

Sexual Behavior of Clients of Commercial Sex Workers, Implications for Hiv/Aids Intervention Programs

¹Shaik Rafi & ²Dr. G. Sreedhar

¹Research Scholar of Rural Development and Social Work, Dept of RD & Social Work, Sri Krishnadevaraya University, Anantapur Andhra Pradesh (India)

²Professor of Rural Development and Social Work, Dept of RD & Social Work, Sri Krishnadevaraya University, Anantapur Andhra Pradesh (India)

ARTICLE DETAILS

Article History

Published Online: 13 March 2019

Keywords

sexual behavior, HIV/AIDS, attitude, perception, sexual behavior, commercial sex worker, sexual gratification.

ABSTRACT

HIV/AIDS is a multidimensional issue and cannot be confined to medical science alone. It is a problem of socio-economic conditions of humans and human behavior. It has necessitated an increased understanding of the sexual behavior of the human population that put the humans to risky behavior, human attitude towards sex etc in order to make proper prediction about the progression of the disease and to help program managers to design effective control programs. After many years of the prevalence of HIV/AIDS in the country, the policymakers and program managers have come to a conclusion that the clients of the sex workers are the core group which spreads the disease from the commercial sex workers to the general population through unprotected sexual contact with the high-risk groups. There are many risk behaviors which make the clients vulnerable to HIV. It is essential to understand their perceptions, attitudes and sexual behaviors to help in drawing suitable intervention programs to change the behavior. This has enormous potential to slow down the epidemic in the region and to improve their lives and the lives of the sexual partners. The present research paper makes earnest efforts to understand the perceptions, attitudes and sexual behavior of the clients who approach the commercial sex workers for sexual gratification and the implications it has for HIV/AIDS intervention programmes.

1. Introduction

The Human Immunodeficiency Virus (HIV) which triggers Acquired Immune Deficiency Syndrome (AIDS) has grabbed the eyeballs of many sections of people, both the common public and the specialists like policymakers, health managers, academicians and the general public. No other disease, previously, has drawn so much of attention in such a short span of time as this disease. The reasons behind these are not difficult to comprehend. The nature of HIV/AIDS, the destructive, ruinous and the catastrophic effects the disease casts on the economic and social dimensions of the human society is drawing the focus of all. AIDS has a distributing impact on the rates of infant, child and maternal, life expectancy and growth (Patil, 2003). HIV virus is both a retrovirus and a lent virus. While a lent virus is a slow acting virus and infections in the infected people continue for a long drawn period without manifesting any symptoms of sickness and at the same time HIV virus is also a retrovirus for the reason that it converts RNA to DNA by forcing itself into the host cell, which will go on to multiply the virus (Ramamurthy, 2003). Irrespective of gender and social class, Aids is a chronic disease which brings about multiple episodes of dependency, serious illness and death. The disease spreads rapidly through the persons who are in sexually active age because the sexual route is the paramount mode of transmission of the HIV virus. Out of the 1.2 million deaths that happen every year in the age group of 15-45, an estimated 10 to 40% of the deaths are believed to be caused by HIV/ AIDS. (NACO, 2006).

Sentinel Surveillance is the annual periodic collection of data which pertains to the Human Immuno deficiency Virus

from targeted population groups. Every year, during the three months from July to September, the data is collected from across the country. The data so collected is utilized to design and implement the prevention and control of HIV/AIDS (NACO, 2004). It is revealed by the Sentinel Surveillance data that when compared to women (29%), men (71%) have got more infected with HIV/AIDS in the country and the infection among the younger women is also increasing year by year (NACO, 2006). Heterosexual contact (86%) has proved to be the predominant mode of transmission of HIV virus in the country (except in the States of Nagaland and Manipur). After identifying the commercial sex workers as the core group which is facilitating the transmission of HIV, most of the intervention programs are focused on these groups of women in the present-day. It is important to bear in mind that the clients of the sex workers are not focus of attention of the intervention programs for many years. It has been taken into cognizance by many program managers because the information provided by the research and surveillance statistics speak that the male clients of the commercial sex workers also need to be targeted for intervention programmes because they constitute an important group which is to be held accountable for the transmission of the virus as they play the role as vector of HIV transmission linking the commercial sex workers (with highly HIV prevalence) to the general population (casual partner, wife, girlfriend) assumed to have lower prevalence of the virus. The information pertaining to the male clients of the commercial sex workers, however is scanty. Hence, they can be a tremendous success in containing the rapid spread of the AIDS epidemic if this male client group is targeted and appropriate intervention programs are conceived and implemented.

