CHAPTER-V

PROBLEMS OF PEOPLE LIVING WITH HIV/AIDS

When researcher mean the problems faced by the People Living with HIV/AIDS (PLWHAs), it does not mean it is only faced by them it also means the problems faced by HIV/AIDS infected and HIV/AIDS affected family members and the general population irrespective of age, sex, caste and occupation. However, the problems discussed here are faced more by PLWHAs. Though the problems are named by different names they are interrelated and interdependent. The present chapter analyzes the Problems of People Living with HIV/AIDS such as social-cultural, economic, religious, Physical, and psychological are in general and health problems in particular. Stigma and discrimination, care-givers, health care services and treatment seeking behaviour are also discussed. In this process, it has brought out the symptoms of different ill-health conditions and the pattern of treatment seeking behaviour, within the broad framework of the culture of the study area and in VCTCs has been carried out.

HISTORY OF THE DISEASE SPREAD:

While HIV/AIDS came much later to Chimmapur, there is no evidence of the first HIV/AIDS case registered. People of Chimmapur said during the years 1995-2000 the disease was para-mounted and which resulted in loss of many lives. It is spreading rapidly and the epidemic is in a fairly advanced stage in high risk groups as well as in general population. According to the available data, the estimated number of people living with HIV/AIDS in the village is about 150 to 200. However, people of Chimmapur acknowledged that about 2.29 per cent of the total population is infected by HIV/AIDS.
However, many people living with HIV infection do not even know that they are carrying AIDS virus within their bodies. And even when they know, since they are devoid of symptoms they feel safe like an ostrich hiding its neck under the sand. For most of its duration, HIV infection remains silent and it becomes symptomatic at its later stages. The time between contracting HIV and developing AIDS is for the most part characterized by an absence of serious illness.

It is generally believed that the virus first affected people with high-risk behaviour or whose work put them at risk of HIV, such as Commercial Sex Workers and their clients, migrant labourers. These were people who are traditionally marginalised because of their social or economic and religious status of due to lack of access to information and health services. The virus then spread to the general population through sexual contact with HIV-infected individuals, transfusion of contaminated blood or transmission from infected mother to her offspring.

As one of the Respondents says—

“It is mainly spread by Devadasi women who are taken up dhande (prostitution) and migrated to cities like Miraj, Sangli, Pune, Mumbai and later came here and spread to those who have visited them”.

The Simple Random Selection (SRS) Technique is used to select the patients. Initially, data on the People Living with HIV/AIDS is collected by cross checking the people who are falling ill for long course, health conditions in Chimmapur. Given the complexities associated with inquiries on stigmatizing illnesses, difficulty in identifying and retaining participants was conventional. The researcher, therefore, simultaneously contacted NGOs and VCTCs working in the study area. In keeping with ethical guidelines in HIV/AIDS-related research, the researcher did not approached some of the possible participants directly. The staff of the organisation and counsellors
introduced the intent of, and explained the purpose of the research to people (either seropositive individuals or their caregivers) accessing services from them. Interviews are made with prior consent of people living with HIV/AIDS.

**SOCIO-CULTURAL PROBLEMS:**

The society under study is basically an agrarian society. It is a society which is based on agricultural produced marketing system and agricultural production has depended on nature for rainfall and ecological conditions and to a very less extent on the artificial setting of man. This has given a way to depend on nature and giving way to religion and cosmic world. This dependence on religion has led to imbalance and division in society as per the dominant people in the society. This is in turn has led to gender disparity and division of occupation. The women are less respected in the society they are less paid, and are favoured for unclean duties which has led to *Devadasi* system. Devadasi system is an age-old custom practiced by the Madiga community in which a girl is devoted to goddess *Renuka* or *Yallamma* and later she pushed into sacred prostitution and the greatly to the spread of disease.

On the other hand the occupational division has led to one of the cause for poverty in the society. The poverty has made the young people to migrate near by cities in search of livelihood. This has given a way for women to have extra-marital relations and also the men migrated for cities to earn high wages keep on practicing sexual activity with commercial sex workers during their stay at cities. Hence most of the youths migrate to Goa for construction work and in ship building companies some of them even migrated to Sangli, Sollapur, Pune, Bombay cities for construction and industrial works. Some youth’s under the influence of alcohol and city life-style make quarrels with their family members and left the village.
STORY: This is the story of Parsu (27) who decides to become independent from his family has migrated and returned with ill-health condition.

He expressed, "When I was twenty-two, it was an Ugadi Festival and I was heavily drunk, started to administer some discipline about money share.... My brother was angry with my behaviour and started beating me on this issue..... That day itself I left the home straight away and migrated to Bombay I served in many jobs i.e., 'goundi' construction labourer, in a cloth center, as a supplier in a hotel....whatever I earned I invested it on alcohol and visited commercial sex worker. I was ....... I didn't go back for years.......

ECONOMIC PROBLEMS:

It is found from the study that most of the People Living with HIV/AIDS are from low income groups. As poverty has made the people depend on the haves for their daily livelihood. Opportunity of getting employment from haves has also led to sexual exchange in favour of financial exchange. Lack, of education and adequate economic resource and dependence of the poor on the rich in general and the women dependent on the male in particular has given way for HIV/AIDS. On the other hand People Living with HIV/AIDS have migrated to distant places to earn money at their working places which added further infections.

In Chimmapur the disease is mainly affecting people in the sexually active age group. A majority of the patients (12 %) are in the age group of 15-44 years, there by making considerable economic impact.

Most of the People Living with HIV/AIDS are belonging to lower economic group. Most of them living under below poverty line are put in problem to earn their daily breads, in such a situation they are not able to afford the treatment. In such cases even there is no financial assistance from the government or any agencies for good quality treatment. This has lead to sever financial crisis into the families affected by HIV/AIDS. It is also found in
the Chimmapur that there are families especially poor and marginalized who become poorer, once a family member developed AIDS. Almost all the family members reduced their daily food intake, most of the families income and savings is using for medical costs of the individuals. Nine families have even sold their property- lands, animal or vehicle, some of them pulled their children out of school, college to help at home and borrowed money to pay for the medical costs and help maintain household needs.

*I really have no alternatives... living longer means taking those expensive medicines, but where is the money for that? The doctor says I need 500 rupees medicines per week to the treatment, so it is out of the question when I earns only 200 per week and I lost everything because of misdeeds, now in this situation who can helps me (Parappa, 29).*

The impact of the epidemic has been documented to be most significant at the family and community level, especially in poor and marginalized groups. The financial problem is the major impact experiencing by the families who are having HIV/AIDS infected person/s. Poor families become poorer and lower middle-income households become poor.

**PSYCHOLOGICAL PROBLEMS:**

Most common problem of PLWHA is stress. Being tested HIV positive is in itself a major stressful and painful event to the individuals who are living with HIV/AIDS. Above all stress is because death is certain, distrustful, because of stigma attached to HIV/AIDS disease. It is believed that people will think that the people get infected disease because of sexual promiscuity. In Indian traditional society the sex is taboo this is the main reason for the stress. Stress is varies in caste, sex, age and economic group. Among the rich family people do not want to disclose their status because of their prestige and when they not disclose the loneliness became more. Due to this loneliness the stress extends to their family members. Where as in the age group between 20- 35 the stress is more whereas the traditional families gives more importance to the marriage
of their children. The stress more found among the male because in traditional society male is authoritative and responsible for all activities compared to the female and he should look after all the matters of the family and community affairs. The stress is not more among female because female believed that the disease has come from her husband and she has to welcome. Whereas, in newly married couple a women has more stress as she happens to be the first in the family to undergo HIV test because she under goes regular anti-natal check-up. She is neglected by her husband when her HIV status disclosed as her husband and conjugal family members suspect her to be having pre-marital sexual relations.

*Laxmi* (32) a married and having girl child is found HIV positive when she undergone routine anti-natal checkups. Later her husband also under-gone HIV test in a private clinic where he found negative. Realizing his status as negative he suspected his wife and revealed the situation all the family members in turn started beating and abusing about her character made to leave her conjugal family. Later in search of her parents, she went to her natal family where she was denied for giving shelter. Meanwhile, her husband started searching for a new bride of which was known to *Laxmi* and she revolted against the act of her husband but nobody in the situation to listen her.

*One care giver explained* - they were deeply distressed by prospect of the losing of family members. A respond heightened in the most of the cases in the study area. And this status is known to family members and also to some members of the society. For the parents who are infected the pain and stress is reasoned of out living their off-spring was very palpable. In the normal course of life parents always think about their children what could I have done for them and parents who are thinking about their infected child that I could not even imagine that my child could get this disease and he will not going before me – it is against the nature, against my dreams and against everything. I was so upset and disturbed which I heard about my child's this (HIV positive status)........... *Savakka*, care giving mother.
STIGMA, DENIAL AND DISCRIMINATION:

The most tragic face of HIV/AIDS is that of stigmatization and discrimination posing threat to human rights. This has also started in our country leading some individuals even to commit suicide.

The stigma and discrimination is found in the all age group, caste and sex and varies among themselves. Once economic and castes status has role in stigmatizing an individual. As HIV/AIDS is non-accepted disease, it has been stigmatized and discriminated compared to other diseases, because this is a disease which is acquired through sexual relations. And having premarital and extramarital relations are taboo in the Chimmapur. The stigmatized not only a single individual problem but also a family, community and a society at large. The stigma attached to this disease has also made the individual to think twice before getting tested. The discrimination starts from individuals mind and then moves to his peer group, and later family level and to the community level. This makes individual delay in, to get testing. Social relations of the People Living with HIV/AIDS depends upon the extent of discrimination the society practices. Discrimination in the community has let to suicide, divorce, broken families, breaks down of cordial relation and individual plight. On the other hand those who have not infected HIV/AIDS get greater awareness about consequences of the disease which leads to safer sexual practice. The sudden change of sexual practice (use of condoms) in the family leads to the doubt on spouse. If a woman/man asks to use a condom as a means of self-protection, he/she may think she/he is suggesting that she/he has AIDS. This in turn leads to further discrimination among them, which may leads to extra marital relation among spouse to satisfy their sexual desire.

