ATTITUDE AND PERCEPTION OF RURALITES TOWARDS AFFECTED HIV/AIDS PATIENTS: A STUDY IN RAJNAGAR AND RAJKANIKA BLOCKS IN KENDRAPARA DISTRICT

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CERTIFICATE

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Certified that the work incorporated in this thesis entitled, ***"Attitude and Perception of ruralites towards affected HIV/AIDS Patients: A study in Rajnagar and Rajkanika blocks in Kendrapara district"*** submitted by Sushama Satapathy for the Degree of Ph.D (Sociology, Utkal University), 2015, is a bonafide research work carried out by her under my direct guidance and supervision. The work has neither been published nor submitted by any one or any where to the best of my knowledge. Further I certify that the work has been done within the area of registration.

Dr. (Mrs) Sanjukta Das
Date :-

DECLARATION

The present thesis entitled **"Attitude and Perception of ruralites towards affected HIV/AIDS Patients: A study in Rajnagar and Rajkanika blocks, in Kendrapara district**" is based on the work carried out by me under the supervision of Dr.(Mrs) Sanjukta Das, Department of Sociology, Kendrapara Autonomous College. So far no part of this thesis has been submitted for any degree or award of this or any other University.

References to the related works have been cited in the text and the list of sources of such information is incorporated in this thesis.

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Signature of the Guide: **Name:-Mrs.Sushama Satapathy**

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PREFACE

HIV/AIDS is emerging as dreaded disease engulfing vast majority of population day by day within the cruel clutches. It is an unprecedented epidemic and public health emergency. HIV (Human Immuno-deficiency Virus) is a virus that causes AIDS (Acquired Immuno Deficiency Syndrome) a health condition in which person is affected by a series of diseases because of poor immunity. HIV by itself is not an illness and does not instantly lead to AIDS. An HIV infected person can lead a healthy life for several years before she/he develops AIDS. HIV attacks the human body by breaking down its immune system that is meant to fight disease. Over a period of time the immune system weakens and the body loses its natural ability to fight disease. At this stage, various diseases affect the infected person.

According to recent estimates, around the world over 33 million people are infected with HIV and over 16 million have died of AIDS related-illness. In many resource poor countries AIDS related morbidity and mortality are causing major reversals in development, childhood mortality and survival and life expectancy. Denial, stigma, discrimination and secrecy regarding HIV/AIDS continue to exist with the high prevalence of HIV and deaths from AIDS in many places.

Several factors put India in danger of experiencing a rapid spread if effective prevention and control measures are not scaled up and expanded through out the country. These risk factors include: unsafe sex and low condom use, migration and mobility and injecting drug use etc.

The problem is aggravated by the fact that there is lack of overall awareness about the disease among majority of the masses. Continuing myths and misconceptions regarding the cause and misconception regarding the cause and transmission of disease are causing “AIDS Phobia” where in people living with or affected by HIV/AIDS are being strongly discriminated by the general population while at the same time it is also leading to “Physician bias” that poses a major deterrent to treatment and care of HIV/AIDS infected People. Further the stigma attached to certain population practicing high-risk behaviour extends the marginalization of the most vulnerable section.

Realizing the fact, now-a-days, government, international agencies and non-governmental organizations are incorporating HIV testing and counseling, programme on a broader and radically larger scales in their HV/AIDS interventions, in order to meet an increasing global demand for access to care and prevention services.

The present study was undertaken with a broad objective to create awareness amongst the ruralites majority of whom are misguided by myths and misconceptions due to illiteracy and ignorance about HIV/AIDS. First of all the researcher wants to have an insight into the respondents' Preliminary Knowledge, attitude and consciousness about HIV/AIDS. The objective aims to know the respondents' awareness about HIV/AIDS the cause of infection, common carrier of infection, initial symptoms of HIV/AIDS, and protective measures necessary to avoid infection.

Since misconception about the causes of HIV/AIDS infection, transmission from one person to another, its prevention and cure leads to various stigma, discrimination and ostracization in every place, in family, community and even in hospital, the need of the assessment of the sample is taken into consideration about the awareness of ruralites regarding the no-risk factors and risk factors spreading HIV/AIDS, behaviour and attitude towards HIV/AIDS infected persons, negligence, discrimination and ostracization of the patient in their family, in their community and among their friends and discrimination of their children in school, playground and picnic etc.

Attitude and perception of the respondents towards HIV/AIDS infected/affected is undertaken in the study to know whether the ruralites rightly or wrongly perceive the disease on the one hand whether they show positive attitude towards the PLWHA and their children on the other. Sometimes wrong perception about HIV/AIDS becomes responsible for negative attitude towards the patients, their children and family members in society. Even own family members of infected persons show indifferent behaviours towards them which leads to emotional stress. To combat these emotional stress and social stigma, discrimination and ostracization supportive measures from family and society is very much essential.

The present study also has objectives of studying the role of family and society in providing moral support to the patient and role of governmental and non-governmental organizations and impact of mass media in creating awareness among the rural masses about

causes, transmission, prevention and cure of HIV, treatment of HIV/AIDS and campaigning against discrimination of the patients in society.

The study depicted the findings that the education has become major factor in rural society to replace ignorance, to increase awareness level, to perceive the disease in right way, to show positive attitude towards PLWHA, to provide moral support and to extend co-operative hand towards HIV/AIDS infected/affected. Awareness creating programmes by governmental and non-governmental organization and mass media campaigning for consciousness of rural masses about HIV/AIDS are successful to some extent only because of education. Comparatively more highly educated respondents and a few less educated respondents were found to be influenced by mass media. The illiterate and poor rural masses no way respond to awareness creating programmes or mass media's advertisements or campaigning. They are otherwise busy or engaged in earning their livelihood.

Therefore, the study concluded with more effective action programmes which can create awareness among majority of illiterate and ignorant rural masses regarding such a deadly disease and its transmission and prevention. As prevention is better than cure; we all extend our co-operative hands to prevent it.

Sushama Satapathy

List of abbreviations and acronyms about HIV/AIDS used in research

AIDS	–	Acquired Immuno Deficiency Syndrome
ABC (approach) – Condoms		Abstain, Be Faithful and Correct and consistent use of
ARC	–	AIDS related complex
ARRM	–	AIDS Risk Reduction Model
ARD	–	Anti Retroviral Drug
ART	–	Anti Retroviral Therapy
ART	–	Anti Retroviral Treatment
AKA	–	Awareness, Knowledge and Attitude
ADC	–	AIDS Dementia Complex
AHP	–	Advancing HIV Protection
AEP	–	Adolescences Education Programme
ANC	–	Antenatal Clinic
APAC	–	AIDS Prevention and Control
AZT	–	Azidothymidine
ASO	–	AIDS Support Organization
BCC	–	Behaviour Change Communication
BISWA	–	Bharat Integrated Social Welfare Agency
CBO	-	Community Based Organization
CDC	–	Centre of Disease Control and prevention
CIDA	–	Canadian International Development Agency
CSWS	–	Commercial Sex Workers
DFID	–	Department For International Development
DCI	–	Drug Controller of India
DHHS	–	Department of Health and Human Services
ELISA	–	Enzyme Linked Immune Sorbent Assay
FHAW	–	Family Health Awareness Week
FHI	–	Family Health International
FSW	–	Female Sex Workers
FHAC	–	Family Health Awareness Campaign
FDA	–	Food and Drug Administration
GAA	–	Global AIDS Alliance
GIPA HIV/AIDS	–	Greater Involvement of People living with or affected by
HAART	–	Highly Active Anti Retroviral Therapy

HIV-	_	HIV Negative
HIV+	_	HIV Positive
HIV	–	Human Immune Deficiency Virus
HCPS	–	Health Care Provider Survey
HRGs	–	High Risk Groups
HRD	–	Human Resource Development
HTLV III	–	Human T-cell Lymphotropic Virus III
IAS	–	International AIDS Society
ICDS	–	Integrated Child Development Scheme
ICMR	–	Indian Council of Medical Research
ICTC	–	Integrated Confidential Testing Centre
IDUs	–	Injecting Drug Users
IEC	–	Information, Education and Communication
ILO	–	International Labor Organization
Int Pd	–	Intervention Period
INP+	-	Indian Network for HIV/AIDS positive people
INGO	–	International NGOs
IN-N	–	Indian Network of NGOs (working on HIV/AIDS)
IP	–	Intervention Programme
IAVI	–	International AIDS Vaccine Initiative
IPC	–	Inter Personal Communication
IHAA	–	India HIV/AIDS Alliance
ICASO	–	International Council of AIDS Service Organization
ICTC	–	Integrated Counseling and Testing Centre
KABP	–	Knowledge, Attitude, Behaviour and Practices
LAV	–	Lymphadenopathy Associated Virus
MTCT	–	Mother To Child Transmission
MSM	–	Men Having Sex with Men
NACO	–	National AIDS Control Organization
NACP	–	National AIDS Control Programme
NGOs	–	Non Governmental Organizations
NAC	–	National AIDS Committee
NAC	–	National AIDS Council
NACC	–	National AIDS Control Council
OVC	–	Orphans and Vulnerable Children
OASF	–	Orissa AIDS Solidarity Forum
OIS	–	Opportunistic Infections

ORG	–	Operations Research Group
ORGCSR	–	Operation Research Group, Centre for Social Research
OSACS	–	Orissa State AIDS Control Society
OPUS	–	Orissa Patita Udhar Samiti
PCI	–	Project Concern International
PCI	–	Population Communication International
PCP	–	Pneumocystis Carinii Pneumonia
PCR	–	Polymerase Chain Reaction
PEP	–	Post Exposure Prophylaxis
PCA	–	Participatory Community Assessment
PLWHAS	–	People Living With HIV/AIDS
PMS	–	Pre Marital Sex
PPTCT	–	Prevention of Parent To Children Transmission
PWHA	–	People Living With or Affected By HIV/AIDS
PWN	–	Positive Women's Network (South India)
PGL	–	Persistent Generalized Lymphadenopathy i.e. enlargement of Lymph Glands
RTI	–	Reproductive Track Infection
RTIS	–	Reverse Transcriptage Inhibitors
SAC	–	State AIDS Cell
SACS	–	State AIDS Control Society
SHAII	–	Stop HIV/AIDS in India Initiative
SIDA	–	Syndrome da Immuno Deficiencia Adquirida (Portuguese)
SIV	–	Simian Immuno Deficiency Virus
SP	–	Simulated Patient
SPPC	–	Strategic Plan For Prevention and Control
SERL	–	Surgery and Evaluation Research Laboratory
STD	–	Sexually Transmitted Diseases
STI	–	Sexually Transmitted Infections
STEPS	–	Striving To Engage People
SNHACP	–	Second National HIV/AIDS Control Project
SPARHA	–	Society for Positive Atmosphere and Related Support to HIV/AIDS (Kolkata)
SSA	–	Sub Saharan Africa
S&D	–	Stigma and Discrimination
TIS	–	Targeted Interventions
TAC	–	The Treatment Action Campaign

TFR	–	Total Fertility Rate
TSSG	–	Transfusion Safety Study Group
TV	–	Television
TIHRG	–	Targeted Interventions among High Risk Group
UCMS	–	University College Of Medical Science
UN	–	United Nations
UNAIDS	–	Joint United Nations Program on HIV/AIDS
UNDCP	–	United Nations International Drug Control Program
UNDP	–	United Nations Development Fund
USAID	–	United States Agency for International Development
UNESCO	–	United Nations Educational, Scientific and Cultural Organization
UNFPA	–	United Nations Population Fund
UNGASS	–	United Nations General Assembly Special Session
UNICEF	–	United Nations Children Fund
USPHS	–	US Public Health Service
UTA	–	Universities Talk AIDS
UTS	–	Union Territories
VCTCS	–	Voluntary Counseling and Testing Centre
VHS	–	Voluntary Health Service
VDRL	–	Veneral Disease Research Laboratory
VCCTC	–	Voluntary Confidential Counseling and Testing Centre
WB	–	World Bank
WBC	–	White Blood Cells
WHO	–	World Health Organization
WBSHP	–	West Bengal Sexual Health Project
WAC	–	World AIDS Campaign
ZACES	–	Zinc, Vitamin A, C and E and Selenium

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CHAPTER-I

INTRODUCTION

World is a beautiful place and so is the experience of living in it. It would be tragic if this beautiful experience of living life is shortened by HIV/AIDS, when its prevention is within one's control, though not the cure. HIV/AIDS is a global menace today. No country, region, state or district is free from this dreaded disease. India is no exception with the number of HIV+ patients increasing exponentially. In the light of such a grim situation, several measures are being undertaken both globally and locally by the government, non-govt. and United Nations agencies. Today the epidemic, HIV/AIDS affects all sections of Indian society, not just in high-risk group such as sex workers, truck drivers and injecting drug users (IDUS)- with whom it was originally associated but now HIV infected and affected are found in all communities including every socio-economic area. The people who belongs to HIV/AIDS did not belong to any one class, caste, race and religion as well as any particular social group- spreading rapidly from high-risk groups to the general population including women and children, it has presented many unique, novel and challenging problems to the entire world and represents a major public health problem of our time. Receiving the diagnosis of HIV positive is like getting the death sentence. Along with the distress associated with the diagnosis of a life threatening disease, individuals with HIV also face huge social and emotional challenges based on the reaction to their disease by other individuals and society.

AIDS cases were first reported in USA in the year 1981. Today it has engulfed the entire world by transforming itself in to pandemic.

Globally the number of people living with HIV/AIDS (PLWHA) at the end of the year2004 stood at nearly 40 million, while the epidemic is estimated to have claimed more than 3 million lives the same year according to the recent UNAIDS/WHO (2004) estimates. The statistics are raising grave concern since the infection is rapidly spilling over to the general population from those with high risk behaviour like commercial sex workers (CS) ,

truck drivers and migrant populations with known vulnerability to HIV. In 2007, the estimated number of people with HIV worldwide was 33.2 million with 2.7 million people newly infected according to a report of Times of India, Bhubaneswar edition on 1st Dec 2008. UNAIDS world AIDS day report 2012 states that now more than 34 million people live with HIV/AIDS, 3.3 million of them are under the age of 15. In 2011, an estimated 2.5 million people were newly infected with HIV. Every day nearly 7000 people contract HIV- nearly 300 every hour. In 2011, 1.7 million people died from AIDS. Since the beginning of the epidemic more than 60 million people have been contracted HIV and nearly 30 million have been died of HIV related causes. (UNAIDS World AIDS Day Report 2012:- UNAIDS Fact Sheet 2012; Kaiser Family Foundation).

The regional picture shows more than two thirds (69 %) of all people living with HIV, 23.5 million lives in Sub-Saharan Africa. In Asia and the Pacific, nearly 3,72, 000 people become newly infected in 2011. AIDS claimed an estimated 3, 10, 000 lives in the region in 2011. More than 13,000 people become newly infected in the Caribbean in 2011 while AIDS claimed an estimated 10,000 lives. There were an estimated 83,000 new HIV/AIDS infections and 54,000 AIDS related deaths in central and South America in 2011. Approximately 3, 00, 000 people are living with HIV in North Africa and Middle East and an estimated 23,000 adults and children died of AIDS. Some 14000 people were newly infected with HIV in Eastern Europe and Central Asia in 2011 where 92,000 deaths were due to HIV/AIDS. In 2011, also there were 30,000 new cases of HIV bringing the number of people living with HIV in Western and Central Europe to 9,00, 000 .

(Source – UNAIDS World AIDS Day report 2012; UNAIDS fact sheet 2012; Kaiser family foundation)

The HIV/AIDS picture in India is serious. India is perhaps on the top of an AIDS volcano. Ray Anderson, a professor and expert of the University of Oxford is of the opinion that, the strong cultural taboo towards pre-marital sex is the reason for the fast spread of infections in India and that India would be one of those countries facing a much bigger HIV problem in coming years. There is still an attitude of denial just among government officials

but also among the health experts and scientific institutions as well. AIDS is not just a health problem but also threatens to tear apart the very socio-economic fabric of the country.

In April 1986, the first cluster of HIV sero-positive was detected in Chennai, Tamilnadu. By January 1990 there were twelve cases of AIDS detected in foreigners and 32 amongst Indians. As on 31st March 1998, out of the cumulative number of 3.29 million persons screened 7960 persons were found to be HIV positive. HIV infections have been reported in all states and union territories. Maharashtra, Tamilnadu and Manipur are the states with highest rate of infection. From Mumbai to Chennai, the migrant workers, truck drivers and paid blood donors are spreading the infections to other areas. At the end of 2004 an estimated 5.1 million Indians were living with HIV/AIDS. Presently the six states, which are Maharashtra, Tamilnadu, Andhrapradesh, Karnataka, Manipur and Nagaland, the HIV prevalence in the general population is more than one percent (1%) indicating the presence of generalized epidemic. (According to UNAIDS / WHO Dec 2004). Out of all reported AIDS cases nearly 75% are represented by men while transmission through sexual mode accounts for the 83% of all the HIV infections (NACO 2002). Many interrelated factors such as poverty, low literacy level, lack of employment opportunity, mobility, migration and exploitation often force them into vicious cycle of poverty to high-risk behaviour to increased probability of acquiring HIV infection, deprivation and death. The problem is aggravated due to lack of awareness and apathy about the disease. Since many of the population most affected by the disease are among the worlds least educated, for which it is said " AIDS is a disease of ignorance", (www.unaids.org, June 1998).

In India, "HIV is a late comer but fast spreading". HIV emerged later in India than it did in many other countries. Infection rate soared through out the 1990s and have increased further in recent years. The crisis continues to deepen as it becomes clearer that the epidemic is affecting all sectors of Indian society, not just the group such as sex workers and truck drivers with which it was originally associated. In a country where poverty, illiteracy and poor health are rise, the spread of HIV presents a daunting challenge. In 2006 UNAIDS estimated that there were 5.6 million people living with HIV in India, which indicated there

were more people with HIV in India than in any other country in the world. However NACO disputed this estimate and claimed the actual figure is lower. In 2007, using a more effective survelliance syctem UNAIDS and NACO agreed on a new estimate between 2million and 3.6 milion people living with HIV. This puts India behind South Africa and Nigeria in numbers of people living with HIV.

- 1986 – First case of HIV detected in Chennai.
- 1990 – HIV levels among high-risk groups like sex workers and STD clinic attendants in Maharashttra, amongst injecting drug users in Manipur reaches over 5%.
- 1994 – HIV no longer restricted to high risk group in Maharashtra but spreading into the general population. HIV also spreading to the states of Gujurat and Tamilanadu where high risk groups have over 5% HIV prevalence.
- 1998 – Rapid HIV spread in the four large southern states.
- 1999 – Infection rate among STD patients have reached upto 30% in Andhra Pradesh and 14.6% in Maharashtra.
- 2001 – Infection crosses 1% in six states accounts for 75% of the country's estimated HIV cases. The primeminister addresses the Chief Ministers of high prevalence states and urges them to intensify prevention activities.
- 2002 – There has been an increase of about 0.6 million infections. This increase has been noticed primarily in states of Karnataka, West Bengal, Tamil Nadu, Bihar and Madhya Pradesh.

The national HIV prevalence rose dramatically in early years of the epidemic, but a study released at the beginning of 2006 suggests that the HIV infection rate has recently fallen in southern India. NACO released figures in 2008 suggesting that the number of people living with HIV has declined from 2.73 million in 2002 to 2.27 million in 2008. By 2009 there are 2.4 million people living with HIV in India while 0.17 million HIV/AIDS related deaths happened.

The following states have recorded the highest levels of HIV prevalence at Antenatal and Sexually Transmitted Disease (STD) over recent years.

- Andhra Pradesh – The HIV prevalence in Antenatal clinics was 1% in 2007. HIV prevalence at STD clinics was very high at 1.7% in 2007. Among high risk groups HIV prevalence was highest among Men who have Sex with M en (MSM) is 17%, followed by Female Sex Workers (FSW) is 9.7% and Injecting Drug Users (IDUs) is 3.7%.
- Goa – HIV prevalence among antenatal and STD clinics attendees was 0.18% and 5.6% respectively. The Goa AIDS control society reported that in 2008, a record number of 26,737 people were tested for HIV of which 1078(3.18%) found positive. (Source- GSACS launched SMS alert service termed as wake up call May 18, 2013.).
- Karnataka – The average HIV prevalence among female sex workers in karnataka was just over 5% in 2007 and 17.6% of men who have sex with men were found to be infected.
- Mizoram – HIV prevalence in antenatal clinics was 0.75% in 2007 in Mizoram.
- Nagaland – In 2003 HIV prevalence among IDUs was 8.43%. In 2007 HIV prevalence at antenatal clinics and STD clinics was 0.6% and 3.42% respectively.
- Punjab – In Punjab there is increase in HIV prevalence among IDUs to 13.8% in 2007.

The new HIV infections have declined by more than 50% over the past decade from 0.27 million in 2000 to 0.12 million in 2009. Of these six high prevalence states account for only 39% while the states of Bihar, Odisha, WB, UP, Rajasthan, MP and Gujarat together account for 41% of new infections.

The state wise distribution of new HIV infections, 2009 shows pictures in Karnataka 8%, Bihar 8%, WB 6%, UP 5%, Rajasthan 4%, MP 4%, Gujarat 4%, Odisha 9%, Maharashtra 9%, Andhra Pradesh 20% and others 30%. The key riskgroups in India are the Female Sex Workers (FSW), Men having sex with Men (MSM), Transgender (TG) and the Injecting Drug Users (IDUs) and the bridge populations are truckers and migrants. The routes of transmission of HIV, India 2010-11 are parent to child 5.4%, Homosexual/ Bisexual 1.3%, injecting drug users 1.6%, blood and blood products 1%, heterosexual 87.4% and others 3.3%.

HIV positive cases detected, mother to child transmission accounts for 5%, infected syringe and needles 1.7%, homosexual 1.5% and contaminated blood and blood products accounts for 1% of HIV infections detected during 2011-12. (Med India >> Health Statistics >> AIDS >> HIV positive cases in India 2009-2012).

To combat the epidemic, the national AIDS control program (NACP) in India was initiated in 1987 followed by setting of the National AIDS control Organization (NACO) in 1992 with the purpose of implementing National AIDS control program at the national and state level. NACO in collaboration with UN and Bilateral agencies, NGOs, Educational and Research organizations and Government as well as private sectors is continuously accelerating a broad based effective response to control the spread of HIV. Some of the major issues being addressed on a priority basis are – awareness generation among the masses through various programs including suitable IEC (Information, Education and Communication) strategies, implementing targeted interventions for specific populations and encouraging health seeking behaviour among the masses. Integrating HIV/AIDS and STD control within the existing healthcare system, ensuring blood safety measures, establishing voluntary counseling and testing centre (VCTC), providing care and support to those infected with HIV and most importantly propelling the participation of NGOs and other voluntary groups in the NACP (National AIDS Control Program) are some of the efforts in the prevention and control of HIV – a notoriously dreaded disease of the century.

Recently there has been a growing focus on the decentralization of prevention efforts and services including financial and administrative powers from the national to the state level. Efforts are also being marshaled to counter discrimination against people with HIV/AIDS which is proving to be a major hurdle in prevention effort in India.

Odisha has been categorized as low risk state in comparison to other states such as Andhra Pradesh, Karnataka, Maharashtra, Gujarat, Manipur and Nagaland etc. The first case of HIV infection in Odisha was detected in 1992 in Nayagarh and the first death due to AIDS was reported in 1993. Cutting across geo-political settings, age, sex and regional barriers, HIV/AIDS has now been reported from all districts and various high risk groups of the state.

The HIV sentinel surveillance Report (HSSR) 2006 estimates that the number of people living with HIV/AIDS cases in Odisha at 46,000 and Ganjam district tops the list among all districts.

In Odisha, by the end of October 2008, 11,156 HIV positive cases have been detected in the state, out of them 815 have been already died.

Table No. 1.1

HIV DATA OF ODISHA (HIV Scenario in Odisha till Sep 2008)

No. of people tested	HIV positive cases	AIDS cases	Deaths due to AIDS
1,72,760	3138	28	28 (year 2007)
1,58,800	2662	108	108 (Till September 2008)
4,17,999	11,156	1032	815 (From 2002 till Oct 2008

(The Times of India, Dec 1st 2008, World AIDS day)

In Odisha, there are 19,188 people affected with HIV till Oct 2010, out of which AIDS was found among 1466 persons. The HIV cases among Males are 11,922 and Females are 7,266. As found from the recorded cases of HIV positive in Odisha, youths in the age group of 25-49 years are found to be affected more, which is 78% of total HIV cases (The Times of India, 1st Dec 2010, Bhubaneswar, National).

In Odisha, four districts came under category –A – Ganjam (3.2%) of total population, Anugul, Bhadraka and Balangir (1%) of the total population. Three districts come under category-B- Khurda, Koraput and Balasore (0.5%) of total population as HIV/AIDS affected area. AIDS is increasing alarmingly in Odisha in spite of constant awareness. As per official report, 71 people died in Odisha during last one year by 1st Dec 2011. So far 1311 AIDS cases have been registered in the state.

The Government report says as many as 22,934 cases of HIV positive has been recorded so far. However experts say that the figure may cross 40,000. Many cases of HIV/AIDS are not reported in the state due to inadequate health infrastructure, lack of awareness and the social structure.

From 1311 cases of AIDS registered in the state, maximum of 501 cases are reported from Ganjam district, where 431 people had died in AIDS. Ganjam has become vulnerable to HIV/AIDS due to a number of causes including mass migration.

If we look deeper, the HIV status in Odisha needs serious attention from all concerns. According to the survey conducted by Odisha State AIDS Control Society (OSACS) in 2002-2011, a total of 14,242 males and 8679 females have been reported with HIV positive. Among them 1538 cases belong to people below 14 years of age. Similarly, out of the total figure 17,356 cases reported includes people with in age limit of 25 to 49 years. This age group has proved to be most vulnerable to this dreaded global phenomenon. As per the study 2041 HIV positive cases belong to within age group of 14 to24 and 1006 people above 50 years have been listed to the syndrome. At least 958 cases of HIV positive is also recorded amongst pregnant women. These figures say about alarming position in state of HIV in Odisha.

HIV is attributed to a number of causes and HIV through sexual transmission happen to be at the top of the list. In Odisha 82.69% HIV cases are transmitted through sexual mode. The number of cases in this category has reached 18,695. Among them 12,316 are males and 6,649 are females. Sex with the HIV positive partner, sex with multiple partners and unsafe sex are the reason behind the situation, experts comment. Similarly among other cases, when 217 people got HIV through blood transfusion, 477 cases attributed to infected needle, 1483 children have been reported as HIV positive due to ignorance of the parents.

When AIDS has spread its tentacles in the coastal districts like Ganjam and Jagatsingpur, its mark has also been felt in the backward districts like Malkangiri, 158 cases of AIDS have been reported in the district which has taken 148 tolls among them. Similarly in block like Boudh 71 AIDS patients have died out of 73. Whereas this figure in Puri is 66 out of 73, in Kendrapada it is 73 out of 74; in Nayagarh it is 7 out of 8, in Keonjhar all 6 patients died and in Dhekanal and Bhadrak 1 HIV cases each has been reported to be dead.

On the eve of World AIDS day, it is time to review the real state of HIV and AIDS in Odisha vis-à-vis our action and approach in government and non-governmental level to curb

the menace. Though government is confident in saying that the cases of HIV have gone down, experts comment that it cannot be believed that our population is protected from the risk of HIV/AIDS. Poor infrastructure in health sector especially in rural areas, lack of awareness among the folks, inadequate facilities across the state to detect HIV cases and large scale corruption in different awareness projects have created challenges towards controlling the disease in the state (December 1st ,2011).

Table No. 1.2

District wise HIV +ve/ AIDS/ Death cases – Odisha uptoFebruary 2013 by OSACS

Sl. No.	Districts	HIV +Ve	HIV +Ve	HIV +Ve	%age	AIDS cases	%age	Death due to AIDS	%age
		General	ANC	TOTAL					
1	Anugul	829	79	908	3.3	60	3.8	56	4.1
2	Balangir	590	43	633	2.3	58	3.7	58	4.3
3	Balasore	808	46	854	3.1	54	3.4	54	4.0
4	Bargarh	360	25	385	1.4	7	0.4	7	0.5
5	Baudh	22	3	25	.1	4	0.3	4	0.3
6	Bhadrak	532	36	568	2	76	4.8	74	5.4
7	Cuttack	3502	69	3571	12.8	119	7.5	46	3.4
8	Debgarh	44	7	51	.2	2	0.1	2	0.1
9	Dhenkanal	187	13	200	.7	15	0.9	13	1.0
10	Gajapati	538	59	597	2.1	6	0.4	5	0.4
11	Ganjam	9922	515	10437	37.5	507	32.0	437	32.1
12	Jagatsingpur	141	13	154	.6	18	1.1	18	1.3
13	Jajpur	311	15	326	1.2	50	3.2	48	3.5
14	Jharsuguda	168	13	181	.6	8	.5	6	0.4
15	Kalahandi	468	11	479	1.7	5	.3	5	0.4
16	Kandhamal	64	2	66	.2	16	1	13	1.0
17	Kendrapara	269	24	293	1.1	74	4.7	73	5.4
18	Kendujhar	249	12	261	.9	6	.4	6	0.4

Sl. No.	Districts	HIV +Ve	HIV +Ve	HIV +Ve	%age	AIDS cases	%age	Death due to AIDS	%age
		General	ANC	TOTAL					
19	Khorda	1210	59	1269	4.6	54	3.4	46	3.4
20	Koraput	1479	70	1549	5.6	158	10	148	10.9
21	Malkangiri	147	9	156	.6	11	.7	6	0.4
22	Mayurbhanj	438	36	474	1.7	19	1.2	16	1.2
23	Nabarangour	539	21	560	2	22	1.4	20	1.5
24	Nayagarh	596	23	619	2.2	8	.5	7	0.5
25	Nuapada	331	11	342	1.2	19	1.2	19	1.4
26	Puri	564	14	578	2.1	73	4.6	66	4.8
27	Rayagada	556	43	599	2.2	67	4.2	52	3.8
28	Sambalpur	1198	45	1243	4.5	39	2.5	33	2.4
29	Sonpur	51	3	54	.2	0	0	0	0.0
30	Sundargarh	388	30	418	1.5	28	1.8	23	1.7
	TOTAL	**26501**	**1349**	**27850**	**100**	**1583**	**100**	**1361**	**100.0**

HIV and AIDS remain a challenge for 21st century. HIV infection by the year 2020 is predicted to be the tenth leading cause of burden in the world (Murray and Lopez 1996). AIDS is not just a biological ailment. It has social and cultural dimensions certainly experts can perform extensive medical research. They can diagnose and treat the patients the way they do with other chronic diseases. However, the emotional aspect of AIDS, the societal complexities associated with and logistical factors like availability of treatment centres need active participation from those directly affected.

The problem is aggravated by the fact that there is a lack of overall awareness about the disease among majority of the masses. Continuing myths and misconceptions regarding the cause and transmission of the disease are causing " AIDS Phobia" where in people living with or affected by HIV/AIDS are being strongly discriminated by the general population

while at the same time it is also leading to " Physician bias" that poses a major deterrent to treatment and care of HIV/AIDS infected people. Further, the stigma attached to certain populations practicing high risk behaviour extends the marginalization of the most vulnerable section.

Efforts are underway in almost all parts of country to implement large scale information and education programs for HIV/AIDS prevention. First of all we should know more about HIV and AIDS, its origin, development, causes, transmission, prevention and treatment etc.

HIV (Human Immuno Deficiency Virus) is a virus that causes AIDS (Acquired Immuno Deficiency Syndrome) in which person is affected by a series of diseases because of the poor immunity. HIV by itself is not an illness and does instantly lead to AIDS. An HIV infected person can lead a healthy life for several years, before he/she develops AIDS. As the name Acquired Immuno Deficiency Syndrome indicates AIDS is health condition that results from the deficiency in the body's immunity following HIV infection. HIV attacks the human body by breaking down its immune system that is meant to fight disease.

The term AIDS for Acquired Immune Deficiency Syndrome, was officially adopted by the Centre for Disease Control (CDC) in the year 1982. AIDS is the final stage of HIV infection.

The human blood stream consist of RBC (Red Blood Corpuscles), WBC (white blood corpuscles) and platelets. The WBCs protect the body against disease. The lymphocytes involved in immunity are subdivided into: B-cells and T-cells. B-cells produce anti-bodies and T-cells are involved in graft rejection. Some T-cells help B-cells to produce anti-bodies which fight disease causing organisms. These T-cells are called "helper" cells. Other T-cells known as suppress or cells work to stop or suppress the fight against invading germs once the infection has been overcome. In a person with AIDS, the suppressor cells outnumber the helper cells, thus making the immune system weak and ineffective in its fight against disease.

HIV is a family or group of viruses called lentiviruses. Lentiviruses other than HIV found in a wide range of non-human primates. These other viruses are known collectively as

Simian (monkey) viruses (SIV) where a subscript is used to denote their species and origin. It is now generally accepted that HIV is descendant of Simian (monkey) Immuno Deficiency Virus (SIV). Certain Simian immune deficiency viruses bear a very close resemblance to HIV-1 and HIV-2. (Source: "The origin of AIDS and HIV and the first case of AIDS" http//www.avert.org)

Only two years after AIDS was first discovered in the USA, scientists in France isolated its causative agent, which is called Lymphadenopathy Associated Virus (LAV). The virus was independently isolated by two groups of research workers in the USA, who called it Human-T-Lymphocyte virus type-III (HTLV-III) and AIDS Related Virus (ARV). The virus is now generally known as the Human Immuno-Deficiency Virus.

The causative agent of AIDS belongs to the family of Retroviridal Virus (Retro-reverse as backward). The Retro viruses have three sub families–Oncovirinal, Lentivirinal and Spumavirinal. During 1980-81 Robert Gallo and colleagues of the National Cancer Institute, Bethesda, Wary land, USA isolated and characterized the Human Retrovirus or HTLV which was called HTLV-1, but in 1982 the same group of workers isolated the second type of virus and called it HTLV-II. Like the AIDS virus, both the virus affects the T-cells. Lentivirinae, (Lente meaning 'slow') are the classic 'slow' viruses. This was called HTLV-III and AIDS associated Retro virus (ARV) by Gallo and LAV by French workers in the year 1983-84.

HIV was first discovered by Baree, Sinoussi, Montagnier and colleagues at the Institute-Pasteur, Paris in 1983. It was named as LAV. In 1984, Gallo and others named it HTLV-III. In May 1986, The International committee on the Taxonomy or Viruses recommended a new name as Human Immuno-deficiency Virus (HIV). AIDS is caused by this HIV. Francis Baresinorasi and Luc Montagnier were awarded Nobel Prize for Medical Science for the year 2008 for being successful in discovering HIV as the cause of the pandemic AIDS.

HIV is a rapidly multiplying virus. It has been isolated from: blood-semen, vaginal/cervical secretions, bone marrow, saliva, brain-tissue, cerebrospinal fluid – Tears,

Urine, Amniotic fluid and Breast milk, however only blood, sexual secretions and breast milk have been shown to transmit the virus. Early infection with HIV may occur with variety of symptoms and signs including lethargy, malaise fever, sore throat, myalgia, anorexia, sweating, arthralgia, headache, diarrhoea etc. The most common clinical manifestation in patients with HIV infections are weight loss and weakness. AIDS is the most severe end of the clinical spectrum of HIV infections.

HIV is a fragile virus. It cannot live very long outside the body. As a result the virus is not transmitted through day to day activities such as shaking hands, hugging or a casual kiss. One cannot become infected from a toilet, seat, and drinking fountain, dishes, drinking glasses, cups, plates, food or pets or from mosquitoes.

HIV is primarily found in the blood, semen or vaginal fluid of an infected person. HIV is transmitted in three main ways:

- Having sex (anal, vaginal or oral) with HIV infected person.
- Sharing needles or syringes with HIV infected persons.
- Being exposed (foetus or infant) to HIV before or during birth or through breast feeding (MTCT- Mother to child transmission)

HIV can also be transmitted through blood infected with HIV. However since 1985 all blood donated in the USA has been tested for HIV. Therefore the risk for HIV infection through the transfusion of blood and blood products is extremely low. The USA blood supply is considered the safest in the world.

Someone may be at increased risk of infection if one has;

- Injected drugs or steroids during which equipment such as needles, syringes, cotton, water and blood were shared with others.
- Had unprotected vaginal, anal or oral sex with who have sex with men (MSM), multiple partners or anonymous partners.
- Exchanged sex for drugs or money.

- Been given a diagnosis of or been treated for Hepatitis, Tuberculosis (TB) or sexually transmitted disease (STD) such as ‘Syphilis’.
- Received a blood transfusion or clotting factor during 1978-1985.
- Had unprotected sex with someone who has any of the risk factors listed above.

The San Francisco AIDS foundation has explained the acronym AIDS as:

A = Acquired – not born with

I = Immune – body’s defense system

D = Deficiency – not working properly

S = Syndrome – a group of signs and symptoms.

Many of the signs and symptoms of HIV infections are also the symptoms minor illness or infections, but with HIV the symptoms either do not go away or keep coming back. Once infected with any kind of disease, people with HIV/AIDS virus will stay sick althrough. These infections are called “opportunistic infections”. These infections take the opportunity of weak immune system of our body. Some of the signs and symptoms or illnesses noticed among the HIV infected are mentioned earlier.

Since HIV/AIDS is a problem that profoundly affects most aspects of people’s life, it raises many social, economical and cultural issues that relate to human rights, ethics and law. Many people with HIV/AIDS suffer discrimination, intolerance and prejudices creating an environment in which there is need of respect for the human rights of the people living with the virus or affected by it, in other ways as AIDS orphans. Let these people to live with dignity without discrimination. People are less likely to present themselves for voluntary HIV testing and as a result they are unable to access treatment, care and support.

While the pandemic of AIDS denotes a medical enigma of modern times, it also signifies a social tragedy. Earlier AIDS was considered to be an impolite subject to discuss in social gatherings. It was glossed over as the problem of gays, harlots and junkies. There are no individuals or groups that could be taken at “Zero risk” level. But even now misconception about AIDS and AIDS patients are abound. Not only do AIDS patients suffer, reportedly from guilt feelings, low self image and lowered status in the family but they also

get socially stigmatized and virtually ostracized. This apart, the presence of an HIV patient in the family has several unhealthy effects. Interpersonal relations turn invariably tenuous where the viruses aggravate into AIDS and the patient be an earning member the family may slip into penury and destitution. Besides, the possibility of social stigma and hence segregation of the entire family-group looms large.

In India, as elsewhere, AIDS is often seen as "someone else's problem" as something that affects people living on the margins of society, whose lifestyles are considered immoral. Even as it moves into the general population, the HIV epidemic is still misunderstood among the Indian public. The people living with HIV have faced violent attacks, been rejected by families, spouses and communities, been refused medical treatment and even, in some reported cases denied the last rites before they die.

The employees are not disclosing their status to their employers for fear of discrimination in the working place by their colleagues and for loss of employment. Of the 26% who did disclose their status, 10% reported having faced prejudice as result. People in marginalized groups – female sex workers, transgender and gay are often stigmatized not only because of their HIV status but also because they belong to socially excluded groups.

Stigma is made worse by a lack of knowledge about HIV/AIDS. Although a high percentage of people have heard about HIV/AIDS in urban areas (94% of men and 83% of women) this is much lower in rural areas where only 77% of men and 50% of women have heard of HIV/AIDS. However, the real challenge lies with the ignorance about how HIV is transmitted – for example, the majority of men and women in rural areas believe that AIDS can be transmitted by mosquito bites. In 2009, NACO carried a population based survey in Nagaland which showed that the 72.8% of people believed HIV could be transmitted by sharing food with someone.

Prevention Methods :

"Prevention is better than cure" is a widely accepted statement. Though, since now no such successful medicine has been invented for cure of HIV/AIDS, the prevention method is

given more importance to curb this. The safest and surest way to avoid HIV is to mend one's behaviour in terms of sexual activities. Prevention method may include the following:-

- Abstain from sex (do not have oral, anal or vaginal sex with infected person)
- Having sex only with uninfected and faithful spouse
- Education about HIV/AIDS: how it spreads and how to avoid it.
- Avoidance of sexual activities with homosexuals, strangers and prostitutes

It is unfortunate that whatever is being supplied in terms of information, dissemination in our country advocates only one message, "use condoms to have sexual intercourse", whereas our traditional, cultural, social and religious values which always gave us one and only one message, " no sex before marriage – have sex, after marriage – that too only with one's own spouse". Pre-marital chastity and marital fidelity is most valued ideals of marriage. If we are faithful to ourselves, then we do not need condoms to protect ourselves against HIV/AIDS/STDs.

To protect ourselves, we should remember the ABC theory for prevention of HIV/AIDS.

A – Abstinence

B – Be faithful to own spouse

C – Correct and consistent use of condom

Programs, directed at the prevention of HIV transmission through information, motivation and education are likely to modify people's life style which in turn, would make a substantial dent into the problem. While most averagely educated persons have heard of AIDS, the knowledge about HIV/AIDS in the general population is woefully low. Looking to the enormity of the problem what is tar gently required is a cohesive, cross-sectorally, coordinated and cost effective awareness generation program, capable of informing, educating and influencing people in both urban and rural areas. In a developing country like India, reaching out to masses is daunting task where three persons out of ten are illiterate. Comparatively, it is a conservative society; sexuality is rarely talked about, what to say of sex education to young boys and girls. These limiting conditions often act as stumbling block in

information dissemination on AIDS. Media of communication have to reckon with them and need to address in the first place sex education, single partner sex, safe sex practice, male's responsibility of safe sex etc. Simultaneously it needs to inform and educate people on nature and gravity of AIDS, routes of its transmission, risk reduction attitude towards the infected etc.

Any long term strategy aimed at preventing AIDS has to head for the modification of peoples thinking and behaviour. Adequate understanding of sexual behaviour and health seeking behaviour of groups at risk lies at the base of AIDS prevention program. On the other hand, it is a taboo subject for conversation and promiscuity is still more so.

The WHO (World Health Organization) has developed a set 10 prevention indicator (PI) with the objective of evaluating National AIDS Control Program (NACP). These indicators were designed to evaluate achievements in respect of knowledge about preventive practices, availability, accessibility and actual use of condoms, quality of STD care and reduction in incidence of STD. the evaluation called prevention indicator (PI) survey has been successfully conducted in five states, viz. Maharashtra, Tamil Nadu, West Bengal, Delhi and Haryana (NACO 1996, Meenu Sharma).

The international AIDS society (IAS) is the world's professional society for scientists, healthcare and public health workers and others engaged in HIV/AIDS prevention, control and care. The IAS is the custodian of the international AIDS conferences, the paramount gathering of all discipline in HIV/AIDS. These conferences started in 1985 in Atlanta, Georgia, USA were annual between 1985 - 1994, but are now held in every two years. They provide a unique forum for the interaction of science, community and leadership with the goal of bringing knowledge together changes in the world's response to HIV/AIDS. The IAS also organizes the highly successful IAS conferences on HIV pathogenesis, treatment and prevention. It aims to bring together participants from around the world by providing an environment for researchers and clinicians to address current issues in HIV research, prevention and treatment.

The President's emergency plan for AIDS Relief (PEPFAR| Emergency) is President Bush's pledge of $15 billion over five years (2003-2008) to fight the HIV/AIDS pandemic.

To slow the spread of the epidemic PEPFAR supports a variety of prevention program: the ABC approach (Abstain, Be faithful and correct & consistent use of condoms), prevention of mother to child transmission (PMTCT), interventions and programs focusing on blood safety, injection safety, secondary prevention (Prevention with Positives) and education.

In addition to providing anti-retroviral therapy (ART) PEPFAR supports prevention and treatment of opportunistic infections as well as services to prevent and treat malaria, TB, water-borne illness and other acute infections. PEPFAR supports training and salaries for personnel (including clinicians, laboratorians, counselors, medical record staff, outreach workers, peer educators etc.), renovation and refurbishment of health care facilities, management for drugs and other.

Anti retroviral drugs which can be significantly delay the progression from HIV to AIDS – have been available in developed countries since 1996. Unfortunately, as in many resource-poor areas, access to these treatment is limited in India; an estimated 3, 00,000 adult (aged 15 and above) were receiving free ARVs by April 2010. When HIV becomes resistant to ARVs, the treatment regimen needs to be changed to second-line ARVs. As with many other parts of the world, the second-line treatment in India is far more expensive than the first-line treatment. In 2008 NACO began to roll out government funded second-line antiretroviral treatment in two centres in Mumbai and Chennai. By 2009 the second-line therapy was available in a total of eight states but treatment remains very limited. However, the large scale of India's epidemic, the diversity of its spread and the country's lack of finances and resources continue to present barriers to India's antiretroviral treatment program.

The impact of AIDS is now being increasingly felt by many countries across the globe. The disease is tearing away the social and economic fabric of the global community by

killing people in prime of their youth on whom the society relies for production and reproduction. The epidemic is eroding the hard earned gains in development, indicators by regressing life expectancy, rising child mortality rates and leading to a substantial fall in GDP (gross domestic product) growth in many countries. Huge number of farmers, teachers, doctors and other human resources are being claimed by the epidemic leading to wide spread shortage of food and access to medical care. (UNAIDS/WHO Dec 2001)

National AIDS control organization in India has implemented National AIDS control program at national and state level. During the first phase of the program (1992-1998) emphasis was on setting up infrastructure at state level monitoring HIV/AIDS cases and top priority given to blood safety. Zonal blood testing centres were established and all blood screening for HIV there by banning paid blood donation. Family Health Awareness Week (FHAW), whereby syndromic approach to treatment of STDs and AIDS adopted in all districts, villages and hamlets of each state twice a year. Phase-2 of the program began in 1999 with institutional strengthening, sentilence surveillance centres functioning was streamlined and awareness and intervention programs gained force. Salient features of the 2nd phase also includes providing facilities for VCT and informing the sexual partners. Emphasis on blood safety continues with setting up of modern blood banks and voluntary blood testing centres. A multi sectoral approach is adopted to combat AIDS in the country.

The 3rd phase of National AIDS Control Program (NACP-III) has been launched from 6th July 2007. The overall goal of NACP-III is to halt and reverse the epidemic in India over the next five years by integrating programs for prevention, care, support and treatment.

This will be achieved through a four pronged strategy during 2007-2012:

- Prevention of new infections in high risk groups and general population through:
    (1) Saturation coverage of high risk groups with TIS (Targeted Interventions)
    (2) Scaled of interventions in the general populations.
- Providing greater care, support and treatment to a large number of PLHA (People living with HIV/AIDS)

- Strengthening the infrastructure systems and human resources in prevention, care, support and treatment programs at the district, state and national level.
- Strengthening the nationwide strategic information management system.

This National AIDS Control Program (NACP) is being implemented through NACO, New Delhi under Ministry of Health and Family Welfare, Government of India with the support of DFID and World Bank fund. Accordingly autonomous organizations namely: State AIDS Control Societies have been formed in each of the states for smooth implementation of the programme.

NACP-I was implemented by Government of Odisha under Director, Health Services from 1992-1999. From 1999 to 13.07.04 program under NACP-II was implemented through Odisha State Health and Family Welfare Society in the name and style of State AIDS cell (SAC). From 14.07.2004 – 05.07.2006: As per the direction of NACO, a new society i.e. Orissa state AIDS Control Society (OSACS) was formed and has registered under Societies Registration Act XXI of 1860 vide Regd. No. 21886/64 of 2004-2005.

Odisha is a low prevalent state but highly vulnerable to HIV/AIDS. The people with HIV/AIDS in Orissa, like other states have been Ostracised and mistreated by their families, friends, communities and medical fraternity driving them to despair and sometimes forcing them to commit suicide. PLWHAS (people living with HIV/AIDS) being denied of treatment at both government and private hospitals are not uncommon in Orissa. We find the affected people stigmatized in the society. Sometimes the PLWHAS exercise self stigma before they are socially stigmatized. Being afraid of social stigma and discrimination they may not go to hospital for testing their blood if they suspect of being HIV positive. Self stigma, institutionalized stigma and social stigma together make some PLWHAS to commit suicide. Such stigma and discriminations towards HIV/AIDS affected/infected are caused due to myths and misconceptions, illiteracy and lack of awareness of the people in the society.

In such a critical situation OSACS has to do a lot of things for creating awareness among the people against HIV/AIDS, because awareness is the one and only way to prevent

HIV/AIDS. So that there is a slogan, “Know AIDS to no AIDS”. OSACS has taken up a lot of ventures for HIV affected people. The then President of OSACS Dr. Parameswar Swain said, “We give ART (antiretroviral therapy) treatment to AIDS patients whose CD4 level in the blood comes down from 300. ART helps to improve their immune system. We are also planning to give (Nutri Plus), the proteinous food to HIV positive people from 1st Dec free of cost. OSACS also organizes IEC (Information, Education and Communication) programs including community mobilization radio program. (The Times Of India, Bhubaneswar, National, 1st Dec 2008).

OPUS (Orissa Patita Udhar Samiti) has also been carrying out its programs like BCC (Behavioural Change Communication), condom promotion, advocacy, networking with (government and NGOs) and community mobilization for the benefit of HIV affected people. (The Times of India, Bhubaneswar, National 1st Dec 2008).

In spite of a number of developmental activities by OSACS, advertisements, propaganda and awareness creation program against HIV/AIDS in mass media (TV, Radio and News paper) people in rural areas have misconceptions regarding infections and transmission of HIV/AIDS.

Therefore the research work aims to study some such objectives to create awareness about HIV/AIDS amongst the rural masses. The specific objectives of the present study were to have an insight into the respondents myth and misconception relating to HIV/AIDS. The present study focuses on awareness level, attitudes, misconception and ostracization by ruralites towards HIV/AIDS infected patients and affected people i.e. the family members, spouse and children of the HIV/AIDS infected patients. It also focuses on the needs of family and social care for HIV/AIDS infected and the roles of governmental and nongovernmental organizations and mass media in changing social attitude towards them.

The objectives of this study are in line with the global AIDS strategies of creating an enabling environment, addressing critical poverty related issues and HIV/AIDS vulnerability while most of the countries have developed strategic framework for effective HIV

prevention. Yet only a fraction of people at risk of HIV infection have accesses to basic prevention services (UNAIDS,2003). Since HIV/AIDS is a problem that profoundly affects most of the aspects of the peoples life, it raises many social, economic and cultural issues that relate to human rights, ethics and law.

The people who are knowingly or unknowingly infected/affected by this dreadful disease have right to life like others. Since everyone is entitled to fundamental human rights without discrimination, people living with HIV/AIDS (PLWHA) have the same right to education, employment, health, travel, marriage, recreation, privacy, social security, scientific benefits, asylum etc. All persons should share responsibility for avoiding HIV infection or reinfections. People who are infected/affected by HIV/AIDS having no fault with them are found suffering from discrimination, ostracization, intolerance and prejudices which create emotional stress on them. They feel alienated from themselves, from their families and from their communities which sometimes lead to maladjustment in society or force to commit suicide.

Therefore it needs change of attitude and behaviour of masses towards PLWHAS. The attitudinal and behavioural change can only be possible through the right knowledge about the causes, transmission and prevention of HIV/AIDS. So that a concerted effort can be made to understand various factors that can effect behavioural changes in the context to HIV/AIDS. Critical ‘ Grey Areas’ in the form of lack of awareness, myths and misconceptions relating to HIV/AIDS, negative attitude towards PLWHA and practicing unsafe behaviour that need urgent attention have been delved into, as they can help in evidence based planning of strategic interventions for the control of HIV/AIDS.

Further, the study envisages to demonstrate how both familiar and social support, care and co-operation can help the PLWHA to lead a normal life like others in society. The present study also undertakes to know the governmental and non-governmental organizations in influencing and changing the attitude and behaviour of the masses toward PLWHAS and towards their family members.

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CHAPTER – II

REVIEW OF LITERATURE

- Introduction
- The Spread of HIV – A regional overview
- AIDS threatening the Global Development: Factor driving AIDS Epidemic
- HIV/AIDS and the timeline
- How HIV spreads
- HIV- The dangerous and Fast mutating virus:- (Counseling, Support, ART and Vaccine development)
- Global Response to the AIDS Epidemic
- International conferences on HIV / AIDS
- World AIDS Day
- Discrimination against people living with or affected by HIV / AIDS (PLWHA): HIV/AIDS and Human Rights
- Community Participation
- AIDS in INDIA
- HIV / AIDS in different States of India: Its prevention & cure
- Awareness creation as a means of prevention
- Use of IEC in creating HIV / AIDS Awareness
- Various possible Prevention, Treatment and cure of HIV/AIDS
- National AIDS Control Programme (NACP) by NACO in India
- World Health Organisation (WHO) Policy for NGOs
- Governmental & Non-Governmental Provisions for well being and maintenance of HIV/AIDS patients.
- Limited success of HIV prevention programme
- HIV/AIDS picture in different parts of Odisha and visible Stigma and Discrimination (S & D) toward PLWHA
- Ostracization scenario of HIV/AIDS patients and their family members in Kendrapara District
- Spread of the wings of services and support in Odisha
- Activities under Odisha State AIDS control Society (OSACS)

CHAPTER-II

REVIEW OF LITERATURE

Before conducting research on any topic it is required to look into different aspects of already existing related study or theory. Since research is a continuous process, some sort of continuity must have to be maintained with the earlier theories. A theory is a set of related ideas. Theoretical debate or review of literature is the most important and accepted technique to acquire information about the different dimensions of study and to synthesize the judiciousness of the study. It is a type of sociological discussion and deliberation on the research topic and different dimensions of study with reference to the earlier studies. It tries to organize the knowledge of the specific areas of research in order to evolve an edifice of knowledge to show that the study would be an addition to the existing knowledge in field.

Theoretical studies provide the rationale for the proposed study. Theoretical debate reveals what problems have already been investigated, what problems have been answered; what issues still remain subjected to research. Theoretical debate sharpens researcher's mind, guides the researcher's thinking and makes it possible for him/her to identify the most relevant methods and tools for study.

In almost all kinds of sociological research it is necessary to review past theories, concepts and studies and establish a linkage. A thorough debate on the past studies and research will help the researcher to understand the present problem more accurately and exactly. It may also helpful in the confirmation or rejection of the findings.

With the increasing number of HIV infections and AIDS related deaths running into thousands the need for prevention of this epidemic has become imperative.

To this, the importance of creating AIDS awareness as one of the best and cost effective methods of prevention has been unanimously accepted world wide. It has been shown time and again that awareness regarding HIV/AIDS can vitally help in bringing down the number of HIV infections by cutting down high risk behaviour and practices. So that

present research is increasingly focused on prevention of HIV/AIDS through creation of awareness against misconception, ostracization and stigmatization of HIV/AIDS infected/affected and changing attitude and behaviour of normal population towards PLWHA through mass media communication program. With the goal of achieving sustainability of the programs and to get comprehensive insight in to the magnitude of the AIDS epidemic and various related aspects accelerating its fast spread and its effect on the whole universe, the available literature was reviewed. It is presented in this section under the following headings:

- Spread of HIV – A Regional overview
- AIDS threatening the global development factors driving AIDS epidemic
- How HIV spreads. (HIV/AIDS and the time line)
- HIV- the dangerous and fast mutating virus (including counseling, support, ART and Vaccine Development).
- Global response to the AIDS Epidemic.
- International Conferences on HIV/AIDS.
- World AIDS Day.
- Limited success of HIV prevention programmes.
- Discrimination of PLWHAS.
- AIDS in India.
- Prevention and cure of HIV/AIDS in different states of India.
- Awareness creation as a means of prevention.
- Prevention, Treatment and Cure of HIV/AIDS.
- National AIDS Control Programme by NACO in India.
- WHO Policy for NGOS.
- Governmental and non-governmental provision for well being and maintenance of HIV/AIDS Patients.
- Activities under Orissa State AIDS Control Society (OSACS).
- Spread of the Wings of services and supports in Odisha.

The Spread of HIV – A Regional Overview:

In the summer of 1981, the Centre for Disease Control and Prevention (CDC), in the USA reported that five homosexual men were suffering from an unusual type of Pneumonia caused by parasite Pneumocystis carini CDC also confirmed that homosexual men in New York and Los Angeles had developed one type of Skin Cancer called Kaposis Sarcoma (WHO 1997). These were the first reported cases that announced the arrival of AIDS. Today, AIDS pandemic (Global epidemic) has become one of the biggest public health problems worldwide.

Africa, the Global epicentre continues to dwarf the rest of the world on the AIDS balance sheet. Since the start of the Epidemic, 83 percent of all AIDS death. So far have been reported from this region and at least 95 percent of all AIDS orphans have been African. The bulk of new infections continue to be concentrated in East and Southern Africa (UNAIDS / WHO, Dec 1998). According to recent estimates Southern Africa is home to about 30% of people living with HIV/AIDS (PLWHAS) worldwide; while the region has less than 2 percent of the world's population. By the end of the year 2003, nearly 27 million people in Sub-Saharan Africa were living with HIV while another 2.3 million succumbed to the disease the same year (UNAIDS / WHO, Dec 2003)

The Caribbean records the second highest HIV infection rates worldwide after Africa. More than 2 million people are now living with HIV in Latin America and the Caribbean with the region experiencing the highest death toll after Sub-Saharan Africa and Asia Hetero Sexual transmission predominates in the Caribbean while the bulk of South American countries, all modes of transmission co-exist.

In the Eastern- Europe and Central Asia the number of people living with HIV/AIDS is estimated to be nearly 1.5 million Injecting Drug use and unsafe sex account for bulk of new infections in these regions along with the possibility of hidden epidemic brewing among men having sex with men (MSM).

Similarly North Africa and Middle East are also experiencing the rise in new HIV infection. The number of PLWHAS had reached 6 lakhs by the end of 2003. Heterosexual

contact men having sex with men (MSM) and injecting drug use (IDU) were found to be mounting the HIV epidemic.

North America, Western Europe, Australia and Canada represent the high income regions of the world and together have nearly 1.6 million people living with HIV/AIDS. Homosexuality is the leading cause for majority of new HIV infections over here followed by injecting drug use. Yet, in these regions AIDS death continue to reduce significantly because of access to anti-retroviral (HIV) therapy. However unfortunately the encouraging wide spread public complacency and giving rise to misperceptions that there is a cure for AIDS (UNAIDS / WHO, Dec 2000).

In Asia, over 7.4 million people are already infected and HIV is clearly spreading fast in the vast population of India and China. Commercial sex and injecting drug use remain the predominant modes of viral transmission in the region with India providing an interesting example of the shifting trends of the HIV.

According to UNAIDS / WHO (Dec. 1998) HIV infections exhibiting the following significant patterns in India.

1. HIV infection in India was concentrated mostly in urban sex workers, their clients and in drug injectors. But the last round of sentinel survelliance has shown that in a few states more than one percent of the pregnant women in urban areas are now HIV infected.
2. India's rural areas which are home to 73 percent of the country's population were thought to be relatively spared by the epidemic. Again new studies show that HIV is becoming worringly common in village too. For e.g. in Tamilnadu a survey of randomly selected households revealed that 2.1 percent of the adult population living in rural areas had HIV, as compared to 0.7 percent of the urban population.
3. The virus is firmly embeded in the general population especially among women whose only risk behaviour is having sex with their own husbands. In a study of 400 women attending STD clinics in Pune, 91 percent had never had sex with anyone but their husbands and yet, 13.6 percent of them tested positive for HIV.

All these trends are acting as warning signs showing the massive transcend of HIV from high risk behaviour population to the general population.

AIDS Threatening Global Development:

The epidemic constitutes an urgent and massive threat to the development in many ways such as:

1. Life expectancy regressed:

Life expectancy at birth is used as an indicator to measure human development. According to UNAIDS / WHO (Dec. 1998) AIDS is wiping out the gains to development by reducing life expectancy. Taking countries like South Africa, Keneya, Zambia and Zimbabwe which have an adult HIV prevalence rate of 10 percent or more, calculations predict that AIDS on an average will cost them 17 years of life expectancy. Instead of rising and reaching by years by 2010-2015, life expectancy due to AIDS will be cut down on an average of 47 years.

2. Rising child mortality rate:

HIV / AIDS is by and large threatening child survival rate. Acc to UNAIDS / WHO (Dec 1998) by the year 2005-2010,61 out of every 1000 infants born in South Africa are expected to die before their 1st birth day. Infant mortality, otherwise, in the absence of AIDS would be only 38 per 1000 births.

3. Pushing children into orphan hood:

The number of children being orphaned and thus, in need of care is rising with each passing day as AIDS is cutting into their families. A study in Zimbabwe showed that many households are being headed by adolescents and children (some as young as II years) as majority of them had lost both parents to AIDS (UNAIDS /WHO, Dec – 1998). The study further revealed that majority of such children on being interviewed, said that they would become delinquent and drift into prostitution and on to the streets if their needs were not met. They were also worried about exploitation and abuse by their relatives.

India, too, faces a grim situation in views of the fact that the country reportedly has the second largest number of HIV in the world. In the absent of any cure, these infections are likely to turn into facilities in the near future, thus rendering many children into orphan hood. Although globally, the number of children orphaned by AIDS is projected to rise at least 25 million by 2010, yet 39 percent of countries with generalized HIV epidemic.

4. Business beginning to suffer:

Many businesses are suffering heavily as AIDS is decimating the pool of skilled workers and eating away the economy too. The epidemic is exacerbating the severe shortage of skilled labour in many sectors of the economy. As a result Botswana is forced to import white collar workers from the neighbouring countries. Zambia is facing an acute shortage of teachers as many of them are increasingly dying of AIDS. In the Indian Capital, Delhi a study conducted by the Operations Research Group revealed that a majority of those infected with HIV / AIDS were in their most productive age group. For instance out of 646 confirmed AIDS cases in city till Nov. 2001, as many as 534 belong to the age group of 15 – 49 years (Indian Express, April 4, 2002). If this trend continues, productivity in many businesses is expected to fall significantly giving a major setback to the economic development. Not only this, but the country's life blood is its teachers, scientists and business professionals could be in jeopardy.

Factors Driving the AIDS Epidemics:

In the recent years there has been a growing awareness of complex biological, socio-cultural, economic, political and psychological forces shaping the face of the AIDS Pandemic meaningful strategies to reduce HIV related risk among population are not possible without a thorough understanding of these factors. Some of the major factors fueling the AIDS epidemic have been summarized in the table.

Table No. 2.1

Factors Shaping AIDS Epidemic

I.	Biological Factors	a. b. c.	Age at the time of initial HIV infection Sexual vulnerability Presence of STD
II.	Socio-Cultural Factors	a. b. c. d. e. f.	Sex and sexuality – A Taboo Machismo Behaviour Violence against women Norms and practices Education and HIV Myths and misconceptions
III.	Economic Factors	a. b.	Migration Prostitution
IV.	Political Factor	a. b.	War Ethnic conflict
V.	Psychological Factor	a. b. c. d.	Physical and sexual abuse Substance abuse Stigma and shame Gender role expectation

I. Biological Factors:

Studies conducted in nine different African countries suggest that for every ten year HIV infected African men there are around 12 to 13 women infected with the HIV (UNAIDS/ WHO Dec. 1999) why more women than men being infected with HIV can be explained by the following basic factors, which are:-

a. Age:

Women across the globe tend to become HIV infected at younger age than men due to prevalent biological and culture factors. Recent studies in Africa show that girls aged 15 to 19 years are about 5 to6 times more likely to become HIV positive than boys in the same age group (UNAIDS 1999).

The increased vulnerability of women can be attributed to cultural norms in many countries which require women to be younger than their husbands. This implies that if husband is subsequently infected with HIV he would be infecting his wife at a far younger age. Researchers in many industrialized countries have shown that the length of survival of HIV positive individual depends on the age at initial infection. The younger, the person at the time of initial HIV infection the longer is the survival time.

Thus, women who become infected at younger age as compared to their male counter parts are expected to live longer and be counted for a longer time as female population living with HIV/AIDS.

b. Sexual Vulnerability:

Currently, almost half of all new HIV infections are taking place among women, Eighty Four percent of these HIV infected women are in the reproductive age group i.e. 15 to 45 years and 9 out of 10 infected women are living in a developing country. In India around 2,30,000 women are getting HIV infected each year and more than four – fifth of all these infections are accounted by un-protected hetero-sexual contact. (NACO 2000)

c. Sexually Transmitted Diseases (STDs) Facilitate HIV Transmission:

The world Health organization (WHO) estimates that about 333 million people worldwide suffer from STD every year and about one million new infections are taking place everyday globally (NACO 2000). The term Sexually Transmitted Disease (STD) is used for all infections that are transmitted through vaginal, anal or oral sex contact STD can also be transmitted from mother to child before or during birth through contaminated blood, blood products, donated organs or tissues and by contaminated needles. Sexually Transmitted Infections (STI) is the new term that is now being commonly used to cover asymptomatic cases (i.e. symptom free cases) of STD. India has also a high incidence rate of STD with 40 million new infections each year and an annual incidence rate of 5 percent (NACO 2000).

II. Socio Cultural Factors:

HIV is certainly a behavioural epidemic that is driven by individual behaviours. Individual behaviours are in turn largely influenced by social, cultural and religious factors that leave people with little or no control over their exposure to HIV.

Sustaining behaviourial change among the rural women was found to be influenced Social, cultural and gender related factors.

Although tremendous progress and advancement in the fields of education, science and technology have led to radical changes in the primitive norms and practices, yet in many parts of the world certain socio-cultural practices have been recognized as hindering factors to HIV prevention efforts. These are:

a. Sex and Sexuality: A taboo:

Talking about sex and sexuality is still a taboo in many parts of the world. Cultural norms, social practices and family values by and large, dictate sex to be a private and prohibited issue which is not to be discussed openly in public. The sense of secrecy surrounding sexually talks has led to a major lack of sex education especially among young people who are making an early sexual debut. A study conducted by Pan American Health Organisation (PAHO) in 1998 in100 Schools showed more than 40 percent of sexually active adolescents had made their sexual debut before the age of ten (UNAIDS, 1999).

In India, relevant data assessing knowledge, attitude and beliefs regarding HIV / AIDS among the School and College going adolescents indicate a lack of AIDS awareness. A study conducted among Secondary School students in rural areas surround Delhi showed that although 25 percent of them are sexually active, yet majority of them were not aware about HIV prevention methods (1997).

b. Machismo behaviour:

Machismo, a Spanish word is often used for predatory behaviour which young men practice to prove their masculinity. It is a commonly practiced and accepted social norms in many parts of the world (UNAIDS, 1999).Youngmen are socialized to be aggressive and

virile where as women are expected to be passive and sexually subordinating. Machismo is leading young men to have early and frequent sex with multiple partners. A study by Reproductive Health Survey in Latin America showed that premarital sex is much more common among 15-24 years old males than females (www.unaids.org.1999).

c. Violence against Women:

Women subjected to violence at the hands of their husbands or partners are greater risk of acquiring HIV. The UNAIDS (1999) report reads "Even when the violence is not sexual, however, the mere threat of it makes women wary of challenging their partner's extra marital relations or afraid to demand condom use". One out of every three women world wide has been abused, beaten or co-erced into sex according to the global data (NACO, April 2000). Forced sex is known to transmit HIV more readily because of the greater probability of genital injury and because of no condom use in such situations (UNAIDS 1999).

d. Norms and Practices:

Adverse societal norms and practices also challenge women's ability to protect themselves from HIV. For instance, certain communities in India like the Bedias and Bancharas have a history of practicing community based prostitution. Like wise in some South Indian states, religious based prostitution (Devadasi System) and exploitation of girls is routine and part of the ritual of 'growing up' (UNFPA, Sept. 2000). Such practices coupled with a lack of negotiating power makes young girls more vulnerable to HIV/AIDS.

