Debates on Intervention Review of HIV/AIDS Related Studies: Perspectives from Anthropology

Shalina Mehta and N. Inaoba Singh

Much like physicians who suffer from therapeutic impotence in their inability to cure, anthropologists who believe they know how to effectively engage people in protecting themselves suffer from a kind of social and political impotence. Some suffer in silence; others write, use gallows humor, or scream; still others disengage. (Brooke G. Schoepf, 2001)

Multidisciplinary research is the current need for understanding complex behaviour related to pandemics and epidemics. From 1981 to 2006, HIV/AIDS has claimed more than 25 million lives[1]. Studies conducted by WHO have estimated that in 2002 alone, AIDS accounted for 3% of all deaths in India. The projections for the future are frightening. The report suggests that the AIDS epidemic is likely to be responsible for 17% of all deaths and 40% of all infectious diseases by 2033. Various civil society organizations[2] and governments are funding research and intervention programmes to combat not only the virus but also accompanying myths, misconceptions and above all stigma. Preliminary reporting on HIV was largely in clinical research. But as the mode of transmission of virus got unfolded, both science and social science journals started publishing HIV/ AIDS related research. However, disciplinary hierarchies also determined the quantum and quality of research being published in these journals[3].

We are trained anthropologists working in India. We started working on the subject examining adolescent attitudes and myths and misconceptions about the virus at local level[4]. Over the years, we had to make a conscious effort to explain the relevance of anthropology for evolving a comprehensive understanding of the pandemic. We have repeatedly explained to naïve specialists in India as to what anthropology has to do with HIV/AIDS research. We decided to confront the challenge by exploring HIV/AIDS related published research not from anthropological perspective alone or in anthropological journals only; but reviewing studies that are published in some of the most reputed journals in sciences and social sciences. The amount of literature published on the subject is immense. We are not claiming that the review presented here is all-inclusive or representative of the plethora of data and opinions published on the subject. What we are aiming to discern is collective multidisciplinary in-put that has facilitated the management processes operating at different levels in different parts of the world today.

We make the beginning by reviewing studies published in the year 2005 and 2006 in one of the most respected journals of epidemiology-*The Lancet*. The journal was founded by Thomas Wakley in the year 1823. The opening statement made by the founder editor is demonstrative of the spirit of the journal. He announced "A lancet can be an arched window to let in the light or it can be a sharp surgical instrument to cut out the dross and I intend to use it in both senses".

The Lancet first appeared on Oct 5, 1823. From the beginning, Wakley's aim was to entertain, instruct, and reform. Instruction came in the form of transcribed medical lectures from the London teaching establishment; entertainment in the early days of the journal came in the form of theatre reviews and piquant political comment. *The Lancet* has been, first and foremost, a reformist medical newspaper. Thomas Wakley and his successors aimed to combine publication of the best medical science in the world with a zeal to counter the forces that undermine the values of medicine, be they political, social, or commercial.

The journal was, and remains, independent, without affiliation to a medical or scientific organisation. More than 180 years later, *The Lancet* is an independent and authoritative voice in global medicine. "We seek to publish high-quality clinical trials that will alter medical practice; our commitment to international health ensures that research and analysis from all regions of the world is widely covered. Critical appraisal of research and reviews is ensured by strong Comment and Correspondence sections; *The Lancet*'s opinion and personality is communicated by three editorials every week; fast dissemination of priority issues

is delivered by early online publication through thelancet.com; and the continued success of our monthly specialty titles ensures that *The Lancet* delivers in-depth knowledge in key medical disciplines." (cf. THE LANCET.com: *The Lancet*-then and now)

We have to acknowledge at the outset that HIV posed challenges that were not confronted by the medical fraternity while researching or responding to various other epidemics or infectious diseases. For sometime the opinion of the social and behavioural scientists were not taken seriously and most medical journals hardly published social science research relating to various epidemics. The reason to start this review article by examining articles published in *The Lancet* or that appeared on *The Lancet* .com was to assess acceptability of the behvioural science research and its impact on medical fraternity.

The first article that we are reviewing is titled *Containing HIV/AIDS in India: The Unfinished Agenda* written by Padma Chandrasekaran, Gina Dallabetta, Virginia Loo, Sujata Rao, Helene Gayle and Ashok Alexander. The contributing authors belong to the Bill and Melinda Gates Foundation and Sujata Rao was at the helm of the affairs at National AIDS control organization at the time of the writing of the article. Only one of the authors was working for CARE in USA. The contributors to this India review argued that the factors that influence Indian epidemic are 'the size, behaviours, and disease burdens of the high risk groups'. It was further stated as a consequence of these factors, there are already substantial epidemics in several states and there are likely to be several subepidemics in what are regarded as low prevalence states in India. Challenges faced by a country having a population of more than one billion living across 31 states and 593 districts are mammoth. The focus of the paper is to explore those dimensions of the epidemic that have remained hidden. One of the reason's could be that the data available with certain disciplines is not properly resourced. It also reiterates policy decision of the government to take prevention as the first priority and treatment as second.

