LEGAL AWARENESS STUDY ON LEGAL RIGHTS OF HIV/AIDS VICTIMS IN NORTH GUJARAT

A Thesis

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CERTIFICATE

It gives me immense pleasure in certifying that the thesis entitled "**Legal Awareness Study on Legal Rights of HIV/AIDS Victims in North Gujarat**" submitted by **Anantkumar Rameshchandra Upadhyay** is based on research work conducted under my guidance. She has completed the following requirements as per PhD regulations of the University:

1. Course work as per the university rules.
2. Residential requirements of the university.
3. Regularly submitted half yearly progress report.
4. Published two research papers in a referred research journal.

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DECLARATION

I, Mr. **Anantkumar Rameshchandra Upadhyay, S/o of Shri RameshChandra Bahi, resident of Vivekanand Society, Arvalli, Modasa -383315 (Gujarat),** hereby declare that, the research work incorporated in the present thesis titled as **Legal Awareness Study on Legal Rights of HIV/AIDS Victims in North Gujarat** is my own original. work and is completely authentic. This work has not been submitted in any other university for the award of any diploma or degree. I have accurately acknowledged the material collected from the primary as well as secondary sources as per required. I solely bear the responsibility for the originality of the entire content.

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PREFACE

In the vast landscape of human rights, certain groups face unique challenges and vulnerabilities that demand specific attention and advocacy. Among these groups, individuals living with HIV/AIDS stand out not only for the physical and health-related burdens they endure but also for the social stigma and legal discrimination they often face.

The Legal Awareness Study on Legal Rights of HIV/AIDS Victims in North Gujarat delves into the complex intersection of legal rights, societal attitudes, and state interventions concerning individuals affected by HIV/AIDS in the region. With a focus on North Gujarat, this study seeks to shed light on the legal landscape and state-mediated awareness programs while examining the role of law in protecting HIV-positive individuals from discrimination.

The introduction highlights the significance of intelligence in distinguishing humans from other animals and acknowledges the continuous process of discovery through research. It emphasizes the importance of legal research, particularly in addressing issues related to HIV/AIDS, a global health concern. Stigmatization and discrimination against individuals with HIV/AIDS are discussed as prevalent societal challenges.

The rationale of the study is explained, focusing on the need to understand discriminatory attitudes towards HIV/AIDS victims. The study aims to assess societal awareness and perceptions related to HIV/AIDS, drawing insights from various stakeholders such as counselors, healthcare professionals, and NGOs. The importance of knowledge in shaping discriminatory attitudes is underscored, and national surveys revealing misconceptions about HIV/AIDS are cited.

The scope of the study encompasses descriptive data collection on discrimination against HIV/AIDS victims, human rights perceptions, and societal variables affecting these perceptions. It aims to investigate the role of family and society in treatment, challenges faced by patients, and awareness levels among different stakeholders. Qualitative data will be collected through interviews with respondents from four districts in Gujarat, including healthcare workers, patients, and their families, with a focus on understanding support systems crucial for recovery and treatment.

Overall, the study seeks to shed light on the legal rights and societal perceptions of HIV/AIDS victims in North Gujarat, aiming to contribute to interventions and programmatic responses to combat discrimination and improve awareness.Critically Assess Legal Rights and State-mediated HIV/AIDS Awareness Programs: This study aims to critically evaluate the legal rights afforded to individuals living with HIV/AIDS in Gujarat. It will also examine the effectiveness of state-mediated awareness programs in disseminating accurate information and dispelling myths surrounding HIV/AIDS.

Examine the Role of Law in Protecting Against Discriminatory Behaviour: By analyzing existing legal frameworks and case studies, this study seeks to understand the extent to which the law serves as a protective mechanism against discriminatory behavior directed at HIV-positive individuals. It will explore legal avenues available to victims of discrimination and assess their efficacy in ensuring justice and equality.

Understand Society's Perspectives Regarding HIV/AIDS: Through surveys, interviews, and focus group discussions, this study aims to gain insights into societal attitudes, perceptions, and stereotypes regarding HIV/AIDS in North Gujarat. By exploring public perceptions, the study seeks to identify gaps in awareness and address misconceptions that contribute to stigma and discrimination.

Examine Discriminatory Behaviour Towards HIV-positive Individuals: This study will investigate the prevalence and nature of discriminatory behaviour experienced by HIV-positive individuals in North Gujarat. It will explore instances of discrimination in various settings, including healthcare, employment, education, and community interactions, to identify patterns and underlying factors driving such behaviour.

There is no significant relationship between HIV patients and their awareness towards legal rights: This hypothesis posits that awareness levels among HIV-positive individuals regarding their legal rights are not correlated with their HIV status. The study will examine factors influencing awareness levels and assess the effectiveness of legal education initiatives targeting this population.

The role of law to protect the legal rights of patients with HIV is not significant: This hypothesis questions the effectiveness of legal mechanisms in safeguarding the rights of HIV-positive individuals. Through legal analysis and case studies, the study will evaluate the impact of existing laws and policies in addressing discrimination and ensuring access to healthcare, employment, and social services for HIV/AIDS victims.

In undertaking this study, we hope to contribute valuable insights to the ongoing discourse on HIV/AIDS rights and advocacy efforts in Gujarat. By addressing legal gaps, challenging societal norms, and advocating for policy reforms, we aim to foster a more inclusive and supportive environment for individuals living with HIV/AIDS in North Gujarat and beyond.

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Above all, I want to express my sincere thankfulness to God for leading me on this road and giving me the fortitude and willpower to finish my doctoral thesis.

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ANANTKUMAR RAMESHCHANDRA UPADHYAY

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LIST OF ABBREVIATIONS

ABBREVIATIONS	**FULL FORM**
ABAD N.P.	Ahmedabad District Network of Positive People
AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
CBO	Community-based Organization
CCC	Community Care Centres
CHC	Community Health Centre
CMIS	Computerized Management Information System
CST	Care, Support and Treatment
CSWE	Council on Social Work Education
ESID	Employees State Insurance Department
FSW	Female Sex Workers
GCERT	Gujarat Council of Educational Research and Training
(GNP+) HIV	Global Network of People Living with HIV/AIDS -positive
GSACS	Gujarat State AIDS Control Society
G.S.N.P.	Gujarat state network of people living with HIV/AIDS
HCP	Health Care Provider
HCW	Health Care Worker
HELP	Health Education and Life-skill Programme
HFWD	Health and Family Welfare Department
HIPPOO	Hidden Investable Potential Power of Organization
HIV	Human Immunodeficiency Virus
HRG	High-Risk Group

ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
IDU	Injected Drug Users/ Injectors Drug
IEC	Information, Education and Communication
IFSW	International Federation of Social Workers
IGOs	Intergovernmental organizations
ILO	International Labor Organization
INFOSEM	Integrated Network for Sexual Minorities
IPC	Indian Penal Code
LAC	Link ART Centre
LGBT	Lesbian, Gay, Bisexual and Transgender
LWS	Link Worker Scheme
MSM	Men who Have Sex with Men
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NAPCP	National Aids Prevention and Control Policy
NASW	National Association of Social Workers
NGO	Non-Governmental Organisation
NFHS	National Family Health Survey
NIHAR	Network of Indian Institutions for HIV/AIDS Research
PHC	Primary Health Centre
PIL	Public Interest Litigation
PLWHA	People Living with HIV/AIDS
PSI	Population Service International
SAC	State AIDS Cell

SACS	State AIDS Control Society
SBPs	Strengths-based Practices
SC	Supreme Court
SCC	State Coordination Committee
SHG	Self Help Group
SIMS	Strategic Information Management System
SIMU	Strategic Information Management Unit
STD	Sexual Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TI	Targeted Intervention
TV	Television
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children’s Fund
UNIFEM	United Nations Development Fund for Women
UNO	United Nations Organization
VKMC	Vatsyayan Kendra &Mamta Clinic
WHO	World Health Organization

CONTENTS

CHAPTER - 1

INTRODUCTION AND RESEARCH PLANNING

1.1 Introduction

If intelligence is a fundamental distinction between humans and other animals, then it is it. Numerous discoveries made by humans have improved their quality of life. Humanity continues to discover new things through numerous studies. In every science, research is a continuous process. In the field of law, a lot of research is conducted. This study aims to provide a legal understanding of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). HIV/AIDS is a major global health issue at the moment. HIV/AIDS patients have historically faced negative attitudes from society. As a result, stigmatisation of an individual living with HIV/AIDS is necessary in society. The people discriminate against them. As a result, the rights of individuals who are not afflicted with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) are still violated legally.

1.2 Importance/Rational of the Study

The researcher has work in the field of **Legal Awareness Study on Legal Rights of HIV/AIDS Victims in North Gujarat**. The researcher has discussed issues of discrimination, awareness, risk behaviour, and risk perception with counsellors from Integrated Counselling and Testing Centres (ICTCs) and Anti-Retroviral Therapy (ART) Centres, doctors, nurses, and staff from Non-Governmental Organisations (NGOs). This made the researcher think of a few important questions. The underlying premise is that the public's discriminatory attitudes towards individuals living with HIV/AIDS are influenced by knowledge, which is a significant predictor of such attitudes. Measuring societal awareness of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) would be necessary for any future interventions or other programmatic responses to the epidemic. National surveys that have highlighted this issue and provided information on the general public's level of knowledge include the National Family Health Survey-3 (NFHS-3) (2005–06). According to the report, in the country, only 17% of women and 33% of men are fully informed about HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). There are many misconceptions concerning the illness. Men who have visited female sex workers and those who have had more lifetime sexual partners have significantly higher rates of HIV (Human Immunodeficiency Virus) prevalence.

1.3 Scope of the Study

The broad objective of the study is in the context of **Legal Awareness Study on Legal Rights of HIV/AIDS Victims in North Gujarat**. The purpose of the study is to provide descriptive data about discrimination against people who are infected with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). A second crucial element is the idea of human rights perception, which is essential to changing behaviour, which is the aim of any implemented programmatic intervention. The goal of the study is to highlight the in society as well as the variables that could affect this perception.

The role of family and society in treatment; the challenges (problems) faced by patients; and awareness of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) in individuals, their family members, and other people. We will collect qualitative data through interview schedule from respondents of four districts **(Aravalli, Sabarkantha, Mehsana and Banaskantha)** of the Gujarat state.

It is possible to investigate which kind of support system is crucial for the recovery and treatment of patients. We have gather data (information) for these purposes from workers in non-governmental organisations (NGOs). We have also use interviews with doctors, counsellors, patients, and patients' families in order to perfect the study. Therefore, the primary participants in this study are physicians, counsellors, patients, and relatives of patients.

1.4 Research Gaps

Based on the above discussion, it can be concluded that the majority of research concentrated on High-Risk Groups (HRGs) such as Men who Have Sex with Men (MSM), Female Sex Workers (FSW), drivers (autorickshaw, truck, etc.), and migrants in order to comprehend the social life of HIV/AIDS and the patterns of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) transmission. The majority of studies used interviews and interview schedules to gather data from people who tested positive for HIV (human immunodeficiency virus). The majority of these studies' respondents are people living with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome), who test positive for the virus. However, there hasn't been much substantial research done on legal awareness and discrimination against people who are HIV (human immunodeficiency virus) positive. Furthermore, the majority of research has been conducted using sociological, psychological, etc. methodologies. There aren't many studies that take a legal perspective.

1.5 Research Questions of the Study

a. How the people discriminate with the Victims of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) in North Gujarat?
b. What are the human rights and state-mediated HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) awareness programs in Gujarat?
c. What is the role of law in protecting against discriminatory treatment of HIV (Human Immunodeficiency Virus) positive individuals?
d. What are the perspectives of the society regarding the HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome)?
e. What kind of discriminatory behavior is done by people with positive persons?

1.6 Objectives of the Study

1. To critically asses the Legal Rights and state-mediated HIV/AIDS awareness programs in Gujarat.
2. To examine the role of law in protecting against discriminatory behavior with HIV positive individuals.
3. To understand the perspectives of the society regarding the HIV/AIDS.
4. To examine what kind of discriminatory behavior is done by people with positive persons

1.7 Hypothesis

H_{01} There is no significant relationship between HIV patients and their awareness towards legal rights

H_{02} The role of law to protect the legal rights of patients with HIV is not significant

1.8 Research Methodology

Qualitative and quantitative information will be used in the present study. Workers of NGOs (Non-Governmental Organizations) working in selected four districts of North Gujarat will be selected as respondents for the collection of information pertaining to the study objectives. To make the study more accurate information will be obtained from people working in the field, such as counselors of Integrated Counseling and Testing Centres (ICTCs) and ARTs (Anti-Retroviral Therapy), doctors, nurses, patients and relatives of the patients. For data collection survey, case study method will be used.

1.9 Detailed Research Plan

Main focus of present research is to study how people living with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) are discriminated against by the people in the society. Also proposed research based on primary and secondary data. Primary data will be collected from five type respondents:

Counsellors, Doctors, Patients (Victims), NGO (Non-Government Organization) Workers and family members of Patent through interview schedules. Total five types interview schedules will use for data collection from each respondent. Separate (Different) interview scheduled will make for each type respondents. Secondary data will collect from National AIDS Control Organization (NACO) reports, Gujarat State AIDS Control Society (GSACS) reports, guidelines, policy documents, NGOs (Non-Governmental Organizations) reports, libraries, websites, journals, newspapers etc. Research related other information will collect from experts, other researchers, interested persons of this area.

Selection of Districts from North Gujarat

For primary data collection, we will select four districts of the Gujarat state. These districts are: [A] Arvalli [B] Sabarkantha [C] Mehsana and [D] Banaskantha.

[A] Arvalli Disrict

Prior to its creation, the districts of Sabarkantha and Arvalli were both a part of the British-ruled "Mahikantha" political agency. The Gujarat Government's notification No. GHM/2013/69/M/PFR/139/2-1, Date 13/08/13 w.e.f. 15/08/2013, established the Arvalli district. The Arvalli district is divided into six Talukas, or sub-districts: Modasa, Bayad, Dhansura, Bhiloda, Malpur, and Meghraj. The Arvalli headquarters are in Modasa. Meghraj and Bhiloda are two tribal talukas in Arvalli, and the world's oldest mountain range, the "Aravalli," runs through it. Arvalli District is located between latitudes 24° 1′ 41.88° North and longitudes 73° 2′ 29.04° East. The Arvalli District covers 3308 square kilometres.

According to Revenue Department notification no. GHM / 2013/69 / M / PFR / 102013/139 / 2-1, dated August 13 to August 15, 2013, Sabarkantha district was divided into the new district of New Aravali, with Modasa serving as its headquarters (under Section-7 of Gujarat LC Code 1879).

The district of Aravalli includes a total of 06 Talukas. Modasa, Bayad, Dhansura, Bhiloda, Malpur, and Meghraj are these.

Following that, according to the declared list, 17 villages from Bhiloda taluka have been included in Himmatnagar taluka (Sabarkantha district), and two villages from Ider taluka are Jumsar and Munai. This was announced in Notification No. GHM / 2013/77/2013 / PFR / 102013/139 / 2-1 of the Revenue Department, dated 15/08/2013. The taluka of Bhiloda has 145 villages in it.

Located in the centre of the Aravalli hill range, the Arvalli district is well-known for its forests and stunning natural surroundings. In addition to historic sites and ancient pilgrims, there are pilgrims like Tirthatham Shamlaji, who are located on the banks of the Meshwo River.