Globally, there exists an imbalance of power between men and women based on gender lines. Women's ability to make decisions about sex / safe sex and subsequently to protect themselves from HIV infections is embeded by poverty illiteracy, lack of economic independence and high level of sexual subordination. In many societies across the globe differentiation based on gender is fundamental. The virginity myth is a necessary condition for women to marry where as no such pre-requisite exists for men.

e. Education and HIV:

AIDS is a disease fuelled by poverty and ignorance. Globally, it is certainly the poor and less educated who are reeling under the impact of HIV epidemic. Since better educated

people have better paid jobs, they can afford goods and services that allow them to protect themselves from HIV. The global HIV / AIDS epidemic report shows that the countries with high level of literacy have low levels of HIV. The data comparison of 161 countries across the globe confirms a pattern of this kind (UNAIDS / WHO, June 1998).Further, analysis of studies focusing on 15 – 19 years old teenagers show that teen agers with higher education are more likely to use condoms than their counter parts with lower levels of education (UNAIDS / WHO, Dec 2000).

f. Myths and Misconceptions:

Myths and misconceptions regarding HIV / AIDS are in abundance and deeply ingrained in almost all communities worldwide. Although myths and misconception are largely associated with low levels of education, yet studies continue to indicate that even medical professionals have their own share of such beliefs.

Myths such as HIV infected people should be totally isolated from the society, HIV infected children should not be allowed to attend a School, eating hot things and urinating at bad places causes sexually transmitted diseases and that AIDS is a God's way of punishing people for their evils have been found to be prevalent among the masses. Besides, myths like getting cured of STD / AIDS after having sexual contact with minors is leading to an alarming trend of infant girls (some as young as 8 to 9 months old) being sexually abused (www.excite.com, 26. Nov. 2001).

III. Economic Factors:

Migration and prostitution, which are often a result of economic compulsions are making people vulnerable to HIV.

a. Migration:

Today migration is one of the leading factors exposing people to HIV. People around the world are experiencing an unprecedented mobility. They are moving for very many reasons but the most common reason is to seek employment. Economic compulsions very often force these people to leave behind their homes us well as their families UNAIDS /

WHO (Dec, 1998) estimates that carltonville the heart of South Africa's gold mining industry is a home to 88,000, mine workers out of which 60 percent are migrants. Around US $18 million are paid to these miners every month as wages. Wages bring along with them the purchasing power to buy sex and drugs. Periodically these migrants return home and transmit the virus to their wives and communities. Similarly a report by Delhi State AIDS Control Society has also recognized migration to be one of the major factors contributing to the increasing risk of HIV transmission (Indian Express, April 4, 2002).

Migration is leading people into extra marital sex and in many communities this trend is being increasingly accepted as a societal norm.

b. Prostitution:

Poverty manifests in the form of sexual abuse, sexual exploitation and prostitution. Economic pressures are forcing an everincreasing number of population into flesh trade. The induction of minors is now being recognized as a key factor in keeping sex trade at flourishing levels. As sex tourism expands so does the pandemic of AIDS. Costarica, the Dominican Republic, Brazil, Haiti and several other countries have become a hot spot for sex tourism with minors. (www.unaids.org.1999).

In India, there are about 9 lac sex workers involved in the flesh trade (UNFPA, Sept. 2000). Although prostitution is illegal in India yet, it flourishes and more so in metropolitan cities of the country. In Delhi, Mumbai and Kolkata, there are well demarcated areas commonly known as the "Red Light Areas" where prostitution is openly practiced as a profession. Young girls including many minors are kidnapped / lured on the pretext of employment or marriage and sold to brothel owners for money. These women generally live in hostile conditions and are most often subjected to abuse and exploitation by the brothel owners as well as clients. Sex industry faces an increased vulnerability to HIV / STD because of low levels of education, lack of ascertive skills regarding safe sex and poor access to health care services. In Mumbai, 70 percent of commercial sex works were HIV Positive (Spam, Sept/Oct. 2001) while in Tamilnadu HIV prevalence among sex workers in the year 1996 was estimated to be around 30 percent (WHO. 1998).

IV. Political Factors:

Political turmoil and Civil war in many countries have also been instrumental in the rapid spread of the HIV. For example, Cambodian soldiers who have been battling Khmer Rouge Rebels in the North West of their country perceive risk as a way of life. For many of them sex is a source of comfort and not of any special danger. Behaviourial studies have shown that over third of Cambodian soldiers visited brothel and HIV prevalence in the military was around 7 percent in 1998 (UNAIDS / WHO, Dec. 1998).

Similarly, there were at least six thousand armed forces personnel in Indian army who were HIV positive by the end of the year 1998. According to a report, since these personnel are subject to immense physical as well as mental stress and they have to stay separated from their families under inhospitable conditions for long periods; the desire to seek sexual satisfaction often leads them to sex workers. Thus perceiving the enormity of the AIDS threat, the Director General of Medical Services (Army) brought out a hand book on AIDS with the aim of promoting safe sex among the armed personnel.

V. Psychological factors:

The word ‘Psycho’ is derived from the Greek word “Psyche” which relates to the mind, spirit and soul. Thus, Psychological factors refer to those social issues, which have a lasting impact on an individual’s mind. Many a times societal oppression in the form of neglect, abuse and exploitation especially during childhood leaves a deep impact on the psychology of an individual. People who have been abused and exploited at the hands of society are more vulnerable to HIV. Their abuse has been known to lead them to a feeling of loss of self esteem and control over their lives. They are also known to become more prone to drug taking and commercial sex.

For instance, 80 percent of children entering the sex trade had been sexually abused (UNAIDS, 1999). According to Morill and Ickovics (1996) women who are physically and sexually abused contribute to risky heterosexual behaviour by virtue of their association with sub stance abuse and depression. Substance abuse in the form of alcohol or drugs is known to increase aggression, diminish inhibition and impair the capacity to make decisions about HIV protection (UNAIDS / WHO, Dec. 1998).

In Indian context, there is a tendency to be psychologically oriented towards morality rather than towards real life issues related to sex. Women are brought up to be psychologically in the passive talking about the sex, sexuality and condom use with their partners. Female sexuality, to them means being sexually subordinate to men and fulfilling roles of reproduction as well as motherhood.

Even the needs of people living with HIV/AIDS have been found to differ in accordance to their gender roles. For instance, in a study in Mumbai, (India) it was found that the needs of HIV infected men were more self-centred relating to their own health condition and personal image in society. On the contrary, the needs of HIV infected women were more family oriented including concerns for jobs, shelter, sustenance of self and children and ensuring the future of their children.

Stigma and shame attached to HIV / AIDS are also proving to be major psychological issues that place hurdles in HIV prevention and care efforts. As HIV/AIDS is largely believed to be a disease associated with infidelity, people ashamed of accepting their HIV positive status due to the fear of stigma and societal rejection. In a study conducted by Kenya's population council in the year 2001, more than half of the women who knew they were HIV positive said they had not disclosed their HIV status to their partners for the fear of exposure to violence or abandonment (UNAIDS/WHO, Dec 2001).In India, upcoming reports keep conforming the fact that majority of women with HIV/AIDS have acquired the infection from their husbands / partners who choose to remain silent about their HIV positivity.

Thus, various factors contributing to the spread of the HIV epidemic need to be urgently as well as seriously explored in order to contain the spread of the fatal disease. The solution to the problem largely lies in adequately addressing these core issues on one hand, while simultaneously, empowering people by creating HIV/AIDS awareness, on the other hand.

HIV/AIDS and the time line:

1958: A 25 year old printer from England named David Carr, who had served in the Royal Navy between 1955 and 1957, contracts a series of mysterious ailments including Pneumocystis carini. He dies early the next year 1959. In 1990, tests by a hospital in Manchester reveal HIV in Carr's tissue samples and he is recognized as first AIDS death.

1959: The first known case of HIV in a human occurs in a person who died in Congo, seemingly later confirmed as having HIV infection from his preserved blood samples.

1975: The first report and wasting and other symptoms later determined to be AIDS are reported in residents of Africa.

1976: Norwegian sailor Arvid Noe dies; it is later determined that he contracted HIV/AIDS in Africa during the early 1960s.

1977: Danish Physician Grethe Rask dies of AIDS contracted in Africa.

- A SanFrancisco prostate gives birth to the first of three children, who would later be diagnosed with AIDS and whose blood when tested after their deaths would reveal HIV infection.

1978: A Portuguese man known as Senhor Jose dies, he will later be confirmed as the first known infection of HIV – 2. He was believed to have been exposed to the disease in Guinea in 1996.

1980: April 24, Sans Francisco resident Ken Horne, the first AIDS case in the United States to be recognized at the time, is reported to centre for disease control (CDC) with Kaposis Sarcoma.

1981: Jan. 15, Nick Rock, becomes the first known AIDS death in Newyork city.

- June 5, CDC reports a cluster of Pneumcysis Pneumonia in five gay male drug users in Los Angeles.

1982: July 9, CDC reports a cluster of opportunistic infections and Kaposis Sarcoma among Haitians recently entering the United States.

July 27: The term AIDS (Acquired Immune Deficiency Syndrome) is proposed in a meeting in Washington of gay community leaders, federal bureaucrats and the Centre for Disease Control and Prevention (CDC).

Sept 24: Current trends update Acquired Immune Deficiency Syndrome (AIDS) – United States

CDC defines a case of AIDS as a disease, atleast moderately predictive of a defect in cell mediated immunity, occurring in a person with no known cause for diminished resistance to that disease.

Dec. 10: A baby in California becomes ill is the first known case of AIDS from a blood transfusion.

1983: In January, Dr. Franscoise Barre, at the Pasteur Institute in Paris isolate a retrovirus that kills T-cells from the Lymph system of a gay AIDS patient. In the following months, she would find it in additional gay and hemophiliac suffers. This retrovirus would be called by several names including LAV and HTLV – III before being named HIV in1986.

- CDC National AIDS Hotline established.
- AIDS high – risk groups should not donate blood / Plasma products.
- Australia has first death from AIDS in Melbourne, the Hawke Labour Government invest a significant campaign that gave Australia one of the lowest infection rate in the world.

1984: American scientist Dr. Robert Gallo discovered the virus which causes AIDS, the retro virus subsequently named Human Immune Deficiency Virus (HIV).

1985: March 2, FDA approves first AIDS anti-body screening tests for use on all donated blood and plasma intended for transfusion.

1986: HIV (Human Immune Deficiency Virus) is adopted name of the retrovirus that was first proposed as the cause of AIDS by Luc Monatagnier of France who named it LAV- (Lymphadenopathy Associated Virus)and Robert Gallo of USA who named it HTLV – II (Human T-lymphotrapic virus type – III).

1993: CDC expands definition of AIDS to include a person with HIV infection and CD4 cell count below 200.

1996: Robert Gallo's discovery that a natural compound known as Chemokines can block HIV and halt the progression of AIDS is hailed by science magazine as one of that year's most important scientific breakthroughs.

1998: Dec.10 International Human Rights Day, Treatment Action campaign (TAC) is launched to campaign for greater access to HIV treatment for all South African by raising Public awareness and understanding about issues surrounding the availability, affordability and use of HIV treatments.TAC campaigns against the view that AIDS is a death sentence.

1999: Jan 31, studies suggest that a retrovirus, SIVCPZ (Simian Immuno Deficiency Virus) from the common chimpanzee may have passed to human populations in West equatorial Africa during the 20^{th} century and developed into various types of HIV.

- The role of Chemokines in protection from progression of HIV infection to AIDS is changing the Medical understanding of AIDS.

2000: WHO estimates between 15% and 20% of new HIV infections world wide are the result of blood transfusions, where the donors were not screened or in adequately screened for HIV.

2001: Sept. 21, FDA licenses the first Nuclic Acid Test (NAT) systems intended for screening of blood and plasma.

2005: Jan 21, CDC recommends anti – retroviral donors post exposure prophylaxis for people exposed to HIV from rapes, accidents or occasional unsafe sex or drug use. This treatment should start no more than 72 hours after a person has been exposed to the virus and the drug should be used by patient for 28 days.

2006: June 5th is the 25th Anniversary of the 1st reported AIDS cases.

Nov. 9th 2006, HIV found in Gorillas, HIV – 1 and HIV – 2.

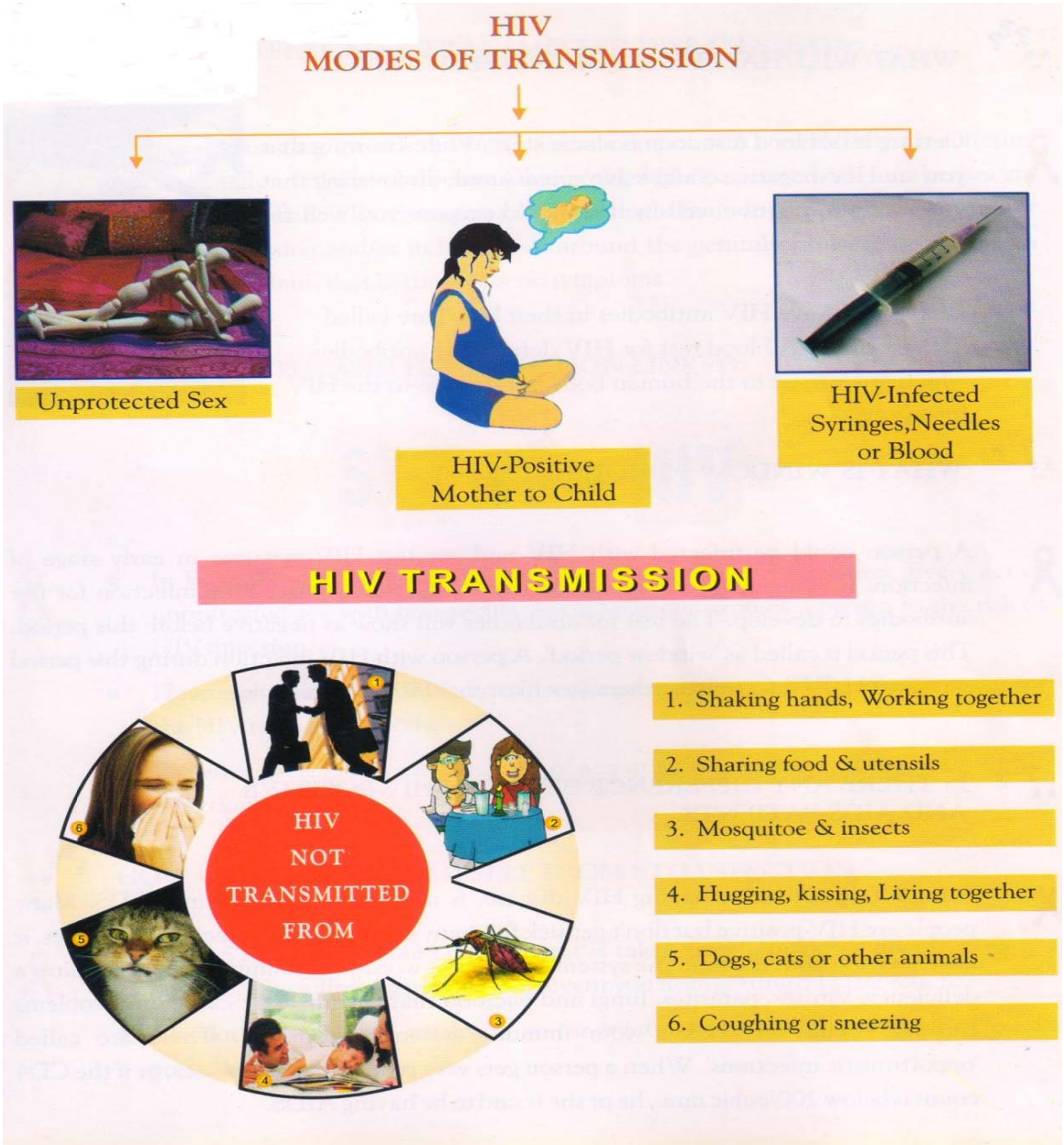
(Misconception of HIV / AIDS, Brijbhusan Singh, P- 228 to 235)

How HIV spreads:

HIV is a fragile virus. It can not live for long outside the body. As a result the virus is not transmitted through day-to-day activities such as shaking hands, hugging or a casual kiss. One cannot become infected from a toilet seat, drinking fountain, door knob, dishes, drinking glasses, food or pets or mosquitoes.

Picture No. 2.1

HIV Transmission Methods



HIV is primarily found in the blood, semen or vaginal fluid of an infected person. HIV is transmitted in three main ways:

- **Sexual Intercourse:** HIV can spread through hetero sexual as well as homosexual intercourse when one of partners is already infected.
- **Blood and Blood Products:** HIV infected blood, blood products, transplanted organs, tissues and contaminated needles and syringes can effectively transmit HIV. This is the most efficient transmission mode with a probability of more than 90 percent (WHO, 1997). Although precautions adopted in the health care set up and blood screening have greatly reduced the risk of HIV transmission in health care settings, yet in some countries HIV transmission risk through blood products remains potentially high (UNAIDS / WHO, 2003)
- **Mother to Child Transmission (MTCT):** A pregnant woman with HIV has approximately 30 percent chances of passing the infection to her child during pregnancy, at birth or shortly after birth i.e. through breast feeding 5,90,000 children are infected with HIV each year by vertical transmission, i.e. mother to child transmission (USAID cited in NACO, 2000).

  The National AIDS control Programme (NACP) in India has initiated feasibility study with the aims of preventing MTCT by Azidothymidine (AZT) prophylaxis. The Prophylactic measures are being provided to HIV positive pregnant women in five high prevalence states which are Maharastra, Tamilnadu, Karnataka, Andhra Pradesh and Manipur (NACO, Dec. 2000).

- **HIV and Drug abuse:** On the basis of Global 1992 data, WHO estimated that more than 5 million people injected drugs and around 2,00,000 drugs injectors died every year with half of these dying due to HIV/AIDS (UNAIDS / WHO, June 1998). HIV is undoubtedly spreading rapidly among injecting drug users (Idus) because many of them share injecting equipment Viz needle and syringe.
- **HIV – The Dangerous and Fast Mutating Virus:** Acquired Immune Deficiency Syndrome (AIDS) is not a single disease but a set of diseases. Hence, it is named as

"Syndrome". With a view to understand the reason for facility of this syndrome, it is important to understand the immune system of a human body.

The functioning of the immune system in our body is shown in Figure No.2.1.

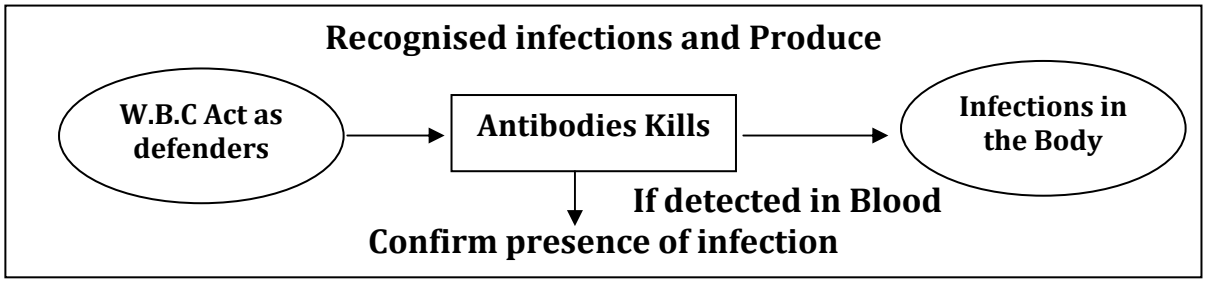


Fig – 2.1: Immune system of the Body.

In health individual, infections are kept at bay by white blood cells (WBC) that act as defenders of our body. The WBC recognizes foreign bodies (infections) and in response produces specific chemicals called antibodies which neutralize the invaders. Each disease results in the production of specific antibodies. The detection of these antibodies in blood is used to determine the present of various infections including HIV (WHO, 1997).

Now HIV is unique in its action as it targets the WBC that are vital in protecting our body from all the infections shown in Figure 2.2.

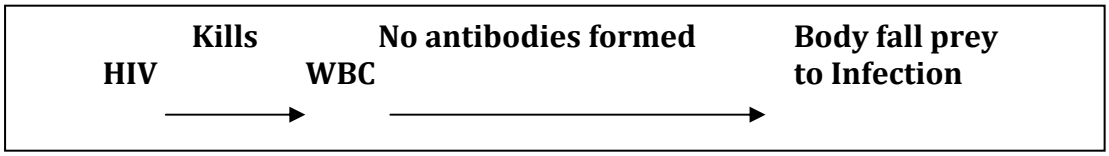


Figure 2.2: HIV Targets the Immune System (WBC)

In other words, HIV directly attacks the protective cells (Immune System) of our body. Once the protection giving cells are destroyed each and every infections (called opportunistic of infections) can prove to be fatal.

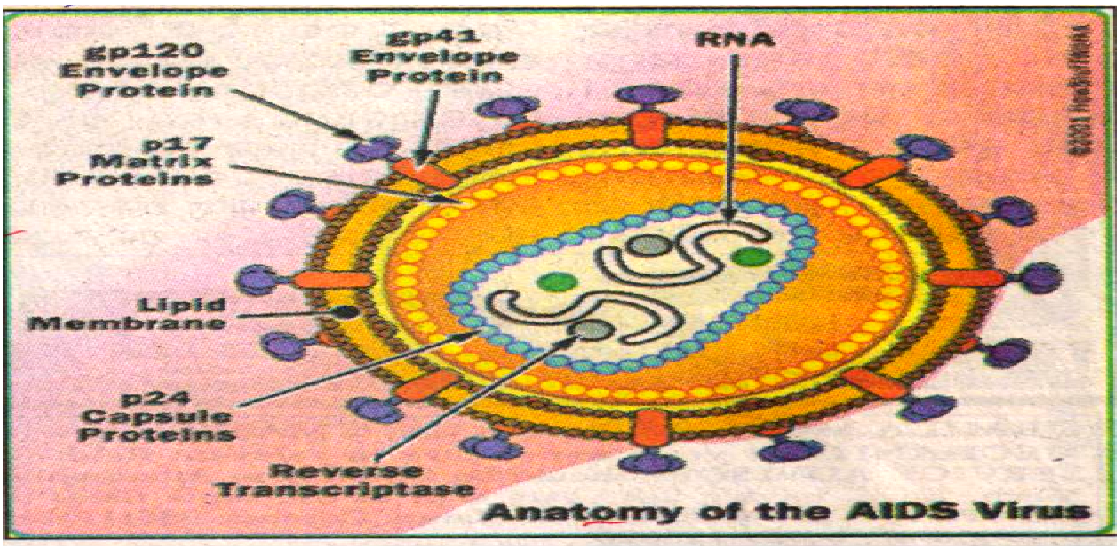
- **Mechanism of HIV replicability:** The crucial process which helps the HIV in escaping the attack of anti bodies and also in its fast and undetected replication in a human body.

White blood cells called lymphocytes have a CD_4 molecule on their surfaces which helps them to communicate with each other. HIV enters into the CD4 molecule and inserts its own generic material into the host CD_4 cell. After this, it lies hidden or dormant for several years, thus escaping the attack of antibodies that are circulating into the blood. Once this dormancy period is over the HIV starts replicating and produces several new copies of it. These newly multiplied HIV destroy the host CD_4 cell come out in the blood stream and start infecting new CD_4 cells (WHO, 1997). Once majority of the white blood cells has been destroyed the body starts falling prey to opportunistic infections.

- **Discovery of the HIV:** In 1983, Professor Luc Montagnier and his team in Paris discovered a new virus from the lymp glands of a male homosexual suffering from persistent generalized lympha denompathy (PGL), i.e. enlargement of the lymph glands. They called the virus as lymphadenopathy associated virus (LAV). Shortly after words, a team led by Dr. Robert Gallo in USA, also isolated new virus from patients with AIDS. The Virus was called human T-Lymphocylic Virus – III (HTLV – III). A general consensus was reached by the international committee on taxonomy of viruses to name the virus as Human Immuno Deficiency Virus (HIV) (WHO, 1997).

Picture No. 2.2

Anatomy of HIV Virus



N.B.: The Microscopic Structure of the HIV is shown here.

HIV: A Retro – Lentivirus:-

HIV belongs to a family of viruses called retroviruses. Retroviruses defy the general biological rule whereby deoxyribose nucleic acid (DNA) leads to the synthesis of Ribose Nuclic Acid (RNA) in most living organisms as shown in the Fig – 2.3

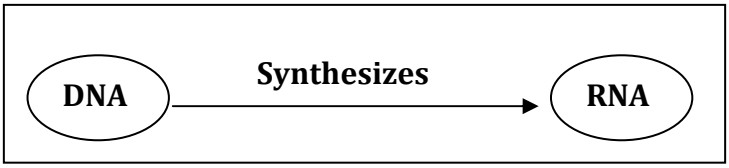


Figure No. 2.3: Process of synthesis of Genetic Material in most organisms.

But in HIV, RNA leads to the synthesis of DNA due to the presence of an enzyme called reverse transcriptase.

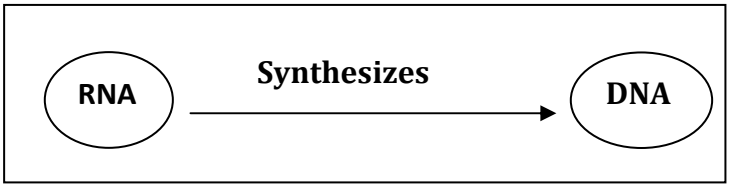


Figure No. 2.4: The process of synthesis of Genetic material in HIV.

HIV is sub classified as a lentivirus "Lentus" meaning "Slow" which explains the long time taken by the HIV to develop AIDS. Depending on nutrition and State of Health, people infected with HIV may take 7 – 10 years to develop AIDS (WHO, 1997).

Sub types of HIV : HIV is classified as HIV – I and HIV – II (NACO, 2000).

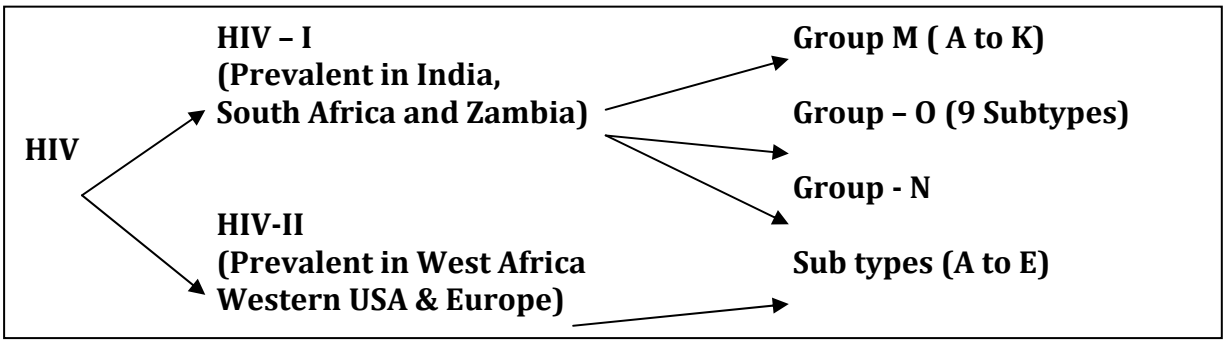


Figure No. 2.5: HIV Classification

HIV – I is predominant and further subdivided into three groups.

1. Group M (Consisting of 11 sub types from A to K)
2. Group O (Consisting of 9 Sub types)
3. Group N

India, South Africa and Zambia have HIV – I subtype as the dominant mode of infection. HIV – II has 5 sub types (A to E) and is principally found in West Africa, Western USA and Europe. Further recent reports are confirming the fast emergence of drug resistant strains of HIV not just from the USA and the Europe but also from Mumbai and Chennai in India.

Life span of the HIV Virus:

The virus, itself cannot survive for a significant length of time outside the human body. Studies at the centre for disease control and prevention (CDC), USA have shown that drying causes 90 – 99 percent reduction in HIV concentration in human body within several hours (NACO, 2000). According to ICMR (cited in NACO, 1997) the life span of HIV producing cells is only about two days.

Progression of HIV infection to AIDS:

The centre for disease control and prevention, USA has used CD_4 count in blood as an indicator to mark the progression of HIV infection to AIDS. According to NACO (2000) the progressive stages of HIV infection are follows.

1. **Primary Infection (Sero Conversion Stage) :**

It begins at 2 – 6 weeks after primary infection and the individual may show symptoms like fever and pharyngitis. The initial illness usually lasts 2 weeks or less.

2. **Asymptomatic disease (CD_4 count > 500/mm^3) :**

This stage may last for 8 – 10years and is usually marked by dermatitis (Skin disease), PGL and various opportunistic infections such as diarrhoea and fever.

3. **Intermediate HIV infection (CD_4 count 200 – 500/mm^3) :**

It is marked by worsening of opportunistic infections like Tuberculosis and lasts for 18 to 28 months.

4. **Last Stage of HIV Disease (CD_4 count is 50 – 200/mm^3) :**

It is marked by neurological manifestations such as dementia, meningitis and visual impairment.

5. **Advanced HIV Disease – (CD_4 count < 50/mm^3) :**

Person dies of opportunistic infections usually within 2 years of diagnosis of this stage.

Clinical confirmation of AIDS: According to the WHO (1997) AIDS is confirmed in an individual by the presence of the following three conditions.

a. **Opportunistic infections:** Like Pneumocystis carinii chronic diarrhoea, weight loss more than 10 percent of body weight, skin cancer (Kaposi's sarcoma), prolonged fever and infection of the nervous system (dementia).

b. **CD_4 Cell count less than 200/ml of Blood:** Number of CD_4 cells drops below 200/ml of blood whereas the normal count is between 800 to 1200 / ml of blood.

c. **ELISA positive test:** ELISA (Enzyme linked immune sorbent assay) is a sensitive blood test, which is used to detect the presence of HIV antibodies in our body.

However it is important to note that antibodies against HIV start appearing in blood in significant amounts only 6 – 12 weeks after a person has been infected with the HIV. This time period, i.e. time from initial infection till 12 weeks is called as the "Window Period".

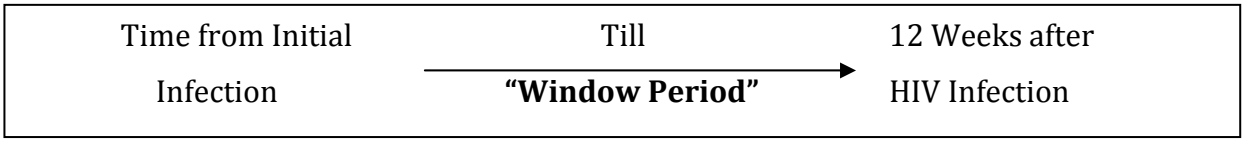


Figure No. 2.6

A blood test to detect HIV antibodies during the window period will give false negative results due to the absence of significant amount of antibodies even when the person is HIV infected.

Objectives of HIV Testing : In 1992 the World Health Assembly adopted a resolution endorsing that there is no public health rationale for any measures like mandatory HIV screening, which limits the rights of the individual (WHO, 1997). WHO emphasizes and recommends voluntary HIV testing (where in an individual volunteer to go a HIV test) as the best measure for HIV control. The Government of India has taken effective step to detect HIV virus in blood of all blood donors. From Dec. 2002 all blood banks have been instructed to reveal the HIV status of blood donors. The Government has taken this stand in view of the fact that an early detection of the virus can help prolong the life of an individual by teaching the how to live with it.

Measures like motivating people to go in for voluntary premarital HIV testing as well as revealing the HIV status to consenting blood donors need to be effectively promoted such strategies can help a long way not only in checking the further spread of the HIV but also in helping HIV positive individuals to cope with the disease in an effective manner.

Globally, WHO in 1997 recommends HIV testing for following purposes.

a. **Surveillance:** To monitor trends of the HIV infection using unlinked anonymous testing (i.e. identity of the person tested is not known).

b. **Transmission safety:** To test blood, organs or tissues for ensuing safety of the recipients.

c. **Diagnosis of symptomatic infection:** Among those clinically suspected of having AIDS.

d. **Early diagnosis of HIV infection:** Among asymptomatic person who would like to know their HIV status (with informed consents)

Counseling and support: - HIV/AIDS counselling helps people to access their risk of HIV infection and also provides them information, so that they a re able to reduce the risk of

passing HIV to others. Counselling is essential to reinforce the safe behaviour and is a cost effective way of supporting prevention efforts. Studies show that people who have received counselling are more likely to adopt or maintain safe behaviours. For instance, patients in an urban primary health care clinic receiving AIDS education skill-training and poor support reported a 40 percent increase in condom use (1996)

It is important to note that people diagnosed with HIV/AIDS require not only clinical care but also profound social, economic and behaviour adjustment in family life, sexual and social relation at work place as well as an understanding of spiritual needs and legal and civil rights. Counselling helps infected people make decision about their life, to cope effectively with stress and to improve family and community relatrionship as well as quality of life. It also provides support to the families as well as loved ones of HIV positive people so that they are able to look after HIV positive members in a more supportive manner.

In order to be effective, counseling needs to be under taken at various levels:-

- **Pre-test counselling:-**counseling before the HIV test is done to provide the individual being tested with information on personal, medical, social and psychological implications being tested positive or negative.

- **Post test counselling:-**This is done to provide support and hope for problems that may result if the person tests positive. The client is informed about the resources that available and possible treatment for symptoms of the HIV infection.

- **Preventive counselling:** - This counseling helps individual to change their behaviour irrespective of their HIV status.It is not restricted to HIV infected people and their families but also available to all people who are at risk of HIV infection.

Anti-Retroviral Therapy (ART):-

Antiretroviral drugs introduced in 1996 are being used to delay the progression from HIV infection to AIDS and to prolong the life of an infected individual.There are various drugs like Azidothymidine (AZT) Saquinavir, Ritonavir, ddc and 3tc that are currently

available. But recent studies show that combination therapy (i.e using three drugs together) is more effective than single drug therapy. This is because HIV rapidly develops resistance to single drug use. Highly Active Anti Retorival Therapy (HAART) is the term commonly used for combination therapy (AZT+3TC+protease Inhibitons). However this regimen should only be started when the immune cell count of the infected person falls sufficiently low (NACO, 2000).

Till recent years, HAART in India costed around RS/15000-20000 per month, thus rendering it inaccessible to majority of people living with HIV/AIDS (NACO, 2000) presently in the Indian scenario, providing free regime of anti retrovirals to a huge population of HIV positive people seems to be a distant possibility. However the government has taken the initiative of providing free HIV/AIDS controls drugs to all HIV positive children less than 15 years of age as well as all HIV positive mothers (Sharma, 2003).

Vaccine for HIV:-

Scientists around the world are working hard to develop an effective HIV/AIDS vaccine. Globally, around $300million is being spent annually for the development of AIDS vaccine and more than 60 HIV vaccine trials have taken place all over the world (SEPT/OCT 2001).The Rock Fellar Foundation launched a programme in 1994, which is now known as the International AIDS Vaccine Initiative (IAV). The major donors of this social venture are the governments of U.K, USA, Canada, The Netherlands, Worldbank and Bill and Melinda Gates Foundations. The equal of this initiative is to develop manufacture and distribute AIDS vaccine at affordable prices.

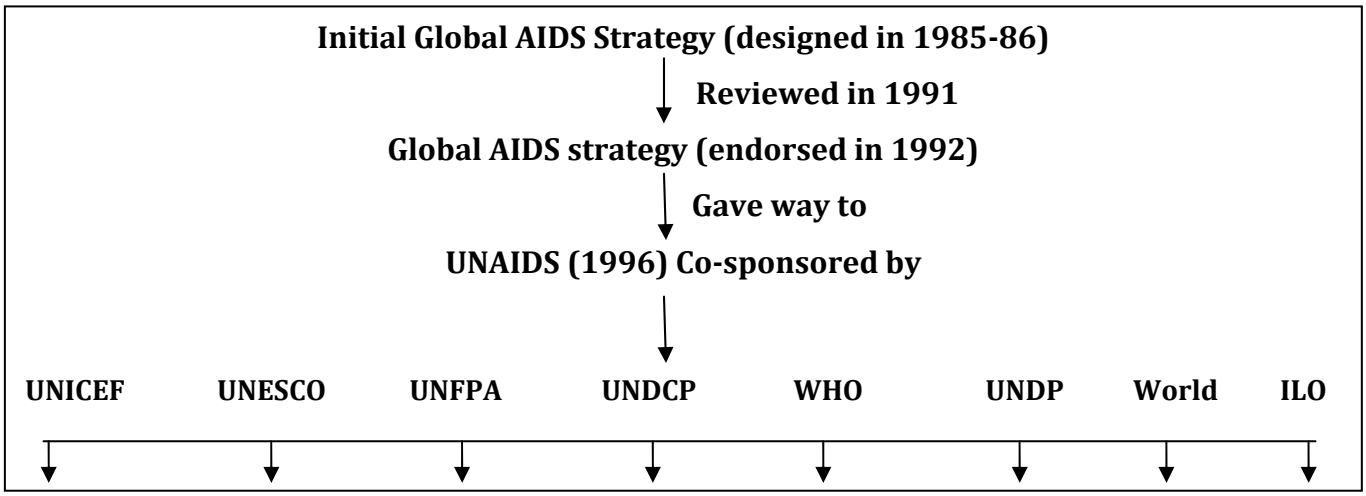
Global Response to the AIDS epidemic: -

The massive devastation inflicted by the AIDS pandemic has led many nations to unite and jointly wage a war to combat the HIV. Some of the efforts that are being jointly implemented by the United Nations at the global level are:-

The Global AIDS Strategy:-The different phases of evolution of the present day global AIDS strategy are shown in fig 2.7:

Figure 2.7

Global AIDS Stratgy



The initial global AIDS strategy was designed in 1985-86. It was reviewed in 1991 and indorsed in1992 by the World Health Assembly and United Nations Social Council (NACO, 1996). The strategy was designed with the following main objectives:-

- To prevent infection with HIV.
- To reduce the personal and social impact of HIV infection.
- To mobilize and unify national and international efforts against AIDS.

The global AIDS strategy was replaced in 1996 by a new joint United Nations programme on HIV/AIDS (UNAIDS) whose secretariat is based in Geneva, Switzerland .UNAIDS is co-sponsored by eight organizations which are the United Nations Children's Fund (UNICEF),the United Nations Development Fund (UNDP),the United Nations Population Fund (UNFPA),the United Nations Educational Scientific and Cultural Organization (UNESCO),the United Nations Internationals Drug Control Programme(UNDCP), the World Health Organization(WHO), the World Bank and the new eighth entrant in 2001, the International Labour Organization (ILO).

The goal of UNAIDS is to lead and assist in an expansion of the international response to HIV/AIDS on fronts medical, social, economic, political and human rights. It

gathers, analyses and disseminates information about the epidemic UNAIDS is also involved in developing and advocating the use of best practices to reduce the impact of HIV/AIDS. It strives to bring a partnership between government organizations Non Governmental Organisations (NGOS), grass root organization, universities, private sectors as well as people living with HIV/AIDS (PLWHA); so as to deal effectively with AIDS pandemic. India is one of the 22 member of states represented on the programme coordinating board.The board acts as the UNAIDS governing body on issues related to policy, finance, strategy and evalution, (NACO, 1996).

Response from the WHO:-

WHO in collaboration with UNAIDS continues to help countries across the globe in their National AIDS Control Programmes (NACPS). It provides support in the health aspect of HIV/AIDS not only to government organizations but also to NGOS and private sectors. The support includes disseminating information, providing training and guidelines to health care workers, supply HIV testing kits, ensuring safe blood transfusion and monitoring trends of the pandemic. WHO is also promoting the concept of Continuum of Care for people living with HIV/AIDS at various levels and puroposes that HIV/AIDS care should be integrated with primary health care.

United Nations (UN) General Assembely Responds to AIDS: -

The United Nations General Assembly Special Session (UNGASS) on HIV/AIDS held in New York in 2001. The Assembly recognized that HIV/AIDS is not just a medical problem, but an economic, social and human rights issue. The meeting unanimously agreed to global agenda of reversing the epidemic by 2015. The UN Secretary General Kofi Annan proposed for the establishment of a global HIV/AIDS fund to finance programmes in the developing nations (Times of India June 2001).

The assembly pledged to pursue a series of targets relating to HIV/AIDS prevention care and support. Some of the important targets are:-

- To reduce HIV infection among 15-24 years old by 25 percent by 2005-2010.
- To reduce the proportion of infants infected with HIV by 50 percent by 2010.

- To strengthen health care system and provide ART at affordable prices by 2003.
- To provide supportive environment for orphans and children infected and affected by HIV/AIDS by 2005.
- To address the factors that makes individuals particularly vulnerable to HIV by 2003.
- To develop multi sectoral strategies to combat HIV/AIDS epidemic at family, community and national levels by 2003(UNAIDS/WHO, Dec, 2001).

The 189 members of General Assembly adopted the "Declaration of Commitment on HIV/AIDS" and this marked the end of an unprecedented special session of General Assembly on a health issue.

Political Response to AIDS:-

Experience across the globe shows that prospects for success of AIDS prevention programmes are brightest when a country has a top level committee or body often reporting to the president or prime minister responsible for planning and managing the AIDS prevention programme (UNAIDS/WHO, Dec, 2000). Such a high level body can collaborate with many sectors such as the education, health, defense, agriculture, industrial as well as the private sectors. A large number of countries have set up top level AIDS co-ordination committee in their respective nations. The global community is also coming closer by forging International Partnership against AIDS in Africa is working to find and mobilize new partners inside and outside the continent in fight against AIDS (UNAIDS/WHO, Dec, 2000).

Similarly Prime Ministers and Finance Ministers of the Caribbean group of countries at a meeting in June 2000 recognized AIDS as a major development challenge.

The Caribbean community (CARICOM) pledged a strong political commitment to combat the epidemic at a massive scale. Growing political commitment has also led countries of the common wealth of Independent States to develop a special declaration on AIDS. Similarly, the president of Ukraine set a positive example by declaring 2002, the year of the fight against AIDS (UNAIDS/WHO, Dec, 2001).

USA president Bill Clinton during his historic visit to India in March 2000 addressed both the Houses of Parliament and stressed on the need of scaling up AIDS prevention programmes as well as putting an end to stigma attached to the disease. The address led to an agreement between India and the USA to jointly wage a war against HIV/AIDS (NACO, April, 2000). Similarly ,while urging to the masses to practice safe behaviour, Indian prime minister Atal Bihari Vajpayee during his Independence Day speech from Red Fort on 15th august 2000,said ,"Recently ,the rapidly spreading disease of HIV/AIDS has become a grave challenge to our nation. I appeal to all sections of society to fully participate in building awareness about the epidemic. They should also make necessary changes in their behaviour so that this dreaded disease can be controlled". The national convention on HIV/AIDS held in Delhi made deliberate efforts to make a political leader take a public stand regarding HIV/AIDS management for which they could be accountable (Times of India, July 28, 2003).

Niraj Mishra of Solidarity Forum said, "The disease should be made a political election issue". Political will and commitment are crucial in fighting the killer disease politicians could help to reduce the stigma and discrimination against these afflicted by it. The political parties were pressurized to pass the HIV/AIDS bill introduced in the parliament last years. They demanded increasing the pension from Rs 200 to 500 and to undertake comprehensive policy to provide social security mechanism for the PLWHAS. They demanded availability of ART in all the districts and to make available of second line ART in Odisha. Free legal services should also be provided by the government to give these people property rights (The times of India April 7, 2009).

It has been two and half years since the Govt. of India began its free treatment programme and now approximately 47000 receiver anti-retroviral treatments (ART). Estimates suggest that about 3000-5000 of these receiving ART have become resistant. "The life of these patients depends on the newer second line drugs," says K.K. Abraham of the Indian Network for Positive People (INP+). The patients who need second line treatment are experiencing drastic decrease in their CD4 counts, an increase of the viral load in the bodies and continuous weight loss. Taking cudgels to fight the dreaded HIV/AIDS, the govt. of India

will launch its second line of treatment for these affected with the diseases from January 1st 2008. Announcing this in New Delhi, health minister Ambumani Ramduss said, the second line treatment should be initially for below the poverty line population and later be extended to the rest of the population of the country from 1st April 2008. The second line treatment is extended to the patients for whom the first line has clinically failed. The govt. is also looking at setting up special orphanages and foster care homes for children who have lost their parents to the disease, the director of NACO, Sujatha Rao told the reports. (The new Indian Express, 2.12.2007).

India has also formulated the national pediatric HIV/AIDS treatment protocol which was launched by congress chief Mrs. Sonia Gandhi and USA president Bill Clinton. The protocol says, "For children below 18 months born to an HIV+ mother, the first HIV DNAPCR (DNA Polymerase Chain Reaction Test) shall be conducted at 6 weeks of the age. If the test proves positive, it has to be repeated immediately for confirmation. If first PCR is negative, confirm with the 2nd PCR test at 6 months". (Times of India, Bhubaneswar, national, 1st dec, 2006).

India became the first country in Asia to introduce DNA Polymerase Chain Reaction (PCR) test, a dry blood sampling method of testing of paediatric AIDS. NACO Plans to start six more regional centres with the PCR in Bangalore, Chennai, Hyderbad and Imphal .NACO D.G, K. Sujatha Rao told to (Times of India) Kalavati Saran children's hospital became the first centre to offer free anti-retroviral therapy (ART) for children. Children below 18 months of age in India will no longer die of HIV for lack of proper diagnosis. Once the child becomes 18 months old we put him /her treatment of (ART). With proper treatment and nutrition the child will be able to live a healthy life.

Pakistan and India united to highlight AIDS awareness. Players, official and administrators of final ICC world Twenty 20 have sought to highlight through the ICC'S on going support for UNAIDS and UNICEF and during this event : love life South Africa's National HIV prevention programme for youth and Africa broadcast media partnership against HIV/AIDS. All the players and officials during the final were wearing 'red ribbons',

the universal symbol that highlights the issues of HIV/AIDS awareness and tolerance and something that has been a common sight during the previous 26 matches played at three venues in South Africa. That action goes hand in hand with the ICC providing free advertising space at each of the host venues- Cape Town, Durban and Johannesburg with boundary boards displaying the message “unite for children, unite against AIDS”. The hope was that by raising awareness it would encourage people and especially youngsters who view the players on show in South Africa as role-models to find out more about the issues involved. (TOI, 25.09.07).

Religious Impact- Helping in AIDS Awareness:-

In most continents across the globe, the daily lives of people are strongly influenced by spiritual beliefs about God, super natural powers and life after death. Religious institutions and preachers form integral part of many communities in these continents especially in rural areas. They have been known to be powerful influences and are being currently trend to create AIDS awareness in the communities. For example religious leaders and volunteers in countries like Kenya, Zimbabwe and USA are actively persuading communities to understand and participate in providing care and support to PLWHA.

The tremendous impact of religion and the vast out reach potential of various festivals in India have also been used for creating AIDS awareness, for example Indian Health Organization (IHO) has organized various AIDS awareness exhibition during major festivals such as Kumbha Mela (in Nasik), Ganapati Immersion (in Mumbai) and Navratri at various places (Bora and Gilada, 1997). In Mysore (Karnataka), a local community has erected a shrine for what they call as AIDS Goddess- ‘AIDS Amma’ (Sept/oct.2001).

An individual in his private capacity became more successful in creating awareness about HIV/AIDS. He is a science teacher named H.N. Girish. He has established a temple for “AIDS Amma” (The Goddess for AIDS awareness) at Main-sikathanahalli of T. Narshipur of Mysore district of Karnataka. This temple was established not for curing AIDS but for creating awareness about AIDS and fighting against stigma for AIDS infected/affected. At the beginning he was criticized by others for such attempt. But now it is found that a number

of people from the nearby villages come to this temple regularly and participated in the awareness programme. As a result of which the people of this area become much more aware of AIDS although this area is within 'AIDS Belt'.(The Sambad , the Odia daily, Aug, 22, 2010).

Prime Minister Mr. Vajpayee while addressing a meeting on HIV/AIDS stressed on the need to involve religious institutes in our fight against AIDS. In his words, "we should also actively involve religious establishments who can have strong positive influence over large sections of society" in combating AIDS.

International conferences on HIV/AIDS:-

The International AIDS Society (IAS) is the world's professional society for scientists; health care and public heal workers and the others engaged in HIV/AIDS prevention control and care. The IAS is the custodian of International AIDS conferences, the paramount gathering of all discipline in HIV/AIDS. The conferences started in 1985 in Atlanta, Georgia, USA were annual from 1985 to 1994, but from 1994 they became biennial. These prestigious conferences provide a unique forum for inter action of science, community and leadership with the goal of bringing knowledge together for changes in the worlds response to HIV/AIDS. The IAS also organizes the highly successful IAS conferences pathogenesis, treatment and prevention. It aims to bring together participants from around the world by providing an environment for researchers and clinicians to address current issues in HIV research, prevention and treatment.

Below is the list of conferences, their venue and theme

Table No. 2.2

International Conferences

YEAR	NO.	VENUE	THEME
1985	**I**	Altanta Georgia, USA	None
1986	**II**	Paris, France	None
1987	**III**	Washington, DC, USA	None
1988	**IV**	Stockholm, Sweden	None
1989	**V**	Montreal, Canada	The Scientific and Social challenge of AIDS

YEAR	NO.	VENUE	THEME
1990	**VI**	Sansfransisco, CA, USA	AIDS in the Nineties
1991	**VII**	Florence, Italy	Science challenging AIDS
1992	**VIII**	Amsterdam, The Netherlands	World United against AIDS
1993	**IX**	Berlin, Germany	None
1994	**X**	Yokohama, Japan	The Global challenge of AIDS: together for the future
1996	**XI**	Vancouver, Canada	One World one hope
1998	**XII**	Geneva, Switzerland	Bringing the Gap
2000	**XIII**	Durban, South Africa	Breaking the Silence
2002	**XIV**	Barcelona, Spain	Knowledge and commitment for Action
2004	**XV**	Bangkok, Thailand	Access for all
2006	**XVI**	Toronto, Canada	Time to deliver

The President's Emergency Plan For AIDS Relief (PEPFAR/Emergency plan) is President Bush's pledge of $15 billion over 5 years (2003-2008) to fight the HIV/AIDS Pandemic. It includes the prevention, treatment and care of PLWHA.

Prevention:-

To slow the spread of epidemic PEPFAR supports a variety of prevention programme the ABC Approach (Abstain, Be-faithful and correct and consistent use of condoms), prevention of mother to child transmission (PMTCT), intervention and programmes focusing on blood safety, injection safety, secondary prevention(prevention with positive), counselling and education.

Treatment:-

In addition to providing anti-retroviral therapy (ART), PEPFAR supports prevention and treatment of opportunistic infections as well as services to prevent and treat malaria, T.B, water borne illness and other acute infection. PEPFAR also supports training and salaries for personnel (including clinician, laboratorian, counsellors, media, record staff, out reach workers, peer educators etc.) renovation and refurbishment of health care facilities, updated laboratory equipment, management for drugs and other commodities.

Care:-

For those who have already been infected with HIV/AIDS PEPFAR provides HIV counselling, resources for maintaining financial stability etc. special care is given to orphan and vulnerable children (OVC) and services are provided that meet the unique needs of women and girls including victims of sex trafficking, rape, abuse and exploitation. Finally the emergency plan works closely with country leaders, military groups, faith based organization etc. an attempt to eliminate stigma and discrimination.

WORLD AIDS DAY

December 1st is a day that reminds us about one of the most dreaded names in the history of mankind. This day is observed as the world AIDS day dedicated to rising awareness of the AIDS pandemic caused by the spread of HIV infection. The concept of a World AIDS Day originated in January 1988 at the world summit of ministers of health on programmes for AIDS preventions and to promote and co-ordinate international efforts against AIDS. The World Health Assembly, the U.N. organizations, the governments and communities across the globe support the World AIDS Day.

In 1997 the first World AIDS Campaign (WAC) took place to stress on the need of sustaining HIV prevention effort all the through the year and not just observing 1st December every year as the World AIDS Day. Since then a particular theme focusing on a priority issue is chosen for the World AIDS Day and the same is observed throughout the year. World AIDS Day is being observed each year, theme based on the course of spread of AIDS and the required urgency of its control. WHO by observing World AIDS Day on Dec. 1st every year tries to join hands with people of cadres in its fight against AIDS.

World AIDS Day banner, European commission building, Brussels.

Table No. 2.3
World AIDS day Themes 1998 – 2011

YEAR	WORLD AIDS DAY THEMES
1988	Communication
1989	Youth
1990	Women and AIDS
1991	Sharing the Challenge
1992	Community Commitment
1993	Act
1994	AIDS and Family
1995	Shared Rights, Shared Responsibilities
1996	One World, One Hope
1997	Children living in a World with AIDS
1998	Force for change: World AIDS Campaign with young People
1999	Listen, Learn and Live: World AIDS Campaign with children and young people
2000	AIDS: Men make a Difference
2001	I care…….. Do you?
2002	Live and Let Live
2003	Stigma and Discrimination
2004	Women, Girls, HIV and AIDS
2005	Stop AIDS, keep the Promise
2006	Stop AIDS, keep the Promise Accountability
2007	Stop AIDS, keep the Promise. Prevention of HIV/AIDS is the responsibility of all
2008	Lead, Empower and Deliver. (AIR, CTC, 1st Dec. 2008) Stop AIDS promising Leadership
2009	Universal Access and Human Rights. (AIR,CTC, 1st Dec 2009)
2010	"Light for Right". Let us determine to make us AIDS Free
2011	Getting to Zero – Zero AIDS related death. (The Times of India, Bhubaneswar, National, 1st Dec 2011)

‘Getting to zero-zero AIDS related death’ signifies a push towards greater access to treatment for all a clarian call for all governments to act with haste. It is a global campaign that brings to the spot light has fundamental right to health is intrinsically in extricable linked to basic rights such as the right to food, to shelter, to freedom, to clean water and safety. That year the focus was on ‘getting-zero-zero new HIV infections, zero discrimination and zero AIDS related deaths’. Supported and assisted by the UN, ‘the getting to zero’ runs until 2015 and builds on last year successful World AIDS Day ‘Light for Rights’ initiative encompassing a range of vital issues identified by key affected population.

Discrimination against people living with or affected by HIV/AIDS (PLWHAS):-

HIV/AIDS is strongly associated with stigmatization, scapegoating, blame and discrimination. Stigma and discrimination affected every one especially from children to AIDS widows, who are particularly vulnerable to violations of their inheritance and property rights. Orphans are frequently denied their right to schooling and adoptive parents sometimes take away their inheritance unlawfully efforts to prevent HIV have at times unintentionally reinforced prejudice and stigma result in an increased burden on those most badly affected.

HIV positive persons suffer neglect and lack of care and are frequently excluded from community gathering children of PLWHA may be carely teased at school and excluded from games and social interaction with their peers. In addition to their social exclusion, the basic human rights of PLWHA to health, housing, education and employment protection are affected. Stigma and discrimination and fear of being labeled, may also prevent people from being tested and from using condoms. In many cases fear prevents people from attending clinics where they can seek and receive treatment.

Key factors contributing to the incident and perpetuation of stigma and discrimination include ignorance and fear cultural values, religious teaching, the absence of legal sanctions, lack of rights awareness, the design of government and NGO programmes and in accurate and irresponsible media coverage.

Discrimination against persons living with or affected by HIV/AIDS is socially, economically and legally detrimental. Under the UN convention people living with HIV/AIDS have same fundamental rights as uninfected people to education, employment, health, travel, marriage, procreation, privacy, social security, scientific benefits, asylam etc.

Yet growing evidence from many countries across the world suggests that many people with HIV/AIDS are being increasingly subjected to discrimination and rejection. For instance many HIV affected children in Europe do not have access to quality health and social services. Similarly in the USA claims of discrimination have been presented in a wide variety of contexts such as in employment housing and health care establishment.

HIV/AIDS is highly stigmatized in India too. The commonly held belief that HIV is associated with promiscuity has led many people too assume that HIV infected people have sinned and thus, deserve their fate (UNAIDS/WHO, Dec 1999). Ironically, the discrimination against women is far greater than men. Women are frequently being blamed by their in laws and husbands for their spouse's HIV infection while on the contrary majority of these women have themselves been infected by their husbands. Many women have been turned out of their homes after their husbands died on AIDS and thus made to lose their children.

Exclusion, isolation and desertion of people living with HIV/AIDS have become usual responses of our society especially towards women. A study conducted in Mumbai showed that responses towards PLWHAS differed according to their gender and relationship in a family. For instance, men/sons/husbands with HIV/AIDS were given greater acceptance, care and support where as the response towards women/daughter/wives infected with HIV/AIDS was not as supportive.

Many hospitals and health care setups have also been reported to be turning away HIV positive patients due to fear of contracting the diseases (Times of India, Dec, 1, 2001). "Physicians' bias" is strongly emerging as a major problem in HIV/AIDS management. For instance many cases of HIV infected people being refused treatment at district hospitals because of AIDS phobia are being reported. This attitude of medical professionals is resulting in non-accessibility of treatment to people suffering from HIV/AIDS related complications.

With the situation taking a deteriorating turn, Delhi government has planned to bring a legislation that will penalize doctors who refuse to treat those infected with HIV. Increasing levels of discriminating attitude towards people living with HIV/AIDS have also led NACO

to work closely with international labour organization (ILO) and ministry of labour for formulating a code of conduct at work place. Similarly many countries are increasingly enacting laws which prohibit discrimination against PWHA in any context or form. A new international code of conduct on AIDS and the work place was ratified in the beginning of 2001 by the ILO with the aim of counteracting discrimination against PWHA at their workplace (NACO, 2001). However a report of UNAIDS/ WHO (Dec, 2003) on the global response to the HIV/AIDS epidemic indicates that 38 percent of countries have yet to adopt legislation to prevent discrimination against people living with HIV/AIDS. It further needs to be emphasized that instead of having all these mandatory measures what is actually is required, is a deep attitudinal change based on awareness regarding the disease and aspects related to it to put an end to discrimination against PWHA.

HIV/AIDS and Human Rights:-

An international consensus stressing equal rights for PWHA is gradually evolving. The need to protect and promote the human rights of HIV positive people has never been so actually felt. Experience in many countries is reinforcing the opinion that non-discrimination of PWHA is an effective tool in preventing the further spread of the HIV. Many worst hit nations have started realizing that without adequate protection under law and a supportive social environment, PWHA are driven underground and do not come forward to avail information and prevention services even when they are freely available (WHO,1997).

Protection and promotion of the rights of individuals living with HIV/AIDS through legal and social environment has been one of the key policies of the “declaration of the Paris AIDS summit” held on 1st Dec 1994. Forty two countries including India signed the declaration and resolved to step up HIV prevention efforts. Keeping in line with the declaration the Human Rights Programme in Zaire has used education and sensitization campaigns which emphasize that women should use their rights for preserving their sexual relation against HIV.

Similarly, legal and social rights of children affected by HIV are being protected and promoted by the UN convention on Rights of children and the European forum on

HIV/AIDS. AIDS activists in many countries are fighting for the rights of HIV infected people. Their efforts to empower PWHA have given rise to a new movement called 'AIDS Activism'.

In India a number of groups and organizations are striving for equal rights for PWHA. Maharashtra network for positive people (MNP+), (Mumbai) is one of such organization which is formed by PWHA. The organization is committed to protect the basic human rights of PWHA including the rights to travel, to employment, to marry, to have children, job security, housing, education, access to medical care and to obtain an insurance cover. Such efforts are at the initial stages in India and need to evolved and implemented at a much wider scale.

AIDS IN INDIA:

India has the highest number of people in Asia living with HIV/AIDS according to the report of UNAIDS/WHO Dec, 2004. The recent estimates suggest that about 5.1 million people in the country are infected with HIV and that children comprise 10percent of infected population (UNAIDS/WHO, Dec 2004, The Times of India, Dec 2, 2003). In six states of Maharastra, Tamilnadu, Andhrapradesh, Karnatak, Manipur and Nagaland, the HIV prevalence in the general population is more than one percent, making it a generalized epidemic with Maharashtra alone accounting for nearly 50 percent of all reported HIV/AIDS cases in India (NACO, 2000). Commercial sex and injecting drug use remains a dominant feature in the spread of HIV/AIDS in India. India had a sharp increase in the estimated number of HIV infection, from the first reported case in 1986 in Chennai among commercial sex workers.

HIV emerged later in India than it did in many other countries of world. Infection rate scored throughout the 1990s and have increased further in recent years. The crisis continues to deepen as it becomes clearer that the epidemic is affecting all sectors of Indian society, not just as the groups such as sex workers and truck drivers with which it was originally associated. In a country where proverty illiteracy and poor health are rife, the spread of HIV presented a daunting challenge.

India is known to have around 5.1 mollion HIV infected people (NACO, 2004) the second largest in the world. Statistics continue to confirm that this number is rapidly growing and if preventive measures are not implemented at the earliest then the situation is very likely to become explosive. Thus many programmes for the common masses as well as targeted innervations for the vulnerable groups are being implemented across the country with the aim of creating HIV/AIDS awareness among them. Similarly efforts are underway to provide appropriate care and management for HIV/AIDS infected people. The ultimate goal is to prevent new infections from taking place while at the same time ensuring care for the infected ones. It is now being realized that preventions is only the awareness of the people about the disease as well as important aspects related to it.

Today HIV/AIDS has acquired a gargantuan dimension worldwide. In 2007 the estimated number of people with HIV worldwide was 33.2 million with 2.7 million people newly infected. The situation is also grave in India with 2.4 million people living with condition in 2009 where 1,70,000 HIV/AIDS related deaths happened, in India high risk groups (HRG) are female sex workers (FSW), men who have sex with men(MSM) transgender (TG)and injecting drug users (IDUS) and the bridge populations are truckers and migrants.

Table No. 2.4
Target and Achievement between 2010 - 2012

Indicator	2010-11		2011-12	
	Target	Achievement	Target	Achievement up to January 2012
New targeted interventions established	140	188	170	208
STR/RTI patients managed as per national protocol	100 lakh	100.1 lakh	120 lakh	74.57 lakh
New Blood Component separation Units established	12	26	7	4
New District level Blood Banks set up	6	7	22	8

Indicator	2010-11		2011-12	
	Target	Achievement	Target	Achievement up to January 2012
Districts covered under Link worker Scheme	186	179	219	209
Clients tested for HIV	111.71 lakh	95.45 lakh	120 lakh	90.52 lakh
Pregnant Women tested for HIV	86.49 lakh	66.38 lakh	90 lakh	70.87 lakh
HIV+ Pregnant Women & Babies receiving ARV prophylaxis	11.350	11,962	17,500	11,074
HIV-TB Cross Referrals	8.5 lakh	10.48 lakh	9.5 lakh	9.97 lakh
ART Centres established (Cumulative)	332	300	340	342
PLHIV on ART	4,04,815	4,07,361	4,50,000	4,86,173
Opportunistic infections treated	2.7 lakh	4.97 lakh	3.1 lakh	5,41,997
Campaigns released on Mass Media – TV/Radio	6	6	9	6
New Red Ribbon Clubs formed in Colleges	1200	5190	1000	585
Persons trained under Mainstreaming training programmes	2,50,000	5,22,337	15,000	5,61,734
Proportion of blood units collected through Voluntary blood donation in NACO supported Blood Banks	80%	79.5%	90%	83.1%
Social marketing of Condom by NACO contracted Social Marketing Organisations	22.46 crore pieces	44.72 crore pieces	34.9 crore pieces	42.9 crore pieces

* Up to December, 2011-12.

Source: AIDS Positive Cases in India 2009-2012

medindiahttp://www.medindia.net/health_statics/general/aidsindia.asp#ixzz2QVh6JMJ2

The routes of transmission of HIV, India, 2010-2011- HIV positive cases detected, parent to child 5.4%, home sexual/bisexual 1.3%, injecting drug use 1.6%, blood products 1.0% during 2010-2011.

HIV positive cases detected parent to child transmission accounts for 5.0%, homosexual 1.5% infected syringe and needles 1.7%, contaminated blood and blood products 1% during 2011-2012.

HIV/AIDS in different states of India, its prevention & cure:-

New HIV infections declined by more than 50% over the past decade from 2.7 lakh in 2000 to 1.2 lakh in 2009 of these, six high prevalent states account for only 39%, while the state of Odisha, Bihar, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat together account for 41% of new infections. States wise distribution of new HIV infections 2009 shows that these are 20%in AP, 5% in UP, 45% in RJ, 4% in MP, 4% in GU, 65 in WB, 8% in KA, 8% in BI, 9% in O disha, 9% in MH and others constitute 23%.

According to survey report in Aug 2006 the total number of AIDS patients in India was 1, 24, 995 among whom 88,245 males and 36,750 were females (The Sambad, Odia daily, 09.07.2007).

Table No. 2.5

AIDS Patients in Different States of India

NAME OF THE STATE	NO. OF AIDS PATIENTS
ANDHRA PRADESH	15099
ASSAM	372
ANDAMAN & NICOBOR ISLANDS	13
BIHAR	155
CHANDIGARH	1934
CHHATTISGARH	NIL
DELHI	2759
GOA	657
GUJARAT	6873

NAME OF THE STATE	NO. OF AIDS PATIENTS
DAMAN & DIU	01
HARIYANA	655
HIMACHAL PRADESH	302
JAMMU & KASHMIR	02
JHARKHAND	258
KARNATAKA	4385
KERALA	1769
MAHARASTRA	14325
MADHYA PRADESH	1769
MANIPUR	2886
MEGHALAYA	08
MIZORAM	106
NAGALAND	736
ODISHA	641
PONDICHERRY	302
PUNJAB	454
RAJSTHAN	1153
SIKKIM	08
TAMILNADU	52036
UTTAR PRADESH	1751
UTTARANCHAL	79
WEST BENGAL	2397
DADRA & NAGAR HABELI	NIL
LAKSHADWEEP	NIL

The number of anti retroviral treatment (ART) centres which provide care and detect new cases also increased from 52 to 217. Incidentally the largest numbers of ART centres are in Maharashtra. “With more facility for testing the number of newly detected HIV positive children increased from 2,253 in Nov. 2006 to 52,973 for all of India in May 2009 said,

health ministry officials. The govt. has admitted that the prevalence of HIV is especially high in Maharashtra, Tamilnadu and Karnataka. Doctors explain that the major source of infection in children is through vertical transmission of the HIV virus from an HIV positive pregnant mother to infant. To arrest this trend the Union Govt. started a programme in 2002 to provide both prophylactic medicines and counselling to HIV positive pregnant women (TOI, Sept, 17, 2009).

Kerala has an estimated 25,000 HIV positive peoples. The prevalence is maximum (5-10%) among drug users (TOI, 14.8.2008). the Kerala state AIDS control society (KSACS) has reserved one vacancy in its office for HIV positive candidates. Officials say that they aim it to improve co-ordination with groups at risk and ensure more effective preventions. “we belive it is better to put somebody who understand the problem in charge”. It will also help us send out our message in a better way as the channels of communications will be better, KSACS, Project Director and Special Secretary of Health, Usha Titus said.

Some NGOS working in the field of HIV/AIDS preventions said, that they were delighted “This is a positive step”. The best way to fight the disease is to break the confidentiality which is maintained by those affected by it to avoid the associated stigma, said Raja Sekhram Nair of Thrani a voluntary group working with the high risk groups like sex workers.