The review article draws our attention to the fact that the present methodology adopted for projecting estimates is inadequate. The logic for making exhaustive use of Anthropological skills emanates from the observations made by the authors that for understanding drivers of an early stage epidemic, programme planning and measurement of programme effectiveness, mapping and size estimation of high –risk groups, periodic assessment of risk behaviors, and biomarker data are crucial. With some exceptions, such data are sparse in India. There are few systematic processes of data collection in these areas; public-health research output in India is low in general (Dandona, 2004: 55).

Identification of high risk categories is also not as clear as it was assumed to be. The review paper cites data generated by AVAHAN programme for commercial sex workers. Contrary to the popular assumptions, data suggests that in Southern states only 5-10% of sex work solicitation occurs in institutionalized brothel settings. Nearly 65% of sex work is street based and about 30% is solicited from the house of the worker. The study also documents sex work now being accessed through mobile phones and bar-based activity. There is no mention of internet usage for the activity or that of traditional institutions like the *Devdasi pratha*. Authors on the basis of cross-reference from other articles published in *The Lancet* acknowledge that 'typologies of sex work are fluid'. They account for economic and environmental pressures for defining typologies of sex work but overlook customary practices and kinship pressures that create additional pressures on women to become sex workers.

It is in this context that through this article, we are trying to build a case for involving greater number of anthropologist in HIV research programmes. Limitations of manpower, lack of appropriate methodological tools and inability to recognize wealth of ethnographic local knowledge available with disciplines like anthropology has plagued the HIV/AIDS management programme in India.

NACO's Intervention Programmes and Its Limitations

NACO has recently launched third phase of its programme for intervention, prevention and treatment of people suffering with HIV/AIDS. First phase of the programme was sketchy riddled with questions of morality, while planning strategies were constrained because of lack of sufficient funds. NACP-2 by its own admission was focused on 'five basic elements shown globally to be effective: behaviour change communication/peer education, STD treatment,

condom promotion/provision, enabling environment, and community mobilization' (ibid: 508-521). We have used the phrase by 'its own admission' as one of the contributing authors in the article was the erstwhile programme director of NACP. Our contention is that to incorporate best practices from 'globally effective' strategies may be a good idea but to visualize it as the most effective means of bringing under control a pandemic known to be determined by social and cultural profile of communities and prevailing socialization practices leaves lot to be desired.

A review of the NACO programmes suggested that there was urgent 'need to mount structural interventions that could substantially change environmental factors increasing risk (e.g., violence faced by sex workers) to organically foster a strong community-led response. The report also suggested that there was inadequate focus on male clients, and limited evaluation of effectiveness' (ibid: 508-521). From the point of view of a Social scientist and in particular that of a cultural anthropologist, the first phase of the NACO in its naivety marginalized already stigmatized sections of the "high risk groups". Many among us have persistently critiqued NACOs 'target approach'. In our opinion these programmes generated further stigma and diverted attention from the need to pursue effective strategies for what are now being termed as 'carrier groups or bridge populations'. The review report talked about 'limited focus on coverage, and diffused programming with substantial interventions in non-priority groups' (ibid: 508-521). The statement is contradictory in certain ways. All of us engaged with HIV/AIDS studies for more than a decade have persistently pointed out financial wastage in the programme, its limited coverage because of its 'target centered approach' and myopic vision of the planners in deciding 'who should be the priority groups'. Excessive focus on CSWs without paying much attention to their clients, inability to connect with the women in general, dithering over sex education programmes for long, continuing to harp on a value system as being self protective without adequate empirical documentation and most important of all failing to recognize local level safety nets devised by different cultural communities for protecting adolescents and vulnerable members.

Another important deficit in India's Health management is meager resource allocation for health care. We noted[5] that the success stories from Thailand were primarily linked to massive investments that were made in the health care and management of HIV. This review article records that 'the estimated total amount spent on HIV/AIDS in India in 2004 was US $ 79 million (including Avahan funds) or about $0.15 per capita of the adult population. This spending compares with an estimated $1.74 per capita for Thailand or $0.28 per capita for China during the same period, but must be seen against the backdrop of overall low general government expenditure on health in India of $7 per capita'(ibid: 508-521). These observations acquire further significance in view of the fact that '80% of health spending in India is private spending, and a single catastrophic illness puts a household into debt for perpetuity……..An Asian Development Bank/ UNAIDS report estimates that AIDS could slow poverty reduction goals by 23% between 2003-2015' (ibid: 508-521).

Lack of funds and baggage attached to poverty that reduces body immunity due to malnutrition and force people into risk behaviours act as potent agents for any epidemic. Our greatest weakness in this regard has been our inability to incorporate HIV management programmes within the existing health infrastructure. We made sizeable investments in starting separate AIDS control societies at the state level. While the focus was on BCC, little investment was made in controlling opportunistic infections. Behaviour change was regarded as a definite end product of intervention. We as students of behaviour studies often questioned the rationale behind this strategy. Empirical studies have suggested that human behaviour is conditioned by prolong socializing practices. It is also governed by social norms that are evolved by communities over generations. Behaviour is a conditioning and any mediation requires negotiations. Who monitors these negotiations with what intent is critical for generating positive responses. To inform is an understandable proposition. What one can do to safeguard the physical being is another logical in-put. But to assume that the interventions so designed can actually change customary or habitual practices is a far fetched strategy.

