CHAPTER VI

SUMMARY OF MAJOR FINDINGS, SUGGESTIONS AND CONCLUSION

The study has been undertaken among the women living with HIV positive in Chennai City, Tamil Nadu. The major findings derived from the analysis and interpretations of primary data are summarized in this chapter.

6. MAJOR FINDINGS

6.1. THE SOCIAL AND ECONOMIC STATUS OF WOMEN LIVING WITH HIV POSITIVE

6.1.1. Age of respondents

The study revealed that a large number of respondents living with HIV positive fall in the age group of 20-29 years (66.5%). The women in this age group are hyper active in reproduction as well as in social and economic activities. The increasing infection among women in sexually active age group will lead to great damage to human resources, national economy and social fabric of the society.

6.1.2. Religion and Caste of respondents

HIV/AIDS is not confined to particular religion. The people from all religions including Hindu, Muslim and Christian are vulnerable to HIV/AIDS. In this study, an overwhelming majority of respondents (85%) belong to Hindu religion which is well known for its high moral and social values. The rapid spread of HIV among Hindus might be due to the changes occurring in the religious attitude of the youth in the contemporary society.

HIV/AIDS epidemic is not restricted to particular caste. Though the infection is found among all the caste, women from the backward (46.6%) and schedule caste (26%) are worst affected by this dreaded disease. Limited or lack of access to information, lower social and economic status always force women to be sexually submissive to their sexual partner which prevent them to adopt safe sex mechanism.
6.1.3. Education of respondents

A vast majority of the women (81.6%) in the study are literate. Therefore, it is a myth that illiterate women are more vulnerable to HIV infection.

6.1.4. Family Structure

As far as the structure of the family is concerned, the nuclear family (77%) is predominant among the respondents. The joint family system can act as informal social control agent to check and control the behaviour of the individual. But in the contemporary society the elders have less control over the youth which led to the rapid spread of HIV infection in the nuclear families.

6.1.5. Employment status of family members

Overwhelming majority (59%) of respondents family members are engaged in unorganized sectors which give less income. The transport workers are found to be less (3.9%) in the families of respondents.

6.1.6. Causes for migration of respondents to Chennai

Majority (62.5%) of the respondents migrated to Chennai due to two major reasons namely marriage, and HIV infection. Marriage necessitated 27% of women to migrate to Chennai whereas 13.5% of respondents migrated to Chennai in order to hide their HIV status from their family members, relatives and friends as well as for treatment in the Tambaram Sanitarium nearby Chennai.

6.1.7. Occupation

The overwhelming majority (42%) of respondents are unemployed. At the same time 30% of women are engaged in unorganized sectors. The women in commercial sex work are also found in significant percentage (16.5%). The power of negotiation about safe sex is strongly influenced by the economic empowerment of women. The unemployed and the women in unorganized sectors are economically deprived and they have less control over their reproductive health. The less or lack of power on reproductive health makes women more vulnerable to HIV/AIDS.
6.2. MARITAL STATUS OF THE RESPONDENTS

6.2.1. Marital status

Married women are predominant (82.5%) in this study. The unmarried women account for only 17.5%. It is revealed that the married women are at the higher risk of contracting HIV infection.

6.2.2. Nature of relationship between respondents and their husbands

Majority (84.2%) of the respondents’ marriage have taken place out side the close kin family relationship. Marriage with unfamiliar persons has high risk of contracting HIV. In this study, majority of husbands are not familiar with the respondents at the time of marriage. The sexual behaviour of the bride or bridegroom can be observed among the known person rather than the unknown person. Marriage among the familiar person has least chance for contracting HIV.

6.3 CIRCUMSTANCES LEADING TO HIV INFECTION AND RELATED BEHAVIOURS

6.3.1. Duration of HIV infection

Majority (81.0%) of the respondents understood their HIV status since seven years during their young and sexually hyper active age.