The A.P. state AIDS control society (APSACS) has unveiled a Rs. 90 crore action plan for 2008-2009 for combating HIV/AIDS even as the prevalence rate has come down 1.5% to 0.88%. The plan will be implemented by bringing about to fundamental shift from project based to programme based approach through 31 target intervention. Giving details at a press conference APSACS, project directors, R.V. Chandravadan said the intervention had been specifically planned to achieve saturated coverage among high risk groups (HRGS) like female sex workers, truck drivers and drug users. The new approach would have community led interventions and district wise programming. District AIDS prevention and control units would also be formed this year. It was planned to strengthen the existing 24 ART centres, open an additional 56 care and support centres, setup another 50 STD clinics and also issue

smart cards to HIV/AIDS patients to enable them to avail of the concession like 50% reduction in the train fair. While there was one mobile testing centre at present, another would start touring the length and breadth of the 10 high prevalent districts in the state.

Mr. Chandravandan said that the red ribbon express, a special train travelling through out India to spread awareness on HIV/AIDS promotes self behavioural practices. (The Hindu, 11.4.2008).

Odisha has a sizable population of over 20,000 people infected by HIV/AIDS and their number seems to be increasing day by day. According to OSACS data, 11,835 HIV positive cases were detected by the end of Dec. 2008. Out of them 1045 were full blown AIDS cases. The AIDS has so far claimed 828 lives. Sexual transmission is said to be the main cause for spread of the disease in the state. The OSACS survey revealed while 82.86% were infected by sexual transmission of the virus 8.91% children got it from their parents and 2.67% through unhygienic syringes (TOI, Feb, 10, 2009).

Odisha state AIDS control society (OSACS) is planning to set up two more Anti Retroviral Therapy (ART) centres at Balasore and Bolangir to treat AIDS patients. At present, three ART centres are functioning in the medical colleges at Cuttack, Berhampur and Burla. Another centre will come up at koraput district head quarter hospital on private-public partnership mode. “Sewa paper mills a unit of Ballarpur industries limited (BIL) will help to build the Koraput unit”, said OSACS project director Parameswar swain at a HIV/AIDS work shop which was organized by the OSACS and Indian institute of mass communivation Dhenkanal. Besides the societies palanning to link ART centres in the state. The porposed centre at Paralakhemundi, Aska and Bhanjanagar will be linked to Berhampur one. Similarly the proposed centre at Puri, Anugul, Bhadrak, Kendrapara and Bhubaneswar are to be linked with Cuttack. Rourkela and Bhawanipatana centres will be linked to Burla, Swain said patients will be regularly checked up at the ART centres and prescribed medicines according to their CD4 counts to help live longer (TOI, Feb, 10, 2009).

In an effort to bring HIV positive persons closer to the mainstream, Xavier institute of management (XIMB) Bhubaneswar has set up the first State Training and Research Centre

(STRC) for the working in the field of fighting this deadly virus. The centre will function in association with NACO and OSACS. OSACS project director Dr. Parameswar swain said, the centre will train their staff who are working in 44 intervention projects in the state. The main objective of STRC is to train counsellors, field staff of OSACS and other voluntary organizations to work with the target community with an aim to prevent spread of the deadly virus. The programme also enables development of sense of passion among the field workers task at hand. After completion of these programmes the participants would become consultants and trainers for the targeted interventions among high risk groups, especially sex workers, drug abusers and migrant labourers.

XIMB had successfully conducted a Leadership and Managerial Proficiency Programme (LAMP) last year for main streaming PLWHAS. Admitting that odisha does not have adequate training facilities for those working with people infected with virus, swain said, “We plan on setting up a centre to impart advanced training and research in the field of HIV/AIDS (TOI Nov, 3, 2008)”.

Awareness creation as a means of preventions of HIV/AIDS

Prevention is better than cure. Since now neither a successful vaccine has been invented nor has a patent medicine been manufactured for permanent cure of such a dreadly epidemic like HIV/AIDS. So that, much more importance is given on creating awareness. It is regarded as a means of prevention. “Know AIDS to no AIDS” is a popular awareness creating slogan which means one has to gain more knowledge to thwart the threat of HIV/AIDS.

To create awareness about HIV/AIDS and to prevent stigma and ostracization towards PLWHA and their children NACO (National AIDS Control Organization) plans to reach out and to cover 43200 villages in 180 district of country (India) through Red Ribbon Express. This special project of NACO plans for bring under it umbrella groups such as youth, women, SHGS, adolescents from schools and colleges as well as Panchayatraj institution members.

The Red Ribbon Express, a specially designed seven coach train which would travel across the country carrying HIV/AIDS prevention messages was flagged from Delhi by the UPA chair person Sonia Gandhi on December 1st 2007, who termed the campaign against the dreaded disease as a battle which can and must be own. It would aim at spreading awareness about HIV, promoting safe behavioural practices and fighting the stigma and discrimination against AIDS (PTI, The New Indian Express 02.12.07). The coaches would have different kinds of exhibition and education materials besides auditorium-cum-conference and counselling as well as medical services.

As per Red Ribbon Express programme, there would be cycle and bus caravans comprising performers who would fan out for social mobilization in a radious of 76 km. (TOI, March 15, 2008).

The Red Ribbon Express had started its journey from New Delhi from Dec 1st 2007 marking the World AIDS Day had an attempt to mount the awareness campaign about HIV/AIDS and safe behavioural practices. It arrived at Balasore station of Odisha on 1st April 2008(UTKAL DIVAS) for creating awareness about AIDS among common people. The Red Ribbon Express for the second time had started its journey in year 2010 for creating awareness among common people about HIV/AIDS through out the country.

The Bollywood film actress Preeti Jinta is appointed as “Good will ambassador from March 11, 2010 for UNAIDS programme launched in India on behalf of UNO. She has to create awareness among Indians for preventions of AIDS. Until now UNAIDS programme was confirmed only in urban area. It will be expected to spread to rural areas with her cooperation. (The Samaya, the Oriya daily Sunday supplement 12.09.2010).

A student of Delhi University, Karan Deep has a special assignment on hand everyday with 100- odd rickshaw pullers in the capital campus area. He chats with them for arround two hours daily on various aspects associated with HIV/AIDS and also educate them on the use of the condoms. He is a part of a group of 20 students from various DU colleges who are currently running an awareness campaign about HIV/AIDS and its prevention to shed

misconceptions associated with the deadly diseases among youth and socially back word classes.

The Nagpur municipal corporation in association with a newly launched NGO, Sahara has started a school for removing the stigma attached to HIV/AIDS affected children. But the local activists have opposed it saying that the school instead of helping the children in integrating with the main stream it will alienate them further. (The New Indian Express, Dec, 18, 2007).

The OSACS (Orissa state AIDS control society) has decided to create awareness on the disease through short films. The people of Orissa will now come to know about spread of HJIV/AIDS and remedial measures through the silver screen. The OSACS has asked Oriya film personalities to make short films on the different aspects of the disease and its treatment. We have decided to make ten documentaries on different aspect of AIDS staring from its source of infection and remedial measures in the initial stages, project directors of the society Dr. Parameswar swain said.

In the first phase about 18 film production units have been chosen to make the documentaries, he said such an effort will have a huge impact in southern states like Andhra Pradesh, Tamilnadu and Maharastra. The NACO has also suggested to the OSACS to create awareness through this media, because the people especially the rural folk, are very much influenced by the silver screen. A 36 member group of film personalities mostly producer , directors and script writers have visited different AIDS preventions centre in Ganjam the district having the highest number of the patients in the state to gain practical knowledge on various aspects of the deadly diseases.

They visited ART, the first AIDS treatment centre of the state which was set up at the MKCG medical college and hospital, Berhampur. Different integrated Counseling And Testing Centres (ICTCS), which are set up by different NGOS and a village named at chadeyapalli where a group of people including women were listening to the programmes on AIDS broadcasted by the AIR centre Berhampur to gain the first hand knowledge on the diseases. The short films made in Odia language would be shown through projectors in the

rural areas. These would also be supplied to 129 different ICTC centres across the state (TOI, July 25, 2008). A lot of meetings, seminars, workshops, mass rally, street plays, mass race (Ganadouda) and drawing competitions have organized for World AIDS Day observations to create awareness among the masses.

Various possible Prevention, Treatment and Cure of HIV / AIDS:-

With prevention programme by NACO and trained man power in place, patients could lead a healthy life with nutritious food. Most of the HIV drugs are made by first generic Indian Pharmaceutical farms. The stigma attached to it, is a big concern. Dr. O.C. Abraham, Prof. of Medicine Christian Medical College, Vellore has advised doctors belonging to all disciplines to recommend HIV test on slightest suspicion. He said that anti retroviral therapy and nutritious diet could stop progressive decline of helper cells. Generally the virus multiplies in such a way that 10 billion viruses were formed everyday, 10 times more than Indian population. Medical intervention could ensure long time non-progression of the virus. Hence, he said the actual status could be known through a rapid or Western blot or ELISA test at a good laboratory (The Hindu 21, 2008).

Dr. Abraham said that even some Doctors and health professionals were under the influence of stigma. The fear among certain sections that touching a patient could also lead infection was totally unfounded. Not so optimistic about developing a vaccine in the near future he said, the most important need was to create awareness on having safe sex practices and discouraging multiple partners. (The Hindu, May 02, 2008).

Can a pill daily, help in preventing infection from HIV, the virus that causes AIDS? No one knows but researchers in a number of countries are conducting trials and planning others to test the unproven strategy that a daily pill or a combination of drugs can prevent HIV.

India’s HIV vaccine programme got a major boost with the scientists of the Tuberculosis Research Centre (TRC) reporting significant progress in the first phase of clinical trials for a vaccine to prevent AIDS. The preliminary result of phase one trial has

successfully proved the vaccine's safety and its ability to stimulate immune response (that might provide protection against infection). The TRC is affiliated to the Indian Council of Medical Research (ICMR) which along with NACO and the International AIDS Vaccine Institute (IAVI) has spearheaded the vaccine trial in India. (The ToI, 11.08.2008)

A research team from Research institute of the Mc. Gill University Health Centre (MUHC) along with researchers from University de Montreal has developed a personalized immune therapy to fight HIV / AIDS. Scientists have long been finding it difficult to create an AIDS vaccine due to high genetic variability of HIV virus. This immune therapy is based on the properties of dendritic cells whose role is to present specific proteins from infectious organisms at their surface, thereby alerting rest of the immune system.

After receiving multiple subcutaneous injections of these dendritic cells eight of the nine patients involved experienced a significant increase in CD8 + lymphocyte activity. At this stage the technique does not cause side effects or an undesirable auto immune responses, said Dr. Routy. (ToI, 18.08.2008)

The virus that causes AIDS could theoretically be eliminated in a decade if all people living in countries with high infection rates are regularly tested and treated, according to a new mathematical model. It is an intriguing solution to end the AIDS epidemic. But it is based on assumption rather than a data. It is quite a startling result; said Charlie Gliks, an AIDS treatment expert at the World Health Organisation. Gilks and colleagues used data from South Africa and Malawi. In their model, people were voluntarily tested each year and immediately given drugs, even they tested positive for HIV regardless of whether they were sick. Within 10 years HIV infections dropped by 95%, other initiatives like safe sex education and male circumcision were also used.

Some Scientists claim to have achieved a major break through in the fight against AIDS with a new stem cell treatment which "protects the immune system from HIV that causes the disease". According to them the pioneering technique involves isolating three genes which curb the spread of HIV inside the body, introducing them into the human stem

cells in a sab and then transplanting the stem cells into a patient's bone marrow. "What we are doing is genetically modifying a fraction of the patient's stem cells with genes that target three different aspects of HIV that allow it to get in the immune cells and replicate. When those stem cells are transplanted into circulate in the patient and protect against HIV, "The Daily Telegraph quoted David Diguisto of city of Hope, Medical centre in California, where the research work was carried out, as saying." (PTI, ToI, Jan 20, 2008).

Some researchers at Bangkok claim to be successful for the first time in preparing AIDS Vaccine to curb its spreading. With this 25 years of research was ended for inventing AIDS Vaccine and it will become a historical success in Medical Science. (The Samaya, Oriya Daily, Dt. 25.09.2009)

Experts in Ayurveda claim to have come up with medicines which can make life more comfortable for patients suffering from HIV / AIDS, cancer and Several Physical deformities Director General of CCRSA. (The Central Council for Research in Ayurveda and Siddha) G.S. Levakar said, "The traditional system in association with modern technology can do wonders in medical science. Diseases such as HIV / AIDS, Cancer, mental illness may not be totally cured but the drugs can definitely improve the standard of life of the patients." Clinical trial for the drug is conducted in four major hospitals including St. John Medical College and Hospital in Bangalore, AIMS, New Delhi and Tata institute of Cancer, Mumbai. QOL 2A, a medicine for HIV infected and AIDS patients has been launched for multi centric clinical trials. "We developed this medicine in association with Indian Council of Medical Research two frontal organizations National AIDS Research Institute (NARI) and National Institute of Virology (NIV)", he said, (The ToI Dt. 8.7.2009)

The traditional healing system of Tamilnadu sometimes might be successful in curing HIV infected persons, The tribal healers of Vellore district claimed that they have cured more than 52 HIV infected persons with meditations derived from medicinal herbs, curd and goat milk. V.R. Govindam and his team of healer from the district, who are participating in the national workshop on tribal healers and exhibition of tribal medicine at Bhubaneswar, said that has shown result in early stage of HIV cases. According to him, Kejunelli (Phyllanthus)

plant and cotton leaf held the secret to curing the terminal disease. The paste of Phyllanthus plant when mixed with curd produces a potent combination that regenerates the dying cells thus giving the patient a fresh lease of life. This can also hold true for cotton leaf when its paste is mixed with goat milk. (The New Indian Express, 15.12.2007).

Life saving free second line Anti – retroviral Therapy (ART) has finally been rolled out for HIV patients who had become resistant to first line drugs. NACO had decided to rollout second line treatment from January starting with J.J Hospital, Mumbai and Tambaram ART centre, Chennai. The treatment will then be available at 10 proposed centres of excellence across the country including Maulana Azad Medical College (Delhi), PGI (Chandigarh) and ART centre in Kolkata, Manipur and Nagaland by April 2008. Union Health Minister A- Ramadass made this announcement on World AIDS Day on Dec. 1st 2008.

The World's first microbicide gel that has an antiretroviral (ARV) drug as its active ingredient has passed the safety test. Scientists at National AIDS Research Institute (NARI), Pune who have been conducting phase – II trials of Tenofovir gel to look at its safety and acceptability, told the Times of India that "the over all safety profile of the vaginal gel is good". Tenofovir gel is an advanced second generation HIV specific microbicide that does not try to kill the AIDS virus or block HIV from entering the body as its predecessors tried to do. Instead, it is designed to prevent the HIV virus from replicating when the virus comes in contact with an uninfected T-cell. The Virus will therefore, fail to survive long enough to cause systematic infection. (The ToI, 25.02.2008).

A five rupee female condom (FC) will now spearhead India's fight to control the spread of HIV among women. Under the first phase the NACO is procuring 15 lakh female condoms from UK's Female Health Company (FHC) which will be doled out to sex workers and house wives in Andhra Pradesh, Maharastra, Tamilnadu and West Bengal.

Ex. Union Health Minister, A. Ramadoss said, when a male partner refuses to wear a condom, women need self initiated methods to protect themselves against unplanned pregnancies and HIV / AIDS.

A team of Indo – Canadian scientists has successfully tested the world's first Saliva based HIV test with an accuracy rate nearly 100%. This test is based on Oral Mucosal

Transudate (OMT), a fluid that secreted at the base of gums before it becomes saliva (The ToI, May 8, 2008).

A good number of researches and experiments have been continuing by the researchers, scientists, bio-engineers, doctors, druggists and chemists to invent new medicines, vaccine, contraceptives and condoms to curb HIV / AIDS.

An Indian lady student had invented one type of molecular condom to protect ladies from HIV infection, when she was doing her Ph.D work in Bio-engineering in the University of Uttah of America (The Sambad, Odia Daily, 01.11.2007).

Some researchers of Albarta University have discovered a type of gene named TRIM – 22, which can protect the immune system from HIV infection after its entry into human body. It can be regarded as an important invention against AIDS prevention (The Sambad, 10.03.2008).

Some of the Australian researchers are trying to create antibodies from the blood of crocodiles and use it to prevent AIDS (The Sambad, 07.03.2011)

It is known from a study conducted in Michigan university of America that “Benlic Lactin Udana,” a chemical component of banana may prevent one from HIV infection (Saptacharya, Sarvasadharam, 20.11.2011).

An Australian scientist of Melborne University Marrit Cramsci knows from his research that cow milk can increase the immunity of human body. So that it can protect the HIV infected person, whose immune system is going to be destroyed (The Samaya, the Odiya Daily, Dt. 17.12.2012).

A group of researchers of London have made a gel medicine to control AIDS from STI (Sexually transmitted infection). This ‘Gel’ has been named as ‘minicidifores’ will be used by the females as condoms (The Prameya, the Odia daily, and Dt. 10.12.2012).

The American researchers have invented a medicine 'Truvada' which can be used by the HIV+ (Positive) patients regularly to curb AIDS. But it can not be given permission for sale in market till now. (The Samaya, 14.05.2012).

Jilled Sciencage has formulated a tablet named 'Quade' having no side effect when used for controlling AIDS. This medicine has been experimented successfully first on seven hundred eight (708) people in Australia, Europe and Thailand (The Sarva Sadharana, 12.07.2012).

Another patent medicine was invented by the medical researchers of Queensland Institute of Medical research, Australia to protect people from HIV infection. It is one type of powerful protein (the Sarva Sadharan, 18.01.2013)

The Assistant Professor, Dr. Sonia Arora of Kin University of Newjersi has discovered and demanded that the 'Neem' which belongs to "Ajardirachta – Indica" species and Mahogani family contains the quality to curb the multiplication of AIDS virus in the infected patient's body. (The Sarva Sadharan, 27.09.2012).

The Food and Drug Association of America has given permission to a kit named (Oraquick in Home HIV Test Kit' for HIV test of human blood. The test report of HIV test – 1 and HIV test – 2 can be known within twenty to forty minutes through this Kit (The Samaya, 03.19.12).

Recently, "Truvada", an HIV preventive tablet was invented which can protect HIV infection from sexual contact if it was used before intercourse with infected infected person. (The Sambad, BBSR, Dt. 03-11-2014)

ELISA Positive Test:-

Enzyme Linked Immune Sorbent Assay (ELISA) positive test is a sensitive blood test, which is earlier used to detect the presence of HIV antibodies in our body. But now-a-days it has been decided that the latest method of HIV test, NAAT (Nucleic Acid Amplification Test) must be followed for HIV testing of blood (The Sambad, the Odia daily, 02.09.2012).

Recently a research work has been done at the Yele Mussachute Hospital in Chennai about HIV/AIDS. The research report said that lives of crores of people can be protected from deadly epidemic AIDS through HIV test in every five years. Though, since now no such successful medicine was manufactured for permanent treatment and cure of HIV/AIDS, only regular testing as well as awareness is very much necessary to be saved from its attack. (The Samaya, the Odiya daily, Bhubaneswar, 12.06.2013)

Some of the researchers of George Masone University of the USA have declared that HIV infection can be treated by Soyabean. Jenistin is one of the components of Soyabean which can protect human cells from HIV infection. It can be used for preventing HIV infection in place of medicine for it. (Source:- The Sambad, Cuttack, 05.08.2013).

National AIDS Control Programme (NACP) by NACO in India:-

The first case of HIV in India was detected in 1986 by the Christian Medical College (CMC), Vellore in the blood sample of a commercial sex worker (CSW) from Chennai soon after a National AIDS Committee (NAC) was set up under the chairmanship of Minister of Health and Family welfare. In 1987, the Government of India has launched National AIDS Control Programme (NACP) with the goal of increasing AIDS awareness and also to keep a check on the spread of the epidemic. The National AIDS control organization (NACO) was established in May, 1992 in New Delhi by Ministry of Health and Family welfare to manage the activities of the NACP. The National AIDS control programme implemented its strategic plan for prevention and control (SPPC) in 1992.As per the updates from NACO 2000, the sex strategies identified to achieve the goals of the SPPC are:-

1. Programme Management:-

The NACP is managed at the National level by National AIDS Committee (NAC), National AIDS Control Board (NACB) and NACO. NACO Coordinates monitors and evaluates the programmes in various states, with the support of National AIDS Control Board. The Board exercises all financial and administrative powers. In order to strengthen the programme management at the state level, all the states and UTS (Union Territories) have established their own state AIDS control societies. NACO encourages the involvement of

every possible sector in the fight against AIDS. It is collaborating with various multi-lateral / bi-lateral agencies, government ministries and NGOs. Effective collaboration with the private sector represented by TATA Iron and Steel Company and the Bengal Chamber of Commerce are successfully ongoing. The private sector has also formed a Business coalition to respond to HIV/AIDS. NACO is working closely with the ministries like Defense, Railways, Labour, Steel and Social sector ministers such as youth Affairs, Social Justice and Empowerment of women and child Development.

2. HIV/AIDS surveillance :-

The main objective of surveillance is to monitor trends of HIV epidemic among various groups of population. There are 62 blood testing centres and 9 reference centres in the country. In addition 180 sentinel sites working with specific population groups (including highly vulnerable groups) are also tracking the progression of the HIV epidemic. Further, State Physicians Responsible for AIDS Management (State PRAM) has been identified in each State and UT to diagnose and manage AIDS cases.

3. Sexually Transmitted Disease (STD):-

Prevention of STD remains as an effective strategy in controlling the HIV transmission. 504 STD clinics as well as 5 regional STD referral centres have been upgraded through the provision of equipment and manpower to deal effectively with the STD cases. The Ministry of Health and Family Welfare has adopted a policy to integrate STD control in the ongoing family welfare services.

4. Condom Programming:-

NACO has initiated a programme to ensure that good quality and affordable condoms are easily accessible to people especially to the vulnerable groups. Condom quality specification as described by WHO have been adhered to thought the revision of schedule “R” of the drugs and cosmetics act.

5. Blood Safety:-

Blood safety is an integral part of the NACP. One hundred fifty four zonal blood testing centres have been established for blood screening. Mandatory measures such as

licensing of all blood banks and testing every unit of blood for HIV are being enforced stringently. Eight hudred fifteen blood banks upgraded and 40 blood component separation facilities have been established. **The Supreme Court of India** passed a judgement on 4th Jan. 1996 which led to the formation of National and State Blood Transfusion councils that ensures the availability of safe blood. Professional blood donation has also been banned w.e.f 1st January 1998 in order to curb the selling of blood especially by vulnerable sections of the Society.

6. Public awareness through Information, education and Communication (IEC):-

Efforts are under way in all parts of the country to educate people about HIV/AIDS. Comprehensive Information, Education and communication (IEC) strategy was prepared by NACO in 1994 and is operational at two levels. At the national level, political and media advocacy is being enhanced to create a supportive environment whereas at the state level. State AIDS Control Societies are undertaking IEC activities in accordance to their social and cultural contexts. The wide spectrum strategy includes the following components:-

a. **Generic Material:-**

It is developed by NACO and disseminated to all states, Union territories and NGOs for further use.

b. **Mass Media Approach:-**

Multimedia campaigns using talk shows, music programmes, T.V., Cinema, Press advertisements, posters and pamphlets etc. are being used to mobilize community efforts against AIDS.

c. **Reaching Rural Youth:-**

NACO is supporting 700 “Yuva Kendras” in rural areas with the objective of spreading HIV / AIDS / STD awareness among the rural youth.

d. **Out reach Projects:-**

The Department of Youth Affairs and Sports has been using rural art forms like Puppetry, Folk dance and musician disseminating HIV / AIDS information messages.

e. AIDS Education Schools:-

In consultation with the National Council of Educational Research and Training (NCERT) NACO has prepared training packages for imparting AIDS education in schools.

f. **Universities Talk AIDS (UTA):-**

The UTA programme was launched in 1991 by the Department of Youth Affairs and Sports with technical assistance from the WHO. The programme continues to sensitize the college going youth on causes, consequences and prevention of HIV / AIDS. It is operational in all Universities in India and has more than 1.35 million student volunteers who act as peer educators. The UTA is a low cost programme which aims to train 10 new peer educators / college (WHO, Nov. 1998).

g. **Mobilising women Organisations:-**

Keeping women vulnerability to HIV infection in mind NACO has held workshops with grass root level women's organizations to specifically address issues related to women and HIV.

Counselling:-

Recognising the vital importance of counselling as a supportive and cost effective measure NACO has established 145 voluntary counselling centres all over the country. A counselling training module for training apex level, intermediate level and grass root level counsellor has also been developed by NACO.

Online discussion Forum:-

NACO in association with UNAIDS has launched an online discussion forum i.e. www.youandaids.org. The forum is operational on every Wednesday between 2 to 3 P.M and shares knowledge and experiences on the Web.

Telephone Hotline:-

A National Telephone Hotline – (No. 1097) has been initiated in most of the states which offer free HIV/AIDS information and counselling to the masses. The helpline is presently operational in 77 cities and towns. (Meenu Sharma, AIDS Awareness Through community participation, Page No. 75)

Second Phase of NACP (1999 – 2004):-

On 15th December 1999 India launched its second five year National AIDS control programme (NACP) with a budget of US $ 230 million including $ 191 million assistance

from the World Bank and $ 39 million from the Government of India and the state governments. The programme emphasized on decentralization of Services, delivery at the state level protection of human rights of PWHA and encouraged ownership of the NACP by the implementing agencies (NACO, Dec. 2001).

The Third Phase of National AIDS control Programme (NACP – III) 2007-2012:-

The NACP – III has been launched from 6th July 2007. The overall goal of NACP – III is to halt and reverse the epidemic in India over the next five years by integrating programmes for prevention, care, support and treatment. This will be achieved through a four pronged strategy during 2001 – 2012.

To evaluate the NACP, WHO has developed a set of ten prevention indicators, which measure achievements in knowledge level, use of condoms and reduction in the incidence of sexually transmitted diseases (STIS). These evaluations are called the prevention indicator (PI) survey (NACO, 1996).

Non-Governmental Organisations (NGOs) complementing NACP:-

In India a number of NGOs have responded very positively to the HIV/AIDS epidemic. The role of NGOs in reaching marginalized groups is vital as they are better acquainted and have close interaction with the communities they work with. Many NGOs continue to help in preventing new HIV infections through awareness generating activities. They are also instrumental in reducing the personal and social impact through their support and counselling programme.

Although NGOs are bringing the gap between NACP and the communities, yet it has been observed that most NGOs remain passive in exchanging information and reluctant in coming together in a coalition format. The Coalition form can promote greater programme coverage and increase the accessibility of different services in an integrated manner.

World Health Organisation (WHO) policy for NGOs:-

WHO collaborates with different NGOs on the basis of World Health Assembly Resolution (WHA 42.34), which call for Governments, NGOs and the WHO secretariat to

work together by complementing each other's activity. WHO has recommended that 15 percent of the fund it provides should be allocated to NGOs for AIDS activities. In 1994, WHO developed guidelines for NACPs, which stress that besides providing technical and material support to NGOs, NACPs should also collaborate closely with them. Assistance and guidance to various NGOs is provided by support organizations (APCASO), the Global Network of people living with HIV/AIDS (GNP+) and the International HIV/AIDS Alliance.

Governmental and Non-Governmental Provisions for wellbeing and maintainance of HIV/AIDS patients:-

India became the first country in Asia to introduce DNA polymerase Chain Reaction (PCR) test, a dry blood sampling method of testing pediatric AIDS, NACO plans to start six more regional centres with the PCR in Bangalore, Chennai, Hyderabad and Imphal. A dry blood test will confirm the HIV status. Children below 18 months of age in India will no longer die of HIV for lack of proper diagnosis. Once the child becomes 18 months old we will put him or her on treatment of ART with proper treatment and nutrition the child will be able to live a healthy life.

India has also formulated the National pediatric HIV/AIDS treatment protocol, which was launched by the Congress Chief Mrs. Sonia Gandhi and former US President Bill Clinton. The Protocol says, "For children below 18 months born to an HIV positive mother the first DNAPCR shall be conducted at 6 weeks of the age. If the test proves positive it has to be repeated immediately for confirmation. If the first PCR is negative, confirm with the 2nd PCR test at 6 months. (The Times of India, Dec. 1st 2006)

The Government of India has provided for free Anti – Retroviral treatment (ART) for HIV/AIDS patients. The patients who become resistant to first line treatment and who are experiencing drastic decrease in their CD_4 counts, an increase in the viral load in the bodies and continuous weight loss are given the facility for second line treatment from January 1st 2008. The Govt. is also looking at setting up special orphanages and foster care homes for children who have lost their parents to the disease.

Perhaps, for the first time in the country, the Odisha Govt. has decided to pay monthly pension to HIV positive people in the state. The Government will also dole out monetary benefits to AIDS widows under the State sponsored Madhubabu Pension Yojana from January 2008. Officials said, “In India the first phase as many as 6,132 HIV Positive people irrespective of age or earning will receive Rs. 200/- each month”.

Promising to increase the number of ART centres providing free treatment and run under NACO from 174 to 650 by 2010 Gopal Subramaniam said, ‘Second line treatment for HIV+ People was in the pilot stage and would soon be available to the needy. All doctors and nurses in the public and private sector would be directed to immediately familiarize themselves and comply with the protocols and policies prepared by NACO which would be made part of the teaching curriculum.

All doctors, nurses and hospitals staff, whether in Public or private sector shall treat HIV+ People in a professional manner treating them always with dignity and care. No doctor and nurse shall refuse to treat them on account of their positive status. In treating them, there shall be no discrimination or stigma what so ever. In an important remedy for HIV+ people seeking treatment the centre said, “The Medical Council of India and consumer Courts are to take active view of Private practitioners to take advantage of illiteracy and provide to prescribe wrong and unnecessary drugs or charge exorbitant amount. Irrational prescriptions using wrong dosages or wrong combinations shall be dealt with severly.” (The Times of India, Bhubaneswar, 07.08.2008).

The centre has decided to provide job cards and employment to PWHA under the National Rural Employment Guarantee Act (NREGA).In addition around one lakh people with HIV who are receiving anti-retroviral therapy (ART) at 174 centres across the country would be treated as belong to below poverty line (BPL) category ensuring them 35 Kg. of food grain every month under Antodaya Anna Yojana (AAY). These promises were part of the 19 point proposal made for public for the first time by the centre before the Supreme Court to make the lives of the HIV+ Positive people a lot better. Responding to Supreme Court’s earlier directive, additional solicitor general Gopal Subramaniam told a bench

comprising Chief Justice K.G Balakrishnan and Justice P. Sathasivam and J.M Panchal that states and Union Territories would be asked to ensure that all HIV positive people be provided with a job card and employment in accordance with the NREGA Scheme (The ToI, 07.08.2008).

Limited Success of HIV Prevention Programme:-

Efforts of massive magnitude are being continuously put into HIV/AIDS prevention and care programmes and many have become success stories world wide in terms of their contribution in arresting the spread of HIV, yet, some programmes have had limited success in containing the HIV epidemic. An understanding of the factors leading to partial success of HIV/AIDS prevention and care programmes can help in the reformulation of programmes that guarantee maximum impact and nearly 100 percent success.

Ignorance, illetracy, customs, attitude and lack of both human and financial resources have been recognized as major factors responsible for the limited success of many programmes. Several constraints in implementing educational programmes effectively, which include the absence of standardized sex education programmes for the youth the cultural stereo types about gender appropriate sexual behaviour and the paucity of trained sex education experts, have been identified.

Prevention of the Global community from HIV/AIDS has become an important research area. The epidemic is the undergoing cause for reversal of hard earned progress on growth and development indicators. The devastation infected by disease in terms of early and painful deaths, increasing numbers of orphans and depletion of human as well as material resources have all necessitated the compulsion of putting the virus under immediate control. Today, prevention from HIV/AIDS has become our prime necessity.

Further, few populations such as those of commercial sex workers, truck drivers, migrant workers, street children and injecting drug users are increasingly being recognized to be vulnerable to the disease because of their indulgence in high risk behaviour and practices. To protect these populations from HIV/AIDS is challenging, yet, an urgently needed task since these groups are serving as bridges for HIV transmission from the high risk behaviour populations to the general population.

The number of HIV/AIDS patients is rapidly growing in India and if preventive measures are not implemented at the earliest then the situation is very likely to become explosive. Thus many programmes for the common masses as well as targeted innervations for the vulnerable groups are being implemented across the country with the aim of creating HIV/AIDS awareness amongst them. Similarly, efforts are under way to provide appropriate care and management for HIV/AIDS infected people. The ultimate goal is to prevent new infections from taking place while at the same time ensuring care for the infected ones. It is now being realized that preventions is possible only if the people are aware about the disease as well as important aspects related to it.

Awareness for sure holds the key to success in containing the spread of the epidemic. People who are aware / educated are known to adopt measures to protect themselves from the virus as compared to those who are unaware about the disease (UNAIDS / WHO, June 1998). Hence there lies an urgent need to create awareness among masses especially those who face increased vulnerability to the disease unfortunately, in India, the task of creating AIDS awareness is complicated by various factors such as illiteracy. Socio-Cultural taboos, restrictions and adherence to gender inequalities as a norm as well as economic compulsions to name a few. Ironically, prevention from HIV/AIDS cannot take place in isolation. There is a need to review these factors while planning any intervention.

Spread of the Wings of Services and supports in Odisha:-

- **Integrated Counselling and Testing Centres (ICTC):-** The ITCT provides testing and pre and post test counselling to HIV/AIDS patients. At present ICTCs are opened at Districts and Sub-divisional Headquarter hospitals and in Ganjam District, ITCTs are opened even at community Health Care (CHC) level.
- **Community care centre: -** A Home away from home. To provide long term support in terms of psychological, social and health care community, five care centre are opened in the state.

- **Drop in centre:- Advocacy for PLHAS:-** In order to strengthen the PLHA networks and giving space for positive living OSACS is providing support to 10 drop in centres managed by different PLHA network at District and Sub-divisional level.
- **ART Centre: A New Hope for PLHA: -** PLHAs now avail of the ARV drug through ART centre established in Odisha. At present, Berhampur, Cuttack and Sambalpur medical colleges and the District Headquarter hospitals of Koraput, Anugul, Balangir, Balasore and Capital Hospital Bhubaneswar are providing this service and 13 link ART centres are running to facilitate services at ART centres.
- **Targeted Intervention : To halt the HIV/AIDS :-** There are four major groups – Female Sex Workers (FSWS), Intervenal Drug users (IDUS), men having sex with men (MSM) and migrant labourers are mostly most vulnerable to HIV. Keeping in view of this OSACS with the support of civil society is running 61 targeted intervention projects in 24 districts of Odisha.
- **Blood Bank and Blood component separation Unit: -** To halt the HIV/AIDS, provision of safe blood is equally important to control HIV/AIDS. At present 89 blood banks with five having blood component separate unit and nine blood storage centres are established in Odisha.
- **Red Ribbon Club: Youth can make a difference: -** Youth are identified as a vulnerable group to HIV/AIDS under the National AIDS control programme Phase – III. For creating awareness onHIV/AIDS among youth (students), OSACS established 600 Red Ribbon clubs in Degree colleges and Universities in Odisha in collaboration with Indian Red Cross Society, Odisha Branch.
- **Red Ribbon Express : World's largest Social mobilization campaign against HIV/AIDS :-** A unique train called 'Red Ribbon Express' (RRE) visited Odisha's nine railway stations from May 2 to 22 starting from Rayagada, Koraput, Berhampur, Mancheswar (BBSR), Cuttack, Jajpur, Keonjhar Road, Jaleswar, Balasore, Balangir and Rourkela railway station. A crowd of more than 30,000 gathered at Berhampur railway stations. During this period a total of 99,987 persons visited the exhibition and 4,049 participated in the training programme 2795 persons were counselled out of which 1,981 persons tested for HIV (The Tol, 1.12.2010).

Picture No. 2.3

Red Ribbon Express

1st April 2008 at Balasore Railway Station, Odisha

- **Main Streaming HIV/AIDS: -** HIV/AIDS issues are largely seen as a cross cutting matter keeping this in view, OSACS has successfully partnered with UNICEF, UNFPA, UNDP, State Blood Transfusion Council, Leepra Society, Action AID, Indian Society, PSI, Indian Red Cross Society, TE & SCERT, Indian Oil Corporation.
- **Madhubabu Pension Yojana (MBPY) Social Security to PLHA: -** Odisha is the 1st State in the Country that provided Social Security to all the people with HIV/AIDS under Madhubabu Pension Yojana. This Pension Scheme provides Rs. 200/- per month. The uniqueness of this scheme is that confidentiality of PLHAs as is prescribed and no physical verification is required in this case.
- **"Mo Kudia Yojana" Social Security to PLHA :-** Odisha is also the 1st State in the country to include all the HIV infected family under "Mo Kudia Yojana" – a free low cost housing scheme in initiated by the Govt. of Odisha.
- **OSACS On-line:-** OSACS has launched its own Web site "www.osacs.nic.in" in Nov. 2008. The Web site hosted by NIC contains information about OSACS and AIDS awareness for counselling and enquiry OSACS has a **toll free No. 1800-345-6778**. Pics courtesy OSACS. (The Times of India, BBSR, 1st December, 2010).

Medical help for people of Odisha is now just a Phone call away. In a unique initiative, Odisha Health and Medical Research Institute (OHMRI) has implemented a State of the Art Health Care information Help line with Toll Free No. 1800-345-6767. Hello Doctor instant Health Care is a registered Service brand of OHMR. It is Health Care information Help Line which provides Health Care information, gives HIV/AIDS related information, Ambulance Service and others through a Toll Free Phone call. Hello Doctor is already associated with major hospitals in Odisha. It has multi Media Contact Channels (Phone, Fax, Mobile, Web, E-mail, SMS and Internet Gateway) to communicate with registration and callers. It aims to reach to the people in the remote rural areas of Odisha and reduce the cost of Health care services (The Tol, BBSR, 2.12.2010).

There are around 20,000 HIV+ cases in the state and their No. is rising despite many, steps taken to control it and 1200 had died so for, OSACS sources said while there were 312 HIV+ cases in 2002, the No. is 19,800 now. This year 64 person died, sources said (The Tol, 02.12.2010). To counter this scourge, Chief Minister Mr. Navin Pattnaik announced that the Blood Bank at the Capital Hospital has been converted into a model Blood Bank to ensure safe blood transfusion through out the state. A blood mobile van has also been provided.

Steps have also been taken to merge programmes of HIV/AIDS with National Rural Health Mission (NRHM) to provide better access and service to people living in far flung and difficult to each area.

To spread awareness on AIDS among the masses and especially the children, a week long event under the initiative “know AIDS to no AIDS” campaign has been started by The Times of India in Association with other partners on world AIDS day, 1st Dec. 2010. (JSPL – Jindal Steel and Power Limited).

This campaign being held at Mali Sahi, BBSR aims to let awareness percolate to those sections of Society residing in slums that are most vulnerable. The campaign launched by The Times of India and supported by OSACS, UNICEF, OHMRI, Adhunik Steel, NRHM, LEERA Society, Action AID, HOPE Foundation, Ashray, JSPL (Jindal Steel and Power Limited), and BISWA was formally inaugurated by Ananta Narayan Jena, Mayor, Bhubaneswar Municipality Corporation, All these organizations come under one roof to

spread awareness we can control and hinder the spread of HIV through awareness (The Tol, 02.12.2010).

The year 2011 will mark the 30th Anniversary of the AIDS epidemic as AIDS cases were 1st reported in the year 1981. Over past three decades AIDS has caused untold suffering and death, but global community has displayed unprecedented united action against the disease. The National AIDS control programme (NACP – III) 2007-2012 has the over all goal of halting and reversing the epidemic in India over the five year period. NACP places the highest priority on preventive efforts while seeking to integrate prevention with care, support and treatment.

In accordance, this year 2011, the theme for world AIDS Day is "getting to Zero – Zero AIDS related deaths". Towards Zero new HIV infections, Zero discrimination and Zero AIDS related Death Odisha Govt. is launching from today (1st Dec. 2011) :-

- Upgradation of five blood banks at Sambalpur, Baragarh, Nayagarh, Sundergarh and Mayurbhanj.
- Blood storage Units at Dasapalla, Bhuban, Gunupur, Muniguda and Sohela.
- Functioning of blood component separation unit (BCSU) at VSS Medical College, Burla and Municipal Hospital, BBSR.
- Functioning of Blood Bank in SCB Medical College, Cuttack.
- Inauguration of Department of transfusion medicine of SCB Medical College.
- CD_4 count facilities at Balasore, Rourkela and Bolangir ART centres.
- 9 Link ART centres at Nayagarh, Bhadrak, Nawarangapur, Mayurbhanj, Keonjhar, Jharsuguda, Nuapara, Malkangiri, Jajpur.
- Link worker scheme of 4 new Districts i.e. Puri, Nuapara, Sundergarh and Cuttack.
- Inauguration of HIV/AIDS message on OSRTC Bus tickets.

- Three more Migration Transit points operationalised at Jharsuguda, Balugaon, and Jajpur Road Railway Station (The Times of India, BBSR, 1st Dec. 2011.)

Activities under Odisha State AIDS control Society (OSACS):-

Report on activities of Health and family welfare Deptt., Odisha, BBSR 2007-2008 Orissa is a low prevalent state but highly vulnerable to HIV/AIDS. The developmental activities and achievements of OSACS are given below.

Activities under taken by OSACS:-

Component - 1: Prevent new infections

Targeted intervention: - Targeted interventions are a specific set of interventions in AIDS control programme targeted towards high risk behaviour group (HRG) i.e. female sex workers (FSW), IDUS, MSM and Migrant laboureres under NACP – III.

OSACS undertakes 23 targeted intervention projects covering 22 Districts. There are 29,975 target populations of highly vulnerable groups like FSWS, MSMS, IDUS, Migrant labourers who are being covered through TI projects. Besides above, OSACS issued advertisement to involve more NGOs / CBOS and also for employment for all Districts to cover more HRG through TI projects.

The main components of the TI projects are Behaviour change communication (BCC), STD treatment, Condom promotion, enabling environment and community mobilization.

Objectives of the targeted interventions are:-

- To provide the services to target population in order to practice safe behaviours.
- To create enabling environment to over come obstacles and to support practice of safe behaviour.
- To empower to lobby and advocate for what they need – (Community mobilization).

IEC & Awareness:-

Communication continues to be one of the most important strategies in the fight against HIV/AIDS. In the absence of a vaccine or a cure, prevention is the most effective strategy for the control of HIV/AIDS. IEC is the tool of behaviour change by combined use of mass media, traditional and impersonal media having the effect of behaviour change and de-stigmatizing HIV/AIDS.

In India, the majority of population is still uninfected. It, therefore, becomes imperative to continue intensive communication efforts that will not only raise awareness levels but also bring out behaviour change.

Electronic Media, Doordarshan:-

The impressive rise in the levels of awareness about HIV/AIDS in the general community can be partly attributed of the electronic media which has taken this message right upto the village level, which has been developed in the local language and ethos. Docudrama (Katha Rakhiba), interactive programme like LIVE panel discussion, phone in and TV awareness spots are being telecasted in regular intervals in various electronic media like Doordarshan, ETV, OTV etc. from time to time. Regional specific TV documentaries are also being produced and telecasted in Doordarshan considering local specific culture and needs.

Radio programmes:-

Radio plays an important role in any development communication as it has a high reach with minimum cost panel discussion, LIVE, Phone – ins, Radio jingles are also being broadcasted to have direct link with the listeners. Special interactive programmes “Mita Janitha” from AIR, Berhampur and Jaipur, Radio jingles in respective dialects are also being broadcasted.

Private F.M Radio channels also play a great role in inflecting youth opinion and disseminating awareness on HIV/AIDS in Urban areas. Special interactive sessions with celebrities and experts on HIV/AIDS have been broadcasted in Radio Chocolate, Big 92.7 FM in the State.

Print Media, News Papers, Magazines, and Souvenirs etc.:-

To give detailed messages print media is the appropriate media as electronic media is costly and only bears recollect effects. To create awareness HIV/AIDS in general public, OSACS publishes messages on HIV/AIDS during special events/occasions in Souvenirs/ Magazine/ Weekly / Odia Dailies from time to time.

Print Media, Posters, Leaf Lets, Booklets, Stickers and Danglers:-

OSACS has developed Posters, Leaf Lets, Booklets, Stickers, Exhibition Kits, Tinsheets and Flex Banner etc. to disseminate message on HIV/AIDS for general population and BCC material have been developed and are being disseminated to all service centres like ICTCS, STD, Clinics, ART Centre, Community Care Centre and drop in centre including all organizations/ Institutions and NGOs who are undertaking awareness activities in the State.

Mid – Media activities:-

Messages on HIV/AIDS are also being disseminated through wall paintings, hoardings and tinsheets. Wall paintings are being done in all the medical premises upto CHC level in the State; permanent hoardings are also being fixed all districts and important public place of the State.

Inter Personal Communication (IPC):-

OSACS is participating in various melas local mohotasv etc. by putting exhibition IEC stalls, where HIV/AIDS counsellor of ICTCS of DHH/SDH are being attending and distributing IEC materials, counselling to HRGS & general population. Free condoms are also being distributed among HRGS. To encourage and ensure maximum participation, OSACS conducting open quiz competitions and prize distribution at the melas in which there are hundreds of visitors.

An innovative programme i.e. all Orissa cycle yatra has been done by Pratap Ch. Padhy of Ganjam. He covered 314 panchayat samiti and 500 police stations of the state and aware people, high risk groups on roads, FSW sites. He started his cycle yatra from

01.12.2006 on the occasion of World AIDS Day, 2006. OSACS has supported him by giving financial assistance for his travel.

Village/ (ULB) level HIV/AIDS awareness campaign:-

In the previous years OSACS covered 17 districts i.e. Koraput, Rayagada, Mayurbhanja, Keonjhar, Ganjam, Khurda, Balasore, Kendrapara, Puri, Bhardak, Gajapati, Malkangiri, Nuapada, Nawarangapur, Cuttack, Jagatsinghpur and Deogarh district under village/ULB level HIV/AIDS awareness activities, conducting 14857 programmes covering 14187 villages and 67 urban local bodies(ULB) of 188 blocks, 3749 Panchayats. Under programmes traditional folk media, street plays, Palla, Daskathia was adopted. Meetings, rally distribution of IEC materials were also done.

During the last and current years special interactive programmes (SIP) are being conducted by directorate of field publicity (DFP).

Observance of Events:-

Special events like World AIDS Day, Voluntary Blood Donation Day, International Women's Day, International Drug Abuse and Illicit Drug Trafficking Day, Vigilance Week, World Health Day, International Youth Day and National Youth Day etc. are being observed throughout the state in collaboration with line govt. departments agencies under the umbrella of OSACS.

Advocacy:-

Advocacy with various Govt. Deptts, NGOs/INGOs, corporate bodies, community based organization (CBOS), religious leaders, Journalists, PRI members, Govt. Officials, SHGS are being undertaken with the help of our state mainstreaming unit.

"ICTC campaign" was launched on 16th august 2007 in the conference hall of SIH &FW, BBSR to raise the in take at ICTCs in the state.

Integrated Counselling Testing Centre (ICTCs):-

129 ICTCs are established in the state. The ICTCs provide testing with the pre-test and post-test couselling, of general public on drugs for opportunistic infections, free

distribution of condoms, follow-up counselling done for HIV positive cases detected in various health camps, HIV testing with pre-test and post-test counselling to pregnant women. HIV+ pregnant women are advised for institutional delivery. During the delivery of HIV+ mother, one Nevirapin 200mg. capsule is given to the mother and Nevirapin syrup is given to the new born baby after two hours of delivery to protect the new born baby from HIV infection. Delivery kits are supplied for the delivery of HIV+ mother and staffs are advised to follow the "universal safety precaution".

Tele-counselling centre/helpline:-

A National AIDS Helpline (non-metered 1097) is operational in Orissa state AIDS control society (OSACS) BBSR and the three medical colleges for Tele counselling of general public on STD/HIV/AIDS.

Sexually Transmitted Diseases (STD) clinics:-

Sexually Transmitted Infections (STI)/ Reproductive Infections (RTI) increase the risk of HIV transmission. Facilities for free treatment of STI & RTI are available in the STD clinics.

Condom promotion:-

Among the probable sources of HIV transmission in our country, hetero sexual promiscuity constitutes the major route. The most successful and practical way to prevent the transmission is the use of condoms according to experience from all over the world and in India.

The promotional programmes are undertaken by the partner NGOs (implementing targeted interventions programmes), in all districts of Orissa, for creating awareness among the target populations and for increasing the uses of condoms in high risk groups and general populations.

The Condom Vending Machines (CVMs) have been installed one at capital hospital, Bhubaneswar one at Badambadi area of Cuttack city & another one is at city hospital Berhampur for easy availability of condoms for the high risk groups on pilot basis.

Blood Safety:-

Transfusion of unsafe blood & blood products accounts for 1% of total HIV infection in the state to provide safe blood & blood products (HIV free), OSACS supports, financial grants to 53 blood banks 1-govts., 50-redcross, 1-charitable, 1-public sector Paradeep port trust and HIV kits are provide to 54 blood banks.

External Quality Assurance (EQAS):-

In order to maintain the quality of the tests being done at each level HIV testing centres i.e. VCCTCS, ICTCS, PPTCTS centres and blood banks EQAS is followed. In Orissa there are three State Reference Laboratories (SRLS) namely the microbiology department of SCB medical college, Cuttack, MKCG medical college, Berhampur & VSS medical college of Burla. The SRLS are supplying the unknown serums to the HIV testing centres twice in year for testing to verify the quality of testing, which cross check the earlier diagnosis of testing. Simultaneously, the HIV testing centres are also sending all HIV +ve samples, all in determinate samples and 5% of all HIV -ve samples to the corresponding SRLS. The process is to maintain the quality of tests done at the level of the HIV testing centres.

Mainstreaming:-

State Mainstreaming Unit (SMU):-

The HIV/AIDS mainstreaming project under NACP-111 is a key initiative taken up with UNDP support for mainstreaming of HIV/AIDS goals and activities into ongoing policies, programmes and activities of relevant govt. departments, institution and civil society organization including involvement of networks of positive people. The main objective is to enable an equitable and inclusive HIV response across six non health departments, 25 districts in five states and select civil society and private sectors organization in 5 years. Out

of 5 identified states (Orissa, Bihar, Chhatisgarh, Rajsthan & U.P.). Orissa is one of them, functioning the state minstreaming unit.

The SMU will work with six departments (rural development, urban development, Tourism, Panchaytiraj, tribal affairs and home); corporate and private sectors and civil society organization at the state level as well as in 5 focus districts (Ganjam, Balesore, Sambalpur, Khurda and Cuttack) for mainstreaming of HIV/AIDS,

State council on AIDS has been formed under the chairmanship of Hon'ble Minister, Health and Family Welfare and the first meeting was held on 31st Oct 2007 attended by Secretaries and other senior officials of the govt. A consultation of work place intervention was organized for corporate and private sector organization on 16th Nov. 2007 in association with HLFPPT, OXFAM, CII and Utkal Chamber of Commerce and Industries.

A co-ordination meeting of greater involvement of people living with HIV/AIDS was organized. To mainstream HIV/AIDS in civil society sector to workshop were conducted involving NGOs working in development sector other than the health sector discuss and develop specific strategy and related co-ordinated mechanism among all the organizations/agencies working in the civil society.

- **Adolescence Education Programme (AEP):-** Under Adolescence Education Programme during the financial year 2005-06 OSACS had covered 2390 No. of Schools in 10 Districts (Anugul, Balasore, Bolangir, Gajapati, Ganjam, Kendrapara, Khurda, Koraput, Puri & Sundergarh).

  During the year 2006-07; as per the decision of NACO the School Adolescence Education Programme has been under taken by the department of School & Mass Education of the State with a view to cover all the Govt. Secondary and Higher Secondary School (+2 Colleges) which includes formation of Red Ribbon Club (RRCs) in the educational institutions.

- **College / University Talk AIDS :-** Indian Red Cross Society, Orissa State Branch has been funded by OSACS for conducting the Red Ribbon Club Activities under

University Talk AIDS in Degree Colleges and Universities. Till October, 2007; 295 Colleges have been funded Rs. 5,000/- each with a guidelines to carry out Red Ribbon Club activities in the College by youths.

- **Health NGOs, Development CBOs & PRIS: -** Training of 240 staff of Health NGOs in 7 batches has been completed by OSACS.

  OSACS participated in formulation of Advocacy strategy for senisitising different target Audience like PRI Members, Media Representatives, Health Service providers, representative of SHGs, Member of Rogi Kalyan Samiti and Village Health and Sanitation Mission. ASHA, ANM, AWW, Civil Society for Advocacy activities under NRHM during April, 2007.

- **Component : 2, Care & Support**

  Management & PEP: - People living with HIV/AIDS (PLWHA) are prone to different opportunistic infections like TB, Diarehoea, Cough, Fever and malignancies. Medicines for such OIS are available in all the hospitals and given to the patient free of cost. As per the decision of the State Govt. patients are allowed to reimburse up to Rs. 2,000/- for medicines prescribed by doctors beyond the free available medicines per course of treatment of the disease per person.

  Anti – Retroviral Medicines are provided to each District Headquarter Hospital & Medical Colleges for post exposure prophylaxis. 3 types of Anti-retroviral drugs are supplied for course 4 weeks (28 days).

- **Drop-in-centre :-** OSACS has established DROP-in-Centre through CBOS (Community Based Organisation) namely Kalinga Network for people living with HIV/AIDS (KNP+) at Bhubaneswar of Khurda District to provide proper counselling, emotional and Social to PLWHA during their stay.

- **Community Care Centre: -** OSACS has established four community care centres (CCC) in the State through NGOs like OVHA at Bhubaneswar of Khurda district,

USS at district headquarter at Cuttack, TSRDS at Berhampur of Ganjam district and Lepra Society at district headquarter of Koraput district.

The community care centres are providing low cost community care to people living with HIV/AIDS in the State. PLWHAS will receive treatment for opportunistic infections, nutrition, counselling and care at the centre. The NGO will take up the treatment and care of 10 PLWHA for a period of maximum 15 days. After 15 days the committee (PD, Clinic Doctor, NGO- member) would decide on whether to extend the patient's stay or not.

As per the direction of NACO, the funding pattern has been changed w.e.f from 1st January, 2008. OSACS will not directly funding to these centres. Population foundation of India (PFI) will be funded through CBCI, Kolkata, OSACS will monitor the programme.

Component: 3, Treatment:-

Anti Retroviral Treatment (ART) Centre: - Anti Retroviral Therapy complies ARV drugs that are given to HIV infected individuals, once they have advanced immune suppression ART suppresses viral replication.

One Anti – Retroviral Treatment (ART) centre is functional at MKCG Medical College, Berhampur from 26.9.06. Drugs for AIDS patients are available in the ART centre. There are 701 no. of patients under treatment till December, 2007.

Every month 25 to 30 samples of blood collected from HIV +ve persons and opportunistic infections cases are sent to School Tropical Medicine & Science, Kolkata from ART centre Berhampur for CD_4 cell estimation 09 Drugs & condoms are available in the ART centre.

Interagency Collaboration :- For the first time all funding agencies both international & national operating in the State like UNICEF, UNDP,DFID,OXFAM, HLFPPT, Lepra Society, CONCERN Worldwide, KIIT Deemed university, Population Service International, Parikar Seva Sanstha, Action AID, Satyam Foundation, Orissa AIDS Solidarity Forum etc. have come together into one platform and determined to fight against

HIV/AIDS in an intensive manner in the arena of IEC, CARE, Support and Treatment on HIV/AIDS.

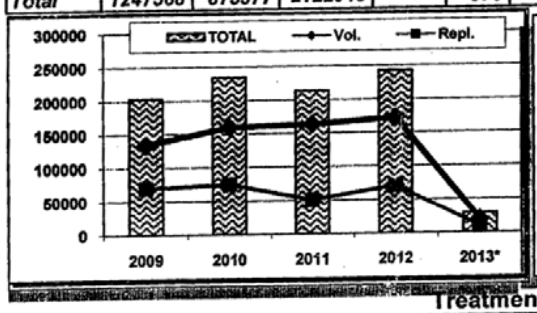
In Collaboration with Clinton Foundation training Programme for private Doctors has been completed for 333 private doctors in five districts, i.e. Ganjam (Berhampur), Sambalpur (Rourkela), Bhadrak, Dhenkanal, Cuttack, Jajpur Road (Cuttack) & Puri and has planned to take up training programme on HIV/AIDS in other districts like Koraput, Rayagada, Jagatsinghpur, Kalahandi, Sambalpur, Sundergarh & Mayurbhanj.

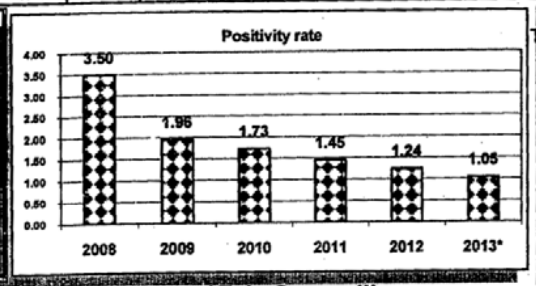
In the first Phase, CD_4 testing blood of PLWHA and child living with HIV/AIDS (CLHA) of the State have been conducted in 17 sites during the month of Dec. 2007.

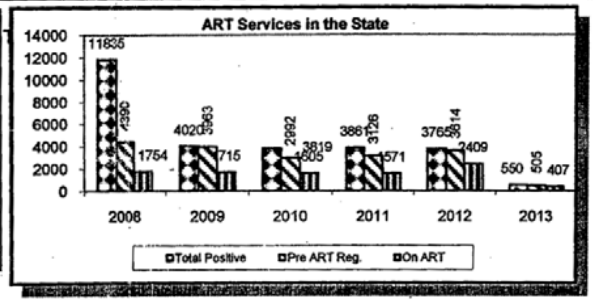
Table No. 2.6 & 2.7- OSACS statistics at a glance & Treatment/Referal Cases/tele counselling

OSACS Statistics at a Glance up to February -2013*

Year	BLOOD BANKS								Intigrated Counselling and Testing Centre								Reported AIDS infection	
	Sample Screened Donors				No. + Ve Donors				General Client(Excluding Pregnant Women)				Pregnant Women					
	Vol.	Repl.	TOTAL	Vol.%	Vol.	Repl.	TOT.	%	Counselled	Tested	+Ve	Positivety %	Counselled	Tested	+Ve	Nevra pine	Case	Death
Up to 2008	599959	600192	1200151	50	390	888	1278	0.11	730936	330231	11545	3.50	251021	159983	290	0	1045	828
2009	133635	69753	203388	66	123	108	231	0.11	270224	193515	3795	1.96	164903	141880	225	95	297	297
2010	159392	74675	234067	68	93	122	215	0.09	336854	207234	3590	1.73	195936	160457	229	162	131	127
2011	162909	50650	213559	76	101	86	187	0.09	333343	247381	3593	1.45	244037	222766	268	124	65	65
2012	171952	70812	242764	71	149	65	214	0.09	350335	279171	3462	1.24	285639	265048	303	178	41	40
2013*	19721	9295	29016	68	20	12	32	0.11	59718	49359	516	1.05	47378	45413	34	24	4	4
Total	***1247568***	***875377***	***2122945***		***876***	***1281***	***2157***		***2081410***	***1306891***	***-26501***		***1188914***	***995547***	***1349***	***583***	***-1583***	***1361***







Treatment / Referal Cases / Tele-Counselling

Year	STD CLINICS					ART services		Tele Couns.	HIV-TB Activities					HRG Covered under Targeted Intervention		
	New Patients		Referred to ICTC	HIV '+Ve	% of +ve	Pre. Reg	On ART		ICTC to RNTCP		RNTCP to ICTC		HIV_TB Coinfection			
	Attending	Treated <episodes>							Reffered	Found(TB)	Reffered	Detected HIV		Typology	No of TIs	Covered HRGs
Up to 2008	213391	145643				4390	1754	25724	7201	1924				FSW	13	4850
2009	39439	39439	15048	156	1.04	3963	1715	**3362**	6031	1452	4183	269	448	MSM	2	650
2010	81065	85307	53388	602	1.13	2992	1605	3429	12950	1712	5761	148	450	FSW (Composite)	24	6350
2011	114040	73489	47919	312	0.65	3126	1571	2964	12654	1473	10879	342	613	MSM (Composite)		3910
2012	149049	76761	45210	218	0.48	3614	2409	3541	13823	1701	15655	245	441	IDUs	7	1980
2013*	28465	11723	9243	43	0.47	505	407	669	2508	221	2425	37	53	Migrants	10	105000
Total	***625449***	***432362***	***170808***	***1331***	***3.3***	***18590***	***9461***	***39689***	***55167***	***8483***	***38903***	***1041***	***2005***	Truckers	1	15000
Since 2002 Couns.	**3270324**	**Testing :-**	**2302438**	**+ve**	**27850**	**Only 2013 Couns.**			107096	**Testing :-**	94772	**+ve**	550	Total	57	137740

Table No. 2.8

HIV Positive Persons by Age, Sex & Mode of Transmission wise

Sl. No.	Particulars	2002 – 2013 February			
A	**Age Group**	**Male**	**Female**	**Total**	**%**
1	< 14	1,028	813	1,841	7%
2	15 – 24	1,109	1,346	2,455	9%
3	25 – 49	14,031	6,830	20,861	75%
4	50 +	1,031	277	1,308	5%
5	Not Specified	30	6	36	01.%
6	ANC		1,349	1,349	5%
	Total	17,229	10,621	27,850	100.00%
B	Routes Of Transmission	Male	Female	Total	%
1	Sexual	14,973	7,971	22,944	82.38%
2	Blood/Blood Products	177	123	300	1.08%
3	Infected Syringes & Needles	490	43	533	1.91%
4	PPTCT	982	786	1,768	6.35%
5	Not Specified	607	349	956	3.43%
6	ANC		1,349	1,349	4.84%
	Total	17,229	10,621	27,850	100%

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CHAPTER – III

METHODOLOGY

- Introduction
- Universe of Study
- Sample Selection
- Pilot Study
- Research Design
- Objectives of Study
- Hypothesis
- Methods of Study
- Variables
- Tools and Techniques of Data Collection
- Classification, Analysis and Interpretation of Data
- Problems and Difficulties
- Limitations of Study

CHAPTER-III

METHODOLOGY

"Methodology is the logic of scientific investigation. In this sense methodology in Sociology includes the analysis of basic assumptions of science in general and of sociology in particular, the process of theory construction, the interrelationship of theory and research and the procedures of empirical investigation. Methodology is not concerned with building substantive knowledge, but rather deals with the procedures by which knowledge is built – conceptual, logical and research procedure". (Dictionary of Sociology, P – 254, William P. Scott).

Methodology is an integral part of social research. It is a logical procedure in the hands of a researcher. It is the foundation on which the entire edifice of social research stands. Because of the validity and reliability of the data chiefly depends upon system of investigation. That is why methodology stands for advanced planning of the methods to be followed for the collection of reliable data and the techniques to be used in their analysis, keeping an eye over the aims of research. Methodology saves time, money and effort and makes various research operations easier. It shows the plan and technique of research in detail. It refers to sequential and logical study of principles guiding scientific investigation. It enables the researchers to formulate and apply research design. Every research requires a particular type of methodology, because methodology is vital for scientific enquiry. Stuart Chase rightly remarked, "Science goes with the method and not with subject matter".

Mrs. P. V. Young opines, "Social research is a systematic method and the primary goal of research is to understand social life and thereby gain greater measure of control over social behaviour". Sociological research involves theory, rigorous pursuance of empirical investigation and use of methodology. The word "methodology", actually refers to the study of methods. It is accepted now that identification as well as solution of all social problems lies in extensive and proper use of social research methods. These methods help in providing theoretical framework.

Karl Pearson has viewed, “The unity of all sciences consists alone in methods not in its materials”. Any branch of knowledge can be science if it can be studied through scientific method. “Scientific method consists of systematic observation, classification and interpretation of data”, opines G. A. Lundberg. Methods help in searching out materials and placing them and arranging them in consistently sequential manner so as to reach at a meaningful conclusion. In the absence of proper method and technique the researcher would be in a dense forest and does not find the way to his destination. Hence, methodology helps the researcher to reach a particular destination through a well articulated procedure. The present chapter is an account of the various methods and techniques adopted by the researcher in her study.

The present study entitled “Attitude and Perception of Ruralites towards affected HIV/AIDS patients: A study in Rajnagar and Rajkanika blocks in Kendrapara District” focuses on the knowledge, the awareness level, myths and misconceptions, attitude, behaviour and ostracization towards HIV/AIDS infected patients and affected people. It also focuses on the needs of the family care and social care for HIV/AIDS infected and the role of governmental and non-governmental organizations and mass media in changing social attitude towards them. The study was undertaken with the goal of creating HIV/AIDS awareness among the sample communities.

In order to analyze the whole research process in a very systematic and scientific manner the researcher adopted different research procedures such as the locale (i.e. the Universe of Study), sample selection (i.e. selection of respondents), pilot study, research design, objectives of study, hypothesis, methods of study, variables, tools and techniques of data collection (interview schedule, participant observation), classification, analysis and interpretation of data, problems and difficulties, limitations of study etc..

Universe of Study:-

One of the most important strategy in social research is to select an area which must be representative in nature and is more responsive to changes. In scientific social research “universe” refers to the area under study or the entire group from which the sample required for the research work is taken.

Here the researcher's Universe or population includes the villages of the two coastal blocks of Kendrapara district of Odisha. According to Orissa State AIDS Control Society (OSACS) 183 persons have been detected as HIV positive by February 2007 in the district. Out of which 10 cases have been reported as infected from parent to child. A number of cases of deaths in AIDS are found in Rajnagar and Rajkanika blocks of the district.

According to district statistical handbook of Kendrapara district 2005, Rajnagar block consists of 310 villages under 18 Gram Panchayats with a population of 1, 45, 301. 35% to 40% within the age group of 15 – 50 years of this population migrated to other states for their livelihood. A survey report of one of the NGO, (Nature's Club, Kendrapara) states that the maximum number of migration of people is found within the age group of 15 – 38 years. The persons within this age group are more vulnerable to HIV/AIDS infection. A number of HIV positive cases have been detected and a death case has also been reported from this block, but it remained confidential as per direction of NACO.

The second block where this research undertaken was Rajkanika block which has 168 villages in 29 Gram Panchayats. The total population of this block is 1, 26, 887. In this block 30% to 35% of labouring class people within age group of 15 – 38 years migrated to other states for their livelihood. From this area people have migrated to the states like West Bengal, Gujurat, Andhra Pradesh, Kerala, Karnataka, New Delhi etc.. The main cause of HIV infection in this area is due to migration to other states. 3 to 5 open cases of HIV positive infections have been found here. One person has also died of AIDS in this block.

According to District wise HIV+/AIDS death cases in Orissa up to February 2013, OSACS, there are 293 HIV positive cases, in Kendrapara district from which 74 cases leads to AIDS. Out of which 73 persons have died in AIDS.

Therefore this area is selected for studying whether only migration or other causes are responsible for HIV infection. What is the impact of HIV/AIDS upon the people of these areas? Whether they are aware of this disease, its causes, transmission, prevention and treatment or not? What are the reactions of the people towards HIV/AIDS affected? What are

the steps taken by the governmental and non-governmental Organizations to prevent this disease?

Selection of Sample:

In the field of social research it is difficult to contact all people and ascertain their views. Hence the researcher has used sampling method for selecting respondents. Sampling is a method for collecting information and drawing inferences about a lager "Population or Universe" from the analysis of only part, there of the sample. (A Dictionary of Sociology, by Gordon Marshal, P – 576) A "sample" consists of limited number of cases selected for study from a particular 'Population' or 'Universe'. (Dictionary of Sociology, William P. Scott) Most of the sociological research deals with samples rather than total populations.

