CHAPTER - IV

PERCEPTION OF PEOPLE LIVING WITH HIV/AIDS (PLWHA)

The stigma and discrimination experienced by the people living with HIV/AIDS (PLWHA) take many forms. This chapter will examines the views of PLWHA about the perception of community, family, health care providers, their experience of being HIV-positive, and their concern for their children. It will also explore and explores the various forms of stigmatisation and discrimination faced by the infected people.

Socio-Economic Profile of HIV/AIDS Infected Respondents

One of the basic important aspects for explaining a particular phenomenon is to look on the socio-economic criteria. This aspect is imperatives in better understanding of PLWHA that has been prevailing in the society. The level of socio-economic position of PLWHA in the society determines their status. It is also a realistic yardstick that helps us to understand the level of inequality and the problems face by them. It can be surmised that in Tangkhul society, the prevalence of high rate of HIV/AIDS cases is basically related to their socio-economic aspects. A detail analysis of the poor socio-economic condition of most of the infected people can sent out a strong message that will in turn attract helpful interaction and provision from the society, NGOs, and also the government. Therefore, it is significant to study the socio-economic aspects in order to better comprehend the stigmatisation and discrimination countered by the infected people.
As per the data collected for the study, the profiles of the respondents are described by choosing certain criteria like age, sex, marital status, educational status, occupational status and income of the infected respondents (see Table 1).

**Table 1: Age Distribution of Infected Respondents**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 – 24</td>
<td>1</td>
<td>1 %</td>
</tr>
<tr>
<td>25 - 29</td>
<td>2</td>
<td>2 %</td>
</tr>
<tr>
<td>30 - 34</td>
<td>25</td>
<td>23 %</td>
</tr>
<tr>
<td>35 - 39</td>
<td>36</td>
<td>33 %</td>
</tr>
<tr>
<td>40 - 44</td>
<td>27</td>
<td>24 %</td>
</tr>
<tr>
<td>45 - 49</td>
<td>17</td>
<td>15 %</td>
</tr>
<tr>
<td>50 - 54</td>
<td>2</td>
<td>2 %</td>
</tr>
<tr>
<td>55 and above</td>
<td>0</td>
<td>0 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>110</strong></td>
<td><strong>100 %</strong></td>
</tr>
</tbody>
</table>

It is evident from the above table that majority of the respondents belong to the age group of 35-39 years constituting 33%. This is followed by age group of 40-44 with 24%. The respondents’ age group of 30-34 has 23%, followed by the age group of 45-49 years with 15%. Those who fall in the age group of 25-29 and 50-54 years are relatively few with 2% each. Therefore, it is understood that the worst affected are those in the age group of 35-39 years.

**Table 2: Gender Distribution of Infected Respondents**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>34</td>
<td>31 %</td>
</tr>
<tr>
<td>Female</td>
<td>76</td>
<td>69 %</td>
</tr>
</tbody>
</table>
As far as the number of gender respondents is concerned female group has 69% and male with 31% (see Table 2). The reason for having more female respondents is because of the fact that most women are more ready to be interviewed, whereas it is not the case with the male respondents. Women are more prone to disclose their HIV-positive status despite the reality that they are given harsh treatment. On the other hand, most infected men conceal their HIV status, not necessarily because of the prevailing societal stigma and discrimination.

### Table 3: Marital Status of Infected Respondents

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmarried</td>
<td>19</td>
<td>17 %</td>
</tr>
<tr>
<td>Married</td>
<td>46</td>
<td>42 %</td>
</tr>
<tr>
<td>Widowed</td>
<td>40</td>
<td>36 %</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>1 %</td>
</tr>
<tr>
<td>Chased Away</td>
<td>4</td>
<td>4 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>110</strong></td>
<td><strong>100 %</strong></td>
</tr>
</tbody>
</table>

The above table (see Table 3) indicates that married respondents constitute the highest percentage with 42% and unmarried with the percentage of 17%. Those widowed have 40 respondents with 36%. There is one case of divorce, and 4 are being chased away from the homestead by their in-laws. From the given figure, it can be ascertained that the chances of spreading HIV/AIDS through sexual intercourse and through mother to child is very high. Gender roles and other issues associated with the care of infected persons within the family can also be taken into account.
Table 4: Literacy of Infected Respondents

<table>
<thead>
<tr>
<th>Education</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>41</td>
<td>37%</td>
</tr>
<tr>
<td>Primary</td>
<td>32</td>
<td>29%</td>
</tr>
<tr>
<td>Secondary</td>
<td>26</td>
<td>24%</td>
</tr>
<tr>
<td>Graduate</td>
<td>10</td>
<td>9%</td>
</tr>
<tr>
<td>Post Graduate</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>110</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Table 4 clearly indicates that large proportion of the respondents is functionally illiterate with 37%. Respondents who completed primary level of education stood the second highest number of respondents with 29%. There are also good numbers of respondents who completed secondary and graduate levels with 24% and 9% respectively. Only 1% respondent reached the higher level of education, post graduation. Majority of the respondents reported that due to poverty and financial problem in the family they could not even afford to go to school and have formal education. From the above data, it can be deduced that large proportions of respondents are either illiterate or have low level of education. Thus, the high level of infection can be significantly link with the literacy status of the individual.

Table 5: Monthly Income of Infected Respondents

<table>
<thead>
<tr>
<th>Monthly Income</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 1000</td>
<td>27</td>
<td>25%</td>
</tr>
<tr>
<td>1000 - 2000</td>
<td>12</td>
<td>11%</td>
</tr>
<tr>
<td>2001 - 3000</td>
<td>14</td>
<td>13%</td>
</tr>
<tr>
<td>3001 - 4000</td>
<td>15</td>
<td>14%</td>
</tr>
</tbody>
</table>
Income is one of the basic criteria for stating the living conditions of people. In this study, most of the respondents expressed their view that they still can contribute something to the family’s income despite of their sickness. As a matter of fact, the contribution they made to the family income is not negligible. However, most of the respondents were hesitant to honestly report their earnings and incomes. This could be because of their low amount of income (see Table 5). Statistics indicate that large numbers of the respondents with 25% are without income or less than 1000 (in rupees). They depended on their husband, wife or parents for their daily needs. The study also found that there are infected people with stable income, though the amount of income varies. The income of 14% of the total respondents falls between Rs.3001-4000. This is followed by those 13% of respondents whose monthly income ranges between Rs. 2001-3000. Percentages of respondents with the income of Rs. 1000-2000, Rs. 4001-5000, Rs. 5001-6000, and Rs. 6001-7000 are 11%, 8%, 6% and 9% respectively. Another 8% of the respondents have their monthly income of Rs. 7001-8000, and 6% of the total respondents have the monthly income of 8001 and above. The data shows that the people infected with HIV/AIDS have thin chance of being employed in a well-paid job.

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>4001 - 5000</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>5001 - 6000</td>
<td>7</td>
<td>6%</td>
</tr>
<tr>
<td>6001 - 7000</td>
<td>10</td>
<td>9%</td>
</tr>
<tr>
<td>7001 - 8000</td>
<td>9</td>
<td>8%</td>
</tr>
<tr>
<td>8001 and above</td>
<td>7</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>110</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Table 6: Sources of Income of Infected Respondents

<table>
<thead>
<tr>
<th>Sources</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture and Farming</td>
<td>35</td>
<td>32 %</td>
</tr>
<tr>
<td>Hunting wild animals/Gatherers</td>
<td>5</td>
<td>4 %</td>
</tr>
<tr>
<td>Wage Earners (carpenters, coolies, unload trucks etc.)</td>
<td>15</td>
<td>14 %</td>
</tr>
<tr>
<td>Business/Entrepreneurs</td>
<td>11</td>
<td>10 %</td>
</tr>
<tr>
<td>Truck Drivers</td>
<td>1</td>
<td>1 %</td>
</tr>
<tr>
<td>Government Employee</td>
<td>2</td>
<td>2 %</td>
</tr>
<tr>
<td>NGO Workers</td>
<td>14</td>
<td>13 %</td>
</tr>
<tr>
<td>Unemployed/Dependent</td>
<td>27</td>
<td>24 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>110</strong></td>
<td><strong>100 %</strong></td>
</tr>
</tbody>
</table>

Table 6 of this chapter shows that majority of the respondents with 32% generate their monthly income through agricultural farming or activities. Another 24% of the respondents do not have a source of income; therefore, they directly depend on their parents, wife or husband for their survival. About 14% of the respondents are daily wage earner, 13% of them are NGOs’ workers, 10% are running their private business, and 4% depended their income on hunting related activities. Few respondents with 2% are employed in the government service, while 1% is a truck driver.

Table 7: Modes of Transmission of HIV Disease

<table>
<thead>
<tr>
<th>Modes of Transmission</th>
<th>Number of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Intercourse</td>
<td>76</td>
<td>70 %</td>
</tr>
<tr>
<td>IDU</td>
<td>33</td>
<td>29 %</td>
</tr>
</tbody>
</table>
The above table (Table 7) clearly exhibited that 70% of the total respondents were infected through sexual relationship with the infected person. Twenty nine (29) % of the respondents were infected through sharing of needles among the drug users. Only one percent of the total respondent was infected through transfusion of infected blood. The above data which has been attained after interviewing 75 female and 1 male, enunciates that most of the infected individual especially women were infected through sexual intercourse. In other words, sexual intercourse is the main mode of transmission of HIV virus in the context of Tangkhul society.

