Conclusion:

AIDS is not a single disease but a syndrome that may involve several pathological states and be transmitted in various ways, affecting persons with diverse disease life histories and identities. About 36 million people in the world are living with HIV/AIDS and over 22 million are estimated to have died of AIDS. In India, with its vast population, the situation has become alarming in the past decade with over 2.5-3 million people estimated to be infected by the virus. Heterosexual route has been the major cause of the infection in the county, affecting mainly the most productive age group between 15-44 years, maximum being males. However, in the recent years the infection has percolated from high-risk practicing groups to the general population. Chandigarh, where this research has been concentrated, has also seen an upswing in the epidemic with more and more infections being reported.

No other disease in the history of medicine has had such a major impact on various sectors, i.e., medical, social and economic. As a social problems HIV/AIDS is a phenomenon provoking reactions of panic, revealing social fissures, inequalities and the discrimination and stigmatization of marginalized groups in society. With the spread of the epidemic, individuals, families, communities and nations have to face deaths on a scale unprecedented in modern times. In countries where rapid social change is already posing shocks to traditional family and social structures, these costs could be enormous, affecting fertility, gender roles, household patterns, etc. and perhaps offsetting many of the gains made in these areas recently. What as person does, who a person and where a person lives can specify what health hazards are most likely to exist in that individuals’ life.

The focus of this study was on the social dimensions related to HIV/AIDS which have received relatively less attention till now. The objectives of the study were to examine the incidence and distribution of the disease globally, in India, and in North India in order to determine its trends in terms of factors such as age and gender. The study also aimed to obtain a profile in terms of age, sex, residence, state/religion, urban/rural residence, education, martial status, present living arrangement, type of family, children, religion, occupation and income, of the people living with
HIV/AIDS, selected for this study. The researcher also strove to discern the etiology of AIDS and HIV infection, i.e., to ascertain the primary sources of the spread of the infection in general and particularly among the respondents. The objective was also to study the infected people in terms of their own and others' reactions to the infection, in other words, to determine what problems they face; to what extent the detection of the infection evokes sympathetic and helpful response to others or conversely, results in their social repression, mistreatment and breakdown of interactional framework. In this study, the researcher try to document the different types of stigma and discrimination in different context. Like in the health care settings, the researcher document the stigma and discrimination in the form of (refusal to provide treatment for HIV/AIDS-related illness, refusal to admit for hospital care/treatment, refusal to operated or assist in clinical procedures, restricted access to facilities like toilets and common eating and drinking utensils, physical isolation in the ward, restrictions on movement around the ward or room) etc. and in the family context, the researcher find a variety of stigma and discrimination i.e. served relationships, desertion, separation, denial of share of property or access to finance, blocked access to spouse, children, or other relatives, physical isolation at home, blocked entry to common areas or facilities, blocked entry to common places etc.

Finally, the focus was also to analyze the coping mechanisms of the infected persons and obtain their perceptions regarding the role of family, friends, doctors and various agencies such as non-governmental organizations (NGOs), media etc., in helping the AIDS and HIV positive persons cope with the situation.

Where there exists methodological instruments able to translate human conduct into figures, one also finds deep feelings of scientificity. However, figures are not the only way to understand the logic of human conduct. AIDS, as a social disease, demands a response beyond that limited to numbers. While statistical models are useful, there is a strong tendency in medical science to overestimate its importance. To understand AIDS, it is becoming increasingly impossible to ignore the deeply-rooted social dimension of behaviour. In the study of any phenomenon both individuals, as well as, society have been employed as the ultimate unit of analysis in understanding the human behaviour by sociologist. The thrust of macro sociological analysis, i.e., perspective on man in society through the functionalist and conflict
perspectives, is on treating society as an external reality that exerts pressure and coercion upon the individual while micro sociological analysis, i.e., perspective on society in man involving interactionist perspective emphasizes on internalization of the social world, that is, the structures of society become the structures of our own consciousness. The social world is demonstrably heterogeneous and it would be inappropriate to study it through any one perspective. Therefore, both the macro and micro sociological approaches are important while dealing with any issue including health and illness. Thus, functionalist and conflict approaches, as well as, interpretive approach, especially phenomenology can be used to understand the social phenomena of HIV/AIDS, Where, on the one hand, social values affect both the way we come to and understand a particular disease and the interventions we undertake, thereby, making disease socially constructed, it is also important that empirical research must take into consideration, the understanding of reasons and intentions people have for acting the way they do and the unintended consequences of human activities. Individuals are knowledgeable agents and they do things that have consequences which influence the overall institutional structure of society.

