CHAPTER 5

Conclusion, Recommendation & summary
CONCLUSION:

Since AIDS is closely associated with sexual intercourse, it is difficult to discuss openly and therefore misconceptions and rumours are likely to prevail. Jackson (1992:55) argued that “people are often more interested in discussing minor or unproven routes of HIV transmission than the main one”. Different sorts of misconceptions about HIV/AIDS came up in the discussions with street children of Anand City.

The participants agreed that HIV and AIDS were just two different ways of calling the same disease. Misinformation and mis-education is one of the roots of the misunderstanding of the disease, and their inability to distinguish between being infected with HIV and developing AIDS can be attributed to a consistent failure of public information campaigns and other commercials to distinguish between an HIV infection and AIDS. Some of them also claimed to have been told by health educators that HIV could be contracted by eating a chicken that had swallowed a condom used by an HIV positive person. Further, another street child claimed that “he learned it is not AIDS itself that eventually kills those who contracted it, rather a poison of some kind that AIDS produces in the body. Further, the informants associated AIDS with bodily appearance, such that healthy looking persons were thought to be HIV negative. They strongly believed that people with AIDS are supposed to show symptoms such as weight loss.
sparse or balding hair, coughing, lesions on the lips and the like. One informant said I have seen one girl teaching in the church as an HIV positive person. I felt I myself had the virus too when I saw her because she did not look any different from any healthy girl and I was very shocked. A large number of mundane activities were also considered to have infective potential. The informants thought that one could get the virus from the food if infected maids accidentally cut a finger and blood spilled onto food. Some even wanted to know if they could get the virus from local beer known as tella if they by chance drink from the same glass used by an infected person with chapped lips. The informants also expressed serious misconceptions related to sexually transmitted diseases (STDs) other than HIV/AIDS. When asked to name STDs, one of the informants named several (gonorrhoea, LGV, and chanchroid) and invited others to add to the list if they knew more. No additions were made. He then proceeded to tell how he got gonorrhoea when he was 16 years old. He said that STDs result from poor vaginal hygiene, and develop in women who do not wash their vagina properly. There was a general consensus that STDs develop in women as a result of poor vaginal hygiene. One informant was of the opinion that STDs cannot be transmitted from the male to the female since, as he put it 'the company' has its base in the vagina. Getnet Tadele (2006).
When the street children were asked what their problems were, it is dismayingly noted that no spontaneous mention was made of AIDS. It appeared that they already have so many other worries and have nothing to look forward to due to poverty. This sharply contrasts with young people attending school who were very quick to bring up the issue of HIV/AIDS as a burning concern without it being hinted at by the facilitator.

Furthermore, street children are not well informed about all aspects of HIV/AIDS transmission and prevention. Even those few who showed some understanding and awareness of the ways in which they can minimize their own risks of infection, their comprehension is still laced with confusion and misconceptions. It also appeared that the level of knowledge about HIV/AIDS among street children in Anand is very low as compared to those attending schools in the same town.

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RECOMMENDATION:

There are success stories for effective prevention and control of HIV infection among CSW as experienced in sex worker intervention programme at Sonagachi, Calcutta where condom use has increased from 0% in 1992 to more than 70% in 1993-94 and sustained over more than 70% till 1998. The VDRL positively has also reduced from more than 20% in 1992 to 5% in 1998. These interventions have been able to prevent the HIV infection from spreading among CSW as evident from HIV prevalence data from 1992 to 1998, which suggest that the infection is still below 5% among CSW in 1998. The Sonagachi experience has provided an opportunity to learn that prevention works in the highest risk groups of population provided effective intervention programmes are implemented with high coverage of risk group population.

Elements of Strategy:

♦ Provide access to information, education and awareness (within the cultural context) necessary to develop life skills required to adopt safe behaviour to reduce vulnerability to HIV infection among young people;

♦ Support youth organizations & structures and enhance their communicational, networking, planning, management,
organizational, MIS, operational research and implementation skills for a broad based sustainable social movement to fight the epidemic;

- Empower youth to become peer educators, assume local community leadership and act as catalytic agents to help others to prevent HIV infection;

- Build capacities of youth to advocate and mobilize community, political leadership and service providers support to fight stigma, discrimination and denial and provide support and care to people living with AIDS.

- Promote young peoples’ including PLWA participation and partnership in the strategic planning exercises, programming process and implementation of activities so as to ensure a true expanding national response to HIV & AIDS;

- Mobilize and sensitize parents, teachers, policy-makers, media, political leadership and religious organizations to exhibit commitment and willingness, influence public opinion and policies with regard to HIV & AIDS prevention and young people;
♦ Access to sexual and reproductive health, HIV/STIs prevention counseling and youth friendly services including confidential voluntary counseling and testing of HIV and referral services.