HEALTH PROBLEMS:

Most people seem to know when they are healthy and when they are not, but there is no universal definition of health. The World Health Organization
(WHO) defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Still today this definition is accepted by social thinkers, physicians and philosophers of all over the world.

Health is cherished as a highly valued resource and a goal that every human being aspires for in order to perform his role effectively and efficiently in the society. Health care is the primary necessity of every society and is directly linked with the health of the people. Development of people depends on the good health of the people and it is a new challenge on which further development depends, because healthy socially aware people are nation’s most important assets. Therefore, the system by which people generally get the medical facilities becomes very important.

In 1978, at a landmark WHO-sponsored conference in Alma Ata, an international declaration that promised ‘Health for All’ was adopted. It was strategy of integrated health and medical care for the ‘need bases’ countries, including India, that were signatories to the declaration. The Anti Retroviral Treatment (ART) by the year 2005- popularly referred to as the ‘3 by 5 initiative’ which was launched by WHO and Joint United Nations Programmed on HIV/AIDS (UNAIDS) in 2003, was certainly failed in its objective to provide antiretroviral therapy to three millions in the year 2005.

Goel S.L. 2004 in his book “Health Care Policies and Programmes” said, “The concern for better public health care is universal. At the G-8 summit in Japan (July 2000) major powers pledged to improve health care system of the developing, under-developed and poor countries. The leaders vowed to reduce by the year 2010 the number of HIV-infected people by 25 percent, tuberculosis deaths by 50 percent; the burden of disease associated with malaria is by 50 percent. AIDS is expected to live 44 million orphans in the next decade. The goal is to encourage initiatives to manage properly, the public health care system and to solve the myriad problems.
Table No.5

Distribution of HIV cases by Age

(Total No. of Respondents=18)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Age Group (in years)</th>
<th>Gender</th>
<th>Total No. of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>0-4</td>
<td>-</td>
<td>1</td>
<td>5.55</td>
</tr>
<tr>
<td>2</td>
<td>5-9</td>
<td>1</td>
<td>-</td>
<td>5.55</td>
</tr>
<tr>
<td>3</td>
<td>10-14</td>
<td>-</td>
<td>-</td>
<td>0.00</td>
</tr>
<tr>
<td>4</td>
<td>15-19</td>
<td>-</td>
<td>1</td>
<td>5.55</td>
</tr>
<tr>
<td>5</td>
<td>20-24</td>
<td>2</td>
<td>1</td>
<td>16.66</td>
</tr>
<tr>
<td>6</td>
<td>25-29</td>
<td>3</td>
<td>0</td>
<td>16.66</td>
</tr>
<tr>
<td>7</td>
<td>30-34</td>
<td>-</td>
<td>1</td>
<td>5.55</td>
</tr>
<tr>
<td>8</td>
<td>35-39</td>
<td>1</td>
<td>2</td>
<td>16.66</td>
</tr>
<tr>
<td>9</td>
<td>40-44</td>
<td>1</td>
<td>1</td>
<td>5.55</td>
</tr>
<tr>
<td>10</td>
<td>45-49</td>
<td>2</td>
<td>-</td>
<td>11.11</td>
</tr>
<tr>
<td>11</td>
<td>50-54</td>
<td>1</td>
<td>-</td>
<td>5.55</td>
</tr>
<tr>
<td>12</td>
<td>55-59</td>
<td>1</td>
<td>-</td>
<td>5.55</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>11</td>
<td>7</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The table No.5 and Figure No.13 gives a closer look to the age-group of People Living with HIV/AIDS in Chimmapur. Generally, the table reveals that the disease has reached all the ages in Chimmapur. Out of total 18 cases 11 were male and 07 female. They mainly fall in the age ranged from 04-59 years. Among the 18 cases 12 were married, 5 were unmarried and one is widower. The majority of the cases 10 (55.55 %) were between the ages of 20 and 39 years. Among these, 6 were married men and 4 were married women.

In the age groups of 20-24, 25-29 and 35-39 each category 3 cases (total 9 cases) and two men fall in the age-group of 45-49. Two children fall in the age-group of 0-4 and 5-9 years. In the age-groups of 15-19, 30-34, 40-44, 50-
54 and 55-59 each one case is identified. However, no cases were fall in the age-group of 10-14.

Table No. 5.1
Distribution of HIV cases by Caste
(Total No. of Respondents=18)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Caste</th>
<th>Gender</th>
<th>Total No. of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Jadar</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Jangam</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Jain</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>Ganiger</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Madar</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Muslim</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Maratha</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>Holer</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Panchamsali</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>Sadar</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>11</td>
<td>7</td>
<td>18</td>
</tr>
</tbody>
</table>

In Chimmapur, Lingayats are the dominant caste. They dominate in every walks of life compared to the other caste-groups. Here the majority of the cases are belonged to Lingayats which includes castes (Panchamsaleru, Jadaru, Jangamaru, Ganigeru, and Sadaru) Jadar 2 cases, Jangam, Ganiger, Panchamsali and Sadar caste having 1 cases each, Madar caste cases were 4 (22.22 %) out of which 2 are male and 2 are females. Muslim cases are 3 (16.16%), followed by Holer and Jain, People Living with HIV/AIDS consisting 1 (5.55 %) equal number of cases are caste are 3(7.14 %)
Table No. 5.2
Distribution of HIV cases by Education Status
(Total No. of Respondents=18)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Education</th>
<th>Total No. of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Illiterate</td>
<td>04</td>
<td>22.22</td>
</tr>
<tr>
<td>2</td>
<td>Primary</td>
<td>05</td>
<td>27.77</td>
</tr>
<tr>
<td>3</td>
<td>S.S.L.C./HSC</td>
<td>06</td>
<td>33.33</td>
</tr>
<tr>
<td>4</td>
<td>College and above</td>
<td>01</td>
<td>05.55</td>
</tr>
<tr>
<td>5</td>
<td>Others (non-school going children)</td>
<td>02</td>
<td>11.11</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The above table shows the educational status of the People Living with HIV/AIDS in the Chimmapur. Most of the respondents 12 (66.65%) were educated and 4 (22.22%) respondents were illiterates and they come from the lower strata of the society. Among educated respondents 5 (27.77%) were studied upto primary level, 06 (33.33%) respondents have studied up to S.S.L.C i.e. 10th class. One respondent has studied upto 10+2 level (P.U.C II). Among illiterates two children (11.11%) are below the age of 6 years and have still not attened the age of schooling. The knowledge and awareness about HIV/AIDS is high among both the educated and non-educated (except children). But the level of awareness and mis-information varies among the educated and non-educated one. However, most of the People Living with HIV/AIDS expressed a great deal of knowledge of HIV/AIDS/STIs, modes of its transmission, modes of prevention including safe sexual practices and the early symptoms, etc., Most of them are taking medicines for their current illnesses and are getting regular health check-ups and counselling from various sources. At the same time some of them expressed fear and anxiety about their health conditions and the later phase of their life.
In Chimmapur and many other neighbouring resources are poor setting, few of these specialized facilities are available for diagnosing opportunistic illnesses. Clinicians have little training in diagnosing or managing complex opportunistic illnesses (OIs) and laboratory back-up is either nonexistent or so expensive that is unaffordable for most of the patients.

As most late-stage AIDS patients in Chimmapur seek medical care for fever, diarrhoea, persistent cough, skin diseases mainly of (Herpis zoster) and lymphadenopathy (lymph nodes that are abnormal in size, consistency, or number) without knowing they have HIV/AIDS, it is likely that OIs will not be suspected, diagnosed, or treated. This situation is of particular concern with regard to tuberculosis. Dr. Mokashi (a private Doctor in Chimmapur) says the most common presenting condition for tuberculosis among their patients with HIV/AIDS (diagnosed by him) is weight loss. Since the tuberculosis programme in India focuses on identifying patients with chronic productive cough, attending clinicians often fail to suspect tuberculosis.

An additional problem in diagnosis is that as the immune system count declines, people with active tuberculosis are less likely to produce positive sputum smears than people without HIV/AIDS.

The availability of ART in Karnataka Institute of Medical Sciences, (KIMS) Hubli hospital has contributed most to the decline in Opportunistic Illnesses and increase in survival of people infected with HIV/AIDS who are accessing ART treatment. As (Maruti; 36) one of the patients reveals the medicines (ART) given in Hubli are effective, which has reduced the incidence of some of his Opportunistic Illnesses (diarrhoea and persistent cough) by restoring the immune system and obviating the need for continuing primary and secondary chemo- prophylaxis, with their inherent problem adherence, cost, and toxicity. He also admitted that the only problem he is now facing is about the affordability, and accessibility of these medicines. He admits that the
medicine is availing only in KIMS hospital in Hubli and the distance is far from Chimmapur.

HIV/AIDS is a predominantly sexually transmitted and incurable disease tends to attract terrible stigma and discriminations against those who are infected; several international medical and human rights conventions have been formulated precisely in relations to this disease. These stipulate that every HIV-test must be carried out with the full consent and knowledge of the person, accompanied by counselling and maintenance of confidentiality. Before the test, the person must receive ‘pre-test counselling’ this includes complete information bout the nature of the disease including factors in his/her own life that might have caused exposure to the infection, the nature of the test itself, and the implications if the test result is positive, negative or indeterminate. The person is then offered the choice of under going the test; this is known as ‘informed consent’. If the person tests positive, he/she must mandatorily be offered ‘post-test counselling’ that maintains the ‘confidentiality’ of the person’s positive status. Post-test counselling is meant to help the person come to terms with the diagnosis, learn how to make responsible changes in lifestyle and how to take care of himself/herself, particularly in terms of nutrition and treatment for opportunistic infections.