The most significant contribution made in this well researched review article is the suggestion that talks about 'ensuring commitment to evidence based HIV programming and *investing in*

strategic knowledge building' (ibid: 508-521). It is here that anthropological skills and ethnographic data bank are likely to play a decisive role. In the second section of this paper we will augment our case for this proposition by citing some studies pursued by anthropologist over the years. We are told by the authors of this paper that 'India's challenge is to ensure that this programme is rapidly brought to scale and implemented with quality, which will require strategic knowledge building, scalable approaches to prevention, and resources for capacity building'(ibid: 508-521). To achieve these goals the authors propose (1) leveraging existing social networks and community structures for reaching large numbers of individuals, (2) reducing vulnerability of marginalized groups by addressing structural barriers, and (3) catalyzing changes in social norms and environmental conditions. We do not understand how the managers of HIV programme in India can do that without substantial in-puts from cultural and social anthropologist. We will be reviewing in another section in this article the kind of inputs that anthropologists have made in the context of African studies, with the intent to show that neglect of anthropological experience in India studies is constraining the prevention efforts.

Lancet Reported Another Study in Its 2005 Issue. The study was located in a remand house. It argued 'Is Abstinence a logical solution for prevention?' The ABC (abortion, be faithful and condomise) debate has dominated HIV discourse from the time intervention strategies on the subject were initiated. Some would describe it as 'pro-Christian right' strategies doing rounds in US policy debates. The ABC debate is now poised vis-à-vis CNN (Condoms, needles and negotiating skills) approach.

This Lancet article reviews studies conducted by Green (2003), Low-Beer and Stone Bunner (2003: 9-21.) that reported changes in sexual activity after abstinence were promoted as a policy intervention in Uganda. These scholars had argued that 'delaying onset of sex or reducing partners) should be viable policy and programme goal for HIV prevention' (p. 591). In India, policy planners were slow to respond to the challenge of HIV, believing that our cultural control mechanism were already well in place to prevent any future catastrophe. From 320 cases in 1992 to more than 5 million projected cases in 2006, it is more than apparent that our understanding of our cultural fabric was awkward. Green (2003) in this study insisted that whatever success ABC model may have had in Uganda was due to a culture specific IEC strategy. This implies that for an intervention strategy to succeed, it is important that perceived objectives are complimented by right information and communication strategies. Messages have to be constructed in local languages and dialogue rooted in cultural vision.

Intervention programmes are persistently asserting the need to create 'multiplicity of messages' (Wower, 2005) Wower also argues that ABC is not necessarily working as a package. One strategy may succeed for one segment of the population and another for the other set of the population. Political patronage granted by political regimes citing success stories from one site may not be a progressive option for another socio-cultural milieu.

Barnett and Parkhurst (2005) rightly ask, "Is it correct to focus prevention intervention on something loosely defined as 'sexual behaviour' when the real issues may be the contexts within which those behaviours take place, the life circumstances that these behaviours address, or the diverse meanings that the term 'sex' may have in different culture and societies'?

It is pertinent to discuss here factors that influence sex behaviour. Poverty, social isolation, conflict and customs have decisive influence on people's choices for safe sex. For people dying of hunger, sex is part of livelihood strategy. In many societies women are socialized into believing that sex is duty. Simply speaking in different societies sex is viewed differently. Intervention programmes have to provide 'local communities, and local leaders, freedom to shape interventions, to local circumstances, and to local understanding' (Barnett and Parkhurst, 2005: 590-93)

Another Lancet article being reviewed here is by Patralekha Chatterjee titled 'AIDS in India: Police Powers and Public Health' (2006:805-806). It examines the question of homosexuality and the state. The article is essentially a commentary on intervention dilemmas that India as a nation confronts. On the one hand, we have debated laws like section 377 of the IPC. The section regards Men having sex with men (MSM) as an unnatural act and thus a punishable offense under the law. The National AIDS Control Organization (NACO) regards MSM as a target group for intervention. It has sanctioned 31 projects in different parts of the country for providing safe

sex information to the group. Law informed agencies and public health workers are simultaneously involved in action programmes that are at cross-purpose. We have in the recent years witnessed public debates in the media and in academia to negotiate and resolve these issues. On the other moral policing by same sections of the politicians, bureaucracy, academia and confusion experienced by general public has made the task relatively difficult. In this paper, Chatterjee draws our attention to Human Rights watch (2002) report that sums up this dilemma. The report states:

"In its official policies and statements, the Indian government has recognized the importance of reaching out to women in prostitution and men ho have sex with men as a central element of its HIV/AIDS response…. But in practice, one branch of the government –the public health service relies on the non-government sector to provide condoms and information to persons at high risk, while another branch of government-the law enforcement establishment –abuses those who provide these services" (cf. Lancet 2006: 805-866)

