CHAPTER - 7

CONCLUSIONS

In the world of the several hundreds of diseases if there is one disease which has assumed pandemic proportions and threatening well being and economy of almost all countries thereby transforming the entire world in the time of just over a decade and a half, and which has swallowed billions of dollars with virtually nothing to show but more confusion, paradoxes and uncertainties, it is the viral infection – HIV/AIDS (Bhatt, 1996). During the recent decade, while much has been learnt about the deadly virus, many fundamental assumptions about the disease are falling apart, fresh problems are surfacing with every new investigation, thus perplexing researchers, and leaving, therefore, a long road ahead before ways to control the most disastrous epidemic can be found out.

However, the importance of HIV/AIDS pandemic cannot be measured solely by the number of infected or ill individuals or those dying agonizingly, for, as a sexually transmitted disease with an array of medical and psycho-sexual dimensions, AIDS mainly strikes high risk behaviour group of young people – the people who are the mainstay of the family and the nation, the people on whom the society relies for production and reproduction; these are men and women who raise the young and care for the old. As countless young people ignominiously die of AIDS, their elders are left without socio-economic support and their young ones become orphans – discriminated and stigmatized. Further, with this most productive demographic group becoming, let invisibly and unknowingly, infected, the basic socio-economic fabric of the country is jeopardized so much so that the industrialization process of a developing nation comes under the grip of the dilemma. The impacts of HIV and AIDS – the disease that thrive on secrecy are, therefore, grave and vehemently multifaceted (ibid.).

The present study is an attempt to gain the sociological insight in the domain of HIV/AIDS. With the genesis of HIV/AIDS, studies in the form of research work were initiated by medical professionals as this disease came out to be a major public health setback. Therefore, this body of knowledge was instigated from the medical viewpoint. However, in a short period of time, the responses of fear in the form of denial, stigma and discrimination were reported. People with HIV positive status were shunned out by their family, community and society after learning
their positive status and thereafter, the sero status was openly revealed by media. The myths regarding the transmission of HIV/AIDS lead to extricate people with HIV/AIDS within the hospital settings by doctors, nursing and paramedical staff and many times they were eluded from the hospital settings. Sontag (1991) suggested that it is a common response to the disease and the fear of contagion is a moralistic theme of punishment. This theme has impacted on the consciousness of common perceptions of HIV/AIDS which is seen as “divine retribution” for the sin of sexuality.

Based on the perception, belief and prejudgment, people craft the realities associated with HIV/AIDS which eventually embark on the process of social construction of HIV/AIDS. Social sciences, thereafter, had to intervene to get the precise image of the crisis led by this global pandemic. Therefore, this study is intended to depict the social reality allied with HIV/AIDS. It aims at exploring the way in which HIV/AIDS is actively constructed by various social elements including family, community and society and thereafter the bizarre meanings that are drawn out of this disease.

**Objectives**

The following objectives of the study were proposed:

1. To know the socio-economic background of the people living with HIV/AIDS.
2. To identify the ways HIV/AIDS is constructed in the family, community and society.
3. To analyze the relation between people living with HIV/AIDS and their family, community and colleagues at workplace.
4. To examine how HIV/AIDS is affecting the marital life of couples.
5. To understand how People Living with HIV/AIDS are discriminated by the personnel in the health care system.

To meet the above mentioned objectives, it was decided to study the problem in the state of Punjab as it has been reported one of the most terribly affected state with HIV/AIDS as the trend of Injecting Drug Users (IDUs) is escalating every day. According to Punjab State AIDS Control Society (2008), Amritsar has reported the highest number of HIV positive cases in Punjab followed by Ludhiana. So, it was decided to study the problem in Integrated Counselling and Testing Centre, Department of Microbiology, Government Medical College, Amritsar where an
average of 10 to 12 patients are diagnosed with HIV positive antibodies every day. For the purpose of this study, 300 HIV positive patients who knew their HIV positive status for at least 20 to 25 days were randomly selected. The patients who were 18 years of age or above were taken into study. Interview Schedule was used for collection of the data. It was prepared after an overall understanding of the problems of the People Living with HIV/AIDS (PLWHA). Data were collected through interviews. The Case study method was also used and 20 case studies were selected for the study. The data have been interpreted and presented through the seven chapters.

**MAJOR FINDINGS**

I. **Socio-Economic Background**

The first chapter was aimed at depicting the socio-economic background of the respondents. Questions related to their age, sex, religion, caste, residential status, education, monthly income, previous and present occupation were asked to know the background of the respondents. Moreover, questions related to their family were also asked which included the details about their education, occupation and monthly income.

