccurate use of terminology**: List the words used inaccurately e.g. AIDS virus, AIDS carrier, full-blown AIDS, AIDS patient etc?
- **Creating fear and panic**: List words/phrases that give the impression of fear and panic e.g. AIDS victim / sufferer, fatal disease, incurable disease, high risk group etc?
- **Associations with stigmatised categories/concepts**: Identify overt instances of association of HIV/AIDS with already stigmatised groups such as sex workers, homosexuals, IDUs etc and stigmatised activities such as rape, relationships with sex workers, homosexuality, crime etc?
- **Bias towards specific groups**: Identify instances where specific category of individuals or groups are portrayed as reservoirs of HIV infection.

(Framework for analysis of structure and language were developed for the study of 'HIV/AIDS in News', UNDP, 2005)

Exercise 2A

Sample Newspaper Clipping for analysis of Data Presentation

मुंबई की आधी वेश्याएँ एड्स की चपेट में

मुंबई २७ मार्च (वा)। महाराष्ट्र के आर्थिक सर्वेक्षण के अनुसार मुंबई की लगभग आधी वेश्याएँ जानलेवा बीमारी एड्स की शिकार हो चुकीं हैं। जुलाई-अक्टूबर २००४ में कराए गए इस सर्वेक्षण के अनुसार देह व्यापार में लिप्त १.१३ प्रतिशत महिलाएँ गर्भवती हैं। १४.७८ प्रतिशत शारीरिक संबंधों के कारण एड्स से पीड़ित हो चुकी हैं। २८ प्रतिशत मादक पदार्थों की वजह से और ९.६ प्रतिशत को समलैंगिक यौन संबंधों की वजह से इस रोग ने जकड़ा है।

Exercise 2A

Sample Newspaper Clipping for analysis of Data Presentation

एड्स पीड़ित बताइए, अपनी आबरू बचाइए

मुजफ्फरनगर में महिलाओं ने अस्मत बचाने के लिए अपनाया नया सुरक्षा कवच

- असरदार साबित हो रही है एड्स संक्रमण की कहानी
- महिला के ऐसा कहते ही भाग खड़े होते हैं दरिंदे
- अगर इज्जत बचती है तो उपाय ठीक : मनोवैज्ञानी

मुजफ्फरनगर। दक्षिण भारत को खास गर्व सविता (काल्पनिक नाम) चरथावल इलाके में 'एड्स' की खतरनाक फैलाकर क्या गई, ऐसा लगता है कैसे मुजफ्फरनगर में महिलाओं को अपनी आबरू लूटने से बचाने का जायाब फार्मूला मिल गया। एक के बाद एक दो दिन में ही ऐसे दो मामले सामने आ चुके हैं, जिनमें महिलाओं ने इज्जत खातिर के पढ़ी देख खुद को 'एड्स रोगी' बताकर हवस के भूखे बहरूपी दरिंदों के होश फाख्ता कर दिए। हो सकता है कि महिलाएं झूठ बोल रही हों, लेकिन 'एड्स खौफ' के डिस्तार के डर से यह झूठ ही असरदार साबित हो रहा है। ऐसा भी नहीं है कि आबरू बचाने को महिलाओं ने पहली बार कोई फार्मूला तलाश किया हो। इससे पहले ब्रिटेन में 'नंबर लाक सेडीज जॉन्स' और अमेरिका में 'बदबूदार कैप्सूल' महिलाओं को इज्जत महफूज रखने के मकसद से ही बनाए गए थे। आखिर लड़कियों के जिस्म पर बुरी नजर रखने वाले दुनिया में कहां नहीं है। मुजफ्फरनगर में तो दरिंदगी का आलम यह है कि लड़कियों को आबरू के साथ जान के भी लाले पड़े हुए हैं।