Table 8: Educational Qualification and Modes of Transmission of the Respondents

<table>
<thead>
<tr>
<th>Educational Qualification</th>
<th>Modes of Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sexual Intercourse</td>
</tr>
<tr>
<td>Illiterate</td>
<td>31</td>
</tr>
<tr>
<td>Primary</td>
<td>20</td>
</tr>
<tr>
<td>Secondary</td>
<td>17</td>
</tr>
<tr>
<td>Graduate</td>
<td>7</td>
</tr>
<tr>
<td>Post-Graduate</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
</tr>
</tbody>
</table>

As shown in Table 8 of this chapter, 76 of the respondents were infected with HIV virus through sexual intercourse. Among them, 31 of them are illiterate, and 20 of them have primary education. 17 of them have secondary education, 7 of
them have graduate level educational qualification, and one of them have a post
graduate degree. The table also shows that 33 of the total respondents were infected
with HIV/AIDS through IDUs. Among the infected drug users, 14 of them are
illiterate, 8 of them have primary education, and 6 of them have secondary
education. Four of them have graduate degree and one of them has a postgraduate
degree. One of the respondents, who have a primary education, was infected with
HIV virus through blood transfusion. From the above-mentioned data, we can say
that most of the HIV infected respondents are illiterate or have lower educational
qualification. In other words, education does play an important role in the study of
HIV/AIDS problem in Tangkhul context. Thus, we can say that “education for all”
could be one successful means in minimising the number of HIV/AIDS patients in
the Tangkhul society.

Experiences of HIV Positive People

Impact on the People after HIV Diagnosis: It can be hypothesised that stigma and
discrimination are always interconnected with a perceived immoral lifestyle. In
Tangkhul society, most of the people diagnosed with HIV/AIDS are suspiciously
viewed as being morally wrong. Therefore, people who contracted AIDS are oftened
viewed with some reservations. They are often stigmatised or discriminated with the
intention of making the infected person feel ashamed and guilty for their “unethical”
conduct. Consequently, it always comes as a shock when one is being diagnosed
with HIV/AIDS. It is found in the study that majority of the infected respondents
found it very difficult to cope with their HIV positive-status. Further, it is found that
after the diagnosis, most of the respondents find it hard to accept the reality and all
of a sudden, they are engulfed with fear of being stigmatised by friends, family and
community. One of the respondents recounted, “When the NGOs and doctor told me that I am HIV-positive, I was shocked and ashamed of my status and did not know what to tell them.” Another respondent reiterated, “When my HIV-positive status was first reported I did lost my words. I just could not believe it. I thought that the result might be incorrect. I felt very shocked and depressed. It was so hard to accept. I was really worried about my future.”

Similarly, one respondent stated, “I felt so hopeless and ashamed on hearing that I am HIV-positive. I thought I would hide away somewhere. I want to get away from the people and do not want to meet anyone.” One of the infected women respondents mentioned, “I grieved when my HIV-positive status was reported by the doctor. I was shocked to hear the report. My husband is responsible for this sickness. He is an IDU. Seeing my sons and daughter, and thinking about their future, it really worries me.” After understanding the above statements, it may be safely concluded that forms of stigma associated with HIV/AIDS often bring about a feeling of embarrassment, hopelessness, shame, and grief when respondents came to learn of their HIV-positive status.

There are also other respondents whose narration talks about death, the fear of dying and the notion of taking their own life, and their concern for their family. For instance, one respondent mentioned, “On receiving my blood test result, I could not think of anything else, except to die. My first thought was I would be dying soon.” Another respondent revealed, “I thought of dying when my HIV-positive status was reported. Thinking of my children I could not do that.” On a similar line, one respondent added, “I think about killing myself when my HIV-positive status was reported after blood test.” Another respondent stated, “I still remember the day when my HIV-positive status was reported. The doctor told me the result was
positive. I was so nervous and I cried. I was very scared because the disease cannot be cured. I knew I would not live long.” An infected woman described, “I was pregnant when my positive status was informed. I was so shocked and worried when I got the report. I thought that some mistakes had occurred with the blood test. I could not believe that I was positive. I was scared that I would die very soon.” A revealing statement of a male respondent also shows how he felt when he collected his report. He mentioned, “At the time when I came to know about my sero-positive status, I was really shocked. I did not believe so I went for another blood test but I received the same result. I never take drugs and I never had sex with anyone. I could not accept that I am HIV-positive at that time. At last, I realised it was through blood transfusion I got this disease.” Another male respondent mentioned, “When health care providers gave me the report of my blood test result which shows the positive status, I was shocked and could not accept the report. I even asked them whether the report was really true or not. I thought the report might not be my report.” All these show that all the respondents had difficulty in absorbing the news. They were at first shocked, and then in denial and disbelief mode. Waves of depression and signs of withdrawals often follow this unfortunate situation. Some even contemplates of committing suicide.

The study also found that many of the respondents lack in-depth knowledge about HIV/AIDS and could not differentiate between HIV and AIDS. Therefore, they use the two terms interchangeably. In non-professional understanding, HIV, which is an abbreviation for “Human Immune deficiency Virus”, is the virus that can cause AIDS. On the other hand, AIDS, which stands for “Acquired Immune Deficiency Syndrome”, is an illness which attacks the body’s ability to resist infection and which usually causes death. Two-third of the male IDUs respondents
mentioned that they did not have much knowledge about HIV/AIDS status when their positive status was reported. In the words of one respondent, “I did not have much knowledge about HIV/AIDS when I was infected. I heard people talking about this deadly disease, how it is transmitted among the drug users through sharing of syringe and unprotected sex in our society, but never thought it would infect me. Only when I had the disease in my body, I came to realise that AIDS really do exist.”

Another respondent lamented, “It was too late when I began to have knowledge about HIV/AIDS. By then, I was already a HIV-positive patient.” Similarly, one respondent added, “When I came to know about my HIV-positive status, I was too addicted to heroin and I could not stop anymore. Even if I try to control myself, it gave me more other problems to the body.” Another male respondent commented, “I had to accept the fact that I am HIV-positive only after the blood test. I did not know about this disease earlier. After joining the HIV/AIDS awareness programme and after listening to some professionals, I came to know about it.” Another respondent reiterated, “I have learnt about HIV/AIDS only when the NGOs gave awareness programme in our locality. Only after attending the prevention programmes, somehow I came to know about HIV/AIDS. But by then I was already infected.” One of the respondents mentioned, “I have heard about HIV/AIDS but I do not know about the difference between HIV and AIDS.” It is evident from the above statements that many respondents became aware of their HIV-positive status only after their blood tests were conducted. Eventually, they came to have more knowledge about this disease after attending NGOs’ awareness and prevention programmes.
Self-stigma and HIV/AIDS: Self-stigma is the process whereby people living with HIV/AIDS impose feelings of indifference, inferiority and unworthiness on themselves. Self-stigma can result in HIV-positive people isolating themselves, limiting contact and physical affection with their families, refusing help and stopping work because they believe that they are no longer capable. Self-stigma sowed the seed of fear among the HIV-positive person. The fear of people finding out about their status and of being judged and rejected, of losing the love and confidence of family and friends, and of becoming an outcast within their community are some of the factors that constantly haunt the infected person, which made them more pessimistic in their thinking as well as in their ways of life.

The study reveals that while all the female respondents openly stated similar opinion of worries and anxieties, only few male respondents correspond to such opinion proving that men are more reserved comparing to women. The idea of self-stigma can be understood better by observing some responses given below: One respondent said, “I was worried what my parents would say about me if I reveal my positive status. Are they going to reject me? Are they going to treat me in the same way as before? What will they think of me?” Another respondent revealed, “I could not disclose my sero-positive status to my family members, especially to my in-laws because I am scared of their reaction.”

Similarly, another respondent added, “There will be not much problem in revealing my HIV-positive status to my immediate family members because they would understand me. However, I could not do the same to my in-laws. I am more concerned of how they would react and treat me if they come to know my HIV-positive status.” Many respondents in this study described that once their status is revealed, isolation and discrimination become a part of their daily life. On the
contrary, there are also respondents who are accepted by their families and received love and support instead of rejection.

The actual enacted HIV-related stigma may be less than the anticipated ‘perceived’ stigma. In other words, the self-stigma people imposed on themselves may be worse than the discrimination they actually faced. Nonetheless, self-stigma definitely affects self-perception. One respondent mentioned, “There are people who said to me that I am educated and smart, and highly qualified to take a leadership role in the student union. However, who would prefer a sick person like me for leadership? There is no one who can understand and encourage me in my society.” A similar statement was given by another respondent, “Some of my friends said I should go and look for a job since I am educated and had finished B.A degree course. However, who will employ me; after all, I am HIV-positive.”

One woman respondent stated, “If chance is given, HIV-positive women can play a big role in our society and Church, in making the people more aware of AIDS and also understand our predicaments. We are being stigmatised and discriminated, therefore, I feel it is better and safer to abstain from being a part of anything.” These statements demonstrate how self-stigma led the HIV-positive person to presume that they would not be welcomed by the society and would not be able to get employed. This kind of internal feeling of inferiority can cause stress and anxiety leading to self-impose social isolation.