It was found that significant proportion of the respondents constituted the age category of 25 to 34 years with mean age as 33.42 years. Majority of the respondents were males and more than one third were females. Data also illustrated that Sikhs constituted above 70 per cent of total respondents with more than half reported as *Jat sikhs*. One third of the total respondents were from lower castes reported as *Kumhar, Ad-Dharmi, Julaha (Kabirpanthi), Mazabi and Balmiki*. More number of respondents from rural areas was reported as compared to urban areas. Similarly, Non migrants were in majority and few of migrants were reported. 90 per cent of the total non migrants were from different districts of Punjab namely *Amritsar, Tarn Taran, Ferozpur, Gurdaspur, Phagwara, Jalandhar, Faridkot, Bathinda and Abohar*. The remaining migrants were from the states of *Himachal Pradesh, West Bengal, Maharashtra, Uttrakhand and Haryana*. Married respondents were reported in considerable proportion. The educational level of nearly one third was stated as matriculation and nearly a quarter of respondents were illiterate. Education of only a few was found to be graduation and post graduation. Sizable amount of respondents were reported as housewives associated with their household activities. Farmers constituted nearly one sixth of the total respondents. Previous occupation of considerable
proportion of the respondents was truck driving. The monthly income of majority of the respondents falls between ₹ 4501 – 5500 with median income of ₹ 3508 per month. Apart from the earning respondents, nearly one third reportedly found to be dependent on the family resources. The family income for majority of the non earning respondents was reported to be ₹ 5000 per month or below. Most of the respondents hail from Joint families.

II. Responses of the Family, Community and Society

The third chapter aims at knowing the way HIV/AIDS is socially constructed within the family, community and society and the way people craft the realities according to their own knowledge and experience regarding this illness. Moreover, the chapter was also intended at knowing the preconceived notion of our society regarding the routes of HIV/AIDS transmission resulting in blaming and labelling on those with HIV positive status. In this chapter the respondents were asked about their route of transmission and whether or not they have shared their agony with someone soon after getting their HIV positive result. Various questions related to making disclosure regarding their HIV positive status to their spouse, family, community, society, friends and colleagues at workplace were also asked. In addition, the information was also collected on the responses and reactions of the family, community, society and the discrimination they faced from the people to whom they have disclosed their status.

As a result more than one third the total respondents mentioned unprotected sexual relations as the major route of HIV/AIDS transmission. Among the remaining, a significant number of respondents mentioned HIV transmission from their family members and majority of them were females who contracted HIV/AIDS from their spouse. Approximately one fifth of the total respondents were Injecting Drug Users (IDUs). Few respondents mentioned that they were treated with a contaminated syringe by the doctor. Needle Stick Injury was reported by those who were associated with medical profession.

Nearly two third of the total respondents shared their agony soon after learning their HIV positive status. Among them, majority shared it with their spouse (husband/wife) followed by their parent in law, relatives and their biological parents. Small number of respondents shared their agony with their children and friends. The remaining respondents felt reluctant in sharing their agony of being HIV positive with anyone. A large number of the married respondents revealed their HIV positive status to their spouse after learning their HIV positive status. The
remaining respondents felt reluctant in making disclosure regarding their sero positive status to their spouse. Nearly two third of the total respondents were extrovert about revealing their sero positive status to the family members whereas one third remained introvert regarding their HIV status to their family members. Sizable proportion of the respondents revealed their status within the intimate partner’s relationship. However, reluctance in disclosing the status to their spouse was shown by the remaining respondents. Family members of significant proportion of the respondents were shocked after learning the sero positive status of their family member. Behavioural change was observed by majority of respondents after disclosing their sero status to their family members in the form of discrimination, suspiciousness of having sexual relations outside the family and commenting on their sero status. A small number of respondents mentioned that their family members showed more concern after learning their HIV positive status.

The data shows that majority of respondents mentioned non disclosure of their sero status to their friends while few favoured disclosure within their friends circle. The reaction of the friends after learning the HIV positive status was humorous, as told by the respondents. Various questions regarding the routes of HIV transmission were asked by their friends. Behaviour change was reported in the form of non invitation for the get together. Among those who were invited to the gatherings, lack of warmth and respect were shown by the friends. Discriminatory attitude was observed by most of the respondents followed by filthy and negative remarks on the character. Majority of respondents mentioned non disclosure of their HIV positive status to their colleagues at workplace. Among those who revealed their sero positive status, frequent alterations in the behaviour of their co-workers was observed by substantial number of respondents. A large number of respondents faced discrimination from their colleagues in the form of non-sharing of food and drinks, showing reluctance in sharing the same workplace and label of being sexually promiscuous was reported by the respondents. A vast majority of them felt dejection by their colleagues resulted in declining of their social status at their workplace. Majority of the respondents were blamed and held accountable for contracting the disease by their colleagues at work place.

About two third of the total respondents felt reluctant while disclosing their sero status within their community. Almost one third went through negative reactions and probing questions on the sexual behaviour from their community members after revealing their sero status.
Behaviour change was observed at regular intervals in the form of refusal, while talking, commenting on their family members and giving funny remarks, as stated by the respondents. Few among them were invited on the social gatherings within their community. However, food and drinks were offered to only few among them. Fear of getting contagion was the reason mentioned by those who were not invited by their community members and were left deserted. Majority of the respondents mentioned that being HIV positive hails low status for them in society as they are characterized as sexually promiscuous which gives bad impression on their social reputation. A vast majority of respondents said that HIV positive status should not be disclosed within the society as people make fun after learning their sero status.

