CHAPTER – V
SUMMARY, FINDINGS, CONCLUSION AND SUGGESTIONS

Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome (HIV/AIDS) attacks certain disease-fighting cells within the body until the afflicted individual becomes immune deficient. Immunodeficiency is the most severe state of infection and is known as Acquired Immunodeficiency Syndrome (AIDS). Upon contracting AIDS, the victim becomes susceptible to potentially fatal diseases that his/her body could otherwise defend against.

Transmission of HIV occurs via four bodily fluids, they are semen, vaginal fluid, blood, and breast milk. The disease is spread most commonly through sexual intercourse and by the introduction of infected blood into another person through shared needles or syringes. Mothers who have HIV may spread the virus to their children during pregnancy, birth, or breast-feeding.

Hence, crisis is one of the factors which cause to spread HIV virus among people. During a crisis, the effects of poverty, powerlessness and social instability are intensified, increasing people’s vulnerability to HIV/AIDS. As the emergency and the epidemic simultaneously progress, fragmentation of families and communities occurs, threatening stable relationships. The social norms regulating behaviour are often weakened. In such circumstances, women and children are at increased risk of violence, and can be forced into having sex to gain access to basic needs such as food, water or even security. Displacement
may bring populations, each with different HIV/AIDS prevalence levels, into contact.

Symptoms associated with initial contraction of the HIV virus include fever, headache, sore throat, swollen lymph nodes, fatigue, rash, and sores in the mouth. These symptoms tend to appear shortly after initial infection and last for approximately 1-2 weeks. However, not all individuals will experience these symptoms and because they are very similar to those associated with the common cold or flu, infected individuals are often unaware they have contracted HIV. An HIV test, which is conducted by detecting HIV antibodies in a blood sample, is the only means of determining whether or not an individual has contracted the virus. While there is no cure for HIV/AIDS, there are medications that prolong the deterioration of the immune system and lengthen the life of the afflicted individual. On the other hand, the infected people sometimes hide their problem due to fear of discrimination and avoid treatment due to stigma. The efficacy with which the global community manages and prevents the spread of the HIV/AIDS pandemic in the coming years will have profound impacts on future generations.

HIV/AIDS stigma and discrimination exist worldwide, although they manifest themselves differently across countries, communities, religious groups, and individuals. They occur alongside other forms of stigma and discrimination, such as Gender, Religion, Community stigma based on physical appearance,
homophobia or misogyny and can be directed towards those involved in what are considered socially unacceptable activities such as prostitution or drug use.

Stigma not only makes it more difficult for people trying to come to terms with HIV and manage their illness on a personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole. On a national level, the stigma associated with HIV can deter governments from taking fast, effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV testing, treatment and care.

Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world.

There are ranges of ways in which these issues can be addressed. Some cases deal with stigma at collective and community levels. Others address the development and implementation of laws and policies to protect against discrimination and support the rights of people living with HIV/AIDS (PLWHA). A non-supportive environment undermines the ability of individuals and communities to protect themselves and to receive care and support. Sometimes, internalised stigma can also prevent PLWHA from seeking treatment, care and support or working/attending school, and stigma reinforces pre-existing
prejudices and inequalities, including gender, racial, and ethnic stereotyping. The discrimination occurs through ostracisation at family and community level. In institutional settings it may result in reduced access to health care, loss of work or denial of access to school. Some countries explicitly restrict the rights of PLWHAs through the absence of laws to safeguard their rights. Violations of rights therefore worsens the impact of HIV and increases vulnerability to infection (for instance, if women do not have the legal power to make choices in their lives and to refuse unwanted sex). It hinders positive responses to the epidemic, restricting civil society from mobilizing effectively.

Fear of contagion coupled with negative, value-based assumptions about people who are infected leads to high levels of stigma surrounding HIV and AIDS. Factors that contribute to HIV/AIDS-related stigma because it is a life-threatening disease, and therefore people react to it in strong ways. The HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatised in many societies.