Shamlaji is the name of Kaliya Thakor's pilgrimage. In Bhiloda taluka of the Aravalli district, Shamlaji is a unique pilgrimage with natural beauty amidst the green grove in the Aravalli hill range close to the Gujarat border. Shamlaji hosts a large fair on Kartiki Poonam, also known as Dev Diwali, each year.The entire tribal community is reflected in this magnificent fair.

The Shamlaji Vishnu temple and its environs have been developed under the state government's Tourist Destination Development Scheme in honour of the 2008–09 tourism year. A grant of approximately Rs. 560.12 lakhs have been allocated, and the district administration has initiated measures to transform a renowned pilgrimage site into a visually appealing pilgrimage hub. One of the most well-known features of Zanzari Falls in Bayad Taluka is its practical beauty pageant.

The talukas of Dhanasura and Bayad have abundant mineral reserves, which will facilitate the growth of the quarry industry in this district. The unique cotton crop is primarily responsible for the emergence of cooperative jeans. The Bhiloda and Meghraj talukas of this district, which is home to numerous picturesque tourist destinations and specialties, are primarily populated by tribal people. The value of forests, rivers, mountains, ponds, and mythological buildings cannot be overstated.

The prominent identity of the Vanvasi tribal people, who live in the district's natural heart, is reflected in their distinctive culture, customs, charms, and festivals. The government has been working to promote holistic development in the weaker social, economic, and educational spheres within and among tribes.

VidyaPurush Umashankar Joshi, who made significant literary contributions, was born in the Bhiloda taluka village of Bamna. The Aravali district is the first in the state to start record promulgation. The Modasa taluka's Khambhisar village was developed using data pertaining to the main stone and turned into a sampling centre for work related to resurveys.

1. At Khadoda and Bhatkota in the district's Modasa taluka, there is a Solar Park. For over 200 residents of the surrounding villages, the Solar Park has opened up employment opportunities. It is also feasible to supply roughly 20,000 households with electricity. More than 150 villages will profit from this solar park.
2. The main occupation of the district is agriculture and animal husbandry.
3. Important crops include maize, wheat, chickpea, mustard, millet, cotton etc.
4. A total of 06 Talukas are included in the district. (Modasa, Bayad, Dhansura, Bhiloda, Malpur and Meghraj).
5. Total villages are 676 and the total population is 9,08,797.
6. Important minerals include grit, grit, metal.
7. The rivers Vatrak, Meshwo, Mazum, Shedhi, Indrashi, Sakri etc. are passed through the district.
8. Modasa and Bayad are urban areas and municipalities exist in these two cities.
9. Jawahar Navodaya Vidyalaya is located in Dhanusura.
10. Dhansura taluka’s Vadagam,Jaswantpura, Simili, Rajpur, Akrund area have been developed as quarry industry.
11. Bayad Taluka’s Sathamba, Pagiya na Muvada, Bordi, Vatrak area have been developed as quarry industry.

The district is in the forefront in the field of education.

[B] Sabarkantha

The district of Sabarkantha is located in Gujarat's northeastern region. Located roughly 80 kilometres from Ahmedabad, the district's administrative centre is Himatnagar.

The districts of Banaskantha and Mehsana to the west, Gandhinagar to the south, Aravalli District to the southeast, and Rajasthan state to the northeast encircle Sabarkantha District.

The Sabarkantha district's western boundary is formed by the Sabarmati River. The district is located between latitudes 23.03 and 24.30 north and longitudes 74.43 and 73.39 east. The district of Sabarkantha is crossed by the "Tropic of Cancer." The district is 5390 square kilometres in total size. The district's northeastern region is dominated by rows of "Aravalli" hills. The district's principal rivers are the Sabarmati, Meshwo, Vatrak, Hathmati, Mazum, Vaidi, Harnav, and Khari.

The district's population, according to the 2011 Census, is 14,73,673. Eight Talukas and four revenue sub-divisions make up the district. The District consists of 6 Municipalities. The Talukas of Poshina, Khedbrahma, and Vijaynagar are predominantly tribal areas. These Talukas are forested, hilly regions. Most of the remaining Talukas are level terrain. The district's two largest community groups are the Patel and Darbar families. Nonetheless, among the tribal people, Dungari garasiya is the dominant group. The district's tiny village was chosen as Gujarat's best village.

[C] Mehsana

Mesaji Chavda of the Chawda Dynasty founded Mehsana in Vikram Samwat 1414. Later, in 1902, the Gaekwads relocated their administrative centre to Mehsana. Following India's independence in 1947, Mehsana became a part of the Union of India. It was under the state of Bombay. Following the split of Bombay state into Gujarat and Maharashtra in 1960. Mehsana was made into a Gujarati district. Mehsana taluka is home to the Mehsana district headquarters.

There is a place built by Gaekwads in city known as Rajmahal. Ten talukas make up the Mehsana district: Satlasana, Jotana, Unjha, Kheralu, Visnagar, Vijapur, Vadnagar, Kadi, and Unjha. Mehsana District occupies 5600 square kilometres. The Patan district borders the north, while the Banaskantha district borders the west. There are two districts: Gandhinagar district is in the southeast and Ahmedabad district is in the south. The district of Sabarkantha is located in the east.

There are numerous prestigious educational institutions in Mehsana. Specialising in fields such as IT, engineering, pharmacy, agriculture, science, management, arts, and commerce, Ganpat University is situated 10 km away from the city. Engineering and management courses are available at Saffrony Institute of Technology and Gujarat Power Engineering College. Pharmacy courses are available at B.S. Patel College of Pharmacy.

The Gujarat Technological University is connected to them. In north Gujarat, numerous schools are operated by the Sarvajanik Kelvani Mandal Trust. It also provides instruction in homoeopathy, nursing, and pharmacy. In the T. J. Highschool Complex, there is a 124-year-old English-medium school called Gurukul. In order to deliver the best English education possible, this school opened as an English-medium institution in 2012. There are numerous elementary and secondary educational institutions in Mehsana, including N.G. International School, a renowned CBSE school.

[D] Banaskantha

One of Gujarat state, India's thirty-three districts is Banaskantha district. The largest city in the district, Palanpur, serves as its administrative centre. The district is named for the West Banas River, which flows through the valley between Mount Abu and the Aravalli Range, the Gujarat plains, and the Rann of Kutch. The district is situated in northeastern Gujarat. The Ambaji temple, which is a popular tourist destination, is the district's main draw. In 2011, the population of Banaskantha was 86.70% rural and 13.27% urban. With a total area of 12703 km2, it is the state's second-largest district.

Banaskantha is bordered to the north by Rajasthan state, to the east by Sabarkantha district, to the west by Kutch district, and to the south by Patan district and Mehsana district.

The district's economy is centred on the processing of agricultural products, tourism, textiles, and mineral-based industries (ceramics). Over the past 20 years, 57% of all investments in the district have gone towards the food processing sector. The district ranks first in the Country in milk production, the Asia's Largest Dairy Cooperative under the Brandname of AMUL is Banaskantha District Cooperative Milk Producers' Union Ltd., Palanpur known as Banas Dairy procuring almost 59,58,134 Lit. Milk on 15.01.2018 as Peak receipt. With 1280 bulk milk chilling units installed, Banaskantha is also the first district with the highest cold supply chain of milk, obtaining almost 90% of its milk as raw, chilled milk and the remaining 10% in cans. There are 1,060 village dairy cooperatives in the Banaskantha District. societies with ISO 9001: QMS Standard certification. The district leads the state in vegetable production, accounting for almost 17.67% of Gujarat's total vegetable output. It is the state's biggest producer of potatoes. The remaining principal crops grown in the district are bajri, maize, tobacco, castor oil, jowar, and psyllium. It is also one of the nation's top producers of isabgul, or psyllium husk. In the state, it ranks third in terms of oil seed production, behind the districts of Junagadh and Jamnagar.

Rich mineral reserves can be found in the district, including China clay, granite, marble, limestone, and building stone. It makes up nearly all of Gujarat's marble reserves (99.3%), and it makes up roughly 15% of the state's total limestone production.

One of the most significant banks in Gujarat is the Banaskantha District Central Co-operative Bank.

Sardarkrushinagar is home to the esteemed State Agricultural University and Dantiwada Agricultural University. Bajra crops are grown as the primary crop.

Banaskantha was listed as one of the 250 most backward districts in the nation (out of 640) by the Ministry of Panchayati Raj in 2006. It is one of the six districts in

Gujarat that the Backward Regions Grant Fund Programme (BRGF) is currently funding.

The population of the Banaskantha district, as of the 2011 census, is 3,120,506, or about the same as that of the US state of Iowa or the country of Mongolia. As a result, it is ranked 111th out of 640 places in India. There are 290 people living in the district per square kilometre (750/sq mi). Between 2001 and 2011, the population of this place grew at a rate of 24.43%. The sex ratio in Banaskantha is 936 females for every 1000 males, and the country's literacy rate is 66.39%. The population is composed of 9.11% and 10.49% Scheduled Tribes and Scheduled Castes, respectively.

96.35% of people in the district spoke Gujarati as their first language, according to the 2011 Indian Census.

The researcher has scheduled interviews to gather data. NGOs' workers who are respondents will choose simple random sampling methods. The Gujarat AIDS Control Society will grant permission to the researcher to conduct the current study. One technique that uses vision as its primary data collection tool is observation. It suggests using your eyes instead of your voice and ears. It is precise observation of events without assuming any knowledge of their causes, effects, or relationships. It involves observing other people's behaviour while it takes place without taking any action.

Additionally, information has been gathered by semi-structured/emphases interview schedules with NGO (non-governmental organisation) employees. Researchers have employed various semi-structured interview schedules for staff members of non-governmental organisations (NGOs), counsellors, physicians, nurses, patients, and clients' families. There are five different kinds of semi-structured interview schedules used to collect data.

1.10 chapterization

The research will be divided into following chapters:

Chapter-1: introduction and research planning

In this chapter discussed about present research, research problem, rationale of the study, nature and the scope of the study, objective of the study, research methodology and sampling.

Chapter: 2 review of literature

The present chapter will present review of the available literature pertaining to the study topic. It will be based on a review of research done at the international, national and state levels.

Chapter-3: human rights and hiv/aids

People not aware of hiv/aids (human immunodeficiency virus/acquired immunodeficiency syndrome) and they have not seriously engaged with scientific knowledge providers. In this chapter, human rights, hiv/aids (human immunodeficiency virus/acquired immunodeficiency syndrome) awareness of the people and discriminatory behaviour with patients of hiv/aids (human immunodeficiency virus/acquired immunodeficiency syndrome) will discuss.

Chapter-4: public awareness program in gujarat and role of ngos

In this chapter discussed about history of naco (national aids control organization) and gsacs (gujarat state aids control society), naco (national aids control organization) and gsacs (gujarat state aids control society) guidelines for prevention and control for hiv/aids (human immunodeficiency virus/acquired immunodeficiency syndrome). Key role of the ngo (non-governmental organization) workers in the prevention, control and awareness about hiv/aids in district. They are trained and skilled person. Also, in this chapter discussed about role and functions of ngo (non-governmental organization).

Chapter-5: the patient and society interaction and the discrimination perception

In this chapter discussed consequences of stigma and discrimination (stopped working, feeling to die, don’t want further treatment, avoided from family/friends and relatives, self-blaming and taking revenge, other consequences of stigma and discrimination, feelings of plhas about meaning of life, sadness and unhappiness in life, less energy and motivation, feeling of depression and frustration, sexual relationship with the partner, sources of knowledge of plhas on hiv/aids); problems faced by plhas in their day to day life (physical problems, problem within the relationships, financial problems, stigma and discrimination); knowledge of hcps on universal precautions, exposure of hcps to hiv/aids training programme, efforts by the institutions to create awareness on hiv/aids among general public, the institutions' initiatives to educate medical professionals about hiv/aids, social work intervention in the context of hiv/aids in india, purpose of social work, social work in the context of health care setting, perception of plhas about social workers, role of social workers/medical social worker; application of social work methods in hiv/aids care setting (social casework, social group work, community organization, social welfare administration, social action, social work research, advocacy, awareness campaigns, networking, resource mobilization, public interest litigation (pil), strength based practice.

Chapter-6: research methodology

This chapter includes the methodology of research which is used to conduct study on legal awareness study on legal rights of hiv/aids victims in north gujarat.this chapter includes the research design, statement of problem, need of the study, hypothesis to be tested and various components of methodology which helps in conducting a survey by collecting primary data with the help of a structured questionnaire. The tools and techniques used to test the hypothesis are explained in the chapter which helped in carrying out data analysis and infer interpretations to support the theoretical base of the research.

Chapter-7: data analysis and interpretation

This chapter is one of the most important chapters of the thesis as it incorporates the analysis of the data collected from the respondents. The previous chapter discussed the research methodology and research design, data collection tool and other aspects of analysis and in this section the implementation of research methodology is presented wherein the data collected is coded and tabulated along with statistical analysis.

Chapter-8: summary and conclusions

This chapter is one of the most important chapters of the thesis as it is the essence of the entire thesis. The chapter emphasizes the importance of thoughtful interpretation, guiding readers through the process of drawing meaningful conclusions and implications from analyzed data. This phase is critical in bridging the gap between raw data and informed decision-making, contributing to the overall validity and relevance of the study.

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REFERENCES

Websites

1. https://arvalli.nic.in/
2. https://sabarkantha.nic.in/history/
3. https://mahesana.nic.in/history/
4. https://en.wikipedia.org/wiki/Banaskantha_district

CHAPTER - 2

REVIEW OF LITERATURE

2.1 Introduction

Investigating is a procedure. From the start of this process to the finish, the researcher must engage in some activity. That is, the research process needs to be broken down into distinct steps in order to be conducted in a scientific manner. Thus, there are distinct phases to the entire social research process. The accuracy of research questions and research designs has been guided by previous studies. As a result, a crucial stage in the research process is evaluating the body of literature that is currently available in relation to a research problem. This helps the researcher get a general idea of what he needs to put together his own research plan.

Who has previously conducted research? Which research question was it? Which method was applied? How was the sample selected? What conclusions did the study reach? What were the research's limitations? It is recognized. It helps the researcher get around some of the limitations of his research. A review of the existing literature is necessary to prevent research duplication. This helps the researcher formulate his research questions.

2.2 Review of Literature

Research on HIV (Human Immunodeficiency Virus) is being presented; it is to be conducted with the affected individuals in the centre. As a result, an effort has been made to review the research and literature on HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) in the reference literature review. The following is the literature review:

According to Jamie Enoch and Peter Piot (2017), the "end of AIDS (Acquired Immunodeficiency Syndrome)" by 2030 remains elusive, and even after more than 35 years since the start of the HIV/AIDS pandemic, the HIV virus still causes nearly two million new infections annually. High rates of new infections among important populations and a widespread epidemic throughout much of sub-Saharan Africa are still being fueled by violations of human rights. Meanwhile, civil society mobilisation and advocacy based firmly on human rights principles have a more vital role to play than ever as global political shifts threaten not only funding for the fight against the HIV virus but also the advancement of global human rights. Positively, there are many instances of human rights-based strategies being successfully incorporated into HIV (Human Immunodeficiency Virus) prevention and treatment programmes. Additionally, data is starting to show that norms upholding the preservation, upholding, and realisation of human rights can contribute to better public health. The historical development of human rights as a central concern of the HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) response will be briefly traced in this essay. Examples of recent successes and failures will be given, and the possibility of using rights promotion to address the structural drivers of HIV (Human Immunodeficiency Virus) will be discussed. Lastly, it will discuss how other areas of global health have been impacted by the importance of human rights in relation to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) and emphasise the ongoing need to collaborate with civil society to safeguard and advance human rights in order to lessen the impact of HIV/AIDS.