6.3.2. Sources of infection

The overwhelming majority (65.0%) of the women were infected through their husbands. At the same time significant percentage (34.5%) of women got infection through their multi sexual behaviour which includes married women (31.0%) and students (3.5%). It revealed that the promiscuous sexual behaviour of women not only led her to acquire HIV/AIDS but it also increases the vulnerability of infection to their husbands and it is identified that 17.6% of respondents husbands might be infected with HIV/AIDS due to the promiscuous behaviour of women.
6.3.3. Reasons for respondents husbands extra marital sexual behaviour

Majority (51.8%) of the respondents husbands also involved in extra marital sex with sex workers (92.9%). Their sexual involvement with commercial sex workers resulted in HIV/AIDS, Migration (30.2%) and alcoholic behaviour (22.6%) appears to be important factors for the development of extra marital affairs of the respondents husbands. Since they satisfy their sexual urge with sex workers they have increased chance of contracting infection and spreading it to their wives.

6.3.4. Reasons for respondents pre and extra marital relationships

Love affairs are the major (43.5%) cause for pre marital sex and difference of opinion between the spouses are the significant (50.0%) reason for extra marital sex of the respondents.

6.3.5. Safe sex practices in the pre and extra marital relationship

Condom usage is found to be low among the respondents who have experienced pre (15.4%) and extra marital (8.8%) sex. The practice of oral pills is higher among the women experienced pre marital sex (53.8%) and adoption of sterilization is high among the respondents experienced extra marital sex (41.2%). These respondents are very much bothered about avoiding pregnancy due to cultural implications of giving birth out side wedlock. The culture surrounding around the notion of pregnancy increases the vulnerability of women towards HIV/AIDS.

Significant percentage of respondents engaged in pre (30.8) and extra marital (23.6%) sex are not practicing any method of safe sex to prevent sexually transmitted infection as well as child birth. The culture of silence around sex and the fear to ask or to buy condom increases the vulnerability of women’s HIV infection. The sterilization also led women not to use condom since they are already safe in avoiding pregnancy.

6.3.6. Contraceptive practices among housewives

Housewives give more importance to avoid pregnancy rather than sexually transmitted infections. Adoption of sterilization, oral pills and IUDs prevented majority (62.6%) of housewives to think about condom as safe sex method to safeguard themselves from sexually transmitted infections.
6.4. CIRCUMSTANCES LEADING TO COMMERCIAL SEX WORK

6.4.1. Marital status of sex workers

The majority (54.8%) of sex workers are married women and among them 43.5% have husbands and children. The unmarried respondents in sex work are accounted for 45.2%. The responsibilities on catering the needs of the family members force the women, especially the married women to involve in exchanging sex for money. Their engagement in multiple sex is considered as potential sources of contracting HIV/AIDS. The husbands of these sex workers also have greater possibility of contracting HIV/AIDS through them.

6.4.2. Reasons for the involvement in commercial sex work

Poverty and related economic deprivation of the family is the central factor for the involvement of 77.3% respondents in commercial sex. The economical necessities force the commercial sex workers to be less empowered with regard to demanding condom use with their customers. Unsafe sex is the major contributing factor for contracting HIV.

6.4.3. Age at induction in commercial sex work

The significant percentage (51.6%) of sex workers inducted in sex at the young age of within 23 years. It indicate that early involvement in sex involve longer duration of sexual participation which has strong influence on the risk of contracting HIV/AIDS. Due to younger age the sex workers have less negotiation power with regard to safe sex which has strong influence both for contracting and spread of HIV/AIDS.

6.4.4. Clients of commercial sex workers

Labourers (38.7%), business people (37.1%), tourist (33.9%), transport workers, including drivers and cleaners (27.4%), students (21 %>) and men who are away from home for longer duration (17.7%) are identified as dominant categories of clients who visit commercial sex workers quite often.

6.4.5. Safe sex practices of clients

Safe sex practice is significant among business (30.6%) people and transport workers (25.6%). The safe sex practice is found to be less among labourers (3.2%).