Sampling is one of the most important, accurate, relevant and widely used method of data collection in scientific social researches. Sampling methods really good for the study of a social problem as it helps in saving time, money and energy. The sample should Picked up in such a manner that it represents the entire population to be studied. This method is selected because it gives significantly accurate results with much less time, money and material.

The sample of the present study consisted of ruralites of Rajanagar and Rajkanika blocks.One Hundread Fifty (150) respondents are selected from each block. The villages from which samples was selected are distributed in three circles in accordance with distance from block head quarters. The first circle is within the 0 – 10 kilometers distance, the second is within 10 – 20 kilometer distance and the third is above 20 kilometers distance from the block head-quarter. In each block, 50 respondents were studied from each circle. The whole universe of the present study is classified into various groups on the basis of different variables, i.e. sex, marital status, caste, occupation, income and level of education.

The sample was selected from various villages of Rajnagar block named Rajnagar, Garjanpur, Rajgarh, Bhatapara, Bandhapatna, Keradagarh, Maidyapara, Ostia, Jagannathpur sasan, Balikana, Kankadia, Chandanpur, Khandamara, Nagad, Balikana, Belpal within 0 – 10 kilometer from block head quarter. The sample within 10 – 20 kilometer from block head

quarter belongs to the villages as Rajpur, Endulapur, Katakana, Dholamana, Prasannapur, Naladia, Kaitha, Kandira, Hariharpur, Nuagaon and Badapalli. The sample from third circle within 20 and above kilometer belongs to the villages namely Righagarh, Gobindpur, Uttar Vekta, Talchua, Kani, Rangani, Mahinsasan.

The other One Hundread fifty (150) samples were selected from various villages of Rajkanika block. Fifty respondents have been selected from first circle within 10 kilometer from block head quarter which includes the villages namely Gokenswar, Ganja, Sebasahi, Nuarasa, Jharam, Kothasahi, Patuli, Poral, Gopalpur, Balipatna and Malisahada. The samples from second circle belong to Pimpudi, Nahuni, Nuagaon, Dalikenta, Barunadia, Baruna and Panki within 10-20 kilometers. The third circle includes the villages namely Kandia, Khandeita and Panimukundapur within 20 and above kilometer.

Pilot Study:

Pilot study is any small scale test of a research instrument such as a questionaire, experiment or interview schedule run in advance of the main field work and used to test the utility of the research design. (Dictionary of Sociology, Gordon Marshall, Page No. 496). Therefore, after the selection of problem, the researcher has undertaken a pilot study to get first hand information as well as to ascertain the relevance of the problem. The pilot study also carried out to ensure appropriateness of research process such as adequacy of the study area, relevance of the study, objectives and hypothesis.

It will be helpful in providing an idea about different variables involved, nature of problem and probable difficulties. Interview schedule is formed on this basis. After finalizing the problem for study the researcher visited the universe to conduct pilot study without taking any hypothesis. The researcher has interviewed five respondents in each block primarily. The researcher herself felt some difficulties lying in some questions in interview schedule. So that respondents faced problem to answer some questions. Therefore the researcher has modified the interview schedule and collected data from the respondents.

Research Design:

Research design as mentioned in the Dictionary of Sociology (William P. Scott, Page No. 348) is any plan for the collection, analysis and evaluation of data. The controlled experiment and the field study are the types of research design.

Research design is strategic plan for a research project or research program, setting out the broad outline and key features of the work to be undertaken including the methods of data collection and analysis to be employed and showing how the research strategy addresses the specific aims and objectives of the study. (Oxford Dictionary of Sociology, Gordon Marshall, Page No. 566).

P.V. Young said, “The design results from controlling general scientific model into varied research procedures”. In a narrow sense research design refers to the procedures for the collection of data and its analysis. In broader sense, a research process involves identification and selection of research problem, choice of theoretical frame work for research problem and its relationship with previous research. A research design will always help us in knowing successive stages. It tells us what to observe, how to observe, how to analyze the quantitative representation of the observations and drawing possible conclusion from the statistical analysis.

Therefore, research design is an advance plan of the research process consisting of researcher’s decision regarding the procedure to be followed, sampling, collection and analysis of data. It provides a picture for the whole research plan before starting of the work.

However designing the research starts from selection of the problem and ends at drawing inferences and generalization.

In the present study both the exploratory and experimental research design are followed. First of all the researcher reviewed the relevant literature related to the subject and then followed the experimental research design where a number of hypotheses have been formulated for the study. It documents the global scenario of HIV/AIDS; the distribution of

HIV/AIDS regionally, the extent India is affected, the state wise problem referring to the state of Odisha, particularly focusing Kendrapara district. For narrowing down, the study has been selected in two blocks i.e. Rajnagar and Rajkanika of Kendrapara district. Specially reflecting the extent HIV/AIDS infected and affected rural people both men and women. The respondents for this study were selected by random sampling method. The study examines the well being of HIV/AIDS infected and affected and suggests strategies to manage with care and compassion to HIV/AIDS infected/affected victims.

Keeping in mind the unanimous agreement that no single research method can take care of all aspects of an issue and the best research design should include elements from both the cross sectional and longitudinal strategies (Clarke and Stewart, 1987), the present study is based on a "Cohort sequential design" combining both cross sectional and longitudinal strategies. Different groups of people of different ages (cross sectional strategies) were studied over a reasonable period of time (longitudinal strategy). The word 'cohort' as used by Bee (1995) describes groups of individuals born within some fairly narrowband of years, who share the same cultural/historical experiences at the same time in their lives. 'Cohort analysis' as mentioned in "Dictionary of Sociology, William P. Scott, Page No. 58) is the study of number of people with some common characteristic over a long period of time.

The term 'cohort' originally referred to a Roman military unit, but now it is used to identify any group of people with a time specific common experience. 'Cohort analysis' as a method of research was developed by demographers and applied primarily to the study of fertility. The most common type of cohort analysis uses age groups (birth cohorts). Cohort analysis refers to any study in which there are measures of some characteristics of one or more cohorts at regular intervals after the defining event. Cohort analysis is a powerful analytical technique. (Oxford Dictionary of Sociology, Gordon Marshall, Page No. 83 and 84).

Thus in this present study the sample may be classified as cohorts since they were closure to each other and share the same cultural experiences.

Objectives of Study:

- To find out awareness among the rural people towards signs, symptoms, transmission and prevention of HIV/AIDS.
- To investigate the factors determining the cause of the spread of HIV/AIDS among rural people.
- To study migration as a major factor contributing to spread of HIV/AIDS.
- To examine social attitude of rural people towards HIV/AIDS infected/affected.
- To enquire about ostracization of HIV/AIDS infected people and their family members.
- To reject myths and misconceptions about HIV/AIDS related discrimination.
- To suggest the rural people to provide family care as well as social care for HIV/AIDS infected to lead the life of normal people.
- To assess the role of mass media, governmental and non-governmental agencies for the well being of HIV/AIDS infected or affected.

Hypotheses:

- Misconception about HIV/AIDS leads to ostracization and discrimination of HIV/AIDS infected /affected by the ruralites.
- Social attitude of ruralites is not positive towards HIV/AIDS infected/affected.
- Negative attitude of rural people towards HIV/AIDS infected/affected acts as a psychological threat on them.
- Positive social attitude provides moral support to the HIV/AIDS affected people to live normal life.
- The governmental and non-governmental agencies create awareness among the ruralites about the causes, transmission, prevention and treatment of HIV/AIDS.
- Mass media helps in changing negative social attitude of rural people towards HIV/AIDS infected/affected.
- Consequently changing social attitude may lessen social discrimination and ostracization against HIV/AIDS infected or affected.

Methods of Study:

An exploratory and descriptive study was carried on by the researcher to study the "Attitude and perception of rural people towards HIV/AIDS infected patients". The researcher has used the stratified random sampling method for drawing sample from the universe. When a small group is taken as the representative of the whole it is called as sampling method. The whole group from which the sample has been drawn is technically known as 'universe' and the group actually selected for study is known as 'sample'. The method of selection assures each individual or element in universe an equal chance of being chosen. But random sampling is not same as chance selection. The researcher has followed the stratified random sampling method. Under this method the universe is first divided into a number of strata or groups. Then from each group certain numbers of items are taken on random basis. Stratified sampling method is a combination of both random sampling and purposive selection. In the selection of strata or groups the researcher uses purposive selection method but in selecting actual units from each, stratified random method is used.

Variable:

In the social sciences the term 'variable' refers to attributes which are fixed for each person or other social entity but which are observed at different levels, amounts or strengths across samples and other aggregate groups. Variables measure a social construct (such as social class, age or housing types) in a way which renders it amenable to numerical analysis. Thus, the key feature of a variable is that it is capable of reflecting variation within a population and is not a constant. Variables may be measured at different levels of measurement, but the basic distinction is between continuous variables such as income and categorical or discrete variables such as class. (Dictionary of Sociology, Gordon Marshall, Page No. 691).

Thus variables mean something that varies or changes. It helps the researcher in making comparative analysis which facilitates in drawing two types of variables i.e. dependent variables and independent variables.

Dependent variables are those which depend on other variables and change from time to time. In the present study the researcher has taken attitudes, perceptions, educational and occupational aspirations as dependent variables. In this study the dependant variable comprised of awareness level, preliminary knowledge, myths and misconceptions relating to HIV/AIDS ostracization, discrimination and stigma attached to HIV/AIDS infected/affected, existing positive or negative attitudes of ruralites towards them. It also includes changing attitudes relating to stigma, ostracization and discrimination of HIV/AIDS infected/affected, impact of mass media on the respondents and the governmental and non-governmental attempts to create awareness and to provide assistance for care and maintenance of infected/affected.

Independent variables: - In this study the researcher has taken age, sex, income, educational background and marital status as independent variables.

Age: - Attitude, beliefs, awareness and opinions vary with the variation of age. It is common fact that the sample, that are young comparatively more conscious about the causes of HIV/AIDS infection, factors of spread and transmission, prevention and cure than the aged.

Education: - Education may be taken as an independent variable to the extent that it helps in increasing awareness level of the sample and changing attitude with the impact of mass media. The respondents should develop their outlook towards the disease and towards the infected/affected by the disease.

Income: - This was found that the persons having different income groups also differ in their attitude towards migration as factor motivating rural people for migration and its consequences.

Tools and Techniques of Data Collection:

Selection of appropriate and useful tools and technique is one of the most important step in any social research. Lexical or dictionary meaning of ‘technique’ in sociology is a specific, culturally patterned means of attaining a given end. Techniques are learned and may

require the acquisition of specialized skills. Techniques may be simple or complex. They may involve manual actions, as in the techniques of a skilled craft or they may primarily intellectual, as in the case of statistical techniques; or social (Dictionary of Sociology, William P. Scott).

G. A. Lundberg opines that, “man is usually credited with being the only tool making and tool using animal. Man’s first concern was with their usefulness….”. In the field of social research different types of techniques of data collection are used such as observation, interview, questionnaire and schedule. Sometimes these tools and techniques are used singly or in combination with other tools depending on the nature and subject of study.

In this study, the researcher has used the ‘interview’ method for the collection of data. Interview is a social interaction which results in transfer of information from the interviewee to an interviewer or researcher. Interviews may be personal, conducted face to face or by telephone or through postal (questionnaire) (Gordon Marshall, P – 328). P. V. Young remarked that, “Interview is a systematic method by which a person enters more or less imaginatively into the life of a comparative stranger”.

The purpose of interview is to secure certain information, from the subject which is known to him or her and cannot be gathered from any other source. The study is conducted mainly with structured interview. Data are collected from the respondents on face to face basis by using interview schedule. Schedule means a list of questions. Interview is conversation between an investigator and an informant for the purpose of gathering information (Dictionary of Sociology, William P. Scott, Page No. 213). Interview schedule is a list of questions used by an interviewer to structure and guide his/her questioning of a respondent. The interviewer asks questions and records the answer herself. The use of an interview schedule allows the respondents to ask for clarification and explanation of unclear or difficult questions. It also allows interviewer to record responses not directly anticipated in the design of the study. However interview schedules may be highly structured with the interviewer simply reading the questions and recording answers based on predetermined alternatives such as ‘yes’ or ‘no’ or ‘agree’ or ‘disagree’.

This method is more advantageous than other in the sense that here the interviewer is personally present to explain the meaning of terms and questions and clear their doubts if any, during the course of enquiry. Interview schedule is used as the main tool because the percentage of response is much higher than the other tools of social research. The interview schedule was prepared in two stages. In the first stage, a pretest schedule was prepared on the basis of hypotheses formulated and was administered for pilot study. Questions which elicited little or no responses were reformulated before the final schedule was prepared. And at last it was administered to the sample by personal interview.

During the course of interview the researcher maintains a personal diary to record her experiences, observations and impression about the respondents under study. Every possible care was taken to collect valid and reliable data.

The interview schedule contains various types of questions such as structured questions, multiple choice questions, open ended and close ended questions. It also contains questions on family particulars, education, occupation, income, health status, changing attitude towards life. The first part of the schedule is designed to know socio-economic background of the respondents.

The second part of the schedule is designed to know the respondent's preliminary knowledge, attitude and consciousness about HIV/AIDS. The third part contains questions about the misconception and ostracisation of HIV/AIDS infected/affected. The fourth part of the schedule is designed to know the attitude and perception of the respondents towards HIV/AIDS infected/affected. The fifth part of the schedule designed to know the necessity of family care as well as social care for HIV/AIDS infected/affected persons. The sixth part is formulated to know about governmental and non-governmental responses towards them. The seventh and final part of the schedule is framed for knowing the impact of mass media in changing social attitude towards HIV/AIDS infected/affected.

Classification, Tabulation and Analysis of Data:

After the completion of interview process the data are carefully verified and scrutinized. The researcher took all care to verify and make necessary correction wherever

needed. The inter relationship between different factors are examined. Then classification and tabulation of data are made. Classification is a process of arranging things in a systematic order, so as to enable comparison and establish relationship between variables. The researcher has designed interview schedule in such a manner that most of the answers could be easily classified. Different data have been classified on different basis, such as caste, income, occupation and education. Thus “classification is the process of arranging data into categories or class intervals to facilitate the comprehension and analysis of data”.

After the completion of systematic classification of data, the tabulation method was adopted. Tabulation, in statistics, is the enumeration of the number of cases that fall in each category or class interval of a variable. Tabulation is often the first step in the analysis of data. (Dictionary of Sociology, William P. Scott, Page No. 434).

The main objective of tabulation is to determine the frequencies or numerical strength of different types of responses. Opinions of the respondents were recorded and documented. Importance of responses was computed by using percentage method.

After completion of the process of classification and tabulation of data, analysis of data is made. Data are analyzed in the context of the objectives to test the validity of the hypotheses. The answers to the open ended questions denied tabulation as these were varied and subjective. Hence, for this type of questions the content analysis technique was followed. Content analysis is a research technique used to describe and analyze objectively, systematically and quantitatively the content of written or spoken or pictorial communications such as novels, editorials, movies, comic books and public speeches. (Dictionary of Sociology, William P. Scott, Page No. 75). The results available through such correlation were analyzed keeping the objectives of research in view.

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Chapter- IV
DEMOGRAPHIC PROFILE

CHAPTER-IV

DEMOGRAPIC PROFILE

Geography of Odisha:

The present study is undertaken in Kendrapara district of Odisha. Kendrapara district is located on the coastal line of Odisha. Odisha is a maritime state situated in the coastal part of India. Jharkhand bounds Odisha in the north, on the north east by West Bengal, on the south Andhra Pradesh, on the east by Bay of Bengal and on the west by Chhatisgarh. Odisha is divided into Odisha coastal region and Odisha inland region. It covers an area of 1,55,848 Sq. Km.. It has 480 km long coastline. The present area of study Rajnagar and Rajkanika block are situated in this coastline.

Climate of Odisha:

The climate of Odisha is mainly influenced by the presence of Bay of Bengal, regional monsoon, Eastern Ghats and geological conditions. Monsoon season commences from early June and stretches upto early October. During the four months of monsoon the quality and duration of rain fall is variable in space and time. July and August happens to be the most raining months.

The rainy season is followed by a quiet period of winter from November till February when people have smooth living unaffected by any severe climatic conditions. By the beginning of March the temperature slowly picksup and by middle of April it hovers around 40°C and 46°C with some premonsoon rains, thunder and lightening. Excessive temperature leads to heat wave, sun stroke deaths and scarcity of water making life unbearable. Middle of June brings relief with monsoon rains again taking over and thus the climatic cycle completes in Odisha.

Demography:

Odisha has a dubious distinction of having maximum number of population (47.15%) under the poverty line. The percentage of population to total population of India is 3.75%.

Table No. 4.1

Population of Odisha

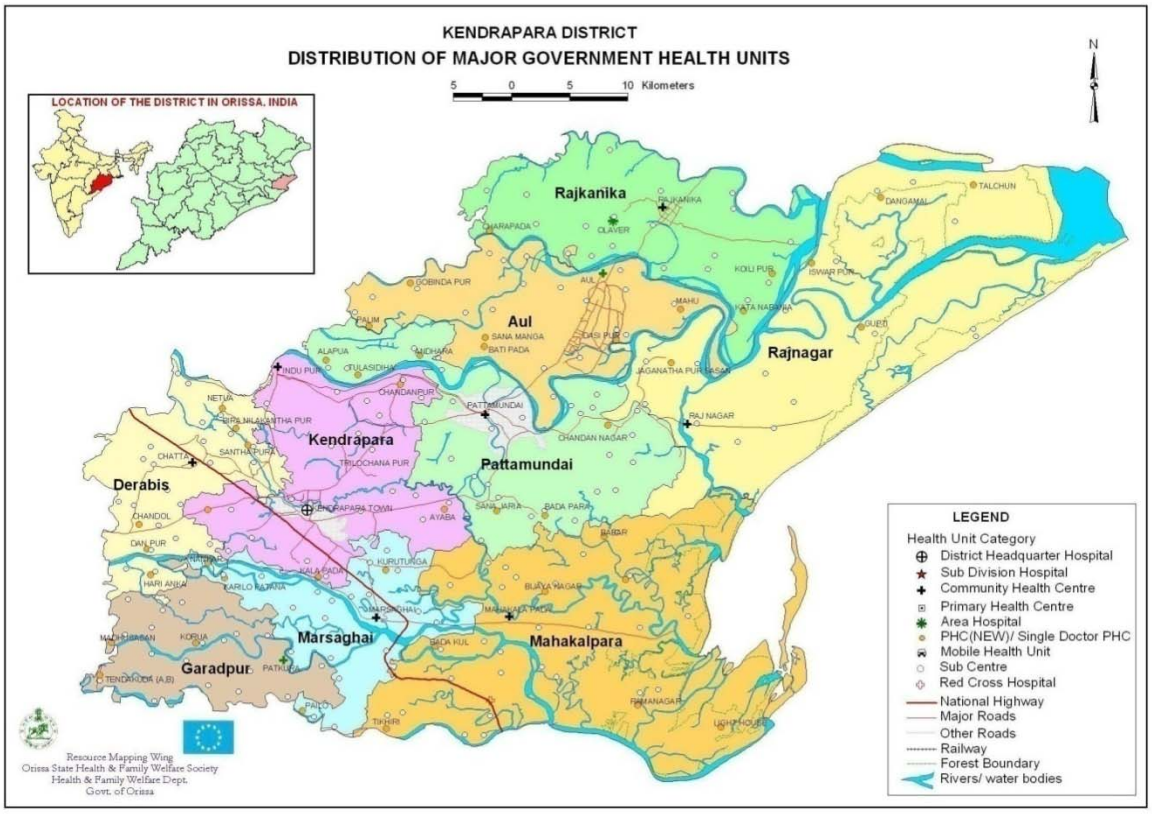
Population				
Total	**Male**	**Female %**	**SC & ST %**	**Urban**
41,947,358	**21,201,678**	**20,745,680**	**38.6**	**14.97**
Growth Rate	**15.94 (1991)**			
Density	**269 (Per Sq. Km.)**			
Sex Ratio	**978:1000 (F.M)**			

Source – Census Report 2011

The above table shows that there is a disparity in sex. The density per sq. km. is 269. The combined percentage of SC and ST population in the state is 38.6%. The urban population is quite minimal at 14.97%, signalizing the very long route to urbanization and the new to concentrate on the development activities in the rural areas.

Geography of Kendrapara District:

Kendrapara district is located on the coastal line of Odisha. Bay of Bengal is in the east of Kendrapara. It bounded by Cuttack and Jajpur in the west, Jagatsinghpur in the south and Bhadrak & Jajpur in the north. Rivers namely Gobari, Brahmani, Kharasrota and Luna are flowing with in this district. The famous temple of Lord Baladevjew is situated in the district.



Map No 1: Map of Kendrapara District

Demography:

Table No. 4.2

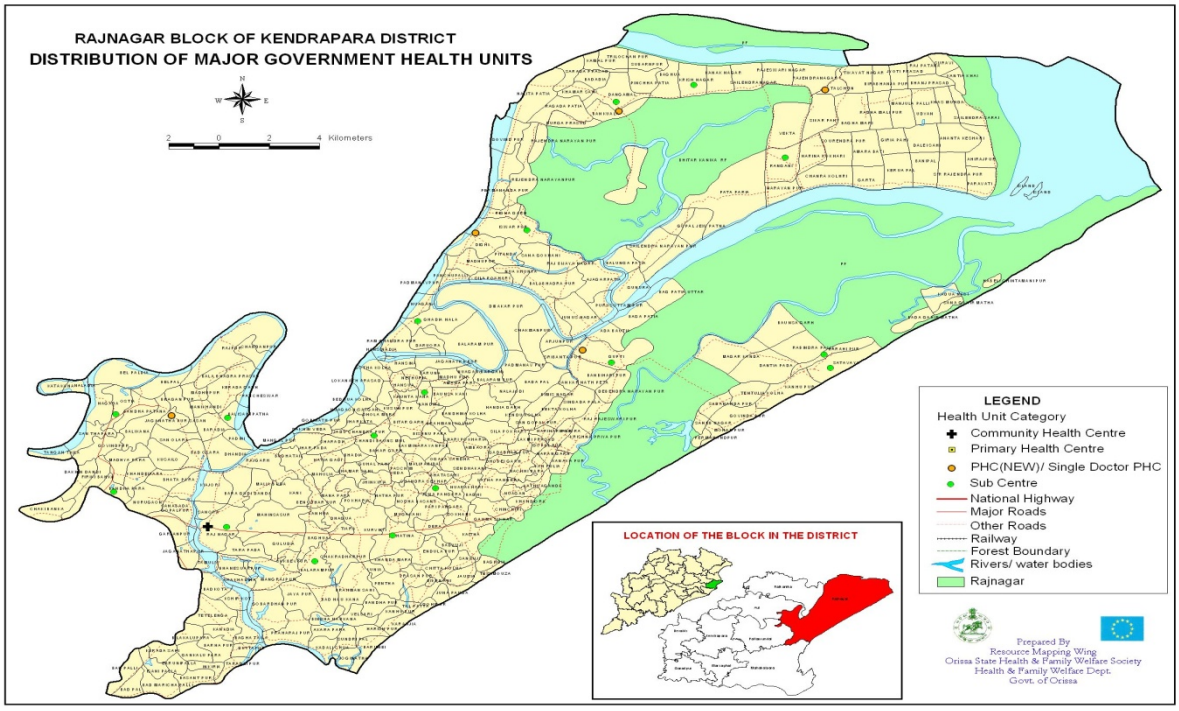
Population of Kendrapara District

	Population	
Total	**Male**	**Female**
14,39,891	**7,17,695**	**7,22,196**

The above table shows the total population of Kendrapara district. As it is shown in the table there are more females than males in Kendrapara district.

Geography of Rajnagar Block:

Rajnagar block is situated in the east of Kendrapara district on coastal line of Bay of Bengal. It is 42 km distant from district headquarter. According to district statistical hand book of Kendrapara district 2005, Rajnagar block consists of 310 villages under 18 Grampanchayats. But now there are 214 habitant villages. The rest of the villages were smashed by sand and saline water of Bay of Bengal. The whole block is within Bhitar Kanika Wild Life Sanctuary. Bhitarkanika National Park spreads with in 145 sq. km. Gahirmatha marine sanctuary is situated with in this block. Dhamara river and Bhadrak district is situated in its north side.



Map No. 2: Map of Rajnagar Block

Climate:

Climate of this area is influenced by the presence of Bay of Bengal. This area is highly vulnerable to cyclonic storm, flood, Tsunami and Saline inundation.

Demography:

According to District Statistical Handbook of Kendrapara District 2005 this block has a population of 1,45,301.

Occupation:

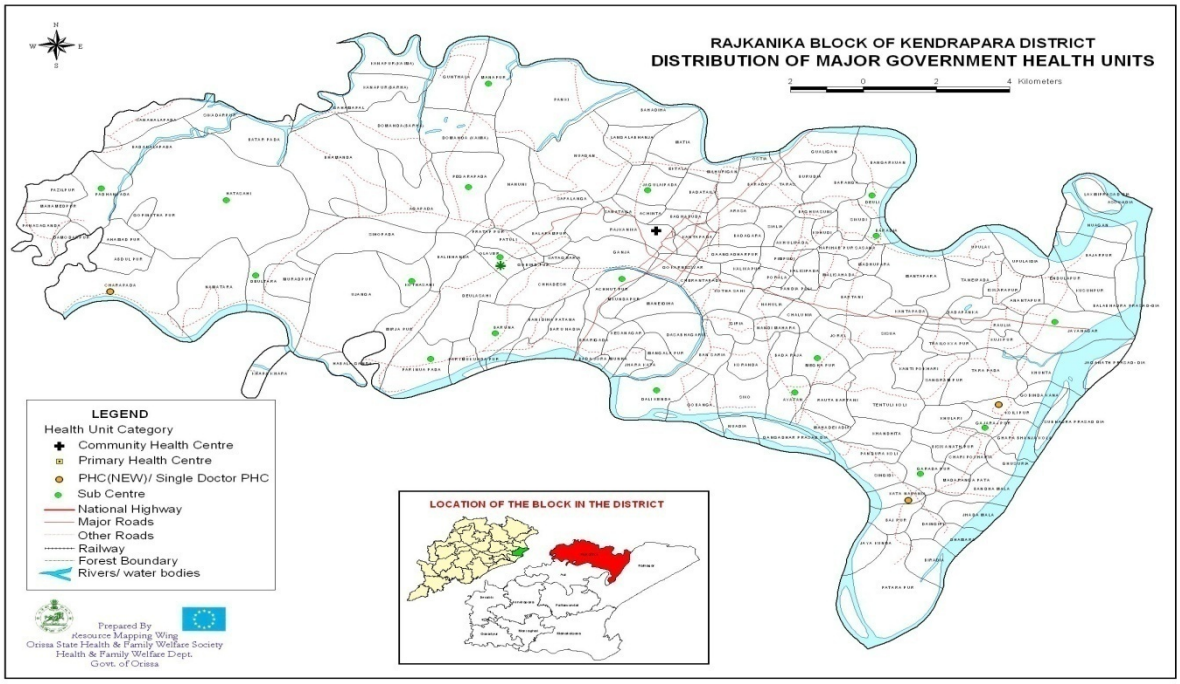
Agriculture is the main occupation of the people of this area. But most of the time agriculture is affected by the cyclonic storm, saline inundation and flood.

Migration:

As a consequence most of the people become landless and migrated to out of states like West Bengal, Gujurat, Maharashtra, Karnataka and some times to outside of India. Because of lack of and narrow source of income other than agriculture people of this area migrated to other states and outside the country namly Saudi Arab, Qatar, Oman, Kuwait and Dubai. Both the push factor of migration as having no scope of employment and the pull factor as to earn more some people migrated to other states and countries. Most of the migrated people are with in the productive and reproductive age group i.e. 20 – 39 years. Some of the people are found to be infected and affected by HIV/AIDS. Migration is the important factor of spread of HIV/AIDS in this area. Migrated labourers become the key bridge population of spreading this dreadly epidemic from urban to rural area, from husband to wife and children.

Geography of Rajkanika Block:

Rajkanika block is situated in the north direction of Kendrapara district. It is 45 km away from district head quarter. The river Baitarani and Kharasrota are flowing in two sides of Rajkanika. It is bordering to Bhadrak and Jajpur district. This block consists of 168 villages in 29 grampanchayats.



Map No. 3: Map of Rajkanika Block

Climate:

This area is regularly affected by cyclone and flood.

Demography:

According to District Sttistical Handbook of Kendrapara District, the total population of this block is 1,26,887.

Occupation:

Agriculture is the main occupation of the people of this area. The people depend on rainfall and lift irrigation facilities for agriculture. Twenty percent people earn their livelihood in working in the field as labourers and six percent people follows caste wise occupation.

Migration:

Due to marginal and sometimes narrow scope of employment 30 to 35 percentage of laboring class people have migrated to other states like West Bengal, Gujurat, Andhara Pradesh, Kerala, Karnatak and New Delhi. Some people have also migrated to outside of India namely Saudi Arab, Oman, Quatar, Bhutan, Kuwait and Dubai. Both the push and pull factors of migration are responsible for migration of these people. No scope of employment

in this area and to earn more in these outside states and countries attract people for migration. The migrated people are within the productive and reproductive age group within 15 – 38 years.

Some of the migrated people are found to be infected/affected by HIV/AIDS. From them HIV/AIDS spread to their wives and children.

HIV Status of Kendrapara District:

District wise HIV +ve/AIDS/Death Cases in Odisha upto February 2013 by OSACS shows 293 HIV positive patients are in Kendrapara district from which 74 cases leads to AIDS. But recently this number has been increased to 570 upto December 2014 (The Sambad, 28.02.2015). In Rajnagar block there are 43 and in Rajkanika block 41 HIV +ve patients.

In Kendrapara district there are three Integrated Counseling and Testing Centres (ICTC) for testing of blood to determine HIV status of the people in Kendrapara District Headquarter hospital, CHC (Community Health Centre), Pattamundai and CHC, Aul. One STD (Sexually Transmitted Disease) clinic is at the District Headquarter Hospital, Kendrapara for STD treatment. One TI (Targeted Intervention) project is working for core composit FSW (Female Sex Workers) and MSM (Men having Sex with Men) in Pattamundai, Kendrapara and Kendrapara Municipality. The link ART (Anti Retro Viral) centre is opened at Kendrapara District HeadQuarter ospital for providing treatment to HIV +ve /AIDS patients.

The non Governmental Organisations namely The “Nature’s Club” and the “Bharat” in Kendrapara district organize various awareness creating programmes in Kendrapara, Rajnagar and Rajkanika blocks regarding causes, transmission, risk factors, no risk factors and governmental facilities for the HIV/AIDS patients and their family members. They help the patients to get assistance through the Madhubabu Pension Yojana, Mo Kudia, and Indira Awas Yojana and other facilities. They organize meetings, rally and other awareness creating programmes on special occasions like World AIDS Day, Human Rights Day etc.

Chapter- V
SOCIO-ECONOMIC PROFILE OF THE SAMPLE RESPONDENTS

CHAPTER-V

SOCIO-ECONOMIC PROFILE OF THE RESPONDENTS

The present chapter concentrates on the analysis of the Socio-economic background of the sample. The socio-economic profile constitutes a vital part because here certain variables are being analysed which present an idea about the very character of the sample taken.

Secondly, variables taken in the socio-economic profile are basically independent variables which determine the attitude, behaviour, perception and action of individuals. In the rural sense, the human behaviour and perception are the processes which are conditioned by his/her social background and economic affiliation. Different social background generates a variant approach in individual and so also the discrepancies in economic content bring about differentiation in individuals response pattern.

Social and economic background basically comprise of a series of variables like age, sex, educational qualification, occupation, income and physical status. All the variables have their individual impact on the response pattern of the respondents or to great extent they react to a particular problem or issue viewed from such a significance of variables, each elements of the socio-economic profile has been analysed in the present chapter.

Age:

Age is an important social variable. It has got its pervasive influence on the individual's attitudes and actions. Sometimes, age becomes a promoter of the level of awareness and sometimes becomes a preventive force making an individual apathetic and inactive for social researchers to ear mark age as an important criterion in describing social profile of the respondents. The age structure of the sample respondents is being present in the Table no. – 5.1.

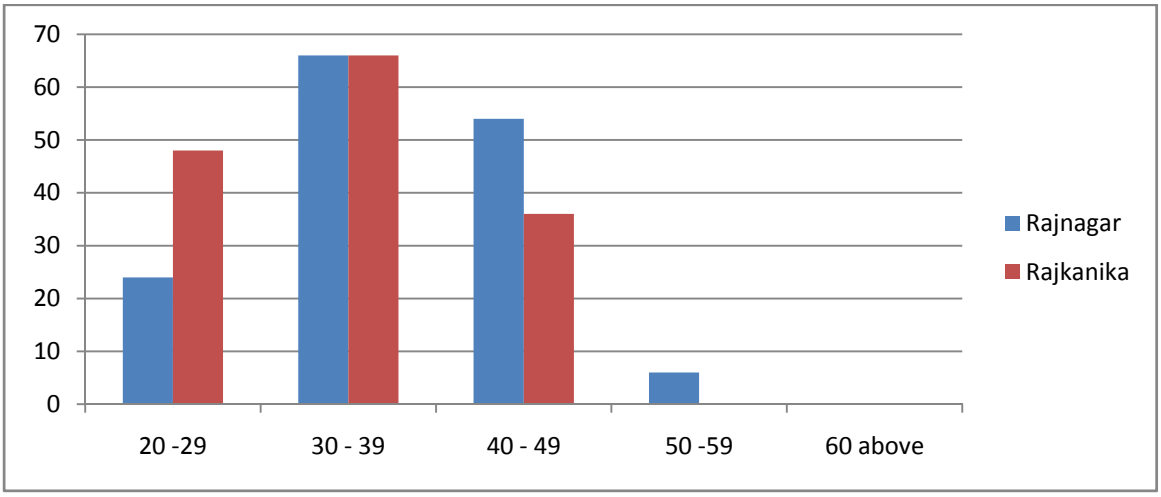
Table No. 5.1

Age Distribution of the Sample **N=300**

Age group in Years	No. of respondents in Rajnagar Block	No. of respondents in Rajkanika Block	Total
20 – 29	24 (16%)	48 (32%)	72
30 – 39	66 (44%)	66 (44%)	132
40 – 49	54 (36%)	36 (24%)	90
50 – 59	6 (4%)	-	6
Above 60	-	-	-
Total	**150**	**150**	**300**

The above table shows the age of the respondents. The respondents within the age group of "30-39" years have highest frequency in both the Blocks, i.e. Rajnagar and Rajkanika Block. They constitute 44% (66), 16% (24) of the respondents of Rajnagar Block and 32% (48) of the Rajkanika Block belong to the age group of "20-29" years . 36% (54) respondents of Rajnagar Block and 24% (36) of Rajkanika Block belong to the age group of "40-49" years only 4% (6) of Rajnagar Block the "50-59" years of age group.

Graph No.5.A Age Distribution of the Sample



Sex:

Sex is an important and independent determinant of an individual's behavioural manifestation. The sex category and frequency have been presented in table no. – 5.2.

Table No. 5.2

Distribution of the Sample Respondents on the basis of sex **N=300**

Sex of the Respondents	No. of Respondents in Rajngar Block	No. of respondents in Rajkanika Block	Total
Male	105 (70%)	72 (48%)	177
Female	45 (30%)	78 (52%)	123
Total	150 (100%)	150 (100%)	300

This table shows that 70% of the respondents of Rajngar Block are males and 30% are female whereas 48% of the respondents of Respondents of Rajkanika Block are males and 52% of the respondents are female.

Education:

Level of education has direct bearing on the action, reaction, perception and attitude of the people. Education enhances the awareness contributing for enlightenment and it is an empowerment mechanism. Therefore in the present study it was decided, it was decided to take education as an important variable and to see its impact on the respondent's perception, awareness and attitude. To testify linkage of education and other dimensions of an individual, the educational status has been presented here in the Table No.-5.3.

Table No. 5.3

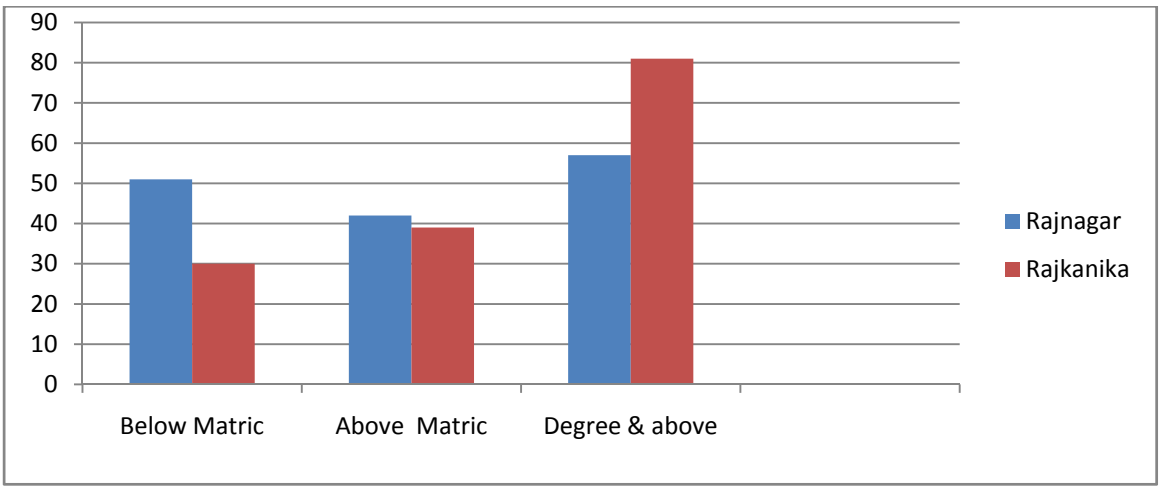
Level of Education among Sample Respondents **N=300**

Level Of Education	No. of Respondents in Rajnagar Block	No. of Respondents in Rajkanika Block	Total Percentage
Below Matriculation	**51 (34%)**	**30 (20%)**	**81 (27%)**
Matriculation &above	**42 (28%)**	**39 (26%)**	**81 (27%)**
Degree & above	**57 (38%)**	**81 (54%)**	**138 (56%)**
Total	**150**	**150**	**300**

The proportion of literate respondents among the sample was found to be high in both the Blocks. 57 (38%) respondents of Rajnagar Block and 81 (54%) respondents of the Rajkanika Block had degree and above educational qualification, 42 (28%) respondents of

Rajnagar Block and 39 (26%) of Rajkanika Block were above matriculation level and 51 (34%) respondents of Rajnagar Block and 30 (20%) of the respondents of Rajkanika Block were below matriculation level of their education.

Graph No. 5.B. Educational status of the respondents



Marital status:

Marriage the very foundation of every society and an institution admits men and women for family life. Marriage to great extent shapes the opinion formation, participation and acts as promoting and preventive force force for all sample respondents. The marital status of the respondents is presented in Table No.-5.4.-

Table No. 5.4

Marital Status of the respondents **N=300**

Marital Status	No. in Rajnagar Block	No. in Rajkanika Block	Total Percentage
Unmarried	27 (18%)	51 (34%)	78 (26%)
Married	183 (82%)	99 (66%)	222 (74%)
Widow	–	–	–
Widower	–	–	–
Divorced	–	–	–
Deserted	–	–	–
Total	150	150	150

The majority of the sample i.e. 82% in Rajnagar Block and 66% in Rajkanika Block consisted of married respondents. The rest of the respondents i.e. 18% of Rajnagar Block and 34% of Rajkanika Block belonged to unmarried category.

Religion:

Religion is the basic foundation of every society. As Durkheim observes, religion contributes for social solidarity. Religion refers to a common set of beliefs, practices and rituals adhered by a group which binds them together. Religion is a belief in power superior to a man which is believed to direct and control the course of nature and of human life. Religion plays a vital role in determining people's perception, predicaments and conditioning their opinion and action. Therefore in the present study the religious background of sample respondents is taken into consideration and analysed. The religious composition of the respondents is presented in the Table No. -5.5.

Table No. 5.5

Distribution of the Respondents on basis of their Religion N=300

Religion	No. of RAJNAGAR Block	No. in RAJKANIKA Block	Total (Percentage)
Hinduism	138 (92%)	150 (100%)	188 (96%)
Islam	12 (8%)	–	12 (4%)
Total	150	150	300

Regarding religious composition of the respondents it was shown in this table as there were 92% of Hindu and 8% of Muslim respondents in Rajnagar Block, but all the respondents of Rajkanika Block were Hindus.

Caste:

Caste is an important index in Indian social System. Caste is predetermined one in which individuals are born to their lot without any hope of changing it. Till now caste has a pervasive impact on the Indian social System. It determines the perception, level of awareness and expression of the individuals. The caste wise distribution of the sample respondents is presented in Table No. - 5.6

Table No. 5.6

Distribution of the Respondents on the basis of their Caste **N=300**

Caste	No. in Rajnagar Block	No. in Rajkanika Block	Total (Percentage)
General	36 (24%)	81 (54%)	117 (39%)
OBC	45 (30%)	45 (30%)	90 (30%)
SC	63 (42%)	24 (16%)	87 (29%)
ST	6 (4%)	--	6 (2%)
Total	150	150	300

This table shows the caste wise distribution of the respondents in two Blocks. In Rajnagar Block 24% respondents belonged to General Caste, whereas in Rajkanika Block 54 % respondents belong to the General Caste. In both the Blocks 30% respondents belonged to OBC, 42% of respondents of Rajnagar Block and 16% of Rajkanika Block were members of Scheduled Caste and only 4% respondents of Rajnagar Block belonged to Scheduled tribe category.

Occupation:

Occupation is basically referred as the way the individuals earn their livelihood. It is the basis of the individual's economic life as they get the very sustenance and maintenance of their lives from this. The various occupations found among the respondents in the current study is focused in Table No. – 5.7.

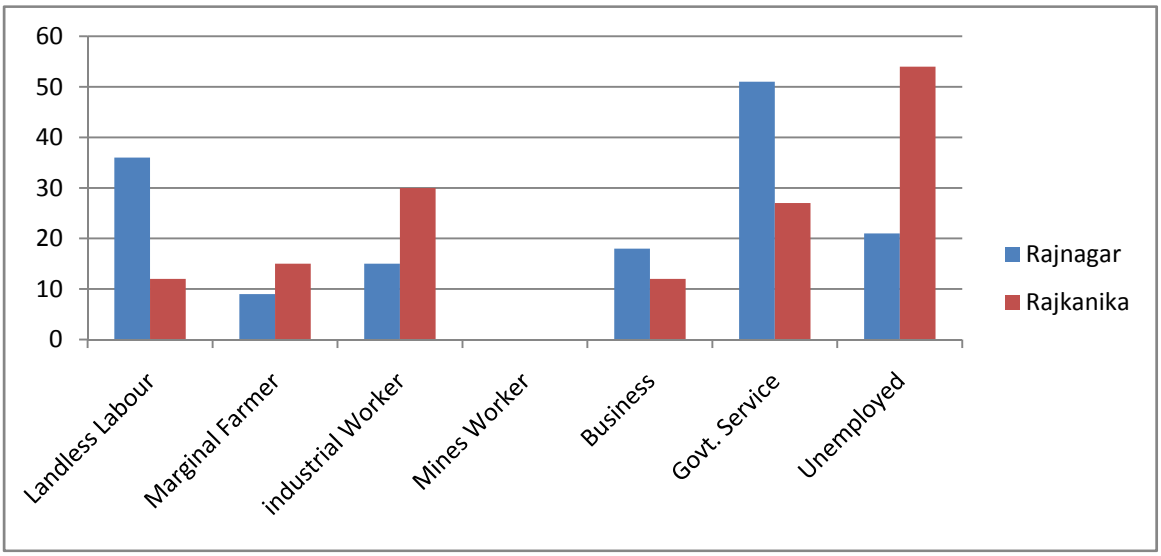
Table No. 5.7

Distribution of the Respondents on the basis of their Occupation **N=300**

Occupation	No. of Respondents in Rajnagar Block	No. of Respondents in Rajkanika Block	Total (Percentage)
Landless Labourers	**36 (24%)**	**12 (8%)**	**48 (16%)**
Marginal Farmer	**9 (6%)**	**15 (10%)**	**24 (8%)**
Industrial Worker	**15 (10%)**	**30 (20%)**	**45 (30%)**
Business	**18 (12%)**	**12 (8%)**	**30 (10 %)**
Govt. Service	**51 (34%)**	**27 (18%)**	**78 (26 %)**
Unemployed	**21 (14%)**	**54 (36%)**	**75 (25%)**
Total	**150**	**150**	**300**

It is shown in the above table shows that, 36 (24%) respondents in Rajnagar Block and 12 (8%) of the respondents in Rajkanika Block were landless labourers, 9 (6%) of Rajnagar Block and 15 (10%) of Rajkanika Block were marginal farmers engaged in agriculture in their native village. 18 (12%) of respondents in Rajnagar Block and 12 (8%) in Rajkanika Block were business holders, 15 (10%) of Rajnagar Block and 30 (20%) of Rajkanika Block were Industrial workers, where as 51 (34%) of Rajnagar Block and 27 (18%) of Rajkanika Block were working in Government Offices. The rest 21 (14%) respondents of Rajnagar Block and 54 (36%) of Respondents of Rajkanika Block were unemployed.

Graph No. 5.C: Distribution of the Respondents on the basis of their Occupation



Income:

Income is one of the determining factors for every individual's life. Persons having different income groups also differ in their attitude, perception and awareness level. The people having low standard of living are found to be busy in increasing their standard. Whereas people having high standard of living may involve in other way of increasing their awareness level through watching TV and reading news papers. So the present study has also made an attempt to study the level of income among the respondents and it has been presented in Table No.-5.8.

Table No. 5.8

Distribution of the respondents of the basis of Annual Income **N=300**

Level of Income in Rupees	No. in Rajnagar Block	No. in Rajkanika Block	Total (Percentage)
Below 30,000/-	30 (20%)	57 (38%)	87 (29%)
30,000 to 89,000/-	87 (58%)	69 (46%)	156 (52%)
90,000 to 1,49,000/-	24 (16%)	24 (16%)	48 (16%)
1,50,000 to 2,04,000/-	9 (6%)	–	9 (3%)
Above 2,04,000/-	–	–	–
Total	**150**	**150**	**300**

The above table shows the level of annual income of the respondents of both the blocks. The annual income of the respondents varied within and across the different sample groups. The highest frequency comes under the income group of Rs.30,000/ to 89,000/ in both the blocks. Fifty eight percent of respondents of Rajnagar block and 46% of respondents of Rajkanika block come under this income group. Twenty percent of respondents in Rajnagar block and 38% in Rajkanika block have below Rs.30,000/ as their annual income. Sixteen percent of respondents of both the blocks fall in the income group of Rs.90,000 to 49,000 and the rest 6% respondents of Rajnagar block income under the income group of Rs. 1,50,000 to Rs.2,04,000/-.

Physical status:

Physical status of the individual influences his / her thinking, opinion or attitude towards others. When one's physical health condition is good, one can express sympathetic and friendly behaviour towards others whereas diseased and weak persons may become indifferent towards others. Therefore, physical status of the respondents is taken into consideration and presented in the Table No.-5.9.

Table No. 5.9

Distribution of the respondents on the basis of their physical status N=300

Physical status	No. in Rajnagar Block	No. in Rajkanika Block	Total (Percentage)
Good	105(70%)	114(76%)	219(73%)
Average	30(20%)	33(22%)	63(21%)
Weak	3(2%)	-	3(1%)
Old age	9(6%)	-	9(3%)
Physically handicapped	3(2%)	3(2%)	6(1%)
Chronic patient	-	-	-
Total	**150**	**150**	**300**

The above table shows the physical status of the respondents of both the blocks. Most of the respondents of both the blocks i.e. 70% of Rajnagar block and 76% of Rajkanika block have good physical status, 20% of Rajnagar block and 22% of Rajkanika block have average status. In Rajnagar block 2% of respondents were weak, 6% were within aging problem and other 2% were physically handicapped and also 2% of respondents of Rajkanika block were physically handicapped.

Findings:

From the above analysis the researcher found variation in age group, sex, education, marital status, religion, caste, occupation, income and physical status of the respondents. Majority of the respondents in both the Blocks came under the age group of "30-39" years. Most of them were married. Majority of the respondents of Rajnagar Block belonged to scheduled caste but in Rajkanika Block majority of them belonged to general caste. Most of the respondents in Rajnagar Block were Government servants whereas most of them in Rajkanika Block were unemployed. Majority of the respondents in both the Blocks came under the income group of rupees 30,000 to 89,000 per Annum. Most of the respondents in

both the Blocks had degree and above qualification. Some had below matriculation and others had matriculation and above qualification. Most of the respondents had good physical status.

From these variations the researcher took education as the independent variable. Taking education as independent variable the researcher had tried to study the dependent variables as migration, preliminary knowledge, attitude and consciousness about HIV/AIDS, attitude and perception of the respondents towards HIV/AIDS infected/affected, misconception and ostracisation, role of family care and social care for HIV/AIDS infected persons, governmental and non-governmental response towards them and impact of mass media in changing social attitude towards them.

Chapter- VI
AWARENESS OF THE RESPONDENTS ABOUT HIV /AIDS

CHAPTER -VI

AWARENESS OF THE RESPONDENTS ABOUT HIV/AIDS

The later half of the twentieth century, among several demographic problems has been characterized by the spread of Acquired Immune Deficiency Syndrome (AIDS). Often termed as pandemic, it has caught many a population group unawares. It goes without saying that HIV/AIDS has in recent years generated considerable general and professional interest. Medical practitioners, social workers, psychologists, media persons and functionaries from voluntary organizations have addressed pertinent aspect of the problem. Consequently, a large number of studies have been conducted globally and a large body of knowledge has been to understand the epidemic in totality, covering various aspects such as awareness and information on HIV/AIDS, attitude and risk, perception and intervention programmes.

In the last decade of twentieth century, efforts to contain the spread of HIV have gained the momentum. On the one hand, medical researchers have worked to develop new cures and vaccine and on the other, social scientists have attempted to develop a better understanding of human behaviour. Doubtless, these efforts have made some dent into the problem.

AIDS awareness and information has been reaching to different population segments, indeed with variable impact. This apart, communication, intervention strategies have been evolved for the population groups which are relatively insulated. Owing to their risky behaviour, these groups are the ones among whom the virus transmits easily. The purpose behind imparting information to them is to make them capable of taking action to prevent the transmission of the infection and in case of illness, to get themselve treated properly. The importance of awareness and knowledge as a predisposing factor for the utilization of prevention and treatment services has received considerable attention. Some studies report show that those with less education have less knowledge and more misconceptions about HIV transmission. Solomon and others (1989) have shown that knowledge about STDs is associated with improvement in seeking treatment and following medical advice.

In the context of HIV/AIDS, emphasis has been laid on knowledge of HIV/AIDS and change in risk behaviour. Knowledge has been shown to influence condom use, number of sex partners and other sexual risk behaviour. The knowledge of HIV transmission has been explained in influencing the behaviour change. Knowledge may influence the first stage of the change process, i.e. problem of perception. Having extensive knowledge, these persons may be somewhere on the continuum of the change process. Knowledge levels would not predict their current behaviour but then one cannot conclude that knowledge does not influence the change process.

While discussing the importance of HIV/AIDS awareness and information, we need to pay attention to communication. Two types of channels of communication have been identified by Kotler and Roberto (1989), Personal communication and mass communication. The former includes face-to-face interaction (peer-group, schoolmates, counsellors etc.) and the later includes print media (news paper, magazines, pamphlets etc.), displays (bill boards, posters etc.), electronic media (radio, TV, cable network etc.), electronic recordings (audio/video tapes, compact discs and cinematic films etc.) and public events (exhibitions, street plays, musical programs, car rallies, health melas etc.). Having a wide outreach, the mass media educate people on HIV prevention, correct misconceptions about the infection and help create empathy towards those suffering from HIV/AIDS. Indirectly and invisibly those promote change, modify thinking and behaviour of the people which is critically important in controlling the epidemic. Further mass media are reportedly among the most cost effective channel for health education.

Although the combination drug therapies presently in use have made it possible for the AIDS affected to live longer, there is no drug for the cure of AIDS. Under the circumstances, prevention is the best approach to control the spread of HIV. In planning and designing prevention strategies, it is important to know whether the respondents in the focal and criterion groups are aware of the nature and extent of HIV/AIDS. It is very much essential to know the respondent’s preliminary knowledge, attitude and consciousness about

HIV/AIDS. The respondents may differ in terms of their knowledge, awareness and information on HIV/AIDS. To ascertain their level of knowledge of HIV/AIDS, the items that have been utilized are (a) heard of AIDS, (b) presence of HIV/AIDS in India,(c) respondent's view on whether AIDS can be cured, (d) awareness about STD, (e) AIDS spread through infected blood transfusion, (f) AIDS spread by the use of an infected syringe, (g) an infected mother or pregnant woman passes on AIDS to her baby, (h) those with multiple sex partners are more likely to contact HIV/AIDS, (i) sharing of toilet sheets leads to AIDS, (j) kissing by an AIDS infected person transmits AIDS, (k) having sex with the person of the same sex leads to AIDS, (l) mosquito bite spreads AIDS, (m) those who visit brothels are more likely to get AIDS, (n) sharing cups and spoons with an AIDS patient causes AIDS, (o) shaking hands with an infected person causes AIDS, (p) those use condoms are less likely to get AIDS, (q) knowledge of diagnostic tests for HIV.

Many people do not understand what HIV/AIDS is or how it is spread, treated or prevented. This lack of knowledge gives rise to incorrect beliefs about the viruses, often derived from and strengthened by, cultural and religious practices and traditions. Some incorrect beliefs include that HIV can be transmitted through:

- Everyday contact such as shaking hands, hugging, coughing or sneezing;
- Using public toilets or swimming pools;
- Sharing bed linen, eating utensils or food; and
- Contact with animals, mosquitoes or other insects.

Therefore, this research is interested in knowing the respondents' preliminary knowledge, attitude and consciousness about HIV/AIDS.

The respondents i.e. the ruralites should know all about HIV/AIDS as what it is, how it is transmitted, prevented, checked etc. HIV is the human immune deficiency virus. HIV attacks the immune system by replicating itself and overwhelming the human body over time, thus opening a way for opportunistic infections (OIS) such as tuberculosis (TB) and

Pneumonia. The Acquired Immune Deficiency Syndrome is the life threatening condition known as AIDS, which is described as a combination of symptoms that attack the human body following progressive damage to the immune system by HIV virus. AIDS is not a disease but a syndrome. The length of the time between when a person becomes infected with HIV to when they develop AIDS varies from person to person. Individuals with HIV can remain healthy for any length of time between a few years to more than years before developing AIDS. Being infected with HIV does not necessarily mean that an individual has AIDS, as some people can be carriers and transmitters of the HIV virus without developing full blown AIDS. Once the disease has progressed to a moderately advanced state, an HIV positive (HIV +) needs a three drug combination of anti retroviral (ART) drug therapy to prevent the virus from destroying their immune system. This treatment is expensive, but is effective in prolonging a person's life. There is currently no known cure for HIV/AIDS.

The HIV virus can be transmitted through:

- Sexual intercourse: The vast majority of HIV/AIDS infections are sexually transmitted, typically between men and women or men and men and in at least one case between women.
- Pregnancy related vertical transmission (mother to child transmission or MTCT): Women can transmit HIV to their babies during pregnancy or child birth. Approximately one quarter to one third of all untreated pregnant women infected with HIV will pass the infection to their babies when they give birth. HIV can also be spread babies through the breast milk of mothers infected with virus.
- Blood transfusion with unscreened or infected blood: Between 5 and 10 percent of HIV/AIDS infection worldwide are estimated to be transmitted through infected blood transfusion.
- Sharing of infected needles and syringes between drug users of either sex who inject drugs intravenously: Small quantities of infected blood may remain in needles or syringes and may contribute to the spread of the disease.

- Tattoos and body piercing may introduce tainted fluids into the blood stream resulting in the transmission of the hepatitis-B virus as well as HIV.
- Disfigurement: Some traditional practices such as circumcision, female genital mutilation and ritualized scarring may also contribute to spread of the hepatitis-B and HIV virus.

HIV/AIDS is strongly associated with stigmatization, scapegoating, blame and discrimination. Stigma and discrimination affect everyone especially from children to AIDS widows, who are particularly vulnerable to violations of their inheritance and property rights. Orphans are frequently denied their right to schooling. HIV positive persons suffer neglect and lack of care and are frequently excluded from community gatherings. Children of people living with HIV/AIDS (PLWHA) may be cruelly teased at school and excluded from games and social interaction with their peers. In addition to their social exclusion, the basic human rights of PLWHA to health, housing, education and employment protection are affected. Stigma and discrimination and fear of being labeled may also prevent people from being tested or from using condoms. In many cases, fear prevents people from attending clinics where they can seek and receive treatment including ARVs.

Key factors contributing to the incidence and perpetuation of stigma and discrimination include ignorance and fear, cultural values, religious teaching, the absence of legal sanctions, lack of right awareness, the design of government and NGO programs and inaccurate and / or irresponsible media coverage.

Only when the ruralites become conscious about the causes of spread of HIV/AIDS, they may not impose stigma and discrimination towards PLWHA or their partners, children or other family members. They may be sympathetic towards them. They may prevent themselves from being infected by HIV/AIDS and make other conscious about the disease.
Therefore in this present study the researcher first of all has tried toknow about the preliminary knowledge, attitude and consciousness of the respondents towards HIV/AIDS.The out come of research survey is presented in Table No. 6.1

Table No. 6.1

Distribution of Respondents on The Basis of Their Knowledge about AIDS with Duration **N=300**

Year	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
1993-1998	--	--	--	--	--	--	--	--
1999-2004	6(4%)	15(10%)	45(30%)	66(44%)	-	15(10%)	51(34%)	66(44%)
2005-2010	15(10%)	15(10%)	--	30(20%)	18(12%)	12(8%)	30(20%)	60(40%)
After 2010	30(20%)	12(8%)	12(8%)	54(36%)	12(8%)	12(8%)	-	24(16%)
Total	51(34%)	42(28%)	57(38%)	150	30(20%)	39(26%)	81(54%)	150

Though AIDS was discovered in1980's, it had been known to the ruralites in later years after 1999. As study shows only 4% of the respondents of Rajnagar Block having below matriculation, 10% of matriculate and above and 30% degree holder respondents knew about AIDS within 1999-2004, 10% below matriculation respondents and 20% degree holder respondents knew about AIDS within 2005-2010. The rest 20% below matriculation 8% matriculation and above and 8% of degree and above educated respondents of Rajnagar Block knew about AIDS after 2010.

Likewise 10% matriculate and 34% degree and above educated respondents of Rajkanika Block knew about HIV AIDS within 1999-2004, 12% below matriculate, 8% matriculate and above and 20% degree and above educated respondents of Rajkanika Block knew about AIDS within 2005-2010. The rest of the respondents of Rajkanika Block as 8% below matriculate and 8% matriculate and above knew about HIV AIDS after 2010.

Table No. 6.2
Distribution of the Respondents on the Basis of Their Knowledge about Full Form of AIDS **N=300**

Level of Education	No. in Rajnagar Block				No. in Rajkanika Block			
	Yes	No	Not Sure	Total	Yes	No	Not Sure	Total
Below Matriculation	--	51(34%)	--	51(34%)	--	30(20%)	--	30(20%)
Matriculation & above	15(10%)	27(18%)	--	42(28%)	--	39(26%)	--	39(26%)
Degree & above	42(28%)	15(10%)	--	57(38%)	66(44%)	15(10%)	--	81(54%)
Total	57(38%)	93(62%)	--	150	66(44%)	84(56%)	--	150

Although sooner or later all the respondents of both the Blocks have heard of AIDS, yet all have not known the full form (acronym) of AIDS. None of the below matriculate respondents of the both the Blocks knew about the acronym of AIDS. Ten percent matriculation and above and 28% of degree and above qualified respondents of Rajnagar Block and 44% of degree and above qualified respondents of Rajkanika Block were aware of acronym of AIDS. The rest of the respondents did not know the full form of AIDS. As it was shown in this table 62% of respondents in Rajnagar Block and 56% of respondents in Rajkanika Block in total were not aware about the full form of AIDS.

Table No. 6.3
Distribution of the Respondents on the Basis of Their Awareness about HIV **N=300**

Level of Education	**No. in Rajnagar Block**			**No. in Rajkanika Block**		
	Yes	**No**	**Total**	**Yes**	**No**	**Total**
Below Matriculation	15 (10%)	36 (24%)	51	18 (12%)	12(8%)	30
Matriculation & above	42 (28%)	--	42	39(26%)	--	39
Degree & above	57 (38%)	--	57	81 (54%)	--	81
Total	114 (76%)	36 (24%)	150	138 (92%)	12 (8%)	150

This table shows that 10% below matriculate, 28% matriculate and above and 38% degree and above qualified respondents of Rajnagar Block were aware about HIV, but 24% were not aware about HIV. Whereas in Rajkanika Block 12% matriculate, 26% matriculate and above and 54% degree and above qualified respondents were aware about HIV and only 8% were not aware about this. This above table clearly shows that education increases the awareness level of the respondents about HIV as a deadly disease.

Table No. 6.4
Distribution of the Respondents on the Basis of Their awareness about STI N=300

Level of Education	No. in Rajnagar Block			No. in Rajkanika Block		
	Yes	No	Total	Yes	No	Total
Below Matriculation	--	51 (34%)	51	--	30 (20%)	30
Matriculation & above	--	42 (28%)	42	--	39 (26%)	39
Degree & above	39 (26%)	18 (12%)	57	48 (32%)	33 (22%)	81
Total	39 (26%)	111 (74%)	150	48 (32%)	102 (68%)	150

The above table shows the respondents' awareness about STI (Sexually Transmitted Infection) only 26% of Rajnagar Block having degree and above qualification knew about STI. Other 74% of the respondents (including below matriculate, matriculate and above and degree and above) did not know about STI. Likewise only 32% of respondents having degree and above qualification were aware of STI, but 68% of respondents from all category (below matric, matric and above and degree and above) of Rajkanika Block knew nothing about STI.

Table No. 6.5
Distribution of the Respondents on the Basis of Their Knowledge regarding HIV infection (N=300)

Level of Education	No. in Rajnagar Block			No. in Rajkanika Block		
	Yes	No	Total	Yes	No	Total
Below Matriculation	15(10%)	36(24%)	51(34%)	18(12%)	12(8%)	30(20%)
Matriculation & above	42(28%)	--	42(28%)	39(26%)	--	39(26%)
Degree & above	57(38%)	--	57(38%)	81(54%)	--	81(54%)
Total	114	36	150	138	12	150

Ten percent of respondents having qualification of below matriculation, 28% having matriculation and above qualification and all the degree and above qualified respondents of Rajnagar Block were aware of the causes of HIV infection and the rest 24% below matriculate respondents were not aware of the causes of HIV infection. Whereas in Rajkanika Block all the respondents having degree and above qualification, 12% below matriculate and

26% matriculation and above qualification knew about the causes of HIV infection. Only 8% below matriculate respondents did not know the causes of HIV infection.

Table No. 6.6
Distribution of the Respondents on the Basis of Their Awareness regarding Causes of HIV infection N=300

Statement	No. in Rajnagar Block				No. in Rajkanika Block			
	Yes	No	NS	Total	Yes	No	NS	Total
A	108	--	6	114	138	--	--	138
B	57	--	57	114	108	12	18	138
C	114	--	--	114	138	--	--	138
D	57	12	45	114	114	--	24	138
E	12	87	15	114	15	27	96	138
F	--	114	--	114	--	138	--	138
G	--	114	--	114	9	120	9	138

N.B:- Total number of respondents of Rajnagar block knowing the causes of HIV infection- 114.

Total number of respondents of Rajkanika Block knowing the causes of HIV infection - 138.

NS – Not sure

a. Infected blood
b. Infected needle
c. Sexual inter course with infected person
d. Infected mother
e. Kissing of infected person
f. Mosquito bite
g. Shaking hand with infected person

From the 150 respondents of Rajnagar Block 114 were aware of various causes of HIV infection where as in Rajkanika Block 138 respondents out of 150 knew the causes of HIV infection. Majority of the respondents of Rajnagar Block replied the HIV infected blood

as the cause of HIV Infection. All most all of them said that sexual intercourse with HIV infected person as the cause of HIV infection. Fifty seven respondents agreed that infected needle and infected mother were also responsible for HIV infection. Regarding kissing of infected person as a cause of HIV infection 12 respondents were not sure about this. None of the respondents agreed that mosquito bite and shaking hand with infected person as causes of HIV infection.

In case of Rajkanika Block total 138 respondents replied that the HIV infected blood and sexual intercourse with HIV infected person as the causes of HIV infection. All of them said that mosquito bite was no way responsible for HIV infection. Majority of the respondents of this Block replied that shaking hand with infected persons was not cause of HIV infection. Only 15 respondents said that kissing of infected persons caused HIV infected.

Table No.6.7

Distribution of the Respondents on the Basis of their Awareness about Common Carrier of HIV infection **N=300**

Response about common carrier of HIV infection	No. in Rajnagar Block			No. in Rajkanika Block		
	Below Matriculation	Matriculation & above	Degree & above	Below Matriculation	Matriculation & above	Degree & above
Blood	15 (10%)	30(20%)	57 (38%)	6 (4%)	39 (26%)	81 (54%)
Saliva	--	--	--	12 (8%)	--	--
Air	--	12 (8%)	--	--	--	--
Water	--	--	--	--	--	--
Total	114 (76%)			138 (92%)		

Seventy six percent of the respondents of Rajnagar Block knew about HIV and common carrier of its infection. Ten percent respondents having below matriculation,20% having matriculation and above and 38% having degree and above qualification replied that

blood as the common carrier of HIV infection while only 8% respondents of this Rajnagar Block having matriculation above qualification viewed air as common carrier of its infection.

Whereas in Rajkanika Block 92% of the total respondents knew about HIV and common carrier of its infection. Four percent respondents with qualification below matriculation, 26% having matriculation and above and 54% respondents having degree and above qualification opined blood as common carrier of HIV infection, but only 8% respondents having below matriculation qualification said that saliva as common carrier of HIV infection.

Table No. 6.8

Distribution of the Respondents on the Basis of Their Knowledge about Initial Symptoms of HIV Infection N=300

Initial Symptoms	No. in Rajnagar Block			No. in Rajkanika Block		
	Below Matriculation	Matriculation & above	Degree & above	Below Matriculation	Matriculation & above	Degree & above
Fever	15 (10%)	15 (10%)	30 (20%)	6 (4%)	27 (18%)	48 (32%)
Headache	--	--	9 (6%)	--	--	--
Body ache	--	--	--	--	--	--
Jaundice	--	15 (10%)	3 (2%)	--	--	18 (12%)
Cough	--	--	15 (10%)	--	12 (8%)	15 (10%)
Any other	--	12 (8%)	--	12 (8%)	--	--
Total %	**114 (76%)**			**138 (92%)**		

This table shows the respondents' knowledge about initial symptoms of HIV infection. Seventy Six percent of respondents of Rajnagar Block and 92% respondents of Rajkanika Block knew about HIV and gave their opinion about various symptoms of HIV infection. Ten percent respondents having below matriculation, 10% of them having matriculation and above and 20% of them having degree and above qualification of Rajnagar Block said that fever was the initial symptom of HIV infection, six percent respondents of this Block having degree and above education said that headache, 2% said jaundice and 10%

said cough as the initial symptoms of HIV infection. Ten percent respondents having matric and above education said that jaundice as the initial symptoms, but 8% of them said that there were other symptoms of HIV infection than those mentioned in the schedule.