Paxton (2002) mentioned that people who publicly disclose their status and confront the prevailing stigma and discrimination had a profound impact of reducing stigma and discrimination including self-stigma. Therefore, HIV infected people need to be educated and be given maximum support when their sero-positive status is disclosed and known to others publicly so that they will not recoil to the web of
self-stigma. In other words, public advocacy should be the prime effort if infected people are to overcome self-stigma.

**Breach of Confidentiality:** In health care settings, people with HIV/AIDS can experience stigma and discrimination because of the lack of confidentiality. The breach of confidentiality has become a persistent menace in health care settings. Some respondents expressed that they withdrew from daily life after having breached their confidentiality. For instance, one respondent exclaimed, “I did not want to talk and eat for many days, I did not want to meet and look at anybody when my HIV/AIDS confidentiality was breached by the health workers.” Similarly, another respondent stated, “I had sleepless nights when my HIV-positive status was known by others, which were meant to be confidential.”

Another respondent also added, “I have not disclosed my HIV-positive status publicly but I was surprised when people came to know my sero-positive status. I want health care providers to respect my opinion and maintain confidentiality. As Kamjong is a small place and everybody knows everyone by name, I do not want my HIV-positive status to become public. I want the health care providers and nurses to be more responsible.” All these suggested that respondents did not want others to know of their HIV-positive status and want to keep it confidential for their well-being.

Most of the respondents want to maintain confidentiality because of the various prejudices surrounding the AIDS disease. Generally, they perceive HIV/AIDS as a “dead disease” that is incurable. Most of the respondents commonly indicated that being HIV-positive means a meaningless or purposeless life. The negative perception on HIV/AIDS as a sort of “death sentence” brings about fear and negative behaviours. One respondent described, “Having HIV/AIDS disease is
to face death.” Another respondent stated, “As there is no curable vaccine to counter HIV/AIDS epidemic, I think about death.” Similarly, another respondent mentioned, “Life is finished, once you are diagnosed with HIV-positive.” In support of this respondent, one of the women respondents also said, “Since I have HIV/AIDS, I feel as though life has come to an end although there is ART to reduce its impact.”

**Religion as a Coping Means:** In the process of finding ways to escape from the cycle of depression and anxiety, many infected people turn to religion. Through faith in religion, they countered various stigmatisation and discrimination. Many respondents revealed that religion is a powerful weapon that enables them to redefine the meaning of life. Most of them find solace in religion. They consider religion as a necessary tool required to manage various negativity that come along with HIV/AIDS. For instance, one woman respondent revealed, “My villagers know that I am HIV-positive. I know our society have negative perceptions about this disease. However, I believe in God, the Creator of heaven and earth who could do everything. Nothing is impossible before Him. I have faith that God will cure my sickness. I do not want to be disheartened and depressed by people’s attitude and judgement about me.”

A male respondent also responded related to the above-mentioned statements. He said, “I know HIV/AIDS is an incurable disease. Our society fear people having this disease. As for me, suffering from this disease has changed my life. Spiritually, I have become much stronger and this is the reason I value life more. Now, I am rehabilitated. Being HIV-positive has made me a better person. Let me not worry too much about people negative reactions towards PLWHA.” Another respondent also stated, “I have learnt that HIV/AIDS status has given me an opportunity to change and draw nearer to God. People see me as someone having
Khonkashi Kazat (cursed disease), Morei Kazat (sin disease), Shuikhangarui Kazat (disease of sexual immorality) and others, but this sickness allows me to consider life more positively and change for the better.” Furthermore, another respondent added, “When I feel down and depressed, I used to pray and meditate God’s words. It gives me hope and relieves me from being living negatively. I do go to Church and it encourages me to be spiritually strong.” All these point to the fact that religion is seen as a coping tool by those PLWHA. Religion allows them to response to their illness in a more positive way.

**HIV/AIDS and Other Illness:** In the study, majority of the respondents gave strong opinion that HIV/AIDS should be viewed and treated as any other illnesses. Some extracts related to the issue are given below: one respondent said, “Efforts should be made to discover curable medicines or vaccines for HIV/AIDS, and this terminal disease should be treated like any other illnesses and should not be discriminated upon.” “HIV/AIDS should be considered like any other diseases. People who carry this disease should not be stigmatised and discriminated,” responded another respondent. Similarly, one respondent added, “I see HIV/AIDS like any other diseases. Ironically, I fear TB more than AIDS.” One other respondent also mentioned, “HIV/AIDS should be treated like any other diseases. People having this sickness should not be blamed and victimised. HIV/AIDS infected people need to be respected and treated like any other patients suffering from other diseases.”

The study located that infected people are hopeful that one day vaccines for curing AIDS will be discovered. Most of them positively responded that they have accepted their illness and would not hesitate to disclose their status to others although it is not an easy task. They have been able to accept their illness mainly because of education and other valuable information about HIV/AIDS, which
empower them to view things positively. Today, they have come to positively view that they would live long and would not die easily. Such positive spirit can be comprehended by observing some statements given by the respondents. One respondent mentioned, “I will live long! I have not given up my hope. I am still going strong. There is ART to control the progression of the illness. I need to maintain a good health and to have a good supplementary diet until the curable medicine is found.” Another respondent stated, “Now there is antiretroviral treatment to check and control the increase of virus in the body. People say curable medicine will be discovered soon. So should I be scared to disclose my positive status? I have to be more positive about my sickness and avoid all those negative perceptions.” In the words of another respondent, “I have learnt to accept my fate and my sickness. I want to be more optimistic and live long enough, then to remain pessimistic for my illness. The ART has sustained my health to this day. I hope curable medicines would be available for HIV infected people very soon.” From the above statements, it is understandable that the increased access to antiretroviral therapy is another main reason for HIV infected people to become more positive about their health and to accept their HIV status.

In today’s technologically advanced era, many infected people seem to have found means to overcome the negative reactions given by the community members. They encourage each other to encounter their difficult situations. Some respondents expressed, “If PLWHA disclose their positive status to the community and educate the general public about the HIV/AIDS disease, people will definitely accept them. HIV-positive patients need to be bold and strong enough to disclose their sero-positive status instead of hiding cowardly.” Most of them stressed that “their community needs to be educated and be well informed about this disease. So that
people having HIV/AIDS are treated like any other diseases and people who are suffering from it are not stigmatised and discriminated. In this way infected people can mingle with the uninfected.” From the above-mentioned statements, we can say that education about HIV/AIDS to both PLWHA and the uninfected people is a prerequisite measure for nurturing positive behaviour and attitude.

It has been observed that despite some positive developments, there are also respondents who gave contradictory responses regarding disclosing their HIV-positive status to neighbours and other member of the society. For instance, one respondent remarked, “I do not think the impact of ART will make a change because it does not cure the disease. Even if antiretroviral therapy is made available in abundant for the PLWHA there is no point as people would continue stigmatising and discriminating us.” Another woman respondent also commented, “As long as curable vaccine is not discovered; it does not matter whether you are on ART or not, people will continue stigmatising you. Their negative attitude will not change. They will not accept you in the society.”

Similarly, another respondent reiterated, “Why should we not keep our HIV-positive status secret. Nobody has the right to force us to reveal our sero-positive status. When people have not fully accepted us, and continue stigmatising PLWHA, who would have the courage to disclose our status openly.” Such cases reveal that some respondents are pulled back by the fact that HIV/AIDS remains an incurable disease. Their understanding about this disease is overwhelmed with negative perceptions that directly or indirectly nurtured their negative behaviour. It is found that they desire to remain silent and not accept their HIV status. The availability and impact of antiretroviral treatment seem to have little or no significance in undermining such negative perceptions.
PLWHA and Positive Life

Many respondents in the study described that even though they suffer from HIV/AIDS, they are able to transform themselves from being pessimists to optimistic lives. This is possible because of the forgiving and understanding nature of their parents in particular and society in general. Many of the respondents described that reconciliation with partners and families is a major factor of making peace with themselves. Some positive reactions of the family members and community towards PLWHA will be given in the following lines. One respondent shared, “I realised that some things are meant to be kept for good and that is my husband. I do not want to give him up simply because of his HIV/AIDS status. I have learnt to live positively with my HIV/AIDS infected husband.”

Another respondent also added, “I have decided to make peace with my wife and make a fresh start. There used to be a “blame game” in the family, which has really jeopardised our relationships. Now I have decided to stop blaming her and make our relationship better.” Similarly, one respondent mentioned, “I do not want to blame my husband anymore for giving me AIDS. Gone is gone! Now, I want him to know that I need him, therefore, he must try to live a much better and positive life in the remaining years.” One of the respondents also mentioned, “Actually, it is my wife who infected me. Earlier, I used to blame her but now I have stopped reminding her of the infection issue. Instead, we are considering and encouraging each other in order to live longer. Thinking about our children’s future, we are trying to live more positively.”

In support of the above statements, one respondent also stated, “I do not want to blame my husband for transmitting HIV/AIDS to me. We both are responsible for what have happened to us.” All these statements show the
importance of reconciliation among the couples in order to do away with the negative connotation of AIDS. It is found that many couples have learnt that every difficult situation always has a positive aspect. The inculcation of positive attitude boosted the spirit of the infected people to fight against the HIV/AIDS. It also encourages them to play more pro-active roles in preventing the spreading of HIV virus through engaging in various awareness programmes and also by testifying the danger of HIV/AIDS.