There is a lot of inaccurate information about how HIV is transmitted, creating irrational behaviour and misperceptions of personal risk. So, HIV infection is often thought to be the result of personal irresponsibility. Sometimes religious or moral beliefs lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished. The effects of antiretroviral therapy on people’s
physical appearance can result in forced disclosure and discrimination based on appearance.

The fact that HIV/AIDS is a relatively new disease also contributes to the stigma attached to it. The fear surrounding the emerging epidemic in the 1980s is still fresh in many people’s minds. At that time very little was known about the risk of HIV transmission, which made people scared of those infected due to fear of contagion.

HIV/AIDS-related stigma is not a straightforward phenomenon as attitudes towards the epidemic and those affected vary massively. Even within one country reactions to HIV/AIDS will vary between individuals and groups of people. Religion, gender, sexuality, age and levels of AIDS education can all affect how somebody feels about HIV and AIDS. The stigma is not static. It changes over time as infection levels, knowledge of the disease and treatment availability vary. woman’s experience reveals the multi-layered nature of stigma. Within her quote she reveals being stigmatised but perhaps unknowingly accepting of the stigma against infected sex workers.

Women with HIV or AIDS may be treated very differently from men in some societies where they are economically, culturally and socially disadvantaged. They are sometimes mistakenly perceived to be the main transmitters of sexually transmitted diseases (STDs). Men are more likely than women to be 'excused' for the behaviour that resulted in their infection.
The epidemic of fear, stigmatization and discrimination has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected. This hinders, in no small way, efforts at stemming the epidemic. It complicates decisions about testing, disclosure of status, and ability to negotiate prevention behaviours, including use of family planning services.

AIDS-related stigma has had a profound effect on the epidemic’s course. The WHO cites fear of stigma and discrimination as the main reason why people are reluctant to be tested, to disclose their HIV status or to take antiretroviral drugs. One study found that participants who reported high levels of stigma were more than four times more likely to report poor access to care. These factors all contribute to the expansion of the epidemic (as a reluctance to determine HIV status or to discuss or practice safe sex means that people are more likely to infect others) and a higher number of AIDS-related deaths. An unwillingness to take an HIV test means that more people are diagnosed late, when the virus has already progressed to AIDS, making treatment less effective and causing early death. The researcher found the possible consequences of HIV-related stigma will be loss of income/livelihood, loss of marriage and childbearing options, poor care within the health sector, withdrawal of care giving in the home, loss of hope & feelings of worthlessness and loss of reputation.

Some of these consequences refer to ‘internal stigma’ or ‘self-stigma’. Internal stigma refers to how people living with HIV regard themselves, as well as
how they see public perception of people living with HIV. Stigmatising beliefs and actions may be imposed by people living with HIV themselves.

5.1 Major Findings

1. The data reveals that majority group of studies sample of HIV infected are belongs to Scheduled Caste and Backward Caste communities and a few are from Schedule Tribes and other castes like Brahmins, Vaishyas, Shkatriyas, etc., has been taken in the present study, and they are distributed all most equally in the age groups except between 26 to 35 years.

2. Most of the HIV/AIDS patients considered in the present study are below intermediate level of education, where majority group are illiterates, and majority group of HIV/AIDS patients in this study are married people, where widowed/widowers and separated number is found significant.

3. Most of the spouses of married men and women HIV/AIDS patients are possessing positive status of HIV, where, spouses of female shows more positive status than male patients, and more than sixty percent of HIV/AIDS effected clients are staying with their families.

4. The occupational status of the sample respondents indicates that majority group of HIV/AIDS patients are daily wage labours, employees under public and private sector organizations. The housewives’ number in the total HIV/AIDS patients’ ratio also at significant, and the income status
shows that majority group of HIV/AIDS patients are earning below 5 thousand rupees and between 5-10 thousand rupees per month.

5. According to the response of sample majority of the HIV/AIDS patients have known their HIV status through their sickness and health condition of their spouse, and it has concluded that most of the male have infected the disease through unsafe sexual participation but in the case of female more than seventy percent are infected through spouse.