In case of Rajkanika Block 92% respondents in total were aware about HIV and gave their opinion regarding various initial symptoms of HIV infection. Four percent respondents having below matriculation, eighteen percent having matriculation and above and 32% having degree and above education said that fever as the initial symptom of HIV infection. Twelve percent degree and above qualified respondents said jaundice and 10% of them said cough as initial symptom of HIV infection, 8% of respondents having matriculation and above qualification said that cough as the initial symptom of HIV infection. But another 8% of them having below matriculation qualification said that there were any other symptoms of HIV infection than earlier mentioned in the schedule.

Table No. 6.9

Distribution of the Respondents on the Basis of Their Knowledge about Initial Symptoms of AIDS **N=300**

Response	No. in Rajnagar Block			No. in Rajkanika Block		
	Below Matriculation	Matriculation & above	Degree & above	Below Matriculation	Matriculation & above	Degree & above
Continuous Fever	15 (10%)	15 (10%)	39 (26%)	9(6%)	15(10%)	33 (22%)
Chronic Diarrhea	--	--	--	--	--	--
Weight Loss	--	--	3 (2%)	--	--	15 (10%)
T.B	--	12 (8%)	--	--	--	15 (10%)
Pneumonia	--	--	15 10%	--	24 16%	--
Jaundice	--	15 (10%)	--	9 (6%)	--	18 (12%)
Any Other	36 (24%)	--	--	12 (8%)	--	--
Total (%)	**51 (34%)**	**42**	**57**	**30**	**39**	**81**

From this table respondents' awareness regarding initial symptoms of AIDS were known. Ten percent of respondents having below matriculation, 10% having matric and above and 26% having degree and above qualification of Rajnagar Block opined continuous fever as initial symptoms of AIDS. Where as in Rajkanika Block 6% respondents having below matriculation, 10% having matric and above, 22% having degree and above education opined the same as initial symptoms of AIDS. Two percent degree and above qualified respondents of Rajnagar Block and 10% of the same qualified respondents of Rajkanika Block said that weights loss as initial symptoms of AIDS. Eight percent matriculation and above qualified respondents of Rajnagar Block and 10% degree and above qualified respondents of Rajkanika Block said that T.B as initial symptom of AIDS. 10% degree and above educated respondents of Rajnagar Block and 16% matric, and above educated respondents of Rajkanika Block opined pneumonia and 10% respondents having matriculation and above of Rajnagar Block and 12% degree and above qualified respondents of Rajkanika Block said that jaundice as initial symptom of AIDS. The rest 24% respondents of Rajnagar Block having below matriculation and 8% below matriculate respondents of Rajkanika Block said that there were any other symptoms of AIDS than those were mentioned in the schedule.

Table No.6.10

Distribution of the Respondents on the Basis of Their Knowledge regarding Curability of AIDS **N=300**

Person with HIV/AIDS will be cured	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	--	--	3(2%)	3(2%)	--	--	6(4%)	6(4%)
No	15(10%)	42(28%)	54(36%)	111(74%)	--	--	60(40%)	60(40%)
Not Sure	36(24%)	--	--	36(24%)	30(20%)	39(26%)	15(10%)	84(56%)
Total (%)	51(34%)	42(28%)	57(38%)	150	30(20%)	39(26%)	81(54%)	150

This table shows the awareness of the respondents about curability of the persons infected with HIV/AIDS only 2% respondents of Rajngar block and 4% respondents of Rajkanika block having degree and above qualification said that persons with HIV/AIDS will be cured. Twenty four percent below matric qualified respondents of Rajngar block and 20% below matric, 26% matric and above qualified respondents of Rajkanika block were not sure about curability of HIV/AIDS patients. All other respondents i.e. 74% of Rajngar block said that HIV/AIDS patients will not at all be cured.

Table No.6.11

Distribution of the Respondents on the Basis of Their Knowledgeabout the Fatality of AIDS **N=300**

Person with HIV/AIDS will survive	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	--	15(10%)	42(28%)	57(38%)	--	27(18%)	51(34%)	78(52%)
No	15(10%)	12(8%)	--	27(18%)	21(14%)	--	--	21(14%)
Not Sure	36(24%)	15(10%)	15(10%)	66(44%)	9(6%)	12(8%)	30(20%)	51(34%)
Total (%)	51(34%)	42(28%)	57(38%)	150	30(20%)	39(26%)	81(54%)	150

This table indicates the response of the sample regarding survival of the AIDS patients. Ten percent respondents having matriculation and above and 28% having degree and above qualification of Rajangar block and 18% matriculation and above and 34% of degree and above educated respondents of Rajkanika block opined in favour of survival of the patients with AIDS. In total 18% respondents of Rajangar block and 14% respondents of Rajkanika block said that AIDS patients cannot survive. The rest 44% respondents of Rajangar block and 34% respondents of Rajkanika block were not sure about the survival of the AIDS patients.

Table No. 6.12

Distribution of the Respondents on the Basis of Their Knowledge regarding the Protective Measures **N=300**

Protective measures	No. in Rajnagar Block			No. in Rajkanika Block		
	Below Matriculation	Matriculation & above	Degree & above	Below Matriculation	Matriculation & above	Degree & above
A	15(10%)	42(28%)	42(28%)	18(12%)	39(26%)	81(54%)
B	--	15(10%)	39(26%)	12(8%)	30(20%)	18(12%)
C	--	15(10%)	24(16%)	--	--	18(12%)
D	--	--	24(16%)	--	15(10%)	45(30%)
E	36(24%)	--	--	--	--	--

N.B.:-

A. Practicing safe sex.

B. Receiving safe blood.

C. Using new needle.

D. Following prophylactic measures for MTCT.

E. Eating green vegetables.

This table reveals respondents' awareness regarding various protective measures from HIV/AIDS infection. Practicing safe sex was regarded as an important protective measure through which HIV/AIDS can be prevented. Ten percent respondents having below matriculation, 28% having matriculation and above qualification of Rajnagar block and 12% below matriculation, 26% matriculation and above and 54% of degree and above qualified respondents of Rajkanika block said that by practicing safe sex one can be protected from HIV/AIDS infections. Ten percent having Matriculation and above, 26% having qualification Degree and above of Rajkanika block and 8% having below matriculation, 20% respondents having matriculation and above and 12% having degree and above qualification of Rajkanika Block gave importance to receiving safe blood (HIV free blood) as protective measure for avoiding HIV/AIDS infection. Ten percent matric and above and 16% degree and above qualified respondents of Rajnagar Block and 12% degree and above qualified respondents of

Rajkanika Block said that including above two protective measures using new needle can also be a protective measure for prevention of HIV/AIDS infection. Sixteen percent degree and above educated respondents of Rajnagar Block and 30% degree and above educated respondents of Rajkanika Block opined that following prophylactic measures can prevent Mother to Child Transmission (MTCT). The only 24% respondents having below matriculation qualification of Rajnagar Block said that eating green vegetables can protect persons from HIV/AIDS infection.

Table No. 6.13

Respondents' knowledge about existence of AIDS patients in their villages N=300

Response	No. in Rajnagar Block	No. in Rajkanika Block
Yes	27(18%)	72 (48%)
No	123 (82%)	78 (52%)
Total	150	150

Eighteen percent respondents of Rajnagar Block and 48% respondents of Rajkanika Block knew the existence of some AIDS patients in their villages or Blocks. Others did not know about any person having AIDS in their villages or Blocks.

Table No. 6.14

Opinion about the place of Treatment of the AIDS Patients N=300

Place of treatment of AIDS patients	No. in Rajnagar Block & percentage	No. in Rajkanika Block & Percentage
Home	--	--
Hospital	72 (48%)	48 (32%)
Both	78 (52%)	102 (68%)
Total	150	150

This table reveals the respondents' opinion regarding the place of treatment of the AIDS patients whether in home or hospital or both. Forty eight percent respondents of Rajnagar Block and 32% respondents of Rajkanika Block opined that the AIDS patients should be treated in hospital whereas 52% respondents of Rajnagar block and 68% respondents of Rajkanika block were in support of treatment of the AIDS patients both in home and hospital as well. This shows that only medical treatment of the AIDS patients

without the support of care and treatment of family member at home cannot fully cure such patients. Like “Doctors treat but God cures” the disease of the patients, the hospital provides treatment to the AIDS patients, but home provides care and support as a whole physical, mental and psychological treatment for easy and early recovery.

Table No. 6.15

Disclosure of HIV infection to one’s Employer/ Colleague N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	15(10%)	12(8%)	9(6%)	36(24%)	21(14%)	12(8%)	66(44%)	99(66%)
No	36(24%)	30(20%)	48(32%)	114(76%)	9(6%)	27(18%)	15(10%)	51(34%)
Total Percentage	51(34%)	42(28%)	57(38%)	150	30(20%)	39(26%)	81(54%)	150

From this table it was known that 10% respondents having below matriculation 8% having matriculation and above and 6% having degree and above qualification of Rajnagar Block said that HIV infection of any employee should be disclosed to his/her employer and colleague. In case of Rajkanika Block 14%respondents having below matriculation, 8% having matric & above and 44% having degree & above qualification were in favour of disclosing HIV infection of any employee to his / her employer or colleague. The rest of the respondents of both of the Blocks said that HIV infection of the employees should not be disclosed to employer or any of the colleagues lest they may mistreat or discriminate them.

Table No. 6.16

Disclosure of HIV infectin to own spouse of the Patient N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	15(10%)	42(28%)	57(38%)	114(76%)	30(20%)	39(26%)	81(54%)	150(100%)
No	36(24%)	--	--	36(24%)	--	--	--	--
Total Percentage	51(34%)	42(28%)	57(38%)	150	30(20%)	39(26%)	81(54%)	150

This table reveals the opinion of the respondents regarding disclosure of HIV infection to own spouse of the infected persons. Only 24% of the respondents of RAJNGAR block having below matriculation qualification were not in favour of disclosing HIV infection to own spouse. But all other respondents of both the blocks said that HIV infection of any person should be disclosed to own spouse.

Findings:

From all the above analysis the researcher gained a lot of informations regarding respondents' preliminary knowledge, attitude and consciousness about HIV/AIDS. All the respondents knew AIDS as a horrendous disease sooner or later within 1999-2010. Highly educated respondents of both Rajnagar and Rajkanika blocks have known more about HIV/AIDS/STI than less educated respondents. Education had played more effective role in gaining knowledge about such dreaded infections. Majority of the respondents of both the blocks having degree and above education were aware about various causes of HIV infection. Highly educated respondents pointed out most accurate causes viz. HIV infected blood, sexual intercourse with HIV infected person, infected needle and infected mother as responsible for HIV infection. Some of the less educated respondents were also aware about causes of HIV infection. Likewise more educated respondents of both the blocks were also aware about the common career of HIV infection as blood. A few less educated respondents replied that saliva and air as common carrier of HIV infection. Most of the educated respondents were aware about initial symptoms of HIV/AIDS. They replied that continuous fever, weight loss, Jaundice and T.B. as initial symptoms of HIV/AIDS. Majority of respondents of both the blocks said that this deadly disease cannot be cured. But a few highly educated respondents of both the blocks viewed that this can be cured. Regarding survival of the patients, majority of respondents of both the blocks were hopeful. Most of the educated respondents viewed that HIV/AIDS patients would survive for some years. But less educated respondents were not sure about the survival of such patients. More educated respondents

knew more about protective measures to prevent infection from HIV/AIDS. They said that such infection can be prevented by practicing safe sex (using condoms),receiving safe blood, using new needle and following prophylactic measures for MTCT (mother to child transmission). Some of the less educated respondents of both the blocks though not knew about all the protective measures preventing HIV/AIDS infection, but had known the most common protective measures as practicing safe sex and using safe blood to prevent such infection. The most of the educated respondents were in favour of treatment of the HIV/AIDS patients both in hospital and home. They were in favour of disclosing of infection of such kind as HIV/STI/AIDS of any person to his/her employer or colleague and to own spouse. But majority of less educated respondents were afraid of disclosing of such infection of the patients in the fear of ostracisation and discrimination in the place of work, in family and in society.

Majority of the respondents in both the Blocks said that this deadly disease cannot be cured. Thus, the individuals succumb to death because the opportunistic diseases associated with AIDS are not cured and become fatal. The HIV/AIDS infected persons become fatalistic in their attitude.

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Chapter-VII
MISCONCEPTION AND OSTRACIZATION

CHAPTER-VII

MISCONCEPTION AND OSTRACISATION

"While AIDS kills victims, social ostracisation kills all those associated with the victims". (Brijbhusan Singh). The spread of HIV/AIDS affected millions of people worldwide. According to the "2006 AIDS epidemic update", published by UNAIDS, World Health Organisation, there were an estimated 39.5 million people around the world living with HIV, 4.3 million with new HIV infections and 2.9 million deaths from AIDS related illness in 2006. In some regions there are indications that HIV infection rates have risen by over 50% since 2004. In the wake of this pandemic, a number of misconceptions have arisen surrounding the disease. The misconceptions about the modes of HIV transmission are present among all, like villagers, school teachers, drug users, STD clinics attendees etc.

There exist certain misconceptions, myths and beliefs in our society regarding modes of HIV/AIDS transmission, traditional and cultural practices with regard to IEC (Information, Education and Communication) and misconceptions prevailing in treatment, care and rehabilitation of HIV/AIDS patients.

Myths and misconceptions regarding HIV/AIDS are in abundance and deeply ingrained in almost all communities worldwide. Although myths and misconceptions are largely associated with low levels of education, yet studies continue to indicate that even medical professional have their own share of such beliefs. A study conducted in Delhi on 100 general medical practitioners registered with the Delhi Medical Association, revealed many of them to be believing that HIV could transmitted by sharing soap, drinking glass or cup, telephone and swimming pool with a HIV infected person.

Myths such as HIV infected people should be totally isolated from the society (Sehgal and Singh, 1997). HIV infected children should not allowed to school (Sehgal,1997), eating hot things and urinating at bad places cause sexually transmitted disease (STDs) (Mittal, et.al,1997) and that AIDS is God's way of punishing people for their evils (Wadhwa, et.al, 1997) have been found to be prevalent among the masses. Besides myths like getting cured of

STD/AIDS after having sexual contact with minors is leading to alarming trend of infant girls (some as young as 8 – 9 months old) being sexually abused (www.excite.com, 26th Nov 2001 – "Meenu Sharma).

The common belief that AIDS is, "Someone else disease", is a universal phenomenon. AIDS is doubly disastrous because the most sexually active years of a person are also the most economically productive years. Moreover, AIDS does not die out with the person it has killed, but it is passed into their families by infection of their spouse as well as to their babies. Finally, AIDS is unlike most communicable diseases which affect largely the poor, affects all sections of the society.

The broad introduction, on myths and misconceptions of HIV/AIDS/STD, deals effectively with the inaccurate informations, which are quite often believed and passed on without the authenticity of the sources. HIV does not spread like cold and is, therefore relatively difficult to catch. Not one case has been reported of HIV being transmitted by contact with air, tear, sweat, shaking hands, hugging, coughing, sneezing, using swimming pools, toilets, seats, sharing towels, bed, utensils, being beaten by mosquitoes or other animals or any other form of every day contact. It is practically impossible to contact HIV while giving medical/nursing care to HIV patients, thus, medical staff and finally members of HIV positive persons have nothing to fear although a few universal and routine precautions have to be observed.

Stigma associated with a number of curable diseases like Leprosy and Tuberculosis still make life hell for those who suffer from them. Thousands of such patients are daily refused treatment for want of proper diagnostic and other facilities. The stigma around AIDS is comparatively very high in our country. Medical care alone is not enough. Tolerance and compassion for individuals, families and communities affected by the virus are required as well. A greater degree of community involvement is also necessary to provide family members with hope and support.

India now comes third among nations with largest number of people living with HIV. The optimistic arithmetic apart, the experiences of ordinary people living with HIV tell another story. Stigma not surveillance is the biggest problem.

A 15 year old boy from Ahmedabad committed suicide to escape the stigma piled on because his parents, both vegetable sellers, were HIV positive. Two little children in Kerala roused a nation's feeling when their grandfather stood up and faught against from their expulsion from school, because they were HIV positive. In the 24 Praganas, district of West Bengal, an HIV positive child's mother was forced to accept a refund of his school fees.

At an age when parents looked after their children, 62 year old Sabitri Mandal worked as a daily wage earner to look after her AIDS affected grandson. Without caring for the villagers' opposition she took up the cudgels to challenge the negative notions associated with AIDS.

Sabitri, an illiterate woman, is a resident of Mangalpur village in Bhadrak district. She has taken care of her son and daughter-in-law who died of AIDS. And now she is looking after her 6 year old grandson. Ravi Mandal, who was also tested HIV positive. Her son Dhaneswar and his wife returned home six years ago after contracting AIDS during their stay in Kolkata. At that time the villagers hesitated to purchase her land for their treatment. "Villagers not only cut off relationship with our family but also asked me to keep away from my son. But I was not bothered by them and made all efforts to save my son. Two years of his death my daughter-in-law passed away", Sabitri said.

"The villagers not only ostracized my family but prohibited me from working in their houses. Initially villagers did not allow Rabi to play with their children. But their views changed after Sabitri did not contract the disease despite living with the couple for years", said Sk. Farque, Secretary Fellowship, a NGO.

"Today the villagers are with me and my HIV positive grandson. They provide me work in their houses and also help me in running family. They have no objection for admitting Rabi in village school", said Sabitri.

Sabitri is provided medicines for opportunistic infections free of cost, ADMO Sarat Chandra Swain said. Though we all know that her efforts to save her grandson will bear no fruit, the illiterate woman has changed the mindset of the entire village about AIDS, he said (The TOI, 07.08.2008).

But there is another case of how villagers ostracized a HIV positive woman of Kendrapara district. Making a mockery of campaigns for AIDS awareness, residents of Baulokani village in the district have boycotted a HIV infected woman because they think that the disease is airborne. The 42 year old woman's husband died of AIDS two years ago. She now lives with her two teen aged sons whom the neighbors have prevented from attending the local school. Her house has become a prohibited zone, a member of Baulokani Panchayat Samiti said.

"We tried to help the distressed family but many took umbrage and threatened to boycott us", the member said. People here are swayed by prejudice about HIV. They are of the view that the woman and her family pose a threat to the villagers and we should keep a safe distance", he added. (The TOI, 07.08.2008).

Global AIDS numbers have dropped dramatically but that is only half the battle won. Stigma towards HIV positive people needs to be countered if the threat of AIDS is to be overcome.

An Indian soldier discovers he is HIV positive and forced to deal with the termination of his service. He must now move to the courts for justice – a burden in itself. A HIV positive pregnant woman from WB has a sticker plastered on her forehead by the hospital staff is isolated in the ward and refused the urgent medical attention she needed. A couple is stoned, branded outcast by the only community they know simply because they are HIV positive. A positive woman in Kolkata aborts her own foetus because hospital staff refused to assist her. This intense stigma can be painful to endure.

The good news is that the number of people contracting HIV infection is dropping worldwide. A few days ago, UNAIDS releasing its AIDS epidemic update for 2007, said

new data show global HIV prevalence (the percentage of people living with HIV) has leveled off and the number of new infections has fallen, as a result of the impact of HIV programs. The new estimate of 2.47 million persons in India living with HIV is released through the National Family Health Survey-III is less than half the official estimate for the previous year.

NFHS-III has generated data on stigma by including surveys on HIV/AIDS knowledge, attitude and behaviours. Stigma is hard to track and its impact even harder to measure. Overall acceptance measured through indicators like willingness to care for a positive person or buy vegetables from a positive person or a teacher who is positive continue teaching in the school is low – 34 percent for women and 37 percent for men. This corroborates a study by International Labour Organisation on which says that two thirds of positive persons face discrimination. The World Bank points to a study in India that found how 34 percent students, faculty and technical staff of the public health services would not associate with people living with HIV/AIDS.

Those vulnerable to and experiencing social stigma and discrimination will be puzzled if they were told that awareness and knowledge about HIV/AIDS is higher than before. Between 1998 – 1999 and 2005 – 2006, knowledge of AIDS in woman (earlier rounds of NFHS did not interview men) went up by 17 percent (from 40percent to 57 percent). But NFHS – III has also found how only 30 percent of the women with no education have heard about HIV/AIDS. Almost two thirds of women and half of men still believe that a mosquito bite can transmit HIV infection. Awareness is not translating into tolerance or a shedding on stigma.

Protection against HIV and preventing its spread is certainly a key message, but protection using stigma and alienation will go nowhere. It is always challenging to fight for legislation and better policy outcomes. Kerala has a law against discrimination of HIV positive children in schools. But laws and policies cannot be a substitute for human approach. (The Writer, Subhadra Menon, authored a book on HIV/AIDS, The TOI, 4th Dec 2007).

AIDS related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV/AIDS. They can result in being shunned by family, peers and the wider community, poor treatment in health care and education settings an erosion of rights, psychological damage and can negatively affect the success of testing and treatment.

AIDS stigma and discrimination exist worldwide, although they manifest themselves differently across countries, communities, religious groups and individuals. Stigma not only makes it more difficult for people trying to come to terms with HIV and manage their illness on a personal level, but it also interferes with the attempt to fight the AIDS epidemic as a whole. On a national level, the stigma associated with HIV can defer governments from taking first effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV testing, treatment and care.

United Nations Secretary General, Ban Ki Moon says, “Stigma remains the single most important barrier to public action. It is the main reason why too many people are afraid to see a doctor to determine whether they have the disease or seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it or taking easily available precautions. Stigma is chief reason why the AIDS epidemic continues to devastate societies around the world”.

Why there is stigma related to AIDS? Fear of contagion coupled with negative value based assumptions about people who were infected leads to high levels of stigma surrounding HIV/AIDS.

Factors that contribute to HIV/AIDS related stigma:-

1. HIV/AIDS is life threatening disease and therefore people react to it in strong ways.
2. HIV infection is associated with behaviours such as homo sexuality, drug addiction, prostitution or promiscuity that are already stigmatized in many societies.
3. Most people become infected with HIV through sex which often carries moral baggage.

4. There is a lot of inaccurate information about how HIV is transmitted creating irrational behaviour and misperceptions of personal risk.
5. HIV infection is often thought to be result of personal irresponsibility.
6. Religious or moral beliefs lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or deviant sex) that deserves to be punished.

The fact that HIV/AIDS is relatively new disease also contributes to the stigma attached to it. The fear of surrounding the emerging epidemic in the 1980s is still fresh in many people's mind. At that time very little was known about the risk of transmission which made people scared of those infected due to fear of contagion.

From early in the AIDS epidemic a series of powerful images were used that reinforced and legitimized stigmatization.

1. HIV/AIDS as punishment (e.g. For immoral behaviours)
2. HIV/AIDS as crime (e.g. in relation to innocent and guilty victims)
3. HIV/AIDS as a war (e.g. in relation to virus which must be faught)
4. HIV/AIDS as horror (e.g. in which infected people are demonized and feared)
5. HIV/AIDS as otherness (e.g. in which the disease is an affliction of those set apart)

Views and examples of alarming 1980s public health advertisements from the UK and Australia associating AIDS with death.

Konni Huq: "If I had HIV, would you kiss me?". HIV/AIDS related stigma is not a straight forward phenomenon as attitudes towards epidemic and those affected very massively. Even within one country reactions to HIV/AIDS will vary between individuals and groups of people. Religion, gender, sexuality, age and levels of AIDS education can all affect how somebody feels about the disease.

AIDS related stigma is not static. It changes over time as infection levels, knowledge of the disease and treatment availability vary. (V Ramamurthy, 2004, P – 05).

Jonathan Mann, the former Director of WHO Global Program on AIDS identified three phases of the HIV/AIDS epidemic, the epidemic of HIV, the epidemic of AIDS and the epidemic of stigma, discrimination and denial. According to him the third phase is “as central to global AIDS challenge as the disease it self”.

Stigma is something that is produced and used to help order society. For example most societies achieve conformity by contrasting those who are “normal” with those who are “different” or “deviant”. Stigmatization not only helps to create difference but also plays a key role in transforming difference based on class, gender, race, ethnicity or sexuality into social inequality. This stigmatization used by dominant groups to legitimize and perpetuate inequalities.

HIV/AIDS is life threatening illness that people are afraid of contracting. The various metaphors associated with AIDS as death, as horror, as punishment, as guilt, as shame have also contributed to the perception of HIV/AIDS as a disease that affect others especially those who are already stigmatized because of their sexual behaviour, gender, race or socio-economic status and that have enabled some people to deny that they personally could be at risk or affected.

HIV/AIDS is associated with marginalized behaviours and groups, all individuals with HIV/AIDS are assumed to be from marginalized groups and some may be stigmatized in a way that they were not before. For example, in some settings, men may fear revealing their HIV status because it will be assumed that they are homo-sexual. Similarly, women may fear revealing their zero status because they may be labeled as “promiscuous” or sex workers and stigmatized as such.

HIV/AIDS related stigma and discriminations take different forms and are manifested at different levels – societal, community and individual and in different contexts. HIV/AIDS related S &D in society is commonly manifested in the form of laws, policies and

administrative procedures; which are often justified as necessary to protect the “general population”. Examples of stigmatizing and discriminatory measures include compulsory screening and testing, compulsory notification of AIDS cases, restrictions of the right to anonymity, prohibition of PLHA from certain occupations and medical examination, isolation, detention and compulsory treatment of infected persons.

One important example concerns limitations on international travel and migration. Despite widespread agreement that laws to prevent freedom of movement of PLHA are ineffective public health measures, many countries have adopted policies restricting travel and migration.

Discriminatory practices include HIV testing for individuals seeking work permits the requirement that individuals seeking, tourist visas declare their zero status and denial of entry to PLWHA carrying medical drugs for HIV/AIDS treatment. Foreigners have been deported from a diverse range of countries after authorities have discovered that they are HIV positive. Some Government, recognizing that such measures are ineffective, has introduced legislations to protect the rights of PLHA to education, employment, confidentiality, information and treatment. However, even when supportive legislation exists it is not always enforced. The failure of Governments to protect the rights of PLHA through legislation or to enforce existing legislation has been described as a form of discrimination by neglect, as has the failure to provide effective prevention, treatment and care for those most vulnerable to HIV/AIDS and for PLHA.

Institutional Levels:

Education and Schools:

Children with HIV/AIDS or associated with HIV through infected family members have been stigmatized and discriminated against in educational settings in many countries. Stigma has led to teasing by classmates of HIV positive school children and children associated with HIV.

Employment and the work place:

Such discriminatory practices as pre-employment screening, denial of employment to individuals who test positive, termination of employment of PLHA and stigmatization of PLHA who are open about their zero status.

Healthcare Systems:

Community Level:-

In societies with cultural systems that place greater emphasis on individualism. HIV/AIDS perceived as the result of personal irresponsibility and thus the individuals are blamed for contracting the infection. In contrast, in societies where cultural system place greater emphasis on collectivism HIV/AIDS may be perceived as bringing shame on the family and community.

Family Level:

Infected individuals often experiences S&D in the home and women are often more likely to be badly treated than men and children. Negative community and family response to woman with HIV/AIDS include blame, rejection and loss of children and home. Families may reject PLHA not only because of their HIV status but also because of HIV/AIDS associated with promiscuity, homosexuality and drug use.

Individual Level:

In individuals, the way in which HIV/AIDS related S&D are manifested depends on family and social support and the degree to which people are able to open about such issues as their sexuality as well as their zero status where HIV/AIDS is highly stigmatized, fear of HIV/AIDS related S&D may cause individuals to isolate themselves to the extent that they no longer feel of part of civil society and are unable to gain access the services and support they need. This has been called internalized stigma. In extreme cases, this has led to premature death through suicide. Even when laws exist to protect PLHA rights and confidentiality many people choose not to know or reveal their zero status due to negative community and family response.

Different Contexts of HIV – Related Stigma:

In 2003, when launching a number of campaigns to scale of treatment in the developing world, the World Health Organization (WHO) claimed that, "As HIV/AIDS becomes a disease that can be both prevented and treated, attitudes will change and denial, stigma and discrimination will rapidly be reduced".

It is difficult to access the accuracy of the statement as levels of stigma are hard to measure. A number of small scale studies have however been conducted with fairly positive results. A study of 1268 adults in Botswana found that stigmatizing attitudes had lessened three years after the national program. Providing universal access to treatment may be a factor in reducing stigma, it does not eliminate stigma altogether and does not lessen the fear of stigma amongst HIV positive people.

The fact that stigma remains in developed countries such as America, where treatment has been widely available for over a decade, also indicates that the relationship between HIV treatment and stigma is not straight forward. An estimated 27 percent of Americans would prefer not to work closely with a woman living with HIV.

Woman with HIV/AIDS may be treated very differently from men in some societies, where they are economically, culturally and socially disadvantaged. They are sometimes mistakenly perceived to be the main transmitter of sexually transmitted diseases (STDs). Men are more likely than women to be excused for the behaviour that resulted in their infection. Even married woman who has been infected by her husband will be accused by her in-laws. In such a male dominated society no one ever accepts that man is actually the one who did something wrong. It is even harder on woman since it is seen as a fair result of their sexual misbehaviour. (HIV – positive Woman, Lebanon)

The effects of stigma:

"The epidemic of fear, stigmatization and discrimination has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected. This hinders in no small way, efforts at streaming the epidemic.

It complicates decision about testing, disclosure of status and ability to negotiate, prevention behaviours including use of family planning service".

AIDS related stigma has had a profound effect on the epidemics course. The WHO cites the fear of stigma and discrimination as the main reason why people are reluctant to be tested, to disclose HIV status or to take anti retroviral drugs. These factors all contribute to the expansion of the epidemic as a reluctance to determine HIV status or to discuss or practice safe sex means that people are more likely to infect others and a higher number of AIDS related deaths. An unwillingness to take an HIV test means that more people are diagnosed late, when the virus has already progressed to AIDS, making treatment less effective and causing early death.

Research by the International Centre for Research on Women (ICRW) found the possible consequences of HIV related stigma to be.

1. Loss of income/livelihood.
2. Loss of marriage and child bearing option.
3. Poor care within the health sector.
4. Withdrawal of care giving in the home.
5. Loss of hope and feelings of worthlessness.
6. Loss of reputation.

Some of these consequences refer to "internal stigma" or "self stigma". Internal stigma refers to, how people living with HIV regard themselves as well as they see public perception of people living with HIV. Stigmatizing beliefs and actions may be imposed by the people living with HIV themselves.

"I am afraid of giving my disease to my family members, especially my youngest brother who is so small. It would be so pitiful if he got the disease. I am aware that I have the disease so I do not touch him – I talk with him only. I do not hold him in my arms now". (a woman in Vietnam).

Self stigma and fear of a negative community reaction can hinder efforts to address the AIDS epidemic by perpetuating the wall of silence and shame surrounding the epidemic. Stigma also exacerbates problems faced by children orphaned by AIDS. AIDS orphans may encounter hostility from their extended families and community and may be rejected, denied access to schooling and healthcare and left to tend for themselves.

Types of HIV/AIDS related stigma and discrimination:

AIDS related stigma can lead to discrimination such as negative treatment and denied opportunities on the basis of their HIV status. This discrimination can occur at all levels of a person's daily life, for example – when they wish to travel, use healthcare facilities or seek employment.

Government:

A country's laws, rules and policies regarding HIV can be a significant effect on the lives of people living with the virus. Discriminatory practices can alienate and ostracize people living with HIV, reinforcing the stigma surrounding the disease.

In 2008, UNAIDS reported that 67 percent countries now have some form of legislations in place to protect people living with HIV from discrimination. However Ban Ki-Moon, Secretary General of the United Nations believes that almost all permit at least some form of discrimination.

There are many ways that governments can actively discriminate against people or communities with or suspected having HIV/AIDS. Many of these laws have been justified on the grounds that the disease poses a public health risk. Some examples of govt. level stigma and discrimination against people living with HIV/AIDS:

1. President Museveni of Uganda supports the national policy of dismissing and not promoting members of the armed forces who tested HIV positive.
2. The Chinese govt. advocates compulsory HIV testing for any Chinese citizens who have been living outside of the country for more than one year.
3. The UK legal system can prosecute individuals who pass the virus to somebody else, even if they did so without intent.

Healthcare:

In healthcare settings people with HIV can experience stigma and discrimination such as being refused medicines or access to facilities, receiving HIV testing without consent and lack of confidentiality. Such responses are fuelled by ignorance of HIV transmission routes amongst doctors, midwives, nurses and hospital staff. That medical staff should perhaps have a better understanding of HIV makes discriminations in healthcare settings all the more damaging.

Lack of confidentiality has been repeatedly mentioned as a particular problem in healthcare settings. Many PLWHAs do not get to choose how, when and to whom to disclose their HIV status. Studies by the WHO in India, Indonesia, Philippines and Thailand found that 34% of the respondents reported breaches of confidentiality by health workers.

Doctors in healthcare settings in resource poor areas with limited or no drugs have reported a frustration with lack of options for treating people with HIV/AIDS, who are seemed as doomed to die. This frustration may mean that AIDS patients are not prioritized or are actively discriminated against fear of exposure to HIV as a result of lack of protective equipment is another factor fuelling discrimination among doctors and nurses in under resourced clinics and hospitals.

A review of research into stigma in healthcare settings advocated a multi-pronged approach to tackling it, requiring action on the individual, environmental and policy level. Healthcare workers need to be made aware of the negative effect that stigma can have on the quality of care patients receive, they should have accurate information about the risk of HIV infection, the misperception of which can lead to stigmatizing actions and they should also be encouraged not to associate HIV with immoral behaviour. Facilities should have sufficient equipments and information, so health workers can carry out universal precautions and prevent exposure to HIV.

Policies within healthcare setting can also be effective in reducing stigma. Such programs would involve participating methods like role play and group discussion as well as training on stigma and universal precautions. The involvement of people living with HIV could lead to a greater understanding of patient’s needs and negative effect of stigma.

Employment:

In the work place, people living with HIV may suffer stigma from their co-workers and employers such as social isolation and ridicule or experience discrimatory practices, such as termination or refusal of employment. Fear of an employer's reaction can cause a person living with HIV anxiety.

"It is always in the back of your mind, if I get a job, should I tell my employer about my HIV status? There is a fear of how they will react to it. It may cost you your job. It may make you so uncomfortable, it changes relationships. Yet you would want to able to explain about why you are absent and going to the doctors". (A HIV positive woman in UK). "Though we do not have policy so far, I can say that if at the time of recruitment there is person with HIV, I will not take him, I will certainly not buy a problem for the company. I see recruitment as a buying- selling relationship. If I do not find the product attractive, I will not buy it". (A head of Human Resource Development, India)

Restrictions on Travel and Stay:

Many countries have laws that restrict the entry, stay and residence of people living with HIV. Almost sixty countries, territories and areas have restrictions that specifically apply to HIV/AIDS based on positive status alone. This number does not include those countries where the legislation uses language such as "contagious" or "transmissible disease", if HIV/AIDS are not mentioned specifically.

UNAIDS has identified around a dozen restrictions applicable to HIV positive people regarding entry, stay and residence. Until the 4th of Jan 2010, the United States restricted all HIV positive people from entering the country whether they are on holiday or visiting on longer term basis. Twenty two countries including Egypt, Russia and South Korea deport foreigners based on their HIV positive status alone. Some countries have policies that could violate confidentiality of status if, for example, a stamp is required on waiver or passport in order to gain entry or stay. Student living with HIV are barred from applying to study in certain countries including Malaysia and Syria.

A database maintained by the German AIDS federation, the European AIDS treatment group and International AIDS society, presents updated information on such travel restrictions in 196 countries, if there are any. (www.hivtravel.org)

This information is also presented in a UNAIDS document which UN country members were asked to verify: “Mapping of restrictions on the entry, stay and residence of people living with HIV”.

Deportation of people living with HIV has potentially life threatening consequences if they have been taking anti retroviral drugs. If they are deported to a country that has limited treatment provision, this could lead to drug resistance and death. Alternatively, people living with HIV may face deportation to a country where they would be subject to even further discrimination. As human rights watch has pointed out, this practice could contravene international law.

Community:

Community level stigma and discrimination towards people living with HIV/AIDS is formed all over the world. A community’s reaction to somebody living with HIV/AIDS can have a huge effect on that person’s life. If the reaction is hostile a person may be ostracized and discriminated against and may be forced to leave their home or change their daily activities including shopping, socializing and schooling.

Community level stigma and discrimination can manifest as ostracism, rejection, verbal and physical abuse. It has been extended to murder. AIDS related murders have been reported in countries as diverse as Brazil, Colombia, Ethiopia, India, South Africa and Thailand. In Dec 1998 Gugu Dhlamini was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking openly on World AIDS Day about her HIV status.

Family:

In the majority of developing countries families are the primary care givers when somebody falls ill. There is clear evidence that families play an important role in providing support and care for PLWHAs. However not all family responses are positive. HIV infected members of the family can find themselves stigmatized and discriminated against within the home. There is concern that women and non-hetrosexual family members are more likely than children and men to be mistreated.

"When I was in hospital, my father came once. Then he shouted that I had AIDS. Everyone could here. He said: this is AIDS, she is a victim, with my brother and his wife. I was not allowed to eat from the same plates and I had to sleep in the kitchen; I was not even allowed to play with the kids". (HIV positive woman, Zimbabwe).

A Dutch survey of people living with HIV found that stigma in family settings in particular avoidance, exaggerated kindness and being told to conceal one's status – was a significant predictor of psychological distress. This was believed to be due to the absence of unconditional love and support, which families are expected to provide.

HIV related stigma and discrimination severely hamper efforts to effectively fight the HIV and AIDS epidemic. Fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly. People with or suspected of having HIV may be turned away from healthcare services and employment or refused entry to foreign countries. In some cases they may be forced from home by their families and rejected by their friends and colleagues. The stigma attached to HIV/AIDS can extend to next generation, placing an emotional burden on those left behind.

Denial goes hand in hand with discrimination with many people continuing to deny that HIV exists in their communities. Today HIV/AIDS threatens the welfare and well being of people throughout the world. At the end of the 2008, 33 million of people were living with HIV with two million having died of AIDS related illness in that year. Combating stigma and discrimination against people who are affected by HIV/AIDS is a vital ingredient for preventing and controlling the global epidemic.

So how can progress be made in overcoming this stigma and discrimination? How can we change people's attitudes to AIDS? A certain amount can be achieved through the legal process. In some countries people living with HIV, lacks knowledge of their rights in society. They need to be educated, so they are able to challenge the discrimination, stigma and denial that they encounter. Institutional and other monitoring mechanisms can enforce the rights of people with HIV and provide powerful means of mitigating the worst effects of discrimination and stigma.

"We can fight stigma. Enlightened laws and policies are key. But it begins with openness the courage to speak out. Schools should teach respect and understanding. Religious leaders should preach tolerance. The media should condemn prejudice and use its influence to advance social change, from securing legal protection to ensuring access to healthcare". (Ban Ki-Moon, Secretary General of UN)

However no policy or law can alone combat HIV/AIDS related discrimination. Stigma and discrimination will continue to exist so long as societies as a whole have a poor understanding of HIV and AIDS and the pain and suffering caused by negative attitudes and discrimatory practices. The fear and prejudice that lie at the core of the HIV/AIDS discrimination need to be tackled at the community and national levels with AIDS education playing a crucial role. A more enabling environment needs to be created to increase visibility of people with HIV/AIDS as normal part of a society. The presence of treatment makes this task easier; where there is hope people are less afraid of AIDS; they are more willing to be tested for HIV, to disclose their status and seek care if necessary. In the future, the task is to confront the fear based messages and biased social attitudes, in order to reduce the discrimination and stigma of people living with HIV/AIDS.

Since the beginning of HIV/AIDS pandemic, prevention and care programs in most of the countries have been planned and implemented with a primary focus on prevention of the spread of infection. However, programs providing care for those infected with HIV and AIDS are yet to be adequately developed in a system with all kinds of constraints. In addition to the physical symptoms of the disease, persons with HIV/AIDS are affected emotionally and together with their families are often ostracized and suffer from social discrimination and rejection.

Consequently it is unscientific and unethical to quarantine HIV positive person as was done to a patients in Goa in 1989 or to refuse hospital admission to HIV infected person as was ordered by several hospitals in Delhi in Feb 1990 for several months or to dismiss a HIV positive person from his job as was done in Goa in 1989.

The society should accept and encourage sex education through parents, teachers and community leaders within the context of HIV/AIDS in order to create a world free from myths and misconception related to HIV/AIDS has taken place in the society. The underlying reason for such situation to exist is mainly due to ignorance about the issue of HIV/AIDS pandemic all over the world. In order to overcome these barriers it is essential for each one of us to know about the disease profile of HIV/AIDS, its modes of transmission, signs and symptoms.

Once we have sufficient knowledge about HIV/AIDS pandemic, it would become easy to understand the facts and misconceptions of HIV/AIDS clearly. The initial attempts of creating awareness of AIDS have worsened the case by creating a fear psychosis in the minds of public at large. Level of HIV/AIDS awareness is low not only in the community but the level of ignorance even among the persons who are in this field of research and other related activities has been found. Hence the information about HIV/AIDS has to reach the entire population in its true sense through adequate planning and commitment along with political will for the welfare of the people.

AIDS patients should be treated in general wards of hospitals like any other patients. Due to lack of awareness sometimes they are treated in special wards or refused treatment. Ostracization is not only a social but a medical problem too. It affects the process of recovery in patients. Recent studies have revealed that patients in isolation develop typical complications, which are uncommon in patients who are treated at home or in general wards. Such patients also show poor response to medicine. Isolation forces a patient towards poor recovery.

Deinstitutionalization has helped the patients to recover more in one's own community, in the presence of his family, relatives and neighbours than in institutional settings. Quarantine will not help in preventing the spread of infection. Infection cannot spread through air, water or of casual contact. Quarantine of the patient will not prevent the disease from spreading. It will drive the patient from the healthcare system. Cuba is classical example where quarantine has practiced. It did not reduce the incidence if new cases, on the contrary the rates increased. Countries like Britain and Australia have reduced their cases not by isolating their patients through care and treatment.

We have heard over and over again about discrimination against people with HIV. We know that it is a deep and pervasive problem. No policy to address the effects of the epidemic can afford to ignore the fact that HIV threatens human rights as profoundly as it threatens public health. (Source UNDP "Public living with HIV: The law, ethics and discrimination, Issue paper – 4, UNDP, New York, 1993.

Recently some sorts of discrimination and ostracisation as the consequent of misconception of general masses have been found all over India. Misconception about the causes of HIV/AIDS infection transmission from one person to another, its prevention and cure leads to various stigma, discrimination and ostracisation in every place in family, in community and even in hospitals.

One such case has been noticed in the SCB Medical College and Hospital Cuttack (Odisha) that an AIDS patient of Jagatsinghpur District has been admitted in this Hospital for treatment. But after 46 days of his admission in the Hospital he has not been provided even with a bed and medicines supplied for the HIV/AIDS patients from the ART Centre. He remained in a helpless condition even being admitted in the Chief Medical Centre of the State because of misconception of Doctor and other Paramedical Staff. This was an example of institutionalized stigma and discrimination for AIDS patients even in 21st century (The Sambad, The Odia daily, Cuttack, 03.07.2013).

Another instance of community level stigma and discrimination towards people living with HIV/AIDS (PLWHAS) was found at Pratap Garh in U.P which had been manifested in social ostracisation of the five AIDS orphans after the death of their parent's death in AIDS. After their parents death they had been forced to leave their village and lived near the cremation ground where their dead parents were cremated (The Sambad, Cuttack, 27.07.2013).

All the informations regarding misconception and stigma discrimination and ostracisation have made the researcher to study and analyze about such scenario in her Universe of study Viz. in Rajnagar and Rajkanika blocks.

Table No. 7.1

Distribution of the Respondents on the Basis of Their Awareness regarding no risk factor in the spread of HIV/AIDS N=300

No risk factors	No. in Rajnagar Block				No. in Rajkanika Block			
	Yes	No	Not Sure	Total	Yes	No	Not Sure	Total
A	12 (8%)	87 (58%)	51 (34%)	150	--	150 (100%)	--	150
B	--	99 (66%)	51 (34%)	150	--	138 (92%)	12 (8%)	150
C	--	99 (66%)	51 (34%)	150	--	138 (92%)	12 (8%)	150
D	27 (18%)	72 (48%)	51 (34%)	150	--	93 (62%)	57 (38%)	150
E	27 (18%)	30 (20%)	93 (62%)	150		63 (42%)	87 (58%)	150

N.B.:

A. Using same toilet

B. Using or sharing same glass, spoon, teacup or other Utensils.

C. Using same towel, dress, bed

D. Shaking hands and embracing

E. Kissing or hugging

AIDS is not hereditary and HIV can only be acquired during sexual intercourses, via infected blood or contaminated syringes or from infected mother to the child (MTCT). But a number of myths and misconceptions prevail as regards the risk factors concerning AIDS. Misconceptions lead to unnecessary fear of AIDS (AIDS phobia) in the minds of masses. The misconceptions are producing stomach churning stories among the people who did not know how HIV spreads whether the virus are transmitted through casual body contact or only through specific routes like blood transmission and sexual intercourse or such other channels.

To find out the level of awareness regarding the mode of spread of the disease and the myths and misconceptions related to it a number of questions were posed to the respondents. It could make clear about the no risk factors of spreading HIV /AIDS existed in the minds of the respondents.

This table reveals the awareness of the respondents regarding no risk factors spreading HIV/AIDS. The respondents varied in their responses towards the no risk factors as using same toilet, using or sharing the same glass, spoon, teacup or other utensils, towel, dress, bed, shaking hands and embracing or kissing or hugging the HIV/AIDS infected persons. The majority of the respondents of both the blocks opined that all these were no risk factors in spreading HIV/AIDS. Only a few respondents in Rajnagar block said that this disease may spread through using same toilets, shaking hands, embracing, kissing and hugging the infected persons. Thirty four percent of the respondents of Rajnagar block were not sure about these factors bringing a risk of HIV/AIDS infection. Thirty Eight percent respondents of Rajkanika block were not sure whether shaking hands and embracing and 58% of respondents of this block were not sure about kissing or hugging the infected persons might bring risk of infection.

Table No. 7.2

Distribution of the Respondents on the Basis of Their Awareness regarding Risk Factor in the spread of HIV/AIDS N=300

Risk factors	No. of Respondents in Rajnagar Block				No. of Respondents in Rajkanika Block			
	Yes	No	Not Sure	Total	Yes	No	Not Sure	Total
A	114 (76%)	--	36 (24%)	150	138 (92%)	--	12 (8%)	150
B	99 (66%)	--	51 (34%)	150	138 (92%)	--	12 (8%)	150
C	54 (36%)	--	96 (64%)	150	78 (52%)	--	72 (48%)	150
D	72 (48%)	--	26 (78%)	150	90 (60%)	--	60 (40%)	150
E	57 (38%)	27 (18%)	66 (44%)	150	75 (50%)	12 (8%)	63 (42%)	150

N.B:

A. Having unprotected sex with the partner of same or opposite sex.

B. Receiving infected blood.

C. Sharing same razor / blade.

D. Using same needle / syringe.

E. Breast feeding of infected mother.

HIV/AIDS is now a leading cause of death worldwide. The acronym AIDS stands for Acquired Immune-Deficiency Syndrome and the full form of HIV is the Human Immune-deficiency virus. That means that disease is acquired by the human beings themselves. If the human beings were conscious about the risk factors through which the disease can be acquired, they may protect themselves from being infected. There are certain specific factors or causes through which HIV/AIDS spread.

The researcher was interested in knowing the respondents' awareness level regarding the risk factors in the spread of HIV/AIDS. This table shows that the majority of respondents of both the blocks positively responded to the risk factors namely having unprotected sex

with the partners of same or opposite sex, receiving infected blood, sharing same razor or blade using same needle or syringe and breast feeding of infected mother to child in the spread of HIV/AIDS. Only 18% respondents of Rajnagar block and 8% of Rajkanika block said that HIV/AIDS cannot be spread through breast feeding of infected mother to child.

64% respondents of Rajnagar block and 48% respondents of Rajkanika block were not sure about sharing of razor or blade as responsible for spreading of HIV/AIDS. 24% of respondents of Rajnagar block and 8% of Rajkanika block were not sure that unprotected sex as risk factor for spreading HIV/AIDS. Whereas 34% of Rajnagar block and 8% of Rajkanika block were not sure about receiving infected blood as risk factor for spreading HIV/AIDS.

Table No. 7.3

Distribution of the Respondents on the Basis of Their Opinion Regarding Behaviour towards persons with HIV/AIDS N=300

Pattern of behaviour shown	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Indifferent	15 10%	--	--	15 10%	9 6%	12 8%	15 10%	36 24%
Hatred	--	--	--	--	--	--	15 10%	15 10%
Friendly	15 10%	15 10%	27 18%	57 38%	--	12 8%	18 12%	30 20%
Sympathetic	15 10%	15 10%	30 20%	60 40%	9 6%	15 10%	33 22%	57 38%
Other wise	6 4%	12 8%	--	18 12%	12 8%	--	--	12 8%
Total	51	42	57	150	30	39	81	150

Due to popular beliefs associated with infectious disease people assume that the HIV/AIDS can be transmitted like any other infectious diseases and thus their attitude towards AIDS patients are largely determined by this perception. If these notions exist among

individuals they might remain scared of people with HIV and any normal and social interaction may get jeoparadized. Thus AIDS victims will be isolated and the individuals on all aspects considered untouchables. The indifferent behaviour adopted by the people around increases the patients' grief and suffering and the stigma becomes enormous. Misconceptions are still prevailing among the general masses. Media being all pervasive and all powerful can go a long way in eradicating misconceptions and during the individuals on all aspects of its spread so that precaution can be taken. Besides media imparting awareness makes the general masses to change their attitude and behaviour towards AIDS victims. If such misconceptions do exist and if people go on believing them, then it would become very difficult in convincing them that people with AIDS should not be discriminated and rejected by the family, friends and society. This would lead to people affected with AIDS facing psychological agony, emotional and psychological stress, depression and neurosis that would also create a fear for those associated with the victim. This rejection and ostracisation of people with AIDS castigates them. Sometimes it leads to optiomal levels of frustration and depression resulting in homicidal and suicidal tendency.

Hypothetically speaking respondents in this study were inclined to be sympathetic towards AIDS victims. This table informs the pattern of behaviour towards the persons with HIV/AIDS. The majority of the respondents in both the blocks were in favour of sympathetic behaviour towards HIV/AIDS patients. Only a few respondents found indifferent behaviour towards patient. Ten percent degree and above educated respondents of Rajkanika block found that the AIDS victims were treated with hatred. Thirty eight percent of Respondents of Rajnagar block and 20% respondents of Rajkanika block were in favour of friendly behaviour for the HIV/AIDS patients.

Table No. 7.4

Distribution of the Respondents on the Basis of Their Opinion regarding disclosure of the HIV/AIDS **N=300**

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Disclosed	36 24%	12 8%	27 18%	75 50%	21 14%	15 10%	18 12%	54 36%
Confidential	15 10%	15 10%	30 20%	60 40%	9 6%	12 8%	48 32%	69 46%
No opinion	--	15 10%	--	15 10%	--	12 8%	15 10%	27 18%
Total	51 34%	42 28%	57 38%	150	30 20%	39 26%	81 54%	150

Confidentiality of HIV status of the individuals should be maintained by the Doctors and other medical staff. The people living with HIV/AIDS are often afraid of being discriminated and ostracized in family, community and society if their positive status is disclosed. Disclosure of HIV status becomes a curse for the infected person.

This table reveals the opinion of the respondents whether infection of HIV/AIDS should be disclosed or be remained confidential from others. 24% respondents having below matric, 8% having matric and above 18% of respondents having degree and above qualification of Rajnagar block said that HIV/AIDS infection should be disclosed but 10% below matric, 10% matric and above and 20% degree and above educated respondents of this block said that such infection should be kept confidential and a few respondents had no opinion regarding disclosure of HIV + status to others.

In Rajkanika block 14% below matriculate 10% matric and above and 12% degree and above respondents said that HIV/AIDS infection of the person may be disclosed, 6% below matric, 8% matric and above and 32% degree and above qualified respondents wanted that such infections should be remained confidential. The other respondents remained silent about this.

Table No. 7.5

Distribution of the Respondents on the Basis of Their Opinion Regarding Confidentiality helping in Protection from Discrimination N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	15 10%	15 10%	15 10%	45	9 6%	12 8%	48 32%	69
No	--	12 8%	18 12%	30	--	--	18 12%	18
Not Sure	36 24%	15 10%	24 16%	75	21 14%	27 18%	15 10%	63
Total	51	42	57	150	30	39	81	150

Though HIV/AIDS has been regarded as a terrible disease associated with stigma, discrimination and ostracization in family, society and among own friends; the government has taken various measures to keep its infection confidential. In individuals the way in which HIV/AIDS related stigma and discrimination (S & D) are manifested depends on family and social support and the degree to which people are able to open about such issues as their sexuality as well as their sero status. Where HIV/AIDS is highly stigmatized, fear of HIV/AIDS related S&D may cause individuals to isolate themselves to the extent that they no longer feel a part of civil society and are unable to gain access the services and support they need. This has been called as internalized stigma. In extreme cases this has led to premature death through suicide. Even when laws exits to protect PLWHA'S rights and confidentiality many people choose not to know or reveal their sero status due to negative community and family responses.

So that AIDS victims feel that confidentiality may help them protect from such stigma, discrimination and ostracisation.

This table reveals the respondents response regarding the effect of confidentiality. Ten percent respondents from each educated group of R N block were in favour of confidentiality of infected persons as it helped in protection from discrimination in the family, society and among friends. Twenty four percent below matric, 10% matric and above and 16% degree and above qualified respondents of Rajnagar block were not sure about this statement. Other stated that confidentiality did not help in protecting discrimination.

In Rajkanika block 6% below matric, 8% matric and above and 32% degree and above qualified respondents were in favour of confidentiality of HIV infected persons, but only 12% degree and above qualified respondents negatively responded and others were not sure about this statement.

Table No. 7.6

Distribution of the Respondents on the Basis of Their Opinion Regarding Negligence of HIV/AIDS Patients by Doctors or Paramedical Staff in the Hospital. N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	-	-	-	-	-	-	18 12%	18 12%
No	15 10%	30 20%	57 38%	102 68%	21 14%	39 26%	63 42%	123 82%
Not sure	36 24%	12 8%		48 32	9 6%	-	-	9 6%
Total	51	42	57	150	30	39	81	150

Sometimes it becomes a rumor that even the educated doctors and paramedical staff neglect the HIV/AIDS patients in the fear of being infected. It made the researchers to enquire about the truth. Here she found that none of the respondents except 18% degree and above qualified respondents of Rajkanika block were in favour of such complain against educated doctors and paramedical staffs. 24% below matric and 8% matric and above qualified respondents of Rajnagar block and 6% below matric respondents of Rajkanika block were not sure about this. The rest of the respondents of both the blocks viewed that the doctors and paramedical staffs did not neglect the infected persons in the hospitals.

Table no. 7.7

Distribution of the Respondents on the Basis of Their Opinion Regarding Negligence of the PLWHA in their Own Family **N=300**

Opinion of the respondents	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	36 24%	15 10%	42 28%	93 62%	9 6%	27 18%	33 22%	69 46%
No	15 10%	15 10%	15 10%	45 30%	12 8%	-	48 32%	60 40%
Not sure	-	12 8%	-	12 8%	9 6%	12 8%	-	21 14%
Total	51	42	57	150	30	39	81	150

Sometimes own family members of HIV/AIDS infected persons neglect them. This table shows the information of the respondents about such negligence. 24% below matric, 10% matriculation and above and 28% degree and above educated respondents of Rajnagar block and 6% below matric, 18% matric and above and 22% degree and above educated respondents of Rajkanika block said that HIV/AIDS patients had been neglected in their own families by their near and dear ones.

Table. No 7.8

The form of negligence of PLWHA in own family **N=300**

Form of negligence	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
A	-	15	3	18	-	-	15	15
B	-	-	15	15	9	27	18	54
C	-	-	-	-	-	-	-	-
D	15	-	-	15	-	-	-	-
E	21	-	-	21	-	-	-	-
F	-	-	24	24	-	-	-	-
Total	36	15	42	93	9	27	33	69

N.B :

(A) Own spouse avoids.

(B) Separate room, bed and utensils are provided.

(C) Other family members do not talk with them.

(D) Family members are indifferent towards them.

(E) Own children are not allowed to met with them.

(D) All

The respondents found various forms of negligence of PLWHA in their own families viz. own spouse avoided, separate rooms, beds and utensils were provided to them and sometimes own children were not allowed to mix with them.

Out of 150 respondents in Rajnagar block 93 respondents noticed one or other form of negligence cited above. Among them 15 Matric & above and 3 degree & above qualified respondents said that the HIV/AIDS patients were avoided by their own spouses in the family. Fifteen degree and above qualified respondents said that separate rooms, beds and utensils were provided to them. Fifteen below matriculate respondents pointed out family members' indifferent behaviour towards them and 21 below matriculate respondents pointed out that even the own children had not been allowed to mix with infected parents. But majority of respondents of this block i.e. 24 degree and above qualified respondents pointed out that in some families all the above form of negligence of PLWHA were found.

In Rajkanika block out of 150 respondents, 69 respondents marked one or other form of negligence of PLWHA in their own families; Fifteen degree and above qualified respondents said that own spouse had avoided their HIV/AIDS infected partners, 9 below matric and above and 18 degree and above qualified respondents said that separate rooms, beds and utensils were provided to them.

Table No.7.9

Opinion regarding Ostricization of HIV/AIDS Patients in Their Own Village N=300

Opinion of the respondents	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	15 10%	27 18%	39 26%	81	21 14%	12 8%	48 32%	81
No	21 14%	-	15 10%	36	9 6%	-	33 22%	42
Not sure	15 10%	15 10%	3 2%	33	-	27 18%	-	27
Total	51	42	57	150	30	39	81	150

HIV/AIDS patients have been discriminated and ostracized in community and society through out of the world. But human rights have been central to the international community's response to the HIV/AIDS epidemic. This approach is initially the inclusion of and non- discrimination against particular risk groups. However as the epicentre of the epidemic has moved from the 1st world to the 3rd world and spread to the general population, so the rights emphasis has begun to shift from a focus in individual rights of privacy and non-discrimination to embrace more global social and economic concerns of poverty and in equality. social and economic rights especially the right to health care, gender equality and women's right as well as men's responsibilities and rights are beginning to emerge within the international discourse of human rights and HIV/AIDS. These provide new weapons in the fight against the pandemic at the same time as they raise new conceptual and practical challenge.

Under Indian constitution, fundamental rights do not differ for people of different caste or creed, sex or race, religion or place. Article 15, the right to equality states that the state shall not discriminate against any citizen on grounds only of religion, caste, race, sex, place of birth or any of them.

Article 16 says there shall be equality of opportunity for all citizens in matters relating to employment or appointment to any office under the state.

Article 17 says that untouchability is abolished and particle in any form is forbidden. The enforcement of any disability arising out of untouchability shall be an offence punishable in accordance with the law.

Thus the right to equal treatment is the fundamental right. Neither do the rights change just because an individual is infected with HIV. The individual infected with HIV/AIDS should not be discriminated in any form either prevented to use wells, ponds, cremation grounds to enter into any educational institution to admit their children for education, or admitted in any hospital for treatment or to be employed or appointed in any office on the ground of being infected by HIV/AIDS. They should not be dismissed or suspended from their service of any kind because of their infection. No form of discrimination and ostracisation is expected from any individual or institution for PLWHA only because of their infection. They should not be treated as untouchable for their infection, while no such instances of discrimination and ostracization were observed for the persons infected with any of other diseases more or less ostracization found to be imposed on PLWHA in their own villages.

In this present study some respondents have pointed out some sorts of ostracization of such patients in their own village. In Rajnagar block 10% respondents having below matric, 18% having matric and above and 26% having degree and above qualification informed that the HIV/AIDS patients were ostracized in their own village. In Rajkanika block 14% respondents having below matric, 8% having matric and above and 32% having degree and above qualification inform that the HIV/AIDS patients were ostracized in their own village.

On the whole this table shows that in both the blocks the majority of respondents having degree and above qualification said that the HIV/AIDS patients were ostracized in their own village.

Table no. 7.10

Different Manifestation of Ostracization of PLWHA in Their Own Villages. N=300

Form of negligence	No. in Rajnagar Block			No. in Rajkanika Block		
	Below matric	Matric and above	Degree and above	Below matric	Matric and above	Degree and above
A	15	-	-	-	-	-
B	15	-	39	9	12	30
C	15	-	-	-	-	-
D	15	-	-	-	-	-
E	-	27	-	12	-	18
F	-	-	-	-	-	-

NB:

A. Own friends avoid touch or any contacts.

B. Patients are not allowed to attend any social function.

C. Prevented from using village pond or well.

D. Patients are not allowed to enter into village temple.

E. The patient may be driven out village.

F. Dead body of patient may not be touched for cremation.

In-spite-of a number of constitutional provisions for Indian citizens not be discriminated, ostracized and prevented from any place some of them become the victims of such ostracization because of their infection into HIV/AIDS. Some such manifestations of ostracization found in the present study are prevention of HIV/AIDS patients from attending social functions, using village ponds, well, entering the village temple etc.

Out of 150 respondents in Rajnagar block 15 below matriculate & above, 27 matriculate, 39 degree and above respondents viewed that HIV/AIDS Patients were ostracized in their own villages. All the below matriculate respondents said that own friends of HIV/AIDS patients avoided their touch or any other contact with them. The patients were not allowed to attended any social function, prevented from using village well or pond and

were not allowed to enter into the village temple. All the matric and above educated respondents found that sometimes the infected persons may be driven out of village and all the degree and above qualified respondents pointed out that the PLWHA were not allowed to attend any social function.

In Rajkanika block from 150 respondents 21 below matric, 12 matric and above and 48 degree and above qualified respondents opined that HIV/AIDS infected persons were ostracized in their own villages. In this block 9 below matriculation, 12 matriculations and above and 30 degree and above educated respondents pointed out that PLWHA were not allowed to attend any social function in their village. 12 below matriculation and 18 degree and above qualified respondents pointed out PLWHA were sometimes driven out of their village in the fear of infection of others.

Table No. 7.11

Opinion Regarding Discrimination of the Children of PLWHA. N=300

Opinion of the respondents	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	15 10%	-	15 10%	30	12 8%	12 8%	-	24
No	-	30 20%	42 28%	72	18 12%	27 18%	81 54%	126
Not sure	36 24%	12 8%	-	48	-	-	-	-
Total	51	42	57	150	30	39	81	150

Some times the children of the HIV/AIDS infected persons are found to be discriminated in the villages, school, playground and other places in the society not because of any fault of their own. But no such discrimination and ostracization were found to be imposed on the children of the persons having been infected with other diseases than HIV/AIDS.

This table reveals the opinion of the respondents in both the blocks regarding discrimination of the children of PLWHA. In Rajnagar block 20% respondents having matric and above and 28% having degree and above qualification said that the children of PLWHA should not be discriminated for the infection of their parents. 10% below matriculation and 10% degree and above qualified respondents said that the children should be discriminated. But other said that they were not sure about the justification of the discrimination of the children of PLWHA having no fault of their own.

In Rajkanika block 8% below matric and 8% matric and above respondents said that the children of PLWHA must be discriminated. But the 12% below matric, 18% matric and above qualified respondents opined that the children of PLWHA should not be discriminated anywhere in the community having no fault of theirs.

Table No.7.12

Forms of Discrimination of the Children of PLWHA **N=300**

Form of negligence	No. in Rajnagar Block			No. in Rajkanika Block		
	Below matric	Matric and above	Degree and above	Below matric	Matric and above	Degree and above
A	15	-	-	12	-	-
B	15	-	15	-	-	-
C	-	-	-	-	-	-
D	-	-	-	-	-	-
E	-	-	-	-	12	-

N.B.:-

(A) To read in village school with other.

(B) To play with other.

(C) To attend feast or picnic in school with other children.

(D) To participate in common prayer in the school.

(E) All.

In Rajngar block out of 150 respondents only 30 respondents and in Rajkanika block out of 150 respondents only 24 respondents opined positively for discrimination of the children of PLWHA. 15 below matriculate respondents of Rajnagar block said that the children of PLWHA were found to be discriminated in the village school to read with other children and also play with other children. 15 degree and above qualified respondents also found the children of PLWHA were prevented to play with other children. But in Rajkanika block 12 below matriculate respondents said that the children of PLWHA were not allowed to read with other in the village school. Other 12 respondents having matric and above qualification said that all forms of discrimination as citied in the schedule viz. Prevention of the children of PLWHA from reading in village school, playing with others, attending feast and picnic and participating in common prayer with other children were found in their block.

Table No. 7.13

Attitude of the Respondents towards PLWHA. **N=300**

Statement	No. of Respondent in R N Block				No. of Respondent in R K Block			
	Yes	No	Not sure	Total	Yes	No	Not sure	Total
A	48	102	-	150	12	138	-	150
B	48	102	-	150	12	123	15	50
C	93	27	30	150	90	12	48	150

N.B.

(A) Infected persons should be separated from others and driven out of Village

(B) Such persons should be suspended or dismissed from the office

(C) They should be given Subsidy/ Stipend/ Dole for their maintainance or treatment

From this table attitude of the respondents towards the PLWHA was found out. Attitude of the respondents can be judged through 3 statements. As firstly **(Statement A)** infected persons should be separated from others and driven out of village, 2nd ly **(Statement B)** such persons should be suspended or dismissed from the office and 3rdly **(Statement C)** they should be given stipend or dole for their maintenance or treatment.

In Rajnagar block 48 respondents were in favour of 1st statement, 48 respondents also in favour of 2nd statement and 93 respondents were in favour of 3rd statement.

In Rajkanika block 12 respondents were in favour of 1st statement, 12 in favour of 2nd statement and 90 respondents were in favour of 3rd statement.

That informed that the majority of the respondents of both the blocks had positive attitude towards the PLWHA for which they were in favour of providing subsidy, stipend and dole for their maintenance or treatment.

Findings:

This chapter furnished with the informations from the respondents in two blocks under study about misconceptions, awareness about risk factors and no risk factors of the infection of the deadly disease HIV/AIDS, its transmission, attitude and behaviour of the masses towards PLWHA and towards their children, discrimination against them in family, community, school and hospital etc. Most of the educated respondents were aware about HIV/AIDS as caused by virus and the virus as not transmitted from the infected to other persons by using or sharing the same toilet, glass, spoon, tea- cup or other utensils, towels dress and or bed and shaking hands, embracing and kissing or hugging to the patients. Majority of the respondents knew that the HIV/AIDS is caused by unprotected sex, receiving infected blood, using same needle or syringe, breast feeding of the infected mother and using the same razor or blade. Most of the highly educated respondents of both the blocks were in favour of friendly and sympathetic behaviour towards HIV/AIDS Patients. Most of the educated respondents opined for confidentiality of their HIV positive status, because

confidentiality help them protecting from discrimination in family, society and among friends. Some of the uneducated and illiterate masses were found to practise discrimination against HIV/AIDS infected patients and their children in family, community and society due to misconception about the transmission of the disease.