2. Scenario In India

The HIV prevalence rate, according to a new estimate in the country, is 0.36% of the total population of the country (NACO, 2006). The present estimate reveals that nearly 2.5 million persons are living with HIV in India. There are certain pockets in the country where Sero-prevalence rate (blood serum tested for HIV and found positive) is more than 1% (118 districts across the country) among antenatal care clinic attendees which is considered as a proxy to the general population. It is more than 3% in 14 districts. The number of districts with HIV prevalence of more than 5% among HIV high-risk group is 53 (The Hindu, 2007). However, different high-risk groups have different prevalence rates and they are 6.9% among the Injecting Drug Users (IDU), 3.7% among Sexually Transmitted Diseases (STD), 6.41% among Men who have sex with Men (MSM) and 4.9% among the Female Sex Workers (FSW) (NACO, 2006). It can be gathered from the estimates that the concentration of the HIV is more among the risk groups than the general population. The estimated adult HIV prevalence rate has been witnessing a downward trend not only in the high-risk groups but also among the general population barring men who have sex with men (MSM) for whom it has been increasing over the years. The entire credit for this achievement should be given to the untiring and committed efforts of both governmental as well as non-governmental organisations (NGOs). HIV continues to be proving to be a curse to the population which is economically productive. Nearly, 89% of the people who are infected with AIDS are in the early age group of 15-49 years of age. Likewise 7.5% of the HIV-infected population is in the age group of above 50 years and the rest of the patients are children who are below the age of 15 years. The incidence of the disease is increasing among the people who are above 50 years and among children. This trend has been witnessed for last five years. It has been observed that more urban people than rural people and more men (61%) than women (39%) live with this infection. It has been observed that in the states of Tamil Nadu, Uttar Pradesh and Punjab, the rural cases have outnumbered the urban cases (NACO, 2008). It has been evident from the Sentinel Surveillance data that HIV has reached every nook and corner of the country.

In India, as is the case with many other countries, adolescents are more vulnerable to the disease when compared to the other sections of the society. This is because of the fact that they tend to have a natural behavior of experimentation which is combined with ignorance. The Indian adolescents who are 2.25 million in number and who constitute 1/5th of the total population are susceptible to this disease. This particular section of the society happens to be a very rich and vital human resource upon which the social and economic well-being of the society hinges. It is saddening to note that HIV cases have been reported without exception from all the States and Union Territories. It is now being revealed that the scale of prevalence is now shifting towards women with an accompanying increase in vertical transmission and pediatric HIV. According to one recent estimate, the women constitute nearly 25% of the new HIV infections. This infection seems to be spreading very rapidly in the informal sector which forms nearly 95% of the total workforce the country. The HIV/AIDS infection among the adult members of the society is proving to be a bane for the healthy and natural growth of the children.

With a huge population and low levels of literacy and awareness among this huge population, HIV/AIDS has come to stay as the more formidable challenge ever faced by the country on the health damage. This epidemic, at the beginning of this decade, was found to be in an advanced stage in states like Manipur, Tamil Nadu and Maharashtra. It was discovered through one study that about 20 to 40% of the patients of major hospitals of Mumbai and Imphal were HIV/AIDS related cases (Narain, 2004). The epidemic has spread across the southern and western States in the country in the last four years. A high prevalence of HIV injecting drug users was reported from the states of Northeast. The states of Karnataka and Andhra Pradesh have been witnessing a rapid rise of HIV-related infections and they are even leaving behind Tamil Nadu. Though other States have comparatively a lower rate of HIV prevalence so far, the presence of high rates of sexually transmitted diseases along with the presence of sexual networks and the high incidence of migration are indicators which speak of high probability of HIV infection. One of the most contributing factors for the spread of HIV virus is injecting drug use which is growing by day. The infection, as pointed out earlier, is spreading its tentacles from the urban to rural areas and from the groups which are practicing high-risk behavior to the general population. Nearly 89% of the reported cases are in the sexually active and economically productive age group of 18-40 years. An estimated 25% of the total infections are currently among the women. Apart from that the female to male ratio of infection is rising sharply. About 30,000 newborn babies are being infected with HIV virus. About 75% of the infections are happening through the sexual transmission.