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Unsafe sex practice and use of alcohol is closely related HIV/AIDS. The overwhelming majority (97.3%) of respondents customers have the habit of drinking alcohol and due to the influence of alcohol the customers are not in a mental state to use condom as safe sex. The unsafe sex between the sex workers and their customers increases the vulnerability of infection for sex workers and their customers.

6.4.6. Number of clients engaged per day

All the 27 part time sex workers are married and they have husband and children. The part time sex workers engage less number of clients (1-2) per day rather than the full time sex workers (3-6). The full time sex workers include 28 unmarried girls, four widows and three deserted. As a result of frequent sexual encounter with multiple partners the full time sex workers are more prone to HIV/AIDS.

6.4.7. Earning per day

The majority (88.9%) of part time sex workers earn less Rs. 300 per day where as the majority (62.8%) of the full time sex workers earn upto Rs. 400 per day. The sex workers are taking risk of contracting HIV/AIDS by involving in multiple sex for earning considerable amount for their survival.

6.4.8. Sources of contact with the clients

Most of the full time sex workers (33.9%) contact and pick their clients directly from the crowded places like bus stand, railway station, market, beach, tourist centres etc. The majority (19.4%) of the part time sex workers use modern communication technology including mobile phone, e-mail to contact the customers who are regular to them. The 17.7% of part time sex workers also have a close link with the brokers to meet their customers. The part time sex workers choose particular place for their sex work and they returned home like other employed women.

6.4.9. Net work and place of residence

The sex workers have strong invisible net work to contact fellow sex workers as well as customers in Chennai and most (37.1%) of the sex workers are residing in slums which is known for many illegal activities. The poor social and economic background of the sex workers residing in slum will not acquire power of negation of safe sex with their customers.
6.4.10. Nature of sex work

The majority (50%) of the respondents involved in sex work independently and 27.5% are under the influence of brokers. The economic necessity resulted many impoverished women to choose prostitution as a means for their survival.

6.4.11. Reason for not insisting the clients to use condom

Lack of awareness on the implication of HIV/AIDS is the major factor for 59.7% of sex workers who do not insist their clients to use condom. The lack of safe sex practices has spread effect for both the sex workers and their customers.

6.4.12. Reason for not using condoms by the clients

Drinking of alcohol prevents majority (38.7%) of customers to use condom during paid sex. The intoxicative mental state has direct influence on unsafe sex and behavioural change with regard to sex and sexuality.

6.4.13. Changes in the sexual behaviour of the sex workers after knowing their HIV infection

Majority (53.2%) of women continues sex work even after knowing their HIV status but significant change in the sexual behaviour of the sex workers with regard to safe sex is observed after HIV infection. At the same time significant percentage (46.7%) of sex workers are withdrawn their involvement from sex work after knowing their HIV infection. It revealed that these sex workers have realized their role in transmitting the virus to the innocent clients.

6.4.14. Present status of the sex workers after knowing their HIV infection

After the withdrawal from the sex work due to infection, the 42% of sex workers found alternative avenues for their survival with the support of non-governmental and governmental organisations.

6.4.15. Causes for remaining in sex work after knowing HIV infection

Lack of alternative job and less income in other job made 53.2% of sex workers to remain in the same work even after knowing their HIV status. The spread effect of HIV is higher due to the involvement of women in sex work with HIV status.
6.4.16. Awareness on HIV/AIDS and willingness to be in special home

After knowing the infection all the sex workers are aware of their role in transmitting the virus to their clients. At the same time they are not willing to stay in the special home if it is run for the infected people. The stigma and discrimination prevent the infected sex workers to be lodged in special home since it has the label which carries HIV positive.

6.5. HIV TEST

6.5.1. Pre and post test counseling to the respondents and their family members

More than 75% of the respondents and their family members are not exposed to pre and post test counseling to understand fully about the HIV, its social impact, care and support and living with HIV peacefully by coping with social stigma. The absence of pre and post test counseling for the respondents and their family members led to discrimination, personality disorder and lack of confidence to live with HIV status.