6. The data reveals that most of the respondents' family members knew about the HIV status of the infected people, the family members or persons, who know about the HIV status of respondents, showed their responsibility towards the female patients, but in the case of male patients, majority are shocked, abused, ostracized, showed understanding and finally tried to help. Regarding the reaction of in-laws family, majority of widows beaten by their in-law family members and majority of widowers scolded by their in-laws' family members.

7. A significant number of respondents (both from male and female HIV infected patients) want to get marry for psychological support and family security, but a dominated group of respondents don't want to marry.

8. Even though the HIV infected patients getting treatment at ART centre they are having problems like general weakness (cough, fever, etc) joint pains and most of female patients are having oral infections.
9. Because of their disease, majority of the HIV infected patients have prone to abuse in all areas in the society and they are discriminated at other family members.

10. A significant of number of male and female respondents avoids health service due to some incidences and reasons to keep confidence of disease, lack of support from family members, friends and other relatives, and because of stigma.

11. Most of the male and female infected patients having knowledge that unprotected sex is the main reason for transmission of HIV/AIDS from one person to other. This knowledge gained by them through their friends and neighbours. Still they got infection due to ignorance in controlling of the disease. But majority of male respondents are having knowledge on proper usage and dispose of condom when compared with female.

12. More than ninety percent of the male respondents agreed that they have extra marital affairs but less number of females accepted that they have extra marital affairs. The males are having extra marital affair due to habits, migration, absence of wife, joint family and journey is also one of the reason for having extra marital affair, whereas, majority of female who are having extra marital affair due to habits and migration. And the duration of extra marital affairs contained by male and female respondents depends on their living conditions and performing activities.
13. The study noticed that majority of male HIV infected patients are having habit of consume alcohol and at that time they participated in sexual intercourse. Sometimes they used condom at participate in sexual intercourse, while they are in drunken stage.

14. Most of the male and female respondents have doubted about infection of HIV because of sickness and unprotected sexual participation, so they went ICTC for the testing of HIV. The role of NGOs in taking HIV infected people for testing found more at male than female.

15. Majority of the respondents both from male and female HIV infected patients shocked, cried and felt very sad at the time of diagnosed and found infection, and they have received counseling and medical care at the ART centres, where the infected persons have a good receiving by the person at ART.

16. It can be revealed from the response of the male HIV infected respondents that they shared their problem with their friends at the first time, but in the case of female respondents, majority have shared with their spouse about their problem. St that time most of people with whom the infected respondents have share the information about their disease, felt sad and cried at the infected patients but finally they gave their support.

17. The analysis of data infers that there is no change in the behavior or affection of family members, relative and friends of infected patients after
they know about the situation but they faced stigma at relative, friends, family members, work place and also at neighbours. To manage stigma, majority of the HIV infected people change the profession and some are managed with family support. Still most of the male and female infected patients did not turned to drug adductors or alcoholic due to stigma or crisis.

18. With the response of HIV infected sample, it can be concluded that more than fifty percent (both from male and female infected patients) did not afraid of society/ family/ health due to their disease and they never committed suicide attempt due to stigma and discrimination. But among the persons who have committed suicide attempt, majority consumed sleeping pills / pesticides.

19. Most of the HIV infected are getting emotional support from the friends, positive network groups and counselors, so the family members did not face any stigma and discrimination from the others. Still more than forty percent families of the infected persons migrate to other place, and they never visit their neighbors’ house / function.

20. According to the data, more than sixty percent of respondents are having school/ college going children, so most of them are facing discrimination and problems due to their HIV status. But almost all the respondents don’t feel their children became a burden to them.
21. More than sixty percent of respondents are facing social problems but they don't have legal problems because they are supported by positive network groups.

22. Majority of HIV infected people (both from male and female) have been overcome the crisis situation and come out of depression mood through counseling, consult with network groups and support of friends and family members.

23. The ART center motivated the infected persons to use drugs, food practice, habitual practice, practice yoga by counselors. More than fifty percent of respondents said that they are availing government benefits and pension, but still they want family counseling support.

24. It can be conclude from the data and response of the HIV infected persons in the study that after getting treatment at ART centre, most of respondents have improved their health, physical strong and psychologically strength.