According to a 2014 article by Bronwen Lichtenstein and Jamie DeCoster, teaching about the causes and effects of stigma is a crucial part of teaching about the sociology of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). Explain the University of Alabama's Sociology of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) course, where stigma reduction is evaluated as a main goal. The curriculum included research by students on community attitudes towards HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome), theory-based instruction, class visits, and service learning. We present our findings on the impact of stigma on service learning and other course components, recommending modifications to our pedagogical strategy. We also describe the pretest/posttest evaluation of the course based on attitudes towards

PLWHA (People Living with HIV/AIDS) [Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome] (enacted stigma) and hypothetical responses to receiving a diagnosis (felt stigma). The findings showed that after taking the class, students were more accepting of PLWHAs (People Living with HIV/AIDS), but they were also more conscious of the stigma associated with HIV/AIDS and its consequences. We provide advice to educators on how to steer clear of stigmatising events and materials that might compromise service learning goals and course objectives when it comes to delicate subjects like HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome).

The drivers of young people's attitudes towards HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) stigma and discrimination in Ghana are examined in a paper by Joshua Amo-Adjei and Eugene KM Darteh (2013). These drivers were investigated using binary logistic regression and descriptive statistics. Higher education was associated with an increase in the odds of having low stigma and discrimination attitudes. As a result, males [OR=l 1.04; 95% CI=4.59-26.54] and females [OR=5.12; 95% CI=2.41-11.28] who had completed more education were significantly more likely to have positive attitudes towards HIV-positive individuals. When assumptions, myths, and knowledge regarding the causes of HIV (human immunodeficiency virus) are taken into account, education has a significantly smaller impact on stigma associated with HIV in both males and females, but the odds are still statistically significant. Stigma was significantly impacted by a variety of beliefs, myths, and knowledge about the causes and prevention of HIV (human immunodeficiency virus). The results also showed variations based on ethnicity, geography, and religion. According to the research, there is a decreased likelihood of stigma and discrimination related to HIV (human immunodeficiency virus), especially among those who possess accurate and comprehensive knowledge about the virus and its transmission. As part of the larger initiatives at reducing HIV, there should be a strong focus on both formal and informal education on HIV (Human Immunodeficiency Virus).

Jennifer (2012) investigated the ways widows in Manipur who were living with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) used health services. The purpose of this study was to investigate the health service utilisation patterns and associated factors among widows who are living with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) in Manipur. The goals of this research are: (a) To determine the perceived health needs of widows infected with HIV; (b) To examine the health-seeking behaviour of HIV-positive widows in relation to their perceived health needs; (c) To identify the factors influencing the pattern of health care utilisation of HIV-positive widows; and (d) To thoroughly investigate the influence of stigma on the use of health services by HIV-positive widows. Thirteen non-governmental organisations (NGOs) that support widows living with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) were contacted for this study's objectives, and they took part in it. Thus, from seven of Manipur's nine districts, a list of 1500 widows whose husbands had passed away from HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) was created. The results demonstrated that opinions about how much health care is needed vary from person to person. Some respondents don't think their symptoms are significant enough to warrant seeking medical attention because they are unaware of their health. Furthermore, despite their awareness, obstacles like distance, lack of time, and financial difficulties prevented them from using the services. Financial difficulties are still a significant barrier for people living in both urban and rural areas.

Evidence from West Bengal was examined by Sarkar (2011) in her study of the social and economic effects of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). This study is based on a field survey conducted at the household level in West Bengal State, India. According to this study, poor human capital and poverty serve as the primary drivers of both rural-urban migration and risky career choices for household income, which in turn fuels the spread of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome).

Furthermore, the epidemic of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) among those households that are already economically and socially disadvantaged results in the ultimate consequence of economic and social poverty, making the benefits of government or non-government organisation initiatives negligible for these households. In the context of a field survey conducted at the household level in West Bengal State, India, this paper aims to investigate the socioeconomic causes and consequences of PLWHIV/AIDS (People Living with HIV/AIDS) and to the benefits of action offered by government and non-government organisations to help them.

Nanda and colleagues (2010) examined media coverage, gender stereotypes, and contextual stigma perceptions regarding HIV/AIDS (acquired immunodeficiency syndrome) and HIV (human immunodeficiency virus), utilising data from Gujarat. The purpose of this study is to analyse and comprehend any potential differences in stigmatisation behaviour that may be linked to media exposure and individual socioeconomic characteristics, as well as the processes that may underlie them. The research questions aim to investigate the impact of media exposure, gender stereotypes, and socio-cultural factors on stigma perceptions related to the HIV virus. What processes are involved in how people with elevated stigma develop their perceptions? In order to determine the mechanism underlying these phenomena, this article investigates whether differences in gender and media exposure could result in different stigma perceptions regarding HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). It makes use of National Family Health Survey (NFHS) data for Gujarat, a significant western Indian state, from 2005–2006, supplemented with some qualitative data. In order to model five distinct stigma perceptions for men and women in various contexts—such as keeping HIV (human immunodeficiency virus) infections hidden, providing care and support to infected individuals, and receiving services from HIV—logistic regressions were conducted. The initial stage of the research involved gathering quantitative data from Gujarat state's NFHS-3 (National Family Health Survey-3) and analysing it using SPSS 15.0 (Statistical Package for the

Social Sciences). A total of 1,24,385 women and 74,369 men in the 15–54 age range were interviewed from 29 Indian states for the NFHS-3 (National Family Health Survey–3). In addition to providing data on important socioeconomic and demographic indicators, the survey also includes information on a number of novel subjects, including attitudes towards family life, education for both boys and girls, use of the Integrated Child Development Scheme (ICDS) services, men's involvement in maternal care, and health insurance. The study's quantitative and qualitative data analyses show that media exposure, especially to print and electronic media like newspapers and television, consistently and significantly affects how different stigmas related to HIV (AIDS) and HIV/AIDS (Human Immunodeficiency Virus) are perceived.

In order to deepen and broaden our understanding of health, development, and security and how they impact people and society, Rebecca Tiessen, Jane Parpart, and Miriam Grant (2010), the authors of this special issue adopt a feminist analysis of gender relations, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome), and human security using theoretical analysis and empirical findings from case studies in several African countries. HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) can cause instability in nations and societies, leading to increased rates of poverty, food insecurity, health problems, and other social, political, and economic problems. It can also have a destabilising effect on communities. The authors of this collection of articles not only push us to reconsider policy and programmatic approaches to addressing the crisis, but they also provide new perspectives on how HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) relates to human insecurity and gender inequality throughout Africa.

Jothivenkatesan (2009) conducted research on prostitutes' susceptibility to various health risks, including HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). This Pudukkottai District study is sociological in nature. This study highlights the behaviours of commercial sex workers, the kinds of clients they serve, the function of middlemen, and other relevant parties. It adds to the

Pudukkottai District reference. The study's primary goals are: To investigate the social context of prostitution—both historical and contemporary—as well as the social aspect of it. To find out what expectations commercial sex workers have, to study their income, spending, and savings patterns; to list the health conditions of prostitutes; and to investigate their awareness of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) and the role that NGOs (Non-Governmental Organisations) play in it. Despite the State and Central Government's efforts to save the women in this area from prostitution, the women of this village panchayat are well-known for this activity. Not only does the government not know what the barriers are to stopping commercial sex activity, but neither do non-governmental organisations (NGOs) operating in the area. Non-governmental organisations (NGOs) were limited in their ability to prevent HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) and could not put an end to the commercial sex activities that women in Viralimali engaged in. One hundred and sixty responders, all of whom work in the commercial sex industry, have freely acknowledged that commercial sex work is inevitable in their neighbourhood. Their work has been justified by references to family, poverty, unexpected family crises, being duped by a man, and other related topics. Despite the respondents' references to these social causes, there are unspoken facts about women's status, capitalism, and patriarchy. The appalling conditions of commercial sex workers are highlighted by this study. They are severely exploited—both physically by clients and financially by brokers—which leads to infectious illnesses and psychological disorders.

According to a report by Peter Moszynski (2009), sub-Saharan Africa continues to be the most heavily infected region. In 2008, it was responsible for 67% of all HIV-positive individuals (22.4 million), 1.9 million new infections, and 72% (1.4 million) of all AIDS-related deaths. In addition to highlighting the downward trend in new infections, Dr. deLay said, "We're also seeing good progress in East Asia and South East Asia, and this represents a clear sign that focused HIV (Human Immunodeficiency Virus) prevention efforts are beginning to make a difference."

The lives of women living with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) are the subject of a 2009 paper by Tinny Dawar and Sarita Anand. It looks at how women's positive status for HIV (human immunodeficiency virus) affects their social and professional lives, as well as the coping strategies they use to deal with discrimination and stigma in society. According to the study, a woman living with HIV (human immunodeficiency virus) can get the most support from her family because it reduces stress and helps her deal with the situation. Therefore, it is crucial that the woman's family members receive counselling. Another means by which women were able to adjust to their circumstances was through raising children. It is recommended that women who test positive for HIV should be encouraged to seek support from local non-governmental organisations (NGOs) by the counsellors employed by government hospitals. However, they found great relief in belonging to a network of like-minded women in NGOs (Non-Governmental Organisations).

Patel (2008) investigated counselling codes of conduct. This study was carried out in the North Gujarati districts of Mahesana, Patan, and Banaskantha. The researcher collected data using three methods: observation, interviews, and interview schedules. Data was gathered by the researcher from a total of forty counsellors. This study's primary focus is on counsellors' awareness of the code of conduct in counselling, how it is implemented, and what problems arise when it comes to the code of conduct in counselling.

After studying the early links between HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) and marginalised groups, such as drug users and homosexuals, Elizabeth Fee and Manon Parry (2008) organised social and political responses to the disease, starting with the implementation of travel restrictions and the consideration of mandatory quarantine for those who were infected. Jonathan Mann was convinced in Africa that the disease was heterosexually transmissible and could spread globally. Because of his eloquence and passion, Mann was able to persuade Halfden Mahler, Director General, to appoint him as director of the World

Health Organization's Global Programme. This allowed him to work with health ministers all over the world. Mann contended that conditions of poverty, oppression, urban migration, gender, and violence were conducive to the spread of AIDS (acquired immunodeficiency syndrome). Based on a human rights framework, he developed a new understanding of AIDS (acquired immunodeficiency syndrome).

Lance Gable, James G. Hodge, and Lawrence O. Gostin's article (2008) The law is an often-ignored tool in the fight against the complex practical and moral dilemmas brought forth by the pandemic of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). The Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) and issues related to sexual and reproductive health are closely related to the law in many ways. People living with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) or at risk of contracting it may benefit from well-written and strictly enforced laws, especially those that pertain to their sexual and reproductive health. It should be illegal to discriminate against someone based on their HIV (human immunodeficiency virus) status in order to prevent them from accessing reproductive health services, which is a legal right. Enforcing laws against sexual violence and exploitation is necessary because these behaviours contribute to the spread of HIV (Human Immunodeficiency Virus) and its harmful effects. Lastly, laws that better protect health should be drafted using a human rights framework.

In spite of high sero prevalence rates, Mark D. Regnerus and Viviana Salinas' 2007 study found that stigma surrounding HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) is pervasive throughout sub-Saharan Africa. Discriminatory acts towards individuals who test positive for HIV (human immunodeficiency virus) are frequently encouraged by stigma. Because organised religion (Islam and Christianity) continues to play a significant role in the lives of many Africans and has a tendency to promote sexual conservatism, it is partially to blame for the stigma that persists and the discrimination that does not cease. However, the idea that religion fosters stigma and discrimination regarding HIVIAIDS (Human

Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) is not well supported by systematic empirical data. Utilising information from the Demographic and Health Surveys of six sub-Saharan nations with high rates of HIV infection, we assess the impact of religious affiliation on various types of AIDS-related discrimination, taking into account potential confounding factors. Upon controlling for ethnicity, a significantly more reliable predictor of discrimination than religion, the majority of analyses show that religious affiliation has no correlation with discrimination against people living with AIDS (acquired immunodeficiency syndrome). Muslims and those who follow other non-Christian religious traditions tend to report more discriminatory attitudes where affiliation does remain significant.

The response of Botswana to the HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) epidemic is covered in an article by Nthabiseng Phaladze and Sheila Tlou (2006). Botswana has initiated a multi-sectoral response to the epidemic, acknowledging that HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) is more than just a health issue. This distinguishes Botswana as a nation that exemplifies 'best practice' in HIV/AIDS prevention and control. But the fight is far from over. In Botswana, AIDS (acquired immunodeficiency syndrome) is the main cause of death for young adult women in the 15–19 age range. In response to the difficulties faced by Batswana women living with and impacted by HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome), this article offers recommendations for future development.

An additional study by Patel (2005) examined the psycho-social issues faced by HIV (human immunodeficiency virus) patients and their families in Ahmedabad. Respondents receiving care at various government and non-governmental organisation hospitals were chosen by the researcher for data collection. Through a schedule of interviews with physicians, nurses, counsellors, clients, and client families, the researcher gathered primary data. This study examined how family members, medical professionals, nurses, and counsellors responded to HIV-positive patients seeking treatment and a cure. It also looked at the social status of HIV-positive individuals both before and after infection, as well as their economic situation and relationships with society and family.

This paper by Chandreyee Roy (2005) examined how gender inequality and men's sexual dominance affect women's ability to control their own bodies and make decisions, as well as raising their risk of violence. Women are more vulnerable to infections due to these factors, particularly those that are sexually transmitted, such as HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). The current study tackles the issue of women's human rights against the backdrop of several socioeconomic variables that increase women's susceptibility to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). It focuses on how different social expectations, roles, status, and economic power of men and women affect and are affected by the epidemic. It also analyses gender stereotypes and investigates inequalities between women and men regarding the control over sexual behaviour.

Two parts of the Iyengar et al. (2003) study are published. Provide details about the population and geographic makeup of the state of Gujarat in the first section. This study includes 21256 respondents in total. Information gathered from a variety of sources, including truck drivers, cleaners, street children, autorickshaw drivers, taxi drivers, migrant labourers, passengers, industrial workers, hotel boys, and FSWs (female sex workers). Thus, statistical data from high-risk sources were collected for this study.

In his research, Gobopamang Letamo (2003) discusses The world's highest rate of HIV (human immunodeficiency virus) prevalence is found in Botswana. Stigma and discrimination are part of the HIV/AIDS epidemic, which allows the virus to spread. HIV stands for human immunodeficiency virus/acquired immunodeficiency syndrome. This study looked at survey data on the prevalence of and factors associated with stigma discriminatory attitudes related to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) in Botswana in order to design effective programmes to combat the high prevalence of these attitudes. Only 11% of the 4,147 respondents indicated that they were unwilling to provide care for a family member who had HIV/AIDS, despite the majority of respondents displaying discriminatory attitudes towards teachers or shopkeepers with the virus. The fact that family members have been caring for their sick family members through a government project called Community Home-based Care, which relieves public hospitals of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) patients, appears to have encouraged more tolerant attitudes towards a family member with the disease. They demonstrated more accepting attitudes towards HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) patients because women bear the majority of the responsibility for caring for ailing family members. Discriminatory views were held towards individuals living with HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) by some, including those who thought eating with an HIV patient could result in HIV infection. In order to educate more people about HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome), the national information and communication programme must be strengthened. Lastly, programmes that seek to increase tolerance towards individuals living with HIV (human immunodeficiency virus) will be more successful if they uphold and promote the human rights of those living with HIV/AIDS (acquired immunodeficiency syndrome/human immunodeficiency virus).