The understanding can be brought about in research through interpretations, stressing upon the first-order, primary, lived concepts of everyday life. Every human situation is novel, emergent, and filled with multiple, often conflicting, meanings and interpretations. The interpretive phenomenological research attempts to capture the core of these meanings and contradictions. Phenomenological approach has been concentrated upon in this study, as the other approaches treat the aspects of human subjectivity, intentionally and meanings only superficially. The social phenomenon when treated through causal explanations, by itself is unable to provide an understanding of the lived experiences of the people affected by diseases such as AIDS. An understanding of the social experience or a sequence of social interaction with the significant ‘others’, as perceived and constructed by interacting individuals, thus, provides an insight into the ‘lived experiences’. The positivist approaches presupposes, a theoretic, analytical conceptual framework that stands independent of the world of interacting individuals. This framework, whether derived from classical or contemporary theory (Marx, Durkheim, Simmel, Weber, Freud, Parsons, Merton, Habermas, or Homans) assumes that human behavior can be meaningfully categorized and analyzed within the conceptual elements of an abstract, grand, or
middle range theory. But this approach by itself divorces human reality from the scientist's scheme of analysis.

Therefore, in order to gain an insight into the life world experiences, qualitative research focusing on interpretative and meanings becomes imperative. Hence, along with the use of tools like structured interview schedules, case study method also becomes significant. Case studies have been preferred for a study of this nature as it is epistemologically in harmony with the experiences of the people in the social world and thus provides a natural basis for generalization. For the phenomenologist, the proper subject matter for interpretive inquiry is the meaningful description of all types of problematic social interaction. Emotionality is present everywhere in interpretive phenomenological research. It is present in the lives of those who are studied. It is present in the interactions that go on between researchers and subjects. To deepen the understanding of a social phenomenon, an in-depth and sensitive analysis of the phenomenon and the emotionality, provides an opportunity of finding fresh insights and new ways of understanding a particular phenomenon.

Thus, to understand HIV/AIDS and the experiences of the people living with the virus, this study, while not quite discarding the functional and conflict theoretical framework and the quantitative research methods, focuses more on the phenomenological perspective and tries to present the life world experiences of the PLWHA/s mainly through qualitative research. Qualitative research can be characterized as an attempt to obtain an in-depth understanding of the meanings and definitions of the situation presented by informants, rather than the production of quantitative 'measurement' of their characteristics of behavior. Phenomenology as a basic premise assumes that it is appropriate to understand a social reality on the basis of meaningful actions of individuals. This study through the narratives of the respondents has tried to understand the experiences of people living with HIV and AIDS.

Chapter III, dealt with a general profile of the respondents since data on their biographical, social and economic aspects forms an integral part of examination of a phenomenon among any group. Our data revealed that the respondents (PLWH/As) belonged to the age group of 30-37 years and majority of them were male. The age
group and sex distribution of the HIV/AIDS cases in India reveals similar findings. Also, maximum number of male respondents is in the age group of 30-37 years while majority of the females are in the age group of 22-29 years. The respondents were contacted in Chandigarh, this being the main city of North India with strong health care set-ups attracting people from all over the country, especially the northern region. It was found that the maximum number of respondents of the study was literate and a large number of them were well educated, living in urban areas, although they may have migrated from different Indian states and even rural areas in search of employment. Majority of the respondents are married and living with spouses and also a large proportion of them have children. Majority of them are living in nuclear families, and continue to do so even after the revelation of the sero positive status, thus, reflecting the functionalist perception that society as an external reality that exerts pressure and coercion upon the individual, and elicits guided responses and reactions, even in terms of illness. Respondents belong to different religions and occupations, which ascertains the fact that HIV/AIDS is not limited to any particular segment of sub-group. However, a large proportion of respondents belonged to the economically weaker section, which supports the belief of the conflict approach, of varying life chances in the society for different class groups.