5.2 Conclusion

HIV/AIDS is a life-threatening illness that people are afraid of contracting. The various metaphors associated with AIDS have also contributed to the perception of HIV/AIDS as a disease that affects "others," especially those who are already stigmatized because of their sexual behavior, gender, race, or socioeconomic status, and have enabled some people to deny that they
personally could be at risk or affected. HIV/AIDS-related stigma and discrimination is, therefore, the result of interaction between diverse pre-existing sources of S&D and fear of contagion and disease. The pre-existing sources, such as those related to gender, sexuality, and class, often overlap and reinforce one another. This interaction has contributed to the deep-rooted nature of HIV/AIDS-related stigma and discrimination, limiting our ability to develop effective responses. It has also created a vicious circle of stigma and discrimination, which works in two ways.

First, because HIV/AIDS is associated with marginalized behaviors and groups, all individuals with HIV/AIDS are assumed to be from marginalized groups and some may be stigmatized in a way that they were not before. For example, in some settings, men may fear revealing their HIV status because it will be assumed that they are homosexual. Similarly, women may fear revealing their serostatus because they may be labeled as “promiscuous” or sex workers and stigmatized as such. Second, HIV/AIDS exacerbates the stigmatization of individuals and groups who are already oppressed and marginalized, which increases their vulnerability to HIV/AIDS, and which in turn causes them to be further stigmatized and marginalized.

Treatment and prevention has centered upon the provision of antiretroviral therapy, particularly in Visakhapatnam. The local government has done a magnificent involvement to help educate the public and provide necessary resources occur in all the cases registered at ART centre. While significant
improvements have been made in public policy efforts, Visakhapatnam has not yet experienced as much success as due to the sheer numbers of infected individuals in this district. Mitigating the risk associated with HIV/AIDS and preventing further dispersion of it is a challenge that transcends boundaries and requires local, national and international cooperation.

There is growing concern about rising numbers of HIV cases among children, especially in Visakhapatnam these days. The rate of infection is relatively very alarming as in purview of the transmission and epidemic for all ages, gender, status, ethnicity, social background and caste.

Although rates of infection vary considerably, methods of contraction are relatively similar in all areas. Sexual contact surfaces as one of the principal means of transmitting the HIV virus. Individuals who are unaware that they are infected exacerbate the spread of HIV/AIDS in all areas.

In Visakhapatnam, HIV/AIDS affects every segment of society. One of the main ways the disease is currently spreading is through sexual contact. A large majority of the public remains uneducated about HIV/AIDS and the ways it can be contracted with those living with HIV/AIDS do not know they are infected. Many believe they are in no danger of becoming infected and are therefore unaware that they can transmit the virus to others. Consequently, many infected individuals continue to have unprotected sex, perpetuating the spread of the HIV virus, and the transmission of the disease from mother to child is also a common
method of contraction and as a result, many HIV/Aids survivors are children who are infected.

HIV transmission through contaminated blood transfusion in the district before screening of the HIV virus was implemented which led to various infections of the deadly disease such tuberculosis, herpes, candidacies, vomiting, high fever, skin disease, mental problem and worse scenario appears to some HIV/Aids victims is ultimate death by committing suicide.

Most people were infected through illegal sex, drug use, contracted HIV/AIDS through men having sex with men (MSM). The reported HIV/AIDS cases among adults and adolescents in Visakhapatnam, the method of contraction was unknown or different from those listed in the ICTC art centers. Additional contraction methods include MSM/IDU, heterosexual contact, hemophiliacs or persons with other blood clotting disorders, transfusions or transplant recipients, and pediatric risk.

Relative to other areas, Visakhapatnam has a very low incidence of HIV/AIDS infection. Because of this, large portions of the population remain uneducated and are unaware of important preventative measures. For instance, in Vizag Agency has a relatively low rate of condom use. In fact, many tribals and locals believe that condoms only help to prevent pregnancies, and are unaware that they can help protect against HIV/AIDS.
To combat the AIDS epidemic, Visakhapatnam District Local Government has been implementing the aids prevention program. This includes increasing the antiretroviral treatment program that is already in place. While the provision of anti-retroviral therapy has expanded dramatically in recent years, due to the proliferating high risk people infected, only a small proportion of those in need of this therapy are actually receiving it.