♦ Introduce and or improve the quality and coverage of school, college and university programmes and extra curricular activities that include HIV & AIDS education and information.

♦ Sex education is essential for these children.

♦ Certain traditional and cultural practices e.g. marriage practices, sexual practices, women status, at to the risk of HIV infection.

♦ Risk taking behaviour and attitude towards sex are the essential factors while studying the concept likes HIV, it is suggested for the research in this area and these two variables should be taken into account.

♦ The role of counseling should be taken independently as a single part of the research.

♦ The role of nutrition intervention is also an important area to be discovered in relation to HIV and AIDS. There are several examples wherein people living with HIV and AIDS have very
successfully prolonged incubation with correct nutrition including vitamin and other supplement.

♦ Research is also needed with stress level of the individual. Modern day stress depresses the immune system. Stress has emerged as a killer like diseases.

♦ The present sample of research is a small. Such study should be taken on a large sample. The duration of the counselling and family therapy should be increased to at least one year.

♦ Train counselor and clinical psychologist are required for counselling as well as family therapy respectively.

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SUMMARY:

Parents and Caretaker who persistently criticize, shame, rebuke, threaten, ridicule, humiliate and put down a child, who induces fear and anxiety in a youngster, and who are never satisfied with the child's behaviour and performance, are emotionally abusive and cruel. Equally, those who distance themselves from the child – by ignoring signals of distress, pleas for help, attention, comfort reassurance, encouragement and acceptance, are abusive. Their behaviour towards the child can be described as overtly abusive, actively painful and developmentally and cognitively damaging. A negatively charged interaction between a child and its Caretaker can induce pain, anxiety, confusion, and cognitive distortion and therefore, can be described as emotionally harmful.

Emotional abuse and neglect affect children in many different ways and to varying degrees: some children are shy, nervous anxious, unsure of themselves, lacking self-confidence and self-esteem, while others are developmentally and educationally retarded or present severe behavioural and emotional problems such as destructiveness, self-harming behaviour, fire setting, bed wetting, soiling and running away from home.

All these above problems lead to sexual abuse behaviour. Most definitions of child sexual abuse do not specify the nature of the sexually abusive acts, but these may range from exhibitionism and fondling to
forced penetrative acts. Sexually abusive includes sexual intercourse, oral and anal sex, fondling of breasts and genitals. Apart from this other behaviour like, exhibitionism, exposure to pornography and solicitation to engage in sexual activity also included in sexually abusive behaviour. Identification of sexual abuse is not easy, as many of signs and particularly the behavioural signs, are associated with the child under emotional stress, and do not necessarily indicate in isolation that child is sexually abused or has been abused in the past. However, awareness of these indicators will enable the social worker to consider sexual abuse as a possibility sudden change of behaviour, which excludes other possibilities of emotional stress, may indicate sexual abuse.

In the early 1980s reports from the Centres for Disease Control (CDC) first described Acquired Immune Deficiency Syndrome (AIDS), an acute illness in gay men that was usually fatal (CDC, 1981). In 1983 an infections agent, the Human Immunodeficiency Virus (HIV) was identified as the causes of AIDS. Since then world – wide, more than 7 million people have been diagnosed with AIDS, 4.5 million have died from HIV associated conditions, and probably around 21 million have been infected with HIV Hedge & Glover (1995). The most frequent route of HIV transmission is through sexual practices such as penetrative sex between men, or between men and women.
In the present study, an attempt was made regarding HIV prevention among street children in which independent variable is manipulated with the help of selection process. In the present research work, counselling and family therapy is a set of independent variable, whereas the level of behavioural signs, parental abusive behaviour and child's reactive and proactive behaviour was taken as set of dependent variable.

To control the sequence relevant variables, all the tests were administered in same sequence to all the subjects. To maintain the homogeneity of the sample, the street children were taken from Railway Station, Bus Stations and street areas of Anand City. Only rag-pickers were selected for the present study as street children.