सिवेड़ा और पुरकाजी इलाके में हाल ही में लड़कियों के साथ रेप के बाद उनकी हत्या की घटनाएं हो चुकी हैं। रोहाना में महिला सविता (काल्पनिक नाम) के जरिए 25 लोगों में एड्स फैलने की सनसनी से जो हड़कंप मचा, शायद उससे ही महिलाओं को इज्जत बचाने की नई ढाल प्रदान की। इसके बाद बीते दो दिन में रसनपुरी गांव और मुजफ्फरनगर शहर में ऐसी दो घटनाएं हुई जिनमें महिलाओं को आबरू सिर्फ एड्स के डीफ ने बचाई। दोनों ही मामलों में महिलाओं के साथ रेप की कोशिश की गई। उन्होंने जैसे ही कहा कि वे एड्स की रोगी हैं तो असमत के लुटेरे वहां से ऐसे गायब हुए जैसे गधे के सिर से सींग। पुलिस की नाकामी का आलम ये है कि दोनों मामलों में शामिल रहे लोगों का हुलिया बता दिए जाने के बाद उनमें से एक भी नहीं पकड़ा जा सका। हवस के भूखे ऐसे लोगों में एड्स के नाम से डरने की एक वजह ये भी हो सकती है कि मुजफ्फरनगर में ये लाइलाज बीमारी बहुत तेजी से पांव पसार रही है। सरकारी रिकार्ड में अब तक मिले, पूरे 50 रोगियों में से 40 को सेक्स की कीमत चुकानी पड़ी है। मनोचिकित्सक प्रेम सिंह का कहना है कि एड्स ऐसी बीमारी है, जिसका नाम सुनते ही जिंदगी खतरे में नजर आती है, वो भी बदनामी के साथ। इसलिए लोग इससे खौफ खाते हैं। अगर महिलाएं इस खौफ को अपनी आबरू बचाने के लिए इस्तेमाल करें तो इसमें बुराई क्या है। ब्यूरो

चरथावल इलाके में दो अप्रैल को दक्षिण भारत की काल गर्ल

Exercise 2A

Handout

UNDP HIV-related language policy

Language and the images it evokes shape and influence behaviour and attitudes. The words used locate the speaker with respect to others, distancing or including them, setting up relations of authority or of partnership, and affect the listeners in particular ways, empowering or disempowering, estranging or persuading, and so on. The use of language is an ethical and a programmatic issue.

UNDP has adopted the following principles to guide its HIV-related language.

Language should be inclusive and not create and reinforce a Them/Us mentality or approach. For example, a term like "intervention" places the speaker outside of the group of people for or with whom he or she is working. Words like "control" set up a particular type of distancing relationship between the speaker and the listeners. Care should be taken with the use of the pronouns "they", "you", "them", etc.

It is better if the vocabulary used is drawn from the vocabulary of peace and human development rather than from the vocabulary of war. For example, synonyms could be found for words like "campaign", "control", "surveillance", etc.

Descriptive terms used should be those preferred or chosen by persons described. For example, "sex workers" is often the term preferred by those concerned rather than "prostitutes"; "people living with HIV" or "people living with AIDS" are preferred by infected persons rather than "victims".

Language should be value neutral, gender sensitive and should be empowering rather than disempowering. Terms such as "promiscuous", "drug abuse" and all derogatory terms alienate rather than create the trust and respect required. Terms such as "victim" or "sufferer" suggest powerlessness; "haemophiliac" or "AIDS patient" identify a human being by their medical condition alone. "Injecting drug users" is used rather than "drug addicts". Terms such as "living with HIV" recognise that an infected person may continue to live well and productively for many years.

Terms used need to be strictly accurate. For example, "AIDS" describes the conditions and illnesses associated with significant progression of infection. Otherwise, the terms used include "HIV infection", "HIV epidemic", "HIV-related illnesses or conditions", etc. "Situation of risk" is used rather than "risk behaviour" or "risk groups", since the same act may be safe in one situation and unsafe in another. The safety of the situation has to be continually assessed.

The terms used need to be adequate to inform accurately. For example, the modes of HIV transmission and the options for protective behaviour change need to be explicitly stated so as to be clearly understood within all cultural contexts.

The appropriate use of language respects the dignity and rights of all concerned, avoids contributing to the stigmatisation and rejection of the affected and assists in creating the social changes required to overcome the epidemic.

(Source: http://www.undp.org/hiv/policies/langpole.htm)

Media and HIV/AIDS

Exercise 2B — Discussion on Gaps in HIV/AIDS Story

Objectives

- To discuss ways to improve journalistic presentation of HIV/AIDS related reports.