The uniqueness of the HIV virus is that it attacks the immune system itself, making the body steadily incapable of fighting common infections. In course of time the person becomes ‘immune-deficient’ and susceptible to what are called ‘opportunistic infections’, well known communicable illnesses such as tuberculosis, bacterial pneumonia, herpes zoster, mouth ulcers, skin diseases, etc., which take on particularly stubborn form in positive patients and require aggressive treatment. These infections are curable if attended to promptly and by doctors skilled in treating these infections in HIV positive patients (‘HIV management’). Prompt treatment combined with good nutrition,
regular exercise and a positive mental outlook can keep and HIV positive person looking and feeling normal and healthy and leading an active and useful life just like anyone else. However, the person continues to remain highly infectious and can transmit the virus, through sexual intercourse where condoms are not used, or if he/she donates blood that goes untested, or shares unsterilised needles if he/she is an intravenous drug user or has a child if the person is a pregnant woman.

**PHYSICAL PROBLEMS:**

The People Living with HIV/AIDS (PLWHAs) as went on passing from the HIV stage to AIDS were found less active to work, more sprain and strain, loss of strength was felt by them when they compared themselves with their past days. The amount of loss of energy varied exclusive from age; the youths did not feel much loss of strength when compared to children, and aged above 50 years old. The strength among PLWHAs varied depending on occupation and body built-up of an individual. Men those work hard in fields daily had more strength in the AIDS stage than non-workers and less physical working men in Chimmapur. The practice of occupation and conformity of strength also depended on the financial position of the family.

The major physical problems found among the People Living with HIV/AIDS are persistent dry and wet cough, intermittent fever, diarrhoea, vomiting, headache, stress, tuberculosis, sprain in muscles, stomach pain, weight loss, indigestion, STIs (including small boils, urethral discharge, lower abdominal pain joint pain, and difficulty in walking, unable to stand long on his legs for long hours, uneasy to walk high lands.

The impact and magnitude of the HIV/AIDS related illnesses and diseases were observed and interviews and case-studies were conducted among the People Living with HIV/AIDS.
Diarrhoea:

Persistent Diarrhoea is a common occurrence among the people who are living in the stage of the AIDS disease, which is found among the people of Chimmapur who are living with HIV/AIDS. When a person has diarrhoea the food passes through the gut so quickly that it is not properly digested and fewer nutrients are absorbed. Out of eighteen PLWHAs in Chimmapur 06 (4 male and 2 female) were having irregular diarrhoea and five are suffering from chronic diarrhoea for the last one month.

Fever:

Most of the People Living with HIV/AIDS has fear about HIV/AIDS and these are frequently suffering from fever. Parappa who is very much afraid about his ill-health conditions now he has fever every evening. He feels uncomfortable and unhealthy by closing of the day and opening to the night. These fevers are found lasting for a month some times one and half month. During fever the individual consumes very less food, he gets sweating too.

Cough:

Dry cough is found among most of the People Living with HIV/AIDS. However, among two cases persistent cough was observed, this problem lead to the chest pain and even headache among the infected people in Chimmapur. However, people are taking treatment for this ill-health condition but this cannot be under control. As one of the infected individual reported that for this condition I have visited many hospitals and spent heavy amount on medicines and tablets to overcome the dry cough thinking that this cough will end my life.

Vomiting:

Weakness in the body and loneliness leads to very less consumption of food which gives the feeling of vomiting sensation. The food that is taken in is
sometimes put out by vomiting due to lack of digestive power. In some of the cases vomiting is persistently found among People Living with HIV/AIDS. Sometimes leading to blood mixed vomiting. This has lead very less hopes to the lives of the HIV/AIDS infected people.

**Stress and Headache:**

Living with HIV/AIDS means suffering with acute mental stress which affects on other health conditions/s. Most of the people living with HIV/AIDS (13) think that it is a long-term disease and it’s ultimately ends in death. Hence, the stress also build-up as the symptoms or the OIs affects individuals. Among the 18 PLWHAs 12 have stress also mentioned headache is also the common problems they are having. Due to the stress burden to the people who are suffering from the current ill-health condition/s the stress is mounting on them this in turn brings severe headache. Most of the family members were also deeply distressed by prospect of the losing of family member/s.

**Depression:**

Depression among PLWHAs is increasing due to increased standard of living making difficult to access treatment depression has also increased because of feeling of infected to HIV which has stigma attached to it. Depression is also because of the disease where there is no cure for it. Depression has also to lead to increase in extent of problem because of mental state of mind in a un-peaceful manner.

**Anger:**

It is certain that when an individual is psychologically disturbed it is likely that he/she gets anger for small and big things/reasons. Anger has led to disintegration of family member of PLWHAs. The care giver cares less in case of angry mood and nature of care receiver. Anger has also given space for unwanted things among PLWHAs such as indigestion, unpeacefulness, breaking of close relations.
Digestion Problem:

This problem is also found common among the People Living with HIV/AIDS. Due to their lack of immune system the digestive capacity of the individual is affected. Out of the total eighteen People Living with HIV/AIDS were found among them one of their health problem. In Chimmapur people who are living with HIV/AIDS are often do not eating enough since

- The illness and the medicines taken for it may reduce the hunger, alter the taste of food and prevent the body from absorbing it;
- Symptoms such as a sore mouth, nausea and vomiting make it difficult to eat and
- Tiredness, loneliness and despair reduce the appetite and the motivation to make an effort to prepare food and eat regularly.

Weight Loss:

When a person does not eat ample due to nausea and vomiting or reduced appetite and distaste or the food eaten is poorly absorbed, the body draws on its reserve stores of energy from body fat and protein from muscle. As a result, the person loses weight because body weight and muscles are lost. Parappa, Khaji-Miya and Paravva’s weight is decreasing day by day. As Parappa and Khaji-Miya mentioned about 20-22 Kilo-grams of their weight is decreased within 5-6 months. If a person loses weight, he or she needs to take action to increase weight to the normal level.

Back Pain:

Due to loss of immune system the bones are left with no strength and as a result one finds back pain. As back bone is important part for an individual to walk or sit, it is the severe problem found among the PLWHAs. Back pain has led to severe physical problem creating mental problem and dependant on others for his/her movement.
Stomach Pain:
Most of the people living with HIV/AIDS especially those are suffering from frequent diarrhoea and vomiting are having stomach pain. To this they are taking treatment from local doctors and even some are visited Miraj and some are to district level hospitals. Due to sever pain in stomach most of them are consuming less quantity of food at the same time the body weight is decreasing.

Sexual Adjustment Problems:
Sexual adjustment of partners depends up on faith and closeness of individuals of opposite as well as of same sex. Adjustment for sex has change right from the time of discloser of HIV status. The partner soon after knowing his partner is HIV+ve has tried to avoid even sex with his/her partner, in case of educated individuals' unsafe sexual practices. But in the moderate and religious minded PLWHAs has left the consequences to the God about the HIV status and have entered in to unsafe sexual practices. This belief has increased the viral load in either sex partner and has resulted in early deaths of PLWHAs. In educated and high income group family the awareness of HIV status has made them to be sexually active with others (extra) than on spouses because of less sexual adjustment among spouses.

Problem of discloser of once HIV status:
To disclose the HIV status to the spouse has found the greatest problem. It is thought by PLWHAs that disclosure could bring down the status in the husband's or wife's eyes respectively. It was also found that in cases where status was disclosed family has opposed a strong opposition towards husband and wife because of illicit relations. When one thinks of AIDS in the community they automatically come to the sexually transmission mode rather than other modes of transmission where sexual relation with multiple partners
is illegal. In few of the cases the status was disclosed but was within the spouse and in later stage of AIDS it was identified and understood by family members and the members interaction with the spouse made them to reveal the status of PLWHAs. Disclose in the family has also brought down status of the family in the entire community. A single person’s infection with HIV has brought decline in day-to-day activities relations as well as the status. In cases of the adult girl who are to be given after marriage has led down the affinal ties to be carried out due to disclosure. This has given hindrance in getting a good spouse by marriage.

NUTRITIONAL PROBLEMS:

Nutrition plays a significant role in helping immune system work well of people living with HIV/AIDS (PLWHAs) along with the presence and increase use of Anti-Retroviral Treatment (ART). People living with HIV/AIDS have to maintain energy and nutritional level. So that they have to eat more to meet the extra energy to prevent from HIV/AIDS related illnesses and onset of AIDS.

Nutritious food intake is normally very low in rural scenario than compared to urban and in particular among the low-level income group people living with HIV/AIDS, because of less income and low standard of living beings. The government nutritional programme has given very less nutritional support to these community groups. People living with HIV/AIDS in Chimmapur are facing malnutrition due to so many factors like poverty, migration, alcoholism, poor health practices, stress and lack of nutritional knowledge and guidelines etc.

When infected with the HIV virus, the body’s defense system- the immune system- works harder to fight infection. This increases energy and nutrient requirements. Further infection and fever also increase the body’s demand for food. Food is often cited by People Living with HIV/AIDS and people affected by HIV/AIDS as their greatest and most urgent need. Yet food
has been forgotten in the standard treatment. Care and support of HIV/AIDS, Mr. Jackson pointed out, nutrition interventions for HIV programmes are often overlooked in the international HIV policy debate and they remain critically under-funded.