In our capacity as independent researchers, working on issues relating to HIV/AIDS for more than a decade now, we like to assert that in the past ten years attitudes and public opinion on the subject of MSM has seen significant change in India. There is greater acceptance and many do not regard it as abnormal or criminal act. Many public personalities like noted novelist Vikram Seth, many others celebrities as have made public their sexual preferences. Despite this, we also have reports coming from Uttar Pradesh, Madhya Pradesh as well as from other parts of the country that records clamping activities of various civil society organizations involved in awareness and interventions programmes. Officials of various international organizations responsible for strategizing policies and intervention programmes have stated that any kind of criminalization of people most at risk of HIV infection may increase stigma and discrimination ultimate contributing to fueling of the AIDS epidemic.

Patrelekha Chatterjee in this paper sums up the problematic-"Police harassment of gay men is a term that includes men who may not identify themselves as gay or homosexual and who may also have sex with women. This community forms a bridge for transmission of the infection to the general population" (Chatterjee, 2006). It is a well documented reality that many 'gay men' are bisexual. Many of them are married and have normal heterosexual lives. In the process they may infect their unsuspecting wives, who have been in monogamous relations only.

SIGNIFICANCE OF ANTHROPOLOGICAL STUDIES

In our endeavour to build case for greater involvement of anthropological skills in AIDS intervention programmes in India, we review one of the most important review studies on the subject that appeared in the *Annual Review of Anthropology* (2001). The paper written by Brooke G. Schoepf examines in a skillful review the contributions that the discipline has made. He records that from a slow beginning in the 'mid-1980s, AIDS research has grown rich and diverse'. The discipline is equipped with a unique methodology to empower further research intervention strategies in any part of the world.

The review essentially takes into account the rich data base from Africa. The exhaustive review article lists important edited volumes on the subject that includes contributions made by Bibeau and Murbach (1991), Dyson (1991), Bolton and Singer (1992), Herdt and Lindenbaun (1992), Farmer et al. (1993), Feldman (1994), Brummelhuis and Herdt (1995), Dozen and Vidal (1995), Orubuloye et al. (1995), Farmer et al. (1996), Parker and Gangon (1995), Bond et al. (1997), Descalux and Renault (1997), Herdt (1997), Ntozi et al. (1997), Singer (1998), Becker et al. (1999), Fay (1999), Descalux and Taverne (2000) and also incorporates various articles published in academic journals and book chapters in various other references.

Discussing the methodologies incorporated by these studies, the author observes that 'these richly contextualized studies allow the voices of sufferes and people at risk to be heard, by incorporating narratives, texts of interviews, observations and public speech. Most adopt a historically grounded "political economy and culture" strategy (Schoepf, 1988, 1998; Singer, 1998).

The reviewer further clarifies that the literature search was restricted to English and French language. In addition the publications by Berger and Ray (1993), Schenker et al. (1996), Baer et al. (!997), Farmer (1997), Seidel and Vidal (1997), Lindenbaum (1998), Singer (1998), Symonds and

Schoepf (2000), Schneider and Stein (2001) are listed as additional resource for topical literature review.

Contrast this with the listed 'search strategy and selection review' listed by the authors of the first study 'Containing HIV/AIDS in India: the unfinished Agenda'. Authors contend at the end of the article ' We did a complete search of the National Library of Medicine for journal articles and abstracts for the year 1995 to the present using broad search terms such as "HIV", "India", "female sex workers", "MSM", "IDU", and "Migrant men". We identified additional sources through a Google and Google scholar search using the same terms and through review of reference lists of relevant publications. We obtained HIV/AIDS/STI surveillance reports from the Indian National Government or State Government offices either through website access (http:www.nacoline.org, http://www.indiastat.com) or on personal requests. We also scanned the websites of international agencies involved in interventions or research projects on HIV/AIDS. Finally, we obtained unpublished field reports through personal contacts with HIV programme personnel in India. We considered references from 2000 onwards for inclusion unless an older publication was the only relevant one identified. In addition, we avoided conference abstracts unless they were the only source of information. We restricted the search strategy to English language publications' (2006).

The contrast in methodologies adopted for reviewing available literature for future planning is self explanatory in limitations experienced by HIV control managers in India. Their approach to the problem is managerial and epidemiological. It misses out completely on the inherent nature of the experiences and sufferings of the individuals in community settings. The fact that social science studies barely find a mention in their approach to literature search and a rich resource that may have remained hidden in abstracts which fail to meet quality control measures of research publications is totally ignored. Leave alone local languages, effort is not even made to examine research reports that document local histories of the pattern of the epidemic.