Duration

20 minutes

Materials

Flip chart, newspaper clippings, handout

Preparation

- Identify and collect some well written articles published recently in vernacular newspaper.

Structure

Presentation and discussion

Group presentation on analysis of data presentation, structure and lanuage of articles, discussion and summary.

Process

- Allow each group to present their findings from the analysis.
- Initiate a discussion on how the structure and language in HIV/AIDS related articles can be improved.
- Summarise the discussion.

Outcome

At the end of the exercise, participants will be knowledgeable regarding how to improve data presentation, structure of report and use of language.

Facilitator's Note

The facilitator may distribute copies of some well written articles from vernacular newspaper and circulate to the participants. The facilitator should also highlight the positive aspects of presentation in the selected articles.

Media and HIV/AIDS

Exercise 3 Discussion on Gaps in HIV/AIDS Story

Objectives

- To understand the difference in perspectives of reporters and editors and find ways to bridge the gap.

Duration
30 minutes

Materials

Note cards, framework for writing story, selected newspaper clipping

Preparation

- Identify a recent articles published in vernacular newspaper. Select some vital information from the article for writing the story.

Structure

Role play & discussion
Role play on reporters versus editor highlighting their understanding, sensitivity and priority.

Process

- ☐ Divide participants into two groups. One in the role of "editors" and the other as "reporters".
- ☐ Ask each group to write a short story (2-3 paragraphs) based on details/facts provided by the facilitator. The story should be written from perspective of reporter and editor by the respective groups.
- ☐ Ask the "reporters" to present their story and give their arguments on why it should be given prominence and published without changing the views or structure.
- ☐ Ask the '"editors" to give their arguments on why/not the story will be edited, Ask them to read out their story.
- ☐ Initiate a discussion to reach a consensus between the reporters and editors.
- ☐ Show the original article for comparison.

Outcome

At the end of the exercise, participants will have a better understanding of the constraints and limitation of reporters and editors and the ways to bridge the gap.

Facilitator's Note
This role play has been derived from the findings of the study on "HIV/AIDS in News". The difference in understanding, sensitivity and priority of reporters and editors was observed among all newspapers and TV channels studied in the states of Haryana, Madhya Pradesh and Gujarat. The findings highlighted the need for understanding each others perspectives.

Exercise 3

Story Writing

Sample information for writing story

N-E rebels' new threat to forces: AIDS

Shillong:

- The Assam Rifles received threats from militant organisations that they would let loose HIV infected women to spread the disease among jawans posted in Meghalaya, Manipur, Nagaland and Tripura.
- Assam Rifles director-general Lt Gen Bhoopinder Singh said: "We have received threats; are not bothered by such threats.
- NACO additional project director added: Biological warfare has become a reality
- AIDS has already claimed the lives of 40 Assam Rifles jawans, while 139 others are lying infected.
- Assam Rifles is spending Rs 2 crore annually on the caretaking programme of infected jawans,
- Assam Rifles has now launched a massive campaign
- Over 40 treatment detection centres and over 275 testing and reporting centres have been built.
- The problem is when HIV positive jawans return to their villages. They are ostracised.

Exercise 3

Original Article

N-E rebels' new threat to forces: AIDS

By Kounteya Sinha/TNN

Shillong: Insurgent groups in the North-East are now threatening to use a new weapon against India's security forces.

The Assam Rifles has received threats from militant organisations of this region that they would let loose HIV infected women to spread the disease among jawans posted in Meghalaya, Manipur, Nagaland and Tripura.

National Aids Control Organisation officials also said that defence minister Pranab Mukherjee had once raised the issue of such a threat in one of the plenary meetings between NACO and armed forces' officials.

However, the threats don't seem to be bothering senior officers of Assam Rifles. Speaking to TOI, Assam Rifles director-general Lt Gen Bhoopinder Singh said: "We have received threats from local insurgent groups who claim they will unleash women infected with HIV to spread the disease among our jawans as a way to neutralising the security forces. This is how sick some people can be. Criminal groups are also trying to infect gullible young girls of this region with the virus in order to leave a trail of HIV in the regions guarded by us. However we are not bothered by such threats. We treat it like a joke."