The World Food Programme estimates that approximately one million of the 6.4 million people who will be enrolled in antiretroviral programmes in 2008 will need some kind of nutritional support.

Poor nutritional heightens individual susceptibility to HIV-related infections while food insecurity makes it more likely that individuals adopt risky lifestyles that increase their vulnerability to being exposed to virus. If infections occur, integrated nutrition, food security and HIV/AIDS interventions can promote positive living and prolong the asymptomatic period of relative health. When AIDS develops, nutrition and food security become important partners on treatment, Mr. Jackson said.

**Economic burden and the nutritional consumption:**

In Chimmapur during the years 1998-2002 most of the families who lost their family member or even a family member developed AIDS, more than half of the household reduced their food intake, almost all their savings for treatment and also the families who are having positive people have sold their property such as land, animals or vehicles most of the family members borrowed money from their relatives or landlords to pay for the medical costs and help maintain household needs it is not stopped here only. Even they pulled their children out of schools and colleges to help at home and go out for labour work.

Malnutrition among people living with HIV/AIDS generally was correlated with the ratio of household income to the cost of calories in the diet.
Table No. 5.3

Distribution of Respondents by household income

(Total No. of Respondents=18)

<table>
<thead>
<tr>
<th>SL. No.</th>
<th>Monthly House-hold Family Income (in Thousands)</th>
<th>Total No. of PLWHAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Within 1,000</td>
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<tr>
<td>2</td>
<td>1,000-2,000</td>
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<td>2,000-3,000</td>
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<td>4</td>
<td>3,000-4,000</td>
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<tr>
<td>5</td>
<td>4,000-5,000</td>
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<td>6</td>
<td>5,000-6,000</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>6,000 and above</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>18</td>
</tr>
</tbody>
</table>

The household income of the people living with HIV/AIDS was also collected to know their economic conditions. Most of the respondents were belonged to low economic groups. However, only two individual were doing business and get over Rs. 5,000/- per month. The economic consequences of the house-holds who are having people living with HIV/AIDS are more complicated. To get timely medicines most of the families had taken lend money from the landlords of the village. Due to low income of the house-hold most of them have also lost their land and house-hold amenities. This in return has made severe impact on the nutritional intake of the people living with HIV/AIDS and the AIDS affected family members. Hence most of them reduced their food intake.

For parental caregivers, the pain of outliving their offspring was very palpable as one of the care-giving mother expressed....

She (daughter) Paravva 29-years-old had been falling ill for a long while...... off and on, she would fall ill, get well. I didn’t think much of it at that time...... when days passed as part of the normal course of things. When heard of this devasted and deadly disease, which contract by involving in this kind (Sex work) of activities but she is not like that and how could it? I am very serious about her.
Why god has given us this type of punishment/problem. I am alone looking her but I'll save her at any cost........ (46-years-old Savakka, a care giving mother)

Paravva (29-years) who has been ill for several months with diarrhoea and persistent cough. She has been tested previously and infected with HIV. Previously she has been hospitalized in Jamkhandi, Government Hospital and their to Miraj hospital. By investing heavy amount she is saved from the death. Savakka is trying hard to save her from the clutches of death she even visited many places to find solution for this deadly disease. The advice of one health care personnel that an infected individual who maintains her health can live for 10-20 years. But, Savakka is deeply distressed by the prospect of loosing her daughter, a respond heightened in most cases by the development stage of the care-receiver. The perception here was that the care receiver was too young to die.

Parappa (29) has been unwell for several months with diarrhoea and cough. He has been tested previously and infected with HIV. However, other than diarrhoea and cough his only other complaint is that he always feels tired sprain and unwell. So knowing there is lack of Health care facilities he moves to Miraj in Maharashtra state.

Khaji Miya (32-year-old) a garage mechanic who is a married and has two children is ill, suffering from chronic diarrhoea and fever for the last two month and persistent vomitting for the last 15-20 days. He also had tested HIV-positive and has Sexually Transmitted Inflections (STI's).

I feel so bad that abba - ammi (father and mother) has to do so much for me in their old age. They have so many health problems of their own my father has joint leg pains and it's giving lot of pain he has difficult in moving in and around.

Well, he (husband) was falling ill off and on for quite some time- that time, I just thought it would pass-off and I would do whatever was required- like what one does normally when a family member is ill. But, when I got to know about this AIDS illness and that it had no cure, and then I knew that it was different.......It was so painful that I was so disturbed and could not think straight for a few weeks after knowing about his disease. It was like I had to not just see to his needs and medicines, but I had to help him to live so that my children could have a full life (Rukhsana, care-giving wife of Khaji Miya).
CARE AND SUPPORT:

Sweet are the uses of adversity, which like the toad ugly venomous, wears yet precious jewel in his head Shakespeare in his “As You Like It”.

People Living with HIV/AIDS need basic care from their family members. Especially spousal care. Which is broadly depends on the structure of the family, the emotional content of the family relationships, the family’s economic conditions and above all the family member’s knowledge and perceptions about the disease and the characteristics of the person living with HIV/AIDS. Care and support depends upon care givers support that is his financial support his mental status and relationship in the community and family to prolonging life of their loved one. Care givers relation with the care receiver depends upon the formers age and sex. The women care givers are the best care givers and care receivers have emotional attachment especially in case of women care givers. Generally it is the duty of women to give care and support to the entire family but in the present study care receivers are children, women and adult men. Care receptor’s support and care in the family depends upon his relation with the family members, economic status that is if the care receiver is an earning member support to him from the family members will be favourable. On the other hand in case care receptor is a non-earning member caring will not be that effective. In the Chimmapur village the support comes from the informal relation, family ties, kin and kith and friends. There is no any formal institution or government agency to give care and support for the People Living with HIV/AIDS. Except NGO’S care and support for the People Living with HIV/AIDS. It is also found that the high caste communities like Lingayat, Jains have no time to support and care People Living with HIV/AIDS due to their busy schedule and less interaction among themselves. In case maid servant cares and support, even her care support depends on how well she is paid and respect. The case in communities such as low caste is
different, there will be very less financial support even then good emotional, sentimental, psychological motivation and support to the People Living with HIV/AIDS is given. The main reason for this is low literacy rate of women and marital ties within the kin groups.

RELIGION:

Religion plays a dominant role in supporting People Living with HIV/AIDS by giving spiritual, moral and emotional support which also motivate individuals to maintain his mental balance by involving or praying once own religious gods and goddess. Religions also maintain charities, schools, hospitals and NGO to support and care. In Chimmapur most of the People Living with HIV/AIDS belongs to Lingayat caste they worship Lord Prabhudevaru and Basaveswara they believe that the religious power will help them in diminishing once psychological imbalance and maintain good health. Most of the patients lying on the bed were praying to their gods and deities. Even HIV/AIDS affected families perform various dharmika karyagalu ritual ceremonies for the well being of their family member. The relatives come to see the patients they bring vibuti (a limestone powder cake) which is sacred for Lingayats. It is believed that applying the vibuti on forehead of the infective cures the disease.

The Muslims brings Angaar (of various Gods) to apply and keep under the bed of the infective. It is also put on the mouth of the infective; it is believed that it fight against the disease and improves health condition of the infective and stabilize the mental imbalance.

Whereas, the Madiga and Holer castes visit sacred place of Renuka or Yellaman gudda and take religious bath to purify their sin and also to purify the disease. In Chimmapur those who were infected by HIV and which kept secret among themselves were devote to Moorumukhadamma deity. They also perform dandavata (prostrate) to the deity. It is believed that the person is
severely ill because deity is anger on him, so in order to get person well deity is requested by sacrificing goat and materialization of various kinds to the deity. On various occasions they observe fast and pooja’s to the deity especially on Wednesday.

**Affordability of Health Care Services:**

In 1980, no one had heard of HIV/AIDS. Now, 25 years later more than 20 million people are dead and 37.8 million people worldwide are living with HIV. Today, more than one in 200 of all adults living on the earth are already infected. HIV is spreading twice as fast across the world today, as five years ago. Every 6 seconds a new person gets infected! It seems incredible, yet it is happening. World-wide large number of people are still suffering and dying because of HIV/AIDS related common conditions, such as diarrhoea, tuberculosis, pneumonia, fever, persistent cough and vomiting etc. Most of these common illnesses and viral infections are easily preventable and are curable in the initial stages at a relatively small cost.

To pay for private health care in most individuals and families rely on savings some times most of the families are in financial burden due to increased cost of medicines and facilities they cannot afford such treatment services to individuals suffering from HIV–related illness or full blown AIDS infective.