One respondent expressed, “I want to work in support of PLWHA and give counselling and awareness to others who are infected with the virus so that they will be more positive, confident and hopeful.” One of the respondents stated, “I have learnt to live positively with HIV/AIDS. I have learnt to overcome the condemnation of others. We must think positively and encourage ourselves, and encourage our friends who are infected as well. Why always worry about the existing stigma and discrimination? Why give up our life because of HIV.” In support of this statement, a woman respondent also mentioned how she found ways to live positively with AIDS despite of the perpetual presence of negative reactions from the society. She narrated, “I have learnt to ignore the discrimination of our society against the infected people, since my parents have always supported me to be positive. They provided me all the best medications and good food to maintain my health. They afforded me everything to make me live long. They always want me to be happy. Because of them, I do not fear what people think about me as I have found ways to live positively with this sickness.” Another respondent also mentioned, “As long as HIV/AIDS exists, our societal stigma and discrimination will continue to exist and we cannot escape from this hard fact. I do not want to
worry too much about people’s reaction towards me anymore. I want to think more positively about my health and my life.”

The study also found that respondents who work in NGOs strive to bring change in the mindset of both the infected and uninfected people by indoctrinating a more positive thought. Some infected NGOs’ workers stated that understanding, acceptance, support and compassion towards the infected people are the best medicine that can strengthen the confidence of the infected people. One respondent who worked as a staff in UNP+ stated, “We ‘positive’ people have to accept ourselves of what we are and who we are, and try to think positively and prove that we HIV/AIDS infected people can bring change in the society.” The coordinator of Ukhrul ART Centre Community Care remarked, “We should be seen as a professional people who can bring social change and not just as HIV-positive people.”

The President of RRF, Kamjong also asserted that “The ability to live and to succeed should not be hampered by our HIV-positive status. We are capable of achieving anything beyond doubt. There are no limitations to do anything that we wish to accomplish in life. Speak what is in your mind and do not let anyone put you down just because you are a HIV-positive. Work hard and continue enjoying the life despite the many hurdles that may come in life. You can live positively with HIV/AIDS, and that is what I have been doing.” This suggests that HIV-positive individuals who work in NGOs are determined to bring positive changes for PLWHA and teach them to live positively with HIV/AIDS. The statements communicate the message that some respondents were able to overcome the impacts of stigma and discrimination and move forward to living positively with HIV/AIDS.
Going Public

Misinformation and lack of understanding of HIV/AIDS are the reasons that have frequently led to public discrimination and stigma. Such prejudices have been firmly constructed in the Tangkhul society because most of the people have little or no knowledge about AIDS. The study found that the respondents’ personal experiences of stigma and discrimination have been a consequence of limited information and understanding about HIV/AIDS. Thus, to curb stigma and social discrimination, mass education about the disease need to be promoted. For mass education to be more effective and productive, HIV-positive people must become community educators by practically sharing their stories. It may be added that going public about one’s HIV status can break the shield of ignorance about AIDS. Some responses that describe the importance of going public are give below:

One respondent described, “My HIV-positive status is known to almost all the people but I do not regret revealing my status. Now, I am a counselor in an NGO and I could boldly educate HIV-positive people and others in a small way within my own community.” Similarly, another woman respondent who works in an NGO described, “I do not regret for making my HIV-positive status public. Now, I can publicly devote my service in educating others about HIV and AIDS.” One UNP+ staff mentioned, “I do not feel ashamed of disclosing my HIV-positive status. It rather helps and encourages people who are still hiding their HIV-positive status to disclose so that they too can avail the right measures to improve their health condition.”

Similarly, one respondent from ART Centre Community Care also stated, “By coming out publicly we want to overcome social stigma and discrimination and give public awareness. And today, public perceptions towards people living with
HIV/AIDS have changed considerably.” Another respondent also narrated, “I could not hide my status because herpes had badly attack one of my eye. Poverty had force me to seek external help, as nobody in the family would want to help me. Fortunately, NGOs intervened, but due to untimely treatment, I had lost one of my eyes. Since then, I have decided to speak openly against the inimical outlook of the society towards HIV infected people.” Publicly disclosing the HIV-positive status and providing community education seem to have slowly enabled the uninfected people to change their attitude towards people living with HIV/AIDS in the society. It also inspires many other infected people to dare social stigma and get timely treatment. In many ways, inspirational stories and measures taken by the infected individual in turn motivate others to overcome the horror of self-stigma. As pointed out by Paxton (2002), positive people who engage in HIV community education are better able to overcome self-stigma. However, it can be again reminded of such story of positivity are not the same for all the infected people. Some are still unable to escape from the vortex of negativety.

Many respondents stressed that HIV-positive people who went public will have no one to support them when they are sick and when they need help. This is what many respondents have observed. Thus, many would not like to go public. One of the respondents added, “I do not want to disclose my positive status to others, as people will still discriminate and ridicule me.” Another respondent also mentioned, “If I reveal my status publicly, I expect hardship and frustration.” One of the respondent also narrated, “As far as possible I feel it is better to keep my HIV-positive status confidential. I do not want people to know my illness. I do not want to publicise my sero-positive status because I do not want to be mistreated by others.” These statements reveal that many infected people feel that receiving
positive reaction from the public still remain a utopian in the Tangkhul society. They have a strong notion that PLWHA will experience discrimination, isolation and may not receive adequate support from the people. Though, some choose to go public as a better option, many also have expressed that they regretted going public.

Many respondents described, “The first time when we publicised our HIV status, everything was okay. People were willing to support us, but things changed later on. Positive public support vanishes after few months.” Similarly, another respondent also stated, “Sometimes, I felt that I should not have gone public because people continue to stigmatise me. Initially, I thought if I go public, people in our community would help me and understand me better. However, it is not the case. They are good only in words.”

The above statements demonstrate the disadvantages of “going public” by some respondents. Instead of receiving public sympathy, they are subjected to stigma and various forms of discrimination. Such reaction from the public disappointed and discouraged many PLWHA from publicising their HIV status, and makes them more reclusive than ever. Whether, they disclose their HIV status or not, people’s attitude remains the same in many cases. Therefore, many continue to keep secret of their HIV status. This is perhaps one reason why the numbers of HIV infected people are many in Ukhrul district.

**Discrimination in the Community**

A community can be defined as a group of people who are linked by social ties and share a common perspective (McQueen et. al. 2001). The HIV pandemic has elicited both negative and positive responses from the community members. Community level stigma and discrimination towards people living with HIV/AIDS is found all
over the world. Such reaction can have a huge effect on PLWHA. If the reaction is hostile, a person may be ostracised and discriminated, and may be forced to leave their home or change their daily activities such as shopping, socialising or schooling. When asked about discrimination in the community, many of the respondents revealed that they experienced both negative and positive reactions of different forms. HIV/AIDS related discrimination within communities ranges from subtle discrimination to overt isolation. The following narratives are given to grasp the underlying community reactions towards the infected people.

One widow stated that her neighbours and friends stopped visiting her after they came to know the knowledge of her infection. She stated, “My neighbours and others have stopped visiting my house after I got infected. They were scared that they might be infected. Neighbours gossip about me as if I am responsible for spreading this disease. People always gaze at me wherever I go, and I feel completely isolated from my community.” Another respondent also narrated on how she was deprived by the butchers while buying meat in her village. She continued, “I was made to stand and wait for almost an hour to buy a kilo of meat by some butchers. I was treated unfairly because they knew that I am HIV-positive. I could feel that they did not want to sell meat to me. Therefore, even to buy things in my locality I had to choose certain shops and owners who understand me. Sometimes, I felt as though I did not belong here.”

These two cases represent an interesting aspect of how infected people are being viewed and discriminated by their neighbours and villagers. In some extreme cases, some infected people are even asked to leave their village. For instance, one respondent illustrated, “Some of my villagers told me that if I stay, I will
contaminate the whole village and transmit the disease to other villagers.” Similarly, another woman described how she was told to leave the village by some of her neighbours. She said, “I was insulted and told to leave the village by some of my neighbours because they feel that it is a disgrace for a woman like me, who has Khonkashi Kazat (cursed disease), to live together with them.” This incident reveals the utter lack of awareness and ignorance of the villagers. Such negative reaction compels PLWHA to be isolated as they do not want to continually experience the trauma of community stigmatisation and discrimination.

**Stigma and Shame:** AIDS disease is shrouded with stigma, shame and fear. HIV-positive is often perceived as a source of disgrace, bringing shame to the families and communities. AIDS psychosocially “is a chronic illness with a long term, incapacitating, terminal and stigmatizing character” (D’Cruz 2004). One who suffers from AIDS is already living a life of stress and frustration. Nevertheless, as though this is not enough, infected people are often subjected to shame and stigma. In fact, shame is an inevitable emotion prominently found among AIDS patients and also those caring the infected ones. Since HIV/AIDS is classified as a sexually transmitted disease and it is thought to be acquired through living an immoral lie. Therefore, it is absolutely considered as a disgrace and a humiliation. This is an indication that society holds against the infected individual. We observed that the society showed a strong reservation because AIDS is perceived as having serious consequences for the ‘Other’ (Fife and Wright 2000).