NACO additional project director N S Dharmshaktu added: "Insurgent groups are now trying new, less expensive ways to attack our forces. Biological warfare has become a reality. AIDS can be quite a deadly weapon. It does not need money, sophisticated weapons or manpower. All they have to do is infect young hapless girls of the region with AIDS and let them infect our security forces with the disease."

AIDS has already claimed the lives of 40 Assam Rifles jawans, while 139 others are lying infected. Assam Rifles is spending Rs 2 crore annually on the caretaking programme of infected jawans.

Keeping the risk factor in mind, Assam Rifles has now launched a massive campaign to sensitise its jawans and their families against the threat of AIDS and educate them about ways they can get infected.

It has established a three-tier HIV/AIDS control facility in the region. An immunodeficiency centre at CPAR Hospital at Sukhoi is also being set up. Over 40 treatment detection centres have also been established. It is also upgrading 30-bed existing unit hospitals to 50-bed nodal centres in Shillong, Lokhua and Silchar. Over 275 testing and reporting centres have also been built at all company posts where samples will be collected.

Assam Rifles has also decided not to ask jawans with AIDS to leave service.

An official said: "Jawans understand each other. So those with AIDS still serve and are treated with respect. The problem is when HIV positive jawans return to their villages. They are ostracised. There have been incidents of jawans committing suicide, unable to take the humiliation. We are trying to remove the stigma attached to AIDS by educating the families of jawans."

Note: This is a sample article for the role play exercise and should not be taken as representation of well-written articles on HIV/AIDS

Session Five

Role of Media

Objectives

- To sensitise participants on stigma & discrimination faced by PLHAs and other vulnerable groups.
- To identify the role media can play in reducing HIV/AIDS related stigma & discrimination.

Structure

- Briefing on session objective
- Exercise one: Face-to-face with PLHAs
- Exercise two: Discussion on role of media

Duration

60 minutes

Media and HIV/AIDS

Exercise 1 — Face to face with PLHAs

Objectives

- To sensitise participants on stigma & discrimination faced by PLHAs and other vulnerable groups.

Duration
40 minutes

Materials

Handout

Preparation

- Invite PLHAs for the workshop in advance. Brief the PLHAs regarding the purpose of the exercise and help them to prepare a short story on stigma and discrimination.

Structure

Sharing experience and discussion

PLHAs will share their experiences and answer participants' queries.

Process

- ☐ Introduce the PLHAs (guests) to all the participants.
- ☐ Brief the participants regarding pointers for effective interview (as given the handout) and emphasise on trust and confidentiality.
- ☐ Ask the guests to narrate a story (their own or of other PLHAs) regarding their life and incidents of stigma and discrimination faced by them (not longer than 10 minutes).
- ☐ Allow participants to ask their questions.
- ☐ Initiate a discussion between PLHAs and journalists regarding the issues of privacy and confidentiality.

Outcome

At the end of the exercise, participants will be sensitised towards issues of privacy and confidentiality. They will also be able to empathise with PLHAs.

Facilitator's Note

During the interactive session, guests may choose not to answer a question, and this must be respected. Initially, the participants should tell the facilitator what they want to know, and the facilitator will formulate the question and ask the guest. The guest may be informed to wait for the signal from the facilitator before answering. In the next stage, the participants may ask their own questions, but again through the facilitator, who has the discretion to change the question to make it more appropriate/sensitive. After a considerable level of trust has been established between the guests and participants, the facilitator may allow the participants to directly ask their questions. If needed, the facilitator may intervene.

Exercise 1

Handout

Pointers for a more effective interview

Time:
The journalist needs to allow 'time' not only for the interview, but the time needed to gain access to vulnerable and marginalised groups of people who often are not sought out by the media. This may be more than a one-day process, requiring the journalist to gain the trust of those being interviewed.

Observation:
The journalist should not just focus on the words coming out of the interviewee's mouth, but also on the interviewee's body language throughout the interview which may give clues as to when the person is becoming, for example uncomfortable with the questions. A silence or pause before an answer may also indicate that a person is searching for an 'appropriate' way to answer the question without giving away much about his or her life. The journalist may then have to think of another way to ask the same question to draw out more information. The journalist should also observe the environment in which the person lives (when the interview takes place within a person's home or community), which again may provide the journalist within information that needs to be followed up on.