With the advent of HIV/AIDS epidemic large number of people are still suffering and dying on account of HIV-related illnesses. Such as diarrhoea, pneumonia, tuberculosis, fever and persistent cough and vomiting etc., Most of these common illnesses and viral infections are easily preventable and are curable in the initial stages at a relatively small cost. However, the village health care services are found suffering from a variety of limitations and shortcomings. These include – lack of HIV/AIDS knowledge to doctors and paramedical staff, unsatisfactory supply and maintenance of equipments, adequate and timely supply of drug and no supply of anti-retroviral medicines at the PHCs and poor supply and maintenance of vehicles. Thus, the existing village health infrastructure touched only the fringe of the village health needs.
Treatment Seeking Behaviour of People Living With HIV/AIDS

- Home Remedy
  - Natural Remedy
  - Supernatural Remedy
- Supernatural Harake (Vow)
- Modern Treatment
  - Indigenous medical Practitioners
### Table No. 5.4
#### Distribution of HIV Cases by Health Problems

<table>
<thead>
<tr>
<th>SL. No.</th>
<th>Age-wise</th>
<th>Cough</th>
<th>Fever</th>
<th>Diarrhoea</th>
<th>Vomiting</th>
<th>Headache</th>
<th>Stress</th>
<th>Tuberculosis</th>
<th>Muscle Pain</th>
<th>Stomach Pain</th>
<th>Weight Loss</th>
<th>Digestion</th>
<th>Sexually Transmitted Infections (STIs)</th>
<th>Skin Diseases</th>
<th>Eye</th>
<th>Backbone Pain</th>
<th>Physical wounds</th>
<th>Total No. of Respondents</th>
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<td>09</td>
<td>05</td>
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<td>18</td>
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</tbody>
</table>

| %       | 61.11 % | 66.66% | 50.00 % | 27.77 % | 55.55 % | 66.66 % | 22.22% | 61.11% | 60.00 % | 61.11% | 38.88% | 50.00% | 55.55% | 22.22% | 44.44% | 33.33 % | 100.00% |

Table No. 5.4
Distribution of HIV Cases by Health Problems
Table No. 5.5  
Distribution of HIV/AIDS Cases by Sex, Age, History of Risk and Reason for Test

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Gender/sex</th>
<th>Age (in years)</th>
<th>History of RISK</th>
<th>Reason for HIV test</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>22</td>
<td>Sex partners other than wife</td>
<td>Doctor advice Blood impure</td>
</tr>
<tr>
<td>2</td>
<td>Male</td>
<td>24</td>
<td>Visited CSW</td>
<td>weakness</td>
</tr>
<tr>
<td>3</td>
<td>Male</td>
<td>25</td>
<td>Visited CSW having Non paid Partners</td>
<td>Stomach Pain, weakness</td>
</tr>
<tr>
<td>4</td>
<td>Male</td>
<td>38</td>
<td>High risk Sexual contacts</td>
<td>At the time of Donating Blood found positive</td>
</tr>
<tr>
<td>5</td>
<td>Female</td>
<td>35</td>
<td>Infected by husband</td>
<td>Referral, Husband found HIV+ve,</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>32</td>
<td>Single partner</td>
<td>weakness</td>
</tr>
<tr>
<td>7</td>
<td>Male</td>
<td>27</td>
<td>Sex partner in neighbour</td>
<td>History of risk</td>
</tr>
<tr>
<td>8</td>
<td>Male</td>
<td>26</td>
<td>High risk sexual contacts</td>
<td>Operation</td>
</tr>
<tr>
<td>9</td>
<td>Female</td>
<td>21</td>
<td>Multi partners</td>
<td>Regular illnesses-fever weakness</td>
</tr>
<tr>
<td>10</td>
<td>Female</td>
<td>43</td>
<td>Multi partners</td>
<td>Regular illnesses Doctor advice</td>
</tr>
<tr>
<td>11</td>
<td>Male</td>
<td>5</td>
<td>Child of infected individual</td>
<td>Diarrhoea, Doctor, VCTC</td>
</tr>
<tr>
<td>12</td>
<td>Female</td>
<td>18</td>
<td>CSW- Multi partner sexual, irregular condom use</td>
<td>Diagnosed STI, Fever, cough, local Doctor + NGO advice</td>
</tr>
<tr>
<td>13</td>
<td>Female</td>
<td>4</td>
<td>Child of infected parents</td>
<td>Doctor advice/weakness</td>
</tr>
<tr>
<td>14</td>
<td>Male</td>
<td>47</td>
<td>High risk sexual contacts, Sex part</td>
<td>Regular illnesses weakness</td>
</tr>
<tr>
<td>15</td>
<td>Male</td>
<td>49</td>
<td>Commercial Sex Visits part</td>
<td>Self Motivated</td>
</tr>
<tr>
<td>16</td>
<td>Male</td>
<td>53</td>
<td>High risk Sexual contacts, STI</td>
<td>Doctor Advice</td>
</tr>
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<td>Male</td>
<td>56</td>
<td>Not known</td>
<td>Diarrhoea, Fever, Weakness, TB</td>
</tr>
<tr>
<td>18</td>
<td>Female</td>
<td>38</td>
<td>Single partner</td>
<td>Stomach Pain</td>
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</table>
WOMEN AND ACCEES TO CARE:

Getting timely health care for people with HIV/AIDS has been a problem particularly to women. Women are more likely than men in the community to be poor, uninsured, or underinsured. Women expressed that lack of money is the largest obstacle to seeking medical care. Poverty is a major correlate in adequate access to health care and it is associated with the acquisition of many chronic diseases and illnesses including HIV AND STI’s. Women who are poor are most likely to be at risk of HIV infection and least likely to have access to health care once infected.

Now, as the HIV/AIDS epidemic expands, women who are infected face another set of challenges. Access to medical care in general, and HIV-related care specifically, is likely to be difficult for women in rural area because of geographical scarcity of services (Lambrew, J.M, Ricketts, and T.C.1993. Patterns of obstetrical care in single-hospital, rural counties. Medical Care, 31.822-833.).

Women with low social status and economic dependence may be sexually exploited and unable to negotiate safer sexual practices. This makes them vulnerable to HIV infection.

Treatment Seeking Behaviour of People Living With HIV/AIDS

Community care and support:

The People Living with HIV/AIDS are needed community care and support to lead normal life without stigma and discrimination and in time of health crisis they need special care and support.

It is observed that People Living with HIV/AIDS are facing stigma and discrimination by the community at micro level and society at macro level.

Today’s need is to set-up community health centers (CHC) to provide community based care and support to the affected one.

“To survive or not to survive from AIDS the answer squarely lie in the society”.
CHAPTER VI

THE ROLE OF NON-GOVERNMENTAL ORGANIZATIONS AND COMMUNITY RESPONSE TO HIV/AIDS

In this chapter researcher has attempted to know the role of Non-Governmental Organizations (NGOs) in implementing the project on prevention of HIV/AIDS and community response to HIV/AIDS in the study area Chimmapur. NGOs on particularly on preventing HIV/AIDS guidance and high risk behaviour, guidance communication/counselling to the target population and act lesion between community people and government. The main source of information on condom for safe sex practices was the goal of NGO campaigns, intervention programmes and the community participation and response to HIV/AIDS are discussed in this chapter in right context and time.

The HIV/AIDS epidemic in India today is beyond the range of any previous epidemic and has reached the general population irrespective of age, sex, caste and religion. Urgent action is called by government and Non-Governmental Organizations (NGOs) to HIV/AIDS awareness and control in time. Traditionally, NGOs have relied on support from government, development assistant groups and other donor agencies. With the magnitude of the AIDS epidemic, there is an urgent need to go beyond traditional partnerships and venture into new ones. Now, most of the work regarding AIDS is being undertaken by the NGOs, CBOs and self help groups and that too the ones that are already committed to the underprivileged.

The role of non-government organizations in the fight against HIV/AIDS has been recognized worldwide. Yet many NGOs may lack the resources needed to undertake prevention and care programmes that could last impact for sustainability and prevention of HIV/AIDS.
Non-Governmental Organizations are people centered and can maintain an on-going relationship with the community over and long period of time. This leads to effective programming as NGO's respond quickly, effectively and sensitively to the needs of the people. On the other hand, the government provides the basic backbone to carry out such programmes; it provides leadership and a policy framework. Co-ordination of National Level plans is essential to the proper functioning and effectiveness of NGO working. All sections of the society need to come together, mobilize resources in the challenge of AIDS (Shalina Mehta and S. K. Sodhi 2004).

Non-governmental organizations (NGOs) - organizations that are voluntarily set up by individuals to perform self-help or socially useful roles - provide critical support to those vulnerable to themselves, develop a sense of community and re-position themselves in relation to the rest of society. They work to prevent the spread of the virus through opening up channels for communication of protective information and awareness of rights among these groups. They make available treatment and care facilities to those who are already infected, in the process conferring on them social value, and advocate their cause among the mainstream medical profession. They work to bring about legal reform so that the civil rights of marginal groups and of affected and infected people are protected under the Constitution. The advocacy on the human rights of all vulnerable groups to be treated as citizens and not criminals, including the right to affordable medicines and treatment especially when they are sick. They seek to bring all these local issues on to national agendas, and help stimulate regional and national networks in the common cause. They work with similar groups based in other countries on common international platforms. The right to health security of all citizens has become a major advocacy issue it is to be provided, thanks to the stimulus provided by the HIV/AIDS epidemic.
Hear an attempt has been made to bring to light the work done by the NGOs in the field of HIV/AIDS in ‘Chimmapur’ village. All NGOs have track record of over a half decade of dealing with an ever-expanding array of concerns in relation to HIV/AIDS epidemic in Chimmapur.

The Karnataka State AIDS cell i.e. Karnataka AIDS Prevention Society (KSAPS) and Some NGOs have already been working with so called Devadasi traditional (sex workers) populations before the advent of the HIV/AIDS epidemic. For example, the Devadasi Vimochan Samsthe was engaged in programmes for the abolition of Devadasi System for the development and welfare of these groups in the study area. But it’s least concerned with the improvement of health conditions of these groups and the practice of Devadasi custom and the people who are indulging in sacred prostitution.