III. Discrimination within the Health Care System

Discrimination against People Living with HIV/AIDS (PLWHA) by the health care workers is prevalent worldwide. It is done in the form of non admission within the hospital and demanding extra money from the patients or their accompanied persons. Furthermore, after getting admission in the hospital PLWHA are discriminated on the grounds of their illness by the doctors, nursing and paramedical staff. To get an overview about the attitude of the health care workers towards PLWHA, the respondents who were admitted in the hospital/s were asked various questions pertaining to the discriminatory attitude of health care workers while getting admission in the hospital. Moreover, the question related to the kind of discrimination faced from doctors, nursing and paramedical staff by them and their accompanied persons. Questions related to the attitude and behaviour of the hospital staff were also asked.

Among the total respondents, 189 were hospitalized following ill health, opportunistic infections and ruined health status. Majority of the respondents reported discriminatory attitude of the health care staff comprising doctors, nursing and paramedical staff of the hospital. It was also reported by the respondents that their accompanied persons were ill treated by the health care workers before and after the admission in the hospital. More than half of the total respondents faced discrimination from the doctors. While disclosing the form of discrimination, more than 95 percent of them were given special remarks on their OPD files and confidentiality regarding their HIV positive status was breached. Derogatory behaviour was also reported by majority of respondents. Discrimination was also faced by the accompanied persons of the respondents in the form of denial for admission within the hospital and demanding extra money
as entry point within the hospital. As against the discrimination faced from the doctors, a large number of respondents faced discrimination from the nursing staff. Majority of them were discriminated by the nursing staff which includes refusal to touch on behalf of patient’s illness, exchange of jocular comments with other staff members, breaching the confidentiality followed by derogatory behaviour and special remarks on the OPD files and slips. Discrimination was also faced by the accompanied persons of the respondents from the nursing staff in the form of filthy and jocular comments followed by derogatory behaviour. Nearly half of the total respondents revealed discriminatory attitude of the paramedical staff. Discrimination was made in the form of refusal for cleaning the room, breach of confidentiality of the respondents regarding their sero positive status and demanding extra money from the respondents. Discrimination was also faced by the accompanied persons from the paramedical staff in the form of derogatory behaviour, refusal to clean the room and demanding extra money. Confidentiality was also breached by the paramedical staff in case of making refusal for extra money demanded by the paramedical staff.

IV. Marital Relations of Couples

It has been observed that soon after learning the HIV positive status, the marital relations of couples were badly affected. It gives a worst impact on the trust and solidarity of the couples resulting in desertion and separation of couples with HIV/AIDS. In the present chapter, the respondents were asked the questions related to the conflicts in their marital relations, discrimination and segregation of the couples, trust and solidarity, blaming made by the spouse after learning the HIV positive status of the partner, negative assumption made by the spouse and making disclosure of their status to other family members. Various questions regarding the relations of respondents in non-marital sexual relations were also asked. They were asked that whether or not they have revealed their status to their sexual partners and whether they know the HIV status of those with whom they are having sexual relations. Lastly, the respondents were asked questions whether HIV testing should be made mandatory before marriage or not.

Majority of respondents disclosed their sero status to their intimate partner. Behaviour change was observed by most of the respondents in the form of suspicion for giving HIV to the spouse followed by non-sharing of food and drinks. Conflicts were reported by majority of respondents in the form of halting of sexual relations and violence among the partners. Few
respondents were also suggested to live separately by the partner. Trust and solidarity among the intimate partners was breached as mentioned by the respondents. Followed by segregation and discrimination, a small number of respondents mentioned about separate living arrangements from their spouse as the counterpart fears of getting HIV contagion. The respondents mentioned that blaming was also done by the spouse in the form of illicit sexual relations outside the marriage. Negative assumptions in the form of death predictions were also reported by the respondents.

Disclosure was also made to other family members of the respondents by the intimate partner after learning the HIV positive status. Male respondents were more comfortable in disclosing their status to their mothers in contrast to their female respondents who were more comfortable to divulge the same to their biological parents.

Majority of the respondent in non marital sexual relations never disclosed their HIV positive status to their sexual partners. High frequency of partner changing, visiting brothels and red light areas was mentioned by the respondents in non marital sexual relations. Demanding extra money, refusal for intercourse were some of the reasons mentioned by them for not disclosing it to their sexual partners. Majority of the respondents never bothered to ask the HIV status of their sexual partner. When asked about the mandatory HIV testing before marriage, again majority of them favoured mandatory HIV testing before marriage. The remaining favoured voluntary HIV testing and strongly criticized the mandatory HIV screening before marriage.