The shame attached with HIV/AIDS can isolate the infected person, which prevents them from being disclosing to the community. Studies show that many respondents living with HIV/AIDS experience shameful treatments from people around them. One respondent explained, “I had to hide my positive-status for a long
time because suffering from HIV/AIDS is considered as a shame in the community. I was scared after witnessing how people living with HIV/AIDS were mistreated in our community. I became worried at the notion that if my status is revealed, my society will mistreat me in the same manner. Because of this fear, I could not have the courage to avail the facilities like HIV tests and drugs, and it almost killed me.”

Another respondent also pointed out, “It is a shame to the family and community if you have HIV/AIDS. Therefore, I prefer to conceal my HIV-positive status from neighbours and friends due to societal negative perceptions against people living with HIV/AIDS.”

Another respondent also substantiated, “I fear whether my society would accept me if my sero-positive status is revealed to them. People say that having HIV/AIDS is a shame to the family as well as to the community. Stigmatisation and discrimination against the infected person by the community make me insecure.”

One respondent also remarked, “When my HIV-positive status was known to the public, one of my neighbours accused me of bringing shame to my locality.” It is learnt that the infected people, in order to avoid themselves from being put to shame and stigma, concealed their positive status. Studies also show that most individual afflicted with AIDS hide their condition not only to safe their image, but also to protect the family dignity from being tarnished. In other words, AIDS has brought about a double shame, a shame to the infected individual and a shame to the family. Steinberg rightly observed that beyond the morally induced shame, lack of control over bodily function is shameful for the AIDS patient and unpleasant for the career (Steinberg et al. 2002).

**Verbal Abuse:** More than sixteen respondents who were diagnosed with HIV-positive mentioned that they experienced verbal abuse from neighbours and other
members of the community. One respondent commented, “People verbally criticised my family for having this Maraikapai Kazat (incurable disease). But, why do blame my family being made a scapegoat because of me. As long as such negative verbal abuses continue to exist in our society, infected people will remain as secretive as ever. People living with AIDS will never open to the society”. One of the respondents also made similar comments, “I feel really bad when people call me cheap, as someone who has no morals. Being a HIV infected person, the community mistreated me.” A woman respondent also mentioned, “People said, I am immoral for contracting HIV/AIDS. They abuse me by calling names such as ‘AIDS’ woman’.

Another respondent mentioned, “My neighbours stigmatised me because they were scared of my sickness. When they knew my HIV sero-positive status, people mocked and scoffed at me. Insulting words are hard to take it. Sometimes, when I think of my difficult situation, I wish to die. For the sake of my children, I used to comfort myself.” On a similar line, one respondent mentioned, “I was called as an immoral woman by my neighbours for having HIV/AIDS disease. They ridiculed me, and even stopped their children from playing with my sons and daughters saying that we are a family of AIDS.” Similarly, another respondent lamented, “My villagers called me a dirty woman for having HIV/AIDS. They gossiped and hurled insult at me all the time. If you have AIDS, people would treat you as an underdog.” From these statements, it can be stated that respondents in the study were often being verbally abused and were imposed negative reaction for their illness. Words like immoral, sinful, dirty and bad were often used to describe the infected person. It may be pointed out that abuse, gossip and mockery are also types of stigma.
**Psychological Fear:** Psychological fear is connected with a traumatised mentality of an infected individual. In Tangkhul society, there is a need for psychological and social support from the community towards the infected people so that the latter could overcome the negative feeling or a sense of insecurity. Many respondents stated that gossip followed with rejection is their worst trauma that often hindered them from revealing their HIV status. The concept of psychological fear can be understood by studying few statements given by some PLWHA. One respondent mentioned, “I have never said to anyone that I am suffering from HIV/AIDS because if they come to know, they will ridicule me and may even hate me.” Another respondent also said, “I am afraid that others may find out that I am sick. Until today, none of my villagers knows that I have HIV/AIDS. I do not intend to let them know because if they find out, I may be rejected and maliciously ridiculed.” It may be generated that ignorance of the uninfected people coupled with their indifferent attitude prompted them to instill psychological fear among the infected people. Such fear makes the infected person to become more secretive and protective.

**Circle of Friends:** The perpetuating presence of the menace of social discrimination and stigmatisation against the infected person motivated them to associate only with the same group of people. They, therefore, develop a mentality of “infected friends only” group. The study found that 85% of the women respondents stated that infected people are not welcomed in any social activities organised by the uninfected people or by the society. As a result, they prefer associating only with their HIV/AIDS infected friends. Some reasons for the formation of such mentality can be understood by examining the following statements given by the respondents.
One of the respondents said, “In any festival or community programme of the village, we (infected people) prefer not to attend. People’s judgemental attitude is difficult to cope with. We are not welcomed. People always look for flaws when we are with them. Therefore, I love to tag along only with my HIV infected friends with whom I can share my hardships and problems.” Another respondent commented, “Mostly, HIV/AIDS people are considered as ‘dirty’ or ‘sinful’ or ‘immoral’ so it is obvious that we are not welcome in any kind of village activities. Therefore, we prefer to associate and mingle only with infected friends. Indeed, it is odd to sit together with uninfected friends.”

Another respondent mentioned, “Infected friends are my true friends. I feel good when I see that everyone in our group is still alive. In this group, we can freely talk, have fun and share our problems and do things together.” According to some, mingling with the same group of people boosts the confidence of the group members. For instance, one of the respondents stated, “Associating with my HIV/AIDS infected friends help me not to feel too isolated. In this group, I can freely chat with my fellow friends. This improves my level of confidence.” One of the respondents also said, “I feel good and happy when I meet other HIV infected friends. Coming to the group and seeing many others who have the same disease make me feel that I am not alone in this world.” The above opinions of the respondents suggest that due to poor acceptance of the infected people’s status by the community, people with HIV/AIDS tend to seek emotional support from their fellow infected friends.

**Unequal treatment between Rich and Poor Victims:** It is found in the study that those HIV-positive patients who belonged to rich family received a better health care and treatment in comparison to those HIV patients who belonged to poorer
section of the society. Many respondents stressed that financial status of the victims is one important determining factor that led to the discriminatory treatment against the poor people. One respondent narrated, “Our community respects only the rich. People did not talk much about them even if they are HIV/AIDS patients. Since they are wealthy, their status and reputation of their family are not affected much by their sickness. On the contrary, this sort of treatment is not given to the poor infected person. In fact, for the poor, everything is being ignored and denied.”

Another respondent also mentioned, “Poor people are easily stigmatised and discriminated. But the rich people who have high position and prestige because of their wealth are often exempted from community contempt and disrespect.” “HIV-positive people belonging to wealthy family are often given better care and treatment by the community”, added one respondent. Further, another respondent also asserted, “Nobody dares to speak ill of HIV/AIDS infected person belonging to richer section or influential section of the society. The degree of stigma and negative reaction they received is absolutely different from the reaction received by the poor infected patients.” From the above statements, it can be surmised that financial status determines one’s position in the society. It indicates that the widely dreaded AIDS disease is not so dreadful if the victim belongs to a rich family. In short, social acceptance of HIV/AIDS individuals are screened through the statuses they occupy in the community.

Unfair Distribution of NREGS ‘Job Card’: The National Rural Employment Guarantee Scheme (NREGS) has provided a unique opportunity to the poorer strata of the society to earn their own wages without any discrimination of caste, sex, religion or gender. For this to capitulate, a ‘job card’ has been issued to one member of every household. However, it is found that NREGS ‘job cards’ were distributed
unequally to PLWHA in the society. Some respondents strongly mentioned their deep resentment about the way NREGS ‘job cards’ are being distributed to people living with HIV/AIDS by their village authorities. A respondent pointed out that, “NREGS job cards are unfairly distributed to HIV/AIDS infected people in the village. While issuing ‘job card’, our village authorities favour the HIV/AIDS uninfected people. Even among the infected group, there is discrepancy in the distribution of job card. Some infected people have more than one job card in the name of ‘quota’, whereas, some of us were given not even a single job card.”

Similarly, a widow respondent narrated, “If you are from poor and HIV/AIDS patient, rejection is always expected even in NREGS ‘job card’ distribution. HIV-positive patients belonging to rich family have more than one ‘job card’; whereas, I did not get even one.” From this finding, it can be concluded that infected people belonging to poorer section of the society are highly deprived and discriminated. This reaffirms the fact that power or influence does play an important role in the implementation of the NREGS. In other words, the village authorities failed to implement the said scheme as per directives of the Government of India.

**Stereotyping HIV/AIDS Patients:** The study found that there is a tendency of stereotyping HIV/AIDS patients. There is a social construction that the infected people must have lived a promiscuous life. Such stereotyping is resulted mainly because in the Tangkhul community most people with HIV/AIDS acquired the disease through IDUs and sexual intercourse. In contradiction to the reality of HIV/AIDS, people do not think that HIV/AIDS could be contracted through other modes of transmission. When they see a HIV-positive person, they tend to view that the person must have infected through promiscuous behaviour. As a result, people often conceptualise AIDS as *Shuikhangarui Kazat* (sexually immoral disease). Many
infected respondents confirm such stereotyping constructed by the community against the AIDS patients.