Maman et al. (2002) concentrated on HIV (Human Immunodeficiency Virus)-Positive Women when discussing lifetime partner violence. One of Dar es Salaam's six free-standing, voluntary HIV (Human Immunodeficiency Virus) counselling and testing clinics, the Muhimbili Health Information Centre hosted the study in 1999. The purpose of this study was to compare the experiences of HIV-positive and HIV-negative women with regard to partner violence. The initial stage of the study aimed to provide a local definition of violence, explain the decision-making process related to HIV testing and sero-status disclosure for individuals, women, and couples, and create survey tools for the subsequent phase. 15 women (13 HIV positive, 2 HIV negative), 17 men (6 HIV positive, 11 HIV negative), and 15 couples who had undergone HIV (Human Immunodeficiency Virus) counselling and testing at the Muhimbili Health Information Centre were interviewed in-depth during the first phase. The study's second phase assessed the prevalence of violence and determined its correlates among 340 women who were enrolled right after their pre-test counselling session for the HIV virus and before learning their test results in the post-test counselling session. Violence is a risk factor for HIV (Human Immunodeficiency Virus) infection, according to this study, and it needs to be addressed using multilevel preventive strategies.

In 2002, Miriam Maluwa, Peter Aggleton, and Richard Parker conducted a discussion regarding the growing worldwide pandemics of HIV/AIDS and other immunodeficiency viruses. They highlighted the calls for a drastic increase in the level of international assistance. The fight against discrimination and stigma is at the forefront of the actions that must be taken immediately. In order to show how these issues are related to one another and to outline the components of a potential future programmatic response that could be more successful, this article provides a conceptual overview of the relationship between discrimination and human rights, the stigma attached to HIV/AIDS, and the human immunodeficiency virus.

In 2002, Susan J. Klein, Daniel A. O'Connell, and William D. Karchner conducted research. Numerous forms of discrimination and stigma threaten the health of both the individual and the community. Preventing the spread of HIV/AIDS, or the acquired immune deficiency syndrome, requires taking action against stigma and discrimination. Implementing targeted initiatives to counter these threats to public health can be advantageous for health departments and other stakeholders. The comprehensive approach to HIV (Human Immunodeficiency Virus) prevention in New York State includes interventions against stigma and discrimination related to the virus. Several interventions are used at the programme and policy levels for optimum effect. In addition to discussing real-world examples of practical applications, this article outlines the necessity of interventions and illustrates how several interventions work together in a logical model.

A 1995 chapter by Ginny O'Brien, Jane Carrier, and David Ward examines some of the most common housing issues that HIV (human immunodeficiency virus) carriers have faced. While background information is provided when needed, this does not aim to be a housing law handbook. The chapter should be read in its entirety rather than being used only as a reference text because it discusses how advice workers can apply their knowledge to the unique issues faced by those who are infected with HIV (Human Immunodeficiency Virus). We start by outlining some of the details that advisors should be aware of regarding the availability of housing in the area before a client arrives to request assistance. This preliminary work is crucial because errors can be stressful and challenging to correct. The chapter examines the principal types of owner-occupation and public and private sector tenures. These sections don't stand alone on their own. The text takes into account problems in the order that they might be brought up with advice workers. The difficulties of applying to a local authority as a homeless person in need of priority is by far the most extensive section. In addition to the fact that these issues have, in our experience, prompted the most inquiries, it's possible that there is more case law in this area specifically pertaining to vulnerability and intentional homelessness. The significance of advisory agencies in shaping housing policies and practices for individuals living with HIV infection is underscored throughout the chapter.

Gryk Wesley (1995) seeks to outline some of the main immigration related issues likely to be relevant to people affected by HIV (Human Immunodeficiency Virus) and AIDS (acquired immunodeficiency syndrome). It discusses how AIDS (acquired immunodeficiency syndrome) may become an issue when an individual seeks entry to the United Kingdom at a port. With respect to those already in the country, it suggests approaches which may be taken with respect to application law- it may be possible to make a successful application to remain in the United Kingdom on compassionate grounds, either because of one’s own HIV (Human Immunodeficiency Virus)- related medical condition or that of a loved one. Finally, it discusses briefly the problems of HIV (Human Immunodeficiency Virus)- positive persons who are contemplating travel to other countries. The main purpose of this chapter has been to outline the position in United Kingdom immigration law with respect to individuals affected by HIV (Human Immunodeficiency Virus) and AIDS (acquired immunodeficiency syndrome). It is perhaps worth saying a few additional words about the problems which may be faced elsewhere in the world by individuals from the United Kingdom who wish the travel abroad.

Michael (1996) observes that people do not easily accept knowledge about scientific procedures, processes and scientific facts, they can reflect upon the epistemological status of that knowledge. He also argues that this reflection can directly affect their responses to science and scientific experts. The aim of this paper is to explore the discourses of ignorance that people mobilize when reflexively commenting upon their lack of scientific knowledge. This paper is based on survey analysis of the contents of the public understanding and attitudes towards science with the theory of social representations and the ‘mental models' approach.

Macdonald (1996) suggests that the role of science communicators is important in the public understanding of science, and science communicators act as authors of science for the public. The main objective of this study was to look at the way in which science is represented in the final exhibition and second aim was to find out this in relation to both the making of the exhibition and its reception by museum visitors. This is an ethnographic study. Researcher has spent much time with the six-women museum staff who constituted the exhibition team. Researcher also studied the stacks of paperwork that had accumulated in the ‘Food' offices, attended exhibition-relevant meetings elsewhere in the museum and interviewed staff in the science Museum and other museums and science centres.

Article by Richard Lewis Siegel (1996) seeks to extend our understanding of such factors and suggests cultural, economic, biomedical, social and political reasons for the failures. This article also considers why most of the leading international public health and human rights organizations have been less than fully effective in their efforts to promote rights together which effective HIV/AIDS (Human Immunodeficiency

Virus/Acquired Immunodeficiency Syndrome) prevention and control. The article then seeks to combine the analyses of these factors with a close look at the policies advanced in a wide array of documents and statements that intergovernmental organizations (IGOs) and international nongovernmental organizations (NGOs) have issued since 1983. This effort is shaped in party by a series of interviews conducted by the author between 1992 and 1994 as well as by many of the seminal interpretative works of scholars in diverse disciplines.

Renee Danziger (1994) discussed the recent increase in HIV (Human Immunodeficiency Virus) seroprevalence in Poland, particularly among injecting drug users, has been accompanied by widespread discrimination against people affected by HIV (Human Immunodeficiency Virus) and AIDS (acquired immunodeficiency syndrome). As in other countries, this discrimination may be attributed to a large extent to fear and ignorance about HIV (Human Immunodeficiency Virus) and AIDS (acquired immunodeficiency syndrome) together with pre-existing prejudices against the people who are most commonly associated with the epidemic. In Poland extreme hostility towards drug users combined with the powerful influence of a traditional Catholic church have so far impeded effective education about HIV (Human Immunodeficiency Virus) and AIDS (acquired immunodeficiency syndrome) and anti-discrimination strategies.

Article by BDD Radipati (1993) identifies some of the problems which HIV/AIDS poses for employment relationship and how law continues to deal with them against background of what has already been written on the subject within the employment relationship. The intention here, is to avoid as far as possible, re-chronicling what others have written on the issue and rather to expose what are basically divergent approaches to the HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) bane in the workplace. Four countries, viz Botswana, South Africa, the United Kingdom and the United States of America will be considered. Because HIV infection continues to invoke unwarranted phobia and undue bigotry, initial focus will be on the clinical aspects of the condition.

Don C. Des Jarlais and Samuel R. Friedman (1992) says that, legal access to sterile injection equipment has been a primary strategy for preventing the acquired immunodeficiency syndrome (AIDS) among persons who inject illicit drugs in almost all developed countries. This strategy has remained highly controversial in the United States, with only a small number of localities adopting it. This article reviews different techniques of providing legal access over the counter sales and syringe exchanges research design issues relevant to evaluating legal access programs, and the findings from the large number of studies conducted to date. The findings are consistent in showing no increase in illicit drug use related to legal access and decreases in AIDS (acquired immunodeficiency syndrome) risk behavior related to legal access programs. The design of legal access programs for maximal impact and the ultimate effect of the decreases in AIDS (acquired immunodeficiency syndrome) risk behavior on transmission of the human immunodeficiency virus (HIV) remain to be determined.

Paper by Barbara Clow and Linda Snyder begins with an overview of the ways in which sex and gender work together to put women and girls at risk of HIV (Human Immunodeficiency Virus) infection. While both men and women are contracting HIV (Human Immunodeficiency Virus) and dying of AIDS (acquired immunodeficiency syndrome)-related illnesses, gender inequity throughout the world is deepening the suffering of women and girls as well as contributing to the spread of HIV (Human Immunodeficiency Virus). Moreover, gender roles and expectations contribute to stigmatization of women and girls, particularly those from marginalized populations. The second part of the discussion provides a gender-based analysis of the HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) epidemic in Canada, followed by a brief comparison with South Africa's experience with HIV. Although the two countries are vastly different - in terms of infrastructure, culture, history and the scope and impact of HIV (Human Immunodeficiency Virus) - nonetheless, the trajectory of the pandemic is disturbingly similar, at least with respect to the vulnerability of women and girls. Disadvantaged groups of women and girls in both Canada and South Africa have been hardest hit by HIV (Human

Immunodeficiency Virus) and AIDS (acquired immunodeficiency syndrome)-related illnesses. The last section of the paper addresses international recommendations for responding to the HIV (Human Immunodeficiency Virus) pandemic, specifically the implications of United Nations (UN) and World Health Organization (WHO) guidelines for countries with a low incidence of HIV (Human Immunodeficiency Virus) infection. By comparing the management of HIV (Human Immunodeficiency Virus) in South Africa and Canada, the argument will be made that international guidelines, by ignoring gender and the plight of women and girls, contribute to the spread of HIV (Human Immunodeficiency Virus). Moreover, because the guidelines recommend focusing on those at highest risk of HIV (Human Immunodeficiency Virus) infection, they may serve to deepen the stigma associated with positive sero-status and encourage discrimination and marginalization of women and girls infected and affected by HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome). Low incidence countries, including Canada and China, may be in a position to learn from this analysis and to fashion more effective responses to the pandemic.

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REFERENCE6

1. Barbara Clow and Linda Snyder. Gender and HIV/AIDS: Understanding and Addressing Stigma and Discrimination Among Women and Girls. Book Title: Confronting Discrimination and Inequality in China, Book Editor(s): Erroi P. Mendes and Sakunthala Srighanthan, Published by: University of Ottawa Press. Retrieved from https://www.jstor.org/stable/j.ctt1ckpdk1.18
2. BDD Radipati (1993). HIV/AIDS and employment law: a comparative synopsis. The Comparative and International Law Journal of Southern Africa, Vol. 26, No. 3 (NOVEMBER 1993), pp. 396-409. Retrieved from https://www.jstor.org/stable/23249472
3. Bronwen Lichtenstein and Jamie DeCoster (2014). Lessons on Stigma: Teaching about HIV/AIDS. Teaching Sociology, APRIL 2014, Vol. 42, No. 2 (APRIL 2014), pp. 140-150. Retrieved from https://www.jstor.org/stable/43187474
4. Chandreyee Roy (2005) Human Rights and HIV/AIDS with Special Reference to Women, *Indian Anthropologist*, March & Sept. 2005, Vol. 35, No. 1/2 (March & Sept. 2005), pp. 97-110. Retrieved from https://www.jstor.org/stable/41919981
5. Charles Ngwena (2000). HIV/AIDS and equal opportunities in the workplace: the implications of the Employment Equity Act. The Comparative and International Law Journal of Southern Africa, MARCH 2000, Vol. 33, No. 1 (MARCH 2000), pp. 96-113. Retrieved from https://www.jstor.org/stable/23251120
6. Don C. Des Jarlais and Samuel R. Friedman. AIDS and Legal Access to Sterile Drug Injection Equipment. The Annals of the American Academy of Political and Social Science, May, 1992, Vol. 521, Drug Abuse: Linking Policy and Research (May, 1992), pp. 42-65. Retrieved from https://www.jstor.org/stable/1046542

7. Elizabeth Fee and Manon Parry (2008). Jonathan Mann, HIV/AIDS, and Human Rights. Journal of Public Health Policy, Apr., 2008, Vol. 29, No. 1 (Apr., 2008), pp. 54-
8. 71. https://www.jstor.org/stable/40207166
9. Ginny O'Brien, Jane Carrier and David Ward (1995). Housing Law and People with HIV Infection. Book Chapter-4. AIDS: A Guide to The Law (second Edition), edited by Richard Haigh and Dai Harris for the Terrence Higgins Trust, London and New York: Routledge.
10. Gobopamang Letamo (2003). Prevalence of, and Factors Associated with, HIV/AIDS-related Stigma and Discriminatory Attitudes in Botswana. Journal of Health, Population and Nutrition, December 2003, Vol. 21, No. 4 (December 2003), pp. 347-357. Retrieved from http://www.jstor.com/stable/23499343
11. Gryk Wesley (1995). AIDS and Immigration. Book Chapter-5. AIDS: A Guide to The Law (second Edition), edited by Richard Haigh and Dai Harris for the Terrence Higgins Trust, London and New York: Routledge.
12. Iyengar, Sudarshan, Kumar, B. L. and Mistry, Ramkrishna. 2003. *District-wise Mapping of Populations Vulnerable to HIV/AIDS in Gujarat State*. Gujarat Institute of Development Research (Gota), Ahmedabad, Volume 1&2, 25th December 2003.
13. JAMIE ENOCH and PETER PIOT (2017). Human Rights in the Fourth Decade of the HIV/AIDS Response: An Inspiring Legacy and Urgent Imperative. Health and Human Rights, Vol. 19, No. 2, Special Sections: Romani People and the Right to Health HIV and Human Rights (DECEMBER 2017), pp. 117-122. Retrieved from https://www.jstor.org/stable/10.2307/90016119
14. Jennifer, Kipgen. 2012. *Utilization Patterns of Health Services by Widows Living with HIV/AIDS: A Study in Manipur*. A thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy in Social Work, School of Social Work, Tata Institute of Social Sciences, Mumbai, 2012.
15. Jesus Ramirez-Valles, Lisa M. Kuhns, Richard T. Campbell and Rafael M. Diaz (2010). Journal of Health and Social Behavior, MARCH 2010, Vol. 51, No. 1