Legitimacy of the claims made in the review study made by Schoepf and position taken by us in the present article has been repeatedly tested in various other parts of the world also. The conclusions drawn by the author are also testimony to what has been wrong in India's unfinished agenda on HIV/AIDS. We use the text of this study and observation made by fellow anthropologist to demonstrate the lacunae's that the first study we cited at the beginning of this paper fails to incorporate. The authors of the Lancet paper are managers and medical professionals. They have not only left out important contributions made by the social scientist but have also in policy planning initiatives in the country have ignored the expertise of anthropologists and other social scientists working tin the field. The situation is not peculiar to India alone, similar indifference marked initial response to HIV/AIDS in other parts of the world.

Mann (1996) in this context remarks, " ……a desire by public health workers to 'own' the problem……by keeping the discourse at a medical and public health level….." and Schoepf (2001: 340-41) notes "marginalization of social sciences was deliberately maintained; political and economic inequalities that drive the pandemic slighted examples of empowering community – based prevention ignored". To augment our case further, we cite the following observations from the review article under discussion:

'Some early studies of culture and AIDS in Africa, undertaken at the behest of bio-medical researchers, were less than competent. Novices to African studies produced rapid assessments and cobbled-together surveys. The worst literature searches tore bits of erotica from context…….. Sweeping statements were made about a special "African sexuality", based on traditional marriage patterns different from those of Europe and Asia. Culture was designated as the culprit of HIV spread. Blaming cultural differences for situations clearly linked to inequality supports the status quo (Sobo,1999). US anthropologists may remember the 1960s' struggle against the "culture of poverty". Frankenberg (1995) describes the travails of anthropologists struggling with categories imposed by epidemiologists in interdisciplinary teams. Anthropologists were "…….token members on research projects [directed] by scientists who regard 'culture' as an obstacle' (Obbo, 1999: 69). Some, like myself, worked on small grants without salaries to maintain their independence'.

The situation for most of us working in India has been no different. Working in a department that is located in faculty of Sciences, we have

struggled for years to communicate efficacy of cultural approach to understanding issues regarded as only bio-medical. We are still questioned in meetings and interviews about our expertise to do research on HIV/AIDS. The method of narratives used by many of us is critiqued as cumbersome subjectivity. We often draw our perseverance from people suffering with HIV/AIDS and other victims of prolonged suffering. '"Witnessing" of social suffering (Farmer and Kleinman, 1989) is a potent subtext to many research rationale' (Schoepf, 2001: 349). Anthropologists by training are also more sensitive to framing notions of the "othering".

Farmer (2003) is one of the most powerful advocates of anthropological understanding. He argues that anthropological analytical skills helps in revealing inequalities built in systems that are exploring and searching for solutions for epidemics like HIV/AIDS. Anthropological skills help explore "these structurally mediated problems in the context of: 1) their historical depth (for they have not emerged out of nowhere in a historical vacuum), 2) their location in geographical breadth, in which the salient interconnections between different parts of the world(e.g., Haiti and the U.S. are mapped, and 3) the interplay of multiple and simultaneous axes of inequality-gender, class, race, and sexual preference- without which anthropologists cannot fully understand the constraints on, and the possibilities for, human agency and our capacity to face up to the AIDS pandemic and prevent it from having an indefinite future of devastating effects " (cf. Harrison, 2005: 6; Farmer, 2003: 42-43). While doing so, we are aware of challenges met by several anthropologists, some of them trained as physicians like Farmer, who used primary data collected by them to advocate changes in health care priorities, policies and care practices, with little success (Schopef, 2001; Vidal, 1996). The challenges faced by the anthropologists, often place them in precarious positions. On the one hand they may face opposition, challenging hegemonies of the state and *brahmanic* control of the 'specialist', on the other they may get entrapped doing what Harrison calls the "macro-logics of power", that examines 'political economics of health and human rights' compromising 'commitment to ethnographic depth' (2005: 6).

In a recent review article titled 'Understanding Cultural Resources for AIDS control: An inter-disciplinary Approach' (2005) in a special issue on 'Women, HIV'AIDS and Human Rights' brought out by *Indian Anthropologist*; Ritu Priya and Sunita Reddy have drawn the attention to indifference shown by NACO to anthropologists. The authors, one of them an epidemiologist and other an anthropologist reason that to an extent it is the community of Indian anthropologist to blame. They have failed to assert their right and have remained rooted in western idiom at the cost of Indian reality. This compels us to draw the attention of our readers to the fact that at one stage senior author of this paper had to write to the former director of NACO to include anthropology as subject specialization for the post of NGO advisor to the State AIDS control society. At one stage of the programme the discipline did find mention in its advertisements but on some wise counseling it was deleted and in its place home science, psychology and business studies were included. Despite this early intervention as the authors of the paper note; 'at the global level the involvement of anthropologists as researchers in the field of HIV and as applied anthropologists, in various capacities, is significant. However, in India; 'anthropologists still have to plunge into this area of specialization. The National AIDS Control Organization, the official body working for AIDS has not recruited any anthropologists, who can contribute significantly in understanding the problem' (2005: 21).