According to one female respondent, “It is distressing when people say you are HIV-positive as a result of being promiscuous. In fact, I was infected by my husband.” Another respondent mentioned, “If you are HIV-positive people think that you are living a promiscuous life and therefore, we are stigmatised.” In support of these statements, a male respondent also stated, “Our societies have negative perceptions about me for having HIV/AIDS. They think that I am being punished for my promiscuous and immoral sexual behaviour. They consider me as someone sleeping around with many women. They also give terrible names for HIV/AIDS infected people.” Similarly, another respondent added, “People scoffed me and I was often called an ugly person. They ridiculed me because I have Shuikhangarui Kazat (sexually immoral disease).”

One widow respondent also mentioned, “Today I have AIDS disease in my body because of my husband who gave me this disease. But people viewed me as a sexually immoral woman (Shuikhangarui Shanao) living a promiscuous life.” The stigma and negative connotations often associated with promiscuity are a barrier to effective HIV prevention. Feinstein and Prentice (2000), state that such a barrier exists because people avoid seeking HIV prevention knowledge out of fear of being labelled promiscuous by others. This is largely because of the continued belief that HIV/AIDS is a disease that primarily affects promiscuous people. One respondent revealed that she overheard a discussion to segregate HIV infected people from the society in order to curbed promiscuity. Such attitude conforms to Parker’s idea of “spoilt identity”. Parker (2002) opines that most individuals with AIDS are faced with the unending task of dealing with a “spoilt identity” and negotiating it in the
interactions with others who may view their character and behaviour as immoral. Generally, people with AIDS are often perceived as being responsible for their infection and are sometimes seen as a threat to the uninfected ‘other’ and “the moral order of the world” (Turner 1984). In short, the Tangkhul society often segregate AIDS patients, considering them as unethical, unprincipled and morally wronged individual who deserve to be contempt and be discriminated.

**Discrimination based on Symptoms:** Even before the diagnosis of HIV, if somebody has symptoms like rashes, ugly wounds, scabies and others in their body. People usually assume that they must be suffering from AIDS. Skinny and sickly people are also look upon negatively. Some of the existential symptoms that lead to negative perceptions are described in the following lines. One respondent cited, “If you have rashes and scabies on your body or have a skinny looks, it is often assumed that you are HIV-positive. Therefore, people feel hesitant to touch anything that belongs to such person and they are often discriminated based on such symptoms.” Some of the respondents reported that their community mistreats them simply because they show some symptoms of unhealthy illness. One woman recounted, “People are reluctant to sit next to me in a Local Taxi because I have rash skin and skinny body.” “Because of HIV/AIDS, I have thin physical stature and pale looks and this puts off many people to mingle with me”, narrated one woman. Some respondents revealed that the community tolerates infected people whose bodies do not show unwanted symptoms. For instance, a male respondent reported, “If the status of your body deteriorates and shows some tangible symptoms of sickness, people will suspect that you are HIV-positive. Earlier, even though I am HIV infected person, I looked very healthy, so people did not mistreat me. But gradually
when I began to lose weight and have all those rashes on my body people began to consider me as having HIV/AIDS disease and stopped mingling with me."

Another respondent also narrated, “I have easily become a target for stigmatisation because I am skinny, and have rashes and wounds on my body. I have never disclosed my status to others. Yet, people suspect me as having HIV/AIDS disease because I have skinny figures, body wounds and rashes. Judging others by a mere physical appearance can be misleading because a person can be skinny due to malnutrition or malnourishment or because of suffering from other sickness.” All these incidents suggest that signs and symptoms of sickness manifested in the body can easily mislead one’s attitude, immediately prompting to suspect the particular person as HIV infected. In other words, unhealthy symptoms create a distinct social identity for that particular group of people and they are stigmatised based on this identity.

**Discrimination in Schools:** Various forms of discrimination are faced not only by the HIV-positive parents, but also by their children in schools. Children of infected parents are discriminated not only through words but also by showing bad attitudes and behaviours, such as not allowing their children to play with children of uninfected parents. Discrimination against the infected parent’s children can be understood by examining some responses given by the respondents. One mother shared, “My son often complained that some of their classmates were scared of him just because we have HIV/AIDS. I really feel bad that people had to stigmatise my son because of me.” Another respondent added, “Frequently, we heard some parents telling their sons and daughters not to mingle with HIV infected students in the school. They are also instructed not to eat or drink anything shared by our kids.” Another respondent also cited that the other students in the school rejected her son
just because he has infected parents. She narrated, “When people realised I am HIV-positive, they not only discriminated me but they also reproved my son. For instance, my son was playing with his friends but their parents intervened and took their children away from my son. They were told not to play with the infected kids. He was even insulted in school.”

**Isolation:** Isolation is an important strategy of PLWHA used in order to protect themselves from stigma and discrimination from the society. Social discrimination and contempt towards the infected people are very strong in Tangkhul society. As a result, often the infected people are depressed and even thought of committing suicide. For them, committing suicide is even more disgraceful because the Church would not officially conduct the funeral service and the dead body will be cremated in a separate burial ground. Thus, to shield themselves from the scorn of their community, the infected people often separate themselves physically or socially from other people. Most of them indicated that they would prefer not to go outside of their home in order to fight against stigmatisation. They revealed that community stigmatisation and discrimination are their bigger nightmare than the disease. On that account one respondent stated, “Villagers’ stigmatisation and discrimination would kill me first before the disease would kill me”. The study found that such view is very common among the HIV infected group of people. To counter the villagers’ contempt, they confine or isolate themselves which they regarded as a self-protective measure.

**Reaction towards Stigma and Discrimination:** It has been frequently emphasised that AIDS disease has acquired a strong stigmatising character because it is directly identified with human sexuality. AIDS is looked upon more negatively because of the common involvement of licentiousness and immorality, and also because it
directly go against social, cultural or religious taboo, which is often not the case with other chronic diseases. As noted by Ruffie and Sournia (1995), HIV/AIDS does not carry with it positive connotation of the kind that attached to tuberculosis or other diseases. The study found that there is a definite presence of stigma and discrimination relating to AIDS. However, reaction to such scornful prejudices differs between men and women. The fact of being male or female directly affects the infected person’s reaction to social prejudices in a patriarchal Tangkhul society. Unlike the female respondents, majority of the male respondents revealed that they are not bothered by the societal stigma and discrimination. They keep their positive status secret not because they fear the negative reactions of the society, but simply because they do not want to share it. Most of them expressed that even if people come to know about their HIV-positive status, they have no problem with that. Generally, they do not share their HIV status; therefore, people often did not know the disease they have in their body. Unlike men, women are more sensitive to people’s reaction. They are more vulnerable than men are. Women tend to complaint more than men on the negative reaction of the society. Such susceptible nature of women prompted to be more open towards their family, friends and community. It can be surmised that taking advantage of the tender and ‘fragile’ nature of the infected women, society also tends to discriminate and stigmatise them more.

According to Baleta (2003), community level stigma and discrimination can manifest as ostracism, rejection and verbal and physical abuse. In some cases, it even extended to murder. AIDS related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand (Ibid.). In Tangkhul context, although AIDS related murder has not been reported so far, yet it
is an inherent truth that infected people are meted with different treatment based on their sex.

**Stigma and Discrimination within the Family**

Generally, stigma is a feeling of disapproval that people have about particular illness or ways of behaving which lead to stigmatisation, i.e., to treat somebody in a way that makes them feel that they are very bad or unimportant. Discrimination on the other hand is the presence of treating somebody less fairly than others, often leading to stigmatisation. HIV infected people experience stigma and discrimination not only at the societal level, but also within the family. Usually, families are the primary caregivers when somebody falls ill. They play an important role in providing support and care for people living with HIV/AIDS. However, not all family responses are positive. Some family members who are supposed to take care of the infected person are sometimes the one who discriminate and stigmatise them. Such irresponsible attitude of the family members can isolate the infected person from their family. The indifferent outlook of the family is to protect their reputation in the community. Abandonment by the family is one of the most common forms of stigma and discrimination received by people living with HIV/AIDS. Within the family, as mentioned by many respondents, women experience the worst negative treatments from their in-laws in comparison to their other immediate family. It has been observed that the infected person often receive positive reactions from their immediate family.

**Ignorance as factor of Discrimination in the Family:** Most of the cases of family related discrimination against the infected member are due to the lack of knowledge and information about HIV/AIDS and its mode of transmission. In this regard, some
respondents stated, “At home there is the practice of stigmatisation, in the sense that family members do not want to share utensils and clothes with us. Our in-laws fear that we will infect them if we share crockery. Therefore, they isolate our goods from theirs.” Similarly, one respondent also said, “After I was infected I noticed strange things happening in my family. My brothers and sisters were not willing to touch anything such as cups, plates or clothes, which I have touched. So my things were segregated from theirs.”

One female respondent said, “Some of my husband’s family members showed that they did not want to eat the food I have prepared, fearing that they might be infected with HIV.” Another woman respondent also mentioned, “I am not allowed to cook food after I was diagnosed with HIV-positive because my mother-in-law was scared that she might get infected.” Another respondent also stated, “When I told my parents that I have been diagnosed with HIV/AIDS, my father yelled at me. He told me to take care of myself.”