Listening:
One of the key communications skills which a journalist must strengthen is that of listening. To capture what is being expressed, as well as what is not being said, the journalist must re-learn how to give the interviewee his or her undivided attention. So suspicious is the ear. Its structure has changed. We sit with only one ear toward the speaker, and the other is turned to the nonexistent nest beat.

The 'next beat' that the journalist is often tuned to is the next question he or she has on the list of queries to be put to the person before him or her, or, even preconceived ideas the journalist may have about how the interviewee will respond to the questions pose. The journalist needs to be open (without any preconceived ideas), and should not allow a prepared list of questions to interfere with the ability to listen carefully to the replies given during an interview, as well as to the changes and tone of voice, body language and other signs of emotion which can help the journalist to pick up on interviewing clues.

Prepared questions should be leading and open ended.
A journalist should be flexible during the interview to allow the process to change from that of directing a story, through prepared questions, to one of letting the story unfold.

In this process, new and unexpected stories might come to light.

(Contd...)

Exercise 1

Handout

Trust/confidentiality:
Taking the time to know the interviewee and to explain why the journalist wants the interview and what will be done with the information, can help to avoid misunderstandings and bridge the distance that often exists between the interviewer and the interviewee which leads to 'stock' answers being given.

The journalist also can gain the trust of people by moving beyond the language of 'us' and 'them' when referring to those infected with HIV. This is important because given the wall of silence, journalists often may be actually talking to people who are infected, who may fear they have been infected, or to people who are trying to stay uninfected, often against considerable odds. The journalist can share personal experiences with the interviewee during the course of the interview to create empathy, show understanding and to break the barrier of 'them' and 'us'.

Using the same analogy of 'them' and 'us', journalists also should avoid asking women: 'what do women want?' This often connotes in tone and in meaning that 'women's concerns are isolated' from the concerns of 'others' in a society.

Trust also involves the journalist not promising to the interviewee more than what he or she can deliver. Usually a journalist cannot help directly in a situation of need, but a journalist may make a contribution by just telling the story.

And, the journalist, once gaining access to someone who is willing to speak while facing discrimination and/or abuse, must find ways to attribute the person's comments without putting them at risk.

It is important for the journalist to be clear from the outset with the interviewee and throughout the interview on what is considered confidential. Issues of disclosure of one's HIV status are often sensitive and have far-reaching implications for those in vulnerable positions. A study on HIV positive women in Zimbabwe found that for women, there is "a considerable tension between the need for the comfort of telling someone (about their status) and the fear of rejection or stigma".

Empathy:
To communicate with the interviewee, it is important for the journalist to exercise interpersonal skills such as knowing when to speak and when to keep quiet. The journalist should show an understanding of a person's situation however without showing pity, which sends a signal of 'victim' and 'hopelessness'. It is also important not to focus on 'how' a person became infected.

(Source: Gender, HIV/AIDS and Rights: Training Manual for the Media, Inter Press Services International Association, Rome).

Media and HIV/AIDS

Exercise 2 — Discussions on Role of Media

Objectives

- To identify the role media can play in reducing HIV/AIDS related stigma & discrimination.

Duration
20 minutes

Structure

Discussion and Summary
Discuss and summarise the role media can play in the light of issues discussed in various sessions.

Process

- Summarise the issues discussed in earlier sessions.
- Initiate a discussion on role of media in the context of issues discussed earlier.
- Summarise the recommendations on the role of media.

Outcome

At the end of the exercise, participants will be able to appreciate their role towards positive and responsible presentation of HIV/AIDS related issues.

Annexes

Workshop on HIV/AIDS in News – Journalists as Catalysts
Evaluation questionnaire

Date:_____ Place:_____

A. Please provide the rating of the following on a scale of 1 to 5

(1 - Very Poor, 2 - Poor, 3 - Average, 4 - Good, 5 - Excellent)

Sl. No.	Rating
1.	Duration of the workshop
2.	Clarity of workshop objectives
3.	Session one
4.	Session two
5.	Session three
6.	Session four
7.	Session five
8.	Sequence of sessions
9.	Overall presentation
10.	Skill of facilitator
11.	Venue arrangement
12.	Food, beverages, etc