V. Case Studies

A detailed investigation was carried out on the life histories of 20 respondents. These case studies throw considerable light on the various issues related with the life of HIV positives and escalation of social construction within the family, community, society and at workplace associated with their disease. It also depicts the way PLWHA and their accompanied persons are discriminated within the health care system. Each and every case study depicts a unique reality aided by social construction of HIV/AIDS and clearly depicts the way people attach strange meanings to the disease. It also shows that this disease is actively constructed by various social segments of society which deliberately attach meanings to the illness resulting in denial, stigma and discrimination against sero positive people within our society.
Conclusions

1. The conclusions drawn from the present study depict that social construction prevails almost everywhere in our social structure, strengthened by orthodox age old myths and misconception. As the study inferred, people carry diverse meanings pertaining to this illness and thereafter weird and strange ideas are depicted out ending in social construction. People living with HIV/AIDS are thus seen with suspicion and their behaviour is often labelled as deviant. The preconceived traditional belief of society restricts the notion of present day knowledge resulting into constructive framework of HIV/AIDS. It is purely based on the outcome of societal beliefs and ideas that are filled with preconceived notions and fixed mindsets. Therefore, it gives limited scope for the emergence of new ideas.

Stereotypes and misconceptions about HIV/AIDS and its routes of transmission have always remained a challenge for most of the people to explore. Even those who claim to be well informed and knowledgeable are unable to differentiate between HIV and AIDS. It is a pity on our part that worldwide billions of dollars are being spent on the name of generating awareness among the people but ironically people are becoming more baffled with the routes of transmission. In society like India where old customs and cultural traditions restricts the mobility of an individual, learning about sex and sexuality, use of contraception like condoms and open talk about the HIV/AIDS as a disease is not acceptable. Though few states in India have responded well in generating awareness and prevention of new infections but it still remains challenge for those states which remain in the condition of tyranny and where the issue of sex and sexuality is tabooed. In such societies, realities are often constructed which conforms the perceptions, norms, values and belief system towards the acceptance of a particular reality.

Social construction is generally understood to be the by-product of countless human choices. It involves looking at the ways social phenomena are created, institutionalized and made into tradition by humans. A socially constructed reality is one that is seen as an ongoing, dynamic process that is reproduced by people acting on their interpretations and their knowledge of it (c.f. www.wikipedia.com). Similarly, HIV/AIDS is fringed within the gamut of social construction. From the moment it was diagnosed
people took it as a sexually transmitted infection and therefore, those found as HIV positives were treated badly. Tracing back to the first instance of the world in USA, it was declared a disease of Gays and were called as ‘Gay Related Immune Deficiency’. During that period the Gays were vindicated and they were subjected to mass discrimination from the local population. Similarly in India, HIV was diagnosed in Female Sex Workers and therefore, it was asserted a disease of illicit sexual relations. With the passage of time it was confronted by the scientists regarding the other mystified routes of HIV transmission. Till that time people had a belief that HIV/AIDS is the disease of promiscuity. Females who offered sex in return for money were given notorious title. Majority of masses still regard all sex workers as HIV positive and if they are not positive today, they will be infected sooner or later. The clients of these women are labelled as sexually promiscuous and segregation is often made against sex workers so that the infection may not transmit to the general population. The age old notion has not altered as yet with the present day given knowledge. People still view it as a sinful act and treat people with HIV as people with bad character. Their involvement within the society is restricted and their access to general facilities remains restricted.

The social construction of HIV/AIDS has come out to be the product of cultural beliefs and practices that are performed by the various groups. Such beliefs and practices are profoundly interwoven within the social fabrications of everyday life. There is very narrow room for the followers to alter their present state of mind and incorporate the new ideas. The belief system is encompassed with traditional perception of what has been given to them by their forefathers and further are perpetuated and reinforced by social institutions and traditional practices. For instance, in many parts of India, people still claim to cure this illness with some Jari Butti (Herbal Medicine). Traditional healers and quacks assert to have the corrective antidote for HIV. Though, it is not medically proven fact regarding the availability of any vaccine that can work against this virus. Perhaps the huge amount of money involved into this field of searching and researching of vaccination for HIV force people to construct the myths pertaining to development of a new vaccine.

It was also mentioned by few of the respondents that they regularly take herbal medicines available from Southern part of country. According to them, doctors (names
taken by the respondents) unnecessarily demand huge amount from the patients and in return provide them herbal medicines in small Purri (packets) and ensures them of getting rid of HIV in short span of time. But the respondents also claimed that by the time they take regular dose of herbal medicine, their body remains healthy but the moment they halt the process their body comes back into bad shape. Many respondents also sold their small landholdings, miscellaneous household items including kitchen utensils to get this herbal treatment for making survival against this infection.

From time immemorial, problems are viewed as ‘Divine Retribution’ in Indian society. It shows the fostering of the age old traditional belief system where the foremost objective was to identify the delinquent and thereafter penalizing them. It was purely based on belief system with no implication of scientific reasoning involved within. With such obsolete and rudimentary ideas prevailing in our society, people misunderstood their mistakes and started self labelling them as sinners. It resulted in juxtaposing of their disease and illness with sins of past life by reviewing it as Purane Janmo Ka Fal. Thus, belief system obsesses people and makes them believe that diseases and illnesses are punishment from God as a result of their past deeds. All those living with any illness are often tagged as Bechara or else they are welcome with slang and abusive language.