VULNERABILITY, TARGET APPROACH

Denial Syndrome in Administrative Strategy

Disease, epidemics are social processes: Spread of infectious agents is shaped by political economy, social relations, and culture. A disease of modernity and global population movement, AIDS has struck with particular severity in communities struggling under the burdens of poverty, inequality, economic crisis, and war. Many people who know about the danger of sexual transmission, especially many girls and women, cannot avoid becoming infected because they cannot control the relations of power that put their lives at risk (Schoepf, 2001: 337).

Cultural categories of vulnerability are often created by administrators and bio-medical sciences as fixed 'segregated groups'. This perception funds research and intervention aimed

at target groups. The 'target group' viewed by many as the 'targeted group' often becomes the victim of oppression, violence, criminalization and marginalization. It also in the process excludes 'non-target' groups from general surveys and results in formation of categories called the 'bridge groups'. While developing these categories, history of the spread of epidemics are also often ignored. Schoepf (1988, 2001) refreshes our memory, when he writes; ' Initially recognized among elites in many countries, HIV rapidly spread along "the fault-lines of society" to the poor and disinherited. ……AIDS brings forth representations that support and reproduce already constituted gender, colour, class and national hierarchies. Societal responses to AIDS, including disease control policies, are propelled by cultural politics'.

Lancet review paper on India is replete with west dominated bio-medical discourse. This view regards, 'illness as a form of dysfunction in the individual and the role of biomedicine are seen to correct this dysfunction. Behaviour of individuals is important in terms of making people accept the technologies prescribed for treatment of various diseases. Often the non-acceptance of treatment is interpreted in terms of lack of knowledge of disease, cultural resistance and not realizing the need to seek care. This kind of an understanding premised on the primacy of biomedicine and that people 'do not know and have to be educated' (Baru, 2005: 47). The entire campaign that is centred on BCC that is behviour change communication and those associated with condom promotion are rooted in this perception. 'People' are regarded as objects, located in relatively isolated domains and are in need of being controlled by external agents. These external agents in the form of agency asked to distribute 'safe sex instruments' are also simultaneously promoted as 'chief control officers of human behaviour'.

The control mechanisms exercised by the west were not only restricted to Africa but have now come to play the same role in India. India has replaced Africa in terms of number of individuals infected by the Virus. The percentage in terms of population proportions may not be significant but the staggering numbers warrant immediate attention.

From NACO's phase I intervention programmes launched in 1992 to its phase III programme launched in 2006, the focus on 'target groups' is often questioned by social scientists working in various research parlance in India. We witnessed in the past how the 'target groups' were subjected to discrimination and complete alienation from the community settings. There is also evident emergence of new identity categories like "MSM", a group that remained hidden till the intervention programme "targeted" them. The third paper that we reviewed from the *Lancet* brings forth anomalies of the 'target approach'.

When we 'target' populations/communities / vulnerable groups, we willy-nilly subject them to 'profound ill effects of structural violence and pathologies of power' (Farmer, 2003). While doing so, we also give a certificate of 'non-vulnerability' or safety to 'non-target' groups. This result in framing of policies that create disconnect between different segments of population. Consequently, policies facilitate social processes of infection, making general population assume that they can never be the likely victims.

Inability to Comprehend Cultural Linkages between Symbols and Transmission of Virus

Complex cultural and psychological meanings also intervene in representations of AIDS. With transmission linked to body fluids –to semen and vaginal secretions, blood, and mothers' milk-to sex, reproduction, and death, AIDS in many cultures is freighted with extraordinary symbolic and emotional power, including ideas about social and spiritual "pollution".

If we review the history of HIV/AIDS management in India, we will realize that the target based approach failed to take into consideration the cultural construction of mode of transmission. We simply said that there was need to fight, myths, misconceptions and orthodoxies. Every time a programme on a target group was shaped into a kind of group specific movement the innocent sections of the population became victims of assault. Take the case of frequently recorded belief from various project sites, in which respondents reported that having sex with a virgin girl would cure them of AIDS. The belief made innocent, unguarded young girls below the age of fourteen become victims of assault, rape and priced commodities in the flesh trade. This enhanced probabilities of their susceptibility, to the virus. We labeled commercial Sex workers as the "most vulnerable groups". In the process, we cautioned their "clients" to become 'aware'. While

doing so, we exposed a section of young, innocent, unaware girls to 'risk'. If we were holistic in the framing of intervention programmes, and had taken adequate care, to develop a module for intervention which was culturally sensitive, the initial pitfalls of the first phase of interventions strategies could have been avoided. It is ironical that the failures of 'programme implementation' of the last two phases have not made any dent in our visioning for the future. The critique becomes self evident when one reads the following content of *The Lancet* review paper. We are repeatedly referring to the paper because; it is our firm belief that this review article is preamble to the third phase of the NACO programme. The section we are citing, details, what needs to be done for 'Human Capacity building'.

Management and technical capacity government and the non-governmental organization sector to implement effective programmes remains an area that requires renewed focus for India to execute the scaled effort required to contain the country's epidemic. Enhanced management skills are required to prioritise action, optimize service delivery mechanisms, and to use data to monitor achievements towards set objectives. Limited technical expertise in general, and in data anlaysis in particular, especially at state and local levels, restricts the country's ability to adjust programming and anticipate emerging areas of need. Building these capabilities will entail flexible recruitment, a network approach to training and on-site support, and tapping resources outside the government sector.