6.5.2. Knowledge on HIV/AIDS at the time of testing

The majority (74%) of respondents have no knowledge on HIV/AIDS when they have undergone HIV test in various hospitals. Lack of awareness on HIV/AIDS at the time of testing created fear and lost confidence and courage to share their infection with their family members.

6.6. IMPACT OF HIV STATUS IN THE SOCIAL RELATIONSHIP IN FAMILY

6.6.1. Husbands’ reaction towards wives after knowing infection

Majority (60.6%) of respondents infected husbands harassed their wives after knowing their HIV status. Though the men fully aware that their wives got infection through them and they are the innocent victims of infection, they involved in harassing their wives due to guilt and shame.

6.6.2. Respondents reaction towards husbands’ infection

Majority (57.7%) of respondents have not provided care and support for their infected husbands. At the same time 42.3% of respondents supported their husbands due to the cultural bound existed between husband and wife in the Indian Society.
The culture of marriage and family made majority (42.3%) women to remain with their infected husbands.

6.6.3. The relationship between respondents and husbands after knowing HIV infection

The relationship between husband and wife after knowing HIV infection is not compassionate and majority (49.2%) have involved in frequent quarrel with each other. The stigma associated with promiscuous relationship and HIV/AIDS led to family dispute resulting in family disintegration.

6.6.4. Nature of restriction imposed by family members on HIV infected persons

Majority of the housewives (85.1%), their husbands (79.3%), sex workers (57.2%) and infected children (57.2%) are restricted to casual contact, for example, touching and sharing articles and to take part in the socio cultural ceremonies of the family. The stigma associated with HIV/AIDS is the primary factor for such restriction imposed on people living with HIV positive.

6.6.5. Participation in the socio-cultural ceremonies in the family

More than 70% of the respondents are not participating in the socio cultural ceremonies of the family due to the fear of discrimination. They voluntarily restricted their participation in such functions. The status of HIV resulted in self imposed restriction and lack of courage to associate with the family members.

6.6.6. Maintenance and property given to the deserted and widows

The majority of the widows (74.5%) and separated women (92%) have not been given property or maintenance support for their survival. The infected women are deprived of getting property or maintenance from their husbands side due to the perception that the infected people will have short life.

6.6.7. The place of present stay of the respondents

The significant percentage (58.5%) of infected women are living along with husband or children. The abundant infected sex workers (12%) got accommodation in short stay home run by the NGOs.
6.7. SOCIAL RELATIONSHIP WITH NEIGHBOURHOOD

6.7.1. Infection known to the neighbours

The people living with HIV positive are maintaining secrecy of their infection from their neighbours due to the problem of stigma and discrimination. The overwhelming majority (97.7%) of respondents and their husbands infection is not known to their neighbours.

6.7.2. Social relationship of respondents and their husbands with neighbourhood

The majority (92.0%) of respondents and their husbands have good relationship with their neighbours before they know their HIV positive status. They participated in all socio cultural functions of their neighbours. But after knowing their infection, 72% have voluntarily withdrawn their participation in socio cultural ceremonies of their neighbours due to guilt and shame. The fear of stigma associated with the diseases resulted in self imposed restriction among the people living with HIV positive.

6.7.3. Neighbours interaction towards people with HIV status

Very least percentage (1.5%) of respondents infection is known to their neighbours. All these respondents were socially distanced by their neighbours. Therefore, social distance is the common response from the neighbours towards the people living with HIV positive.

6.8. SOCIAL RELATIONSHIP WITH FRIENDS

6.8.1. Frequency of respondents, their husbands with their friends before and after infection

The majority (64.5%) of the respondents and their husbands (77.2%) have frequent contact with their friends before knowing their HIV status. Their relationship with the friends has drastically changed after knowing their HIV status. The majority (42.5%) of infected respondents were completely out of their friendship circle and at the same time 50% of their husbands have frequent contact with their friends. The infected women were more reluctant to meet their friends than their husbands. The myth that the immoral people or the multisexual alone get HIV made women to restrict their contact with their friends.
6.8.2. Reaction of the friends towards the respondents infection

Majority (58.4%) of the respondents and their husbands (74.0%) are getting moral and financial support from their friends. But when compared to men, less number of infected women are getting support from their friends.