Chapter IV, the study discusses the source(s) of transmission of HIV among the respondents. Maximum number of HIV infections among the respondents was through sexual route, and a large number of respondents did indulge in extra-marital, casual sex or sexual intercourse with sex workers. Although, a large percentage of respondents indulging in high-risk activities did alter their risk behavior after the knowledge of the infection, a considerable proportion still continues to practice the behaviour. A large number of respondents cited entertainment and easy access as the reason for high-risk sexual behavior. A very small number of respondents were using condom as a safety measure with either spouse of other women/men.

Not a very large percentage of the respondents have been infected through the use of intravenous drugs. But, from among the ones infected through this route, peer pressure was given as the reason for indulgence, by a large proportion. Also, blood transfusion was the source of infection for a small percentage. A large proportion of the respondents had limited information about HIV/AIDS prior to the knowledge of
being infected, but not many had in-depth knowledge. For those who had some knowledge of HIV/AIDS, mass media was the source of information.

When it came to examining the reactions of the respondents themselves, and those of the significant others in their lives, to their sero positive status, it discovered a variety of reactions. Most respondents experienced anxiety, hysteria and fear during the waiting period for test result and maximum respondents were informed about the positive test result by trained counsellors or doctors. A large number of respondents experienced anger, shock or frustration on hearing the news but a large number accepted the situation at a later stage. Many respondents did not blame anyone for having infected them, followed by a considerable number blaming their spouses.

Compared to spouse, the news of their sero positive status was first shared with family and friends. However, at a later stage, maximum married respondents had shared the news with their spouses. A large number told their families in due course of time also and in most cases shock and concern were the dominant reactions from family and spouse which were perceived as ‘normal’ or ‘encouraging’ responses by the respondents.

Almost an equal proportion of respondents had told and not told any friends and the friends who had been told, a large number responded with concern and sympathy, which is why the respondents perceived it as encouraging. However, majority of the respondents did feel that the relationship with friends had undergone change, thus, representing the change in the life world with the change in the reactions and behavior of the significant others. Similarly, not many respondents had revealed their HIV positive status to neighbours and from among those who did, the treatment of neighbours towards them had worsened, for a large proportion. Again, a very small percentage of those working had disclosed their positive HIV status at their workplace. Of those who did, a large proportion experienced resentment and avoidance in the form of professional discrimination or social ill-treatment. Although, a significant proportion of respondents experienced an attitude of help and welfare from the medical staff, a large number did experience avoidance and resentment, as well.
In the Vth chapter, the researcher discusses about the different types of stigma and discrimination faced by the respondents at different settings i.e. health care settings, home, school, community and at the time of death. Health care institutions are the main sources of stigma and discrimination i.e., delay in the treatment, isolation at ward, refused for operating and dressing of the AIDS patients, labelling and name calling by the health staff and mandatory HIV testing at the time of pregnancy and surgery. At the time of HIV testing, testing centre does not follow the principle of confidentiality and does not take the consent. Health care settings are important for AIDS patients where they get treatment for their opportunistic infections (OIs). HIV and AIDS-related stigmatization and discrimination present a major barrier for people want access to treatment and care, and to education and information to prevent the transmission of HIV. People who are members of already stigmatized groups within communities may find that access to needed services is inhibited by the attitudes and reactions from people providing those services. This fear discourage PLWHA/s to come forward for information, HIV testing, support, counselling and treatment. The stigmatised and discriminated behaviour of health staff restrict PLWHA/s to access the hospital services.