(MARCH 2010), pp. 30-47. Retrieved from https://www.jstor.org/stable/27800367

16. Joshua Amo-Adjei and Eugene KM Darteh (2013). Drivers of Young People's Attitudes towards HIV/AIDS Stigma and Discrimination: Evidence from Ghana. African Journal of Reproductive Health / La Revue Africaine de la Sante Reproductive, December 2013, Vol. 17, No. 4, Special Edition on HIV/AIDS (December 2013), pp. 51-59. Retrieved from https://www.jstor.org/stable/24362086
17. Jothivenkatesan, D. (December -2009). *Vulnerability of Prostitutes to HIV/AIDS and other Health Hazards- A Sociological study in Pudukkottai District*, Thesis submitted to Bharathidasan University for the award of Doctor of Philosophy in Sociology, Bharathidasan University, Tiruchirappalli, December -2009.
18. Lance Gable, Lawrence O. Gostin, and James G. Hodge, HIV/AIDS, Reproductive and Sexual Health, and the Law, Am J Public Health. 2008 October; 98(10): 1779–1786. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636460/
19. Maman, Suzanne et al. 2002. “HIV-Positive Women Report More Lifetime Partner Violence: Findings from a Voluntary Counseling and Testing Clinic in Dar es Salaam, Tanzania”, *American Journal of Public Health,* 92 (8).
20. Mark D. Regnerus and Viviana Salinas (2007). Religious Affiliation and Aids-Based Discrimination in Sub-Saharan Africa. Review of Religious Research, Jun., 2007, Vol. 48, No. 4 (Jun., 2007), pp. 385-400. Retrieved from https://www.jstor.org/stable/20447458
21. Michael, Mike. 1996. “Ignoring science: discourses of ignorance in the public understanding of science”, In *misunderstanding science?* edited by Alan Irwin, Brian Wynne, 107-125. South Africa: Cambridge University Press, 1996.
22. Miriam Maluwa, Peter Aggleton and Richard Parker (2002). HIV- and AIDS-Related Stigma, Discrimination, and Human Rights: A Critical Overview. Health and Human Rights, 2002, Vol. 6, No. 1 (2002), pp. 1-18. Retrieved from http://www.jstor.com/stable/4065311

23. Nanda, Satyajeet and Pramanik, Aparimita. 2010. “Media Exposure, Gender Stereotype and Contextual Stigma Perceptions about HIV and AIDS: Evidences from Gujarat, India”, *Journal of Health Management*. 12 (4): 461-481.
24. Nthabiseng Phaladze and Sheila Tlou (2006). Gender and HIV/AIDS in Botswana: A Focus on Inequalities and Discrimination. Gender and Development, Mar., 2006, Vol. 14, No. 1, HIV / AIDS (Mar., 2006), pp. 23-35. Retrieved from https://www.jstor.org/stable/20461113
25. Patel, Hiteshkumar N. 2005. *Gyana nu Samajashastra* (Gujarati), Ahmedabad, Gujarat, India: Parshwa Publication.
26. Patel, Twinkal. 2008. *Counseling ma Aachaar Sanhitaa: Vyaavasaayik Sthiti ane Prashno*, unpublished M.Phil Dissertation in M.S.W., Gujarat Vidyapith, Ahmedabad.
27. Peter Moszynski (2009). Discrimination risks derailing progress against HIV and AIDS. BMJ: British Medical Journal, Vol. 339, No. 7733 (5 December 2009), p. 1281 Published by: BMJ. Retrieved from https://www.jstor.org/stable/25673404
28. Peter Baume (1999). Chapter Titled AIDS AND DISCRIMINATION (1999) in book A Dissident Liberal. Retrieved from https://www.jstor.org/stable/j.ctt183q3f4.43
29. Rebecca Tiessen, Jane Parpart and Miriam Grant (2010). Gender, HIV/AIDS, and Human Security in Africa. Canadian Journal of African Studies / Revue Canadienne des Études Africaines, 2010, Vol. 44, No. 3, Gender, HIV/AIDS, and Human Security in Africa / Les sexes, le VIH/SIDA, et la securite humaine en Afrique (2010), pp. 449-456. https://www.jstor.org/stable/23236804
30. Richard Lewis Siegel (1996). AIDS and Human Rights, *Human Rights Quaterly*, Vol. 18, No.3 Aug 1996, Retrieved from https://www.jstor.org/stable/762474
31. Renee Danziger (1994). Discrimination Against People with HIV And AIDS In Poland. British Medical Journal, Apr. 30, 1994, Vol. 308, No. 6937 (Apr. 30, 1994), pp. 1145-1147. Retrieved from https://www.jstor.org/stable/29723396

32. Sarkar, Debnarayan (March 2011). “Social and Economical Implications of HIV/AIDS Evidence from West Bengal”, *Man and Development*, March 2011, 19-38.
33. Sharon, Macdonald. 1996. “Authorising science: public understanding of science in museums”, In *misunderstanding science?* edited by Alan Irwin, Brian Wynne, 152-171. South Africa: Cambridge University Press, 1996.
34. Susan J. Klein, William D. Karchner and Daniel A. O'Connell (2002). Interventions to Prevent HIV-Related Stigma and Discrimination: Findings and Recommendations for Public Health Practice. Journal of Public Health Management and Practice, Vol. 8, No. 6, Issue Focus: HIV and STD Prevention (November 2002), pp. 44-53. Retrieved from https://www.jstor.org/stable/44968209
35. Tinny Dawar and Sarita Anand (2009). Narratives of Women Living with HIV/AIDS: An Exploration. Indian Anthropologist, Jan - Dec 2009, Vol. 39, No. 1/2 (Jan - Dec 2009), pp. 35-48. Retrieved from https://www.jstor.org/stable/41920089.

CHAPTER - 3

HUMAN RIGHTS AND HIV/AIDS

3.1 Introduction

Human rights are those freedoms to which every individual has an inherent right just by virtue of being a human. They are based on imperatives that are fundamental human needs. A few of these requirements are essential to one's survival and physical health. Others are necessary for the psyche's survival and well-being. Human rights can therefore be recognized and enumerated. The well-established concept of natural law is linked to these rights.

The promise that some actions cannot or ought not to be taken against a person's will is known as an immunities concept. This theory holds that due to their humanity, people ought to be protected from cruel and degrading treatment. Stated differently, human rights constitute an exemption to the application of arbitrary power. A person can only exercise their human rights in an organized community, like a state, or, alternatively, anywhere there is a civil social order. No one can imagine using them in a state of anarchy where there is scarcely any just power to which a citizen can appeal against violations of their rights. The fundamental ideas guiding the defense of human rights stem from the idea of man as an individual and his interaction with a social structure, both of which are inextricably linked to the essence of humanity.

3.2 Human Rights

Because they are essential to the overall development of every person's personality, human rights must be upheld and made available to all members of society. They must be cherished, dependable, and safeguarded in order to bring about peace and prosperity. Because human rights are the cornerstone of a meaningful life, upholding human dignity is the government's ultimate goal. The unavoidable growth of government power over citizens' conduct has led to a need for protection, which is something that is never, ever desirable. Many states do not uphold the fundamental standards of human behavior. Human awareness of their rights has also contributed to the need for state protection. It has come to light that all laws—whether they be local ordinances or principles of international law—should work to safeguard individuals for the benefit of all living things.

The acceptance of human dignity and honor is one of the achievements of contemporary international law. The person is now of legal age according to international law. Additionally, it has been determined that the state should no longer act as a person's guardian ad litem in order to give them protection from the state abroad. This is clear from the many conventions with various purviews that have been adopted under the United Nations Organization's auspices over the course of the last 60 years or so. The adoption of several declarations by the UN and its specialized agencies demonstrates the commitment of its members to advancing the promotion of universal respect for and observance of fundamental freedoms and human rights. States are conscious of their personal accountability for protecting human rights. By including the necessary clauses in their constitutions, they have taken action to safeguard individual rights. They have also established national conventions to establish regional agreements. On a national, regional, and worldwide level, non-governmental organizations are also honored for their efforts in exposing human rights abuses and devising solutions to prevent them in the future. The importance of human rights in the international system is now widely acknowledged due to their impact on politics, morality, and the law.

Because they involve the fulfillment of the obligations and rights specified in international treaties, human rights are legitimate. As a value-based system designed to protect human dignity, human rights are political in the widest sense of the word. Additionally, they seek to curtail the power that governments wield over the populace. Regarding the protection of these rights, one will not hesitate to admit that there is uncertainty about the precise nature, extent, and application of international law.

3.3 Kinds of Human Rights

There are no distinct categories of human rights since they are all interconnected and indivisible. Every person is born with the equal importance of all human rights. Consequently, the Universal Declaration of Human Rights lacked definitions for the various categories of human rights. It just listed them in different articles. However, the subsequent developments in the field of human rights under the United Nations System demonstrate that there are two distinct categories of human rights:

(1) Civil and Political Rights, and

(2) Economic, Social and Cultural Rights.

Since humans are sentient beings, they possess a variety of basic, inalienable rights that are bound together and called human rights. According to the New International Webster's Comprehensive Dictionary of the English Language, the word "right" literally means anything done in accordance with or conformable to truth or fact, correct, true, accurate, not mistaken, conformable to a standard of propriety, fit, suitable, and the word "human" means pertaining to characterizing man or mankind.[1]

3.4 Origin and Development Meaning and Nature of Human Rights

Conversely, human rights encompass a broad range of rights, including civil, cultural, economic, and social rights. As such, it is difficult to give a clear definition of the term "human rights." However, human rights are those that every individual possesses just by virtue of being a human. These rights were already theirs by virtue of their very existence, and they became operative at birth. Everyone by default has human rights because they are fundamental human rights, irrespective of caste, creed, religion, sex, or nationality. Since they preserve people's freedom and dignity and promote their physical, moral, social, and spiritual well-being, human rights are essential to everyone. Their importance is indisputable, especially in the present era, as they establish the proper foundation for people's moral and material progress. Because of their immense importance to people, human rights are also occasionally referred to as fundamental rights, basic rights, inherent rights, natural rights, and birth rights. The philosophical and pragmatic approaches are the two main ways that have occasionally been used to

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[1] H.O. Agarwal, Human Rights, Universal Book Traders, New Delhi. 2002. p.2

explain the nature of human rights. i) The Philosophical or Theoretical Approach: This method has produced five different theories that each attempt to explain a human right. These are:

3.4.1 The Natural Rights Theory

According to this theory, all people are born with certain basic rights. Humans have these rights because they are complete beings who are masters of themselves and their actions in accordance with natural law. [2] Because of this, the evolution of "the Rights of Man" has been strongly associated with conventional theories of natural law. In actuality, these theories never presented the concept of individual rights as a distinct aspect, and law itself implies both duties and rights.[3] Rights and obligations are therefore connected to one another. As D. D. Raphael rightly noted, "Duties are obligations to other people, and rights are rights against other people." Consequently, a framework of inherent rights that protect people from one another."[4]

3.4.2 The Legal Right Theory

The theory of legal rights is supported by the theory of natural rights, which has been criticized by many scholars. According to this theory, rights were established by the state. As such, they are neither absolute nor a component of what constitutes man. Every right, including the rights to property, liberty, and life, is a construct of the legal system. This theory went on to say that the state could only acknowledge these rights in order to enforce them; otherwise, it would be impossible for the state to do so. Among these fundamental rights is the right to self-preservation, which the state can only safeguard in a way that is superior to any other.

3.4.3 The Historical Theory of Rights

Historical theory holds that rights are the result of historical processes. A long-standing tradition eventually acquires legal status. In this context, Ritchie states that "those rights

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[2] H.O. Agarwal. Human Rights, p.2.

[3] J. Maritain, The Rights of Man and Natural law, Macmillan. 1951, p.65.

[4] D.D. Raphael. „'Human Rights Old and New”. In D.D. Raphael, (ed.). Political Theory and the Rights of Man, Macmillan, 1967, p.55.

that people believe they should have been simply those that they have grown accustomed to having, or that they have a 'tradition' (true or false) of having previously possessed." Primitive law is custom.

3.4.4 The Social Welfare Theory of Rights

This theory is also known as the Social Expediency theory. This theory's proponents assert that social expediency shapes natural rights, custom, and the law in all respects. The contributions of the social welfare theory have benefited several human rights. Consequently, a large number of social and economic rights are included in the Universal Declaration of Human Rights.

3.4.5 The Idealistic Theory of Rights

The idealistic theory of rights is also known as the personality theory of rights. This theory emphasizes the importance of man's inner development and reaching his greatest potential. It therefore considers the right to one's own privacy to be of utmost importance. According to this theory, all other rights have restricted and denied the right to personal integrity.

3.5 Concept of Human Rights

All major world religions have been deeply committed to the concept of human rights since the dawn of human civilization. It often shows itself quite clearly, whether it is a duty to one's neighbor. The concept of the universal brotherhood and fraternity of humanity, as well as empathy for one's fellow humans, originates from various pre- and post-Christian religious doctrines. Thus, in spite of appearances to the contrary, human rights are not a modern concept; rather, they have very ancient roots.[5] From a humanist standpoint, all of the major world religions uphold human rights, notwithstanding their differences in doctrine. The concepts of "natural law" and "natural rights," as well as ancient philosophy, are the sources of human rights. A few classical Greek and Roman philosophers agreed with the idea of natural rights. Plato (427-348 B.C.) was among the

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[5] (ed.). Human Dimity- The Internationalization of Human Rights. Oceana Publication, 1979.p. 16. Dr.Gokulesh Sharma, Human Rights and Legal Remidies. Deep and Deep Publications, New Delhi, 2001.p

first writers to advocate for a general code of ethics. Thomas Buergenlhal, cited in Alicc H. Hankim, asserts that both ancient and contemporary texts contain references to the codification and application of international human rights.

The natural law was what nature and history guaranteed to every human being, according to the Roman jurist Ulpian. This meant that even though the scriptures don't name basic human rights, it is still expected of foreigners to uphold them. The concept of the 1215 CE Magna Carta is attributed to contemporary history. In reality, every human being possesses inherent dignity and worth, which is the source of human rights. The human person is the primary focus of both fundamental freedom and human rights. Stated differently, even though the concept of human rights took some time to fully emerge, anything that improves a person's capacity to live in dignity and freedom should be considered a development of those rights. The concept of human rights was originally developed as something different from the natural rights that political philosophers had previously espoused; nevertheless, the latter have come to be understood as a single, comprehensive concept.[6] Despite being fundamental to international law, few people really comprehend the concept of human rights. Regarding its nature, meaning, or content, no one can agree. It is a notion akin to how one interacts with fellow citizens. It also meant that conflicts would be waged in a civilized manner. It was proposed in The Republic (c. 400 BC) that there were universal truths that ought to be recognized and that collaboration was necessary for the benefit of all. Aristotle claimed in Politics that the effects of various circumstances and constitutions on justice, virtues, and rights vary. Caesar lived from 104 to 43 BC. A Roman statesman outlined the fundamentals of human rights and natural law in his writings. The laws date back to 52 B.C. Cicero believed that laws pertaining to human rights should be universal and take precedence over both civil and customary law. Sophocles (495–406 BC) was one of the writers on the list who promoted the idea of free speech against the government. Stoces used the term "natural law" to allude to a

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[6] Thomistic Reflection" in Alan S. Rosenbaum, (ed.), The Philosophy of Human Rights International Perspectives. 1980. Sec also H.O. Agarval Human Rights, pp. 7-8. "Vijay Kumar. Human Rights Dimensions and Issues. Vol. I. Anmol Publications Pvt. Ltd., New Delhi, p 42.

higher law, especially Christian law, that is in harmony with nature and is to serve as the standard for laws governing civil society and the government. Based on a divine law that Sir Thomas Aquinas (1225–1274) thought was partially discoverable by man using his divinely endowed rational faculties, this "natural law" was established. Greece, a city-state, guaranteed equality before the law and equal freedom of speech. The Jus-Civilie of Roman law gave the Roman people similar rights, such as the ability to trade, vote, and hold public office as well as the ability to access justice for their citizens. The idea of human rights is widely recognized to have its roots in the Greco-Roman natural law doctrines of Stoicism, the philosophical school founded by Zeno and Citium. These doctrines held that human conduct should be judged according to the law of nature because a universal force permeates all of creation. S.J. Henie, "A Catholic understanding of human rights, hotly debated between developed and developing nations, as well as between the East and West (representing former socialist states and liberal-democratic states). Every group of countries has a different perspective on human rights. They are as follows:

3.5.1 Western View of Human Rights

Human rights do not have special status in the West. They don't meet the cosmic order's requirements for an eternal source. All of the sources combined are either entirely fictional, or, similar to the French Charter of Human Rights, the French Declaration of Human Rights, the Magna Carta, and the ten amendments to the United States Constitution, they are regional texts that arose out of the distinct political and social contexts of Britain, France, and the United States. The concept of fundamental rights has developed there in tandem with human awareness. And these rights were born one by one out of the agreements made for the balance of power, the decision of the parliament, charter declarations, and the theories put forth by political thinkers during the long struggle between the people and the king or other rulers. The more this conflict went on, the more rights were granted. That is to say, yesterday's "fundamental rights" were not what they are today. They weren't really rights in the true sense of the word until the Constitution and local laws acknowledged each of these rights and granted them legal standing. But in most Western countries, the main goal of these rights is to shield the person from the government. As a result, these rights are valued higher in the West than the common laws established by the state. Because of their inclusion in the Constitution, the state's legislative power is limited, and the judiciary is tasked with protecting fundamental rights.