In some regions of the country, HIV is as common in villages as is in the urban areas. The virus, finally, is firmly embedded in the general population, especially among the women are put to risk by their husbands because of their only behavior of having sex with their husbands. It has been revealed through one study that in at least five states, more than 2% women in urban areas are infected (AIDS Epidemic Update: 2005).

3. Factors conducive for the spread of HIV

1. Poverty and HIV

Poverty, social inequality, urbanization and gender discrimination are some of the factors which increase the vulnerability of individuals (Barnett and Whiteside, 2002). India is a poverty ridden country with a substantial section (44.2%) of its population living below the poverty line (UNDP, 2003). The formidable poverty in the countryside and urbanization accompanied by increasing industrialization are forcing the poor laborers from the countryside to migrate to the urban areas in search of livelihood leaving behind their families and their native places. To satisfy their sexual lust, most of the migrant laborers at the urban areas pay visits to the commercial sex workers and without their knowledge they get infected with HIV virus and when they visit the native places and have intercourse with their wives at the native places they pass on the virus to them and in this way the virus is carried from urban to rural areas. (Hira S et al 1998; Bhattacharjee et al, 2000). In contrast to this, many poor, divorced and hapless women who are denied a source for earning livelihood fall prey to the sex business to earn their livelihood. Because of their helplessness and poverty, they cannot compel their sexual

partners to use condoms and as a result they cannot protect themselves from getting infected with HIV.

2. Gender Discrimination and HIV

The women in the country are treated to be a liability by their family in spite of the fact they contribute a lot to the household economy. The Indian women are endowed with low levels of literacy and self-confidence and as a result they have less control and less freedom for their resources and are living under the control of their male folk in their families, be it, father, husband or sons. This kind of situation often leads women to powerlessness and economic dependency. Women in such fragile depending positions cannot demand for safe sex practices. They are at the mercy of their husbands when it comes to sex practices.

3. Social Norms and HIV

It is a common to observe in Indian society that male superiority is accepted in sexual matters. While women should practice monogamous relationship with her husband, the husbands can have any number of sexual partners. The women are expected to be passive and ignorant about sexual activities. This culture of silence in sexual matters is proving to be a big impediment regarding the availing of health services and following safe sex practices. Many women, unfortunately, remain untreated for any sexually transmitted infections for a long time because they have limited access to health services. HIV and sexually transmitted infections prevention strategies that emphasize male condom use, mutual monogamy practices of non-penetrative sex are often dependent. Hence, safe sex practices are difficult for women to be practiced. (Gupta, 2000).

4. Government views regarding HIV

The first HIV case in India was found in Madras in 1986 with a commercial sex worker after launching nationwide Sero-surveillance program (Kandela, 1991, Dumsia, 1990). India, at the outset, denied the existence of HIV in the country. The Indian Minister for Health and family welfare, in the year 1986, announced in Parliament that 6 commercial sex workers in Madras were found infected with HIV. The Indian health personnel emphasize the 'moral strength of the country' instead of giving priority to educating the general public about the prevention and transmission of AIDS/HIV for restricting the spread of the disease (Kandela, 1991). They also started telling that AIDS had reached the shores of India through the students who came from Africa, the Sri Lankan militants and the foreign tourists and the infection was endemic only among the commercial sex workers (Jayarama, 1987). This gave an impression among the general public that HIV/AIDS is a disease pertaining to a specific community and the general population is immune to that. For next several years, the Government of India was of a firm belief that HIV/AIDS would not be a problem to be reckoned with in the country because of its strong traditional and cultural background but however, within no time AIDS/HIV started spreading alarmingly in India (WHO, 1994). The epidemiological research however proved is believed to be wrong and the HIV infected cases were growing rapidly in the country not only through sexual mode but also through the other means of infection.