In the family context, for HIV/AIDS patients being rejected by families because of the attitudes related to homosexuality, drug use and sexual behaviour. For a person with HIV the fear of rejection, as well as the worry about the burden his/her illness may cause to the family, could result in many people denying their illness to the family or avoiding their family when care is needed most. It has been suggested that it is partly their anticipation of stigma and rejection which may preclude people with HIV from informing their families of their HIV diagnosis. Their family members deprived them from their right in ancestral property. Other forms of verbal stigma include expression of blame and shame, often through scolding or judgemental statements like “they got what they deserved.” PLWHA/S are blamed for infection with HIV through their “irresponsible” and “selfish” behaviour; bringing shame to themselves and their families. In households, HIV/AIDS related stigma can result in the neglect of people who depend on care due to the caregiver’s fear of transmission, anger or moral condemnation, fear of experiencing stigma by association or a combination of these factors. If men are still young and they indulge in play and get infected (with HIV), that is general story of society. If a girl gets this disease, no one
would like to get close to her, because it is a problem of her conduct and her morality. It is not tolerated in females compared to males."

In the employment context, the PLWHA/s reported a different type of stigma and discrimination like less payment or non payment of allowances, change in conditions of work, and social isolation, labelling and name calling. They experience a behaviour change of their colleagues and start neglecting them only because of their sero status. By the employer, PLWHA are forced for their resignation or removal from the job. In few cases, it was found find that they are denied from the health or insurance benefits. People with HIV often endure insults, taunts and name-calling. In addition, derogatory and demeaning language is often used to talk about or label people with HIV and AIDS. To avoid these entire situation, PLWHA/s does not disclose their sero status at the work place, otherwise people start neglecting them. They do not want to sit and eat with PLWHA/s.

In the community context, people with HIV often find that they are no longer welcome at important community events, such as weddings. In the realm of daily life, they often find that their friendship disappear and that neighbours, friends and relative are reluctant to visit or to lend or borrow common household implements and food item, after the disclosing their sero status. Similarly, HIV positive people lose power, respect and identity through the taking away, or diminishing, of their roles, responsibility and social standing with the community. People start taunting and name calling related to their HIV status. Gossip and rumors focus on speculation about whether a person has HIV, usually because of visible signs of illness or association with high risk groups.

At the death of AIDS patients, it was also found a variety of discrimination with the dependent or relatives of the AIDS patient. A majority people experience this type of stigma and discrimination. At the time of death, the hospital staff does not want to touch the dead body and they wrapped dead body in the plastic bags which is a signal of their sero status. They faced difficulty in getting the transporting the dead body. Community members or the friend of the HIV positive person do not want to attend the last rites of the dead person. They taunt like he paid for his sins.
Where reactions of the HIV/AIDS affected people and those of the people around them form an integral part of the understanding of the life and experiences of people living with HIV/AIDS, it is ultimately the coping aspect the eventually determines the quality of life that these people lead. Any action mounted by an individual to confront a stressful situation is called coping. The process of coping with HIV/AIDS assumes medical-physical, psychological-emotional and social, dimensions. The medical and physical coping, for the PLWH/As involves mechanisms such as regular visits to doctors, proper dietary regiment exercise routine and change in high-risk behavior. A large proportion of the respondents were found to be visiting their doctors regularly and also taking precautions regarding their diet. However, not many follow a regular exercising routine and sadly, a significant number of respondents had not made any changes in the high risk practicing behavior, in spite of their knowledge of HIV status.