Several mass media campaigns are also being used as educational tools for the public. These campaigns utilize radio and television ads as well as billboards and print media such as newspapers to communicate health risks associated with HIV/AIDS. One example of campaign can be called loveLife, which can target the youth and adults where information about current research, treatments, and prevention is accessible.

The government has also used the distribution of free condoms as a prevention strategy. One future goal of prevention in Visakhapatnam is to increase the number of pregnant women who receive antiretroviral prophylaxis, which is used to prevent mother to child transmissions. The local and national government must form some educational groups that are reaching out to the youth, tribal communities and gay community in an attempt to plan safe sex as well as organize HIV/AIDS support groups. Even though with the available treatment, many HIV infected individuals are unaware of the help available to them and therefore suffer in silence.
The government may provide financial assistance for the people living with HIV/AIDS to support their needs. The goal must be associated into building holistic lives and to provide treatment, counseling, and improvement to those affected by HIV/AIDS. The facility makes sure to protect the privacy of those living with HIV/AIDS. Counseling and testing for HIV are important strategies as it struggles with the effects of the HIV/AIDS epidemic. HIV detection is the first step towards treatment and help. Once aware of their infection, HIV victims can make lifestyle changes to stop the spreading of the virus. The infected can receive medications to help them live longer, healthier lives. Some people have been taking medication regularly over the years and have been living with HIV/AIDS for much longer years. But despite medical breakthroughs, there is still no cure.

It is also observed, the speed at which the disease is spreading is higher than the speed at which the awareness is created among the public. It is a barrier in the minds of most of the people that this context cannot be spoken openly. Primarily the Government and NGOs and volunteers shall further come up with campaigns in order to inculcate the public about the factors and circumstances contributing to this disease thereby explaining them about the loss of most precious human life that is given by God. Any improvised suggestion will add a day’s life to the patient suffering with HIV. Needless to say how important a day is for a human being with a family.
5.3 Suggestions

The family of people living with HIV/AIDS must take a holistic approach to HIV/AIDS, with a concentration on maintaining both the physical and psycho-emotional wellbeing of those who have been infected. These efforts are aimed at helping those infected live a longer, healthier life and extending the duration of their productive existence. Programmes include wellness advice, medical consultations, pathology, counseling and support, prophylactic medication to prevent opportunistic infections such as tuberculosis, as well as nutritional supplements.

Investment in community HIV/AIDS programmes is primarily carried out in partnership with government, national and international donor agencies, NGOs and community based organisations. Activities include support for education and awareness building initiatives, outreach and training support, and home-based care support. In Visakhapatnam, the ICTC art centers of HIV/AIDS and VACS have inclined to support community projects over the past decades. In some areas, especially community care also includes access to doctors, pathology testing, nutritional supplements and access to medication through government and private company hospitals. Stigma and discrimination may kill the people who are living with HIV/AIDS. They keep people from getting tested, and from getting care and support if they need it. Ending stigma is one of the most effective ways over other things that anyone can do to stop AIDS.
The promotion and protection of human rights are a fundamental part of any response to HIV/AIDS. They need a help to prevent and reduce the vulnerability of high risk groups to infection and empower individuals and communities to respond to and manage the impacts of HIV. This includes the need to protect individuals with HIV from discrimination, stigma and violence and to promote sustainable and inclusive health care practices. HIV can exacerbate existing inequities and vulnerabilities leading to increased rates of infection among women, children, the poor and marginalised groups.

Demographic groups who are particularly vulnerable to HIV infection (including women, children and men) should be free from violence, including sexual violence. Consequences: Responsible practice demands that workplace polices and management systems offer employees (and, where relevant, their families) full protection from workplace-related violence, abuse or physical humiliation.