It was believed by the Government of India that HIV/AIDS is "an imported" disease from the foreign tourists who had

sexual contact with the Indian women. In this context, it was opined that bringing a legislation banning sexual relations between foreigners and Indian women would suffice to contain the spread of this disease effectively but this proposal was shot down by the Law Ministry (Pandey, 1998, Jayaram, 1988). It was rightly perceived that such kind of law would be difficult to be enforced because sexual interactions take place only clandestinely and not in public. However, the Government of India, in 1989, proposed the AIDS Prevention Bill with the consent of the Law Ministry and it was a subject of criticism by the human rights organizations on the grounds that the people were forced and harassed to have blood tests and doctors were being forced to reveal the name of patients who were infected with the virus and the people who are infected by the virus was secluded from the general public. The Bill was ultimately withdrawn for amendment (Iman, 1992).

There was the emergence of opinion among the public and the medical officials and the Indian Council of Medical Research as to how much priority should be accorded to HIV/AIDS. According to the Medical and public officials, HIV/AIDS is not a dangerous disease when compared to typhoid and cholera which were widely prevalent. In contrast to this, declaring that India is entering "disaster phase", the Indian Council of Medical Research (ICMR) has called for a massive public health education campaign in the promotion of safer sex practices. Educational and other organizations were asked to help in the campaign. Newspapers and television stations were compelled to provide space to give health education messages regarding HIV/AIDS to Indian population (Jayaraman, 1990).

5. Government Response

Section 51, Public Health Act of the Constitution, is the only law which provides for the notification of AIDS. Apart from this, the local municipal laws necessitate every medical practitioner who treats or becomes cognizant of any dangerous disease to give information of the same to the Executive Health Officer, vide section 421, Bombay Municipal Corporation Act. Since AIDS is considered to be the deadliest disease, several provisions were made in a legal framework to combat it effectively. Section 2 of the Epidemic Disease Act assigns power to an officer of the state government to take such steps including prescribing temporary regulations to be observed by the public or any class of persons as may be deemed necessary to eliminate the outbreak, spread of any such epidemic diseases.

6. The National Aids Control Program (NACP-I)

After the first case of AIDS was detected in 1986, the National AIDS Committee was constituted and the National AIDS Control Program was launched in 1987 with the basic intention of providing surveillance regarding the disease, screening of blood & blood products and to educate people regarding the disease, its prevention and control. The Government of India established National AIDS Control Organization (NACO) in 1982. It is entrusted with the mandate of carrying out National AIDS programs which apart from others included the formulation of policy, prevention and control programs. AIDS prevention programs were launched in a phased manner. The emphasis in phase-I (1992-1999) was on generating awareness, improving blood safety and capacity building.

7. The National Aids Control Program-II (NACP-II)

NACP-II was implemented from April 1999 with the help and assistance of international agencies like USAID, IDA and DFID with the stated objectives of containing the growth rate of HIV in the country and to improve the country's strength to respond to HIV/AIDS with the help of newly created State AIDS societies. The program has the following components- intervention program to high-risk groups, preventive intervention program to general population. The main strategies are to conduct IEC programme, promotion of voluntary and testing facilities, blood safety and prevention of occupational exposure, low-cost care and support to people who live with HIV/AIDS, institutional development and inter-sectoral collaborations.

8. The National Aids Control Program-III (NACP-III)

The NACP-III was initiated with the dual objectives of curbing the progression of the epidemic in low-risk States by 40% and reversing the epidemic to 60% in high prevalence states during 2006-11. The main focus of the program is towards prevention, care, support and treatment. This was to be accomplished through following 4 ways; prevention of new infection among high risk group and general population; providing high-quality care as well as support to maximum number of patients who were suffering from HIV/AIDS; upgrading the existing facilities and skill and capacity building of the manpower at all levels for prevention, care, support and treatment programs and strengthen the information and management systems throughout the country.

NACP-III visualizes coverage of high-risk group up to 80% during the five-year programme period. All the people for limited HIV/AIDS will get anti-retroviral therapy (ART) during the programme period and the number will come down to 3.8 2 million by 2011 and transmission through blood to be reduced to 0.5%.