Majority of the respondents opined that the infected persons were neglected in their own families as sometimes their own spouse avoided, separate rooms, beds, utensils were provided them, some of the family members were in-different towards them and sometimes their own children were not allowed to mix with them. Not only in their families but in their own village also the infected were ostracized. Various forms of ostracization were found in their area as the own friends avoided touch or any contact with them, deprivation from attending social function, preventing from using village well, pond and entering the village temple. Sometimes the innocent children of the infected persons were discriminated in the village and were not allowed to read and play with other children in the school. Because the uneducated and less educated rural masses were misguided by the common beliefs that this incurable disease may spread by talking, playing, eating and touching the infected persons and others those live with them. But most of the educated respondents were against such type of discrimination and ostracization of the PLWHA, on the one hand and in favour of providing governmental assistance, stipend or any dole for their maintenance and treatment instead of their suspension or retrenchment from any service, on the other.

Thus, it was noticed that misconception with regards to the risk factors and no risk factors for the transmission of HIV/AIDS leads to discrimination, stigma and ostracisation of the infected persons, their family members and children. Such darkness of misconception can only be replaced in the light of awareness about these factors through education. If the social ostracization of the HIV/AIDS victims and others those who are associated with them will not be stopped it becomes impossible for them to live peacefully. For which it is said, “it is better to die than to live with the curse of being socially ostracized”.

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Chapter- VIII
ATTITUDE AND PERCEPTION TOWARDS HIV/AIDS INFECTED/AFFECTED.

CHAPTER-VIII

ATTITUDE AND PERCEPTION OF THE RESPONDENTS TOWARDS HIV/AIDS INFECTED/AFFECTED

"If our society cannot save a few people who are HIV/AIDS affected, it may not be able to save as many who are healthy".

That means a society can protect a few people by changing its attitude towards HIV/AIDS affected, on the one hand and save a many through creating awareness among the masses about HIV/AIDS, on the other hand. That can only be possible when the individuals in the society perceive the disease in right way. The attitude towards the people living with or affected with HIV/AIDS (PLWHA) may be classified as positive if they favoured HIV risk reduction and prevent stigma towards PLWHA. Contrary to this if they are found to be increasing HIV vulnerability or social discrimination of infected or affected individuals, they are classified as negative. (Meenu Sharma, 2006).

The attitude of the respondents regarding sex and sexuality and towards PLWHA may be assessed on the attitude assessment scale. For the ruralites talking about sex and sexuality still remained a big taboo. Young girls often observe older women and follow the same trend. Thus, this model of knowledge transmission continues being followed from generation to generation. The "culture of silence" thus prevails. In order to contain the spread of HIV, it is vital to break this culture of silence and talk freely about all the information that is needed to protect precious lives from HIV/AIDS. Contrary to the general assumption that talking about sex and sexuality exposes young children to adult behaviour at an early stage, it has been found that such programs may successfully change attitude towards sex and promiscuous behaviour. It was said that women and children should not be given sexual, HIV/AIDS and STD education. The reason cited for this attitude being that the children are too small to understand such issues where as women are barred by socio-cultural factors to discuss sexual matters. Women in our society do not talk about all these. Although various such inequalities are known to contribute, to the vulnerability of women yet, nearly one third of countries lack policies ensuring women's equal access to critical prevention and care service. (UNAIDS,

2003). Some 65 million girls worldwide are kept out of school, increasing their risk of suffering from extreme poverty, dying during child birth or from AIDS and further passing these dangers to future generations (UNICEF, cited in Times Of India, 12th Dec 2003). Contrarily an effective response to contain the spread of HIV/AIDS requires enforcement of policies, which while addressing gender discriminations also ensures an equal access of basic prevention services to women too.

In India the social reactions to people with HIV/AIDS have been overwhelmingly negative. For example, in one study 36% of the people felt it would be better if infected people killed themselves the same percentage believed that the infected people deserved their fate. Also 34% said they would not associate with people with AIDS and one fifth stated that AIDS was a punishment from God. (C.P.Yadav, 2007).

The healthcare sector has generally been the most conspicuous context for HIV/AIDS related discrimination, stigma and denial. Negative attitudes from healthcare staff have generated anxiety and fear among many people living with HIV/AIDS. As a result, many people keep their status secret, fearing still worse treatment from others. It is not surprising that among a majority of HIV Positive people, AIDS related fear and anxiety and at times, denial of their HIV status can be traced to traumatic experience in healthcare setting.

Other example of discrimination are children of HIV positive parents, whether positive or negative themselves, being denied the right to go to school or being separated from other children. HIV positive children should not be allowed to study with HIV negative children because of the risk of HIV transmission through casual contact. Thus, it is evident that an attitude of discrimination, stemming from various myths and misconception prevalent amongst the ruralites against the people living with HIV/AIDS. A recent report revealing the denial of admission by various schools to HIV positive children (Times of India, 18th July, 2003) shows the intensity of discrimination being practiced on the basis of misconceptions even by educationist as well as educational institutes. Some of the children still forced to take school lessons and write their exams at home, despite appeals from several high ranking officials. A lack of knowledge about the virus remains an important factor in fuelling discrimination (UNAIDS/WHO, Dec 2003).

Women are often blamed by their parents and in-laws for infecting their husband or for not controlling their partner's urges to have sex with other women. HIV/AIDS related stigma and discrimination are linked to action and attitudes of families, communities and societies. Stigma is something that is socially constructed or socially produced and used to help order society. Stigmatization is also used by dominant group to legitimize and perpetuate inequalities. HIV/AIDS related stigma and discrimination has been reinforced by religious leaders and organizations which have used their power to maintain the status quo rather than to challenge negative attitude towards marginalized groups and PLWHA. Denial of the realities of HIV/AIDS have helped create perception that those infected have sinned and deserve their punishment increasing these stigma associated with HIV/AIDS.

Consequently, more efforts are needed to dispel myths and misconceptions of such communities to decrease levels of discrimination towards PLWHA. Further IEC programs also need to effectively address the fears and baseless apprehensions of the people.

In India as elsewhere, AIDS is perceived as a disease of "others" – of people living on the margins of society whose life styles are considered perverted and sinful. Discrimination, stigmatization and denial are the outcomes of such values, affecting life in families, communities, workplace, schools and healthcare settings. Because of HIV/AIDS related discrimination, appropriate policies and models of good practice remain underdeveloped. People living with HIV/AIDS (PLWHA) continued to be burdened by poor care and inadequate services whilest those with power to help do little to make the situation better.

HIV/AIDS may be perceived as a result of personal irresponsibility and thus individuals are blamed for contacting the infection. In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS may be perceived as bring shame on the family and community. Local cultural beliefs and explanations about disease and causes of disease may also contribute to HIV/AIDS related stigma and discrimination. For example, where illness is believed to be the result of "immoral" or "improper" behaviour, HIV/AIDS may reinforce pre-existing stigma of these behaviour is considered to be deviant. HIV/AIDS related stigma and discrimination in families and communities is commonly manifested in the form of blame and punishment.

The families are the main source of care and support for PLWHA in most of the developing countries. However, negative family responses are common. Infected individuals often experience stigma and discrimination in home and women are often more likely to be badly treated than men or children. Negative responses from family and community to women with HIV/AIDS include blame, rejection or loss of children and home.

Since HIV/AIDS related stigma and discrimination reinforce and interact with pre-existing stigma and discrimination, families may reject PLWHA not only because of their HIV status but because HIV/AIDS associated with promiscuity, homosexuality and drug use. In many cases, HIV/AIDS related S&D has been extended to families, neighbours and friends of PLWHA. This secondary stigmatization and discrimination has played an important role in creating and reinforcing social isolation of those affected by the epidemic, such as children and partners of PLWHA.

In individuals, the way in which HIV/AIDS related stigma and discriminations are manifested depends on family and social support and the degree to which people are able to open about such issues as their sexuality as well as their serostatus. In contexts where HIV/AIDS is highly stigmatized, fear of HIV/AIDS related S&D may cause individuals to isolate themselves to the extent that they no longer feel part of the civil society and are unable to gain access the services and support they need. This has been called internalized of stigma. In extreme case this has led to premature death through suicide.

Individuals who are already marginalized may be fearful of negative or hostile reactions from others regardless of their serostatus reflecting interaction between HIV/AIDS related and pre-existing sources of stigma and discrimination. Fear of telling the family about their homosexuality has been cited by HIV positive men in Mexico and Brazil as equal to the fear of revealing their serostatus. Even when the family response is positive, fear of stigmatization and discrimination by the community may mean that an individual's serostatus is not revealed outside the home.

For understandable reasons, knowledge of one's seropositive status shakes not only the concerned individual but also his family. In most situations, thinking, attitude and behaviour of the HIV infected as well as others are adversely affected. Different kinds of emotions may emerge strong fears of contagion along with aversive emotions compel many to break all bonds with the AIDS afflicted.

Fight against HIV/AIDS is not just a fight against biological virus, but a battle against bigotry, fear, denial and ignorance. A fundamental step is to realize that the HIV/AIDS epidemic is not just a biomedical health problem. It represents a public problem and a socio-economic problem one which behaviour change communication can help address and possibly solve.

As we approach the 21st century, we must reassess our attitude about sexuality, if we are to win the global war against HIV and AIDS.

This chapter deals with the attitude and perception of the respondents towards HIV/AIDS infected and affected.

Table no. 8.1

Distribution of the Respondents on the Basis of Their Opinion regarding Individuals' Self Vulnerability to HIV infection **N=300**

Response	No. of Respondents in Rajnagar Block				No. of Respondents in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	15 10%	42 28%	57 38%	114 76%	18 12%	39 26%	63 42%	120 80%
No	-	-	-	-	-	-	18 12%	-
Not sure	36 24%	-	-	36 24%	12 8%	-	-	12 8%
Total	51	42	57	150	30	39	81	150

In Rajnagar block 10% respondents having below matriculation, 28% having matriculation and above and 38% having degree and above qualification and in Rajkanika block 12% respondents having below matriculation & above, 26% having matriculation and 42% having degree and above qualification said that individual themselves were responsible for HIV infection. Twelve percent respondents of Rajkanika block said that individual were

not solely responsible for infection. But the rest of the respondents of both the blocks were not sure about individuals' self vulnerability of HIV infection.

Table no. 8.2

Distribution of the Respondents on the Basis of Their Knowledge regarding Preventive Methods of HIV Infection **N=300**

Preventive methods	No. of Respondents in Rajnagar Block			No. of Respondents in Rajkanika Block		
	Yes	No	Not sure	Yes	No	Not sure
A	114	-	-	120	-	-
B	114	-	-	120	-	-
C	114	-	-	120	-	-
D	114	-	15	87	-	33
E	81	-	33	87	-	33

N.B.:-

(A). Not having sex with infected persons.

(B). Practicing protected sex (using condoms)

(C). Self control.

(D). Not reusing the needles/syringe.

(E). Using safe blood.

Regarding methods of preventing HIV/AIDS it is important to observe that the knowledge about prevention of HIV/AIDS was directly related to the knowledge about modes of HIV transmission. To clarify if an individual knew about particular mode of HIV transmission then the preventive method for that particular mode was likely to be known and one can avoid the transmission by following that method. For example : Individuals who knew that AIDS was caused by unprotected sexual contact, blood transfusion with infected blood and sharing the contaminated needles were also more likely to know the preventive aspects for these modes. Similarly individuals who did not know the AIDS could also be transmitted from an HIV positive pregnant woman to her unborn child were obviously not aware that giving antiretroviral drug (Azidothy Midine-AZT) during pregnancy could reduce the chances of mother to child transmission (MTCT).

Out of 150 respondents of Rajnagar block 114 respondents and out of 150 respondents of Rajkanika block 120 respondents said that individuals themselves were responsible for their own HIV positive status. They may avoid HIV transmission by certain preventive methods. All the 114 respondents of Rajnagar block and 120 respondents of Rajkanika block said that one can avoid HIV transmission by not having sex with HIV infected person and practicing protected sex that was using condoms during sexual relation and through exercising self control. But 99 respondents of Rajnagar block and 87 respondents of Rajkanika block approved another preventive method as not reusing the needle/ syringe to avoid HIV transmission and the rest of the respondents of the block were not sure about that method avoidance. In Rajnagar block 81 respondents and in Rajkanika block 87 respondents said that individual can avoid HIV transmission by using safe blood, i.e. HIV free blood. But the rest of the respondents were not sure about that method protecting the HIV transmission.

Table no. 8.3

Distribution of the Rspondents on the Basis of Their Opinion regarding Voluntary Testing of Blood in Hospital N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	15 10%	42 28%	57 38%	114 76%	18 12%	39 26%	81 54%	138 92%
No	36 24%	-	-	36 24%	12 8%	-	-	12 8%
Not sure	-	-	-	-	-	--	-	-
Total	51 34%	42 28%	57 38%	150	30 20%	39 26%	81 54%	150

From this table opinion of respondents regarding voluntary testing of blood in hospital was known. In Rajnagar block 10% respondents having below matriculation, 28% having matriculation and above and 38% having degree and above qualification said that voluntary testing of blood of the individual in hospital was essential. Likewise in R. K block 12%

below matriculate, 26% matriculate and above and 54% degree and above qualified respondents were in favour of voluntary testing of blood in hospital to know the HIV status of the individual. The rest of the respondents in both the blocks were not in favour of voluntary testing of blood in hospital.

Table No.8.4

Distribution of the Respondents on the Basis of Their Opinion regarding Mandatory HIV Testing of Blood N=300

Response	No. of Respondents in Rajnagar Block				No. of Respondents in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	30 20%	15 10%	33 22%	78 52%	-	12 8%	33 22%	45 30%
No	6 12%	12 8%	24 16%	42 28%	-	12 8%	18 12%	30 20%
Not sure	15 10%	15 10%	-	30 20%	30 20%	15 10%	30 20%	75 50%
Total	51	42	57	150	30	39	81	150

Under this study 20% below matriculate respondents, 10% matriculate and above and 22% degree and above qualified respondents of Rajnagar block said that HIV testing should be mandatory for all. In Rajkanika block 8% matriculate and above and 20% degree and above qualified respondents said that HIV testing should be mandatory for all. The other 28% respondents of Rajnagar block and 20% respondents of Rajkanika block in total belonging to all educational category were not in favour of mandatory HIV testing of blood for all people and the rest of the respondents were not sure whether HIV testing of blood is mandatory or not.

HIV testing of blood, which is done compulsorily without any consent, is known as mandatory testing. This method of testing is not recommended. It is against Human Rights and Fundamental Rights of the individuals. Testing against the will of any person leads to

many problems. Patients may not come to the health care system if they know that they will be checked for HIV. The fear and stigma of the disease is enough to prevent from going to a hospital. Mandatory HIV testing is not justified. Our country follows this principle. Mandatory testing is done on all blood and blood products before these were transfused. Law requires that a unit of blood is tested but not an individual compulsorily. The donor is not informed of the test. This is done because the recipient should always receive only uninfected blood.

The others situation where mandatory testing can be done, is among the pregnant woman in order to prevent mother to child transmission (MTCT). A mandatory testing will help to identify mothers who are at risk and provide them with prophylaxis.

Table No. 8.5

Distribution of the Respondents on the Basis of Their Opinion regarding Proper Treatment of HIV Patients in the Hospital N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	36 24%	-	18 12%	54 36%	-	12 8%	36 24%	48 32%
No	-	27 18%	24 16%	51 34%	18 12%	27 18%	45 30%	90 60%
Not sure	15 10%	15 10%	15 10%	45 30%	12 8%	-	-	12 8%
Total	51	42	57	150	30	39	81	150

In Rajnagar block 24% below matriculation and 12% degree and above qualified respondents and in Rajkanika block 8% matriculation and above and 24% degree and above qualified respondents said that the HIV infected persons were provided with proper treatment

in the hospitals. But majority of the respondents in both the blocks i.e. 34% respondents in Rajnagar block & 60% respondents in Rajkanika block were not satisfied with the treatment of HIV infected persons in the hospitals. They felt some sorts of negligence of the patients in the hospitals. The rest of the respondents were not sure about proper treatment of the HIV patients in the hospitals.

Table No. 8.6

Disclosure of HIV Infection by Health Care providers leads to Mistreatment of the Infected Persons N=300

Mistreatment by	No. in Rajnagar block				No. in Rajkanika block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
The spouse	36 24%	-	-	36 24%	-	-	-	-
Family member	-	15 10%	-	15 10%	-	-	-	--
Villagers	-	27 18%	27 18%	54 36%	9 6%		51 34%	60 40%
Other members of society	-	-	15 10%	15 10%	-	12 8%	15 10%	27 18%
Total	36	42	42	120 80%	9	12	66	87 58%

Since HIV is such a serious disease, much care should be taken to make a diagnosis. Emphasis should be laid on confidentiality. The right to confidentiality is one of the important rights of the patients. The information disclosed to a physician during the course of the relationship should be kept confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure to the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential information without the expressed consent of the patient, unless required do so by law.

A doctor's primary duty towards the patient is to maintain the confidentiality of information imparted by the patient. If confidentiality is either likely to or has been breached, the person has the right to go to court and sue for damages.

People living with HIV/AIDS (PLWHA) are often afraid of going to court to vindicate their rights for fear of their HIV status becoming public knowledge. The disclosure of HIV infection by the Health care providers leads to social ostracisation, discrimination and mistreatment of the infected patients. With this fear of discrimination and mistreatment, most of the persons do not go to the hospital for HIV testing of the blood. Sometimes this disclosure may become responsible for mistreatment of the infected persons in the family by the own spouse or other family members, in the villages by the villagers and friends and other members in society.

This table reveals the opinion of the respondents regarding some such mistreatment of infected after the disclosure of the person's HIV positive status. In Rajnagar block 24% respondents having below matriculation qualification said that the infected were mistreated by their own spouse, 10% having matric and above qualification said that the infected were mistreated by the other family members, 18% respondents having matric and above and another 18% respondents having degree and above qualification pointed out that such infected persons were mistreated by the villagers and 10% degree and above qualified respondents found other members in the society mistreating the infected persons. In Rajkanika block 6% respondents having below matriculation and 34% having degree and above education pointed out the mistreatment of the infected persons by the villagers. The other 8% matric and above qualified respondents and 10% degree and above qualified respondents found the mistreatment of HIV infected persons in society. None of the respondents of Rajkanika block found mistreatment of the infected persons by their own spouse or family members.

Table No. 8.7

Distribution of the Respondents on the Basis of Their Opinion regarding Discrimination of HIV/AIDS Infected N=300

Response	No. of Respondents in Rajnagar Block				No. of Respondents in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Should be discriminated	-	12 8%	-	12 8%	12 8%	-	-	12 8%
Should not be discriminated	15 10%	15 10%	57 36%	87 58%	9 6%	24 16%	81 54%	114 76%
Not sure	36 24%	15 10%	-	51 34%	9 6%	15 10%	-	24 16%
Total	51	42	57	150	30	39	81	150

The right to equal treatment is the fundamental right of all individuals. The law provides that a person may not be discriminated against on any ground of sex, religion, caste, creed descent or place of birth either socially or professionally by a Govt. run or controlled institution. Still there are a lot of stigma and discrimination attached with HIV/AIDS patients despite awareness programmes, and educational campaigns. There are growing social atrocities against HIV/AIDS infected patients. These persons being ostracized in society have undergone mental and physical trauma.

In this present study the researcher wanted to know the respondents' opinion regarding the discrimination of HIV/AIDS infected in society. In Rajnagar block only 8% matriculate respondents said that the patients should be discriminated in society .But majority of respondents belonged to degree and above category was not in favour of discrimination of HIV/AIDS patients. In total 34% of respondents of Rajnagar block were not sure about whether discrimination should be attached with infected persons.

In Rajkanika block 8% below matriculation qualified respondents were in favour of discrimination. Other 6% respondents having below matriculation, 16% matric and above and all the degree and above qualified respondents said that such patients should not be discriminated in society. In total 16% respondents in R. K. block were not sure about discrimination of HIV/AIDS infected persons in society.

Table No 8.8
Statement of the Respondents in Support of Discrimination for PLWHA in Society
N=300

PLWHAS are discriminated because	No. of respondents in Rajnagar Block			No. of respondents in Rajkanika Block		
	Below matric	Matric and above	Degree and above	Below matric	Matric and above	Degree and above
A	-	-	-	-	-	-
B	-	-	-	-	-	-
C	-	-	-	-	-	-
D	-	-	-	-	-	-
E	-	12 8%	-	12 8%	-	-

N.B:- **(A) The infected has done immoral action.**
(B) Discrimination as punishment for immoral action.
(C) A warning to check immoral action in society.
(D) Infection may spread to healthy person.
(E) All

Out of 150 respondents in R. N. block only 12 matriculation and above qualified respondents that was 8% of the total respondents and in R. K. block out of 150 respondents also 8% of the respondents below matriculation qualification level said that HIV infected persons should be discriminated in society. They should be discriminated because they had done immoral action. This discrimination of PLWHAS in society was treated as warning for the infected persons and for others to check immoral action. Other healthy persons may be saved from infection through self control in the fear of being discriminated and ostracized in the society for such immoral action.

Table No 8.9

Statement of Attitude of the Respondents who are not in favour of Discrimination of PLWHA in Society **N=300**

PLWHAS should not be discriminated because	No. in Rajnagar Block			No. in Rajkanika Block		
	Below matric	Matric and above	Degree and above	Below matric	Matric and above	Degree and above
A	-	15	-	-	-	-
B	-	-	-	-	-	-
C	-	-	-	-	-	-
D	-	-	-	-	-	-
E	15	-	57	9	24	81

N.B:- (A) They should have the same sight as normal persons.

(B) Discriminated may lead to more high risk behaviour.

(C) Innocent persons may suffer having no fault of theirs.

(D) Discrimination may bring isolation leading to suicide.

(E) All.

Majority of the respondents under this study were not in favour of discrimination of PLWHAS in society. As table No.8.7 shows in Rajkanika block 87 respondents out of 150 and in Rajkanika block 114 respondents out of 150 respondents in total were not in favour of discrimination of the HIV/AIDS infected persons in society. This table shows their attitude towards these PLWHAS as why they should not be discriminated in society. On the whole, they said that the people living with HIV/AIDS should not be discriminated in society because they should have the same right as other normal persons; discrimination may lead to more high risk behaviour, sometimes innocent persons may suffer having no fault of theirs and discrimination may bring isolation leading to suicide. Only 15 of Rajnagar block matriculate and above qualified respondents said that PLWHA should not be discriminated in the society because they have the same right as the normal persons. All other respondents who were against discrimination had supported all of these above statements of not discriminating PLWHAS in society.

Table no. 8.10

Distribution of the Respondents on the Basis of Their Opinion regarding Discrimination of the Children of PLWHAS in Society N=300

Opinion of the respondents	No. of respondents in Rajnagar Block				No. of respondents in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	-	-	-	-	-	-	-	-
No	15	30	57	102	30	24	81	135
Not sure	36	12	-	48	-	15	-	15
Total	51	42	57	150	30	39	81	150

Newspapers and television media are replete with stomach churning stories of HIV positive children being ostracized by their peers and prevented from attending school by parents of other children. HIV positive children were not allowed to study with HIV negative children because of the risk of HIV transmission through casual contact. Sometimes even the innocent children of HIV+ parents were ostracized in the school without having any fault of theirs. They were not allowed to take admission in the school where HIV- children read. They were discriminated in School in various ways due to lack of awareness and misconception regarding transmission of the virus of this deadly epidemic.

This situation made researcher to undertake the study about discrimination of such innocent children in the universe under study. This table reveals the opinion of the respondents regarding discrimination of the children of PLWHA in society. None of the respondents of the blocks were in favour of discrimination of the children of PLWHA. Thirty Six respondents having below matriculation and 12 having matriculation and above qualification of Rajnagar block and 15 respondents of Rajkanika block were unable to give their opinion regarding discrimination of the children of PLWHA due to lack of awareness about the transmission of the disease. The rest of the respondents including all the degree and above qualified respondents of both the blocks opined not to discriminate the innocent children in society.

Table No. 8.11

Attitude of the respondents who are not favour of discrimination of the children of PLWHAS **N=300**

Statement of the Respondents	No. in Rajnagar Block			No. in Rajkanika Block		
	Below matric	Matric and above	Degree and above	Below matric	Matric and above	Degree and above
A	-	15	15	-	-	-
B	-	-	-	-	-	-
C	-	-	-	-	-	-
D	-	-	-	-	-	-
E	15	15	42	30	24	81

N.B.:

(A) The children have not committed any offence.

(B) They have equal right as of normal children.

(C) The children of person having other diseases are not discriminated.

(D) Child hood depression may lead to aggressive activities in future.

(E) All.

This table reveals that 15 resdpondents having matriculation and above and 15 respondents having degree and above qualification of Rajnagar block viewed that the children of PLWHA should not be discriminated in the society because they have not committed any offence, on the one hand and on the other, they have equal rights as of other normal children, the children of persons having other diseases are not discriminated and unnecessary discrimination during child hood may lead to early depression and aggressive activities in future.

Findings:

In this chapter the researcher has tried to know the attitude and perception of the respondents towards HIV/AIDS infected patients and their children. Informations have been collected from the respondents regarding self-vulnerability of individuals to HIV infection, awareness about preventive method of HIV transmission, voluntary /mandatory testing of blood to know the HIV status of general masses, whether the infected and their children were punished in the society in the form of discrimination or not.

From the present study it was known that the individual themselves were responsible for HIV infection. Majority of the respondents of both the blocks were in favour of this statement. They said that as the individual themselves were responsible for HIV infection, they can avoid the infection by certain preventive method like not having sex with infected persons, practicing protected sex that was using condoms during sexual intercourse, exercising self control, not reusing needles or syringe and using safe blood and HIV free blood for the transmission wherever necessary. Most of respondents opined for the voluntary testing of blood in the hospital to know HIV status. Even most of them were in favour of mandatory blood testing of all people though it was against human rights.

Comparatively more respondents were not satisfied with the treatment of HIV/AIDS patients in hospital. Almost all the respondents agreed that the hospital maintained confidentiality of the HIV status of the patients. Disclosure of HIV status by health care providers led to more or less mistreatment of the infected by the spouse, family members, villagers and other members of society. In maximum cases mistreatment of the infected found by the villagers in both the blocks under study. But the majority of the respondents of the blocks especially all the degree and above qualified respondents opined that the HIV /AIDS infected should not be discriminated in the society. None of the respondents perceived HIV infection or AIDS due to one's sin committed in previous or present life or as punishment by the god for immoral action performed by the patients.

Only a few less educated respondents of both the blocks were in support of discrimination of PLWHA (people living with HIV/AIDS) in society because the infected has done immoral action and discrimination was treated as punishment for immoral action in society. If they were not discriminated the infection may spread to healthy persons. But the attitude of majority of respondents was positive towards PLWHAS. They had argued that the PLWHAS should not be discriminated in society because they have the same right as of normal persons. Any sorts of discrimination of PLWHAS may lead to more high risk behaviour. Innocent persons may suffer having no fault of theirs. Some time discriminated persons due to isolation may committee suicide to avoid such unpleasant situation. None of the respondents were in support of discrimination of children of PLWHAS in society. All of them had positive attitude towards the innocent children. The innocent children have not committed any offence. They have equal rights as of other normal children. Through children of persons suffering from other diseases were not discriminated why such social punishment to be given to the children of the PLWHAS. They have argued that if the children were given such social punishment as discrimination and ostracisation they may be depressed. That childhood depression may lead to aggressive activities in future.

Though none of the respondent perceived HIV infection or AIDS occurred due to one's sin committed in previous or present life or as punishment by God for immoral action performed by the parents earlier, the majority of the respondents said that the individuals themselves were responsible (self-vulnerability) for HIV infection.

This attitude of the respondents towards HIV/AIDS infection is reflected by the doctrine of karma. The theory of karma is the central theme of Srimad Bhagabat Gita. “As he sows, so he reaps” is the unfailing law. The great Indian philosopher Dr. S. Radhakrishnan views that man is the maker of his own destiny. This self vulnerability of HIV/AIDS infection emphasizes that man is solely responsible for own infection which is not applicable for infection of any other disease. As this deadly disease HIV/AIDS is transmitted mainly through the sexual relationship, man can avoid this infection through having protected sex with HIV infected partners.That means a person, whether man or woman can prevent himself / herself from HIV infection in accordance with his / her own wishes. Whether one is infected by HIV or not it depends on oneself. This supports “the Doctrine of karma”, as man is maker of his own destiny.

References:

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Chapter- IX
FAMILY CARE AND SOCIAL CARE

CHAPTER-IX

FAMILY CARE AND SOCIAL CARE

"It is better to die than to live with the curse of being socially ostracized." When a person is diagnosed to be HIV positive, he will have several emotional reactions like fear, anxiety, guilt, denial, anger, depression, shock, grief etc. There is fear of death of the unknown, of losing everything, anxiety for himself, his future and the future of his dependents. He is anxious about his health and about the response of the society. He feels guilty about his infection, of infecting others and about being a burden on his loved ones. There may be anger at the powerlessness and hopelessness that accompanies an incurable illness and at the negative reaction of the family, friends and society. As a result, the patient may become abusive, aggressive and non-cooperative. Depression stems from the patient living his guilt and anger towards himself. There will be sorrow, helplessness, emptiness and despondence. There may be intense grief at having brought so-much trauma into a family, at loss of life and at having positive children.

All these emotions can occur one at a time or altogether. There may be lack of self esteem, feeling of unworthiness, a desire to attempt suicide. These feelings may worsen as the disease progress, because of associated deterioration in physical appearance.

When an individual in the family becomes HIV positive and his family comes to know about it, the concerns in the family are considerable. Many families because of ignorance immediately tend to reject the individual and stigmatize him. They feel that the person has brought a bad name to the family. They are hurt and they show their hurt and anger. They assume that he got the disease through sex and sex is a taboo topic in our country. Another major concern of the family is that by living with a person who is HIV positive, they also will get the infection. The fear of death from this disease is so great that they advise or force them to leave the house and live separately or put him in an institution that cares for HIV positive people.

We find many ignorant families dumping AIDS victims. One such example of a woman suffering from AIDS was left abandoned in a hospital in Jagtsinghpur by her in-laws after they come to know about her disease. Banita Biswal (32) wife of Bijay Biswal of Bailo village in Jagatsinghpur district was dumped by her in-laws and some relatives in the

Jagatsinghpur district hospital. Her mother-in-law, Sanjukta (55) said, “My daughter-in-law was dying overshadowed by discrimination. We are facing discrimination on account of her disease. We are made to feel like Parihas”.

Ever since Banita’s family abandoned her, she had been shifted to community care centre run by Utkal Sevak Samaj, Cuttack. State AIDS cell of Bhubaneswar provided funds to the centre. She has been depending on the staff of the district AIDS cell to spare some food for her and counting her last days. (The Times of India, 22-08-2008).

Families also tend to reject the wife of a man especially if he is recently married. In many instances, the wife is blamed as the primary cause for the misfortunes that have been fallen the family. They consider her the curse. They blame her for his illness; though in a majority of cases the opposite is (the wife gets the disease from her husband). According to community based care and support project investigator, a considerable number of male migrant workers engage in sexual encounters with women other than their wives while working away from their home. After their return these men recommence sexual relation with their wives. Usually no precautions, for example, use of condom are taken either with the wives or with other women. The wives are thus exposed to the risk of HIV/AIDS transmission. An interesting aspect of this situation is that “When men are infected, their wives are suspected of infidelity; when women are infected, they are assumed to have had multiple partners” – according to Bledsoe (Encyclopedia on HIV/AIDS: problems and control, C.P.Yadav, vol-1, p-230).

In many instances, the HIV positive person is young and the sole earning member in the family. The families worry about how they will cope with the loss, the emotional and physical loss of loved one. They worry about the survival of the family without regular source of income after their death. They also worry about who will care for them and for their widowed wives and orphaned children. They worry about looking after them at home when they are ill. If hospitals will not take care of them, how they will take care of them?

In India many families are completely isolated from the support system that are available very often, the family is completely isolated in society itself and the family has to cope with several factors at one time and that of dealing with a life threatening illness at home and stigmatization and rejection from society.

But in some cases, unlike the western countries, the family support system in India is very strong. “Indian families always have strong support for struggling members, but more needs to be done about educating families about HIV/AIDS and making them speak more freely about the dangers of having the virus and how to avoid infection”, Poppye and Plainedl (Brijbhusan Singh, “ Misconceptions of HIV/AIDS” P-197). In many instances, the families are very supportive, once they are educated about the disease. Often the HIV positive person requests the help of counsellor in informing his wife and other family members. The counsellor can help to ease the situation and clarify the doubts and questions then and there. Therefore it is needed to educate the family about the disease and its transmission, to clarify doubts about the disease, stigma, reactions to disclosure of diagnosis and risk factors, fears of contagion, reactions to anticipated death of the family members and other losses, shame, impulse to reject etc.

“1994” being the International Year of the Family WHO chose the theme “AIDS and The Family”, for World AIDS Day. The family can play a pivotal role in controlling the spread of HIV/AIDS. The family can help to prevent promiscuous behaviour by grooming the youth well, imbibing values and cultural norms and strengthening family ties. Family also plays important role in providing support and understanding especially to PLWHA. Only when all members of human kind join hands as one family, will this dreadful scourge be wiped out from surface of the earth. Families whose bonds are based on love , trust and nurturing and openness are best placed to protect their members from infection and give compassionate care and support to those affected by HIV/AIDS”, says Dr. Hiroshi Nakajima, Director General of World Health Organization.

“It is in the families, the young people can learn about the importance of safe behaviour and non discrimination” says Dr. Michale H Merson, Executive Director of Global Program on AIDS. (Understanding AIDS; Myths, Efforts and Achievements – Shalina Mehta and K Sodhi).

A general fear of AIDS as an unknown phenomenon easily ends up with society condemning those already infected. There could rejection of the individual and family from

lack of awareness on the part of the community. By marginalizing and isolating those infected or at risk of infection it would practically drive the disease underground, thus making effective health education and prevention all the more difficult.

The ignorant society and community impose stigma and restriction on the HIV positive persons and their family members both on adult and children. Social ostracizations have profound impact on their social and economic lives. It threatens basic human rights and invades the right to privacy and human dignity. The HIV positive persons feel socially isolated and alienated from him, from family members and society becomes psychologically frustrated and increase tendency towards committing suicide.

During this time family care and social care is very much essential. Society is expected to provide care, support, love and affection to the infected people. Society and community are expected to extend their helping hand towards the HIV infected persons. As a result of which they may lead normal lives and live with human dignity with others.

Giving importance to the role of society in providing support and care to the HIV/AIDS affected and infected it is said, “If our society cannot save a few people who are HIV/AIDS affected, it may not be able to save a many who are healthy”. It means providing family care and social support to people living with HIV/AIDS (PLWHA) is very much essential to prevent and protect a many who are healthy. People living with HIV/AIDS (PLWHA) require care and support at various levels such as – home, community, clinics and hospitals thus necessitating a continuum of care. Apart from the therapeutic measures which treat opportunistic infections, supportive measures are also essential to combat stress and stigma. National AIDS Control Organization (NACO) plans to train family members, community volunteers, health care workers and doctors so as to reduce the social and psychological impact of AIDS and improve the quality of life of PLWHAs.

In Manipur, a “Continuum care” project initiated jointly by NACO, WHO and OXFAM has been a success (NACO 1996). The project provides care and support to PLWHA through a network of home, community and healthcare services as shown in the figure.

Continuum of Care

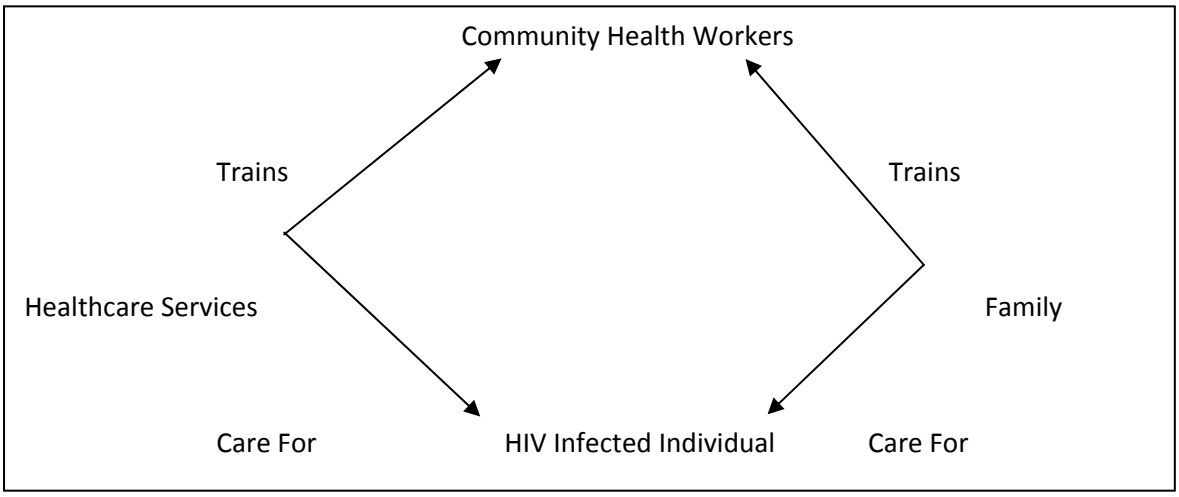

Figure No.9.1
"AIDS awareness Through Community participation" – Meenu Sharma, P – 74.

Similar projects have also been taken up in Tamilnadu and Maharashtra, since they represent the worst affected areas. At present twelve care and support centres which aim to provide low cost community care for people living with HIV/AIDS and their families are operating in different states. (NACO Dec 1st, 2002)

Sehgal (1997) while describing ways to reduce the social and personal impact of the HIV infection observes that to reduce discrimination and marginalization of HIV positive / AIDS cases, family or community, education and counseling services are necessary. One of the finest examples of peer education and support system is provided by self help therapy. Groups formed by people living with HIV/AIDS in various countries which are using self help groups techniques to give mutual support to each other. Similarly "Art Therapy Support Groups" are trying to reinforce self esteem of PLWHA. The emergence of PLWHA as a new social movement is significant as it reflects an increasing sense of bonding and unity among HIV positive people.

In India, NACO under National AIDS Control Organization's community care and support initiative, the first community care centre for PLWHA has inaugurated in New Delhi on 6th April 2000. The centre called Michael's care home is collaborative effort by NACO and Sahara which houses HIV infected people with dignity and without stigmatization. The home makes effort to train families to take care of their loved ones who are HIV positive in

an effective and supportive manner. Six similar projects are underway on pilot basis (NACO, April 2000).

Experiences of various researchers have shown that reliance on energy, commitment and spirit of group members of various communities can be used to evolve an appropriate operational model for implementing a local initiative (Nowlan, et.al. 1996). Similarly Chipo (1996) observed that community counselling could be effectively help in facilitating the community to take responsibility for change. Chipo further states, “It is important to note the influence that change in one community can have in another community. The process is an indicator of behavioural change and sustainability. Since community participation can play a vital role in planning, implementing and sustaining HIV/AIDS prevention efforts; the same needs to be ensured for carrying out effective interventions.”

People living with HIV/AIDS require a wide range of service including psychological, social, legal and clinical ones. Care and support programs must therefore be developed to respond to these needs and demands, complicating the situation, these needs reflect an environment in both industrialized and resource constrained settings in which stigma, discrimination, fear, neglect and impoverishment surround HIV/AIDS to various degrees in the community, work place and health care settings. To address these needs HIV/AIDS care and support programs should have the objectives of:

1. Ensuring equitable access to diagnosis, healthcare, pharmaceuticals and comprehensive supportive services;
2. Reducing morbidity and mortality from HIV/AIDS and related complications;
3. Promoting opportunities for preventing HIV transmission with-in the delivery of care and support services; and
4. Improving the quality of life of both adults and children living with HIV/AIDS and their families.

Providing care to PLWHA and to their families requires a broad range of services that include not only clinical care focusing on diagnosis and treatment but also supportive and complementary services to ensure that adequate nutrition, psychological, social and daily

living care supports are available. Efforts to prevent HIV transmission also need to be strengthened whenever opportunities arise. Comprehensive HIV/AIDS care must include:

1. Clinical care for everyone;
2. Psychological support;
3. Socio-economic support;
4. Involvement of PLWHAS and their families; and
5. Respect for human rights and legal needs.

(PP – 261, V. Ramamurthy – "Guidance and Counseling of HIV/AIDS)

While the provision of care and support in facilities / care homes is fundamental to ensuring effective care, PLWHA'S actual experience of care is also significant. Hence PLWHA'S experience of care and support can be diverted into four broad areas:

1. PLWHAS' contact with experience of human and physical care;
2. PLWHAS' cognition that is the level to which he/she understands what is happening to him or her and why?
3. The respect, dignity and equity of care each PLWHA receives during his/her life and finally
4. The emotional support he/she receives during his/her life.

Another example, many factors in the living environment can include stigma and discrimination. Fear, stress and anxiety may be increased by the living environment. That is emotional support, in this context refers not only to a PLWHA'S access to his/her social and emotional support given by his or her family members.

Care and support was understood as a behavioural change program to move people through early levels of awareness, consideration of change towards safe sex and the maintenance of these new practices aided by a wider normative acceptance of condom use in society. However care and support projects overall aim to create an enabling environment for improved care and support for PLWHAS. (C.P.Yadav, Vol-1).

Therefore, both the therapeutic measures which treat opportunistic infection as well as the supportive measures by the family and society which combat emotional stress and social stigma , discrimination and ostraciation are very essential for healthy and Aids free society.

Table no-9.1

Distribution of the Respondents on the Basis of Their of Views of respondents regarding Isolation of HIV/AIDS Patients from The Family. N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Agree	36	12	-	48 32%	12	15	-	27 18%
Donot agree	15	30	57	102 68%	18	24	81	123 82%
Total	51	42	57	150	30	39	81	150

This table reveals that 68% of the respondents of Rajnagar block and 82% respondents of Rajkanika block did not agree that the HIV positive persons should be isolated from the family. They should remain within the family with all other family members. Thirty six below matriculate and twelve matriculates and above respondents of RAJNAGAR block and 12 below matriculate and 15 matric and above qualified respondents of RAJKANIKA block agreed that the HIV positive persons should be isolated from the family and its members.

Table no-9.2

Statement in support of isolation of HIV positive person from Family N=300

Statement	No. of Respondents in Rajnagar Block			No. of Respondents in Rajkanika Block		
	Below Matriculation	Matriculation & above	Degree & above	Below Matriculation	Matriculation & above	Degree & above
A	9	12	-	-	-	-
B	-	-	-	-	-	-
C	21	-	-	-	15	-
D	6	-	-	12	-	-
E	-	-	-	-	-	-
Total	36	12	-	12	15	-

N.B:-

A. HIV can be transmitted to other family members.

B. HIV can be transmitted by using same utensils and lavatory.

C. Family members may be discriminated by others in the village.

D. Presence of HIV infected persons may affect the family prestige.

E. All.

Out of 150 respondents in Rajnagar block 36 respondents having below matric and 12respondents having matriculation and above qualification agreed that HIV infected persons must be isolated from their family. Nine respondents having below matriculation and 12 having matric and above qualification said that HIV infected members should be isolated from family because HIV can be transmitted to other family members if they live within the family with others.

Twenty one respondents having below matriculation qualification said that family members may be discriminted by the villagers if the HIV infected persons live within their family. The rest 6 respondets viewed that the HIV infected persons should be isolated from the family; otherwise their presence in the family may affect the prestige of whole family. In Rajkanika block out of 150 respondents only 27 in total agreed that HIV infected person should be isolated from their own family. Among these respondents 12 having below matric qualification viewed that the HIV infected persons should be isolated from their own family because their presence may affect the prestige of the whole family. The rest 15 respondents having matric and above qualification said that these infected persons should leave their own family, otherwise the whole family members may be discriminated and ostracised in the village for them.

Table -9.3

Distribution of the Respondents on the Basis of Their Opinion Regarding free movement of HIV Infected Persons with in the Community N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	15 10%	12 8%	-	27 18%	12 8%	15 10%	-	27 18%
No	36 24%	30 20%	57 38%	123 82%	18 12%	24 16%	81 54%	123 82%
Not sure	-	-	-	-	-	-	-	-
Total	51	42	57	150	30	39	81	150

This table shows the opinion of the respondents regarding free movement of HIV infected persons within the community. In both the blocks under study 18% of respondents were in favour of free movement of HIV/AIDS patients with the community, but majority of the respondents in both the blocks viewed that they should not move freely within the community. Even the more educated respondents having degree and above qualification said that the HIV infected persons should not move freely within the community. That means they have fear in their minds regarding transmission of HIV/AIDs. They thought that HIV/AIDS may spread throughout community by these infected persons. So they should be discriminated and ostracized within the community.

Table -9.4

Distribution of the Respondents on the Basis of their Opinion regarding Voluntary Leave of HIV Infected Patients from Village N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Should leave	30 20%	12 8%	-	42 28%	12 8%	15 10%	-	27 18%
Should not leave	21 14%	30 20%	57 38%	108 72%	18 12%	24 16%	81 54%	123 82%
Total	51	42	57	150	30	39	81	150

All the highly educated respondents of both the blocks viewed that HIV infected persons should not voluntarily leave their village to save other from infection. In Rajnagar block 72% and in Rajkanika block 82% respondents in total opined that the infected person should not leave their villages. Only 20% respondents having below matric and 8% having matric and above qualification in Rajkanika block and 8% respondents having below matric and 10% having matric and above qualification in Rajnagar block said that the HIV infected persons should voluntarily leave their village in order to save healthy person from infection.

Table no-9.5

Distribution of the Respondents on the Basis of Their Opinion regarding Discrimination of HIV/AIDS Patients in Community N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Should be discriminated	30 20%	12 8%	-	42 28%	12 8%	15 10%	-	27 18%
Should not be discriminated	15 10%	30 20%	57 38%	102 68%	18 12%	24 16%	81 54%	123 82%
No opinion	6 4%	-	-	6 4%	-	-	-	-
Total	51	42	57	150	30	39	81	150

From this table it was known that only a few respondents having below matric and above qualification of both the blocks were in support of discrimination of the HIV/AIDS patients in their own community. But the majority of respondents in both the blocks including all the highly educated (degree and above) respondents opined that the HIV/AIDS patients should not be discriminated in the community.

Table no-9.6

Distribution of the Respondents on the Basis of Their Opininon regarding Equal Right of HIV/AIDS Patients N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Agree	15 10%	30 20%	57 38%	102 68%	18 12%	24 16%	81 54%	123 82%
Disagree	30 20%	12 8%	-	42 28%	12 8%	15 10%	-	27 18%
No opinion	6 2%	-	-	6 4%	-	-	-	-
Total	51	42	57	150	30	39	81	150

The right to equality is the fundamental right of all Indian citizens. All are equal in the eyes of law. All Indian citizens irrespective of their caste, sex, tribe, race, religion and place of birth or any of them deserve same rights. So that no person because of infected by any disease is prevented from any place or denied of any right or discriminated against or ostracized in family, community and society.

This table reveals the opinion of the respondents regarding equal right of HIV/AIDS infected/affected persons with other normal persons. In Rajnagar block 10% respondents having below matriculation, 20% having matric and above and all the degree and above qualified respondents agreed that HIV/AIDS infected and affected persons deserve the same rights like other normal persons in society.

In Rajkanika block 12% respondents having below matriculation, 16% having matriculation and above and all the degree and above qualified respondents agreed that the HIV/AIDS infected/affected persons deserve the same rights like other normal persons in society. That means the majority of the respondents in both the blocks agreed that the

HIV/AIDS infected persons must have the same rights with other normal person. In Rajnagar block 28% respondents and in Rajkanika block 18% respondents in total disagreed with this statement.

Table no -9.7

Statement in Support of having Same Rights of HIV/AIDS Infected/Affected with Normal Persons N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
A	15 10%	15 10%	-	30	18 12%	12 8%	-	30
B	-	15 10%	30 20%	45	-	12 8%	60 40%	72
C	-	-	27 18%	27	-	-	21 14%	21
Total	15	30	57	102	18	24	81	123

N.B:

A. All persons have equal right to live in any place.

B. Person suffering from other diseases are not ostracized in society.

C. The affected persons feel psychologically secured and free from tensions having equal rights.

This table supplies informations about the supportive statements of the respondents of both the blocks with regards to having same rights of all HIV/AIDS infected/affected patients with other normal persons.

In Rajnagar block out of 150 respondents 102 respondents and in Rajkanika blocks out of 150 respondents 123 respondents in total agreed that equal rights in all cases should be given to HIV/AIDS affected/infected patienst like other normal persons.

Ten percent respondents having below matric and 10% having matric and above qualification in Rajnagar block and 12% respondents having below matric and 8% having matric and above qualification in Rajkanika block said that the HIV/AIDS infected/affected should have the same right with others to live in any place. The other 10% respondents

having matric and above and 20% having degree and above qualification in Rajnagar block and 8% respondents having matric and above and 40% degree and above qualification in Rajkanika block opined that HIV/AIDS infected/affected deserve same right with other normal persons because persons suffering from other diseases were not ostracized in society. The rest 18% of the respondents of Rajnagar block and 14% respondents of Rajkanika block having degree and above qualification viewed that such persons must have same rights through which they feel psychologically secured and free from tension.

Table no-9.8

Distribution of the Respondents on the Basis of Their Opinion regarding the Necessity of Family Care for Treatment of HIV/AIDS Patients. N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	15 10%	42 28%	57 38%	114 76%	30 20%	24 16%	81 54%	135 90%
No	36 24%	-	-	36 24%	-	15 10%	-	15 10
Not sure	-	-	-	-	-	-	-	-
Total	51	42	57	150	30	39	81	150

Family care is very much necessary for treatment of HIV/AIDS infected persons. So that providing care and support to people living with HIV/AIDS (PLWHA) are included in National Aids Control Programme (NACP) Phase-ii as an integral component. People living with HIV/AIDS require care and support at various levels such as home, community, clinics and hospitals thus necessitating a continuum of care.

This table shows the opinion of the respondents regarding necessity of family care for HIV/AIDS patients. In Rajnagar block 10% respondents having below matriculation all the respondents having matriculation and above and all the respondents having degree and above qualification said that family care was very necessary for the treatment of HIV/AIDS infected persons. In Rajnagar block 20% respondents having below matriculation, 16% having matric and above and 54%, i.e all the respondents having ‘degree and above’ qualification viewed

that family care was necessary for the treatment of HIV/AIDS infected person. This shows that highly educated respondents realized the responsibility of the family members for care and treatment of HIV/AIDS infected persons. The others negatively responded to the necessity of family care for their treatment.

Table no-9.9

Distribuion of the Respondents on the Basis of Their Opinion regarding Family Care providing Moral Support to the Patients. N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	36 24%	42 28%	57 38%	135	30 20%	24 16%	81 54%	135
No	6 4%	-	-	6	-	15 10%	-	15
Not sure	9 6%	-	-	9	-	-	-	-
Total	51	42	57	150	30	39	81	150

This table reveals the respondents' opinion regarding the necessity of care and moral support of the spouse and children of HIV/AIDS infected persons for early recovery. Unlike the persons suffered from other diseases, persons affected by HIV/AIDS have lost moral support because this deadly disease, HIV/AIDS has been mainly transmitted through sexual relation ship with infected persons; the infected persons themselves felt shame of doing immoral action like this. Whether they were solely responsible for their infection or not, they felt as if they were hated by others, discriminated in family and ostracized in community and society. Such feelings made them isolated from others. In such a crucial circumstance the infected needs the care and support from their own spouse, off springs and siblings.

In Rajnagar block 36 respondents having below matriculation and all the respondents having matric and above and degree and above qualification opined that family care and particularly the care of own spouse and children provided moral support to patients for recovery. In R.K. block all the below matriculate and all the degree and above educated respondents and 16% matriculate and above respondents also support this statement. The

majority of the respondents in both the blocks agreed with this, that the care and support of the family members particularly of their own spouse and children are very much essential.

Table no-9.10

Distribution of the Respondents on the Basis of Their Opinion regarding the Role of Neighbours, Friends and other Members of Society Providing Moral Support N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	30 20%	30 20%	57 38%	117 78%	21 14%	24 16%	81 54%	126 84%
No	15 10%	12 8%	-	27 18%	9 6%	15 10%	-	24 16%
Not sure	6 4%	-	-	6 4%	-	-	-	-
Total	51	42	57	150	30	39	81	150

As this deadly disease HIV/AIDS is found to be associated with social stigma and discrimination, the role of neighbours, friends and other members of society is very important in providing moral support to those persons infected by this disease. If neighbours and other members of society discriminate those infected persons it will become intolerable for them to live being physically infected, socially ostracized and emotionally stressed. So moral support, is expected for those infected patients from neighbours, friends, and all other members of society.

This table revels the ‘respondents’ opinion regarding the role of neighbours, friends and others. In R.N. block 20% respondents having below matric, 20% having matric and above and all other respondents having degree and above qualification positively responded for the role of neighbours, friends and others providing moral supports to the HIV/AIDS patients. In R K block 14% respondents having below matric qualification, 16% having matric and above and 54% i.e.all other respondents having degree and above education all positively responded to role of neighbours, friends and others in society providing moral support to these patients. The rest of other respondents in both the blocks said that neighbours, friends and others in society did not have any role in providig moral support to the patients.

This shows that all the highly educated respondents gave importance to the neighbours, friends and other members in society playing their role in providing moral support to the patients which is equally important to cure the patients with medical treatment.

Table no-9.11

Respondents' finding about sympathetic behaviour of the villagers towards PLWHA

N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	-	30 20%	15 10%	45 30%	9 6%	12 8%	24 16%	45 30%
No	51 34%	12 8%	30 20%	93 62%	21 14%	27 18%	36 24%	84 56%
Not sure	-	-	12 8%	12 8%	-	-	21 14%	21 14%
Total	51	42	57	150	30	39	81	150

This table shows that 30% of respondents in each block found sympathetic behaviour of the villagers towards the people living with HIV/AIDS (PLWHA). But majority of the respondents of each block i.e. 62% in Rajnagar block and 56% in Rajkanika block responded that they did not find sympathetic behaviour of the villagers towards PLWHA. The rest of the respondents were not sure about the behaviour pattern of the villagers towards them.

Table no-9.12

Distribution of the Respondents on the Basis of Their Opinion regarding Social Support and Care **N=300**

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	-	30 20%	42 28%	72 48%	15 10%	24 16%	60 40%	99 66%
No	36 24%	12 8%	15 10%	63 42%	15 10%	15 10%	21 14%	51 34%
Not sure	15 10%	-	-	15 10%	-	-	-	-
Total	51	42	57	150	30	39	81	150

This table reveals whether society should extend care and support to HIV/AIDS affected persons. In Rajnagar block 48% respondents and in Rajkanika block 66% respondents in total said that society should extend support and care to HIV/AIDS affected persons. The rest of the respondents were not in favour of giving social care and support to such affected persons.

This shows that inspite of a lot of awareness creating programmes launched by various governmental and non-governmental organisations all people did not accept HIV/AIDS affected/infected persons as normal persons. To lead normal and peaceful living every person needs social care and support. If such care and support cannot be provided to any person he/she felt being isolated from society which leads emotional stress. This emotional stress leads to either self-stigmatization or more high risk behaviour or committing suicide by the HIV/AIDS infected/affected persons.

Table no-9.13

Distribution of the Respondents on the Basis of Their Opinion regarding Necessity of both Family Care and Social Care N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below Matriculation	Matriculation & above	Degree & above	Total	Below Matriculation	Matriculation & above	Degree & above	Total
Yes	30 20%	42 28%	57 38%	123 86%	30 20%	24 16%	81 54%	135 90%
No	15 10%	-	-	15 10%	-	-	-	-
Not sure	6 4%	-	-	6 4%	-	15 10%	-	15 10%
Total	51	42	57	150	30	39	81	150

Family care and social care both are essential to make HIV/AIDS infected/affected as normal persons. This table shows that the majority of the respondents in both the blocks are in favour of the role that the family and society played in making the HIV/AIDS infected

persons as normal persons. While the hospitals provide the rapetic measures for the treatment of the disease of the patients, the family provides care and support to combat emotional stress and the society provides equal treatment and justice against discrimination and ostracization. As a result of which the infected persons felt psychological security as well as social security which make him/her as normal person.

Findings:

This chapter provides a lot of informations about the role of family care and social care for HIV/AIDS infected persons. The respondents of both the blocks gave their opinion regarding the conditions of living of PLWHA in family and village, discrimination against them in family, community and society, their equal rights with other normal persons, the necessity of family care especially the care of their own spouse and children for their recovery, the role of neighbours, friends and others in society providing moral support to them, behaviour of the villagers towards them and as a whole the necessity of both the family care and social care to make PLWHAs as normal persons in society.

Majority of the respondents of both the blocks were not in favour of isolation of HIV positive persons from their family. Only a few less educated respondents said that the HIV positive persons should not remain within the family because HIV may be transmitted to other family members by living together and using same utensils and lavatory. They said that the family members may be discriminated for them and their presence may affect the family prestige. Majority of the respondents of both the blocks though were not in favour of free movement of HIV infected persons within the community. Yet they opined that these infected persons should not leave the village voluntarily to save others from infection. They should not be discriminated in the community.

All the highly educated respondents and majority of less educated respondents were agree that HIV/AIDS infected/affected persons deserved the same rights with other normal persons. Most of the respondents opined that HIV/AIDS infected persons should have the same rights with normal persons because the persons suffering from other diseases were not ostracized in the society. The rest of the others said that all persons have equal rights to live

in any place. The affected persons feel psychologically secured and free from tensions having equal rights with others. The majority of the respondents including all degree and above qualified respondents viewed that family care was necessary for the treatment of HIV/AIDS patients. Family care particularly care of own spouse and children of the patients provide moral support for their early recovery. The neighbours and friends and other members are expected to provide moral support also. Some respondents found such type of moral support from the neighbours and friends in their villages. But most of the respondents did not find sympathetic behaviour of the villagers towards them in actual field.

Majority of the respondents viewed that both the family and society should extend support and care to them which are essential to make them normal persons.

Society plays significant role in developing individuals' personality, as C.H Cooley has expressed that the individual has no separate existence. Individuals are units of society. The personality of the individuals is developed only within the society by the mutual contact with others in society. For which long ago Greek philosopher Aristotle had said that 'man is social by nature and one who lives without society he is either a god or a beast.

C H Cooley has explained his thought on the basis of social contact. Till the person does not come in contact with others and he has no opportunity to know contacted person's habits attitude, recognition, faith etc. he does not procreate any thought about him or his self. In reality growth of one's self is done by the thoughts about him from others. If a person learns about himself wrong from others he had an inspiring complex in him and if he is praised by others then he is overcome with superiority complex. Hence Cooley says that others thoughts, concepts, attitude are "Looking- glass of self" to an individual and the individual adapts the society and develops social qualities.

When a person comes in contact with others he gains different experiences. On the basis of these experiences individual knows the concept of other persons about himself. In the sense others behaviour, conversion, statement and emotions are like looking glass where in individual sees his protrait or knows from others what they think about him. When he knows the concept of others about him, he attempts to know their evaluation.

If a man falls from his acts he feels that he is downtrodden in society. If his misdeeds are not taken as bad actions or not punished he does not feel inferior to others.

As said by Dr A K Sinha in his "Master of Social Thought". "The personality structure and the system of values of an individual is moulded particularly by the primary group of which he is a member". An individual is afraid of sarcasm, boycott and likes to remain safe from bad acts, envisaged by the society.

This is true in case of HIV/AIDS infected persons. If family, community and society exercised stigma and discrimination against the infected persons they felt emotional shock. When they are socially ostracized for their infection, they are mistreated with in their own family by their own spouse and children, suspended from their offices or employment, misbehaved and avoided by their friends because of their own infection; they may react in various ways. They may feel that they are ostracized for their immoral action through which they have been infected, they may feel isolated, they may try to committee suicide to avoid such situation. Sometimes some patients become over excited and want to show more high risk behaviour. As a consequence, they cannot be cured inspite of medical treatment. That shows only medical treatment may not be successful for recovery of such patients. Family care and social care are equally important for their treatment. When the patients feel that they are not discriminated for their infection, they are given care and support by their family members, friends and others are friendly and sympathetic towards them, they feel socially and psychologically secured and free from emotional stress which leads to easy recovery. They do not feel inferior because of their infection. They feel as equal with other normal persons.

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Chapter- X
AWARENESS ABOUT GOVERNMENTAL AND NON-GOVERNMENTAL STRATEGIES

CHAPTER-X

AWARENESS ABOUT GOVERNMENTAL AND NON-GOVERNMENTAL STRATEGIES

The Theme "Getting to Zero – Zero AIDS related Deaths:-2011" intends to Unite Governments of the world and prompt them to take necessary actions to prevent the spread of HIV and AIDS. Since the World AIDS Day originated at the 1988 World Summit of Ministers of Health on programme for AIDS prevention, every year UN agencies, Governments and all sectors of Civil society worldwide unite to campaign around specific themes related specifically to AIDS.

This year, the focus is an 'Getting to Zero – Zero New HIV Infections, Zero – Discrimination and Zero-AIDS related deaths, supported and assisted by the U.N the 'Getting to Zero" campaign runs until 2015 and builds on last years successful World AIDS Day "Light for Rights" initiative encompassing a range of vital issues identified by key affected population. It is a global campaign that brings to the spot light how fundamental right to health is intrinsically and in-extricably linked to basic rights such as the rights to food, to shelter, to freedom, to clean water and safety. (The Times of India, 1st Dec. 2011)

Currently many organizations, governmental bodies and others involved in the field of prevention and control of HIV/AIDS. UNAIDS is a joint response to HIV/AIDS. Established in 1994 by a resolution of the UN Economic and Social Council (Eco Soc.) and launched in January 1996, UNAIDS is the main advocate for global action on the epidemic, leading responses aimed at preventing transmission of HIV improving care and support, reducing vulnerability of individuals and communities to HIV/AIDS and alleviating the impact of epidemic.

The United States (US) Government has several initiatives including ones led by the Global AIDS Coordinator and the Director of the Office of National AIDS Policy. It has provided an annual AIDS budget of USS 2.4 billion that will be spent globally, primarily by the US Agency for International Development (USAID). Among the United Kingdom (U.K)

government initiatives to combat and address HIV/AIDS globally is the program by the Department for International Development (DFID). Canada also provides funding for HIV/AIDS globally; information can be accessed from the website of the Swedish International Development Co-operation Agency (SIDA).

Organizations involved in both prevention and control programmes as well as care and support can be divided into four categories: the UN agencies, bilateral, international NGOs (INGOs) and domestic NGOs / CBOS.

UN Agencies:

USAID is one of the largest donors to HIV/AIDS prevention and control programmes in the country (India) allocating $12.2 million in 2002 an increase from $9 million in 2001. USAID India's primary objective is to focus on HIV prevention and containment of the epidemic. Prevention activities target at risk populations such as commercial sex workers and truck drivers, who are likely core transmitters of HIV in India. It is also working to build awareness in low risk rural population and will endeavour to promote prevention activities through health service outreach projects.

USAID has developed a partnership approach with the Govt. of India, non-governmental organizations, business houses and others to fight HIV. USAID began to tackle India's HIV/AIDS epidemic in 1992 with the development of the AIDS prevention and control (APAC) project in the Southern Indian State of Tamilnadu, one of India's recognized epicentres. In 1999, USAID expanded its programme to include the state of Maharashtra. In 2002 USAID increased the number of grants to non-governmental organizations and began addressing new issues such as care and support for HIV infected persons, voluntary counselling and testing (VCT), interventions with industrial workers and geographic expansion of the APAC project to include Pondicherry.

Other USAIDS funded HIV/AIDS activities include supporting the national ports project, project Light house implemented by population services. International in the 12 major ports of India, this project addresses vulnerable population associated with ports which

include casual workers, migrants, formal port employees, truckers and commercial sex workers. The project strategies include behaviour change communication, condom promotion and sexually transmitted infection treatment.

USAIDS also supports Family Health International through the IMPACT project. Family Health International supports non-governmental organizations to provide support to children infected and affected by HIV/AIDS and other vulnerable children, pilot activities on care and support, applied research and developing models for HIV/AIDS programming. (Encyclopedia on HIV/AIDS: problems and control, Vol – 1, PP – 100 to 103, C.P. Yadav)

Bilaterals, Private foundations and International NGOs:

The major bilateral players are USAIDS, DFID, CIDA, SIDA and AWSAID. European Union (EU) has also emerged as an important player. Besides those there are other International Foundations and NGOs (INGOs) like the Ford Foundation, Mac Arthur Foundation, Population Council, Family Health International (FHI), HIV/AIDS Alliance etc. that have added significance the overall activities around HIV/AIDS in India.

Most of the donor interventions are in the areas of prevention through targeted interventions and awareness campaigns and primarily focused in the states of Maharashtra, Andhra Pradesh, Tamilnadu, Manipur, West Bengal, Kerala and Gujarat. One of the few international agencies working on HIV/AIDS care and support in India is Oxfam in Manipur and India HIV/AIDS Alliance in the States of Andhra Pradesh, Tamilnadu and Delhi. The States with limited donor HIV/AIDS interventions are Bihar, Rajasthan, Karnataka, Odisha, Assam, Arunachal Pradesh and Tripura.

BBC World Service Trust is working on communication for the Northern States of Uttar Pradesh, Rajasthan and Delhi. Catholic relief Services, plan International Organisation also working on HIV/AIDS who are beginning to support more prevention as well as care and support programmes in the high prevalent states (C.P. Yadav, P – 105 & 106)

CEDPA will be working on HIV/AIDS and youth as a part of the USAID funded IFPS project in Uttar Pradesh. Some of other foundations funding in India are Bill and Melinda Gates Foundation for whom India and HIV/AIDS are becoming a key focus area, pack and foundation (focus on Bihar and Jharkhand for reproductive health and sexuality). Francisco Xavier Bagnoud (FXB), Elton John foundation, Richard Gere Foundation etc.

In addition to these organizations, India has seen an emergence of several competent NGOs. While it is difficult to list all the NGOs working on HIV/AIDS and related issues, some of the more notable ones are Y.R.G care (Chennai),Indian Network of Positive People (INP+) NAZ foundation India Trust (Delhi), Sahara (Delhi), Saharan (Delhi), Society for positive Atmosphere and Related support to HIV/AIDS (SPARSHA, Kolkata), Freedom Foundation (Bangalore, Hyderabad), SOS Medical Foundation (Nasik), Prayas (Pune), CASA (Mumbai),Prepare (Chennai), Lawyers Collective (Mumbai & Delhi), Durbar Mahila Samanvaya Committee (DMSC, Kolkata) etc. (Page No. 107, Encyclopedia of HIV/AIDS, Problems and control, C.P. Yadav)

In India a number of NGOs have responded very positively to the HIV/AIDS epidemic. The role of NGOs in reaching the marginalized groups is vital as they are better acquainted and have close interpersonal interaction with the communities they work with (Narain & Jha, 1997).Many NGOs continue to help in preventing new HIV infections through awareness generating activities. They are also instrumental in reducing the personal and social impact through their support and counselling programmes.

Some of the NGOs recognized for their efforts in combating HIV/AIDS epidemic are:-

1. AIDS Awareness Group (Delhi) – working with commercial sex workers.
2. Calcutta Samaritan (Kolkata) – Working with street children.
3. CINI – Children In Need Institute, Calcutta – Working with street children.
4. Community Health Education in Society (Chennai) – Working with children.
5. Krip Foundation (Monitor) – Working with street children for community based rehabilitation.

6. Nazza Foundation (Delhi) – Working with men who have sex with men (MSM) and also run a care home in Saket (Delhi) where HIV infected patients are taken care of both physically and spiritually.
7. Prayas and Prachi (Delhi) – Working with different communities.
8. Prerana (Mumbai) – Working with children.
9. Salaam Balak Trust (New Delhi) – Working with street children and children affected by HIV/AIDS.
10. Smaran (Delhi) – Working with intravenous Drug users.
11. Society for promotion of youth and masses (Spym, Delhi) working with Truck drivers.