India's national political leadership has made a strong commitment to robust HIV/AIDS response. The process for developing NACP-3 has been transparent and ***collaborative****, and the strategy appropriately puts prevention programmes for* ***high risk*** *populations at the forefront……* And the article concludes suggesting ***technical and especially management capabilities and systems*** *must be enhanced at all levels.* (2006: 508-521).

The highlighted portions of the excerpt underline the agenda of the managers responsible for running the programme in the country. The emphasis on 'high risk groups' and need to build management capabilities and delivery mechanisms, demonstrate our worst apprehensions that we have been repeatedly addressing through the text of this paper. Providing ARV to those who are infected is essential. Nobody is questioning the need to monitor the health of those who have already fallen prey to the disease and need care. In a similar vein, we also immediately need to discuss the questions of rehabilitation of the HIV positive people and their families. We are now confronted with growing number of orphan children some of them may be HIV positive, the others may not be but are victims of stigma and discrimination as no confidentiality clause is able to hide the fact that their parents died of HIV. We are also aware of denial by schools to keep HIV positive children for fear of large drop out by children, who are not infected. The information, education, communication (IEC) strategy have not trickled to the population as the managers of the programme expected. *The Lancet* paper is written by frontline managers of the programme. There is talk of collaboration but the paper fails to support those claims. There is no reference to understanding the cultural approach that UNESCO in its various documents is propagating. There is overemphasis on corporatization of the programme and for involving more and more mangers with masters in business administration in the programme. On the basis of our personal experience of being involved with the programme for more than a decade, and having participated in various workshops addressed by some of these business graduate, we are familiar with the level of discomfort that some of them have discussing what they believe are slow and cumbersome understanding of cultural processes.

We would like to conclude this paper by excerpting a paragraph from Schoepf's article that is representative of the position that not only anthropologists assume but those involved with HIV/AIDS research in various parts of the world have believed for many years.

The cultural politics of AIDS are now well understood-their effects on the pandemic less so (Symonds and Schoepf 2000). *At the outset, epidemiologists in government agencies designated entire populations as "risk groups," obscuring differences among people assigned to the categories* (Farmer 1988, Bolton 1992). *A focus on risk groups implies that everyone not included within the boundaries of stigma is not at risk* (Parker 1987, Lytteton 1996). *Common in public health discourse, such constructions are part of a "hegemonic process" that helps dominant groups to maintain, reinforce, re-*

construct, and obscure the workings of the established social order (Glick-Schiller 1992). *In Gramsci's elaboration of the concept, hegemony does not simply flow from the class structure as an expression of power. Rather, it comes about through struggle between forces with opposing interests*. (cited from *Annual Review of Anthropology*, Vol. 30: 335-361).

The hegemonic processes in India are not only in the domain of official managers of the programme, but are being dictated by the managers of international funding agencies, their appointed agents in the system. Voices of reasoning coming from marginalized disciplines like anthropology are dismissed as 'cultural baggage'. Young adults who are trained in the business schools and have little or no interaction with the texts and discourse in social science research are restless with the qualitative methods and its importance in mapping the epidemic. People's sufferings, their experiences are nothing beyond data that does not merit much consideration as it is not supported by quantitative verification. Our worry is that like the family planning programme of the mid 70's; in particular during emergency, existing 'target approach' and method of delivery mechanism may derail India's on-going HIV management programme.

NOTES

1. Global HIV/AIDS Estimates, End of 2006

The latest statistics on the world epidemic of AIDS and HIV were published by **UNAIDS/WHO** in November 2006, and refer to the end of 2006.

More than 25 million people have died of AIDS since 1981.Africa has 12 million AIDS orphans. At the end of 2006, women accounted for 48% of all adults living with HIV worldwide, and for 59% in sub-Saharan Africa. Young people (15-24 years old) account for half of all new HIV infections worldwide - around 6,000 become infected with HIV every day. In developing and transitional countries, 6.8 million people are in immediate need of life-saving AIDS drugs; of these, only 1.65 million are receiving the drugs.

The number of people living with HIV has risen from around 8 million in 1990 to nearly 40 million today, and is still growing. Around 63% of people living with HIV are in sub-Saharan Africa.

During 2006 around four million adults and children became infected with HIV (Human Immunodeficiency Virus), an estimated 39.5 million people worldwide were living with HIV/AIDS. The year also saw around three million deaths from AIDS.

Asia's vulnerability to AIDS owes evidently to high risk sexual behavior and sharing of needles among IDUs, high incidence of STI, gender inequities which heighten vulnerability of women and girls at many levels, poverty and low level of education and cultural taboos that surround sexual behavior. Information dissemination and negotiation for safer sex are yet a challenge. Highly mobile populations are more likely to engage in risk behaviors and act as breeding stocks transmitting HIV from one population to another. Cross boarder trafficking of girls and women and rapidly growing urbanization and high unemployment rates of youth might reinforce the transmission.