Berger and Luckmann (1966) in their book *The Social Construction of Reality* have argued that all knowledge, including the most basic, taken-for-granted common sense knowledge of everyday reality is derived from and maintained by social interactions. When people interact, they do so with the understanding that their respective perceptions of reality are related, and as they act upon this understanding their common knowledge of reality becomes reinforced. Since this common sense knowledge is negotiated by people, human typifications, significations and institutions come to be presented as part of an objective reality. In this sense it can be said that reality is socially constructed.

According to Sontag (c.f. Goldstein, 2009), HIV/AIDS is an infectious disease whose principal route of transmission is sexual which puts sexually active group at a high risk of contracting this virus and thus makes it easier to view this illness as a punishment for that activity. Those infected with this disease experience shame and isolation by the society. Dansky (c.f. Goldstein, 2009) believes that, the individuals with HIV/AIDS are
unable to discern between their sense of self and the virus and begin to self-label themselves as "diseased", "infected" or "contaminated". This perception may create a sense of isolation and non-belongingness towards their family, community and society. Miller (c.f. Goldstein, 2009) also supported this view and mentioned that, in turn ‘negative self-talk’ may link them to depression, isolation and apathy which activate the stressful response. They mark themselves as polluted or impure after being diagnosed with this medical condition. Few of them construct false and negative attitude and take it as misdeeds of past life.

Pokarna (1994: 14) in his study of Manchwa and Begas villages in Rajasthan, India found that, “The history of disease in human society is as old as man himself. It has been a fundamental problem for all societies and hence every society has developed, according to its cultural experiences, both empirical and transcendental, system of values regarding health and disease and also methods for coping up with them. He also mentioned that there is a significant relationship between culture and system of health. Culture defines the sickness and sick role, its causes and belief system and practices associated with it. Within the culture, the class, ethnic, religious and educational background also influences the meaning and perspective of health. The villagers believe that sickness occurs, to some extent, as a result of sins (paap) and faults (dosh). The villagers were also of opinion that one’s sinful act not only brings illness upon him but also on the members of his family and community (ibid., 1994: 116-117). The view is also supported by Green (c.f. Van Dyk, 2001) in a study conducted in Uganda. Taylor (c.f. Van Dyk, 2001) similarly found that people in Rwandan were educated about the perils of HIV/AIDS but none of the participants in the study used condoms. Taylor further concluded that the choice not to use condoms was related to culture rather than ignorance.

A study conducted by Ungvarski & Flskerud, (c.f. Goldstein, 2009) also found that, Culture and ethnicity are significant determinants of individual perceptions and understanding of HIV/AIDS. It affects significant aspects of life that have cultural meaning specifically reproduction, birth, death, the role of women and sexuality. Furthermore, because HIV/AIDS is a sexually transmitted disease that has a long incubation period, a terminal prognosis and constantly changing scientific knowledge is
often subject to alternative lay beliefs and explanations which contradicts the current medical and scientific knowledge at any stage. Thus, cultural world views gain much force and tenacity. These cultural values and interpretations in turn manifest in behaviour and attitudes, which may be potentially dangerous, at times reinforcing stereotypes, stigmatisation and isolation of people living with this illness as well as reinforcing their participation in a potentially dangerous behaviour.

2. The findings of the study reveal that nearly one third of the respondents were females and majority of them have contracted HIV from their husbands. In India and elsewhere, women are quoted as silent victims of HIV/AIDS as they are the recipient and their husbands or the ally are the benefactors. The vicious circle of dependency on their families repudiates the emancipation of woman and orthodox patriarchal norms prohibit their freedom of expression. Their voices remain unheard even after revealing their problems and their pleas are discarded soon after unveiling of status.

Varma (2010: 92) in his study conducted in Rajasthan, among the women living with HIV/AIDS came out with similar findings. He mentioned that most of the husbands, in spite of the fact that they themselves were HIV positive, showed unhappiness with such wives and started being aloof. Quite a few women have been beaten up, abused and even thrown out of the houses. The reaction of society was far worse and full of hatred, stigmatization, discrimination, aloofness, isolation considering them as persons from hell and treating them as criminals were the general feelings against positive women. The view is also supported by Sharma (1991: 197). According to her, “A woman health is harmed by social customs and cultural traditions simply because she is born female.”