The psychological and emotional problems faced by the PLWH/As are those of loneliness, depression, fear of disfigurement and death, future uncertainties and dread of abandonment. To cope with these fears a PLWH/A again uses various coping mechanisms. For instance, a large number of the respondents of the present study underwent a repeat test in order to ascertain their sero positive status again. Similarly, a large number had undergone counselling and found it helpful. Surprisingly, only a few had turned towards religion and religious practices as a means of coping. In recent times, self-help organizations have become more and more integral to the process of coping, as the hope for rapid medical solution is not in sight. More and more people living with HIV/AIDS undergo a ‘coming out’ process as HIV-infected people (Pollack, 1992). Many of the respondents were also involved in interaction with other PLWH/AS through support groups and maximum found this helpful in coping with the situation. A substantial number of respondents also felt that through work they were able to cope better with the situation. Hope for finding a cure also kept a large proportion of respondents in a positive frame of mind.

To cope with the problems social in nature, majority of the respondents found being close to their family and socializing with friends as effective coping mechanisms. Marriage was also seen by some of the unmarried respondents as a coping technique, which would help them. A significant number visits their doctors.
shown that medical treatment and doctors play a significant role in the lives of PLWH/As and also the attitude and encouragement from the doctor plays an important role in their situation and cope with the illness. They are regularly taking a nutritious diet and for good health they do exercise also.

Some respondents felt that socializing with friends helped as it did take their mind off the general problems and even sharing the situation related problems helped ease some of the stress. Role of NGO’s is very important in making HIV positive NGOs could do a lot to make their position and plight better and such organizations would be effective and beneficial for them, as well as, for the society as whole. A large number of respondents felt that media could be helpful while a small number also felt that non government organizations could make a positive contribution towards helping the PLWH/As, as well as, in doing away with the stigma and discrimination attached with HIV/AIDS.

Key Findings of the Study

Concisely, the major findings of this study are as follows:-

1. It is the risk behavior and not membership in any particular group that determines the changes of acquiring the virus. That is, it is not who you are, but what you do, that puts one at risk. The prevalence of the infection was not found related to occupation, education or religion.

2. More men than women are infected by HIV/AIDS. However, the number of women getting infected either through their husband or clients in the case of sex workers is on the rise.

3. It appears that the low-income group is more affected by this epidemic. However, it would be inappropriate to generalize on the basis of a relatively small sample such as the present study, and that too, collected through snowballing technique.
4. Awareness regarding correct and complete knowledge about HIV/AIDS among the respondents was found to be good.

5. Mass media plays an important role in information dissemination and education the masses, whereas, family, friends and NGOs are not that useful in this respect.

6. Contrary to the long held belief that HIV/AIDS affect homosexual persons, it is the heterosexual intercourse that has emerged as the main source of the infection transmission. However, the spread of HIV/AIDS through unsafe needless and unsafe blood also can not be underestimated, as more and more such cases are being reported.

7. One shocking finding of the study was that a fair proportion of people living with HIV/AIDS had still not informed their families about their condition which may have significant future implications with regard to transmission of the disease due to absence of precautionary measures, such as sharing the same razors, blades etc. Similarly, a few had still not told their spouses about their condition and continued to have unsafe sex with them, thereby putting their lives in danger.

8. Another alarming revelation was the continuation of high-risk behavior by the respondents even after learning about their sero positive status; for example, many were still visiting sex workers and having sex with their wives, without condoms.

9. Another disturbing fact reveals out of this study was that the sero status of the spouse of the respondents is also the same, presenting the high rate of transmission through sexual route.

10. The more important reasons of their high risk behaviour are away from home/ spouse and easy access to Commercial Sex worker.
11. Complete absence of guilt among many of the respondents, even though their unguarded high risk behavior had brought not only them but also their spouses closer to death, was also a notable finding of this study.

12. Majority of the respondent felt anxiety, fear or hysteria while waiting for the report of their test, they are well informed for their high risk activities which bring them closer to the HIV infection. After the declaration of their status by the counsellor majority of them understandably experienced anger, shock and frustration on hearing the news of their HIV positive status. Few of them blamed ‘other’ i.e. spouse, CSW, hospital setting and other men for their sero status.