The following tests were used for the present investigation:
1. Signs of Child’s Possible Sexual Abuse (Behavioural Signs) – by Kelly et al. (1991)  
2. Parental Abusive Behaviour (by Iwaniec, 1995)  

In the present investigation, with the help of randomized sampling technique, 200 street children were selected irrespective to the sex. Their age range was 9 years to 18 years. All of them are belonging to the similar kind of family system i.e. the joint family system and were living by and large in similar condition.
In the first session of pre-test counselling and family therapy, the following points are considered: explain what the test means and what it does not tell; alert to possible ramifications of a positive test result; assess personal risk; discuss the advantages and disadvantages of knowing HIV status; develop coping strategies; identify social support; who to tell and why to be circumspect; educate in safer sex and safer injection practices; explain confidentiality of test result. After pre-test counselling and family therapy, in the second session of post-test counselling, the following points are considered: focus on the reason for the session; give clear, simple, unambiguous information; clarify the meaning of an HIV positive test; expect emotional reactions: shock, denial, anxiety, anger; address individual's immediate concerns; identify and address issues of immediate importance, e.g. who to and who not to tell; who to use for support; safer sex and injecting practices; provide a lifeline, e.g. 24-hours helpline telephone number and written information about HIV, giving details of services available; give a further appointment within a few days.

Table 1 highlights the Mean, SD and 't' value between the two Means for before and after sessions of Behavioural Signs Scale. In before session, the Mean is reported at 65.93, whereas for after session, the Mean is 61.31. The significant difference between the two Means is ('t' = 4.66, p < .01). It reveals that counselling and family therapy works to reduce the behaviour problems like difficulties in trusting adults and fear of a
particular individual, poor relationships, running away from home, sudden changes in behaviour and school problem including truancy, delinquency, inability to concentrate or sudden drop in school performance. Apart from this the level of the problems like poor self-image and low self-esteem, isolation/withdrawal, self-destructive tendencies including suicidal attempts, self-mutilation and drug/alcohol abuse are also reduced. Aggressive behaviour including hostility, irritability and defiance of authority is also reduced remarkably after the counselling and family therapy session.

Table also represents reduction in the level of certain physical and medical symptoms like sleeplessness, nightmares, fear of the dark, anorexia nervosa, eating disorders, recurring urinary track problems, vaginal infections and vague pains and aches.

Table 2 indicates parental abusive behaviour before and after introduction of counselling and family therapy sessions. It represents a Mean of 54.5 for before parental abusive behaviour and a Mean of 49.88 after parental abusive behaviour. The significant difference between the two Means is also reported significant at .01 level (t = 3.96). It can be said that a remarkable change is noticed after the sessions of counselling and family therapy. The attitude like participation of the child in the family circle, ignorance of him, not allowed him to take an active part in the
family affairs, persistently deprived of privileges and treats as means of discipline. It was also reported that these street children faced frequent punishment, criticism, no praise at all, no reinforced and acknowledged for positive behaviour, always put down in front of peers and siblings before the application of sessions of counselling and family therapy. Improvement was observed after these sessions and change in the attitude of the parents towards the child is shown. Socialization of the child started in various ways, permitted to show the emotions, realistic developmental expectations, proper supervision and guidance is given; allow taking part in the family affairs as an important member of the family. All these represent a change in the attitude of the parents towards the child after the counselling session.

Table 3 highlights the characteristics of reactive and proactive behaviour for before and after session. After introduction of the family therapy and counselling sessions, improvement of behaviour characteristics like playing freely, laughing, running, talking freely, comfort, cuddling up to parents, response to the affectional feelings of the parents, participation in the game activities with other children, fearless when approached by the parents or corrected.

Table 14 & 15 reveal the correlation matrix between Behavioural Signs and Parental Abusive Behaviour \( r = .221, p < .05 \) \( r = .344, p < \)
.01) respectively. It also highlight the relationship between Behavioural Signs and Reactive Proactive Behaviour \( (r = .284, p < .01) \) \( (r = .059, p > .05) \) respectively. In the last part of the tables, correlations between Parental Abusive Behaviour and Reactive Proactive Behaviour are not reported significant. It highlights that the characteristics like difficulties in trusting adults and fear of a particular individual, poor relationships, running away from home, sudden changes in behaviour and school problem including truancy, delinquency, inability to concentrate or sudden drop in school performance are related to the characteristics like participation of the child in the family circle, ignorance of him, not allowed him to take an active part in the family affairs, persistently deprived of privileges and treats as means of discipline. It was also reported that these street children faced frequent punishment, criticism, no praise at all, no reinforced and acknowledged for positive behaviour, always put down in front of peers and siblings before the application of sessions of counselling and family therapy. Improvement was observed after these sessions and change in the attitude of the parents towards the child is shown. Socialization of the child started in various ways, permitted to show the emotions, realistic developmental expectations, proper supervision and guidance is given; allow taking part in the family affairs as an important member of the family.

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