2. Major Organisation Working on HIV/AIDS

Gere Foundation*:* The Gere Foundation awards grants to humanitarian organizations supporting victims of war and natural disasters, providing HIV/AIDS care and research and addressing human rights violations occurring around the world.

Bill and Melinda Gates Foundation*:* Bill and Melinda Gates believe every life has equal value. In 2000, they created the Bill and Melinda Gates Foundation to help reduce inequities in the United States and around the world. Headquartered in Seattle, Washington, the foundation is led by co-chairs Bill Gates, Melinda Gates, and William H. Gates Sr., and by CEO Patty Stonesifer.

The Department for International Development (DFID)*:* The Department for International Development (DFID) is the UK government's department responsible for the UK's contribution to global efforts to eliminate poverty. India is a key partner for UK both nationally and internationally in the worldwide effort to achieve the UN's Millennium Development Goals. In recent years, India has made good progress in reducing the number of people living below the poverty line. However, progress against other key goals like health, education and gender equality has been more limited.

UNAIDS*:* The joint United Nations Programe on HIV/AIDS Brings together the efforts and resources of ten UN system organizations to global AIDS response. Cosponsors, WHO and the World Bank. Based in Geneva, the UNAIDS secretariat works on the ground in more than 75 countries world wide.

	Estimate	*Range*
People living with HIV/AIDS in 2006	39.5 million	34.1-47.1 million
Adults living with HIV/AIDS in 2006	37.2 million	32.1-44.5 million
Women living with HIV/AIDS in 2006	17.7 million	15.1-20.9 million
Children living with HIV/AIDS in 2006	2.3 million	1.7-3.5 million
People newly infected with HIV in 2006	4.3 million	3.6-6.6 million
Adults newly infected with HIV in 2006	3.8 million	3.2-5.7 million
Children newly infected with HIV in 2006	0.53 million	0.41-0.66 million
AIDS deaths in 2006	2.9 million	2.5-3.5 million
Adult AIDS deaths in 2006	2.6 million	2.2-3.0 million
Child AIDS deaths in 2006	0.38 million	0.29-0.50 million

Clinton Foundation: The mission of the William J. Clinton Foundation is to strengthen the capacity of people in the United States and throughout the world to meet the challenges of global interdependence. To advance this mission, the Clinton Foundation has developed programs and partnerships in the following areas: Health Security, Economic Empowerment, Leadership Development and Citizen Service Racial, Ethnic and Religious Reconciliation

CHAI's Work

The Clinton Foundation HIV/AIDS Initiative (CHAI) strives to make treatment for HIV/AIDS more affordable and to implement large-scale integrated care, treatment, and prevention programs. Since its inception, CHAI has helped bring AIDS care and treatment to over 415,000 people living with HIV/AIDS around the world.

3. Journals Publishing Articles on HIV/AIDS Regularly

1. The Lancet, 2.Journal of Health Communication, 3.Medical Anthropology Quarterly, 4. Health Education Quarterly, 5.Indian Anthropologist (special issues), 6.Human Organization, 7.Social Medicine, 8.Contemporary Anthropology, 9.Annual Review of Anthropology, 10. Journal of Substance Abuse, 11.Journal of Infectious Disease, 12.Nursing Research,13. Journal of Human Ecology and 14. Journal of Social Science, 15. The Anthropologist.

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KEYWORDS Risk Behaviour. Vulnerability. Community Approach. Susceptibility

ABSTRACT From 1981 to 2007; history of HIV/AIDS has witnessed thousands of documentation. There are stories on origin, molecular genetics of the virus to extensive national surveys reviewing state of the epidemic in various nation-states across the globe. Every reputed Journal or research publication in medicine, epidemiology, social medicine and community health, social sciences in particular anthropology and psychology, publish regularly on the subject. This review articles examines publications from two important journals namely *The Lancet* and *Annual Review of Anthropology.* Locating our arguments in a multidisciplinary framework, the paper dwells on a position that the disciplines which have theoretical and methodological skills to help in strategizing control of the virus are caught in a myriad of disciplinary hierarchies. It is not only that various segments of the population in HIV management programmes are marginalized, while structuring a paradigm of 'risk behaviour'; but also in a 'systems approach', significant anthropological data bank and subject skills are ignored or pushed to the periphery. It is time that the National AIDS control organization in India and other planning instruments of the Governemnt machinery recognize and utilize all resources available to meet the challenge of the pandemic. We are convinced that the effective control is feasible only when the political leadership understands the dynamics of the spread of the virus. It is not only subject to individual behaviour but processes of political and economic control. The cultural construction of social realities, in which individuals function, is critical to the understanding of the larger dimensions of the epidemic/pandemic.

Authors' Address: **Dr. Shalina Mehta,** *Professor* and **N. Inaoba Singh**, Department of Anthropology, Panjab University, Chandigarh 160 014, India
E-mail: shalinamehta1@rediffmail.com