Although NGOs are bridging the gap between NACP and the communities yet, it has often been observed that most NGOs remain passive in exchanging information and reluctant in coming together in a coalition format. (Gardner, et al, 1996). The coalition form can promote greater programme, coverage and increase the accessibility of different services in an integrated manner. (Meenu Sharma, P – 76)

WHO collaborates with different NGOs on the basis of World Health Assembly Resolution (WHA – 42, 32) which calls for Governments, NGOs and the WHO Secretariat to work together by complementing each other's activities (Narain and Jha, 1997). WHO has recommended that 15% of the fund it provides should be allocated to NGOs for AIDS activities. In 1994, WHO developed guidelines for NACPs, which stress that besides providing technical and material support to NGOs, NACPs should also collaborate closely with them. Assistance and guidance to various NGOs is provided by support organizations such as Asia – Pacific Council of AIDS Service organizations (APCASO) the Global Network of people living with AIDS (GNP+) and the International HIV/AIDS Alliance (Narain and Jha – 1997) Maharashtra Network for positive. People (MNP +Mumbai) – (Meenu Sharma).

Shortly after reporting the first AIDS case in 1986 the government of India established a National AIDS control programme (NACP) which was managed by a small unit within the Ministry of Health and Family Welfare. The programme's principal activity was then limited to monitoring HIV infection rates among risk population in selected urban areas. A National AIDS control programme was launched in 1987 with the programme activities covering surveillance screening blood and blood products and health education. In 1992 the National AIDS control organization (NACO) was established. NACO carries out India's National AIDS programme which includes the formulation of policy prevention and control programme. The same year the NACO was established, the Govt. launched a strategic plan for HIV/AIDS prevention under the National AIDS control Project (NACP). The Project established the administrative and technical basis for programme management and also set up state AIDS bodies in 25 states and 7 Union territories. The project was able to make a number of important improvements in HIV prevention such as improving blood safety. (Page No. 248, HIV/AIDS and you, Savita Sharma)

In 1991 Govt. of India and the World Bank expanded their collaboration on infectious disease control programme and by 1992 the first National AIDS Control Project was launched with a World Bank credit of US $ 84 million. The Project helped the Govt. to broaden prevention efforts and to establish institutions and procedures necessary to curb the spread of HIV/AIDS.

NACO established under the Ministry of Health and Family Welfare implemented the programme lasted from 1992-1999. It focused on initiating National commitment, increasing awareness and addressing blood safety. Professional blood donations were banned by law. Screening of donated blood became almost universal by the end of this phase. By 1999, the programme had also established a decentralized mechanism to facilitate effective state level responses. Whereas states such as Tamilnadu, Andhra Pradesh and Manipur demonstrated a strong response and high level political commitment many other states such as Bihar and Uttar Pradesh have yet to reach those levels.

The second phase of the NACP began in 1999 and will run till March 2006. Under this phase India continues to expand the programme at the state level India Govt. has established 25 community HIV/AIDS care centres across the country. Greater emphasis has been placed on targeted interventions for high risk groups, preventive interventions among the general population and involvement of NGOs and other sector and line departments such as education, transport and Police. During this period NACO provides funds to state AIDS control societies for targeted interventions blood safety, youth campaigns VCT, care and support and social mobilization. This phase of programme aims to promote co-operation among public, private and voluntary sectors.

In 2001, Government adopted the National AIDS Prevention and Control policy. During that year Prime Minister Vajpayee addressed parliament and referred to HIV/AIDS as one of the most serious health challenges facing the country. The Prime Minister also met the Chief Ministers of Six high prevalence states to plan implementation of strategies for HIV/AIDS prevention.

In early 2003 the Indian Health Minister Sushama Swaraj told the Press that the countries AIDS programme had to focus on sexual abstinence and faith rather than just condoms. Among other things in 2004 the expanded Theme group on HIV/AIDS in partnership with the Govt. and the Parliamentary Forum on HIV/AIDS organized a “National Student and Youth Parliament session on HIV/AIDS” bringing together 3000 young leaders from all 600 Districts of India. The young people were trained on HIV/AIDS issues, discussed their role in the response and debated legislation on HIV/AIDS.

The Govt. of India is currently in the early stage of preparing the third phase of the NACP – 3, for which a multidisciplinary design team has been constituted to lead the preparation. The design of NACP – 3 envisages a complete consultative process including nationwide consultation with various national stake holders as well as International development partners.

India on Dt. 30.11.06 became the first country in Asia to introduce DNA Polymerase chain Reaction (PCR) Test, a dry blood sampling method of testing for pediatric AIDS. NACO plans to start six more regional centres with the PCR in Bangalore, Chennai, Hyderabad and Imphal. NACO's D.G. K. Sujata Rao told, Kalavati Saran children's Hospital, New Delhi became the first centre to offer free anti-retroviral therapy (ART) for children. Asia's first PCR should have also been installed here. India has also formulated the National Pediatric HIV/AIDS treatment protocol which was launched by Congress Chief Mrs. Sonia Gandhi and former US President Bill Clinton. The protocol says, "For Children below 18 months born to an HIV positive mother, the first HIV DNA PCR shall be conducted at 6 (six) weeks of the age, Clinton said that his foundation had negotiated agreements to lower the price of HIV/AIDS treatment for children in poor countries. (The Times of India, 1st Dec. 2006).

Pakistan and India also have united to highlight AIDS awareness. Players and official during the final the ICC World Twenty 20, were wearing red ribbons, the Universal symbol that highlights the issue of HIV/AIDS awareness and tolerance. (The Times of India, 05.09.07).

Taking up cudgels to fight dreaded HIV/AIDS, the Govt. will launch its second line of treatment of those affected with the disease from Jan. 01.2008.Announcing this in New Delhi on Dec. 1st 2007, Health Minister, Ambumani Ramadoss said that the second line treatment would be initially for below the poverty line population and would later be extended to the paients for whom the first line has clinically failed. The Govt is also looking at setting of special orphanage and faster care harnes for children who have lost their parents to the disease, director of NACO Sujata Rao told.

A specially designed seven coach train which will travel across the country carrying HIV/AIDS prevention message was flagged off by UPA chair person Mrs. Sonia Gandhi who termed the campaign against the dreaded disease as a battle, which can and must be won. The Red Ribbon Express which was launched on the occassion of worlds AIDS Day, on 1st Decmber 2007 will aim at spreading awareness about HIV, promoting safe behaviourial practices and fighting the Stigma and discriminination against AIDS. (The TOI, 02.12.2007).

For the big relief to tribals suffering from HIV/AIDS a community care centre, the first among 46 proposed In the state funding by NACO has been set up at Paderu (A.P.), Andhra Pradesh State AIDS control Society (APSACS) Director R.V Chandravadan has inagurated the community care centre. He said that the Govt. had decided to provide support facilities in all the tribal areas (The Hindu, 20.04.2008)

The A.P State Legislative services Authority is contemplanting to persuade the Govt. to amend section 12 of the Legal Service Authority Act, 1987 to provide free legal service to HIV/AIDS positive persons. (The Hindu, 25.05.2008)

The Govt. of India has applied for a credit from the International development Association and a grant from DFID towards the cost of Third National HIV/AIDS Control Project (NACP – III). The NACO is supporting the state programme. State AIDS control societies (SACS) implement the programme in the states. NACO has decided to identify competent organisations / training institutes to become “State Training and Resource centres (STRCS). The state for which NACO is requesting STRC are the following States:- 1) A.P. (2) Bihar, (3) Chhatisgarh, (4) Delhi, (5) Gujarat (including Daman / Diu) (6) Punjab (including Chandigarh & Hariyana), (7) Jammu & Kashmir, (8) Jharakhand, (9) Karnatak, (10) Keral (Lakshyadweep), (11) Madhyapradesh, (12) Maharastra (Goa, Dadra, Nagar Haveli), (13) Odisha, (14) Rajasthan, (15) Tamilnadu, (16) Uttarakhand & Himachala Pradesh, (17) U.P., (18) W.B (Sikim, Andamanas), (19) Assam, (20) Mizoram (Meghalaya & Arunachal Pradesh), (21) Manipur & Nagaland, (22) Tripura. (The TOI, 14.01.2008)

Launched In 1994 Bharat integrated Social welfare Agency (BISWA) has been working for the upliftment of the poor and downtrodden suffering from HIV/AIDS for the past 14 years. BISWA has launched a Micro Finance strategy for HIV/AIDS mitigation and prevention in India. It can help ease the financial and other burdens of those living with HIV/AIDS and promote behaviourial change vital to stemming the tide of infection. In terms of prevention efforts BISWA offers HIV/AIDS education conducted by its own staff or VIA its NGO network. BISWA with its multi dimensional approach and community partenership endouverous to address the pandemic, through increasing awareness any impact of the

disease eliminating stigma and discrimination, empowering economically, socially and politically to reduce their vulnerability promoting income and employment oppertunities for PLHAS through imformal sector and small enterprise.

The central govt. has decided for compulsory HIV testing of all pregnant women of the country to prevent mother to child transmission (PMTCT) of HIV/AIDS. (The Samaj, Oct. 10, 2009).

The Keral State Govt. for the first time in country has taken a new step to bring the ostracised AIDS patients to the main stream of Society by reserving one post of the States AIDS control organisation for HIV positive persons. Through it is expected that the AIDS affected may disclose their status which can be very much helpful for their treatment. Otherwise most of them suffer silently out of fear for social stigma and discrimination. (The Sambad, CTC, Aug. 14, 2008)

Maharastra Network for Positive People (MNP, Mumbai) is one of the organisations which is formed by PWHA is commited to project the basic human rights of PWHA including the rights to travel, to employment, to marry, to have children, job security, housing, education, access to medical care and to obtain an insurance cover. Such efforts are at the initial stages in India and need to be evolved and implemented at a much wider scale. (Meenu Sharma PP - 79)

Odisha is one of the most vulnerable states of India for HIV infection duee to large scale of migration of odia people to different highly HIV prevelent states of India like A.P., Gujarat, Maharastra, Tamilnadu, Karnatak, Goa, New Delhi etc. Odisha is vulnerable to HIV infection due to tourism, Long stretches of national highways, trafficking of women, labour intensive mining activities and poor availability of HIV preventive measures. The invisisbility of HIV issues and the adhoc response of the Govt. towards the same make the situation worse.

In Odisha four Districts come under category – “A” – Ganjam (3.2% of total population), Anugul, Bhadrak and Bolangir (1% of total population). Three Districts come under category – “B” – Khurdha, Koraput and Balasore (0.5% of total population)

In this bleak scenerio the state Govt., Orissa State AIDS central Society (OSACS) and other NGOs like BISWA, OPUS (Orissa Patita Udhar Samiti) are doing their bits to prevent the disease from spreading.

OSACS has taken a number of ventures for HIV affected people. OSACS' President Dr. Parameswar Swain said, "We give ART (Anti retroviral therapy) treatment to AIDS patients whose CD4 level in the blood comes down from 300. ART helps improving their immune system. We are also planning to give "Nutri Plus" to HIV positive from Dec. 1.2008, free of Cost". (The TOI, 1st Dec. 2008)

OSACS also regularly organizes IEC (Information, education and Communication) including community mobilisation radio programmes on its efforts on rehabilitation, Swain said. For those, who have been detected with HIV+ virus and still enjoying good health, SSGs have been formed and income generating activities taken up. OSACS is also examining the possibility of establishing Voluntary Counselling and Testing Centres (VCTCS) and anti-retroviral centres in several industries. Dr. Swain said that the ILO should provide technical support to OSACS to implement HIV/AIDS programmes in work place policy in the industries in Odisha. The corporate Community should come forward to put in place a work plae policy on HIV/AIDS as the first step in its battle against the disease. (The Times of India, 1st Dec. 2008)

The NACO & OSACS have urged Indian Industries and corporate houses to come forward with specific policies to combat HIV/AIDS in the State, to create better work atmosphere for HIV/AIDS patients and to reach a wider cross section of the Society OSACS has also formed a state mainstreaming Unit involving corporate houses and bodies of industries.

A specialised programme is being made for truckers in Sukinda mining belt where a large number of trucks come from other parts of the country and have maximum chances of carrying the virus – said a spokes person of the TATA group. Nalco has been giving time to time informations on HIV/AIDS in its news letter and is planning to facilitate medical facilities for the infected persons – said a Nalco representative. Niranjan Mohanty of Utkal

chamber of Commerce and industries urged OSACS to provide HIV/AIDS treatment facilities through employees State Insurance (ESI) hospitals; so that it would help the small and medium enterprises and their employees. (The TOI, Nov. 18.2007)

OPUS (Orissa Patita Udhar Samiti) has also been carrying out its programmes like BCC (Behaviourial change communication) Condom promotion advocacy, networking (with Govt. / NGOs) and community mobilisation for benefit of HIV affected people.

Every PLHA irrespective of their age and income gets a monthly pension of Rs. 200. To rehabilitate AIDS patients shelter homes have been set up at Berhampur and other places. Vocational Training is also being imparted to help them eke out aliving. Around 85 HIV positive people have been rehabilitated – said Pramila Mallik, State Women and Child development Minister. Also to rehabilitate sex workers the Govt. is providing them with loans, vocational training and Indira Awas. In 30 Districts around 200 sex workers have been rehabilitated in the past two years – "she added.

The Government of Odisha has decided to build a modern orphan centre to accommodate HIV positive children. The capacity of proposed centre would be 80 and will be the first of its kind in the state. A medical Unit with four bed hospital will also be run in the proposed centre to provide the medical facilities to the children. (The Times of India, BBSR, July 11. 2012)

Perhaps for the first time in the Country, the Odisha Govt. has decided to pay monthly pension to HIV positive people in the state. The Govt. will also dole out monetary benefits to AIDS Widows under the state sponsored Madhubabu Pension Yojana from Jan. 2008. In the first phase as many as 6,132 HIV + people irrespective of age or earnings will receive Rs. 200/- each month. OSACS has already sent a list of affected persons to the district collectors. The concerned Block Development officers would send an account payee cheque to the address of each beneficiary every month.

Though the OSACS had detected 8,200 HIV+ cases by Dec. 2007, it has decided to provide pension to only 6,132 persons during the first phase. The highest number of

beneficiaries (2527) is from Ganjam District. This is followed by 350 beneficiaries in Koraput, 342 in Khurda, 227 in Puri, 214 in Balasore, 211 in Rayagada, 170 in Anugul, 166 in Jajpur and 165 in Kendrapara, Boudha district with any 7 HIV+ cases accounts for the lowest number (The Times of India 7th Feb. 2008)

AIDS patients in the state are set to get sophisticated gadgets for their treatment, courtesy the Clinton foundation. A CD4 machine, an essential device to count CD4 cells for the HIV infected patients will be set up at Anti-retroviral treatment (ART) centre at MKCG Medical College and Hospital. Earlier the centre used to send blood samples to Kolkata for CD4 cell testing. With rising cases District authorities along with OSACS and Lepra India had started sending samples to Hyderabad from last month.

The antigen test using Polymer Chain Reaction (PCR) method to detect HIV in blood before transmission is yet to start in the state. A year ago Odisha High Court had asked the State Govt. to adopt it in all blood banks. The costlier PCR method is more accurate compared to the prevalent blood test called ELISA. The ELISA method which is prevalent in Odisha blood banks cannot detect HIV in window period of up to 90 days of infection.

Authorities said the Govt. is planning to start the Nucleic – Acid Amplification Test (NAAT) under PCR method through the Public private partnership (PPP) mode. The NAAT – PCR equipment costs around Rs. 18 crore. The NACO provides funds for Elisa method of testing. If the Govt. adopts NAAT-PCR Govt. has to use its own resources at the rate of around Rs. 2000/- per unit of blood. The Govt. is planning to partly finance the test from "Odisha Health System Project" (OHSP) fund and initially launch it in selected blood banks.NAAT – PCR can detect HIV within two days of infection, significantly reducing chances of the window period of non-detection. (The Times of India, 24 July, 2012)

But according to the report on 30 July, 2012 of the Times of India, a high level government committee is against introducing of a more accurate test to detect HIV in blood banks. The Government is yet to take a final decision. The Govt. is mulling to file a review petition in the Odisha High Court against the court's July 28, 2011 order for a mandatory PCR Test adjudicating on the petition of a resident of Badamba in Cuttack District.

Mr. Naveen Pattnaik said, “For Counselling and blood testing, the OSACS has set up another 36 Integrated Counselling and Testing Centres (ICTC) this year. With this now there are 129 such centres in the state of which 28 are in Ganjam (The Times of India, 07.11.2007).

For creating awareness among the ruralites the OSACS has asked Oriya film personalities to make short films on the different aspects of the disease and its treatment. The Project Director of OSACS, Dr. Parameswar Swain said, “We had decided to make at least 10 documentaries on different aspects of AIDS, starting from its source of infection and remedial measures on the initial stages.” The short film in Oriya language would be shown through projectors in the rural areas. These would also be supplied to different ICTCS across the state. CDS will be supplied to the ART centres which will help during counselling and treatment period. The NACO has suggested to create awareness through this media, because the people especially the rural folk are very much influenced by the silver screen (The Times of India, July 25.2008)

In an effort to bring HIV+ persons closer to the mainstream, city’s leading B-School Xavier Institute of Management, Bhubaneswar (XIMB) has set up the first state Training and Resource Centres (STRC) for those working in the field of fighting this deadly virus. The centre will function in association with NACO and OSACS. The centre will train the staffs those who are working 44 interventions projects in the state. The main objectives of the STRC is to train Counsellor, field staff of OSACS and other voluntary organizations to work with the target community with an aim to prevent spread of the deadly virus. XIMB had successfully conducted a leadership and managerial proficiency programme (LAMP) last year for mainstreaming people with HIV/AIDS (The Times of India, Nov. 3.2008)

The Odisha Govt. has announced to give travelling expenses to HIV/AIDS patients to travel from their home to the ART (Anti - Retroviral Treatment) centres. The benefit has come into effect from April 1st, 2008. The Govt. has made budgetary allocation for this purpose. There are three ART centres set up in the state at MRCG Medical College and Hospital Berhampur, SCB Medical College and hospital, Cuttack and VSS Medical College and Hospital, Burla. The OSACS is planning to set up two more ART centres at Balasore and Bolangir to treat AISD patients. Another centre will come up at Koraput District Headquarter Hospital.

On Private – public partnership mode Sewa paper Mills a unit of Ballarpur Industries limited (BILT) will help to build this Unit; said P. Swain. Besides, the society is planning to link ART centres in this state.

In addition to full travelling concession to the HIV/AIDS patients travelling in Public transport services including buses and trains to the ART centres the ministry of railways, however has announced to provide 50 % concession in the railway travel in the country from this year. (The Times of India, April 7, 2008). The travelling expenses both to and fro would be provided at the places of ART, the anti-AIDS officials said concession card for trains which was announced by the central Govt. would also be issued to the patients at the ART centres soon. The efforts were made to provide the supplementary nutrient food (SNF) to the AIDS patients at the ART centres. The Govt. is holding with the World Food Organisation (WHO) for this purpose. (The Times of India, April 7, 2008)

The proposed centres at Parlakhemundi, Aska and Bhanjanagar will be linked with to Berhampur one. Similarly the proposed centres at Puri, Anugul, Bhadrak, Kendrapara and Bhubaneswar are to be linked with Burla, Rourkela and Bhawanipatana centres will be linked to Burla.

Patients will be regularly checked up at ART centres and prescribed medication according to their CD4 count to help them live longer, Odisha was the first state in the country to consider AIDS patients as physically handicappeds and announced monthly allowances for them. (The Hindu, April 8, 2008). Chief Minister Naveen Pattnaik urged the centre to include all disadvantaged groups including primitive tribes and HIV+ patients in the proposed 2009 census for BPL (Below Poverty Line) households (The Times of India, Oct. 22,2009)

The OSACS initiative to employ HIV+ people in its offices without stigma or discrimination is really a great initiative. (The Times of India, Aug. 20.2008).

The Odisha state Govt. is preparing a special programme (Yojana) for providing Indira Awas and Pension for those HIV affected persons who are ostracized from Society.

This Yojana will be implemented very soon – said, the Health Minister Duryodhan Majhi. (The Sambad, 02.12.07).

It was decided in a meeting of OSACS under the chairmanship of Health Minister Duryodhan Majhi to provide pension to widow of any person died of AIDS and Scholarship to his children for education. The Govt. will assist the children for higher education till the completion of University education.

The Odisha State Govt. has decided to set up one centre in every Panchayat to control HIV infection due to migration. The persons who want to go outside the State (Surat etc.) for searching job have to register their name in this centre. Some other centres will be set up at train stations to keep informations about outgoing persons and to test their HIV status before their journey and also when they return back to villages. The villagers will voluntarily take the migrants to Integrated Counselling and Testing Centres (ICTCS) for their HIV testing which is free one. Through this process HIV/AIDS affected due to migration may be known and provided with required treatment – said project Director Dr. Parameswar Swain (in a discussion, conducted by AIR, Cuttack on 1st Dec. 2008, World AIDS Day.)

Another decision was taken to involve Anganawadi officials and Mahila Swayam Sahayak Organisations for creating awareness for AIDS on rural areas and to send a special trained team of officials to Surat or other areas where migrated odias were engaged in work to create awareness about HIV/AIDS prevention among the workers (AIR, CTC, Oct. 31.2007).

Sixty Five (65) NGOs are working throughout our State Odisha for creating awareness about HIV/AIDS. These are namely:- (1) Utkal Sevak Samaj, (2) Aruna (Ganjam). (3) Sova (South West Orissa Voluntary Action), Koraput.

BISWA, Action Aid, JSPL (Jindal Steel and Power Limited, Adhunik, Leepra Society, Unicef, Sai creation TEAM (Outdoor media partner), HOPE Foundations, Ashrya etc. Work for prevention of HIV/AIDS and creation of awareness among the people.

Action Aid has been implementing the link workers scheme effectively in six Districts of Odisha to spread awareness about HIV/AIDS. Considering the evidence of rural risks and vulnerabilities to HIV and the over burdened rural health functionaries NACP – III has designed the link worker Scheme (LWS) to provide HIV prevention, referral and follow up service to High Risk Groups (HRGs) and vulnerable population in rural areas.

Action Aid is an international anti-poverty agency working in over 40 countries. Action Aid India Society has been implementing the Link Workers scheme (LWSs) in 1595 vilages of 295 Gram Panchayats of Six Districts in Odisha., Viz, Anugul, Balasore, Bhadrak, Balangir, Ganjam and Khurda in close coordination with OSACS,Supported by NACO and United Nation & Development programme (UNDP), India since Oct. 2008.

The objective of the project is to build a community centred model with an outreach strategy to address HIV prevention care support and treatment requirements in collaboration with NGOs, CBOs, Positive networks, District Administration and Government departments in these six Districts of Odisha Action Aid has been implementing project with special focus on HIV/AIDS. As on Oct. 2010, the project has covered 1,722,230, population 5,138 fenmale sex workers, 2746 MSMS, 182 injecting Drug users (IDUS) 2,14,245 vulnerable population 3,336 PL HIVS, 1,131 Orphan and vulnerable children with sexually Transmitted infections (STIS), Reproductive Tract Infections (RTI), HIV & AIDS preventive, curative and Treatment Services through different innovative Programmes like Mid Media programmes, Community programmes, One-to-one and One-to-one group counselling Meetings and special events (The TOI, 7.12.2010)

“HIV is a development and human rights issue. Universal access to prevention, care, Support and treatment systems can only be possible by addressing the human rights issues of PLHIVS through Multi sectoral response and collaboration.” Says Sashikanta Malik, team leader, HIV initiative, Action Aid, Odisha (The TOI, 07.12.2010)

LEPRA India has responded to the growing challenge of HIV/AIDS by implementing prevention and awareness projects. Since 1989 LEPRA India has been helping the

disadvantaged and downtordden population of the country in combating the negative impact of the diseases including leprosy, tuberculosis, malaria, blindness, lymphatic filariasis, HIV/AIDS and sexual & reproductive health.

LEPRA cleprosty Elimination Project for rural Awareness starts its project for HIV/AIDS prevention and awareness in the State of Andhra pradesh and subsequently expanded the interventions to Odisha and other States Viz, Bihar & Madhyapradesh. Sakhyam is one of the projects implemented by LEPRA India in Odisha. Co-funded by European Commission, Interact Worldwide and LEPRA UK, the project aims to promote rights based action to improve slum dwellers and key vulnerable communities sexual and reproductive health including HIV/AIDS in Urban slum of Bhubaneswar.

Being implemented in four identified urban slums, Salia Sahi, Mali Sahi, Niladri Vihar and Bharatpur the project caters to a total population of 1,42,000. The Key vulnerable communities include female sex workers men having sex with men (MSM) and other sexual minorities injecting drug users, people living HIV/AIDS and adolescent boys and girls. The overall objective of the project is improved sexual and reproductive health status aand reduced vulnerability to HIV/AIDS for slum dwellers in Bhubaneswar through integrating sexual reproductive health and prevention programmes with care, treatment and support in line with Govt. of India's National AIDS Control Programme (NACP – III) (The TOI, 7.12.2010).

Kaling Network of people living with HIV (KNP+) and Bhubaneswar Network of people living with HIV (BNP+) are the two PLHIV networks supported by this project. The project has also developed partnership with other three community based organisations (CBO) named SAKHA (The CBO of MSM and sexual minorities), ASHRAYA (The CBO of female sex workers {FSW}) and HOPE Foundation (The CBO of injecting drug users) (The TOI, 7.12.2010).

Jindal Steel and Power Ltd. (JSPL) have set up a comprehensive response system to spread awareness about HIV/AIDS that is threatening innumerable lives. Anugul District has

been declared as an “A” category District the “National AIDS Control Organisation” including high incidence of HIV/AIDS cases. JSPL has set up a response system to address the situation and to achieve the goal set and Millennium Development Goals by restricting the growth of HIV/AIDS by 2015. Population stabilisation Policy by the CSR services of JSPL examples HIV/AIDS awareness:-

Strategy:

Two programe strategies to cater to both employees and community through awareness and advocacy out reach programmes encompassing the peripheral villages and beyond, with more focus on the socially vulnerable.

Partners:

State Govt. District Administration and responsible agencies like Odisha State AIDS Control Society (OSACS) and District level agency like DAPSU.

- Community based institutions NGOs.
- Community at the household level for community level awareness generation and action.
- Truckers associations, Mahila Samitis, SHGs (Self Help Groups)

Intervention:

- Awareness generation tools through folk art and folk media (Pala, Daskathia, Danda Nacha, Ghoda Nacha, Street Plays)
- At community level partnerships are developed with community based organisation like youth club including Kishori Mandals, female self help groups, pregnant and lactating mothers, migrant populations of the villages framers clubs, village based communities like village health and education committees.
- Communities are sensitised with the adverse effect of HIV/AIDS on the life of the people and its preventive aspects. Women and adolescent girls are provided informations on life skills emphasing on present hygiene. Activity based partnership

has been developed with NGOs like Utkal Sevak Samaj for inducing appropriate awareness in the vulnerable population like truckers, migrant labourers etc. through –

- Use of awareness generation programmes like Street Plays, Informatics leaflets, pamplets, audio-video-AIDS, folk arts on issues like preventive mechanism of HIV transmissions and on the prevailing social myths and misconceptions.
- Awareness rally, human chains, signature campaigns and banyan tree meetings are being organised round the year to induct awareness and preventive measures.
- Regular Health Check ups and linkage with Govt. supported testing and medicinal support for early stabilisation of the infected persons.
- Counselling and symptomatic studies through the mobile units of the company in the peripheral villages.
- Partnering with Govt. and Non-Govt. agencies for (1) identification of HIV+ peoples, (2) Supporting them with both social and medical care.
- Sensitising both permanent and contractual employees on HIV/AIDS and its preventive measures.
- Jindal Mahila Samiti has been consistently playing the role of an effective social communication in sensitising the community house hold maids, security guards, school children and house wives.
- Identifying cases on reproductive Tract inefection (RTIs) & Sexually Transmitted Disease (STDs) which play a crucial role in HIV transmission.
- RTI ans STD cases treated with the support of Govt. Medical practitioners.
- 10 condom vending machines installed in strategic locations in the periphery of plant, so as to enhance the availability of condom within reach.
- Integrated counselling and testing centres (ICTC) has been established to provide need based control and consistent counselling to the infected persons and their family. More can be done in the field of AIDS/HIV awareness.
- Corporate support in Social and clinical Research.
- Proper rehabilitation of the affected family by supporting education of their children. Members of the family should be linked with various income generation activities for respectful social and economical life.

- Capacity building of the Service providers on social sensitisation issues covering right from grass root workers like ASHA, ANM, AWW etc. to the professional health officials, field experts and administrators (The TOI, 08.12.10).

Likewise the central Government, state governments and a number of non-governmental organizations have launched a lot of programmes for creating awareness among the masses about transmission, prevention and cure or treatment of HIV/AIDS. Both the central government and state governments have taken major steps to prevent this deadly disease and provided some governmental assistance for prevention and cure of this disease.

In this chapter the researcher had tried her best to seek whether the ruralites knew about various programmes launched by the governmental and nongovernmental organizations and the awareness of the respondents about the steps taken by the government for the creation of awareness among the ruralites about prevention, cure and treatment of the HIV/AIDS infected persons. The researcher was also interested to know whether they knew about the provisions of governmental assistance for the infected persons, for their offsprings and other family members.

Table.No-10.1

Distribution of the Respondents on the Basis of Their Opinion regarding Adequate Governmental Steps to Control AIDS

N=300

Response	**No. in Rajnagar Block**				**No. in Rajkanika Block**			
	Below matric	**Matric and above**	**Degree and above**	**Total**	**Below matric**	**Matric and above**	**Degree and above**	**total**
Yes	30 20%	30 20%	42 28%	102 68%	18 12%	39 26%	81 54%	138 92%
No	21 14%	12 8%	15 10%	48 32%	12 8%	-	-	12 8%
Total	51	42	57	150	30	39	81	150

This table shows that majority of the respondents of both the blocks i.e 68% of Rajnagar block and 92% of Rajkanika block agreed that the government had taken adequate steps to control the deadly disease like AIDS in Odisha . Among the total respondents most of respondents belonging to degree and above qualified group in both the blocks said that the government had taken adequate steps to control this disease. The rest of the respondents comparatively less qualified respondents did not know about governmental measures to control this disease in odisha.

Table no.10.2

Distribution of the Respondents on the Basis of Their Awareness regarding Governmental Steps to Prevent AIDS

N=300

Response	**No. in Rajnagar Block**				**No. in Rajkanika Block**			
	Below matric	**Matric and above**	**Degree and above**	**Total**	**Below matric**	**Matric and above**	**Degree and above**	**Total**
Yes	-	15 10%	30 20%	45 30%	9 6%	12 8%	45 30%	66 44%
No	45 30%	27 18%	27 18%	99 66%	21 14%	27 18%	30 20%	78 52%
Not sure	6 4%	-	-	6 4%	-	-	6 4%	6 4%
Total	51	42	57	150	30	39	81	150

This table shows the awareness of the respondents about the steps taken by the state/central government to prevent this disease while people migrate to other state in search of employment. As migration was regarded as one of the most important cause of spread of HIV/AIDS in Odisha the state government should check this disease while people migrate to other state and while return back. In reality state government has recently taken some steps to register the migrants and to check up the HIV status before migration and after returning back

at the railway station. The researcher had tried to know whether the ruralites know about these steps. Only 10% respondents having matric and above qualification and 20% having degree and above qualification of Rajnagar block and 6% respondents having below matric, 8% having matric and above and 30% having degree and above qualification of Rajkanika block knew about the governmental steps in preventing HIV/AIDS while migrating to other states. The rest of other respondents did not know about such government al steps for prevention of this disease.

Table no. 10.3

Distribution of the Respondents on the Basis of Their Awareness about Governmental Measures for HIV/AIDS Infected/Affected

N=300

Governmental measures for HIV/AIDS infected	No. in Rajnagar Block						No. in Rajkanika Block					
	Below matric		Matric and above		Degree and above		Below matric		Matric and above		Degree and above	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
A	-	51	-	42	42	15	-	30	12	27	48	33
B	-	51	-	42	42	15	21	9	24	15	81	-
C	-	51	-	42	42	15	-	30	24	15	48	33
D	-	51	-	42	42	15	-	30	-	39	66	15

N.B.:

(A) Existence of ICTC (Integrated Counseling and Testing Centre) in district head quarter hospital for free blood testing of HIV/AIDS patients.

(B) Government providing medicine and nutrient food to the patient free of cost.

(C) State government has given railway/ bus concession to HIV/AIDS infected from their native place to ART centre.

(D) Central government had provided for compulsory blood testing of every pregnant woman for checking MTCT (Mother to Child Transmission) for HIV/AIDS.

This table reveals the respondents' awareness about various governmental measures for HIV/AIDS infected/affected viz. existence of ICTC in district headquarter hospitals for free blood test of HIV/AIDS patients, supply of medicine and nutrient foods to the patients free of cost, provision of railway and bus concession to HIV/AIDS patients from their native place of ART centres and Central Government's provision for compulsory blood testing of every pregnant woman for checking of MTCT of HIV/AIDS. In Rajnagar block none of the respondents having below matric and matric and above qualification knew any of these governmental measures and facilities for the HIV /AIDS patients. But the majority of degree and above qualified respondents knew about all these measures and facilities.

But in Rajkanika block 21 below matric respondents, 24 matric and above and all the degree and above qualified respondents knew about governmental supply of medicine and nutrient food to the patients free of cost.

Some of the matric and above and the majority of degree and above qualified respondents knew about all these measures for HIV/AIDS patients. But most of the below matric and matric and above qualified respondents were not aware about these governmental measures and facilities for them.

Table no.10.4

Distribution of the Respondents on the Basis of Their Knowledge about Governmental Programmes for Creating Awareness N=300

Governmental and non-governmental programmes	No. in Rajnagar Block						No. in Rajkanika Block					
	Below matric		Matric and above		Degree and above		Below matric		Matric and above		Degree and above	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
A	-	51	30	12	57	-	18	12	39	-	81	-
B	15	36	30	12	57	-	18	12	24	15	63	18
C	15	36	-	-	45	12	-	30	24	15	63	18
D	-	51	-	42	42	15	-	30	12	27	81	-

N.B.:

(A) Red Ribbon express moved all over India to make people aware of this disease.

(B) Governmental programmes for creating awareness about HIV/AIDS.

(C) Non governmental prorammes for creating awareness about HIV/AIDS.

(D) Establishment of Red Ribbon clubs in degree colleges and universities of Odisha to create awareness among young students about HIV/AIDS.

A lot of programmes have been launched by the government and implemented by a number governmental and non-governmental organizations for creating awareness among ruralites about HIV/AIDS and both these organizations have planned the action programmes like arrangement of meetings, Gana Dauda (mass race), rally, street plays, essay writing, painting, debate, competition etc. on certain special occasions as AIDS Day celebration to create awareness about HIV/AIDS among the rural masses. The central government had made an arrangement for Red Ribbon Express to move all over India to make people aware of this disease. The state government had established Red Ribbon clubs in degree colleges and Universities of Odisha to create awareness among young students about HIV/AIDS and to engage these students to assist in creating awareness among illiterate and uneducated masses about HIV/AIDS.

This table shows the awareness of the respondents about these Governmental & Non-Governmental programmes creating awareness among rural masses about HIV/AIDS. Out of 150 respondents of Rajnagar Block all the degree and above qualified respondents and 30 matric and above qualified respondents knew about Red Ribbon Express moving all over India for creating awareness. All the degree and above qualified respondents 15 below matriculate and 30 matriculate and above respondents knew governmental programmes creating awareness among the masses. 15 below matriculate and 45 degree and above qualified respondents were aware about Non-governmental programmes for creating

awareness among the rural masses. 42 graduate and above respondents knew about establishment of Red Ribbon Clubs in Colleges and University and their role in creating AIDS awareness. Likewise in Rajkanika Block out of 150 respondents 18 below matriculate, 39 of the matriculate & above and all the degree & above qualified respondents knew about Red Ribbon Express moving within the country creating AIDS awareness. 18 below matriculate, 24 matriculate and above and 63 degree and above qualified respondents knew regarding Governmental programmes creating HIV/AIDS awareness. 24 matric and above and 63 degree and above qualified respondents were aware about Non-Governmental programmes creating awareness among the ruralites only 12 matriculate and above and all the degree and above qualified respondents knew about existence of Red Ribbon Clubs in Colleges and Universities and their role in creating AIDS awareness among the ruralites through young educated college students.

That shows majority of less educated respondents of both the blocks did not know about Governmental and Non-Governmental programmes for creating awareness among ruralites about HIV/AIDS.

Table No. 10.5

Distribution of the Respondents on the Basis of Their Knowledge about Governmental Assitance for HIV/AIDS Infected / Affected

N=300

Governmental Assistance	No. in Rajnagar Block						No. in Rajkanika Block					
	Below matric		Matric and above		Degree and above		Below matric		Matric and above		Degree and above	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
A	21	30	30	12	42	15	18	12	24	15	81	-
B	-	51	-	42	27	30	-	30	-	39	48	33

N.B:

A. **Odisha Govt. allocated Rs. 300/- as monthly pension for HIV/AIDS infected Patients.**
B. **Reservation of Govt. Service for HIV/AIDS patients in OSACS Office. OSACS (Orissa State AIDS Control Society)**

The Odisha State Govt. launched and implemented Madhu Babu Pension yojana under which it had allocated 300 Rupees as monthly pension for HIV/AIDS infected patients. It had also made provision for reservation of Govt. Service for HIV patients in OSACS Office.

This table shows the awareness of the respondents about these Governmental assistance for HIV/AIDS infected / Affected. Out of 150 respondents of Rajnagar block 21 below matric, 30 matric and above and 42 degree and above qualified respondents knew about Odisha Government provision of 300 rupees monthly pension for HIV/AIDS infected / affected persons irrespective of age. But only 27 degree and above qualified respondents knew about the reservation of Govt. service for HIV/AIDS patients in OSACS. All other respondents were ignorant about the provision of reservation.

In Rajkanika Block out of 150 respondents 18 below matriculation, 24 matriculation and above and all the degree and above qualified respondents knew about Rs.300/- as monthly pension for all the HIV/AIDS infected/affected irrespective of age under Madhu Babu Pension Yojana. But regarding reservation of Govt. Service in OSACS office for HIV/AIDS infected only 48 degree and above qualified respondents were aware.

Table No.10.6

Distribution of the Respondents on the Basis of Their Knowledge about the Governmental Facilities for the Families of HIV/AIDS Infected/Affected

N=300

Governmental Facilities	No. in Rajnagar Block						No. in Rajkanika Block					
	Below matric		Matric and above		Degree and above		Below matric		Matric and above		Degree and Above	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
a	-	51	15	27	27	30	18	12	13	-	81	-
b	15	36	15	27	42	15	18	12	13	-	81	-
c	51	-	15	27	42	15	18	12	13	-	81	-

N.B.: a. Facility for Indira Awas

b. Inclusion in Odisha Government BPL List.

c. Inclusion in Mo Kudia Yojana

The Odisha state government has provided a number of facilities for the families of the HIV/AIDS infected/affected. As irrespective economic status the HIV/AIDS infected persons should have been extended the facilities of “Indira Awas”.

Odisha’s chiefminister Sri Naveen Pattnaik has given instruction to include all HIV/AIDS patients in BPL list irrespective of their income. Their families should also be included in “Mo kudia yojana.”

This table reveals the respondents’ awareness about these governmental facilities for HIV/AIDS infected/affected and their families. Out of 150 respondents in Rajnagar block 15 matriculation and above and 27 “degree and above” qualified respondents knew about facilities of “Indira Awas” for HIV/AIDS infected families. 15 below matric, 15 “matric and above” and 42 degree and above, qualified respondents knew about Odisha government facility for inclusion of HIV/AIDS affected/infected families in BPL list. 15 “matric and above” and 42 “degree and above” qualified respondents knew about “Mo kudia yojana.” Regarding this new facility of Odisha government under the leadership of the Chief minister

Sri Naveen Pattanaik to provide house to HIV/AIDS infected families all the respondents were not aware of.

In Rajkanika block out of 150 respondents 18 below matric, 13 “matric and above” and all the “degree and above” (81) qualified respondents knew about the facility of Indira Awas for HIV/AIDS infected/affected families. All of these respondents knew about the other two facilities of Odisha government as inclusion of HIV/AIDS infected/affected persons in BPL list and their families in “Mo kudia yojana” to provide them house to live.

Findings:

On the whole, this chapter has been furnished with the informations from the respondents whether governmental interference is essential to prevent and control the horrendous disease like HIV/AIDS, and Odisha government has taken adequate steps in this regard. As it has been mainly spread because of migration to other AIDS affected states in search of employment there, the government should take steps to check the persons while migrate to other states and to other countries. In this chapter the researchers found that education had played important role in making the ruralites conscious about various governmental plans, programmes, policies, assistance and facilities for prevention, treatment, cure and survival of HIV/AIDS infected/affected and raising theirs and their families’ economic conditions. It was found that the majority and sometimes all the educated respondents of both the blocks were aware about existence of ICTC in district head quarter hospitals for free testing of blood of HIV/AIDS patients, governmental supply of medicine and nutrient food to the patients free of cost, railway and bus concession to HIV/AIDS patients and central governments provision for compulsory HIV testing of blood of every pregnant woman for preventing mothers to child transmission (MTCT) of HIV/AIDS.

Most of the educated respondents knew about various governmental programmes for creating awareness among the masses: both rural and urban as Red Ribbon Express moving all over India to make aware of the disease, governmental non-governmental organisations’ awareness creating programmes as meeting, rally, races, street plays, dramas etc. On the celebration of AIDS Day and other occasions and establishment of Red Ribbon clubs in

degree Colleges and Universities of odisha to create awareness among the young students about HIV/AIDS, WHO will assist in making awareness of the masses in future.

Like wise majority of educated respondents were also aware of the governmental assistance for HIV/AIDS infected/affected persons as allocating Rs. 300/- a monthly pension for HIV/AIDS patients irrespective of age and economic status through their Bank Account which should be kept confidential and reservation of Government Service for HIV/AIDS patients in OSACS Office. The educated respondents knew more about the Governmental facilities for the families of HIV/AIDS infected persons as facility for house for them under "Indira Awas Yojana" and "Mo Kudia Yojana" and inclusion of those in BPL (Below Poverty Line) list to avail some other facilities like getting rice, wheat, Kerosene & Sugar in concession rate. Some of the less educated have been found being aware of all these Governmental provisions and facilities.

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Chapter- XI
IMPACT OF MASS MEDIA IN CHANGING SOCIAL ATTITUDE

CHAPTER-XI

IMPACT OF MASS MEDIA IN CHANGING SOCIAL ATTITUDE

HIV/AIDS continues to challenge our societies in many ways. It is incumbent on the Nations, States, Communities, Societies and Individuals to address extremely difficult and pervasive societal issues which have always been present in our societies and to identify solutions there to be. AIDS is a disease of ignorance and intolerance as well as a biological illness. When the mass media profile AIDS as a disease of Gays, IDUs and CSWs it perpetuates stigma. Fear, prejudice, injustice and stigma are every bit as dangerous, if not more so than the biological virus. AIDS stigma evokes negative reactions – denial, shame, fear, anger, prejudice and discrimination – that manifest themselves in interpersonal and group relationships. Discrimination of PLWHA forces them to remain socially invisible and to deny their status to protect themselves from social ostracism from their own families and communities. Someday, perhaps, we will live in a world without stigma of AIDS, and that will be possible through impact of mass media in changing social attitude towards HIV/AIDS infected and affected.

Mass media plays an important role in educating people and sensitizing them in pertinent issues. It holds multiple responsibilities such as dissemination of information, educating public opinion and modifying individual and group behaviour. Information has to be given cautiously, lest it results in fears and phobias or stigmatization or in a total avoidance of the message. At present AIDS coverage is there in both print and electronic media. Prevention messages are often times conveyed and endorsed by popular media personalities. Posters and hoardings are used fairly extensively to convey the message of AIDS prevention.

“Broadcast media have tremendous reach and influence, particularly with young people, who represent the future and who are the key to any successful fight against HIV/AIDS. We must seek to engage these powerful organizations as full partners in the fight to halt HIV/AIDS through awareness, prevention and education . . . . .” said Kofi Annan, the then President of United Nation’s Secretary General.

As AIDS is no longer a public health issue but has become a socio-economic and developmental concern, there is an immediate need to act with an utmost sense of urgency and seriousness. Media is one of the instrumentalities which facilitates and gives a directional thrust to the efforts to cure the disease if not to treat it. If medicine can treat HIV/AIDS, media is capable to prevent it with an ultimate goal to cure it through its capabilities to impart education through entertainment.

The media has the potential to create widespread awareness on HIV/AIDS, to promote the positive attitude towards people living with HIV/AIDS (PLWHA) and influencing people to change high risk behaviour that make them vulnerable to infection. It has a pivotal role to play in a fight against AIDS. It is a well known saying that, “Education is the vaccine against AIDS”. In the absence of a vaccine, a social vaccine of education and awareness is the only preventive tool we have. It is appropriately said that prevention begins with information, media which conveys information and moulds public opinion must remain at the heart of our campaign to help people make informed choice. Leaders of media, in cooperation with other segment of our polity and society can play a significant role in educating public opinion.

Each and every member of the society is oblivious that everybody is vulnerable but misconception is that only those individuals who are immoral and societal deviant are HIV/AIDS affected. On the other hand, the stigma and discrimination attached to the disease may keep away from seeking information or help is they are infected and on the other hand, for some the belief that they cannot be infected, promotes denial and keep them away from realities of the disease being allured by the false sense of security. All such issues are capable of being resolved when ignorance gives place to knowledge.

An article entitled, “An Innovative approach to reducing HIV/AIDS prevalence through targeted mass media communication in Mumbai, India”, to causes on the need for dissemination of related information and realities pertaining to the epidemic so that the ignorance is replaced by awareness and creating multiplier effects of awareness engulfing the wider cross sections of the society.

While addressing the Media Leaders Summit on HIV/AIDS, on January 06, 2005 held at New Delhi, the Prime Minister, Dr. Manmohan Singh stressed on strengthening the national AIDS control efforts as commitment of the National Common Minimum Program. He emphasized the need for supplementing all such efforts with an active and vivid participation from all sections of the society culminating in a mass movement for creating awareness of AIDS. The media plays an important and determining role in educating the public, creating awareness among them and transmitting crucial information so that public become aware, remain alert and take measures to prevent its occurrence. We all know that information is power and that awareness, therefore empowers.

As the main factor behind the multiplication of HIV/AIDS is that about fifty percent of PLWHAs are not even aware about the disease, the power of media is tremendous as media cannot only break the silence but can also educate the people and can launch a war against the stigma, discrimination and taboo attached with the disease by encouraging the people to openly discuss about AIDS. Effective media coverage personalizes the HIV issue, encourage the people to interact or share their views which in turn prompts the Govt. to priorities HIV/AIDS issue in the social and political agenda.

In June 2001, at UN General Assembly Special session on HIV/AIDS, the Heads of the State and Representatives of Govt., affirmed that: "Beyond the key role played by communities, strong partnerships among governments, the United Nation's system…….., people living with AIDS and vulnerable groups….., the media, parliamentarians, foundations, community organizations and traditional leaders are important". (Singh, Brijbhusan). At this special session, it was agreed by the governments of states that "By 2005 ensure that 90% and by 2010, 95% of youth aged 15-24 have information, education, services and life skills that enable them to reduce their vulnerability to HIV infection.

According to a survey conducted in India, 70% Indians identified television as a primary source of information about HIV/AIDS. An effective media can raise the awareness

level and can also bring about sustainable behaviour change thereby reducing vulnerability to the virus. Media is capable of performing following important role in preventing HIV/AIDS.

- A channel for communication and discussion:- One of the roles of media is to open channels for communication and foster discussion about HIV and interpersonal relations. Addressing HIV/AIDS in the entertainment programs can have an enormous impact on the society at risk.
- A vehicle for creating a supportive and enabling environment: Mass media can be instrumental in breaking the silence that envelopes the disease and in creating an encouraging behaviour for combating with existing social norms and making positive changes in the society.
- Facilitator for removing stigma and discrimination attached with the disease: HIV/AIDS affected individuals besides the anatomical discomforts undergoes the mental sufferings of stigma and discrimination at the hands of the society. A number of media campaigns have focused on the need to overcome prejudice and encourage solidarity with people infected or affected by virus.
- A tool for creating a knowledge base for HIV/AIDS related services: The collaborative efforts of all modes of media in association with NGOs, State Organizations, service providers have brought to the lime light the availability and source of beneficial services like counselling, testing and condom provisions, treatment and social care. The broadcasters and print media have a specific role to play as their efforts have tremendous recall value. The Kaiser Family foundation in partnership with media companies have promoted dedicated toll free hotlines and has launched websites for educating the people about HIV/AIDS.
- Education through entertainment: For creating an efficacious awareness about HIV/AIDS, the message needs to be informative, educative as well as entertaining as these are mutually exclusive. For instance, in 2002, Doordarshan, NACO and BBC World Service Trust joined hands in order to launch country's mass media awareness program about HIV/AIDS. The campaign was launched with an idea of spreading

education in a more entertaining way with a popular interactive detective series, "Jasoos (detective) Vijay", and a reality youth show, "Haath se haath mila", which had won the prestigious Indian Television Awards, 2003. In November 2005, BBC World Service Trust in association with Doordarshan and NACO were running world's largest HIV/AIDS awareness mass media campaign. In an interview Richard Gere, AIDS activist, Actor admitted that most public service announcements are unsuccessful as they are not entertaining.

- The Heroes Project is a public education initiative launched by Richard Gere and Parmeshwar Godrej to work with Indian media companies and leaders to develop coordinated public education campaign on HIV/AIDS. It is supported with a grant from the Avahan Initiative of the Bill and Melinda Gates foundation and by Henry J. Kaiser Family Foundation which provide technical and substantive expertise to the project. An actress Prachi Rathore has been awarded with Special Max Stardust award, 2005 for her contribution towards creating awareness about HIV/AIDS in Rajasthan. Movies like "My brother Nikhil" and "Phir Milenge" are an attempt in educating people with entertainment.

- Mainstreaming: Broadcasters are mainstreaming the HIV issue across a number of programs ensuring that the message permeates a diverse range of output, not just outlets and public service messages dedicated specifically to the issue. A coordinated, multifaceted campaign has greater impact than a single program. Documentaries, new items, concerts, public service announcements, competitions, hotlines, books and websites can be linked together to reinforce awareness, information and messages about HIV related attitude and behaviour.

- Putting HIV/AIDS on the news agenda and encouraging leaders to participate: The more the leaders see about HIV/AIDS in news, the greater the resources they invest in anti AIDS strategies, which in turn leads to increased media coverage of the issue and helps in sustain public awareness which again has an impact on leaders priorities.

- Media is an institution of oversight, restraint and collaborative efforts: Media can render Yeoman's service in providing accurate and correct news coverage of HIV/AIDS facilitates eliciting and generating public response to state sponsored efforts. Such efforts have the potentials to awaken social and political leaders to review their strategies and take a mid course corrections in regard to policy concerning HIV/AIDS.

In such a process, the media has the potential to influence public opinion and attitudes about HIV/AIDS including attitude towards people living with HIV/AIDS. Attitudes affect how people respond to HIV/AIDS and how people with HIV/AIDS are treated or cared by their peers, employers, families, communities, the health care system and the justice dispensing system. Media too have the capability to bring about transformation in the thinking pattern of the society in respect of PLWHA and thus showing the seeds of attitudinal changes. The media can be a great facilitator for preventing process while imparting the need for a healthy behaviour towards the section of the society and those individuals are most vulnerable to HIV/AIDS and those individuals affected by it.

The importance of and the need for the participation of media in fighting AIDS, has been time and again felt by the governmental and non-governmental organizations on the inauguration of a seminar organized by "Sachetana", an NGO convenor of the program and a well known journalist Rahul Deo commented that the media could play a motivational role to free the society of myths and misconception attached to HIV/AIDS.

The reporting of hidden HIV cases from the remote places of the country, instance of the poor medical treatment provided to PLWHA, instances of stigma and discrimination attached with the disease shapes the belief of the people, influences the attitude of the people and response of the government.

Media combats the disease through public education and awareness as the disease not only a battle against a virus but is also a battle against the stigma, discrimination, cultural taboo and the ideas. Media should understand its role and should refrain from reporting exaggerated and distorted fact as the same can criminalize the disease. Let us hope that media continues to play a key role in reversing the progression of HIV.

Worldwide: Mass media Program:

To date virtually every country in the world affected by HIV/AIDS according to the joint UN program on HIV/AIDS (UNAIDS, 1997). In response most countries have established National AIDS program and have conducted some sort of mass media HIV/AIDS campaign (WHO,1994). According to WHO data on 126 countries, 93% broadcast HIV/AIDS message on TV, 85% conduct radio broadcast and 67% of countries promote condom use through the media (WHO 1994). Although the precise impact of mass media on reducing AIDS risk behaviour is continually debated, knowledge about AIDS is obtained most often from mass media (i.e. TV, radio, news papers, magazines, pamphlets and posters) rather than from interpersonal sources (i.e. friends, health workers or the work place, Ross and Carson,1988).

In June 2001, Kofi Annan called a special UN general session of HIV/AIDS with delegates from 180 countries, 350 NGOs and 24 heads of states, in which he called on the world community to raise $ 7-10 billion (US) each year for 10 years towards a global fund for HIV/AIDS (UNAIDS).

Centre for Disease Control (CDC) in Atlanta, as a part of its global AIDS program, utilizes entertainment education " Soap Operas" in its Modeling and Reinforcement to combat HIV (MARCH) project in four African countries: Botswana, Ethiopia, Ghana and Zimbabwe. Population Communication International (PCI) established in 1985, works within country, partner organizations to implement entertainment education for radio and TV intervention in Asia, Africa, Latin America, The Caribbean and The United States.

The entertainment education strategy has been consciously applied to HIV/AIDS prevention and control in the form of so popular radio and TV soap operas, for instance, " Soul City" in South Africa, " Twende Na Wakati (Let's go with Times)" in Tanzania, "Tinka Tinka Sukh (Happiness lies in small things)" in India, "Nshilakamona" in Zambia, and " Kamisama Mo Sukoshidake (please God just a little more time)" in Japan. Entertainment education programs appeal to the emotions of audience members. The entertainment education strategy through the use of formative research, role models, epilogues, a multi media campaign approach and other creative techniques such as humor and animation can be highly effective in promoting HIV/AIDS prevention.

In 2002, All India Radio (AIR), the Indian National Radio Network in cooperation with Popular Communications International (PCI), New York, broadcasted an entertainment education radio soap opera "Taru (The name of the female protagonist)", in four Hindi speaking states: Bihar, Jharkhand, Madhya Pradesh and Chandigarh. The 120 episode long entertainment education detective series title "Jasoos Vijay (Detective Vijay)", runs for 10 months from June 2002 to April 2003. Complementing Jasoos Vijay, there was another youth reality TV show as "Haath se Haath Mila (hand in hand together)".

Meena Saraswati Seshu, an activist whose courageous work in southern India has helped women in prostitution and others at high risk of HIV/AIDS to combat abuse and discrimination and become important allies in the fighting against growing AIDS epidemic . She seeks consistently about the HIV/AIDS crisis as human rights issue. She is the general secretary of SANGRAM, an organization that works to stem the epidemic in Maharashtra state, which has one of the highest infection rate in India.

In Odisha, All India Radio (AIR), Cuttack has been broadcasting an weekly program, "Jeevan Jindabad", on every Wednesday at 5.30 PM regarding HIV/AIDS and its various controlling steps, awareness program and remedial measures. Another program launched by AIR, Cuttack regarding HIV/AIDS prevention is "Katha Rakhiba, AIDS Rokiba, Mo Pasanda" on every Sunday at 9.00 AM to 10.00AM. All India Radio, Cuttack has been broadcasting a program entitled as "Jaya Jatra" to create awareness regarding HIV/AIDS among rural people by OSACS (Orissa State AIDS Control Society) from 1st December 2009. (Khabar, 10.12.2009).

Doordarshan National channels have launched various programs for creating awareness against HIV/AIDS as "Jasoos Vijay", "Haath Se Haath Mila" and "Kyonki Jeena Isika Nam Hai" on Monday, Tuesday and Wednesday at 8.30 PM by UNICEF. DD-1 also creates awareness about HIV/AIDS in its popular program "Kalyani".

A number of daily newspapers in English and Odia language have written articles and news about awareness programs. The English daily like “The Times Of India”, “The Hindu”, “The New Indian Express” etc. and the Odia daily news paper as “The Sambad”, “The Samaj”, “The Samaya”, “The Dharitri”, “The Khabara”, “The Prajatantra”, “ The Sarba Sadharana” etc. publish news relating to prevention and awareness about HIV/AIDS among people.

The first and unique newspaper of India as well as of the whole world is, “The Positive +” has been published from Chennai, since December 1st 2008. Asama Nasir is the editor of the newspaper. She has faced a lot of problems for continuing its publication. This newspaper published in two languages i.e. English and Tamil includes detail information regarding the number HIV infected persons, AIDS awareness programs, telephone helpline number, hospitals, blood banks, counselling centres, disease testing centre, community care centre and other related information. (The Sambad, 18th December 2012).

A large number of rallies, meetings, camps, debate discussions, seminars etc. are organized for creating awareness about this deadly disease, HIV/AIDS, among the people.

But, now the time comes to find out and to investigate how far these programs have been successfully implemented and influenced the ruralites.

Here the researcher wanted to investigate to what extent the respondents of the study were influenced by the Mass Media in relation to their knowledge, behaviour and attitude towards HIV/AIDS infected persons, their children and family members and whether their preliminary knowledge, behaviour and attitude towards PLWHAS and their family members been changed or not through the impact of mass media.

Table No-11.1

Distribution of the Respondents on the Basis of Their Contact with variety of Mass Media Communication

N=300

Having and Using mass media by the Respondents	No. in Rajnagar Block						No. in Rajkanika Block					
	Below matric		Matric and above		Degree and above		Below matric		Matric and above		Degree and above	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
A	15	36	42	-	57	-	30	-	39	-	81	-
B	36	15	15	27	39	18	-	30	-	39	45	36
C	-	51	30	12	57	-	9	21	24	15	81	-
D	-	51	15	27	57	-	18	12	24	15	66	15
E	-	-	-	-	-	-	-	-	-	-	-	-

N.B:-

(A) Having Radio/TV of their own at home/ at workplace.

(B) Going to cinema hall for watching movie.

(C) Reading newspaper.

(D) Watching advertisement/article/feature in media for awareness about HIV/AIDS.

(E) Any other.

This table shows the respondents' contact with various mass media communication. Their possession of radio and TV at their own home and workplace, watching movie in cinema hall, reading newspaper in which they read advertisement, article and features regarding HIV/AIDS made them aware about this deadly disease. In Rajnagar block out of 150 respondents 15 below matric, 42 'matric and above' and 57 'degree and above' qualified respondents had radio and TV in their home and work-place and they usually listened to these. Thirty six respondents having matric and above and 57 having degree and above qualification said that they watched movie in cinema hall. Thirty 'matric and above' and all the 'degree and above' qualified respondents regularly read newspapers. Fifteen 'matric and

above' and all the 'degree and above' qualified respondents watched advertisements, article and features in media regarding awareness of HIV/AIDS.

In Rajkanika block all respondents i.e. 150 had radio and TV in their home and work place and they regularly listened to them. But only 45 degree and above qualified respondents went to cinema hall to watch movie. In this block 9 respondents having below matriculation, 24 matriculation and above and all having degree and above qualification read newspapers. Eighteen below matriculation, 24 matriculation and above and 66 degree and above qualified respondents watched advertisement, article and feature in media regarding awareness about HIV/AIDS.

On the whole, this table shows that more educated respondents of both the blocks had contact with mass media and they also watched and read advertisements regarding HIV/AIDS.

Table No - 11.2

Distribution of the Respondents on the Basis of Their Awareness Regarding Organisation of Meeting/ Rally, by various Institutions About HIV/AIDS

N=300

Name of the Organisation	No. of Respondents in Rajnagar Block	No. of the Respondent in Rajkanika Block
A	30(20)%	84(56%)
B	72(48%)	39(26%)
C	21(14%)	27(18%)
D	27(18%)	-
E	-	-
Total	150	150

N.B:

(A) Government officials

(B) Non-governmental Organizations

(C) Educational Institutions

(D) Medical officials

(E) Any other.

Government officials, non- governmental organizations, educational institutions and medical officials organized meetings and rallies for creation of awareness among the rural masses about HIV/AIDS. This table shows the opinion of the respondents in both the blocks i.e. Rajnagar and Rajkanika about organization of such awareness creating programmes.

In Rajnagar block twenty percent respondents said that awareness creating meetings and rallies had been organized by the Government officials, 48% respondents viewed that such meetings and rallies had been organized by the Non-Governmental organizations 14% said that educational institutions and 18% respondents said that medical officials had organized meetings and rallies in their locality on different occasions to create awareness among the rural people about HIV/AIDS.

In Rajkanika block 56% respondents said that awareness creating meetings and rallies had been organized by the Government officials in their locality. 26% respondents viewed that Non-governmental organizations had organized meetings and rallies on different occasion to create awareness among the rural people about HIV/AIDS and 18% respondents said that educational institutions had organized awareness creating meetings and rallies in their locality.

On the whole, the majority of respondents in Rajnagar block said that non-governmental organizations arranged meeting in there locality to create awareness about HIV/AIDS. Where as in Rajkanika block the majority of respondents viewed that the government officials arranged such meetings in their locality to create awareness about HIV/AIDS.

Table No-11.3

Distribution of the Respondents on the Basis of Their Findings about Changing Attitude of the Villagers

N=300

Response	No. of Respondents in Rajnagar Block	No. of the Respondent in Rajkanika Block	Total (Percentage)
YES	87(58%)	123(82%)	210(70%)
NO	63(42%)	27(18%)	90(30%)
Total	150	150	300

This table shows the respondents opinion regarding change of attitude of the villagers towards HIV/AIDS. Fifty eight percent of respondents Rajnagar block and 82% of respondents in Rajkanika block had found certain change in attitude of the villagers towards HIV/AIDS. The rest of the other respondents had not found any change in the attitude of the villages towards HIV/AIDS.

Table No-11.4

Distribution of the Respondents on the Basis of Their Opinion regarding Visibility of Changing Attitude

N=300

Changing attitude towards various cases	No. of respondents in Rajnagar Block			No. of respondents in Rajkanika Block		
	Below matric	Matric and above	Degree and above	Below matric	Matric and above	Degree and above
A	15	30	18	9	12	48
B	-	-	-	-	-	18
C	-	-	-	-	12	15
D	-	-	24	9	-	-
E	-	-	-	-	-	-
F	-	-	-	-	-	-

N.B:

(A) HIV/AIDS patients

(B) Life partners of the patients

(C) Other family members

(D) Using condom for safe sex/to check HIV infection

(E) Any others

(F) All.

The respondents had found some changing attitude of the villagers in various cases. In Rajnagar block out of 150 respondents, 87 respondents and in Rajkanika block out of 150 respondents 123 respondents had found changing attitude of the villagers.

In Rajnagar block 15 below matriculation, 30 matriculation and above and 18 degree and above qualified respondents and in Rajkanika block out of 123 respondents 9 below matriculation, 12 matriculation and above and 48 degree and above qualified respondents had found changing attitude of the villagers towards HIV/AIDS patients. In Rajkanika block 18 degree and above qualified respondents had found changing attitude towards life partners of the patients. Twelve percent respondents having matriculation and above and 18 respondents having degree and above qualification had found changing attitude of the villagers towards other family members of the HIV/AIDS patients, the other 24 respondents of Rajnagar block having degree and above qualification and 01 below matriculation qualified respondents of Rajkanika block had found changing attitude of the villagers towards using condoms for safe sex and to check HIV infection.

That means the majority of respondents of both the blocks had found changing attitude of the villagers towards HIV/AIDS patients.

Table no. 11.5
Distribution of the Respondents on the Basis of Their Opinion regarding Consciousness of the Villagers about the Causes of HIV/AIDS.

N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	15	30	42	87 58%	18	39	81	138 92%
No	36	12	15	63 42%	12	-	-	12 8%
Total	51	42	57	150	30	39	81	150

This table shows that out of 150 respondents of Rajnagar block 15 below matric, 30 matric and above and 42 degree and above qualified respondents said that the villagers were conscious about the cause of HIV/AIDS. In Rajkanika block out of 150 respondents 18 below matric, 39 matric and abone and 81 degree and above qualified respondents opined that their villagers were conscious about the causes of HIV/AIDS. In total 58% respondents of Rajkanika block opined that the villagers were conscious about the causes of HIV/AIDS.

Table No:-11.6

Distribution of the Respondents on the Basis of Their Consciousness about Using Condoms to Check the Infection of HIV/AIDS

N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	15	42	57	114 76%	18	39	81	138 92%
No	36	-	-	36 24%	12	-	-	12 8%
Total	51	42	57	150	30	39	81	150

This table shows that out of 150 respondents of Rajnagar block 15 below matric, 42 matric and above and 57 i.e. all the degree and above qualified respondents opined that HIV/AIDS infection can be checked by using condoms during sex. Like wise out of 150 respondents of Rajkanika block 18 below matric, 39 matric and above and 81, i.e. all the degree and above qualified respondents had the same opinion. In both the blocks majority of respondents i.e. 76% in Rajnagar block and 92% in Rajkanika block said that the infection of HIV/AIDS can be checked by using condoms during sex or through practicing safe-sex.

Table No:-11.7

Distribution of the Respondents on the Basis of Their Appreciation of Advertisements about Condoms in TV

N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	-	30 20%	57 38%	87 58%	18 12%	24 16%	81 54%	123 82%
No	51 34%	12 8%	-	63 42%	12 8%	15 10%	-	27 18%
Total	51	42	57	150	30	39	81	150

Majority of respondents in both the blocks as 58% in Rajnagar block and 82% in Rajkanika block appreciated the condom using advertisements in the most common media like T.V. The more educated respondents as all the degree and above qualified respondents in both the blocks and comparatively more matric and above qualified respondents of both the blocks had appreciated condoms using advertisements in T.V.

Table No. 11.8

Distribution of the Respondents on the Basis of Their Feeling to watch the Advertisements Regarding sex/ use of condoms in T.V with Family Members / Grown up children N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	36	27	12	75 50%	21	15	-	36 24%
No	15	15	45	75 50%	9	24	81	114 76%
Total	51	42	57	150	30	39	81	150

This table reveals the respondents' felling towards advertisements regarding sex / use of condoms in T.V while watching with family members and grown up children. In Rajnagar block total 50% respondents opined that they had felt shame while watching advertisements regarding sex and condoms use in T.V with the family members especially with grown up children. The other 50% respondents did not feel shame while watching such type of advertisement in T.V with family members and grown up children. This 50% respondents not feeling shame included more educated respondents.

In Rajkanika block 76% respondents in total had not felt shame in watching advertisements regarding sex and using of condoms in T.V with family members and grown up children. Here all the degree and above qualified respondents had not felt shame of watching such type of advertisement in T.V. But more respondents having comparatively less education had felt shame in watching advertisements about sex on using condoms for safe sex.

This shows that education can have certain impact on feeling and attitude of respondents.