3.5.2 Socialist View of Human Rights

The dialectical process of history, according to Karl Marx and Lenin, is the real source of fundamental rights. These rights are not natural; rather, they are the outcome of this process, which has contributed to various historical periods; in the "classless society" that Communists support, these rights must ultimately be eliminated. At first, these rights helped the bourgeois class establish the "Capitalist Society" and free itself from the feudal system. They were later used as a weapon by the proletariat in their fight against the capitalist class. For the sake of equality and freedom, human rights will ultimately be eliminated under communism since, in the current socialist system, they serve to defend the interests of the working class. This philosophy holds that neither these rights nor the impressionable are innate to man or fundamental to his identity. They are not very significant or noteworthy. The general law of the land applies to them. I'm asking the question while keeping the previously mentioned point of view in mind. Socialists believe that a person's pursuit of financial success is their only reason for existing. Their worldview logically dictates that, once it has been decided what other rights a person can be granted aside from food and shelter, nations will only guarantee these material rights and will not recognize any other rights based on moral principles. It is unreasonable to expect them to expand and widen the definition of fundamental rights unless and until they adopt a more human-centered viewpoint.

3.5.3 Religious View of Human Rights

All of the world's major religions are humanist in nature and support human rights, despite differences in content. One of the ancient religions' holy books, the Vedas, may have inspired the concept of mercy, kindness, and sympathy for humans.

This idea clarifies amicable relationships and conduct with all living things, not just humans.

"Oh Lord! Let my eye view be firm in order that all creatures may look at me by friendly sight. In the same way I also may see all creatures with friendly sight and all of us(creatures) may see others in friendly view."[7]

The same concept can be extracted from the text of the Bible that Paul used to explain his theory of equality. Paul wrote the following in his letter: "There is no such thing as Jew and Greek, slave and freedom, male and female, for you are all one person in Christ Jesus".[8]

Buddhism's doctrine of nonviolence, both in words and deeds, is unparalleled in its compassion, having its roots in the third century B.C. In addition, similar human rights doctrines have been preached and upheld by other religions, both ancient and modern, including Sikhism, Jainism, Zorastarism, and Judaism. Islam has a solid base and has always been a major religion in theocracies, having been established as a divine religion. The belief that human rights can only be bestowed by Allah Himself is reinforced by Islamic customs. The world has not produced more just and fair laws than those that were established over a millennium ago. Consequently, one could contend that religion itself provides the essential basis for human rights throughout history and at all ages and that no religion, ideology, or ism encouraged the cruel treatment of society's members.

Although they have been around for a long time—since antiquity, in fact—human rights have only lately gained popularity. The United Nations' establishment in 1945, which reaffirmed its belief in the fundamental rights, dignity, and worth of every human being at every level and in every situation, was the catalyst for its official recognition. All of the rights that are fundamental to our identity and without which we would cease to be human are collectively referred to as "human rights."[9] Human rights

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[7] Nayyar Shamsi, Human Rights and Islam, p 28.
[8] H.O. Agarwai, Human Rights, p 6.
[9] Mawdudi..Human Rights in Islam. MarkaziMaktaba Islamic. Delhi, l<)82, p 56.

are a social phenomenon because they include remedies, despite being essentially individual in nature because they are meant to be enjoyed by individuals. Of those for whom they are fixed.[10] Some researchers claim that human evolution began with the ancient Greeks. An illustration of how human rights have evolved to be recognized as fundamental human rights is found in the Greek play Antigone. All of the world's major religions and the legal systems of Babylonia, Assyria, and the Hittite civilizations contain the foundations for protecting an individual's rights. The concept of a man's natural rights developed philosophically in large part thanks to the contributions of the stoic philosophers. They first created the natural law theory to explain the nature of human rights, which are rights that every person has merely by virtue of being a human.

The battle for human rights in the West is generally thought to have started around the time that the well-known English charter known as Magna Carta was released in the early thirteenth century. In actuality, though, the battle had started 200 years earlier—in 1037 C.E.53, with the publication of the charter outlining the rights of the parliament.

Sophocles tells the story of Antigone's brother, who was killed while rebelling against the king, and how Crcon, the king, refused to bury him. When Antigone was imprisoned for defying the order, she buried her brother against the orders. She maintained that she had behaved in accordance with the immutable, "unwritten laws of heaven," which even the king could not change. Sophocles' Antigone.

King Alfonso later agreed to the Habeas Corpus Principle in 1188. The second important document was the Draft of Right (1689). Another important document was the English Bill of Rights. 1689; American Declaration of Independence, 1776.

There were rights in place before the Magna Carta, or Bill of Rights, was drafted. On the other hand, Magna Carta is acknowledged as a pivotal moment in the history of human rights. Henry I, Stephen, and Henry II betrayed their pledge to accept this charter. King John, who was known by his rough exterior as "The Tyrzint," signed

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[10] Teaching Human Rights. United Nations, New York. 1989, p 5.

this charter. The term "fundamental rights of man" was used in the declaration. Consequently, the phrase "human rights" came into common usage somewhat belatedly. It is a 20th-century term for concepts that were previously known as "natural rights" or "the rights of man." Thomas Paine was the one who first translated the French Declaration of the Rights of Man and Citizen into English. Later, "natural law" was dropped because it was no longer widely accepted, and "the rights of man" was rephrased to avoid offending anyone who wasn't in favor of women's rights.

During the 1990s and the beginning of the 20th century, the idea of total state sovereignty prevailed, and concerns about human rights were seen as falling under the purview of each state's Protection of Human Rights (National and International Perspectives). Consequently, the notion that international law could supplement local law in defending human rights emerged gradually.

Additional instances comprise the thirteen American States' 1776 Declaration of Independence from Great Britain. (The Declaration of Virginia, 1776): A number of human rights were established by the United States Constitution of 1778, as amended in 1789, 1865, 1869, and 1919. The Virginia Declaration of Rights states that every man has certain inherent rights and is inherently free and independent. The French Declaration of the Rights of Man and of the Citizens, which was published in 1789, led other European countries to incorporate human rights protections into their legal frameworks. Humans have their own domestic legal system and are completely unsuited for international law enforcement, H. Aganval. International human rights laws were seen as an attack on the concept of state sovereignty. The adoption of the Slavery Conventions in 1926 and the establishment of the International Labor Organization in 1919, along with its subsequent operations, are two instances where the aforementioned rule was clearly broken. The League of Nations covenant, which was ratified following World War One, did not mention human rights. A paradigm shift in the traditional understanding of international law occurred in the 1940s, amid the grave human rights violations that were taking place in war-torn Europe during World War II. Basic human rights were totally suppressed, and heinous crimes against humanity were committed.

German Nazi leaders brutally disregarded human values and dignity in the territory they occupied, installing an authoritarian government that disregarded the law. It was later discovered that the restoration of freedom to the majority of people is one of the most important conditions for the establishment of world peace and security. Human rights abuses were considered to be a major cause of international conflict, and upholding human rights was thought to be crucial to preserving global peace. President Franklin D. Roosevelt declared what became known as the "Four Freedoms" (freedom of speech, freedom of religion, freedom from want, and freedom from fear) on January 6, 1941, in accordance with this belief. "Freedom means that human rights prevail everywhere," he said in his message.

The same attempts were being made to create a worldwide organization to bring about peace even as World War II raged on. Following several conferences and meetings, the international organization known as the United Nations was established in 1945. A number of declarations emphasizing the importance of human rights were adopted by the conference. Later, at the San Francisco conference, a number of delegates proposed that the UN draft a "International Bill of Rights." Members of the organization realized that, despite the impossibility of it, the international community ought to work together to put an end to the scourge of war. Consequently, they decided that the United Nations Charter should include the promotion and respect for human rights, which are so important and well-known right now. Because of this, the preamble of the charter contains clauses pertaining to the advancement and protection of fundamental freedoms and human rights. The most important task facing the UN following its entry into force was the implementation of the principles outlined in Article 55 of the UN Charter, which include respect for human rights and freedom for all without distinction as to race, sex, language, or religion. The December General Assembly decided to draft a "International Bill of Rights" in order to achieve this.[11]

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[11] For instance, see Declaration of ST. James Palace (1941): Atlantic Chancr (1941);United Nation Declarations (1942); Moscow Declaration (1943); Tehran Declaration (1943); Dumbarton Oak‟s Conference (1944); Sun Francisco Conference (1945); etc. " 10, 1948 through a resolution adopted an

3.6 Universal Declaration of Human Rights of 1948

It is obvious that, despite appearances to the contrary, the concept of human rights is not a modern one but rather has very deep roots in eternity since it is rooted in the very beginnings of human civilization and is upheld by all major world religions, both before and after the birth of Christ. All of the world's major religions are humanist in nature and support human rights, despite differences in content. Which is seen in the compassion, mercy, and empathy for people described in different scriptures as its manifestation. Human rights are also based on the philosophical notions of natural law and "natural rights." Ancient texts and historical accounts mention the fundamental human rights, though they are not always referred to by the same name. The well-known English charter known as Magna Carta, which was written in 1215 CE, is regarded as a watershed in the development of human rights. Most people agree that the Western world saw the start of the human rights movement in the early 13th century. But the history of human rights has only just begun to take off. Following the two World Wars, the League of Nations and the United Nations were established with the goal of preserving human fraternity and thereby restraining humanity's inclination toward barbarism. Through a number of international agreements and conventions, the concepts of human rights were acknowledged and accepted as the fundamental laws of national borders in the form of draft constitutions. In 1948, the United Nations formally adopted the Universal Declaration of Human Rights as a moral precept with corresponding legal obligations.

On December 10, 1948, the United Nations General Assembly adopted and proclaimed the Universal Declaration of Human Rights. The pages that follow contain the declaration's entire text. The Assembly then called on all signatory states to "cause it to be disseminated, displayed, read and expounded in principal in schools and other

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'International Bill of Human Rights' known as 'Universal Declaration of Human Rights 'The resolution was
adopted without dissent by forty votes with eight states abstaining The Declaration consisted of thirty
articles besides a preamble.

educational institutions, without distinction based on the political status of countries or territories," and to make the text of the Declaration widely known. According to the preamble of the Declaration, the foundation of world freedom, justice, and peace is the recognition of each and every member of the human family's inherent dignity and unalienable rights. The advent of a world free from fear and want, coupled with freedom of speech and belief, has been declared the highest aspiration by the General Assembly in Resolution 217(111), passed on December 10, 1948. Humanity has been outraged by barbaric acts that have been committed with disregard and contempt for human rights.[12]

The nations that make up the United Nations have reaffirmed their commitment to the equality of men's and women's rights under the Charter, to fundamental human rights, and to the value and dignity of every individual. In a more libertarian world, they also pledged to promote social progress and higher living standards. Together with the UN, Member States have pledged to advance universal respect for and observance of human rights. Because it is essential for the full realization of this commitment that all people and all nations have a common understanding of these rights and freedoms, the General Assembly declares the Universal Declaration of Human Rights to be a common benchmark of achievement for all people and all nations. In the end, every person and every institution of society must strive toward these goals by teaching and educating to promote respect for these rights and freedoms in order to secure these rights and freedoms' universal and effective recognition and observance, both among the peoples of member States themselves and among the peoples of territories under their jurisdiction.

Every human being is born free and with an equal sense of dignity and rights, according to Article 1 of the Declaration. Treating each other with brotherly affection is appropriate since they are sentient entities with conscience and reason. Regardless of race, color, sex, language, religion, political opinion, national origin, or any other status, everyone has the right to all the freedoms and rights outlined in this declaration.

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[12] H.O.Aganval. Human Rights, p 30.

Furthermore, there should be no differentiation based on the political, legal, or international standing of the country or territory of which an individual is a citizen. This includes whether the country or territory is an independent, trust, non-self-governing, or subject to any other forms of sovereignty limitations. Everybody has the right to personal safety, liberty, and life. All forms of slavery and the slave trade shall be prohibited, and no one shall be forced into servitude or slavery. No one shall be subjected to torture or cruel, inhuman, or degrading treatment. Everyone has the right to be treated by the law as a person, everywhere. "There should be no discrimination in the application of the law; everyone is equal before it."

Every individual is entitled to equal protection from discriminatory practices that contravene this Declaration, as well as from any encouragement of such practices. Everyone has the right to a successful remedy from the relevant national tribunals in the event that their fundamental rights under the law or the Constitution are violated. Nobody may be arbitrarily arrested, detained, or banished. Every individual is entitled, without exception, to a fair and public trial before an impartial tribunal that will ascertain both the legitimacy of any criminal charges filed against them as well as the individual's rights and obligations. Everyone who is charged with a crime has the legal right to have all necessary protections for their defense before being found guilty in an open courtroom. Anyone who does an act or omission that did not, at the time of the act, violate any national or international law is not guilty of a criminal offense. Moreover, no punishment that is harsher than the one that was in effect at the time the criminal offense was committed may be applied. Nobody shall be the object of malicious attacks on their honor or reputation, or of deliberate encroachment upon their personal space, that of their loved ones, their homes, or their correspondence.

Everyone is entitled to the protection of the law against these kinds of attacks or intrusions. Everyone has the right to live and move anywhere within the borders of their state. It is everyone's right to travel and return from any country, including their own. Everyone is free to apply for and be granted asylum if they are being persecuted abroad. This right is not applicable in situations where the accusations are genuinely related to non-political offenses or behavior that contravenes UN objectives and principles. Everyone has the right to be a national. Nobody's ability to maintain or change their nationality may be arbitrarily denied. Men and women of legal age have the right to marry and form families without hindrances based on race, nationality, or religion. They are entitled to equal rights under Article 10 of the Universal Declaration of Human Rights.