National AIDS Control Organization (NACO) is the apex body at national level, which manages and coordinates the NACP-III. Similarly, the State AIDS Control Societies (SACS) have been created at the State-level with an intention to execute the programs of NACP-III the state-level. NACO will support the SACS with technical assistance for the sake of targeted interventions. The NACP-III mainly focuses on the following core areas-prevention, care, support and treatment, decentralization and monitoring and evaluation.

Prevention:

The HIV prevention programs focus on high-risk groups which include sex workers, injecting drug users and men having sex with men and highly vulnerable population which consists of truck drivers, migrants, men and young women in general population. It is proposed to set up 2100 targeted intervention sites to provide primary prevention services like treatment of STI, condom promotion, behavioral change communication to 80% of high-risk groups. Programs to change risky lifestyle, reduce vulnerability, promote condom use and reduce condom misconception, encourage voluntarily HIV testing with the help of private and government organisations, communicate prevention messages etc were also implemented.

Provision of Care, Treatment and support

Since increasing number of people, in recent times, have been seeking care for HIV-related illnesses and AIDS, the need for care and support is being increasingly felt. NACO supports the establishment of community care centers, drop-in centers and networks of people living with HIV/AIDS. At present, 35 community care centers have been funded by the government and these are mainly in the high prevalence states.

Linkages have been established between the HIV care services and the Revised National TB Control Program to facilitate the pretreatment of TB. Treatment of other common infections is also provided free in government hospitals. Training manuals and other materials for doctors, nurses and counselors have been developed and are being widely used.

Anti-retroviral drugs are being used with an intention to prevent the parent-to-child transmission program (PPTCT) program, in the post-exposure prophylaxis programme for healthcare professionals and also in various health insurance and contributory health care schemes. Free antiretroviral treatment is being given to the patients since 1 April 2004 and by the year 2011, the program was planned to treat 3.8 lakh opportunistic infection episodes, provide TB treatment to 28 lakh people who are living with HIV/AIDS. Development of indigenous vaccine and operational research are the main activities and research priorities of the program. Efforts are on to develop indigenous vaccines based on some type C of HIV.

Impact Mitigation

The program is launched with an intention to reduce the impact of HIV among infected and affected children and adult population. In case of the children, it'll be implemented through various child-welfare organizations and as far as the adults are concerned, the adult HIV-infected individuals will be done through other welfare agencies which provide nutritional support, opportunities for income generation and other welfare services. To create healthy environment, the program will take review and reform of structural constraints, legal procedures and policies that hamper the interventions aimed at marginalized population. It will encourage greater involvement of People Living with HIV/AIDS (PLHA) and facilitate establishment of networks and civil society forums in each district by 2010. Legislation should be brought to control stigma and discrimination is against the people with HIV/AIDS.

Decentralization

Decentralization was made to implement the program with an aim to implement it perfectly and also to cover rural areas. The basic unit of implementation now is the district. Based on the epidemiological vulnerability, all districts in the country have been classified into four categories to design and implement need-based plans and accordingly different packages of services have been developed for each category of district.

9. Monitoring and Evaluation

140 measurable indicators were identified with an aim to monitor the program. Strategic Information Management System (SIMS) units are set up at national and state levels with an intention to address the issues relating to planning, monitoring, evaluation and surveillance and research. The Surveillance system will focus on tracking the epidemic,

identifying the pockets of infection and estimating the burden of infection. Two types of behavioral Surveillance Surveys (BSS) will be conducted a.) Annual risk assessment at the district level and 2.) Systematic survey at National/State level once in three years.