6.9. SOCIAL RELATIONSHIP WITH RELATIVES

6.9.1. Reaction of the relatives towards respondents and their husbands

One-third of the respondents are isolated by their relatives after revelation of their HIV status. Social isolation by the relatives is high among the sex workers than the housewives. One fifth of the relatives have restricted their visit to the respondents house. Very few (16.4%) respondents got moral and financial support from their relatives. While comparing the discrimination experienced by infected respondents and their husbands, the infected women are subjected to severe discrimination and criticism by the relatives than their husbands. The 50% of respondents husbands got moral and financial support from their relatives. It revealed that due to the influence of culture, men’s extra marital sex is tolerated by the society.

6.9.2. Participation in the socio-cultural ceremonies by respondents

Before infection, 70.5% of married respondents participated in the socio-cultural ceremonies of relatives house along with their husbands. In the case of unmarried respondents, deserted and widows their parents have participated in the socio cultural ceremonies of their relatives house. After infection, significant changes have taken place in the participation of respondents in the socio-cultural ceremonies of relatives house. As against 70.5% of participation, only 18% have taken part in the socio-cultural ceremonies after infection. The fear of discrimination resulted in self imposed restriction by the respondents in participating all functions in the relatives house.
6.10. DISCRIMINATION IN MEDICAL TREATMENT

6.10.1. Place of treatment

N.G.Os played a vital role in providing treatment to the respondents either at free of cost or by charging very less amount. Majority of the housewives (41.5%) and sex workers (74.3%) availed treatment in the N.G.Os which is working in AIDS intervention programmes. While comparing the place of treatment by the respondents and their husbands, 66.9% of respondents’ husbands got treatment in the private hospital by paying considerable amount. The economic power vested with the men facilitated them to avail treatment in private hospitals. Taking treatment in the private hospitals also helped them to hide their infection status from others. Lack of control over economic resources increased gender discrimination in treatment.

6.10.2. Problem faced by the respondents In the hospitals

The overwhelming majority (96%) of women faced discrimination in the hospitals. The health care personnel have an opinion that the women get infection through their promiscuous contact. Though the health care personnel are aware of the means of the spread of HIV, they are more reluctant to treat the infected patients and they discriminated them by denying admission in the hospitals, maintaining confidentiality of infection, calling them with the label of AIDS patient etc. The discrimination in the health care sector is mainly due to irresponsibility of medical personnel.

6.11. DISCRIMINATION IN THE PLACE OF WORK

6.11.1. Discrimination experienced by the respondents and their husbands

The 20.7% of respondents employed in Tamil Nadu State AIDS Control Society and N.G.Os working in AIDS intervention and Control Project have revealed their HIV status to their employer and colleagues. Though the revelation of HIV status brought them certain monetary benefit, they faced discrimination in different forms. Whenever the visitors come to these organisations, the employee with HIV status is introduced by them as HIV infected people. Such kind of introduction resulted in certain psychological problem which always made them to think about early death due to AIDS.
6.12. ATTITUDE TOWARDS PREGNANCY AND CHILDBIRTH AFTER INFECTION

6.12.1. Causes for pregnancy after infection

The respondents who have given birth after infection is accounted for 17.5% from the 165 married respondents. Lack of awareness on mother to child transmission (34.5%) and lack of practices of birth control measures (44.8%) are the major causative factor for the pregnancy of women after infection.

6.12.2. Reaction of respondents and her husbands about pregnancy after infection:

The majority (89.7%) of respondents and their husbands have decided to terminate the pregnancy after knowing the impact of infection on their children. The high cost in antiretroviral treatment to prevent mother to child transmission force the respondents and their husbands to think about the termination of pregnancy.