**Description of NGO’s:**

The four NGO’s surveyed are working on HIV/AIDS education and almost all provide awareness, counselling services, care and support to the people of Chimmapur village.
Table No.6
NGOs and Type of Programmes

Total No. of NGO’s= 4

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Name of NGO</th>
<th>PROGRAMMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ICHAP</td>
<td>Situational Assessment Study, Building partnership with the community and organizing Community Meetings, community need assessment, Building Local Leadership and support. Establishment of VCTC's.</td>
</tr>
<tr>
<td></td>
<td>India-Canada Collaborative HIV/AIDS Project, Bagalkot.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CHAITANYA</td>
<td>IEC, Positive Networking (women) Care and support, STI Clinics, CSW's meetings,</td>
</tr>
<tr>
<td></td>
<td>AIDS Tadegattuva Mahila Sangha, Mudhol.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>UJWALA-</td>
<td>One-to-one BCC IEC Flip chart, Handbill and Broucher Distribution, Condom Demonstration &amp; Distribution, STI Clinic Camp, STI Referrals, Community Meetings, VCTC Referrals &amp; Follow up, Games (Ruby cube Demonstration), Street-Plays, Folk-shows, Village Health Committees (VHCs) and training programmes.</td>
</tr>
<tr>
<td></td>
<td>UJWALA-ICHAP Bagalkot Demonstration project, Jamkhandi</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>JEEVAN JYOTI</td>
<td>Care and Support, STI Clinics, referral to Anti-retroviral Treatment</td>
</tr>
<tr>
<td></td>
<td>(Bagalkot network of PLWHAs), Bagalkot</td>
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</tbody>
</table>

About ICHAP:

ICHAP– INDIA-CANADA collaborative HIV/AIDS intervention project:

Coordinate HIV/AIDS response through capacity building and awareness is a project under formulation, with two nations (India and Canada), NACO and state cells agencies. The purpose is “To reduce vulnerabilities and increase capacities against STIs and HIV infection”.

The project is a multi-agency effort, with the India and Canadian agency being the major partners. The project starts with a preparatory stage includes Need Assessment, District level base-line study, and District level plan – bringing stakeholders together.
ICHAP aims to reduce vulnerability of people (including high-risk groups and general population) by providing information, improving their skills and accessibility of health care services to protect from STIs/HIV/AIDS. It also aims to bring behavioural changes among the people and builds leadership, support networks and the necessary enabling environment in Bagalkot district. Through this process, it seeks to empower women especially marginalised, Devadasi’s and commercial sex workers to protect themselves against HIV/STIs and realize their rights.

ICHAP has started its demonstration project in the state in the year 2000-01. It is first kind of it in India. The project started its demonstration project in the year 2000-01 initially for the period of five years in 2 states in India (Rajasthan and Karnataka) where the high-risk groups and high prevalence areas have been identified to heightened vulnerabilities to HIV/AIDS. In Karnataka state this project initiated in Dharwad (Urban) and Bagalkot (Rural and Urban areas) districts. In Bagalkot District it has begun its surveillance study under the Chairmanship of Mrs. Usha Rani in 6 talukas (Badami, Bagalkot, Bilgi, Hungund, Jamkhandi and Mudhol). In Hungund and Jamkhandi taluk it is initiated through UJWALA organisation, in Mudhol and Badami taluk it is working through the organization BIRDS. It is independently initiated in Bilgi taluk.

This project has taken lot of people’s effort to begin in Bagalkot district and to gain National and International fame as a model project. Among these the former Director of the ICHAP Canadian Jams Blanchard, University of Manitoba, Dr. Joan, Dr. Steven, the representative of University of Manitoba and the district planning officer Mrs. Usha Rani and Shri.Shivu Halli were prominent who struggled bringing awareness about HIV/AIDS to the risk group and general population by different projects.
Situational Assessment Study:

The situation of Bagalkot district in terms of vulnerable groups, high-risk groups and the marked HIV/AIDS incidences has made, India Canada Collaborative HIV/AIDS Project (ICHAP) to select Bagalkot District for its Demonstration Project and to conduct a surveillance study in 2001-02.

Later it designed a committee and was informed of the procedures and arrangements for selection of local NGOs who are already working on HIV/AIDS prevention programmes. The initiative of ICHAP has promoted the target intervention projects in various parts of Karnataka among different high-risk populations. The main objective of HIV/AIDS control societies is to fund small and medium-sized, local-level NGOs to implement the intervention of HIV/AIDS prevention projects. Initially, these NGOs were asked to submit a proposal and bid for funds to deliver the intervention among high-risk populations. This included assessment and scoring of the proposals and past work experiences of NGOs, interviews with NGO managers or co-coordinators.

After its initial situational assessment study in 2001-02, the ICHAP instituted a programme in which they provided awareness camps, training to community leaders, and training to sex-workers, who took on the role of peer educators.

The project is a multi-agency effort, with the Canadian agency and Government of India being the major partners. The project starts with a preparatory stage includes Needs Assessment, District level base-line study, and District level plan – bringing stakeholders together.

Overview of ICHAP strategy

Awareness:

Provide context HIV/AIDS awareness to high-risk groups and general population, and sensitive information to women on reproductive health and
rights, which will increase their awareness and lead to behaviour change. It will also help people understand their situation better, their options and action leading to protection.

Building Skills:
1. Building partnership with the community: Formation of Village-level committees and briefing details about the study and seeking co-operation.
2. Building skills of women to negotiate and to have more control over their reproductive health and their rights in general within their existing community and domestic frameworks.
3. Building up of local leadership and support networks to take up issues of young women, where it does not exist.

Social Sustainability:
The project aims at enhancing self-esteem and a positive attitude among the community members so that they show an active interest, involvement and responsibility, resulting in the amalgamation and perpetuation of the project activities. Ownership of the various development programmes is a criterion for sustainability which is possible through an attitude of responsibility and liability in the community and a participatory approach to decision-making. Training programmes, workshops, meetings and exposure visits help in the capacity-building of the community, which serves as a foundation for economic sustainability.

Improving Services:
ICHAP works on the demand and supply side. On the demand side improving capacities of people to demand quality services and on supply side, working with service providers (Government and other NGOs) to provide HIV/AIDS sensitive and user friendly services. It will also examine and evaluate the current ‘blocks’ to access various interventions programmes and work with the various NGOs and people in overcoming them.
It will strengthen existing infrastructure of State Government and NGOs and not create new ones. Close overlap with Government at District Levels through sharing of management arrangements (where RCH committees exist, ICHAP will try to work through them). It will work in strengthening Government’s implementation, especially those initiatives aimed at women (with special emphasis on agencies dealing with abolition of Devadasi system and HIV prevalence among the women).

Building Support Structures:

Where no Community Based Organisations (CBOs) or support groups for women exist, ICHAP will facilitate formation of such groups. Where civil society institutions exist, it will work to build their capacities in being active support structures for young women. It builds and nurture for a larger discussions and actions.

1. Information, Education and Communication (IEC) Campaign:

The IEC campaign is designed to create awareness and influence individual behaviour. Most of the intervention projects in Chimmapur believe that the increased awareness is the key to change in behaviour, thus preventing the spread of the HIV infection. Culturally relevant methods of publicity of preventions includes-

- Awareness about STIs/HIV/AIDS to community people by using pamphlets, banners, posters, dramas, street-plays, folk-songs, video-shows.
- Distributing condoms to the needed individuals including Commercial Sex Workers and their clients.
- Organizing Condom Demonstration Camps and motivating people to use condoms correctly and consistently.
- Imparting knowledge about VCTCs and PPTCTs centers to undergo for counselling and testing.
• Awareness of 'Hejjegallu Tarabeti' programme which aims at changing sexual or risky behaviours at different stages, and motivate people to undergo 'Hejjegallu tarabeti' and to learn about STIs/HIV/AIDS.

• Conducting regular meetings of Community Leaders and commercial sex workers.

2. Focused Group Prevention:

• Identifying target groups- New CSW's and clients and imparting knowledge and awareness about STIs/HIV/AIDS.

• Preparation of IEC materials for projects which was focused to communicate illiterate, low income and high risk populations.

• Establishing Networks with Key informants, Positive people, Lodge owners, Police and condom outlet holders.

3. Voluntary Counselling and Testing Centre (VCTCs):

• Establishing VCTCs at district hospitals and high risk talukas and its uses in the time of high incidences of HIV/AIDS.

• Identifying high-risk behaviour groups including people who are indulging in unsafe and unprotected sexual activities and motivate to undergo counselling and test.

• Maintaining records of STI, positive people and awareness to take regular VCTC follow-up services.

4. Management of Sexually Transmitted Infections (STIs):

• Awareness about STIs and its consequences to the community people and to undergo regular STI clinic Camps.

• Identifying the community people who are infected or suffering from STI/s.

• Organizing regular clinical (STI) camps and giving treatment and follow-ups from trained physicians.
5. Care and Support:

- Providing Care and support to the people living with HIV/AIDS.
- Counselling and motivating the people living with HIV/AIDS that they can also lead normal life.
- Motivating people to seek treatment and counselling STI/HIV-related illness management from Jeevan Jyoti.
- Referral to people living with HIV/AIDS to undergo ART treatment.
- Identifying high-risk groups including commercial sex workers, clients and those indulging in unprotected or unsafe sexual activities to undergo counselling and blood test from nearest VCTC centers.

Capacity Building of the Staff:

Capacity building of the staff through regular training is one of the important strategies implemented by the organisations. The authorities of the organisation where training of the staff was regular were of the opinion that it is worth giving regular orientation on issues related to HIV/AIDS prevention, condom promotion, STD diagnosis, treatment and behavioural change communications, conducting key-informant interviews, Focused Group Discussions (FGDs) and partner meetings. Also the sessions on writing a project proposal, documentation, accounting and report writing would benefit the key staffs of the organisations in understanding intervention programmes and its need for effectiveness.

Situational Assessment Study:

ICHAP Conducted a situational assessment study during August –October 2002 in six talukas of Bagalkot district.