The main objectives of this research study are:

- To study the socio-economic and demographic profile of the clients of commercial sex workers.
- To assess the clients' knowledge about HIV/AIDS
- To understand the dynamics of sexual behavior of clients with sex workers
- To know the prevalence of sexually transmitted diseases (STD) six months prior to the survey and treatment seeking behavior among the study population.
- To know the extent of condom use and misconceptions associated with it among the clients

10. Study Area

Anantapuramu district happens to be one of the most backward districts in the country and has a very poor rainfall and as a result drought is a common visitor to the district. The people of the district are leading pathetic lives in very appalling conditions. With an average rainfall of less than 600 mm, agriculture happens to be a ruined profession. Most of the people migrate to cities like Bangalore, Hyderabad and even Pune and Bombay. Most of the people belong to the Scheduled Castes, Scheduled Tribes and Backward Class communities. The poverty severely affected the livelihood of the people. Chronic poverty, frequent visitations of drought, lack of employment opportunities and unequal social relationships has contributed to the prevalence of prostitution of the people of this region. The easy availability of the commercial sex workers and the habits of not confirming to safe sex practices has resulted in the growth of AIDS/HIV in serious proportions in the region.

11. Data and methodology

The present research study is an exploratory one which is based on primary data which is collected mainly from the commercial sex workers in the study area in the year 2018. The survey has used both qualitative and quantitative data collection techniques.

With regard to qualitative data collection, interviews were conducted with the commercial sex workers who were practicing commercial sex and also with the clients who frequented these commercial sex workers. Apart from this, interviews are also conducted with the NGO heads who were working on HIV/AIDS projects and information which is collected through qualitative techniques were utilized for the designing of the questionnaire, interpreting the qualitative survey results and program implications.

With regard to the quantitative survey, semi-structured questionnaire has been administered among the clients of sex workers who have agreed to provide information. The principal investigator and a trained interviewer who had experience working with the commercial sex workers and HIV/AIDS Project collected the data.

Sample size

60 clients of sex workers have been interviewed for this research study. While 50% of the clients who were interviewed for the study were primarily from the home-based sex access points, 30% were from the lodge-based sex-clusters and the rest were from the street-based sex workers sites.

12. Summary of the findings

The findings of the research study revealed that the clients of the sex workers hailed from all communities of the society. Most of the respondents of the study revealed that they were practicing one or more than one habit which included drinking and watching pornographic films and the watching of the pornographic films prompted many of the clients to have sex with sex workers or with any other partners.

It was also revealed through the study that knowledge among the sex workers in relation to HIV/AIDS was very rudimentary and they had only one or two knowledge indicators of the disease. As expected HIV knowledge among the commercial sex workers led to safe sex practices while it had no significant impact on the condom use with regard to the non-commercial sex partners.

Among the clients who were interviewed, most of them belong to 'casual clients/regular clients' who had chosen a different sex worker every time. Non-penetrative sexual activities and vaginal sex, and anal and oral sex were also practiced by some clients. It was found that the clients had sexual contact with a wide range of non-commercial partners without condom. This happens to be the main transmission mechanism of HIV infection from high-risk group to low-risk population. The main reason for non-usage of condoms or low usage of condoms was that condom use reduces sexual pleasure. To show one's fidelity to the sex partner was the reason for non-use of condom with girlfriend, wife, relatives etc.. The common misconception that is prevailing among the clients is that condom use indicates their sexual affairs with prostitutes. The clients were visiting sex workers for different reasons.

It was revealed through the research study that nearly 10% of the clients have experienced one or other STD symptoms during the last six months preceding the survey. It was found to be very high among the clients who were using condoms less frequently and had sexual affairs with more than one partner, illiterates, clients who had less knowledge of HIV/AIDS, SC/ST/OBC declines etc. One third of the patients perceived the right cause for the sexual health problems. Nearly 40% of the patients suffering from sexually transmitted diseases did not seek treatment for the diseases. Large chunks of the clients did not get themselves tested for HIV status. 30% of the informants knew that the chance of getting HIV was high.

The present study has thrown adequate light on the sexual behavior of the clients of sex workers, their social and demographic background, the knowledge of HIV/AIDS, their sexual morbidity, and opinion about condom and its usage which will be highly essential for the program managers to design intervention programs.