**Shame for the Family:** As discussed earlier, shame is seen as a phenomenon with substantial social roots, functions, implications and effects. Shame always requires ‘the other’- an audience (Bartky 1990). Pattison (2000) asserts, “People induce shame it as a product of comparison with others, it affects the nature of relationships, and it can affect the whole nature of a group or society”. In the study, although majority of people has come to know about HIV and AIDS, there is still widespread belief that being infected with HIV/AIDS disease is a disgrace or shame for the family. People continue to consider HIV infection as an embarrassment for the family. Sensing the risk of tarnishing the family reputation, most infected people kept their HIV status secret, which did more harm than good.
One respondent mentioned, “My parents did not want me to tell my HIV-positive status to others. They say it is an embarrassment for the family.” Another respondent reported, “I am compelled to conceal my HIV-positive status from other people. My parents do not want others to know about my illness. So they insisted me to stay inside the house.” Similarly, another respondent said, “My parents called me “black sheep” for bringing shame to the family. Sometimes, they called me bad and disobedient son for bringing this disease into the family.” The above-mentioned statements reveal that there is a tendency among the family members of not disclosing the HIV status of the infected family member to others in order to avoid experiencing embarrassment from others.

Shame attached to HIV/AIDS in the family environment is a common occurrence. The study found that rejection suffered at home often lead to distress and insecurity of an infected individual. Often the status of family is considered more important than the individual’s health and emotional well-being. The development of such attitude may be because most people often fear to get the blame for contracting the disease, as HIV/AIDS is perceived as bringing shame to the family and the community as a whole (Augustson and Forsberg 2006). Despite this fact, the study also found that eventually all the family members accepted the infected individual back into their family after their parents allayed their fears about transmission.

**Positive role of the Family:** Chronic illness impacts not only on the individual but also on the family and forces several adjustments within the household. It is for this reason that the family unquestionably represents the first line of emotional and material support (Pierret 2003). Similarly, D’Cruz (2004) is of the opinion that study
on family care giving for AIDS sufferers in India shows that familial values underlie support and care given to an ill family member.

The primary sources of help for most infected individuals are financial and emotional support received from family members. Majority of the respondents reported their family as a source of an all round support. Responses of some respondents are mentioned in the following lines. One respondent mentioned, “My family members are very protective when they came to know about my suffering. They maintained confidentiality and supported me. They are my only source of care giver morally, physically and spiritually.”

Another respondent also expressed, “When I revealed my sero-positive status to my family members they were not angry. Instead, they consoled me by saying that there are many other people who are suffering from this disease. I was asked to be strong and not worry too much about my sickness. They provided me with good medication and food. They are my care giver.” One of the respondents also said, “My parents are very understanding and sympathetic about the sickness I have. They cared for me always. They are always there for me when I needed them.”

The above narrations indicate that in times of hardship, infected people need their family. Family members of the infected person often take the role of care-giver. Family ties “are instrumental in providing caregivers with the tenacity and grit to go on with their role in the face of acute burden” (WHO 2002). In essence, family obligation and emotional attachment compelled the family members to act as the primary source of help for AIDS patients.

Some respondents even explained that their sickness have brought the family more closely. The bond of the family became stronger when their status was diagnosed. For instance, one respondent explained, “After my status was being
diagnosed I was loved even more by my family members. I feel closer to my family than before. They never let me feel otherwise. I am their priority in the family. They never left me alone.” Similarly, one respondent also described, “When I became ill and my status was known to my family, I was showered with more love than I actually had before.” Other respondents also stated a similar opinion, “Everyone in my family knows about my sickness. All of them love me and did not hate me.”

One infected woman narrated, “My family members never turn their back on me. They treated me with love and care. I received all the love and support from my family. I have no problem in telling them that I am HIV-positive.” This confirms that family play a big role as primary care-givers to HIV/AIDS infected family members. The love and care showered by their family encourage them to view life more positively. It motivates them to recuperate from their sickly condition as fast as possible. This indicates that those victims who received family care and love could improve their situation even better than those who were disown and rejected by the family members. In fact, those who disclose their status feel less isolated in their experience with AIDS. Furthermore, it is found that closer bonds have evolved following disclosure for some HIV-positive individuals and their significant others (Cardo 1999; Steinberg 2002). However, we also cannot deny the fact that not all family responded positively. As pointed out earlier, HIV/AIDS-related stigma and discrimination are seen both within and outside the family space.

**Discrimination in Health Care Services**

The study found that even in the health care settings, PLWHA experience stigma and discrimination. The existence of stigma and discrimination within the provision of health care services has a negative impact on the health and well-being of HIV-
positive people. It heightens the negativity of the public against the infected people. Hammer (2008) rightly pointed out that the judgemental attitudes of health care workers contribute to stigmatisation and make it unlikely for patients to return for a follow-up. In the areas of the study, government hospital and community health care centre functions without sufficient doctors, nurses, incompetent medical staffs and inadequate facilities. Many responded that some of the available human resources, instead of taking care of the infected people, often mistreat and contempt the infected people. HIV-positive patients often received sub-standard care under the hands of the care-providers. Some of the negative services and treatment received by the infected people are illustrated below:

One respondent directly pointed out, “Some health staffs and nurses never listen to what we say. They behave unprofessional and were very rude to us. They often lose temper and displayed their anger on us. When we do not give proper response to what they say they easily get angry. It is really embarrassing.” Similarly, a woman respondent also said, “I do not like the attitude of some medical staffs, they are very rude. Each time I took an appointment with doctors for medical checkup, they would let me wait for hours and hours, and sometimes the entire day. Many of them are very irregular. Sometimes, they even send me back without any medication and without giving the appointment date.”

Another respondent mentioned, “We are often taught how HIV spreads and how it can be prevented, but sometimes health staffs and nurses behave just the opposite way. Because of my skinny looks and rashes on my body, they do not want to come near me. So what is the point of educating people about the ways of how HIV can be prevented.” The above statements indicate that the health care providers
do not walk the talk. As a result, it is seen by many that the staffs of the health care providers did stigmatise and discriminate the HIV infected people.

The study found that doctors and nurses deny some infected people for physical examination. They were often segregated from patients suffering from other diseases. In other words, the infected people did not receive equal service like the other patients. This often discouraged the infected people from seeking further assistance from the health care centres. One of the respondents expressed, “It hurts a lot when doctors and nurses just prescribe some medicines without examining my sickness”. Similarly, another respondent mentioned, “When I went to our health centre to meet the doctor, there was no physical examination. I was just given medication on the basis of what I told the doctor.” Apart from getting differentiated treatment in comparison with the other diseases, even within the AIDS infected people, those with unwanted physical symptoms are often subjected to more severe discrimination. In support of this view, one respondent added, “Nurses and medical staffs think that I deserve to be given different or improper treatment unlike the treatment given to other AIDS patients just because I got rashes on my body. Because of my skinny looks, they do not want to give me physical examination.”

**Discrepancy in availing Medical Care Facilities:** It has been observed that there is a huge gap of variance between the rural and the urban infected people while availing medical care facilities. For those living in rural areas, access to adequate medical care is practically non-existent or scanty available. According to the WHO (2006) report, there is a massive scarcity of medical personnel in most developing countries in addition to insufficient medical facilities, medication and other services. Such problem prevalent in developing countries is also found in a community like that of the Tangkhul society. Studies shows that PLWHA in this community need
efficient medical assistance, intervention from the health care providers and NGOs in order to do away the further spreading of HIV/AIDS. However, resources for treating the infected people are scarce with limited ART drugs. This problem is specifically damaging for those who live in villages with no proper health care facilities. Majority of the respondents gave a common opinion about their difficulties of getting transport expenses even to reach the health care clinic, which are often located in rural areas like Ukhrul town and Imphal city.

One respondent asserted, “Most of us (PLWHA) have many constraints in accessing health care services if we are to go to Ukhrul and Imphal. Financial constraint is the main problem for us. We have difficulty to pay transport fares and other related expenditures.” Similarly, another respondent also stated, “To avail ART and other treatments from Ukhrul district hospital is a big problem for me and others (PLWHA) especially when there is shortage of medicines. The journey and the costs of transportation are also not easy for us.”

The study found that there is frequent shortage of ART and other drugs required for treating AIDS disease in rural areas. This indicates that AIDS patients in the village encounter difficult situation not only because of social discrimination and stigma, but also because of the improper health care centres, wherein, most clinics in the villages are either defunct or exist only in name or they either function without adequate facilities. Many HIV/AIDS infected people in the Kamjong rural areas lamented that there is little hope for them to avail to right and timely treatment from the Community Health Centre. Therefore, they have to travel to Ukhrul for medications and for receiving ART, which is an expensive affair for many poor infected people. In many cases, due to acute financial constraints, many poor infected people refrain themselves from being treated.
The study also found that almost all the HIV-positive respondents have common resentment about the malfunctioning of CD-4 count test machine available in the Ukhrul District Hospital. Such malfunctioning causes a financial burden for many poor infected people, as they have to go to Imphal city to avail the basic treatment. As stated by one respondent, “I do not want to go to Ukhrul or Imphal for CD-4 count test or to get ART. We usually spend unnecessary expenditures for that. Sometimes the nurses and medical staffs did not understand our problem. We have to wait the entire day to meet the doctors or even go to the extent of wasting 2-3 days. Their services are below satisfactory.” Similarly, another respondent mentioned, “We wish there is an effective CD-4 count test functioning 24 hours both in Ukhrul District Hospital and Community Health Centre at Kamjong, for the interest of the HIV infected people. We want ART (Anti-Retroviral Therapy) to make available at anytime not only for HIV-positive people in the District Hospital at Ukhrul, but also in Kamjong as well.”