Nonetheless, the General Assembly declares the "Universal Declaration of Human Rights" to be the universal standard of success for every person and every nation. But it could not be enforced against the states. The commission on human rights decided to draft a separate covenant in 1947 while reviewing the drafting committee's initial draft of the Universal Declaration of Human Rights (UDHR) because it was not intended to be legally binding on the member states. The rights that could give rise to legally enforceable obligations would be the main focus of this covenant. The documents were collectively referred to as the International Covenant on Human Rights. The International Covenant on Civil and Political Rights and the International Covenant on Economic, Social, and Cultural Rights were thus adopted by the General Assembly on December 16, 1966.

There are 53 articles in the six parts that make up the Covenant on Civil and Political Rights. Parts I, II, and III list the various freedoms and rights; the remaining three parts deal with the actual application of those freedoms and the concluding remarks. Article 1 (the right of peoples to self-determination) states that every people has the freedom to select their political status and to actively pursue their economic, social, and cultural advancements. These articles impose obligations on the state parties to uphold and promote the right to self-determination. Part II set forth the rights and obligations of the covenant's parties. It included the state's obligations to take the necessary steps to incorporate the covenant's provisions into domestic laws as well as to adopt any legislative or other measures that might be needed to give effect to the rights recognized in the covenant. It was requested of the state parties to ensure equal access to all civil and political rights for men and women. Part III addresses the responsibilities of the States Parties as well as the individual's specific rights. As specified in the covenant, these rights are not unconditional and are subject to limitations.

The Covenant on Economic, Social, and Cultural Rights is composed of 31 articles that are categorized into five sections. The first section of the Covenant of Civil and Political Rights, Article 1, addresses peoples' right to self-determination. One of the additional rights that Article 6 protects is the right to life. Article 9 guarantees the right to liberty and security; Article 7 prohibits slavery, servitude, and forced labor; and Article 8 prohibits inhuman or degrading treatment. Treatment based on humanity is mandated by law (Article 10). exemption from jail time for not fulfilling a legal duty (Article 11). the freedom to travel around and choose where to live (Article 12). freedom for foreigners to be expelled without cause (Article 13). Article 14 guarantees the right to a fair trial. No criminal law can be used retrospectively (Article 15).

Articles 16 and 17 of the constitution guarantee the rights to privacy, family, home, and correspondence, respectively. Conscience, thought, and religion are all liberated (Article 18). liberty of speech and ideas (Article 19). Propaganda during war is forbidden (Article 20). The right to peaceful assembly (Article 21). Freedom of association (Article 22) and the right to marry and have children (Article 23). rights of children (Article 24). the capacity to cast a ballot, take part in elections, and manage governance (Article 25). Equality before the law (Article 26). Article 21: Rights of Minorities. The Covenant/s lists people in Part III. The Covenant's second part lists the promises given by the signatory states. In order to fully realize the rights recognized in the covenant, each state party is required by Article 2 to take the necessary actions, including the adoption of legislative measures, both on an individual basis and through international assistance and cooperation, especially economic and technical assistance, to the fullest extent of its resources.

Consequently, the covenant has set the bar that the State Parties will need to keep going forward. However, the development of international humanitarian law—a body of laws pertaining to the protection of war victims and the conduct of war—has been greatly influenced by the expansion of legal protection for human rights that followed World War II. In the field of human rights, the 1948 Universal Declaration of Human Rights, the 1966 International Covenant on Civil and Political Rights, and the 1966 International Covenant on Economic, Social, and Cultural Rights were all important international instruments that contributed to the affirmation of the idea that everyone has the right to exercise their human rights, regardless of whether they are in times of peace or war.

3.7 Human Rights and Fundamental Rights

In the modern world, the right to privacy is still important. According to the New Oxford Dictionary, privacy is defined as "the absence or avoidance of publicity or display; the state or condition of being withdrawn from the company of others, or from public interest; seclusion." The Black's Law Dictionary defines the right to privacy as the freedom from unwarranted publicity, the ability to live without unjustified public interference in matters that are not necessarily of public interest, and the ability to be left alone. "The state of being alone and not watched or disturbed by other people, the state of being free from the attention of the public," is what the Oxford Advanced Learners Dictionary defines as privacy.

In a democracy, the concept of privacy is fundamental. The Indian Constitution makes no mention of privacy guarantees at all. But in the 1963 case of Kharak Singh v. State of Uttar Pradesh [13]. The Supreme Court holds that privacy is adequately covered by Article 21, which deals with personal freedom (protection of life and personal liberty). The worst thing that can happen to a man's physical happiness and health, according to the court, is an intentional invasion of privacy.

In almost every democratic nation where fundamental liberties are guaranteed, there has been fierce debate over the scope of the state's authority to conduct searches and seizures and the right to privacy. Returning to the Semayne case in history [14], is the source of the proverb "A man's castle is his home." William Pitt's 1763 speech to the British Parliament is among the best examples of the proverb. "The poorest man may

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[13] 1963 AIR 1295, 1964 SCR (1) 332

[14] (1603) 7 ER 194 (KB)

bid defiance to all the force of the crown," he declared from his cottage. None of the forces of the King of England dares to cross the tenement, no matter how weak it is, how its roots shake, how the wind blows through it, how the storm enters, and how the rain enters.

In Article 12 of the 1948 Universal Declaration of Human Rights, the following is stated regarding privacy:

> "*No one shall be the target of a hateful assault on their honor or reputation, or of a random intrusion into their family, house, or correspondence. Everyone has a right to legal defense against these types of attacks or invasions*.

The following is stated in relation to privacy in Article 17 of the International Covenant on Civil and Political Rights, to which India is a party:

1. No one shall be the victim of malicious or illegal attacks on their honor or reputation, or of malicious or illegal intrusions into their right to family, home, or correspondence.
2. Everyone is entitled to a legal defense against these types of attacks or incursions.

Article 8 of the European Convention on Human Rights, which went into force on September 3, 1953, goes on to state further Individuals are entitled to privacy, encompassing their living quarters, family members, and correspondence.

Public authorities are not permitted to intervene in a democratic society unless it is mandated by law, required to protect others' rights and liberties, or required to protect the security, safety, or economy of the country. Everyone has the right to be free from arbitrary search and seizure, according to the Canadian Charter of Rights and Freedoms. As per the New Zealand Bill of Rights, Section 21, every individual is entitled to protection from unjustified searches and seizures of their person, belongings, or correspondence.

American courts attribute the "Right to Privacy" to the English Common Law, which regarded it as a right related to the "Right to Property." The case of Entick v. Carrington (1965) established that the right to privacy extended to cover trespassing on private property. Respected Lord Camden:

Men entered society primarily to safeguard their possessions. If a public law acting in the public interest hasn't limited or revoked a right, it is presumed that the right is untransferable and sacred. Any access to private property, no matter how small, is considered trespassing in England. No one is allowed on my property without my permission, and even if they don't break any laws, they could still face legal consequences.

After four decades, in Ohnstead v. United States[15], The majority determined that the action in question—which involved wiretapping and electronic surveillance—was not subject to Fourth Amendment restrictions because there was no actual physical invasion involved. According to Justice Brandeis' dissent, the amendment protected the right to privacy, which he defined as "the right to be left alone." Its goal was to "secure conditions favorable to the pursuit of happiness." "To protect Americans in their belief, their thoughts, their emotions, and their sensations," he continued, was the goal of the right. Forty years later, the law finally acknowledged the dissent.

3.8 Development of Privacy Law in India

In India, the first case to address privacy issues was M.P.Sharnia v. Satish Chandra[16] wherein the argument that a search and seizure infringed upon Articles 19(1) and 20(3) of the Constitution was dismissed by the Supreme Court. The Court found that although a seizure did affect a person's right to property, it only did so in a realistic and transparent way. In Govind vs. State of M.P8.[17] Justice K.K. Mathew stated that "Any right to privacy must encompass and protect the personal intimacies of the home,

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[15] 277 US 438

[16] 1954 AIR 300, 1954 SCR 1077

[17] 1975 AIR 1378, 1975 SCR (3) 946

the family, marriage, motherhood, procreation, and child rearing," and " right to privacy was not absolute."

Unless there is a valid reason for it, the Constitution protects citizens' rights and liberties by guaranteeing their freedom from governmental interference. Included are the person, his personality, and everything that reflects his personality. It could be argued that the right to privacy is one of the many fundamental liberties that citizens enjoy. Two theories could be used to safeguard domestic privacy. First, activities conducted within the home only cause harm to others to the extent that they raise suspicions that they may be doing so; furthermore, the state's constitutional protections do not apply to this kind of "harm." People require a place to hide from social control, which is the second reason. This kind of place is crucial because it allows people to take off their masks and temporarily stop projecting the version of themselves that they hope to be accepted for—a version that may actually reflect the values of their peers rather than who they truly are.

In ADM Jabalpur v. Shivakant Shukla[18] when the Supreme Court examined any restrictions on an individual's right to personal liberty that weren't made clear by the Constitution or other legal statutes. Justice Khanna noted that the right to personal liberty is derived from both common law and statutory law, including the personal law that is in force in India, and that Article 21 is not the only source of this right. No one may be deprived of their life without the permission of the law.

In R. Rajagopal & Another v. State of T.N. & Others[19] As another Vehicle After being found guilty of six murders and given the death penalty, Shankar wrote his autobiography while he was in prison. With the permission of the jail administration, he gave it to his wife, who then gave it to his lawyer and asked for it to be published in the petitioner’s magazine. The prisoner's close friendships with multiple IAS, IPS, and other officers-some of whom were his criminal partners—were detailed in his autobiography. The petitioner made an announcement in their magazine about their

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[18] 1976 AIR 1207, 1976 SCR 172

[19] 1995 AIR 264, 1994 SCC (6) 632

decision to start serializing the autobiography. Subsequently, the original petitioner received a letter from the Inspector General of Prisons stating that Auto Shankar was not the real author of the disputed serial and requesting that he cease publishing it immediately. To contest the letter and assert their right to press freedom and book publication, the petitioner filed a writ with the Supreme Court of India in compliance with Article 32. The writ petition did not name Auto Shankar or his spouse as parties. After examining whether the State or its officials had the legal right to forbid the publication of anything that was defamatory of the State or its officials, Justice B.P. Jeevan Reddy concluded that the respondents could not place any prior restrictions or prohibitions on the petitioners' proposed publication of the alleged autobiography of "Auto Shankar." This is not something that the State and its operatives can do. The rights to life and liberty that are granted to the citizens of this country by Article 21 are intrinsically linked to the right to privacy. "The right to be left alone" exists. In addition to other things, a citizen has a right to protect their private information regarding their family, pregnancy, childrearing, and education. Nothing about the aforementioned subjects, whether positive or negative, may be published without his permission. If he does, he will be infringing the person's right to privacy and could face legal repercussions.

In Mr. vs. Mr. Z & Another[20], Justice V.S. Aggarwal of the Supreme Court has stated that the right to privacy is not an unqualified right, despite being a fundamental right and a component of the right to life guaranteed by Article 21. A specific relationship, like marriage, or a contract may grant the right to privacy. However, once that right has been made public, the individual in question cannot claim that any such test infringes upon their right to privacy.

Whereas in another case Sharada v. Dharnipal[21] Even parties to a divorce had to undergo a medical examination, according to the Supreme Court. In this instance, the court had mandated the spouse's medical examination, and the privacy claim was

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[20] 96 (2002) DLT 354, I (2002) DMC 448

[21] AIR 2003 SC 3450

disputed. Referring a party to a medical examination may be required in matrimonial disputes where divorce is sought due to impotence, schizophrenia, or another illness. The Supreme Court maintained the validity of these judicial powers, arguing that following them would be necessary to get the correct decision. However, even in cases where a party had received such an order against him, the Supreme Court held that he could not be made to submit to the medical examination. The following conclusions were reached by the Supreme Court:

1) A matrimonial court may order medical testing;
2) The respondent's right to personal liberty under Article 21 was not violated by the court's issuance of the order; and
3) The respondent may refuse to submit to a medical examination, in which case the court may infer a negative outcome against him.

In Surjit Singh Thin vs. Kanwaljit Kaur[22] a situation where the husband requested that the wife's virginity be verified through a medical examination. According to Justice J.M. Kumar, allowing a woman to have a medical examination to determine her virginity would definitely violate her right to privacy and personal liberty, which are guaranteed by Article 21 of the Constitution. An already helpless woman would be the subject of a roving investigation under such an order.

In Rayala M Bhuvaneswari v. NagaphanenderRayala[23], When the husband surreptitiously recorded his wife's phone conversations with her Indian parents and friends, the circumstances were comparable. Acting Chief Justice Bilal Nazki decided that the wife's right to privacy was violated when her husband listened in on her phone conversation to others.

3.9 Crimes related to the Spread of Infectious Diseases: (Articles 269 to 272)

Maintaining law and order is the responsibility of the state government. It is imperative that we safeguard people's health. The largest threat to public health is disease, especially infectious diseases. The state health department needs to be vigilant

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[22] AIR 2003 P H 353

[23] AIR 2008 AP 98.

enough to prevent the spread of infectious diseases. The department guards against illnesses that arise naturally, etc. Every member of society must also maintain discipline in order to protect their own health as well as the general health of the society. Nothing he does should throw the body's systems out of balance. However, when someone behaves irresponsibly and puts the community's health in jeopardy by spreading illnesses, disciplinary action must be taken against them. This sub-section's three sub sections, along with the next two and third, all contain guidelines for preventing behaviors that negatively affect social interactions.

Article 269 penalizes people who break the law or behave irresponsibly, knowingly or unknowingly dispersing diseases that can be fatal. The punishment is as much as six months in prison and a fine. Section 270 stipulates that such an act is a serious offense punishable by a fine and up to two years in prison if it is carried out with knowledge or malice.

Quarantine is the requirement that ships arriving from diseased areas be kept away from the port for a few days as a preventative measure if any kind of epidemic has started. In the interim, there are regulations governing the exchange of goods with the occupants of the ship or location. If this control is violated, the epidemic is likely to spread to the local populace. In accordance with Section 271, disobeying a quarantine order carries a fine and a six-month prison sentence.

This crime has all of the following components in equal measure:

A. Communicable disease
B. Information of the accused party
C. Offensive behavior

3.9.1 Communicable disease

According to health sciences, diseases that are spread by people are contagious, which means that an infected person becomes infected or contagious when they are in close proximity to another person. The first type is dispersed by the weather, even in situations where there is no direct or physical contact between two people. Typhoid, cholera, smallpox, plague, and conjunctivitis are a few of them. Examples of tactile diseases include gonorrhea, AIDS, syphilis, and other STDs. This group cannot contain viral infections or viral diseases.

Either or both of these illnesses may be covered by section 269 of this section. Section 269 of the penal code stipulates that a person with this kind of disease faces a six-month prison sentence and a fine if they recklessly spread the disease, whether on purpose or accidentally.

3.9.2 Information of the accused

It can only be deemed a punishable offense if the accused knows that his actions could expose the general public to these diseases. It cannot be presumed, nevertheless, that the accused is informed about or conversant with every illness. The existence of such information or not is a factual matter substantiated by proof. The plaintiff need only present the particular facts of each case to substantiate this information. It's possible that judges are ignorant of the illness type. When even medical science itself is unsure about how a disease spreads, a judge cannot make an informed guess. The plague presents a dilemma.