6.12.3. Contraceptive practices of respondents

The majority (40.5%) of respondents have adopted non-terminal method of contraception including oral pills (10.5%), IUDs (14.0%) and condom (16.0%) to avoid pregnancy. Significant percentage (17%) has undergone sterilization to avoid pregnancy after knowing their infection. Condom usage is not popular among married women rather than the women in sex work. The unmarried women have taken the decision to avoid marriage in order to further spread of infection to others.

6.12.4. Attitude of Respondents towards Pregnancy and Childbirth

The infected women are in favour of pregnancy right and many (47.5%) respondents are unaware of mother to child transmission and the availability of antiretroviral treatment (50.0%) to prevent child from getting infection from mothers.
6.13. SUGGESTIONS

1. Since most of the women are getting infection only after their marriage from their infected husband. Therefore, both the women and men should be motivated to voluntary testing of HIV before marriage for both bride and groom. In order to ensure HIV test, all marriage should be registered under the Marriage Act and a certificate of HIV positive test should be produced at the time of registration.

2. Poverty plays a vital role in the existence of prostitution. The women who are in sex work should be rehabilitated or they should be provided alternative avenues for their survival. This can be made possible by associating the sex workers with the women self help group for micro credit. The Department of Social Welfare and Corporation for Women’s Development could play a significant role in this regard.

3. Defective socialization is the primary cause for sex outside the marriage. Family and schools are the primary agencies to socialize the individual in accordance with the expectation of the societal norm. Counseling centres should be established in all schools and colleges with the involvement of Sociologist. Community counseling centres should also be established in all villages and towns in co-ordination with local N.G.Os to provide counseling and education to the parents and youths.

4. Exposure to multi media due to the implication of globalization, peer group pressure, modern communication facilities and easy availability of paid sex directly influence the youth to experience pre marital sex. The youth should be advocated the implication of pre marital sex and the importance of having sex after marriage. The youth forum should be formulated in all schools, colleges, villages, towns and cities with the support of N.G.Os, academicians and local government leaders to sensitize the implication of pre marital sex in the context of HIV/AIDS.

5. HIV/AIDS information, its implication and preventive mechanism should reach to the door step of each and every house. This is only possible through mass media, especially through television. The information related to AIDS should be telecasted in all channels frequently between the serials or
programmes like other advertisements. The same may also help to overcome stigma and discrimination associated with HIV/AIDS.

6. HIV/AIDS Care Centre should be established in every district with financial support of Government to provide shelter to the abandoned people living with HIV positive.

7. Migration, especially rural to urban migration has direct influence on contracting HIV by youth and transmitting the virus to the housewives. Rural migration owing to economic necessity should be controlled by creating employment opportunities by using locally available resources in the villages and extending financial support to the youth to establish their own enterprises in the village.

8. Gender inequalities should be addressed in all possible ways to empower the women to control over their reproductive health. Women should be educated to negotiate safe sex with their husbands without any hesitation. Gender Sensitization through mass media is a step in the right direction.

9. Culture and tradition of Indian society acting as stumbling block for the implementation of AIDS intervention programmes. The culture prevents people to negotiate issues on contractive practices. Therefore, the culture and tradition of each and every society should be taken into consideration while planning AIDS intervention programmes.

10. Sex education should be incorporated in school and college curriculum in order to influence the students to share their feelings and doubts with regard to their general health and reproductive health without any inhibitions.

11. Government should enact strict law to prevent cross border and internal trafficking of women and girls for sexual exploitation.

12. The reproductive health programme should be incorporated with the programmes of family planning in order to educate the women not only on the methods of fertility control but also the AIDS, route of spread, its implication, safe sex and prevention and control.

13. People living with HIV positive are experiencing various kinds of discrimination in the hospitals. The health care personnel should have the
commitment to treat all the patients equally irrespective of their diseases. The discrimination in the hospitals resulted in strengthening the discrimination in the society. Therefore, the health care personnel should be given regular orientation with regard to the treatment of people living with HIV positive.