The given statements clearly reveal that all the respondents have common dissatisfaction over the malfunctioning of CD-4 count in the district. They are also dissatisfied with other available inadequate medical and health care facilities. One of their primary difficulties is the transportation fares. Because of the unavailability of adequate facilities in the village as well as in town and sub-town like Ukhrul and Kamjong, most of them have to travel to Imphal for medical treatment, which is more than 80 km way from the Ukhrul District headquarters. In short, the unavailability of adequate medical care facilities for the infected people worsened their social and economic predicaments, stigma and discrimination.
HIV/AIDS Parents fear and anxiety about their Children

Fear is one big issue for someone living with a chronic or serious illness, which often involves the emotional and physical pain in the dying process. Even though death has a definite character, in the sense that we all know that we will die, we may not know how much suffering our dying will impose both on ourselves and our loved ones (Riezler 1944). In the case of PLWHA, the fear of death is an addition to the fear related to AIDS stigma. Russell and Schneider (2000) opined that dying parents have fears beyond their impending death. Parent’s fear for the welfare of their children appears to be a common phenomenon among those infected with HIV/AIDS. They all narrated that they have fear of dying thinking about how their death would affect their children.

The study found that all the infected parents expressed anxiety about the fate of their children. They basically fear that their children may not receive the required support from their relatives. They also fear that their children may not be accepted by the society, and may perhaps be isolated since their parents were AIDS victims. They do not want social stigma and discrimination to pass on to their children’s generation. However, surprisingly, majority of the male respondents did not show much worry about the fate of their children. On the other hand, all the female respondents mentioned deep emotional concern for their children. Some of the opinions of the respondents are mentioned below:

One respondent mentioned, “Because of my sickness, I know I am dying very soon. The feeling of my children becoming orphan scares me and worries me more than anything else.” Similarly, another respondent reiterated, “My worry is that if I pass away, what will happen to my children? Who will take care of them? What would they be doing when they grow up? Such questions disturb me a lot.”
Another woman respondent also added, “Even if I am weak, somehow I can afford to send my children to schools and provide some of their needs. Seeing them growing every day, it makes me happy and worry as well. What will their future be after I die? Thinking of my children’s future, I do not want to die.” One of the female respondents also mentioned, “I cannot imagine my children’s future after I die. My in-laws have taken all my land and other properties after the death of my husband. I have nothing now. Who will support my son after I die?”

Some respondents also mentioned about the strained relationship that they have with their family members. Because of such unhealthy relation, they fear that their children will not be taken care. It can be concluded from the above statements that most parents dread dying thinking about the future of their children. Such fear may be largely because of the prevalence of social stigma and discrimination against the infected people, including condemnation from the immediate family members. It has been indicated by some that children affected by AIDS will often experience many negative changes in their lives and can start to suffer physical and emotional neglect, long before the death of the parent or caregiver (Germann 2004). Although, all children with infected parents need not necessarily inherit the disease, yet the chance of transmitting HIV is very high. Thus, the community also gives the children of the infected parents the same treatment. They are often subjected to public humiliation even before the demise of their infected parents. This indicates that their situation is unlikely to improve even after the demise of their parents. Most of the infected parents wish to live longer in order to care and support for their children’s education and other basic needs. Based on the finding of the study, the indifferent attitudes of the relatives make the life of the innocent children more vulnerable.
Role of NGOs and Government in abating the Danger of AIDS

There are numbers of NGOs in Ukhrul district actively engaging in HIV/AIDS prevention and treatment activities. These non-governmental organisations play a crucial role in the lives of people living with HIV/AIDS, especially for those poor infected people living in rural areas. Despite the fact that HIV cases are steadily rising in the district, the contributions and initiatives taken by various NGOs in combating HIV/AIDS problem cannot be sidelined. However, pro-activeness of NGOs varies between those funded internationally and those funded by the state government. MACS and NACO are the organisations that mostly funded sub-NGOs groups operating in Ukhrul. It has been observed that the performance of the state funded NGOs are very poor in the district. In fact, most NGOs perform only limited activities because of the problems associated with poor infrastructures and limited funding, and strictures of NACO rules among others. For instance, one staff of UNP+ mentioned, “Government poor funding is the main obstacle in our organisation to carry out effective works.” Coordinator of ISWAR also identified, “Funding is a major obstacle in HIV/AIDS prevention and treatment programme in the district.” The staffs of RRF also provided such views.

In the words of President of WHC, “We need sufficient fund to pay our staffs regularly and maintain our organisation properly so that our projects are carried out well. However, the state government is not responding well to our grievances.” In support of the statement, one MACS staff also added, “Our government is serious in funding only the valley based organisations. Hilly areas are mostly neglected without proper funds, staffs, doctors and infrastructure. As we can see, ninety percent of financial and other assistance are confined in Imphal and valley areas. And NACO guideline is also one major reason for little funds and for
not bringing the required changes and improvement.” The above statements show that Manipur state government has not done enough to support and understand the grievances of NGOs based in the hilly areas. Most of the government’s supports are confined with the valley areas inhabited by the Meitei ethnic group. It can be stated that there is a politicisation in fund distribution for the HIV/AIDS people in the state of Manipur. One of the demands of the hill people to the state government is to sanction enough fund in order to meet the needs of the infected people as well as for the NGOs to function smoothly and efficiently.

The study found that there is one NGO working effectively without any fund from the government and international agencies. This organisation is the Red Ribbon Forum, Kamjong. The organisation is also known as Self Counselling Cum Referring Centre. It is a non-profit centre run by an individual with the help of some likeminded people. The founder of this organisation (Phaoreingam Chithung) is the recipient of Bharat Excellence Award & North East Golden Personalities Award on 22nd July, 2011.

Despite, many grievances and limited resources receive from the state government; some NGOs constantly bestowed their support by educating the people about AIDS and providing counselling and other services to the infected people. Almost all the infected respondents in the study noted that they sought assistance from both the Government and NGOs. Surprisingly, effective governmental activities and contribution were hardly mentioned. They often accused of the state government for giving on a lip service to the HIV infected people of Ukhrul district. It has been reported that government’s commitment and politician’s promises remain unfulfilled, except ART, which is distributed without price. On the contrary, they highly praise NGOs for advocating to reduce public stigma and discrimination.
towards HIV/AIDS infected people, and promoting educational activities to prevent AIDS and for other assistance provided by them which are particularly helpful for those infected people living impoverished life. Educational and nutritional supports given by various NGOs in the past years are found to be highly acclaimed by the respondents. In this respect, NGOs like UNP+, CARE, CHAHA, ISWAR, RRF, Spring of Hope, World Vision and others are worth mentioning. Opinions of some respondents are mentioned below.

One respondent narrated, “I received dhal, rice, sugar and other foodstuffs from UNP+ and CHAHA. I wish they continue to help the down-trodden people like us.” Another respondent mentioned, “At the time of our sickness the World Vision, Ukhrul, have immensely helped us. The organisation gave us nutritional support. They provided dhal, oil, milk, groundnut, vitamins and even gave us financial assistance for medical treatment.”

One of the respondents also added, “ISWAR gave me counselling. It also provides me with vitamins and other assistance when I approached them.” Some respondents also thank MNP (now defunct) for providing rice, pulse, milk, oil, vitamins, exercise book, clothes and others. There are also respondents who appreciated the initiative taken by the Red Ribbon Forum for assisting the HIV positive victims nutritionally, financially and educationally. Many women respondents also thank CARE and other organisations for providing clothes, blanket and plate utensils to the HIV/AIDS infected families. Some respondents also mentioned the financial assistance and school fees paid by the UNP+, CHAHA and Spring of Hope. This shows that NGOs played a pivotal role in the lives of people living with HIV/AIDS and gave them extra support when they are in need. They expressed that the financial aid and other assistances provided by the NGOs enabled
them to meet pressing needs in their struggle for daily survival. On the contrary, the gratitude of the infected people towards the Manipur state government is not seen in the study.

In pertaining to medical care, governments in rich countries provide social grants to the chronically ill people. However, such kind of assistance to PLWHA and other chronically ill individuals is not found in Ukhrul district, Manipur. The state government’s assistance to improve the financial position and other related problems of the infected people are extremely limited or unavailable. The only available grant or assistance received is found to be NREGS, but the Central Government of India funded this scheme. For most infected people, NREGS was one of its main primary sources of income. NREGS wages have helped PLWHA to cope with their limited income and resources. Some opinions of the respondents are studied accordingly.

One respondent mentioned, “NREGS is the best scheme to alleviate poor people, especially for me and for other HIV-positive people. The wages received from this scheme is immensely helpful to meet our daily basic needs.” Another widow respondent also illustrated, “I am a farmer who works and sales vegetables to sustain my family but this has never been sufficient. The introduction of NREGS has helped me in paying my children’s school fees and it for buying foods for my family consumption.”

It is observable that since majority of the respondents are poor they could not save money received from NREGS but it definitely helped them in meeting the basic needs of the family. NREGS enabled them to think positively and gave them the hope to live. It is also found that their economic dependence on others has reduced considerably. However, the scheme is no longer in operation today.