B. Write three things that you found useful in the workshop

1. _____
   _____
2. _____
   _____
3. _____
   _____

C. Write three things that you did not like about the workshop

1. _____
   _____
2. _____
   _____
3. _____

D. Suggestions for improvement

_____
_____
_____
_____
_____
_____

Sample Workshop Programme

	SESSION	DURATION
SESSION ONE:	ORIENTATION	60 minutes
Exercise 1:	Participants' Introduction	10 minutes
Exercise 2:	Discussion on Media Expectations	30 minutes
Exercise 3:	Introduction of the Workshop	20 minutes
SESSION TWO:	**UNDERSTANDING HIV/AIDS**	**60 minutes**
Exercise 1:	Presentation on HIV/AIDS Scenario	15 minutes
Exercise 2:	Presentation on the Basics of HIV/AIDS	20 minutes
Exercise 3:	Quiz on the Facts & Myths	25 minutes
SESSION THREE:	**UNDERSTANDING STIGMA & DISCRIMINATION**	**60 minutes**
Exercise 1A:	Listing forms of Stigma	15 minutes
Exercise 1B:	Listing Causes and Effects of Stigma	15 minutes
Exercise 1C:	Group Presentations on Stigma & Discrimination	20 minutes
Exercise 2:	Suggestions to Counter Stigma and Discrimination	10 minutes
SESSION FOUR: MEDIA & HIV/AIDS		**120 minutes**
Exercise 1A:	Gender Quiz	10 minutes
Exercise 1B:	Analysing Gender & Human Rights in Media Reports	20 minutes
Exercise 1C:	Discussion on Gender & Human Rights	15 minutes
Exercise 2A:	Analysing HIV/AIDS Story	25 minutes
Exercise 2B:	Discussion on Gaps in HIV/AIDS Story	20 minutes
Exercise 3:	Role Play – Reporter vs. Editor	30 minutes
SESSION FIVE: ROLE OF MEDIA		**60 minutes**
Exercise 1:	Face-to-face with PLHAs	40 minutes
Exercise 2:	Discussion on the Role of Media	20 minutes
Total Duration – 6 hours		

National AIDS control project – phase II (1999 – 2006)

Giving a major focus to targeted intervention amongst groups with the highest risk behaviors (sex workers (SWs); injecting drug users (IDUs); truck drivers and broadening the approach to a multi-sectoral one. The current phase of the national programme has seen the emergence of a strongly decentralised programme with responsibility for implementation clearly placed with the states. State AIDS cells were created in all the 32 states and UTs of the country for the effective implementation and management of the national AIDS control programme. However to remove the bottlenecks faced by the programme implementation at the state level new and more flexible state structures of state AIDS control societies have been formed with strong mechanisms for programme management at state level including a strong NGO component of targeted interventions, supported by efforts for mobilising the community around awareness and treatment of sexually transmitted diseases/reproductive tract infections. Innovative approaches to providing technical support to state programmes have been launched through a network of 12 technical resource groups (TRGs) each covering different thematic areas of the epidemic. Surveillance has been both expanded and strengthened. With a new round of resource mobilised from government of India, the international development agency, major bilateral donors and the UN system, the programme is moving into an important new phase of implementation.

The preparation of the new programme has contributed to a growing momentum behind the national response, symbolised by the prime minister's strong statement to parliamentarians in December 1998 calling for renewed efforts to combat HIV, not as a health problem but as a threat to India's development. The country has clearly moved, beyond denial into a new phase of response.

The phase II of the national AIDS control programme has become effective from 9th November, 1999. It is a 100% centrally sponsored scheme implemented in 32 states/UTs and 3 municipal corporations namely Ahmedabad, Chennai and Mumbai through AIDS control societies.

The national AIDS control project – phase II aims:

(i) to shift the focus from raising awareness to changing behaviour through interventions, particularly for groups at high risk of contracting and spreading HIV;
(ii) to support decentralisation of service delivery to the states and municipalities and a new facilitating role for national AIDS control organisation. Program delivery would be flexible, evidence-based, participatory and to rely on local programme implementation plans;
(iii) to protect human rights by encouraging voluntary counseling and testing and discouraging mandatory testing;
(iv) to support structured and evidence-based annual reviews and ongoing operational research; and
(v) to encourage management reforms, such as better managed state level AIDS control societies and improved drug and equipment procurement practices. These reforms are proposed with a view to bring about a sense of 'ownership' of the programme among the states, municipal corporations, NGOs and other implementing agencies.