It was gathered from the study that there was a dire need to change the attitudes of the clients of sex workers regarding safe sex practices. It was found that many clients followed their own false method of precautions for avoiding sexually transmitted diseases and HIV. Some of these precautions were used before the sexual encounter and some after it. It was discovered that the clients had the habit of washing the penis with soda water to kill the microorganisms if any, after the sexual encounter. Few other clients had the habit of examining the private parts of the sex workers for ulcers, boils etc. If they found anything suspicious did not have sex with the sex worker. Some others would touch the vagina of sex workers and if they found it to be hot, they concluded that the commercial sex worker had some sexually transmitted diseases and seek sexual favors from another sex worker. If they found the commercial sex worker looking healthy, they concluded that this commercial sex worker did not have any diseases and approached her for sex. As the clients were following their own methods of precautions they felt that there was no need to use condom. Appropriate intervention need to be done to take care and address the false precautions that are being practiced by these clients.

The study findings also revealed that many patients who were suffering from the sexually transmitted diseases were unable to identify the real cause for the sexual health problems because they believed that they were following their own precautions and as a result they thought that the problem that was there with them was not due to their sexual practices and it was due to something else.

It was also revealed through the study that it was not only the clients but also the non-commercial partners and their spouses were not interested to use condoms. The persisting notion in the community regarding the condom was that it had to be used only with sex workers or with persons who maintain sexual relations with other than the regular partner. The awareness programs should address these sensitive issues along with the usual messages.

The non-governmental organizations which are working in the study area for the prevention and curtailment of the HIV/AIDS group do not have intervention programs for the clients of the commercial sex workers. They are covered under the program for general population. Since mobilizing the sex workers' clients is rather a challenging task, workplace intervention and interpersonal communication should be chosen for bringing awareness among them regarding HIV/AIDS. The clients should be contacted at one place where the sex trade takes place with the help of lodge owners, sex workers or pimps. With the help of interpersonal communication, sexual education must be imparted to the clients and providing the knowledge pertaining to HIV are condom alone will not serve the purpose. The misconceptions and misunderstandings that are present in the minds of the clients of sex workers should be addressed properly. It is only then that behavioral changes are possible. Awareness programs alone will not bring the desired results to the expected level rather it should be coupled with socio-economic and development programs. Some innovative schemes need to be launched to improve the socio-economic condition of women in the society, change certain pro-man social norms, values and customs of the society.

References

1. 'Strategic Approaches to HIV and AIDS Prevention and Control': AUTHORS PRESS Publishers scholarly Books, New Delhi. (Ramamurthy, 2003).
2. 'UNGASS India report: progress report on the declaration of commitment on HIV/AIDS' (NACO, 2006).
3. Addresses the problems in India caused by donated blood that is contaminated with the human immunodeficiency virus (HIV). Blood screening program launched; Indian health officials play down the real AIDS picture; Some doctors speaking out; Attempts at public AIDS education.(Kandela,1991).
4. *AIDS in the twenty-first century Disease and globalization Essential reading for social and medical scientists and all those interested in infectious diseases and public health, AIDS and the Twenty-First Century examines the social and economic origins and impacts of the HIV/AIDS epidemic.* (T.Barnett and Whiteside,2002)
5. Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How. Gupta, 2000.
6. India report: progress report on the declaration of commitment on HIV/AIDS. NACO-2004
7. January). Improved estimates of India's HIV burden in 2006. *Indian J med Res*, Pandey, A. (2009,
8. Knowledge about HIV/AIDS, the perceived risks of infection and sources of information of Asian-Indian adolescents born in the USA. Bhattacharjee 2000.
9. *Living with the AIDS virus The Epidemic and theresponse in India.* Sage Publication. Panda, S (Eds.). (2002).
10. NACO Phase I of the Programme spanned 1992-1999. (The emphasis in phase-I (1992-1999).
11. NGO comes to the rescue of HIV positive. *The Hindu*, 2007
12. Severe weight loss: The predominant clinical presentation of tuberculosis in patients with HIV infection in India. Hira 1998.
13. Sexual Behavior and AIDS in India: State-of-the-Art. *Indian Journal of Social Work*. Nag, M. (1994).
14. Sexual Behavior among Truck Drivers in Pakistan. *Culture, Health & Sexuality* 4(2), 191-206 retrieved on 8th July 2010 from <http://www.istor.org>. Agha, S.(2002, Apr.-Jun.)
15. The annual AIDS Epidemic Update reports on the latest developments in the global AIDS epidemic. AIDS Epidemic Update: 2005.