The audience/clients served by these NGO’s vary, but the majority are working on so called high-risk populations sex-workers and their clients, Migrant labourers, Men having sex with men youths and gay/bisexual and includes general population of adolescents, Youths, men and women People Living with HIV/AIDS (PLWHAs) in the district (Table No. 6.1).
Table No. 6.1

Target Groups Covered by these NGOs

Total no. of NGO’s = 4

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Target group</th>
<th>Total No. of NGO’s currently working</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Commercial sex workers</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Clients</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Adolescents and Youths</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Gay/bisexual Men</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Women</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Others</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(General Population)</td>
<td></td>
</tr>
</tbody>
</table>

* Note- No Check: Provision for multiple answers.

Description of Evaluation:

Of the total 12 intervention projects evaluated in Chimmapur; 3 NGOs are working on Commercial Sex worker, 2 are migrant labourer projects, and 2 are programmes with other type of high-risk populations such as men-having-sex-with-men (MSM) and general population and 2 projects including Jeevan Jyoti (Bagalkot district network of PLWHAs), on people living with HIV/AIDS (PLWHAs).

In Chimmapur, sexual activity outside the marriage began to project the fact that the sex worker as more victim than culprit, worse, she was caught between life and livelihood. We have livelihood. We’d helped to help stop HIV we helped to help stop HIV didn’t.

NGO’s Perceptions:

All of the NGOs mentioned that funding was the primary motivation for working for the people. Equipment and other material resources were named the second (3).
Table.No.6.2

NGO’s Perception of working

Total no. of NGO’s= 4

<table>
<thead>
<tr>
<th>SL. No.</th>
<th>NGO's Perception</th>
<th>Total no. of NGOs currently working</th>
</tr>
</thead>
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<tr>
<td>1</td>
<td>Funding</td>
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</tr>
<tr>
<td>2</td>
<td>Equipment</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>Marketing of NGO</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Expertise</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Access to Employees</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Public Relations</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Networking</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Intervention programmes</td>
<td>3</td>
</tr>
</tbody>
</table>

The qualitative and quantitative data indicate that people of the study area including HIV infected and AIDS affected are visits various NGOs and the Government Hospitals to seek information, counselling on HIV/AIDS and testing centers. The various counselling and testing centers of Bagalkot district are listed in the below table.

Their face-to-face sessions with youths and married men included role plays and other interactive techniques to build skills such as how to negotiate abstinence or use condoms correctly and consistently. Peer educator uses drama to emphasize preventive and promotive STI and unplanned pregnancy risks to youth in Chimmapur.

Condom Demonstration/promotion Camp received training and promotion from Ujwala-ICHAP NGOs and more than 10,000 condoms were distributed among the people of Chimmapur.
The Condom Demonstration Camps (CDCs) to Sensitizing about Condoms and HIV/AIDS:

Condoms have been part of the national family planning programme for decades. Apart from being an effective contraceptive, condoms are also a good tool for protection against getting infected to STIs and HIV/AIDS. However, despite sustained efforts, both awareness and the use of condoms have remained low. UJWALA-ICHAP, with financial assistance from the international, centre and state collaborations ICHAP conducted a pilot study to make people aware of STI's/HIV/AIDS and the use of condoms to prevent unwanted pregnancies and STI's/HIV/AIDS.

One innovation was organizing a condom demonstration camps to raise awareness about condoms and sensitize people to its utility, both as a contraceptive and as protection against STIs/HIV/AIDS.

As illustrated by the NGO co-ordinator:

To popularize awareness of condoms and their use, a condom demonstration camps were held in Harijan Keri block and plot areas for three days immediately after Holi, a popular festival in the study area. The time was carefully chosen because majority of the migrant villagers return to Chimmapur to observe the festival. The condom demonstration camp was well advertised in the village.

These camps created a lot of interest in the community. More than thousand people visited the camps in three days to find out information and knowledge about condom/s and AIDS. Many came out of curiosity because such camps have never been organized before. Condoms and their uses were openly discussed by performing demonstration and how to use condoms correctly and consistently. When Ujwala-ICHAP Demonstration Project evaluated the impact of the pilot project on awareness about STI’s/HIV/AIDS and condom usage, the result showed a substantial increase in awareness of
STI's/HIV/AIDS. Probing on the condom demonstration camps revealed that at least 42 of the 100 persons interviewed (22 men and 20 women) were aware of the Condom demonstration camps and 18 percent of the men had visited it. The respondents were selected randomly from different localities.

Most of the respondents who knew about the camp felt that it was an interesting way to popularize condoms and educate people about HIV/AIDS. Similarly, most of those who visited the camp found it unusual informative and useful. In the words of Ujwala co-ordinator-

These condom demonstration camps were a kranti (revolution). These camps have given condoms a Samajik Manyate (community approval). Earlier discussion about condom and AIDS were confined only to people like us. But now (due to these camps) Janaru (people) have opened their mouth and are talking about condoms openly.

The community in general and particularly those who visited these Condom Demonstration Camps felt that similar camps should be organized at regular intervals. According to a community member who had visited the camp:

"Organizing or such camp again will be useful. It should be organized at public places because people often meet there".

One of the visitors said:

"Such special camps help in breaking shyness and people can discuss these issues more openly".

It was interesting to note that one camp was organised in the plot area conducted by women peer workers. Several women (30-40) visited the condom demonstration camp and most of women listened to it. The study indicates that the unusual nature of camps stimulated considerable discussion among spouses and peer groups.
However, villagers were not clear whether a special condom demonstration camps or a few spots/stalls in a general festival camps would be more successful in educating about contraceptive and HIV/AIDS and STI's.

Street Plays:

Ujwala NGO had conducted three street plays in the year 2004 in Chimmapur village at New plot area, Gandhi Nagar and in the market in different places with gap of three months each. These Street Plays were performed by hounsa dhwani kala tanda, Hulyal. To first street play about 225 spectators (180 men and 45 female) and 250 (175 male and 75 female) spectators/audience and members of the community were gathered. Through these street plays the Ujwala tries to cater HIV/AIDS awareness among the public. It covered other aspects like HIV/AIDS, Modes of HIV transmission, myths and misconceptions and created awareness about safe-sexual behaviour practices, being faithful to single partners and condom usage was advised. Most of the community people were appreciated the performance and the need of these street plays. People of Chimmapur were actively participated. Community leaders, and Panchayat leaders, Link workers/officers from Ujwala have attended and inspected the street plays were also participated and sought suggestions from the situations.

Drama's:

People of Chimmapur on special occasions of festivals and fairs organize dramas. Most are based on social, religious, political and economical aspects. Knowing the utility of drama Ujwala after successfully completion of street plays organised drama in front of ITI College. The subject of the Drama was focused to cover HIV/AIDS knowledge, safe-sexual practices and how individuals are contracted by HIV/AIDS and the later consequences faced by them. It also gives a clear picture about how infected individuals are treated in communities and what should be the role of individual, family, community and society members to deal with stigma and discrimination.
Folk Shows:

Folk-shows in Chimmapur had created greater awareness about HIV/AIDS among large audience. The folk shows were performed by ‘Sharif Janapada Kala Tanda’. Large number of public including community leaders and Panchayat and Ujwala-ICHAP officials were attracted. Through choudaki pada and janapada folk songs it made easy to understand topics such as HIV/AIDS knowledge and awareness, myths and misconceptions regarding HIV/AIDS and discrimination and the threat posed by the disease and how people should take preventive measures.

STI Camps:

Ujwala-ICHAP demonstration projects organize regular STI clinic camps in Chimmapur. STI diagnosis, treatment and referrals by specialist doctor, several clinic camps were conducted. Most of the men and women including Devadasi's and commercial sex workers were diagnosed STI symptoms includes tinny boils accompanied by itching, rashes, genital herpes, burning mictuation, lower abdominal pain, and they were provided free treatment and referrals to a range of symptoms.

These camps were also provided a wide counselling and guidance to the people of Chimmapur to manage and to take the best use of these camps. However, most of these camps were covering high-risk group’s mainly commercial sex workers and migrant workers. They should extend these to other community areas that other people in the general population can also access these services without barrier.

Condom vending machine:

One of the strategies for prevention of STIs and HIV is to make condoms available and accessible to those who need them. In this context, Hindustan Lever Limited (HLL) has been given contract by National AIDS Control Organisation (NACO) to install condom vending machines in the Karnataka
State, Bagalkot District was one to install in the Chimmapur Village. The mechanical machine which delivers only one type of condom pack (i.e., USTAD) @ Rs. 5/- per packet and each pack has four pieces of condoms. Only Rs. 5/- coins can be used for in this machine. The machine will installed free of cost and all maintenance will be by HLL vendors retailers/collectives who desires to safe guard the machine and look after operation (replacing packs when empty) will have to purchase condoms at Rs.4/- per pack for the ‘Ustad’. Thus the vendor gets a margin of Re.1/- for every pack or for every Rs.5/-.

This vending machine has attracted by the community people. Most of them expressed that it is a good move by the NGO that people can get different type of condom (other than Nirodh). However, most of the people expressed that how one can operate this machine in presence of the others (including elderly people) that most of the time this place is busy with villagers and most of them cannot dare to use this machine because of shy.

Ujwala-ICHAP demonstration project installed Condom Vendors near bus stop and at old Talati office (old-office near Dhadoti house) and other convenient locations in Chimmapur and set-up a multipurpose youth center, NGO’s Centre provided voluntary HIV counseling and testing, STI diagnosis, treatment and referrals and other reproductive health services for the first time in an integrated setting in Chimmapur.