Project objectives

Phase II of national AIDS control programme has two key objectives namely;
(a) To reduce the spread of HIV infection in India; and
(b) Strengthen India capacity to respond to the HIV/AIDS on a long-term basis.

Some special features of program delivery and management in Phase II:

- Delegated financial and administrative authority to NACO
- Ownership of the state and decentralised program at the state level
- Involvement of the community in social mobilisation and awareness at the grass-root level
- Major role of the NGOs in the implementation of intervention programs for marginalised population
- Involvement of democratic institutions (Panchayati Raj) and youth organisation at the district, block and village level

Project scope

Reflecting the extreme urgency with which HIV prevention and control need to be pursued in India, the AIDS – II project of the national AIDS control programme covers across all state and union territories as a centrally sponsored scheme with 100% financial assistance from government of India direct to state AIDS control societies and selected municipal corporation AIDS Control Societies. The scope of the project would vary with each intervention taking into account the need and absorptive capacity, feasibility and efficiency. The immediate need is to have a paradigm shift in our response against HIV/AIDS at all levels with the overall goal to contain the further spread of HIV at a fairly low level of HIV prevalence.

Project targets

The programme has the following firm targets to be achieved during project period:-

(i) To reduce blood-borne transmission of HIV to less than one percent of the total transmissions.

(ii) To introduce Hepatitis C as the fifth mandatory test for blood screening.

(iii) To set up 10 new modern blood banks in uncovered areas, upgrading of 20 major blood banks setting up of 80 new district level blood banks in uncovered districts, establishing another 40 blood component separation units, promotion of voluntary blood donation and increase its share in total blood collected to at least 60%. The total blood collection in the country which is now around 3–3.5 million units is sought to be raised to 5–5.5 million units by the end of the project.

(iv) To attain awareness level of not less than 90% among the youth and those in the reproductive age group.

(v) To train up at least 600 NGOs in the country in conducting targeted intervention programmes among high-risk groups and through them promote condom use of not less than 90% among these groups and control of STDs.

(vi) To conduct annual family health awareness campaigns among the general population and provide service-delivery in terms of medical advice and provision of drugs for control of STIs and reproductive tract infections (RTIs). These campaigns will be conducted jointly by NACO and RCH programme managers at the state level. Through this it is proposed to reduce the prevalence of STIs/RTIs in the general community from the present level by about 15–20%.

(vii) Promotion of voluntary testing facilities across the country at the end of the project. It envisages that every district in the country would have at least one voluntary testing facility.

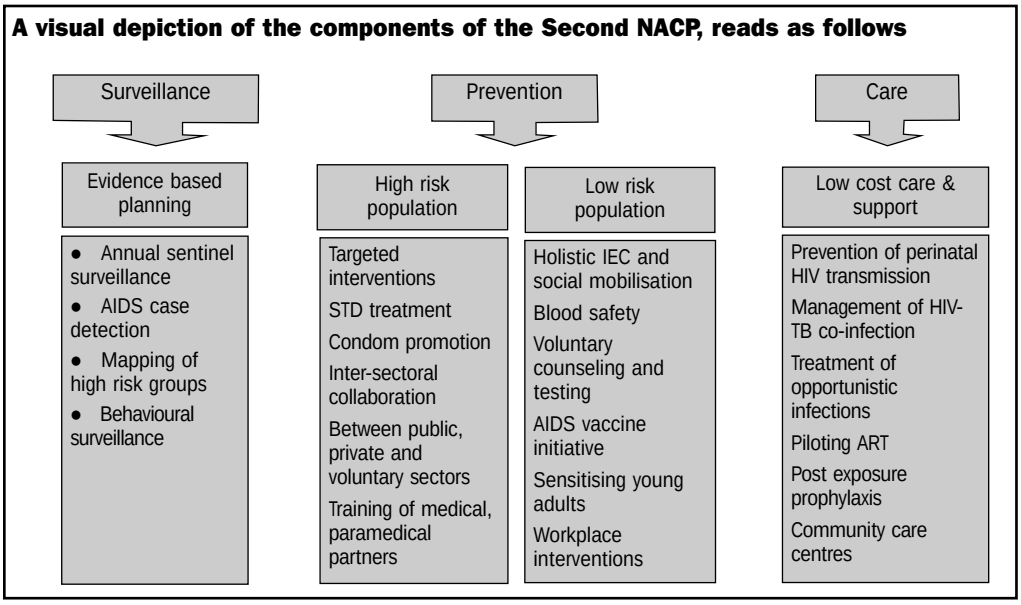
(viii) Awareness campaigns will now be more interactive and use of traditional media such as folk arts and street theatre will be given greater priority in the rural areas. It is proposed to cover all the schools in the country targeting students studying in Class IX and Class XI through school education programmes and all the universities through the "universities talk AIDS" programme during the project period.