13. Health care settings are the main source of discrimination. In these institutions PLWH/As are experiencing different types of discrimination at the every level of health care institutions. Frequently, women with HIV infection have great difficulty accessing health care, and carry a large burden of caring for children and other family members who may also be HIV-infected. They often lack social support and face other challenges that may interfere with their ability to adhere to treatment regimens.

14. In the issues related to testing, confidentiality of HIV positive disclose by the counsellor of the testing centre to the family members of the PLWHA and by the doctor to the supporting staff and marking of the patient’s treatment record by different codes is also one type of stigmatized behaviour.

15. In the hospital settings, respondents experience varieties of discrimination i.e. delay in treatment, postponed surgery, isolation in the ward and at the time of death the health care provider packed the dead body in the plastic sheet.

16. In the family setting, women are major victims of the stigma and discrimination by their own family members. If she is married, she will be rejected by the in-laws and their parents a family and AIDS patient has
also deprived from the share of the property. In few cases, it was found that the women are blamed for the transmission of the virus to her husband. Her in-laws did not allow her to meet with her children and the spouse.

17. At the community level, PLWHA/s experience a different type of stigmatized and discriminated behaviour like labelling and name calling. They blame them for infection and states that you are paying for your sins. They are not to enter in the temple and the community function i.e. marriage etc. In the community, it is not only the individual who is experiencing the discrimination but their family also not allowed attending the community functions.

18. The worst part of the educational institutions, the children of the PLWHA/s did not allowed to sit in the class room. Some of the schools, who are well informed about the transmission mode, the pressure of the parents did not allow them to study in the schools. Some respondents revealed that teachers are not properly teaching their children i.e., not checking the copies, not asking the question etc. It shows not only the infected people face the stigma but their family members; those are affected by the disease, also face stigma and discrimination.

19. It also emerged, that the only people who really stand by the HIV/AIDS affected persons in such trying times are the family and spouse, while relationships with friends, neighbours, colleagues etc, undergo a change for the worse.

20. As far as medical and physical coping with HIV/AIDS is concerned, regular visits to the doctor are important but they only provide treatment of the ailments and prolong life, as far as possible

21. For handling psychological problems, counselling turned out to be the only coping mechanism, which was of some help to our respondents.
22. For social coping, interaction with friends and close contacts with family emerged as primary coping mechanisms.

23. Unfortunately, non government organizations (NGOs) which can play a major role in helping people cope are unable to do so because of the limited awareness of their existence.

Looking at the above discourse, the following thoughts come to the researcher:

Firstly, Information can be delivered by advertisements, brochures, information packs, classes, or lecture presentations. This approach frequently includes a factual description of the disease along with details on modes of transmission and methods of risk reduction. Since behaviour determines incidence of HIV infection, concentrated and long term efforts to change it are imperative, which can be done through strategic interventions, such as community level projects for HIV/AIDS awareness and condom promotion.

Secondly, since HIV/AIDS are not confined to any particular group, information strategies should concentrate on all categories, in general. Therefore, sustained effort has to be made to acquaint people about prevention of HIV/AIDS, with its fullest medical, legal and social implications.

Thirdly, people living with HIV/AIDS need to be better educated about their rights as patients and about how to access justices for discrimination and stigmatization faced in treatment setting. Also, they need to have access to legal education and justice system for violation of their rights in the context of employment and education, all of which can be provided by various types of media.

Fourthly, not only information regarding safer sex needs to be imparted, but also safe needle use, safe blood should be integrated in the information generation programs.
Fifthly, the medical professionals have to treat not only the disease, physically but also the person, psychologically, which demands a more humane than medical outlook towards them.

Sixthly, women should be educated and well informed, to empower them about the risk factors of the behavior.