There is a danger that poor management of VCT could result in the leak of high sensitive and personal information about participants. Any disclosure of a person’s HIV-status may result in discrimination in hiring and firing patterns, pay and training, as well as stigma in the workplace. Therefore, there is a need of strict confidentiality policies and management systems should be established by companies in order to eradicate the disclosure of the HIV-status of employees – whether deliberate or inadvertent. Any violations of such policies should be met with strict sanction.
HIV/AIDS can affect workers’ families in two key ways. The first is direct infection through sex and/or other forms of close contact. The second is through the economic, psycho-emotional and practical consequences of a member of the family being infected or dying as a result of infection. This is particularly the case if they are the main bread-winner or care-giver in the family. Women may also be ostracised when widowed as a result of HIV. So, the organizations should consider the extension of protection, care and support not only to their workers but also to workers’ families. This may include the free provision of condoms, education programmes, full treatment programmes and/or financial mechanisms to minimise the economic impact of infection or death on families.

Persons with HIV/AIDS are vulnerable to discrimination and stigma, both in society and the workplace. This includes discrimination in access to basic services e.g. healthcare and education. So the organizations need to make sure that policies and management systems are in place to ensure that they, nor their employees, discriminate against persons with HIV/AIDS in recruitment, pay or training opportunities.

Those infected with HIV/AIDS are at risk of being refused for employment, fired or discriminated against in career advancement on the basis of their HIV/AIDS status. The right to work is closely linked to the rights of just and favourable working conditions and the right to non-discrimination. Therefore, care needs to be taken to ensure that as few barriers are in place as possible to the continued, harmonious and productive employment of individuals with HIV. This
not only means measures to counter discrimination, but also those to ensure confidentiality, provide professional and personal support, and ensure infected employees stay as healthy as possible for as long as possible.

The national and local government must go beyond workplace programmes focused on HIV/AIDS to cover prevention of infection in the community, and as such requires a more wide-ranging approach to risk management. The organizing committees and implementing ART centers must certify the people living with HIV/AIDS and would be subject to evaluation a transmission standard. Despite having known numerous strategies and coping mechanisms and crisis management and effective intervention for people living with HIV/AIDS, conduct sports activities, socio-economic income generating activities, skills and vocational trainings, marriage and family counseling.

There is a gap in the process which is related to the lack of a “systems approach” in the management of prevention, community response and treatment initiatives. Some aspects that is required is planning to rectify the lack of individual risk assessment or management data, a lack of rigour in checking service provider compliance with standards, as well as a lack of comprehensive outcome and impact indicators. Many of these gaps exist because HIV coordinators tend to be untrained in systems management and thus focus on their areas of competence e.g. nursing, social work, psychology and human resources.
The government has already implemented a range of awareness-raising activities, ranging from formal manager training programmes to Knowledge, Attitude and Practice (KAP) surveys, poster campaigns and art competitions. These events and campaigns also help address stigma by approaching the issue in an open, constructive and non-judgmental manner. VCT forms a key element of HIV/AIDS programmes. It allows the company to help those found to be negative to stay negative, and to offer those who are infected access to relevant health programmes. Testing is available to employees, spouses, life partners and contractors. It has also been extended into local communities through private-public partnerships.

Treatment and adherence rates are effective when operations in Visakhapatnam are given free access to ART. ART is also provided to spouses and life partners without payment. The various institutions joint venture also provides ART to the children of employees. The company works closely with public health authorities to ensure treatment is continued through government programmes if and when employment ends. There is a need for ART programmes that are externally coordinated by a disease management service provider, Aid kits for AIDS survivors. Key indicators enable the people living with HIV/AIDS to understand more clearly how well its service providers perform in getting services and clients to adhere to disease management programmes and implementing standards.
Finally it is strongly suggested and recommended that both print and electronic media shall come forward to take up this challenge of:

a. building knowledge, remedial measures, and impacts in not adhering the same, especially among the tribal, illiterates and literates separately;
b. building confidence among the HIV patients who are masking themselves without coming out/forward to take treatment;
c. creating awareness among the general public that:
   a. Living to the possible extent is always precious and valuable than stigma
   b. This disease deteriorates the life span, unless health care services opted on “better late than never” basis
   c. Precautionary measures must be taken during sexual intercourse especially with new persons;
d. organizing a continuous news feature to reach the general public about the pros and cons of this disease including the latest medical advancements in order to improve the knowledge level of the public