**Chaitanya AIDS Tadegattuva Mahila Sangha, Mudhol.**

The Chaitanya AIDS Tadegattuva Mahila Sangha, Mudhol is started in the collaboration of BIRDS NGO. This organization initially instituted by the name ‘Shakthi AIDS Tadegattuva Mahila Sangha’ in Belgaum. It was extended to other 22 districts in Karnataka state after the successful running of this women organization in the Belgaum district. Among these Chaitanya AIDS Tadegattuva Mahila Sangha is also one. It is registered under the Karnataka registration organization/institution Act of 1960 in Mudhol taluk of Bagalkot
district. In Mudhol taluk it started functioning in the year 2000-01 in collaboration with BIRDS and in the year 2000-01 it was also extended its work in Bijapur and Bagalkot District under the banner of “BIRDS Chaitanya AIDS Tadegattuva Mahila Sanga”.

‘Chaitanya’ instituted various programmes in which they provided training to sex workers, who took on the role of peer educator, or

*Chaitanya AIDS Tadegattuva Mahila Sangha* aims to reduce vulnerability of commercial sex workers in the taluk by providing information, improving their skills and accessibility of health care services to protect from STIs/HIV/AIDS. It also aims to bring behavioural changes among the CSWs and *Devadasi* women.

**Financial Assistance:**

*Chaitanya AIDS Tadegattuva Mahila Sangha* initially make independent financial arrangements for its programmes. Earlier, ICHAP funded for most of its projects. Currently it is financed by Karnataka Health Promotion Trust.

**Aims and Objectives:**

- To prevent STIs, HIV/AIDS among Commercial Sex Workers.
- To motivate commercial sex workers for economic savings.
- Care and support to HIV/AIDS & STI infected commercial sex workers by the organization.
- To facilitate loans to commercial sex workers.
- To provide knowledge on legal act and to get justice.
- Curbing injustice and violence against commercial sex workers.
- To abolish *Devadasi* system by the organization.
- Training and empowering commercial sex workers to lead independent life.
- Working for the development of depressed and oppressed women.

The ultimate target of the project is the self-sufficiency of the sex worker community.
Outreach Encounters:

*Chaitanya AIDS Tadegattuva Mahila Sangha* appointed and involved Devadasi's and commercial sex workers who have good knowledge of particular Community Sex Environments (CSEs) were recruited as outreach field staff. They were provided training in STIs, HIV/AIDS prevention and in outreach, and their field-work was well structured and regularly monitoring by the higher authorities. Outreach encounters initially focused on their own community/ localities and later extended to other villages. Outreach workers were included establishing good rapport, informing about STIs, HIV/AIDS and providing *Nirodh* condoms. Supportive IEC material was provided and when possibly outreaches workers demonstrated consistent use of condom. They were also getting trained on *hejjegallu tarabeti* programme which aims at bringing behavioural change among Devadasi's and commercial sex workers.

While it is clear that there is a substantial population of Devadasi women in Chimmapur, interventions addressing the needs of this community are grossly inadequate. There are hardly two NGOs which are trying to bring awareness among this population. In designing intervention programmes to this group a number of important lessons that emerge need to be kept in mind. What are the strategies that can work with the Devadasi (the high risk group). The answer to this is not simple, through some generalizations can be made. While the work of ICHAP and that of other addressing the Devadasi groups has focused on outreach and service provisions at ‘Chaitanya AIDS Tadegattuva Mahila Sangha’ and Ujwala, the work with these alias NGOs has taken on a community mobilize or community development approach, with HIV/AIDS as a focus area. It has looked at empowerment of the community members basically Devadasi women and CSWs through literacy, skill building, and additional income generation to minimize dependency on selling sex, advocacy with others, including the police, and working with the media to raise awareness about this community and thereby creating an enabling environment in Chimmapur Village.
Thus fulfilling the needs of the community various intervention programmes intended to enabling and persuasive effective strategies. Behavioural change communication focusing on one-to-one education, one-to-group (interaction), out reach work, Community Meetings, individual and group condom Demonstration, providing free and easy access to good quality of Nirodh (condom), Audio cassettes distribution, Street shows, dramas, Handbill and Broucher Distribution, HIV Positive Identity, Counselling to People Living with HIV/AIDS, facilitation of improved sexual health services to guarantee respectful and non-stigmatizing treatment, counselling and advocacy to minimize denial and discrimination and stigma, regular STIs Clinic (referral and follow-up) camps are the broad strategies that have been found to be effectively organizing by these NGOs in Chimmapur.

Sthanik-sangha-samsthegalu or Local organisations such as Vivekanand mitra mandal, Prabhudevar yuvak mandal, Pooja (Devadasi) sangh, Laxmi (Devadasi) sangh are seen as a route to stronger civil society in Chimmapur. By helping community people engaged in dialogue with the cooperation these NGOs to address HIV/AIDS. Eventually, local people’s own organisations, will link people-centered networks and come to influence globalised notions of development itself. Community leaders also trying hard to address issues related to HIV/AIDS in Chimmapur. Community leaders showing their much needed interest and attending the meetings organised by ICHAP, Chaitanya and Ujwala NGOs at various levels. Even though, the participation of members is less but those have attended have strongly opinioned that they should fight against this diseases.

Community Perceptions:

The success of each and every programme and plan depends on people’s participation. A person’s participation in development action plans is a greater extends depends on local community leaders and political commitment in Chimmapur. In health management programmes and plans people as well
community leader’s lacking knowledge to effectively address reproductive and sexual health related issues and that requires intervention of governmental and NGO agencies.

In Chimmapur the culture of silence that keeps women ill-informed on matters of sex, sexuality and their bodies, male dominated societies, makes them even more worry than men about seeking information pertaining to sexuality, sexual behaviour/s and HIV/AIDS from NGOs.

Women of Chimmapur village particularly the upper-caste women would begin by saying that it was only after much hesitation that they were accessing the knowledge and awareness about HIV/AIDS; they were not sure if it is proper for a women to verbalize matters relating to sex; that it is important for them to know whether they were the only ones; whether the awareness is at all accessing by other women. Even most of the upper-caste women expressed that knowledge and awareness about HIV/AIDS is most essential to the low-caste women especially to the Devadasi women.

One hand women by saying this are trying to avoid their risk of contracting HIV/AIDS and at the same time the male dominated community leaders were exploiting the other women not to seek information on sex, sexuality and HIV/AIDS/STIs.

However, it is not enough to design a technically sound and efficient intervention programme to improve the health status of community people including commercial sex workers and general population and controls’ STIs/HIV infection among them. The introduction of intervention components in response to the perceived needs of the community to evolve a comprehensive development programme, the active participation of sex workers at all levels, including policy-making, transparent management social and economic status by reducing the existing gap between the interests of community and sex workers.
The failure to control the epidemic:

After more than two decades into the epidemic, policy discussion are still full of abstract planning language, with promises to organize, decentralize, and base the work within the community. There was no desire among government and NGO representatives to discuss precisely what would work in local setting and why. This was jarringly different from the down-to-earth language and examples offered at family planning conferences and immunization workshops.

Efforts to ensure a higher level of condom use during sex with commercial sex workers might well succeed in the study area even though the circumstance are less propitious than in urban or metros.

A successful condom intervention here would have a disproportionate impact on the epidemic. The central plank in the victory over HIV/AIDS is the recognition by Indian governments of social and sexual reality.

The ignorance of people towards HIV/AIDS and STI make them more susceptible to the disease. In this direction NGOs still needs to undertake programmes to bring attitudinal and behavioural change among the people and lower the HIV prevalence rate in the study area.

The higher officials of NGOs should take time to communicate with each other and provide each other with support, which is found much lacking. As for as preventive, promotive and rehabilitative health activities at village level, a strong political will is needed, which is possible by, enlightened community participation and involvement community in health programmes.

Recruit true peers. In order to be credible, youth peer educators must be true peers—similar age range, sex, marital status, and sexual experience—to the program’s target audiences. Recruitment and training should emphasize the ability to listen, guide discussions, and talk about sensitive topics. A good peer educator does not preach, but instead listens and responds to the audience.
They must be perceived empathetic and genuine—but not perfect. A major challenge is to recruit and train peer educators who are poised and self assured and, at the same time, comfortable deferring to experts when appropriate.

The objectives of the NGOs and government should be welfare oriented so as to minimize the risk of HIV infection. It has to succeed in creating a positive atmosphere of the modification of risk behaviour and address issues of people living with HIV/AIDS in the community.

NGO should try hard to bring behavioural changes among the high-risk groups including commercial sex worker and their clients, migrant workers and general population to indulge in safe sexual practice.

Further, the success of any program should be monitored not only from the perspective of the medical authorities but also from that of the ‘at risk community’ themselves, and thereby bring out more effective interventions in the future.

It is plausible that the population sample of the study indicated an overwhelming knowledge of the disease and this trend could reflect the general feeling of the entire population in Chimmapur. While most people were aware that the disease was incurable and that the cure was not in sight, HIV/AIDS infections were increasing. There was a general feeling of frustration from the people that despite massive awareness among the population, the disease was not under control. What appeared to be a consensus among the people was that HIV/AIDS education and awareness provided was not adequate. What remains crucial is the type of adequate or proper education to be provided. Adequate education and awareness has to include well organized HIV/AIDS programmes and activities involving experts or people who are knowledgeable local socio-cultural constructions of the disease.
NGOs and Future:
Most of the NGOs including ICHAP and UJWALA-ICHAP are completed their demonstration projects and they are submitting their final reports of the study based on this the future programmes must be initiated by Government agency of international agency to continue the half work done by these NGOs. It is today’s need that any other NGO should take in place of these NGOs because commercial sex workers, high-risk groups and HIV infected and AIDS affected people and general population still need information, education, care and support in present and future.

HIV/AIDS has opened up channels of more effective communication between government and non-governmental agencies like no other disease did. HIV/AIDS has created panic and degrading discrimination on the one hand, and on the other, it has brought to light heroic support and understanding from partners/spouse, families, friends and entire communities.