Berger and Luckmann (1966) stated that society is the creation of Human beings. They create ‘recipes’ for living in their social world, a standardized ways of carrying on social life. These recipes can become embodied in institutions which consist of interlocking recipes. One particular group may have a certain set of agreed upon truths, while another group might have a different set. This allows different communities and societies to have very different notions of reality and truth about the external world. The religion and belief of people or communities are one example of this level of socially constructed reality.
Burr (c.f. Goldstein, 2009) in this regard stated that, meanings, perceptions, understandings and knowledge of the world are not pre-given but rather actively constructed. Crystal and Jackson (c.f. Goldstein, 2009) mentioned that, “Diseases are not mere biological entities but rather socially constructed phenomena.” Qadeer (1991: 185) in his study on Beyond Medicine: An Analysis of Health Status of Indian People also supported the findings. He said that, “Social realities created by men acquire a very significant place as they not only influence the objective conditions but also the subjective conditions, that is, the perception and evolution of knowledge and its influence on human health.” Largely the females in India and elsewhere learn of their being HIV positive during pregnancy which puts them at high risk of giving HIV to their unborn child. Moreover they are accused of bringing HIV at home on most of the time if they deliver a child with HIV. Above all is the vicious circle of poverty, illiteracy, early marriage, child bearing capacity and rigid social norms escalates and manifolds the susceptibility of women in contracting HIV infection.

Ramasubban (1995: 214) in this regard mentioned that, “What makes women particularly vulnerable in the context of the growing possibility of an HIV epidemic is the state of their sexual and reproductive health”. There are a range of biological and social factors at work here. Finally, the inability of women to protect them from being infected due to the nature of power relations between men and women in the society, the family also contributes to women’s vulnerability. The view is also supported by Usdin (2005: 45). According to her, “A woman’s body structure makes her at least twice as likely to contract HIV from an infected man.”

As the HIV/AIDS epidemic is largely a result of heterosexual transmission, people falling in such groups are often blamed by the society. In such incidence, Female Sex Workers (FSWs) are accredited as the driver of the HIV/AIDS epidemic. They are held responsible for dissemination of this infection worldwide. Blame is often shifted on them for giving HIV to their clients by offering unprotected sex. They are held accountable as they willingly give HIV to their clients who unintentionally transmit the same infection to their wives.

3. In India, the epidemic was reckoned as a disease afflicted by certain occupational groups that contract HIV and subsequently transmits it to their family members while they return
back home. In the early years of HIV epidemic, sex workers were assigned bad name as *Gandi Aurat* in society since their occupation (*Dhanda*) makes them susceptible with regard to HIV/AIDS. With the passage of time, occupational groups like migrant labourers, truck drivers, military and paramilitary forces were suspected of being the carriers of HIV infection. But as the epidemic was reported more among truck drivers, the group came under the scanner and the disease came to be known as *Truckan Wali Bimari* with special reference to Punjab. They were treated at par with female sex workers in our society and labelled as the driver of the HIV/AIDS epidemic in India and other parts of the world.

Kulis *et al.* (2004) in World Bank Report on Truck Drivers and Casual Sex in Baltic Regions came up with similar facts that Truck drivers constitute an especially vulnerable group who contract and spread HIV because of their high-risk behavior at truck stops where they engage in sexual contact with commercial sex workers. The risk was compounded by occupational conditions, which motivated truckers to drive long hours, often using drugs to stay alert. Similarly, Madhurima and Meenu (2009) in their study on Truck Drivers in Punjab depicted that the extended periods of time that truck drivers spend away from their families place them in close proximity to high risk sexual networks and often results in them having as increased number of sexual contacts.

4. The present study also finds that people living with HIV/AIDS are the target of ill-treatment within the medical institutions. They are unwelcome guests in majority of hospitals and receive denials for getting admission owing to their sero status. PLWHA are treated as they are befouled by the health care professionals and on most of the occasions they are charged with extra money for getting admission in the hospital. They are ostracized and compartmentalized in exiled rooms and the entry of majority of staff members is forbidden. All those who are obligated to provide medical assistance to them endure stigma resulting in scapegoating of the patients or their accompanied persons in the form of derogatory remarks. It has already been demystified by the medical sciences that HIV/AIDS cannot be transmitted through such instance of casual touching and it requires strong contact with the blood of the infected persons. However, the constructed mindset within the domain of medical institutions overrules the notion of majority of staff members and consequently results in non acceptance of PLWHA. The findings are also
corroborated by Pokrana (1994: 6) which holds similar viewpoint that hospitals often create a system of stratification and build a hierarchy among people with various illnesses. The categorization of wards in terms of general, private, deluxe and super deluxe is determined by the money which is paid for room. In View of Berger and Luckmann (1966: 127), “He who has the bigger stick has the better chance of imposing his definitions of Reality.”

Polgar (c.f. Goldstein, 2009) suggested that, Social constructions of AIDS as disease or punishment by the society are advanced by moralists who equate HIV with social taboo and promiscuous sexual behaviour. Political constructions of AIDS highlight public health in the face of obstacles to treatment and the delivery of services to people living with HIV. These political and moral constructions are at odds over AIDS as a form of social stigma, magnifying many forms of prejudice and discrimination. Each construct is supported by an institutional authority while framing the problems and responses to HIV/AIDS.