(ix) Promotion of organisations of people living with HIV/AIDS and giving them financial support to form self-help groups.

Components of phase – II

1. Priority targeted interventions for populations at high risk: This component of the project aims to reduce the spread of HIV in groups at high risk by identifying target populations and providing peer counseling, condom promotion, treatment of sexually transmitted infections etc. This component would be delivered largely through non government organisations; community based organisations and the public sector.
2. Preventive interventions for the general population: The main activities would be: (a) IEC and awareness campaigns; (b) provide voluntary testing and counseling; (c) reduction of transmission by blood transfusion; an (d) prevention of occupational exposure.
3. Low cost care for people living with HIV/AIDS Under this component activities would provide financial assistance for home based and community based care, including increasing the availability of cost effective interventions for common opportunistic infections.
4. Institutional strengthening: This component aims to strengthen effectiveness and technical managerial and financial sustainability at national, state and municipal levels, strengthening surveillance activities and building strong research & development component, including operational research etc.
5. Inter-sectoral collaboration: This component would promote collaboration amongst the public, private and voluntary sectors. The activities would be coordinated with other programmes within the ministry of health & family welfare and other central ministries and departments. Collaboration would be focused on:
   (I) learning from the innovative HIV/AIDS programmes that exist in other sectors; and
   (II) sharing in the working, generating awareness, advocacy and delivering interventions.

A visual depiction of the components of the Second NACP, reads as follows



Source: http://www.nacoonline.org/abt_phase2.htm

Monitoring and evaluation of the progamme

For the effective monitoring and evaluation to asses the implementation of the phase–II of the national AIDS control project at national and state level, the following mechanism has been envisaged.

(i) Creating a computerised management information system (CMIS) at the national and state levels;
(ii) Training NACO staff and health specialists in evidence based health programme management.
(iii) Conducting base line, mid term and final evaluation;
(iv) Conducting the annual performance and expenditure review (APER); and
(v) Conducting the national performance review (NPR) under the national AIDS control board.

A National level independent outside agency is being identified who would b assigned the responsibility of development of CMIS conduct of base line, mid-term and end term evaluation.

Financial Management System

It is envisaged to maintain an adequate project financial management system to provide accurate and timely information regarding project resources and expenditure to facilitate efficient project management. For this purpose a consultancy agency is being selected for developing a project financial management system for NACP-II

The financial management system would be integrated one for the whole project. A common set of policies and procedures would apply to the entire project and a consolidated set of financial reports for the project would be prepared from the FMS.

Source: http://www.solutionexchange-un.net.in

List of HIV/AIDS related websites

www.aegis.com
www.aids.com
www.aidsalliance.org
www.aids-india.org
www.aidsinfo.hih.gov
www.avert.org/aidsindia.htm
www.cdc.gov/hiv/dhap.htm
www.gnpplus.net
www.hdnet.org
www.hivanonymous.com
www.hivpositive.com
www.hivtest.org
www.hsph.harvard.edu/hai/home.html
www.ias.se
www.icasi.org
www.icrw.org
www.indianngo's.com
www.info.com/hiv
www.kaisernetwork.com
www.lawyerscollective.org
www.nacoonline.org
www.napwa.org
www.nfi.net
www.panos.org.uk
www.plwhs.org
www.redribbon.com
www.saathii.org/stapp/searchIndia.jsp
www.strashope.org
www.unaids.org
www.undp.org
www.unesco.org
www.unicef.org
www.unifem.org.in
www.whoindia.org/cds/cd/hiv
www.youandaids.org