Seventhly, counseling, as a means of coping, should also be further strengthened. Information-based approaches are often combined with counseling (e.g., support groups for people living with HIV/AIDS). This strategy provides praise and social support for positive attitudes, behavior change, and maintenance of safe behaviors. Participants receive personal support for resolving issues with spouses, partners, families, and others in a safe environment.

Eighthly, Contact with HIV-infected or HIV-affected individuals is used alone or in combination with other strategies. Contact can create an environment in which the general population can interact with members of the stigmatized group, either directly or vicariously (e.g., through the media). The theory is that more personal contact with an HIV-positive person will demystify and dispel misinformation, generate empathy and, in turn, reduce stigma and prejudice. This contact can range from face-to-face conversations to hearing testimonials from HIV-infected or -affected persons.

Ninth, master imagery and group desensitization are two techniques for acquiring coping skills. In master imagery, a person is presented with a hypothetical situation in which he or she has contact with an HIV-positive person and is taught appropriate coping skills for resolving the situation. Group desensitization begins with relaxation training and then progressively exposes the individual or group to a number of situations involving people living with HIV/AIDS. Participants use the newly learned relaxation techniques to decrease tension in a hypothetical situation.

Tenth, the support group concept, which can be an important coping mechanism, should be further encouraged. This could act as a voice for the people living with HIV/AIDS and can bring them into the mainstream life instead of
alienating them from the social framework.

**Suggestion to remove stigma and discrimination:**

- Use public education opportunities to put a human face on AIDS.
- Involve people living with HIV/AIDS in public education.
- Show the diversity of the epidemic.
- Support HIV prevention education materials developed by and for communities.
- Maintain a proactive presence in the community (e.g., in schools, at health fairs, at World AIDS Day, and at National HIV Testing Day events).
- Involve and support families and communities (infected and affected).
- Engage leaders from the business community and faith communities.
- Develop and implement training, policies, and procedures for all staff activities and programs.
- Integrate within contracts relevant provisions for prevention, care, and supportive services.
- Seek, value, and support a staff reflective of the diversity of communities.
- Provide training and technical assistance on confidentiality, nondiscrimination, and cultural diversity to staff, contractors, and other health and human service providers.
- Educate clinicians so that they are not reluctant to treat people living with or at risk of HIV/AIDS.
- Ensure access to confidential and anonymous HIV testing.
Integrate HIV prevention into primary care.

Integrate primary and secondary prevention.

Communicate that HIV-related discrimination is illegal.

Support and promote legal services for consumers.

Remain cognizant of issues related to social isolation and stigma in rural areas.

Identify and support one or more staff members in the role of consumer advocate.

Implement policies and procedures for complaints.

Follow through on enforcement.

Some Parting Thoughts

Among some final thoughts that come to mind are that the phenomenon called AIDS has far reaching ramifications on the social system, as well as, the individual affected by it. Thus, stigma and discrimination related to HIV/AIDS is not merely a disease which can be understood by quantitative research, but also required is its understanding through research of qualitative nature dealing with the emotional and social aspects in order to develop its comprehension in totality. Family, by and large play their role as a support system, however, it is the society and other supportive institutions outside of these, that doesn’t fulfill its obligations to the extent required, mainly because of their ignorance about the disease. To counter this ignorance, media can play a major role. Apart from family and media, a stellar role has to be played by support groups which perform the task of linking the people living with HIV/AIDS with their own group, i.e., stigmatized individuals. This crucial link differentiates those stigmatized people who belong to collective organizations such as support groups and form a ‘we’ that helps them cope with their disease and associated problems of everyday life, from the one who choose silence and concealment. These collective organizations help people
live with their stigma in dignity and pride (Goffman, 1963).

To conclude, there are various aspects to the study of HIV/AIDS, sociological being one of the most important. No doubt, the statistical dimensions of stigma and discrimination related HIV/AIDS are important, yet, a phenomenological interpretation seems to us to be more relevant in order to gain an insight into the real social implications for the persons living with HIV/AIDS, which is what the present study aimed at and hopefully has successfully achieved.
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