It is no less than a product of society that constructs new facts about this illness and therefore leads to dissemination of distorted information. The knowledge, ideas and belief are not pre-given but actively constructed by various elements that prevail within our social system. It results into inkling of erroneous information which unfolds the hidden truth about the persons’ past knowledge and belief. Therefore, they become the agent of transmitting wrong information regarding HIV/AIDS to the sufferers of this illness and create a chaotic social environment within the families, communities and societies from every angle. In other words, as Berger and Luckmann (1966) put that, it can be said that individual himself absorbs the constructed reality and hence he becomes just a product of the social interaction. Rosales (2006) also supported this view. He said that reality is socially constructed and each individual is born into a world where others have a strong sense of what is the reality of this world. It is a sense which they have learnt from their parents, teachers, guardians and friends etc.

According to Crimp (c.f. Goldstein, 2009), HIV/AIDS does not exist apart from the practices that conceptualize it, represent it and further respond to it and we know HIV/AIDS only through those practices. This assertion does not contest the existence of viruses, antibodies, infections or transmission routes. Least of all does it contest the
reality of illness, suffering and death. What it does contest is the notion that there is an underlying reality of AIDS upon which the representations are constructed within a specific culture. If we recognize that AIDS exists only in and through these constructions, then hopefully we can also recognize the imperative to know them, analyze them and wrest control over them.

Gilman (c.f. Goldstein, 2009) suggested that, the society forms an authenticity and legitimacy to shape the existence of the disease from the past to the present. The circumstances are constructed in a way that it must govern the judgment of the upcoming generations who are unable to make any distinction between the hype and reality of this disease. In other words, the social construction will direct the perception and insight of the future generation with regard to HIV/AIDS.

Brandt (c.f. Goldstein, 2009) holds a view that, AIDS is an unfinished chapter in the medical and social history, demonstrating the nature of contemporary biomedical science and research, our beliefs about health, disease, and contagion and our ideas about sexuality and social responsibility. AIDS demonstrates how economics and politics cannot be separated from disease indeed these forces shape our response in powerful ways. In the years ahead we will, no doubt, learn a great deal more about AIDS and how to control it. We will also learn a great deal about the nature of our society from the manner in which we address the disease. AIDS will be a standard by which we may measure not only our medical and scientific skill but also our capacity for justice and compassion.

National AIDS Control Organization in India has claimed to spend nearly 67 percent of the total National AIDS Control Programme (NACP III) finances on awareness and prevention during the next 5 years, that is from 2007 to 2012 (NACO Newsletter, 2007). The evidence gathered from the respondents shows that substantial amount of work is yet to be done to increase the knowledge and awareness among the countrymen and reducing the myths and misconceptions amid families, communities and societies pertaining to HIV/AIDS transmission.
SUGGESTIONS AND RECOMMENDATIONS

There is no swift justification to the crisis of HIV/AIDS. Absolute exclusion of HIV/AIDS is not feasible at present since it has already made its route inside the human body. Complete annihilation of HIV/AIDS requires gigantic efforts from the nations worldwide. The eradication of the problem is a long process and requires sustainable efforts. The social policies needs to be so framed as to reduce the gravity of HIV/AIDS and thereby improve the social conditions of PLWHA and diminish the acceleration of the rapid spread of HIV/AIDS (Usdin, 2004). On the basis of the study the following suggestions have been formulated:

1. The study shows that most of the respondents are illiterate or have education up to matriculation and thus less education becomes one of the important factors of massive spread of HIV/AIDS. Education in this regard can play a crucial role in reversing the terrifying impact of HIV/AIDS since the school going adolescents are much vulnerable to the impacts of this disease and all the education regarding the sex and sexuality among them remains distorted. The governing bodies like Punjab State AIDS Control Society in collaboration with Health and Family Welfare Department should mainstream with educational agencies like National Council of Education Research and Training (NCERT) and Punjab School Education Board (PSEB) to implement HIV/AIDS education within the education curriculum and adopt a holistic approach to impart this sensitive teaching program. Furthermore, this education should be disseminated by the professionals who are working in this field of HIV/AIDS information, education and communication (IEC), particularly the HIV/AIDS counsellors who are professionally trained.

2. Participation of the religious organizations in imparting HIV/AIDS education should be given primary importance owing to the fact that these organizations have the innate potential to tranquil the mind and therefore can encapsulate the HIV/AIDS education within the religious domain. These religious organizations should try motivating people to accept this education in lieu of the developing outrageous attitude towards the knowledge and awareness regarding HIV/AIDS transmission. For instance, the Islamic Medical Association of Uganda has trained over 8,000 Islamic religious leaders and their volunteer teams in 11 districts of Uganda to launch a spiritually motivated grassroots
movement to change HIV/AIDS-related behaviour. Similarly, in northern Thailand’s Mae Chan district, bordering Myanmar and Laos, several hundred monks regularly incorporate HIV prevention messages in their sermons, pay home visits to PLWHA and provide counselling (Singhal et al., 2003).

3. HIV/AIDS test should be made mandatory by the government before entering into the institution of marriage. It can be the key factor where the naive partners especially the women get trapped into the vicious circle of HIV/AIDS. Moreover, the government should provide the facility of Polymerase Chain Reaction (PCR) test which can deduct the HIV antibodies within 72 hours of the contact and the couple can overcome their dilemma of getting the accurate results.