Table No. 11.9

Distribution of the Respondnts on the Basis of Their Opinion Regarding Horribility of HIV/AIDS on the Villagers Today as before

N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	36	27	27	90 60%	12	24	15	51 34%
No	15	15	30	60 40%	18	15	66	99 66%
Total	51	42	57	150	30	39	81	150

This table shows that the villagers were afraid of this deadly disease HIV/AIDS today as before inspite of a lot of awareness campaigning in mass media. In Rajnagar block out of 150 respondents 36 below matriculation, 27 matriculation and above and 27 degree and above qualified respondent said that the villagers were afraid of the disease as before.

In Rajkanika block out of 150 respondents 12 below matriculation, 24 matriculation and above and 15 degree and above qualified respondents viewed that the villagers were afraid of the disease today as before. In total majority of the respondents of rajnagar block said that villagers were afraid of the disease today as before but in Rajkanika block the majority of respondents said that the villagers were not afraid of the disease today as before mass media campaigning.

This shows that mass media campaigning regarding HIV/AIDS was not so successful in lessening fear of the villagers towards HIV/AIDS. That means HIV/AIDS more or less has frightened the villagers till today after a lot of awareness creating campaigning in mass media.

Table no. 11.10

Distribution of the Respondents on the Basis of Their Opinion regarding Villagers' Awareness about Medical Facilities for Treatment of HIV/AIDS Infected

N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	-	-	12	12 8%	9	12	18	39 26%
No	51	42	45	138 92%	21	27	63	111 74%
Total	51	42	57	150	30	39	81	150

This table reveals that a few respondents i.e. 12 degree and above qualified respondents of Rajnagar block and 9 below matric, 12 matric and above and 18 degree and above qualified respondents of Rajkanika block viewed that their villagers were aware of medical facilities for treatment of HIV/AIDS infected/affected. In spite of mass media campaign the majority of the respondents of both the blocks 92% in Rajnagar block and 74% in Rajkanika block said that their villagers were not aware of medical facilities for the treatment of HIV/AIDS infected persons.

Table No.11.11

Distribution of the Respondents on the Basis of Their opinion Regarding Villagers' changing Attitude Towards Discrimination/Ostracisation of HIV/AIDS Infected/Affected

N=300

Response	No. in Rajnagar Block				No. in Rajkanika Block			
	Below matric	Matric and above	Degree and above	Total	Below matric	Matric and above	Degree and above	Total
Yes	-	30	42	72 48%	18	24	63	105 70%
No	51	12	15	78 52%	12	15	18	45 30%
Total	51	42	57	150	30	39	81	150

This table provides information about the villagers' changing attitude towards discrimination and ostracisation of HIV/AIDS infected persons. Out of 150 respondents 30 matric and above and 42 degree and above qualified respondents said that they found the changing attitude of the villagers towards discrimination and ostracisation of PLWHAS. In Rajkanika block out of 150 respondents 18 below matric, 24 matric and above and 63 degree and above qualified respondents viewed that they found changing attitude of the villagers regarding discrimination and ostracisation towards HIV/AIDS infected persons. The rest of respondents did not find any change in the attitude of the villagers regarding discrimination and ostracisation of the HIV/AIDS infected/affected persons.

Table no. 11.12

Distribution of the Respondents on the Basis of Their Opinion Regarding Forms of changed Attitude Towards HIV/AIDS Infected/Affected

N=300

Changing attitude towards various cases	No. of Respondrnts in Rajnagar Block			No. of Respondents in Rajkanika Block		
	Below matric	Matric and above	Degree and above	Below matric	Matric and above	Degree and above
a	-	15	-	9	-	15
b	-	-	9	-	-	-
c	-	-	15	9	12	18
d	-	15	18	-	12	-
E	-	-	-	-	-	-
Total	-	30	42	18	24	63

N.B.: (a) No feeling of hatred towards the patients.

(b) Their children are not discriminated.

(c) All extend co-operative hands towards them.

(d) All accept them as normal person and are friendly towards them.

(e) Any other.

In Rajnagar block out of 150 respondents 72 respondnts and in Rajkanika block out of 150 respondents 105 respondents in total found changing attitude among the villagers towards PLWHAS. In Rajnagar block 15 matric and above and in Rajkanika block 9 below matric and 15 degree and above qualified respondents found that the villager had no feeling of hatred towards the patients. Only 9 respondents of Rajnagar block having degree and above qualification found that the children of the HIV/AIDS Infected patients were not discriminated in the village as before, 15 respondents of Rajnagar block having degree and above qualification and 9 respondents having below matric 12 having matric and above and 48 having degree and above qualification of Rajkanika block found that all the villagers extending their co-operative hands towards PLWHAS. The rest 15 matric and above and 18 degree and above qualified respondents of Rajnagar block and 12 matric and above qualified respondents of Rajkanika block found that all the villagers accepted PLWHAS as normal person and became friendly towards them.

Table no. 11.13

Distribution of the Respondnts on the Basis of Their Opinion about Role of Mass Media in Decreasing Discrimination / Ostracisation

N=300

Form of mass media	No. of Respondrnts in Rajnagar Block			No. of Respondents in Rajkanika Block		
	Below matric	Matric and above	Degree and above	Below matric	Matric and above	Degree and above
A	-	-	-	9	12	15
B	-	-	-	-	-	-
C	-	30	42	9	12	48
Total	-	30	42	18	24	63

N.B.:

(A) Electronic media (TV & Radio)

(B) Printed media (News Papers & Pamphlets)

(C) Awareness programs (Rally & meetings).

In Rajnagar block out of 150 respondents 72 respondents and in Rajkanika block out of 150 respondents , 105 respondents found changing attitude of the villagers regarding discrimination and ostracisation of the PLWHAS. These respondents viewed that this changing attitude was possible due to the impact of mass media, electronic media as TV and radio and the awareness programmes as rallies and meetings organized by various governmental and nongovernmental organizations. In Rajkanika block 9 below matric, 12 matric and above and 15 degree and above qualified respondents said that the changing attitude of the villagers was obviously the impact of electronic media. TV and radio played important role in changing attitude of the villagers through various discussion, drama, story and advertisement about HIV/AIDS, its causes, transmission, prevention and cure and meaningless ostracission and discrimination towards infected persons, their spouse, children and other family members. The rest of the respondents as 30 matric and above and 42 degree and above qualified respondents of Rajnagar block and 9 below matric, 12 matric and above and 48 degree and above respondents viewed that the changes in discrimination and ostracisation were found as consequences of various awareness creating programmes as rallies and meeting on the different occasions by the governmental and nongovernmental organizations in their locality.

Findings:

This chapter has been furnished with the information about the contact of the respondents with various mass media communication i.e. radio, television, cinema and newspapers which make them conscious about the deadly disease like HIV/AIDS, its prevention and protection of the PLWHAS (People Living With HIV/AIDS) and there family members from social discrimination, stigma and ostracisation , prevention of this disease by using condoms during sex and the impact of mass media in changing social attitude towards HIV/AIDS infected/affected persons, their children and other family members.

It was found that all the highly educated i.e. ‘degree and above’ qualified respondents in both the blocks and the majority of matric and above qualified respondents in both the blocks had possessed Radio/TV of their own at home or at work places and read newspaper

regularly and also watched advertisements, article and feature in media regarding awareness about HIV/AIDS. Meetings and rallies had been organised in the locality by various governmental and nongovernmental organizations, educational institutions and some of the medical officials on certain special occasions for creating awareness among the rural masses. Majority of the respondents have found changing attitude of the villagers towards HIV/AIDS patients. Some of the respondents found changing attitude towards life partners of the patients and other family members .The villagers of both the blocks also had changed their attitude towards using of condoms for safe-sex and to check Hiv infection .Majority of the respondents of both the blocks viewed that their villagers were conscious about the causes of HIV/AIDS. They knew that they can avoid HIV infection by using condoms during sex, as unprotected sex with the HIV infected person is the most important cause of HIV infection. This consciousness was developed among the ruralites due to various awareness creating advertisements and drama, in Radio, TV and Newspaper. The majority of the educated and conscious respondents felt no shame while watching advertisements regarding sex and use of condom in TV with family members and grownup children. This change was visible in rural areas as a result of awareness creating programme by various governmental and non governmental organizations in their locality but inspite of a lot of awareness creating programmes by the governments the villagers were afraid of the disease today as before. The majority of the respondents of both the blocks had found such type of 'Aids phobia' in the mind of the villagers medical facilities for treatment of HIV/AIDS infected persons were unknown to the villagers. A few respondents knew about the facilities for treatment.

It was found that although the villagers were afraid of the deadly disease till today but they had changed their attitude towards discrimination and of HIV/AIDS infected/affected persons. The majority of the respondents of both the blocks found same change among the villagers regarding discrimination and ostracisation of the patients, their family members and their children. It was observed that the villagers had no such feeling of hatred towards the patients. Their children were not discriminated and ostracized in various field in society. All extended their co-operative hands to help the patients and to their family members. All most all the villagers accepted them as normal persons and became friendly towards them.

On the whole, all sorts of these changing attitude and changing situation which were visible in the villages were because of the impact of mass media. Now the people are afraid of the disease not of the patients.

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Chapter- XII
SUMMARY, CONCLUSION, RESEARCHER'S EXPERIENCE AND SUGGESTION

CHAPTER-XII

SUMMARY, CONCLUSION, RESEARCHER'S EXPERIENCE AND SUGGESTION

Acquired Immune Deficiency Syndrome (AIDS) is recognized as the most divasting disease, human kind has ever faced. The epidemic began in 1981 and by the end of 2012 more than 24 million people across the Globe were afflicted by it as stated by UNAIDS World AIDS day report 2012. The disease is caused by Human Immuno Deficiency Virus (HIV) which breaks down the Immuno system of a body completely to combat infection. The virus remains dormant for 5 to 10 years before the unset of full blown AIDS. Today AIDS is rapidly wiping out the hard earned gains of human development in terms of regressing life expectancy, rising child mortality rates and killing the most productive and reproductive population in the prime of their youth. The economic impact of AIDS in terms of costs resulting from treatment and care of people living with HIV/AIDS (PLWHA) is magnanimous.

With the rising spread of HIV/AIDS there has been a growing emphasis on understanding its epidemiology and manifestation. Various factors such as biological, socio cultural, economic, political and psychological have been broadly seen as causing the spread of the virus. Migration, prostitution, machismo behaviour, low literacy level, prevalence of myths and misconceptions further aggravate the rapid spread of the disease. It is seen that the infection is rapidly spilling from populations with high risk behaviour to the general population and also from urban to rural areas. Since there is no sure cure for the disease, its prevention become paramount.

Till now there are only four well-defined routes by which HIV is transmitted. These are through sexual intercourse with an HIV infected person, by exchange of HIV infected blood and blood products as in transfusion, by sharing contaminated needles/syringes and lastly transmission from an HIV infected mother to her child before , during or after child birth. Certain populations are more vulnerable to the disease because of their high risk behaviour. These are the commercial sex workers (CSWS), the truck driver, the rickshaw pullers and the injecting drug user (IDUS).

There is global reaction and response to HIV/AIDS advocating the importance of education, awareness generation and also for adopting ‘safe practices’. Here ’safe practices’ has connotations to safely in sexual acts and medical safety (against sharing of needles and syringes). Many million people know nothing or too little about the virus to protect themselves against (UN AIDS/WHO DEC 2001). Globally low level of knowledge coupled with myths and misconceptions are driving the disease out of control.

Various NGOs along with government bodies and also private sectors are putting in their best efforts to lunch ‘Global Media AIDS Initiative’. The initiative aims to activate media organizations to reach the worlds people especially youth with information about how to prevent and treat HIV and to help combat AIDS related stigma and discrimination. These include efforts in developing and implementing programmes to bring about changes in knowledge, attitude, behaviour and practices (KABP) of people with regards to HIV/AIDS. In the absence of any cure for HIV presently, creating HIV/AIDS awareness takes on significant and life saving role.

In India HIV is late comer but fast spreading. The HIV Prevalence in India has risen to alarming levels with 5.1 million people living with the virus by the end of the year 2004 (NACO,2004). Up to December 2013, 3 million HIV positive cases were reported in India (The Samaya, The Odia, Daily, Bhubaneswar 20.12.2013). This report shows that the number is decreasing. If concerted efforts are not made to contain the virus, a threat to human welfare and social stability is imminent. Various surveillances as well as KABP studies continue to show an overall lack of awareness among the masses about the disease, its prevention especially amongst some of the most vulnerable populations. AIDS is regarded as disease of ignorance. Since now no sure cure is invented, its prevention is the only way to control this disease. Prevention is better than cure. But in the absence of any vaccination for its prevention awareness of the masses is regarded as the best way of prevention. In the national level a lot of governmental and nongovernmental organisations have tried their best to organize awareness creating programmes to replace ignorance about HIV/AIDS from the minds of the people. A lot of money was spent in this regard. But no such remarkable change has been found in attitude, perception and behaviour of the masses.

Odisha has been categorised as low risk state in comparision to other states namely Andhra Pradesh, Karnataka, Maharashtra, Gujarat, Manipur and Nagaland. The first case of HIV infection in Odisha was detected in 1992 and the first death due to AIDS was reported in 1993. Upto February 2013, 27,850 HIV positive cases and 1583 AIDS cases were reported by the Odisha state AIDS control society (OSACS). Among whom 1361 HIV infected persons have been already died of AIDS. (District wise HIV+/AIDS/Death cases –Odisha up to 2013 by OSACS).

Though Odisha is a low prevalent state but it is highly vulnerable to HIV/AIDS. Like other states, the people with HIV/AIDS in Odisha have been found to be discriminated, mistreated and ostracized by their family members, friends, neighbours and medical fraternity driving them to despair and sometimes forcing them to commit suicide. Sometimes the PLWHAs exercise self stigma before they are socially stigmatized. Being afraid of social stigma and discrimination they may not go to hospital for testing their blood even when they suspect of being infected by HIV. Self stigma, institutionalized stigma and social stigma together make some PLWHAS to commit suicide. Such stigma and discrimination were the consequent of myths and misconnections and illiteracy and lack of awareness of the people about transmission, prevention, treatment and cure of HIV/AIDS.

In such a critical situation OSACS has to do a lot of things for creating awareness among the people against HIV/AIDS because awareness is the one and the only way to prevent HIV/AIDS. OSACS has taken up a lot of ventures for HIV affected people. It has provided for ART (Anti-Retro-Viral Therapy) treatment to AIDS patients to improve their immune system and to give 'NUTRIPLUS' the proteinous food to HIV + people free of cost. OSACS also regularly organise IEC (Information, Education and communication) programmes including community mobilization radio programme for abolishing ignorance and creating awareness among the masses. (The Times of India, BBSR, National 1st Dec.2008).

Inspite of a lot of expenditure for the developmental activities by OSACS for advertisements, propaganda and awareness creating programmes about HIV/AIDS in mass media, (TV, Radio, Newspapers) people in rural areas have misconceptions regarding infections and transmission of HIV/AIDS. Their attitude and perception are not found to be influenced and changed so rapidly by the awareness creating programmes.

Therefore this research work aimed to study some such objectives to create awareness about HIV/AIDS among the rural masses and to find out changes in perception and attitude of the rural masses towards HIV/AIDS infected persons and their family members and children.

By "attitude" we mean "opinion or way of thinking or behaviour reflecting this." (Oxford Dictionary, B.K. Tripathy and K.M. Pattnaik, Oxford Unniversity press).

The lexical meaning of 'perception' is act of perceiving or understanding,'-(Oxford Dictionary, B.K. Tripathy and K.M. Pattanaik).

The researcher aimed at studying the attitude and perception of ruralites towards affected HIV/AIDS patients because rural community is an important aspect of Indian social life. India is a classic land of villages. About 80% of the total population of India lives in villages.

Gandhiji, the father of nation used to say that "villages constitute the very heart of India ".A.R. Desai is of opinion that 'the real India lives in villages". The village is the unit of rural society. It is the theatre where in the quantum of rural life unfolds itself and functions. The nation's progress and prosperity depend on the progress of the villages. For which it is rightly said by Mahatma Gandhi, "Back to villages, if villages will prosper, we will prosper, and if villages will perish India too will perish'. It has become a national slogan, so Indian life mostly represents rural ways of life. India lives in villages and villages are the centre of Indian culture. Human society has been cradled in rural groups.

Therefore, attitude and perception of Indian people towards HIV/AIDS infected patients can better be understood and known through the attitude and perception of ruralites

of India. Awareness or consciousness of such a horrendous disease like HIV/AIDS of Indian masses should be started from rural masses.

So that in this present study taking education as independent variable the researcher has tried to find out how attitude and perception of ruralites have been changed towards affected HIV/AIDS patients and their family members.

Methodology:

Methodology is an integral part of social research. It is a logical procedure in the hands of researcher. Methodology stands for advance planning of methods to be followed for the collection of reliable data and the techniques to be used in their analysis keeping an eye over the aims of research.

Universe of study or locale:

The study was conducted in two coastal blocks, i.e. Rajnagar and Rajkanika of Kendrapara district of Odisha. In Rajnagar block 30 HIV + cases were detected from which 7 persons have already died of AIDS. In Rajkanika block 34 HIV + cases were detected from which 7 person have already died of AIDS. (The Prameya, The Odia Daily, Bhubaneswar, 2nd Dec 2013).

Sampling strategy:

The sample of the present study consisted of ruralites of Rajnagar block and Rajkanika block. One hundred and fifty respondents were selected from each block. The villagers from which sample was selected from each block were distributed in three circle in accordance with distance from block head quarters. The first circle is within the '0-10' kilometer and the third is within '10 – 20' kilometer and third is within 20 and above kilometer distance from the block head quarter.

Research Design:

Research Design is a strategic plan for a research project or research programme setting out of the broad outline and key features of the work to be undertaken including the methods of data collection and analysis .In the present study the exploratory and the experimental research design were followed and the study is conducted taking a number of hypotheses.

Objectives of study:-

The present study was undertaken with the following objectives.

- To find out awareness of the rural people towards signs, symptoms, transmission and prevention of HIV/AIDS.
- To investigate the factors determining the cause of the spread of HIV/AIDS among the rural people.
- To examine social attitude of rural people towards HIV/AIDS infected/affected.
- To enquire about ostrascization of HIV/AIDS infected people and their family members.
- To reject myths and misconception about HIV/AIDS related discrimination.
- To suggest rural people to provide family care as well as social care for HIV/AIDS infected persons to lead a life of normal people.
- To assess the role of governmental and non governmental agencies and the mass media for the well being of HIV/AIDS infected/affected.

Hypotheses:-

- Misconception about HIV/AIDS leads to ostracization and discrimination of HIV/AIDS infected/affected by the ruralites.
- Social attitude of ruralites is not positive towards HIV/AIDS infected/affected.
- Negative attitude of rural people towards HIV/AIDS infected/affected acts as a psychological threat on them.
- Positive social attitude provides moral support to HIV/AIDS infected people to live normal life.
- Governmental and non-governmental agencies create awareness among the ruralites about the causes, transmission, prevention and treatment of HIV/AIDS.
- Mass media helps in changing negative social attitude of rural people towards HIV/AIDS infected/affected.
- Changing social attitude may lessen social discrimination and ostracization against HIV/AIDS infected/affected.

Variables:

Variable means something that varies or changes. It helps the researcher in making comparative analysis which facilitates in drawing two types of variables i.e. independent variables and dependent variables.

The independent variables are the age, sex, income, occupation educational background and marital status of the sample of the present study. The researcher has undertaken her study mainly basing on education as independent variable. Education is taken as independent variable to the extent that it helps in increasing awareness level of the sample and changing attitude with the impact of mass media. The respondents' outlook towards the disease and towards the infected/affected by the disease is developed through education.

Dependent variables are those which depend on other variables and change from time to time. In the present study the dependent variables comprised of the awareness level ,preliminary knowledge, about HIV/AIDS and its causes, symptoms , transmission, myths and misconception relating to HIV/AIDS, stigma, discrimination and ostracization against HIV/AIDS infected/affected, existing positive or negative attitude of ruralites under study towards them. It also includes changing attitudes relating to stigma, discrimination and ostracization of HIV/AIDS infected/affected, impact of mass media on the respondents and the governmental and non-governmental attempts to create awareness and to provide assistance for care and maintenance of HIV/AIDS infected/affected.

Salient Study Findings:

Keeping in line with the research objectives the findings of the study are discussed under the following heads:-

1. Socio-economic profile of the sample was taken up as the base to begin with. It includes age, sex, educational status, marital status, religion, caste, occupational status, annual income and health status or physical status.
2. Awareness of the respondents HIV/AIDS.
3. Misconception of the ruralites regarding HIV/AIDS leading to ostracization of HIV/AIDS infected/affected.

4. Assessment of sample on attitude and perception towards HIV/AIDS infected/affected.
5. Assessment of sample on the role of family care and social care in easy recovery of HIV/AIDS patients and in making them normal persons.
6. Governmental and non-governmental strategies towards HIV/AIDS infected persons.
7. Impact of mass media in changing attitude of the ruralites that means changing social attitude towards HIV/AIDS infected persons.

Economic Profile of the Sample:

The economic profile of the sample portrayed the following trends:-

a. The sample came under the most productive and age group of 20-49 years.
b. Out of 150 respondents of Rajnagar block 105 respondents are male and 45 respondents are female. In Rajkanika block out of 150 respondents, 72 respondents are male and 78 are female.
c. The proportion of highly qualified respondents among the sample was found to be high in both the blocks.
d. Majority of sample i.e.82% in Rajnagar and 66% in Rajkanika block consisted of married respondents.
e. Majority of the respondents of Rajnagar block and all the respondents of Rajkanika block belong to Hinduism.
f. Majority of respondents of Rajnagar block belongs to scheduled caste but the majority of respondents of Rajkanika block belong to general caste.
g. In comparison to Rajkanika block more respondents in RAJNGAR block are appointed in Govt. services.

Awareness of the respondents About HIV/AIDS:-

- Though AIDS was discovered in 1980s, it had been known to the sample in later years after 1999. All the respondents knew AIDS as a horrendous disease sooner or later within 1999-2010. The majority of highly educated respondents of both Rajnagar and

Rajkanika blocks knew about prevalence of AIDS in our country (India) sooner or later within the years of 1999-2004.

- Although sooner or later all the respondents of both the blocks have heard of AIDS yet all have not known the full from of AIDS. None of the below matriculate respondents of both the blocks knew about the acronym of AIDS. A few respondents having 'matriculate and above' qualification of Rajnagar block knew about full form of AIDS. The majority of respondents of both the blocks having degree and above qualification were aware about acronym of AIDS i.e. Acquired Immune Deficiency Syndrome. Even 10% highly educated respondents of each block were not aware about full form of AIDS till today.
- The sample in general was not aware about HIV. A few respondents i.e. 10% of Rajnagar block and 12% of Rajkanika block having below matriculation qualification knew about HIV. 28% of respondents of Rajnagar block and 26% respondents of Rajkanika block having matric above qualification knew about HIV. But all the highly educated respondents of both the block knew about HIV. This shows higher education increases the awareness level of the respondents about HIV as a deadly disease. The highly educated respondents have known more about AIDS/HIV/STI, than less educated respondents. The majority of respondents of both the blocks were ignorant about STI (Sexually Transmitted infection) and its relation with HIV-(Human Immune-deficiency Virus)/AIDS.
- All the highly educated (Degree & above) respondents of both the blocks knew about the causes of HIV infection. Some of the below matriculate respondents i.e. 10% of Rajnagar block and 12% of Rajkanika block knew about the causes. In Rajnagar block 26% respondents having matric & above qualification also knew about HIV and its causes of its infection.
- Highly educated respondents pointed out most accurate causes of HIV infected blood, sexual intercourse with HIV infected person, infected needle/syringe, infected mother. Some of the less educated respondents were also aware about causes of HIV infection.
- The majority of the sample was aware that blood as the common carrier of HIV infection.

- All the highly educated respondents pointed out that blood as common carrier of HIV infection and most of them replied that continuous fever ,weight loss, jaundice and TB as initial symptoms of HIV/AIDS.
- Information has been collected from the sample regarding awareness about curability of HIV/AIDS affected patients. The majority of the respondents of both the blocks were aware that these deadly diseases cannot be cured permanently but they may survive for certain years.
- The highly educated respondents were aware about protective measures of HIV/AIDS infection practicing which one can avoid HIV infection. These are :-
    1. Practicing safe sex (using condoms).
    2. Receiving HIV free blood when needed.
    3. Using new needle or syringe.
    4. Following prophylactic measures to prevent MTCT (Mother To Child Transmission).

Some of the less educated sample also knew these protective measures to avoid HIV/AIDS infection.

- The most of the respondents viewed for the treatment of HIV/AIDS patients both in family and hospital. Whereas the hospital provides treatment, family provides care and support for physical, mental and psychological treatment for easy and early cure.
- Confidentiality of the patients' HIV status should be maintained by the hospital. But their infection should be disclosed to their employer or colleague and spouse and family members mentioned by highly educated respondents. But majority of less educated respondents were not in favour of disclosure of the patients' HIV infection because they were afraid of being discriminated and ostracized or stigmatized in family, workplace or society for their HIV infection.

Misconception of ruralites regarding HIV/AIDS leads to ostracization of HIV/AIDS infected:-

- While AIDS kills victims, social ostracism kills all these associated with the victims.

- Misconception about the transmission of HIV/AIDS from one person to another, risk factors and no-risk factors leads to ostracization of HIV/AIDS infected/affected.
- The present study reveals the awareness of the respondents regarding no- risk factors spreading HIV/AIDS. The respondents varied in their responses towards the no-risk factors as using same toilet, using or sharing same glass, spoon, tea cup or other utensils .towel, dress, bed, shaking hands and embarrassing or kissing or hugging the HIV/AIDS infected persons. The majority of respondents of both the blocks opined these were no-risk factor in spreading HIV/AIDS.
- The majority of the respondents of both the blocks positively responded to the risk factors namely having un-protected sex with the infected partners of same or opposite sex, receiving HIV infected blood , sharing same needle or syringe, razor or blade with HIV infected persons and breast feeding of HIV infected mothers in the spread of HIV/AIDS.
- The indifferent behaviour and hatred adopted by the people around the HIV/AIDS infected patients increase their grief and suffering, such behaviour of family members, friends, and others in villages leads to self stigmatization of the patient which affects their easy and early recovery. This study shows that the majority of the respondents of both the blocks were in favour of sympathetic behaviour and friendly behaviour towards infected persons. But a few respondents found indifferent behaviour and hatred towards HIV/AIDS patients.
- Confidentially of HIV status of individuals should be maintained by the doctors and other medical staff. The people living with HIV/AIDS are often afraid of being discriminated and ostracized in family, community and society if their positive status is disclosed.
- Disclosure of HIV status becomes a curse for the infected person. Most of the educated respondents of both the blocks opined that positive status of HIV infected persons should be kept confidential , because confidentiality help them protecting from discrimination in family ,society and among friends, some of the illiterate and uneducated were found to practice discrimination against HIV/AIDS patients in society due to misconception about the transmission of the disease.

- Besides, a few respondents of Rajkanika block, other respondents viewed that the doctor and paramedical staff did not neglect the HIV/AIDS infected persons in the hospital.
- Sometimes, own family members of HIV/AIDS infected persons neglect them. Majority of the respondents opined that the infected persons were neglected in their own families, even sometimes their own spouses avoided, separate rooms, beds, utensils were provided for them. Some of the family members were in-different towards them and sometimes their own children were not allowed to mix with them.
- Majority of respondents of both the blocks opined that the infected persons were found to be ostracized by the villagers. Ostracization of the infected persons in the villages were manifested in various forms as they were avoided by their own friends, deprived of attending social functions in their own villages, prevented from using village pond, well and entering village temples. Sometimes it was found that the HIV infected persons had been driven out of villages.
- Sometimes the innocent children of HIV/AIDS infected persons were found to be discriminated in some villages of both the blocks. They were not allowed to read and play with other children. They were prevented from attending common prayer in the school and participating in feast and picnic organized by the schools.
- Most of the educated respondents were against such type of discrimination and ostracization of PLWH on the hand, and in favour of providing governmental assistance, stipend or any dole for their maintenance and treatment instead of their suspension and retrenchment from their service on the other.

Attitude and Perception of the Sample towards HIV/AIDS infected/affected:-

- The respondents' attitude towards self-vulnerability of HIV/AIDS infection was the most important finding of this study. Individuals themselves are responsible for HIV infection. Majority of respondents of both the blocks are in favour of this statement.
- They can avoid the infection by certain preventive methods like not having sex with infected persons, practicing protected sex (using condoms during sexual inter course)

exercising self control, not reusing needle or syringe and using safe blood for the transfusion wherever necessary .

- The attitude regarding self vulnerability of the individuals to HIV infection/ acquiring AIDS is reflected by the traditional theory of "Karma". As you sow, so you reap. "Man is the maker of his own destiny," said by Dr. S. Radhakrishnan, our renowned philosopher. Individuals may not be infected by HIV throughout whole life through knowing and avoiding the causes of HIV transmission.
- Most of the respondents opined for the voluntary testing of blood in hospoital to know HIV status.
- Majority of the respondents were in favour of mandatory HIV testing of blood though it was against human rights.
- Comparatively more respondents were dissatisfied with the treatment provided to HIV/AIDS patients in the hospitals.
- All the hospitals maintain confidentiality of HIV status of the patients.
- Discloser of HIV status by health care providers led to more or less mistreatment of the infected by the spouse, family members, villagers and other members of society.
- The majority of respondents of both the blocks especially all the degree and above qualified respondents opined that HIV/AIDS infected patients should not be discriminated in the society.
- None of the respondents' perceived HIV infection or AIDS due to one's sin committed in previous or present life or as punishment by the god for immoral action performed by the patients.
- Only a few less educated respondents of both the blocks were in support of discrimination of PLWHA in society because
    a. The infected has done immoral action
    b. Discrimination was treated as punishment for immoral actions.
    c. Discrimination was regarded as a warning to check immoral action in society.

They have negative attitude towards the HIV/AIDS infected/affected persons. They think if the infected persons are not discriminated the infection may spread to other healthy persons of the community.

- But the attitude of the majority of the respondents was positive towards PLWHA. They said that the HIV/AIDS patients should not be discriminated in the society because-
  a. They should have the same rights as normal persons.
  b. Discrimination may lead to more high risk behaviour.
  c. Innocent persons may suffer having no fault of theirs.
  d. Discrimination may bring isolation leading to suicide.

- None of the respondents were in support of discrimination of the children of PLWHA in society. All of them had positive attitude towards innocent children.
  a. The children of PLWHA have not committed any offence.
  b. They have equal rights with the other children of un-infected persons.
  c. The children of persons having other diseases are not discriminated.
  d. Childhood depression may lead to aggressive activities in future.

Role of family care and social care in making the HIV/AIDS patient as normal Person

- Both the therapeutic measures which treat opportunistic infections as well as the supportive measures by the family and society which combat emotional stress and social stigma, discrimination and ostracization are very essential for healthy and AIDS free society.
- Majority of the respondents of both the blocks viewed that the HIV/AIDS patients should not be isolated from their family. Only a few less educated respondents viewed that these patients should not remain in the family because HIV may be spread to other family members by living together and using same utensil and lavaratory.
- Some of the less educated respondenst said that HIV positive and AIDS affected persons should be isolated from the family otherwise the family members may be discriminated for them and their presence may affect the family prestige.

- The majority of the respondents opined that the HIV/AIDS patients should not freely move within the community.
- The HIV/AIDS infected persons neither should leave the villages voluntarily to save others from infection nor should they be discriminated in the villages. All persons have equal right to live in any place.
- All the highly educated respondents and most of the less educated respondents were agree that HIV/AIDS infected/ affected deserved the same rights with other normal persons, because the persons suffering from other disease were not normally ostracized in the society. Therefore, equal rights in all cases should be given to HIV/AIDS infected/affected persons. The affected persons can feel psychologically secured and free from tension having equal rights with others.
- The majority of respondents including all the degree and above qualified respondents of both the blocks viewed that family care was necessary for treatment of HIV/AIDS patients. Family care especially care of own spouse and children of the patients provide moral support for their early recovery.
- As the dreadly disease HIV/AIDS is found to be associated with social stigma and discrimination the role of neighbours, friends and other members of society is very important in providing moral support like family to those persons infected by this disease. All the highly educated respondents and most of the less educated respondents gave importance to the neighbours, friends and other members in society playing their role in providing moral support to the patient.
- Majority of the respondents did not find sympathetic behaviour of the villagers towards the HIV/AIDS infected persons.
- Majority of the respondents of both the blocks viewed that Society should extend support and care to HIV/AIDS affected persons.
- Majority of the respondents viewed that both the famly care and social care are essential to make HIV/AIDS infected / affected persons as normal persons. Family provides care and support to combat emotional stress where as society provides equal treatment and justice against discrimination and ostracization.

Governmental and Non-Governmental response toewards HIV/AIDS infected persons:-

- The majority of the respondents belonging to degree and above qualification group are aware of the Governmental steps controlling HIV/AIDS transmission.
- Central Government and State Government both have taken some steps to prevent and control HIV infection while people migrate. But a few respondents knew about this. Comparatively more educated respondents knew about these steps.
- In Rajnagar Block none of the respondents having below matriculation and matriculation and above qualification knew about the Governmental measures for HIV/AIDS infected. But most of the degree and above qualified respondents are aware of the Governmental measures for HIV/AIDS infected persons as:-
  a) The existence of ICTC in District headquarters hospital for free blood testing of HIV/AIDS patients.
  b) Government providing medicine and nutrient food to the patient free of cost.
  c) State Government giving railway / bus concession to HIV/AIDS infected patients from their native place to ART centre.
  d) Central Government's provision for compulsory blood testing for every pregnant woman for checking MTCT.

In Rajkanika Block some of the matriculate and above and most of the degree and above' respondents knew about these Governmental provisions.

- Government has launched a number of awareness creating programmes which can make the rural masses well aware about HIV/AIDS.
  a) Moving of Red Ribbon Express through out the country for creating awareness about HIV/AIDS.
  b) Various Governmental and Non-Governmental programmes like arrangements of meetings, mass race, rally, street play, essay writing, painting, debate competition etc. In certain special occasions like AIDS Day celebration to create awareness about HIV/AIDS.

c) Establishment of Red Ribbon Clubs in degree colleges and Universities of Odisha to create awareness among young students about HIV/AIDS.

Such Governmental programmes are known to most of the educated respondents and some of the matriculate and above qualified respondents of both of the blocks. Most of the less educated respondents did not know about those measures.

- The Government of Odisha has launched and implemented Madhubabu Pension Yojana under which it has allocated Rs. 300/- as monthly pension for HIV/AIDS infected patients. Most of the respondents of both the Blocks knew about this Governmental assistance for HIV/AIDS patients.
- Most of the highly educated respondents of both the blocks knew about the reservation of Government services for HIV/AIDS patients in OSACS office. The less educated respondents were not aware about this provision for reservation.
- The Odisha State Government has provided a number of facilities for the families of HIV/AIDS infected persons as irrespective of economic status they are provided with the facility of “Indira Awas”, they must be included in the odisha government BPL List and “Mo Kudia Yojona” most of the highly educated and some of the less educated respondents of the blocks knew about these governmental facilities for the families of HIV/AIDS infected persons.

Impact of mass media in changing attitude of the ruralites towards HIV/AIDS infected persons:

- The respondents of the present study are more or less influenced by the mass media communication, Their knowledge, behaviour and attitude towards HIV/AIDS infected and towards their children were found to be some how changed.
- All the highly educated respondents of the blocks and majority of matric and above qualified respondents and some of the below matriculate respondents of both the blocks have contact with radio, TV, newspapers. But only the most of the highly

educated respondents watch the advertisements/articles/features in media regarding HIV/AIDS awareness.

- Government officiasl, non governmental organizations, educational institutions and medical officials organized meeting and rallies for creation of awareness among the rural masses.
- The majority of the respondents of both the blocks found changing attitude of the villagers towards HIV/AIDS patients.
- Changing attitude is visible towards HIV/AIDS patients ard their family members and using condoms for safe sex or to check HIV infection.
- The majority of respondents including all the highly educated respondents of both the block said that the villagers were conscious about the causes of HIV/AIDS.
- The majority of them knew that use of condoms during sex can check HIV/AIDS infection.
- Comparatively more educated respondents of both the blocks had highly appreciated condoms using advertisements in T.V., they did not feel shame while watching advertisements regarding sex and condom use in TV with family members and grown up children.
- But more respondents having comparatively less education had felt shame in watching advertisements about sex and using condoms for safe sex.
- Education influenced attitude and felling of respondents regarding HIV/AIDS infection.
- Yet the majority of the respondents viewed that HIV/AIDS had frightened the villagers today as before mass media campaign about it. The mass media campaign regarding HIV/AIDS was not successful in lessening fear of the villagers towards it.
- The majority of respondents of both the blocks viewed that inspite of a lot of campaigning about HIV/AIDS and medical facilties by the government for its treatment, the villagers were not aware of these facilities.

- In Rajnagar block 48% respondents and in Rajkanika block 70% of respondents viewed that some sorts of changing attitude were found among the villagers regarding discrimination and ostracization of HIV/AIDS infected/affected.
- Mass media was responsible for such changes in the attitude of villagers towards HIV/AIDS patients, their children and family members. Radio and television played important role in changing villagers' attitudes through various discussion, drama, story and advertisements about HIV/AIDS its causes, transmission, prevention, treatment, cure and unnecessary and meaningless stigma, discrimination and ostracization towards HIV/AIDS infected and their family members.
- Comparatively, the awareness creating programmes as rallies and meetings on different occasions by the governmental and nongovernmental organization had more impact on the villagers than radio, TV or other printed media.
- As a consequence of the impact of these of mass media programmes it was observed that-
  (a) The villagers had no such feeling of hatred towards the HIV/AIDS patients.
  (b) Their children were not discriminated as before.
  (c) All extended co- operative hands towards them.
  (d) All accepted to them as normal persons and were friendly towards them.
- It was found that mass media had more impact on educated ruralites than uneducated and illiterate ones.
- Due to this impact of mass media some sort of changes were found in the perception of educated ruralites towards HIV/AIDS. Now they are afraid of the disease not of the patients.

CONCLUSION

The present study was undertaken in two costal blocks. i.e Rajnagar and Rajkanika with a number of hypotheses:

- Misconception about HIV/AIDS leads to ostracization and discrimination of HIV/AIDS infected/affected by ruralites
- Social attitude of the ruralites is not positive towards HIV/AIDS infected/affected
- Negative attitude of rural people towards HIV/AIDS infected acts as psychological threat on them.
- Positive social attitude provides moral support to HIV/AIDS infected people to live normal life.
- Governmental and nongovernmental agencies create awareness among the ruralites about the causes, transmission, prevention and treatment of HIV/AIDS.
- Mass media helps in changing negative social attitude of rural people towards HIV/AIDS infected/affected.
- Changing social attitude may lessen social discrimination/ostracization against HIV/AIDS infected/affected.

Taking education as independent variable the researcher had experimented these hypotheses on the selected sample. The level of education of the ruralites is responsible for increasing their awareness and replacing myths and misconception about HIV/AIDS, its causes and transmission. The prevailing myths and misconception of the masses with regard to HIV/AIDS/STD and their manifestations lead to discrimination and ostracization of such patients.

Education is one of the the important factors which can bring change in attitude and perception of ruralites towards the dreadly disease i.e. HIV/AIDS, its causes, transmission, prevention, risk factors and no risk factors on the one hand, and towards the HIV/AIDS infected/affected, the stigma, discrimination and ostracization of the patients, their children and the other family members, on the other.

The present study brings to light the true picture of perception and attitude of the ruralites towards HIV/AIDS infected patients. The majority of highly educated sample know the actual causes, risk factors and no risk factors of the HIV/AIDS, so that they have positive attitude towards the infected patients. This proves that less educated and illiterate masses being ignorant about causes, transmission, risk factors and no risk factors of HIV/AIDS show negative attitude towards HIV/AIDS patients.

The attitude of the most of the ruralites towards self-vulnerability of HIV/AIDS patients and imposition of ostracization on them make the researcher to conclude that "man is the maker of his own destiny". That means the person is responsible for his/her own infection and for the discrimination and ostracization in family, community and society. If he is not infected, he cannot be discriminated, proves that "As he sows, so he reaps" the unfailing law of karma.

It is true that positive social attitude provides moral support to the HIV/AIDS infected/affected. Being discriminated and ostracized by the own family members, friends and neighbours in the villages life become a curse for the patient. He feels isolated and neglected which leads to emotional stress. When the masses are aware that their support is very much essential for the patient, becoming normal persons, they can extend their co-operative hand towards him. This positive social attitude in the form of social support makes the infected patient feel psychologically secured and not exercising self-stigma on himself/ herself.

The patient cannot think himself in negative way when society does not think him negatively and does not discriminate and ostracize him.

As C. H. Cooley says in his – 'Looking glass of self' theory, 'one's self is made by the througts about him from others. Others thought, concept and attitude are looking-glass to an individual's self and the individual adopts society and develops social qualities.

Majority of educated sample supported the necessity of family care and social care for HIV/AIDS patients to be normal persons. This proved the hypothesis that positive social attitude provides moral support to HIV/AIDS infected people to live normal life.

As far as awareness creating programs by the governmental and non-governmental organizations are concerned the central government and state government should give more stress on it especially for rural masses. The central government's launching of Red Ribbon Express which moved throughout the country had no effect in creating awareness among these ruralites about HIV/AIDS, because in these areas no railway service is available. Some other awareness creating programs by the governmental and non-governmental organizations are found to be successful to some extent, because most of the awareness creating rallies, meetings, etc are normally organized within a few kilometers distance from the block headquarters. In these areas majority of the educated respondents and some of the less educated respondents are found to be aware about this disease and the governmental assistance and facilities etc for the infected patients.

But the less educated and illiterate masses of remote villages (a long distance from block headquarters) are no way influenced by these awareness creating programs of the governmental or non-governmental organizations.

Another point is that the poor rural masses spend most of their time in earning their livelihood. They have practically no time and interest in attending these awareness programs. Therefore, they become ignorant about this deadly disease and related problems. Thus poverty, illiteracy and ignorance of those rural people about HIV/AIDS lead to discrimination and ostracization of the infected persons.

Regarding mass media approach in changing social attitude of ruralites under present study it was found that the educated rural masses were influenced by the mass media communication i.e. Radio, TV and newspapers etc. Mostly the educated masses have contact with these media through which they become conscious about the disease and perceived the infected/affected as normal persons like others. As such neither they have feeling of hatred and indifferent behaviour towards infected persons nor are they in favor of discrimination and ostracisation of the patients, their children and family members in society.

But such changes of behaviour cannot be found among less educated and illiterate masses. Though some of them sometimes listen radio, watch TV and read newspapers, they do it for entertainment not for knowing advertisements for anything.

In spite of a lot of awareness creating programs by the governmental and non-governmental organizations in these rural areas and a number of campaigning and advertisements in radio, TV, newspapers, cinema etc about the horrendous disease like HIV/AIDS and against stigma , discrimination and ostracisation of infected persons and their children, the practice of stigma, discrimination and ostracisation of infected persons in the village and their children in the school were the stark reality in most of the villages under study. The illiterate ruralites are afraid of this disease as before.

Thus the present study concludes with the propositions that awareness about HIV/AIDS leading to decreasing misconception and ostracization of infected patients, positive social attitude providing moral support to infected patients to live normal life , more governmental and nongovernmental efforts to create awareness among the remote villagers about causes, transmission, prevention and treatment of HIV/AIDS with follow up actions and innovative and need based strategies in mass media communication should be developed which will help in changing social attitude of ruralites towards HIV/AIDS infected/affected.

Regarding change of perception and attitude of the people, it is believed that education can change the perception of the masses towards anything, here towards the deadly disease like HIV/AIDS. The change in the perception may lead to change in the attitude of the persons. But sometimes it is found that even some of the educated doctors and Para-medical staffs are also under “AIDS phobia”, what to say of ruralites? Theoretically, they show positive attitude towards HIV/AIDS infected/affected, but practically AIDS phobia frightens them. Overtly, their attitude is positive, but latently, their attitude is negative towards them.

Recently one AIDS patient was found to be neglected in the SCB medical college, hospital, Cuttack, Odisha.

An instance of discrimination of HIV + children in school was noticed recently in Pune city. Some educated parents of some students demanded for driving out of the HIV + students from that school. This is not the only and one case. There are so many cases in urban areas.

This proves the most important factor like education can bring change in the perception of the people not in attitude of the people. Perception changes rapidly than attitude. There is a wide gap between speed of change of perception and attitude. As long ago W.F. Ogborn says about “cultural lag” between material and non- material culture. Material culture changes more rapidly than non material culture.

So is the change of perception and attitude. Perception towards HIV/AIDS disease and towards affected patients may be changed through education but attitude towards the patients may not be changed in the same speed with perception. There is a lag between perception and attitude, attitude of persons towards HIV/AIDS infected/affected changes more slowly than their perception towards them. Therefore, the researcher has to conclude that “the Synthesis of Attitude is Natural Order of Phenomenon. It cannot be changed through any artificial manner. It can be changed slowly through natural order.”

Thus, “the Attitude of people towards such a terrible disease like HIV/AIDS stills remains unchanged.” It frightens all, may be illiterate or educated, rural or urban.

Therefore, a holistic approach of integrating HIV/AIDS information along with innovative need based strategies that rely on interactive and interpersonal modes of communication should be developed and implemented rather than having one side communication from the top. It needs a lot of time and money for changing the prevailing situation relating to HIV/AIDS in our country especially in rural India.

RESEARCHER'S EXPERIENCE:

This research project is very close to my heart because it involved my days of effort on the field and off the field. I got opportunity to understand the reality from the grass-root level. Everywhere there is debate and discussion on the issue of fatality of HIV/AIDS and its related misconception, Stigma & discrimination of its infected and affected in family, community and society. It is anticipated that the ruralites may be comparatively more affected by this deadly epidemic due to their illiteracy and ignorance about the risk factors. But to understand the problem from a deeper insight was only possible after this research which provided me with ample scope to know the reality.

While conducting, the research was a passion but at the same time it was a problem because the topic is very sensitive. During the period of research, the researcher had faced a lot of problems and difficulties. The first major problem the researcher had faced is the problem of selection of samples. It is not possible to study all the members of rural society. Hence, it was decided to select representative samples of the whole area for the purpose of research. The researcher had faced problems while selecting samples, identifying the respondents, fixing time for interview, collecting data from the respondents and eliciting response. However, the researcher became able to overcome these problems by establishing rapport with the respondents, their family members and the local people. Suspicious attitude of the respondents and their family members towards researcher's motive was the major problem the researcher had faced during the data collection. Because of this some of the respondents tried to hide some facts considering it is an official enquiry. But the researcher became able to clear their doubts by establishing rapport with them and convincing them that this was purely an academic work.

I also found that some could not reply freely and tried to hide information about their personal family income, health status, their attitude towards HIV/AIDS infected/affected, stigma and discrimination towards PLWHAS and their family members and children and governmental help and assistance and negligence of medical fraternity towards PLWHAS. At times some communication gap also developed during the course of data collection between

researcher and respondents. Some of the respondents could not understand some English terms and sociological concepts.

However, the researcher successfully overcame these problems by making them understand the correct meaning of the terms and concepts. The researcher tactfully managed the above situation and finally achieved success in eliciting accurate response and collecting correct data.

But, I felt an unpleasant situation when I had visited The District Headquarter Hospital, Kendrapara for collecting some information from its AIDS cell some other medical staff watched me in curiosity as I was a new patient (AIDS Victim) there either to test blood or for knowing HIV status or getting counseling for confidential disease like HIV/AIDS. This situation made me think that in spite of a lot of awareness creating programmes launched and worked in the district some educated mass also fear the disease as before.

SUGGESTIONS:

- As the study revealed that education had played major role in changing the level of perception and in influencing the negative attitude of the ruralites towards affectd HIV/AIDS patients and their children, the level of their education should be increased.
- The rural India is represented by majority of illiterate masses lacking adequate education making themselves aware about sex, sexuality, STD, HIV and AIDS. Education can replace the ignorance about such issues transmission of the deadly disease like HIV/AIDS from the affected few to the general masses. Steps should be taken to spread education adequately among them.
- To combat discrimination and ostracisation of PLWAS, more and more awareness creating programmes should be generated and organized in rural areas.
- Awareness creating programmes by the governmental and non-governmental organizations should not be confined in the district and blocks headquarters or nearby villages. These programmes should be organized in remote villages equally in same manner.

- Awareness creating programmes as meetings, rallies etc should not be organized only on certain festive occasions as AIDS DAY celebration and others. These action programmes must be organized in regular intervals with follow up actions.
- AIDS awareness programmes targeting people in the age group of '15-49' years should be the regularly organized at national level on similar lines such as the Pulse Polio-programmes, Malaria eradication programmes, DOTS programmes etc.
- These programmes should not be one sided only from the top, but should include and involve the rural masses.
- Awareness raising programmes may be more effective when the PLWHAS are involved with these.
- As the illiterate ruralites, most of the times listen radio and watch T.V. for entertainment purpose only; they should be made conscious to observe minutely the advertisements regarding the terrible disease like HIV/AIDS and its tremendous effects over the productive and reproductive units of the country. Unless the awareness creating programmes in mass media remain meaningless.

APPENDIX-I

CASE STUDIES

CASE STUDY-I

Sri Amulya Rout, 45 year old of Koilipur village of Rajnagar Block had worked as a welder in cotton mill in Mumbai. He had migrated from his village for employment there. He returned village after HIV infection. Meanwhile his wife Smt. Pramila Rout got infected from him. They both are on ART (Anti-Retroviral Therapy) treatment. Both of them are getting Rs.300/- per month under Madhubabau Pension Yojana. He had left his job and now living in his village. He has four children, two of them are sons and other two are daughters. Fortunately no children of him have been infected by HIV. Without having any source of income it becomes very difficult to manage the expenditure of their family and their own treatment.

CASE STUDY-II

Sri MaheswarManguala, 45 years old of village Giria of Rajkanika Block has been infected by HIV. He was a migrated labour in Gujarat. After infection he returned to village. His wife Smt. JayantiManguala, 38 years old and his son Sri MahendraManguala, 8 years have also been infected by HIV. But fortunately his daughter Sarita, 14 years old is HIV-ve. After her birth her mother has been infected. The parents and their HIV+ve son are on ART treatment. These three are getting Rs.300/- per month each under Madhubabu Pension Yojana. He is getting TA support from District Redcross every month to ART centre. He has got ‘ MoKudia’ facility.

He says that there is no stigma for them in family and community. He is living together in the family. His children are studying in school. They are not discriminated in the school. His son is getting double Mid-Day-Meal (MDM) ration.

Now Sri Manguala is working in part-time agricultural labour. But it becomes very difficult to maintain the family with this little income.

APPENDIX-II

INTERVIEW SCHEDULE

INTERVIEW SCHEDULE FOR THE RURALITES FOR THE STUDY OF ATTITUDE AND PERCEPTION AMONG THEM TOWARDS AFFECTED HIV/AIDS PATIENTS.

SOCIO-ECONOMIC PROFILE OF RESPONDENTS

1. Serial No. :
2. Name of the Village :
3. Name of the Block : Rajnagar / Rajkanika
4. Sex : Male / Female
5. Age completed in years :
6. Level of Education : Below Matriculation/ Matriculation / Graduate
7. Marital Status : Married / Unmarried
8. Caste : Gen / OBC /SC /ST
9. Religion : Hindu / Muslim / Others
10. Occupation : Landless Labourer / Marginal Farmer / Industrial Worker / Business / Govt. Service / Unemployed.
11. Annual Income (In thousand Rs.) :
12. Physical Status : Good/Average/Weak/Old age/PH/Chronic patient
13. Have you been suffering from any disease : Yes / No
14. If Yes

    (a) When have you visited any clinic or hospital for treatment? (year only)

    (b) What is the nature of disease for which you are being treated?

    (c) Do you know about contagious diseases: Yes / No

    (d) If yes, name such disease :

AWARENESS OF THE RESPONDENTS ABOUT HIV/AIDS

1. Have you heard of AIDS? : Yes / No
2. If yes, Can you recall when did you Hear about AIDS for the first time?
3. Is AIDS prevalent in our country : Yes /No
4. Expand the abbreviation of AIDS : Yes /No
5. Do you know about HIV? : Yes / No
6. Is there any relationship between HIV / AIDS ? : Yes / No
7. Are you aware of STI? : Yes / No
8. If yes, Do you think STI is an important Factor for HIV infection : Yes / No
9. Are you aware of the causes of HIV Infection? : Yes / No
10. If yes, among the following which are the causes of HIV infection?
    (a) Infected blood : Yes / No /Not sure
    (b) Infected needle : Yes / No /Not sure
    (c) Sexual intercourse with infected person : Yes / No /Not sure
    (d) Infected mother : Yes / No /Not sure
    (e) Kissing the infected person : Yes / No /Not sure
    (f) Mosquito bite : Yes / No /Not sure
    (g) Shaking of hands with infected person : Yes / No /Not sure

11. Which is the common carrier of HIV infection? : Blood / Saliva / Air / Water
12. Which among the following is the symptoms of HIV infection?
    (a) Fever
    (b) Headache
    (c) Bodyache
    (d) Jaundice
    (e) Cough
    (f) Any other

13. What is the initial symptom of AIDS?

(a) Chronic Diarrhea
(b) Continuous fever
(c) Weight loss
(d) T.B.
(e) Pneumonia
(f) Jaundice
(g) Any other

14. Is it a curable disease? : Yes / No / Not sure
15. Can a person survive with HIV / AIDS ? : Yes / No / Not sure
16. If yes, how many years ? : 0-4 years/ 5-9 years/ 10-14 years
17. How can a person protect himself / herself from acquiring this disease?
    (a) By practicing safe sex
    (b) Receiving HIV free blood when transfusion is required
    (c) Using new needle in the syringe for injection
    (d) By following prophylactic measures during pregnancy in case of HIV positive mother
    (e) Eating green vegetable
18. Do you know someone in your neighborhood or Village or block who had AIDS? : Yes / No
19. Do you think an AIDS patient should be Treated at : Home / Hospital / Both
20. Do you think the information about one's Infection should be given to one's Employer or colleague? : Yes / No
21. Do you think the information about HIV Infection should be given his or her spouse? : Yes / No

MISCONCEPTIONS AND OSTRACISATION

1. Have you heard anything about HIV/AIDS? : Yes / No
2. Are both of these caused by virus? : Yes / No
3. Do you know ,how HIV/AIDS transmitted from : Yes / No
   One person to another
4. Is it transmitted by touch or contact with patients? : Yes / No
5. Is it caused by using or sharing the following with the patients?
   (a) Toilet : Yes / No / Not sure
   (b) Glass, spoon, teacup and other utensils : Yes / No / Not sure
   (c) Towel, dress and bed : Yes / No / Not sure
   (d) Shaking hands and embracing : Yes / No / Not sure
   (e) Kissing or hugging : Yes / No / Not sure
6. Do you think that HIV/AIDS is caused by
   (a) Having unprotected sex with the partner being
   Of same sex or opposite sex : Yes / No / Not sure
   (b) Receiving infected blood : Yes / No / Not sure
   (c) Sharing same razor or blade : Yes / No / Not sure
   (d) Using same needle or syringe : Yes / No / Not sure
   (e) Breast feeding of infected mother to child : Yes / No / Not sure
7. Can god protect the devotee through worship? : Yes / No / Not sure
8. Is medical test necessary for knowing one's
   HIV/AIDS status? : Yes / No / Not sure
9. How would you like to behave with the person who is diagnosed as HIV positive / AIDS infected?
   (a) Indifferent
   (b) Hatred
   (c) Friendly
   (d) Sympathetic
   (e) Otherwise
10. Do you think that the HIV/AIDS infected should : Yes / No / Not sure
    Tell his/ her spouse about the status?
11. Should the information be disclosed or be kept : Yes / No / Not sure
    Confidential?
12. If disclosed will it affect the stability of his / her : Yes / No / Not sure
    Mental status?
13. If it be confidential, can he/she be protected from : Yes / No / Not sure
    Discrimination in the family / society / friends?
14. Whether patient is condemned where ever he : Yes / No / Not sure
    Stays or moves?

15. Whether the patient is neglected by the doctors : Yes / No / Not sure

Or paramedical staff in the hospital?

16. Do you find the patient is neglected in own family? : Yes / No / Not sure
17. If yes how?
    (a) Own spouse avoids.
    (b) Separate room, bed and utensils are provided for the patient
    (c) Other family members may or may not talk with them
    (d) Family members may be indifferent towards them
    (e) Own children may not be allowed to mix with them
    (f) Any other
18. Whether the patient is ostracized in own village : Yes / No / Not sure
19. If yes, how?
    (a) Own friends avoid touch or any contact
    (b) The patient is not allowed to attend the any social function
    (c) Prevented from using village well or pond
    (d) Not allowed to enter into the village temple
    (e) The patient may be finally driven out of village
    (f) Sometimes the dead body of the patient is not touched by villagers for cremation
20. Whether the children of the affected are discriminated? : Yes / No / Not sure
21. If yes, how?
    (a) Children are not allowed to read in village school with others
    (b) To play with other children
    (c) Not allowed to attend feast or picnic in school with others
    (d) Not allowed to participate in common prayer in the school
    (e) Any other
22. Is it because of common beliefs that the disease may Spread like epidemic by talking, playing, eating with each other? : Yes / No / Not sure
23. Should the infected persons be separated from others And driven out of the village? : Yes / No / Not sure
24. Should such persons be suspended or dismissed from office? : Yes / No / Not sure
25. Should they be given job in solitary work place / subsidy / Stipend / dole for their maintenance including treatment? : Yes / No / Not sure

ATTITUDE AND PERCEPTION OF THE RESPONDENTS TOWARDS HIV/AIDS INFECTED/AFFECTED

1. Do you think that the individual himself/ : Yes / No / Not sure
   Herself is responsible for HIV infection?
2. If yes, do you think, the person may avoid HIV infection by
   (a) Not having sex with infected person : Yes / No / Not sure
   (b) Through practicing protected sex (using condoms) : Yes / No / Not sure
   (c) Self control : Yes / No / Not sure
   (d) Not reusing the needle/syringe : Yes / No / Not sure
   (e) Using safe blood when transfusion required : Yes / No / Not sure
3. Should an individual go to hospital for testing : Yes / No / Not sure
   Blood if he/she suspects of having HIV infection?
4. If yes, should he/she voluntarily go to hospital : Yes / No / Not sure
   For blood testing?
5. Do you think HIV testing of blood should : Yes / No / Not sure
   Mandatory for all?
6. If yes, why? Because
   (a) Having infected by HIV is a stigma to himself/herself
   (b) HIV infected member brings shame, to the entire family
   (c) HIV infected persons may have to face discrimination in society
   (d) The children of infected persons may be discriminated and neglected in society
   And educational institutions.
7. Do you think the infected persons may not : Yes / No / Not sure
   Be treated properly at the hospitals?
8. May confidentiality of his/her HIV status be : Yes / No / Not sure
   Maintained by the hospitals?
9. If confidentiality is not maintained by the health care providers, then
   (a) The infected may be mistreated by the spouse
   (b) By the family members
   (c) By the villagers
   (d) By other members of the society
10. Do you think that having HIV infection/ AIDS is : Yes / No / Not sure
    Due to one's sin committed in previous birth/ present life.
11. Is HIV infection /AIDS a punishment by the god : Yes / No / Not sure
    For immoral action?
12. Should HIV/AIDS infected be discriminated : Yes / No / Not sure
    In the society?

13. If yes, because
    (a) The infected has done immoral action
    (b) Discrimination should be made as punishment for immoral action
    (c) A warning to check immoral action in society
    (d) It may spread to the healthy members of the society
    (e) All
14. If no, because
    (a) The HIV/AIDS infected persons should have the same rights as any normal person
    (b) Discrimination may lead to more high risk behavior
    (c) A few innocent persons may suffer because of no fault of theirs
    (d) Discrimination may bring isolation which sometimes leads to suicide
    (e) All
15. Do you think that the life partner of HIV/AIDS Infected should be stigmatized? : Yes / No / Not sure
16. Do you think that the children of the HIV/AIDS Infected should be discriminated in the society? : Yes / No / Not sure
17. If yes, because
    (a) The disease may spread
    (b) The friends will have no fear about immoral action
    (c) The sinners are to be condemned
    (d) A lesson is to be taught to the parents
18. If no, because
    (a) The children have not committed any offence
    (b) They have equal rights in the society as those of normal children
    (c) The children of persons having other diseases are not discriminated
    (d) The depression developed at the childhood may lead to aggressive activities in future
    (e) All

FAMILY CARE AND SOCIAL CARE FOR HIV/AIDS INFECTED PERSON

1. Do you agree that the HIV positive persons : Agree/ Don't agree
   Should be isolated from the family?
2. If you agree, then why?
   (a) HIV can be transmitted to other members of the family by living together
   (b) It can be transmitted to other members by using same utensils or same lavatory
   (c) Family members may be discriminated in society for the infected persons
   (d) Presence of HIV infected persons in the family may affect the prestige of family
3. Do you think HIV is transmitted by air or water? : Yes / No
4. Are the affected persons prevented from moving : Yes / No
   Freely within the community?
5. Should they voluntarily leave the village to : Yes / No
   Save others from infection?
6. Should they be discriminated in the community? : Should / Should not
7. If you disagree, then do they deserve same rights : Agree / Disagree / no opinion
   Like other normal persons in the society?
8. If yes, then because –
   (a) All persons have equal right to live in any place
   (b) Persons suffering from any other disease are not discriminated or ostracized in society
   (c) The affected persons feel psychologically secured and tension free when they have Equal rights with others
   (d) All
9. Is family care very much needed for treatment : Yes / No.
   Of HIV infected persons?
10. Should family care, particularly of spouse and : Yes / No
    Children provide moral support to patient for recovery?
11. Do you think that the infected persons should not : Yes / No
    Be ostracized/ stigmatized in the society?
12. Should the infected not be forced to leave community? : Should / Should not
13. Do you think neighbours have any role to play : Yes / No
    In providing moral support to the patients?
14. Have the friends and other members in society : Yes / No
    Any role to make them free from tension?
15. Do you find sympathetic behavior of villagers : Yes / No
    Towards them?
16. Should society extend care and support to : Yes / No
    Affected persons?
17. Is social as well as family care essential to : Yes / No.
    Make them as normal men?

GOVERNMENTAL AND NONGOVERNMENTAL STRATEGIES FOR HIV/AIDS INFECTED/AFFECTED

1. Should the govt. take adequate steps to Control the deadly disease like AIDS? : Yes / No
2. Can this disease be controlled without any Major steps taken by the government? : Yes / No
3. Has any state or central govt. taken steps To prevent this disease while people migrate Of late in search of employment? : Yes / No
4. Are you aware of ICTC in district headquarter Hospitals to test blood free of cost provided By the government? : Yes / No
5. If yes, how sincerely the doctors and paramedical Staff take the job and how much confidentiality They maintain? : Yes / No
6. Are you aware of the govt. providing medicine And nutrient food to the identified patients free Of cost at such hospitals? : Yes / No
7. If so ,how is the quality of service provide by the staff : Yes / No
8. Are you aware that the central govt. has made Provision for testing blood of pregnant women Compulsory for checking of transmission of virus From mother to child? : Yes / No
9. Do you know that the state government has given Railway/bus concession to HIV/AIDS infected from Their native place to ART center? : Yes / No
10. Do you know that state government has allocated For Rs.200/- monthly pension to the affected? : Yes / No
11. Is it adequately provided and paid in time? : Yes / No
12. Have the HIV/AIDS infected persons irrespective Their economic status have been extended the Facility of " Indira Awas"? : Yes / No
13. Is it really reaching them who deserve? : Yes / No
14. Do the patients get government services Reserved for them? : Yes / No
15. Are you aware that Odisha Chief Minister Sri Naveen Pattanaik has made instruction to Include all HIV/AIDS patients in the BPL list Irrespective of their income? : Yes / No
16. Is it being made available to all? : Yes / No
17. Do you know about Odisha State Government : Yes / No

Provision for including all HIV/AIDS affected
Families in " Mo Kudia Jojana"?

18. Certain services in OSACS office has been Reserved for HIV/AIDS infected person? : Yes / No
19. Do you know about Red Ribbon Express moving All over India to make people aware of horror Of the disease? : Yes / No
20. Do you know that OSACS has established "Red Ribbon Club" in degree colleges and universities Of Odisha for creating awareness on HIV/AIDS Among youth(students)? : Yes / No
21. Do you know that a number of non-government Organization are engaged in awareness program? : Yes / No
22. Do they work sincerely in your area? : Yes / No
23. Do they carry out governmental programs For creating awareness about HIV/AIDS or Other programs of their own? : Yes / No

IMPACT OF MASS MEDIA IN CHANGING SOCIAL ATTITUDE TOWARDS HIV/AIDS INFECTED/AFFECTED

1. Do you have Radio/TV in your home/ Work place? : Yes / No
2. How much time can you devote to listen/view? : 0-2hour/3-5hour/ more than 5 hour
3. Do you go to cinema hall for watching films? : Yes / No
4. Do you read newspaper? : Yes / No
5. If so, do you watch advertisement/article/ Features in printed media about awareness? : Yes / No
6. Whether the coverage about the disease in Printed media is adequate? : Yes / No
7. Is public address by leaders/social workers/ Govt. officials in any gathering sufficient enough To protect the society from the deadly disease Like HIV/AIDS? : Yes / No
8. If not what else should be done in mass media And public speech which can appeal a gathering At one place or one occasion? : Yes / No
9. Is there any other media to make all human Being conscious? : Yes / No
10. Improvement programs in electronic media/ Better writings in printed media/ good approach In speeches given in public has major role in Creating awareness about HIV/AIDS? : Agree/ Disagree
11. Is there any meeting or rally in your area About HIV/AIDS? : Yes / No
12. If yes, by whom?
    (a) By govt. officials or OSACS
    (b) By N.G.O.s
    (c) By educational institutions
    (d) Medical officials
    (e) Any other
13. Do you find any change in attitude of your Villagers towards the disease? : Yes / No
14. If yes, then say in which case changing attitude is visible?
    (a) Attitude towards HIV/AIDS patients
    (b) Towards life partner of the patients
    (c) Towards other family members
    (d) Using condoms for safe sex or to check HIV infection
    (e) Any other

15. Do you think your villagers are conscious About the causes of HIV/AIDS infection? : Yes / No
16. Can infection be checked by using condoms During sex? : Yes / No
17. Do you appreciate the advertisement about Condoms in TV, the common media? : Yes / No
18. Don't you feel shame to watch the advertisement Regarding sex or use of condoms in TV with Family members especially with the grown up Children? : Yes / No
19. Whether the villagers are afraid of this Disease as they were before mass media Campaigning? : Yes / No
20. Whether they are aware about medical Facilities for the treatment of this disease? : Yes / No
21. If yes, whether mass media is responsible for this? : Yes / No
22. Do you find any change in discrimination or Ostracisation of the HIV/AIDS infected/affected? : Yes / No
23. If yes, in which way?
    (a) No one has such feeling of hatred towards the HIV/AIDS patients
    (b) Their children are not discriminated in the community and educational institution.
    (c) All extend their co-operative hands towards them
    (d) All accept them as normal men as before infection and be friendly to them.
    (e) Any other
24. Whether it is due to campaigning through Radio /TV/News papers/ Rally/ Meeting? : Yes / No
25. Whether mass media confines its role only In campaigning for awareness for the people? : Yes / No
26. Do you find any follow-up action of mass media to protect community or society from HIV/AIDS? : Yes / No
27. Do you suggest any other steps and improvement in existing steps for total eradication of the disease? : Yes / No

APPENDIX-III

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