14. Every Government hospital should have exclusive ward for HIV/AIDS patients with specialized doctors and other medical personnel. It will promote treatment seeking behaviour among the people living with HIV positive.

15. All red light areas in India should be abolished in order to arrest sale of illegal sex, trafficking of girls and the spread of HIV to the general population.

16. Under existing law the sex workers are punished rather than the men who seek sex from them. Therefore, effective law should be enacted to give severe punishment to the women who involve in prostitution as well as to the men who seek sex from prostitutes.

17. The Members of Parliament and Legislative Assemblies should be given target to ensure AIDS free status to their respective constituency.

18. In India, especially in Tamil Nadu, women self help groups are emerging as powerful agents in the social transformation of villages as well as empowering the women in family and community. Therefore, women self help group should be encouraged to participate in implementing AIDS intervention programmes in their respective areas. Their participation in AIDS intervention programmes will help to eliminate stigma and discrimination associated with AIDS and to bring family and community care to the people living with HIV positive.

19. The local panchayat members should be trained to take up AIDS intervention programmes in their panchayat. The participation of panchayat members in the AIDS intervention programmes will help to prevent and control HIV/AIDS in rural areas.

20. Financial support should be strengthened to the N.G.Os by the Government to ensure regular intervention programmes in all sections of the community.
Social inequalities, gender discrimination and cultural prejudice made women and children to become the worst victims of HIV/AIDS. The low social and economic status of women and dependence on men limit their control over their sexual and reproductive lives. The power imbalance, violence, and abuse in the family and society increase the chances for women to get exposure to HIV and other sexually transmitted diseases.

Women in sex work are most defenseless and they have no power to insist their customers to use condom. They have not taken this profession on their own choice. Abject poverty, domestic abuse and violence, destitution and abduction and trafficking have pushed these women into this profession. Appalling living condition, entertaining many clients in a day, lack of power to negotiate condom use make them most vulnerable to HIV infection.

Economic uncertainty and growing rural unemployment and underemployment resulted in rural migration. Separation from the family and the hazardous nature of work forces the migrant to seek pleasure with sex workers. The poor access to contraceptive practices and AIDS increased not only their vulnerability to HIV but also to their wives. In the context of HIV/AIDS, housewives are adversely affected and they are prone to get infection through their husbands in the marital life which is described as sacrament. Gender insensitivity, discrimination, lack of social and economic status and basic rights reduce the access of women to gain knowledge on HIV/AIDS and its prevention.

As consequences of HIV/AIDS, women has to shoulder triple burden - facing stigma and discrimination and caring sick and bearing loss of income in the family. The study has revealed that women experienced more discrimination in the society rather than men. The discrimination is higher in the family due to lack of counseling to the family members and poor knowledge and misconception of HIV/AIDS,

The awareness and knowledge in the practice of safe sex is not correlated in the marital life due to certain cultural importance given to sex and procreation. The notion of sex and sexuality in the Indian context is acting as an obstacle to create safe ground for women to protect themselves from the dreaded infection HIV/AIDS. The power imbalance in interpersonal relationships and in society which create women’s
subordination must change if women are to be able to protect themselves from HIV/AIDS infection and its consequences. This can be possible through empowerment of women with regard to their reproductive health and it should be given high priority in all matters related to HIV/AIDS. The empowerment of women alone helps to realize the dream of AIDS free society.

Commitment from all sections - political, religion, academic, family, health care sector, Government, Non-governmental organisation, public, mass media - is essential to mobilize the people to join together to fight against AIDS to create AIDS free India. Social transformation through Millennium Development Goals in Indian context involves this coordination to realize the vision of HIV/AIDS free world with a missionary zeal. The success depends through value education, morality and social ethics based life among people. The task in this regard is voluminous, let all people living in the 21st century take a collective pledge to root out this Global killer as a challenge. IF THERE IS WILL DEFINIELY THERE IS A WAY.