4. Mainstreaming and collaboration should be done by the Non Governmental Organization (NGOs) with National AIDS Control Organization (NACO) with regard to halt the growth of HIV/AIDS and towards the advancement of HIV/AIDS education. Presently, innumerable NGOs are working for this cause but most of them have a false perception towards the “No Profit No Loss” motto. Many of them are working fake and misappropriating the funds allocated to them to improve the social and the medical health of the PLWHA. NACO should oppose nepotism towards allocation of the projects to NGOs since most of them came into its contact through political route and thus resulted in biased scrutiny.

5. The proportion of drug addiction, particularly Intravenous Drug Users (IDUs) is rising in India with regard to the Northern states where majority of drug addicts are IDUs. In Punjab, drug addiction is rapidly fuelling among the youth which has led to high mortality rate among the youth. The administration should impose ban on such drugs and in addition the chemist and drug peddlers who are the hub in penetrating the drugs should be nabbed and prosecuted under the NDPS law.

6. To reduce the myths and misconceptions against HIV/AIDS, the government needs to put together the correct information with electronic and print media. Moreover, radio channels can also be the source of mass awareness and to raise the accountability among the teenagers and youth to halt the further spread of HIV/AIDS.

7. As the study depicts that one third of the respondents are women and most of them are reported to contract this disease from heterosexual route. It signifies that women are the
most vulnerable category who is at high risk of contracting HIV/AIDS particularly the rural women of Punjab. To empower the rural women who are trapped inside the clutches of social norms, HIV/AIDS awareness campaigns can play a significant role. Local NGOs and CBOs like Mahila Mandals and Organizations working for the cause of women upliftment need to come in front for this social cause. The administration must provide some funding to these CBOs for the efficacious work performance.

8. Majority of PLWHA have poor socio-economic conditions and cannot even meet their monthly travelling expenses to collect Anti Retroviral Therapy (ART) from the government hospital. The state government can play a vital role in providing financial assistance in the form of monthly pension scheme for PLWHA. Moreover, health cards must be allocated to them so that they might get some travelling concession on railways and public transport.

9. Regular sensitization programs needs to be planned for the health staff as well as for the pedagogy to improve the awareness level and to keep them rationalized and attentive towards the ongoing scenario of HIV/AIDS. It will result in declining of the prejudicial and stereotyped behaviour and attitude of teachers and health staff since they have a key role to play in society.

10. In the study, it was noted that the most of the respondents were from rural background and few of them reported to be infected through treatment with contaminated syringe by the Registered Medical Practitioners (RMPs) and quacks who are actively surviving in the rural areas of Punjab and elsewhere. Governmental response is essentially required in curbing the mushrooming of the quacks and the RMPs who are no doubt responsible for the massive spread of HIV/AIDS in the rural areas.

11. The Judicial adoptive response towards legalization of homosexuality in India needs to be revised. Perhaps the judiciary has forgotten that homosexuality was one of the major causes of spread of HIV/AIDS in America and some parts of the European nations. On one side the plans are going on to curb the growth of HIV positivity within the nation and on the other side the judiciary itself is motivating people to follow the indifferent life style.
12. People should try to adopt the preventive strategy of ABC, particularly the Adolescents, that is, Abstain from premarital sex, Be faithful to one partner and use Contraceptives/condom.

13. Last but not the least; India should try to adopt the effective model of HIV/AIDS control accepted by few nations to reverse the HIV/AIDS pandemic. For instance, Uganda’s HIV infection rate has fallen down as the result of educational efforts, extensive HIV testing and counselling, and very active condom promotion. Thailand focused on its sex industry and Cambodia generally followed its neighbour’s lead, also promoting 100 per cent condom use by CSWs. Senegal emphasized sex education, clean blood supply and condom promotion (Singhal et al., 2003).

The above mentioned suggestions and recommendations are based on the results produced by the present study and may not fulfil the universal response towards HIV/AIDS or the policy makers but it is no doubt an endeavour to enlighten those who are at high risk of contracting HIV/AIDS and to empower those who are living with HIV/AIDS positively.

In nutshell, we can say that HIV/AIDS is human product as the perception towards this burning issue is deeply rooted within the social basis of our society. Human beings have been producing the reality related to this disease since its inception. Therefore, the understanding of HIV/AIDS is largely concentrated within the framework of social construction which, ultimately, has brought up the issues of stigma, discrimination, scapegoating, vilification, labelling and denial. We may say that the social construction of HIV/AIDS has exhibited a reality which needs to be addressed. The social impediments like the low level of literacy and poverty have hampered the growth of human thoughts and breaking of the stereotypes constructed around the disease. Therefore, from time to time rumours hit hard and generate controversies and manage to derail the efforts of the government and voluntary sector in dealing with mammoth problem. Under such critical circumstances, it is a big challenge for the administration to halt the growth of HIV/AIDS pandemic and to reverse the mounted statistics.

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