3.9.3 Offensive behavior against the law

For the accused's initial act to be classified as a crime, it need not have been unlawful or illegal. A course of action may be illegal even if it is lawful but has a detrimental impact on the public at large. A person living in a remote place may purposefully avoid social contact, but he is not responsible if the illness spreads. Nevertheless, whether through negligence, malice, or breaking the law, it may be illegal for someone to engage with people in public while fully aware of the illness.

3.10 HIV/AIDS and Human Rights[24]

A tripartite meeting of experts on HIV/AIDS and the World of Work, comprising representatives from international governments, employers, and workers, adopted the ILO Code of Practice on HIV/AIDS and the World of Work on May 21, 2001. The tripartite ILO constituents' request for guidance on workplace actions to mitigate the impact of HIV/AIDS on individuals, businesses, and communities led directly to the creation of this Code.

HIV/AIDS affects the most productive workers, reduces wages, and causes a decline in productivity in many countries as a result of increased labor costs and knowledge and experience loss. Furthermore, the epidemic worsens gender inequality and the problem of child labor by targeting vulnerable populations like women and children and endangering fundamental workplace rights. The issue directly affects the ILO and threatens decent work in the purest sense of the word.[25] In 1988, the ILO and WHO adopted a joint statement from the Consultation on AIDS and the Workplace (1988) that stressed the significance of protecting human rights and dignity in the fight against the pandemic. A moral and legal framework for the protection of workers affected by AIDS is established by the ILO Declaration on Fundamental Principles and Rights at Work, as well as by international labor conventions and recommendations.

Since none of these tools is a targeted response to the epidemic, ILO constituents urged the Organization to increase its involvement in the fight against AIDS at the June 2000 International Labour Conference. They passed a resolution advocating for the development of international guidelines to address HIV/AIDS and the workplace as well as the launch of an ILO program on the disease. The ILO Governing Body formally adopted the Code in June 2001, following the Program's

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[24] Marie-Claude Chartier (2002). HIV/AIDS and Human Rights. ILO Programme on HIV/AIDS and the world of work Geneva, November 2002. Retrieved from https://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/documents/publication/wcms_117148.pdf

[25] See the document submitted to the Special High-Level Meeting on HIV/AIDS and the World of Work: ILO,
HIV/AIDS: A threat to decent work, productivity and development, Geneva, 8 June 2000.

November 2000 launch. The application of the Code serves as the cornerstone for all Program activities, including advocacy, technical assistance, and advisory services. The world community is still responding in this way. It was presented at the UN General Assembly's Special Session on HIV/AIDS in June 2001.

Since the beginning of the epidemic, the United Nations, specialized agencies, and non-governmental organizations have strongly advocated for respect for human rights as the cornerstone of the fight against HIV/AIDS. This came about because of the knowledge that effective prevention can only take place in an environment where these rights are respected, as well as the desire to put an end to the widespread stigmatization and rejection of those who are infected. This paper aims to give a brief overview of the important role that the ILO Code of Practice on HIV/AIDS and the Workplace can play in safeguarding fundamental rights. The text's second section includes a summary of the Code's provisions as well as a brief examination of the specific rights it aims to uphold. The text's first section addresses how rights should be applied in the context of HIV/AIDS.

This section discusses the role that fundamental rights play in the fight against HIV/AIDS. As we'll see, states must work to protect and advance these rights, and they can only be prevented from doing so under very specific circumstances. Its climax is its examination of a few international laws that particularly deal with HIV/AIDS-related issues. The International Guidelines on HIV/AIDS and Human Rights, which aim to implement particular HIV/AIDS-related measures based on international human rights standards, will receive special attention.

3.10.1 The Relevance of Human Rights

Among the fundamental rights that are in jeopardy in the context of HIV/AIDS are the freedom from discrimination, the right to privacy, the right to sufficient social security protection, and the right to work. The protection of basic rights needs to be a major focus of any effort to stop the HIV/AIDS epidemic. The fact that there are clear links between the HIV/AIDS epidemic and human rights helps to explain this. These links were clearly stated in a 1995 report that the Secretary-General gave to the Human Rights Commission:

"First of all, when human rights are violated, there is a greater chance that the illness will spread. Intimate and sometimes unlawful behavior must be changed, and this is a challenging and delicate process known as "transmission prevention." The prevention of transmission depends on people coming forward with information about how to stay healthy, how to have safe sexual relations, and how and why they should behave responsibly. This process of changing behavior is thwarted by coercive tactics such as mandatory screening, lack of confidentiality, and segregation, which drive people away from health care and preventive services.

Second, because they have limited or no access to HIV/AIDS-related programs for health care, prevention, and education, marginalized individuals and groups are particularly vulnerable to acquiring the virus. A few examples of these groups are women, children, people of color, immigrants, indigenous peoples, men who engage in inter-gender sex, commercial sex workers, and injecting drug users. It is possible that these groups lack the information and abilities needed to take appropriate action to stop infection. These organizations quickly infected the entire society.

Lastly, the devastating effects of HIV/AIDS on the lives of those who are infected or suspected of being infected, as well as their families and friends, are greatly exaggerated by stigmatization and discrimination against them.

This form of discrimination is widespread. Not only does it violate the rights of those affected, but it also makes it harder for them to function because it keeps them from accessing important social support networks like jobs, housing, and healthcare.[26] Therefore, protecting human rights in the context of HIV/AIDS is essential, not only for the basic reason that it upholds the dignity of those who are infected but also because it is essential to combating the epidemic.

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[26] Report of the Secretary-General on international and domestic measures taken to protect human rights and
prevent discrimination in the context of HIV/AIDS, Commission on Human Rights, Fifty-first session, 1995. E/CN.4/1995/45, paragraphs 12-14.

3.10.2 States' Responsibility to Uphold and Preserve Human Rights

Regardless of their political, economic, or cultural framework, states are obligated to uphold and protect all internationally recognized fundamental rights and individual freedoms in compliance with international human rights instruments. The Universal Declaration of Human Rights is distinct among these UN-adopted texts[27], the Convention on the Rights of the Child, the International Covenant on Economic, Social, and Cultural Rights, the International Covenant on Civil and Political Rights, and the Convention on the Elimination of All Forms of Discrimination Against Women. The adoption of the HIV/AIDS Declaration by the UN General Assembly on June 26, 2001, signified a further worldwide commitment to intensifying national, regional, and international efforts in the fight against the epidemic on all fronts, with a focus on human rights.

The Declaration specifically asks States to guarantee that people who are HIV-positive and members of vulnerable groups can fully exercise their fundamental rights and to put an end to all forms of discrimination against them. States are also urged to enact, strengthen, or enforce laws, rules, and other policies as needed.[28] There is also a strong emphasis on carrying out national strategies that "promote the advancement of women and women's full enjoyment of all human rights."[29]

It is important to remember that the ILO Declaration on Fundamental Principles and Rights at Work states that by voluntarily joining the ILO, all member states—including those that have not ratified the fundamental Conventions pertaining to these rights—affirm the principles and fundamental rights enshrined in the ILO Constitution and the Philadelphia Declaration.

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[27] Even though it is not a treaty, the Declaration is binding on all members of the United Nations as customary
law. In addition, the mentioned Conventions have been widely ratified.

[28] Articles 13,37 and 58

[29] See especially sections 59-61

3.10.3 Possible Restrictions on Human Rights

According to the Universal Declaration of Human Rights, states are allowed to restrict some rights, but only under very specific conditions. Similar to situations involving public health, other people's rights, public morality, or the general welfare, these situations would be recognized as legitimate concerns in a democratic society, and any restrictions would have to be kept to a minimum.[30]

In the context of HIV/AIDS, the most frequently cited defense used by governments and individuals to restrict human rights is public health.[31] International human rights law, however, often finds these restrictions to be unreasonable. This is the case, for example, when HIV testing is required of employees at work and those who are infected are either denied employment or kept out of it. Mandatory screening does not effectively help in the fight against AIDS. Conversely, it is conceivable for individuals who are HIV positive to maintain excellent health for several years following infection. Moreover, in the vast majority of occupations, their presence at work does not raise the possibility of contracting an infection from another person.[32] There's no reason to be concerned that infrequent, casual contact with HIV-positive people will spread the virus to coworkers or employers. The virus can spread through hand-to-hand contact, sneezing, coughing, and the use of any of the following: public phones, door openings, sharing food or cutlery, water fountain use, toilet or shower use, and sharing food. On the other hand, mandatory HIV testing fuels the epidemic by

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[30] The exercise of certain rights cannot be limited under any circumstances. These include the right to life, the
right not to be subjected to torture, the right not to be held in slavery or servitude, protection against imprisonment of debtors, the right not to be subjected to retrospective penal legislation, the right to the recognition of juridical personality, the right to freedom of thought, conscience and religion. For further details
see the International Guidelines on HIV/AIDS and human rights:, paragraph 82 (see note 2 above).

[31] Ibid. Paragraph 83

[32] Exceptions include professions where there is a risk of contact with blood or other human organic liquids, such as health and laboratory workers. The risk is low but real. In these professions extra measures must be taken to ensure that workers are properly familiar of the universal precautions and of procedures to be followed in case of workplace accidents, so that universal precautions are always taken and the necessary equipment is available for that purpose. For further information on the universal precautions, see Appendix 2 of the ILO Code of Practice.

creating a climate of fear and animosity among the public. People with HIV are more likely to conceal their status and spread the virus when they are worried about losing their jobs or being stigmatized. It is preferable to adopt a preventative approach in order to decrease the epidemic's effects. Examples of this include educating the public, encouraging voluntary, confidential HIV testing, and offering both initial and follow-up counseling. The following is specified in this regard by the international guidelines on HIV/AIDS and human rights:

A person's right to liberty is violated when their HIV status is used as an excuse for their confinement or denial of liberty. It's common knowledge that having to take an HIV test and disclosing one's status has restricted one's right to privacy. These treatments may work well for diseases that can be treated and are spread through casual contact, but they cannot treat HIV/AIDS because HIV cannot be spread through casual contact. Moreover, these coercive measures are not always the least restrictive options; rather, they often discriminate against already vulnerable groups. Lastly, as was already mentioned, the effectiveness of public health outreach is decreased when individuals are discouraged from taking part in prevention and care initiatives by these coercive measures.[33]

3.10.4 Other International Instruments

Early in the 1990s, one of the Sub-Commission's experts was designated as a Special Rapporteur to investigate the problem of discrimination against HIV/AIDS patients and those who are infected with the virus. In a series of reports delivered between 1990 and 1993, the Rapporteur[34] which emphasized the need for educational initiatives supported by suitable legal safeguards to foster an environment that respects human rights. Since 1989, the Sub-Commission has also approved a number of resolutions addressing discrimination against people who test positive for HIV/AIDS.[35]

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[33] International Guidelines on HIV/AIDS and Human Rights, op. cit. note 2, paragraph 83.

[34] E/CN.4/1990/9, E/CN.4/Sub.2/1991/10, E/CN.4/Sub.2/1992/10, E/CN.4/Sub.2/1993/9.

[35] Decisions and resolutions of the Sub-Commission: 1989/17, 1990/118, 1991/109, 1992/108, 1993/31, 1994/29,
1995/21, 1996/33, 1997/40

On the other hand, the Human Rights Commission has also passed a number of resolutions restating that discrimination against an individual based on their perceived or actual HIV status is illegal under international human rights law, and that discrimination against an individual based on their health status, including HIV/AIDS status, is covered by the prohibitions against discrimination found in international human rights instruments.[36] These resolutions call on States to immediately implement the necessary measures to end this kind of discrimination, ensure that people with HIV/AIDS have access to medicine, permit them to fully exercise all of their civil, political, economic, social, and cultural rights, and involve non-governmental organizations, community organizations, and people living with HIV/AIDS in the process of formulating policies for the fight against AIDS.

3.11 The ILO HIV/AIDS Code of Practise and the Work Environment[37]

Being the first international HIV/AIDS instrument that specifically addresses the workplace, the ILO Code of Practice on HIV/AIDS and the World of Work is a very significant document. The acknowledgement of HIV/AIDS as a workplace issue is one of its tenets. This is due to the fact that employers and employees play a critical role in the global effort to stop the spread and effects of the epidemic, as 75% of HIV-positive adults are employed. In accordance with the International Guidelines on HIV/AIDS and Human Rights, the writers below give an example of how the Code can support workplace human rights. To do this, first discuss the objectives, limitations, and structure of the Code, and then quickly review the human rights that it aims to safeguard.

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[36] Resolutions of the Commission on Human Rights: 1990/65, 1992/56, 1993/53, 1994/49, 1995/44, 1996/43,
1997/33, 1999/49, 2001/33, 2002/32. Reports of the Secretary-General to the Commission on Human Rights:
E/CN.4/1995/45, E/CN.4/1996/44.

[37] Marie-Claude Chartier (2002). HIV/AIDS and Human Rights. ILO Programme on HIV/AIDS and the world of work Geneva, November 2002. Retrieved from https://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/documents/publication/wcms_117148.pdf

3.12 Human rights contained in the Code

3.12.1 The right to non-discrimination and equality before the law

It is commonly acknowledged that international human rights law forbids discrimination of any kind against a person based on that person's HIV status.[38] As will be covered in more detail below, the Commission on Human Rights has affirmed that discrimination is against the law and that one of the prohibited practices is based on one's HIV status. In a similar vein, the UN and other international organizations have reiterated in a number of resolutions their commitment to the non-discrimination principle in relation to HIV/AIDS.

Many of the Code's provisions, including those that prohibit discrimination in the hiring process and in preserving the continuation of the employment relationship, are based on the fundamental precept of non-discrimination;[39] There are benefits from occupational schemes and social security programs[40], as well as in elements of the job, like pay, respectable working conditions, and opportunities for promotion.[41] "There shall be no discrimination against employees based on their actual or perceived HIV status," the Code declares, "in the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS." The stigmatization and discrimination of people living with HIV/AIDS impedes efforts to promote prevention of the disease.[42]

Other groups, like members of ethnic minorities and homosexual men, who experience discrimination and are thus more susceptible to infection, are also given special consideration under the Code. The Code contains a list of potential risk factors for infection for different worker groups. Other groups, like members of ethnic

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[38] Articles 2 and 7 of the Universal Declaration of Human Rights; Articles 2.2 and 3 of the International Covenant on Civil and Political Rights, Articles 2, 3 and 26 of the International Covenant on Economic, Social
and Cultural Rights, Article 2 of the International Convention on the Rights of the Child.

[39] Sections 4.8 and 8.1; see Section 2.2.3 of the present document on the right to work.

[40] Sections 4.10, 9.5, 9.6 and 5.1 f). See also Section 2.2.5 of the present document on the right to social security.

[41] Section 9.1

[42] Section 4.2

minorities and homosexual men, who experience discrimination and are thus more susceptible to infection, are also given special consideration under the Code. The Code contains a list of potential risk factors for infection for different worker groups.[43] Governments and social partners are urged to take action in order to determine which worker populations are most vulnerable to infection, what factors contribute to that risk, and how to reduce it.[44] They ought to make sure these workers have access to the proper training and preventative measures, among other things.[45]

3.12.2 The Freedom of Assembly and Association

International law protects the right to assemble and form associations[46] particularly by two core ILO Conventions that have been widely ratified.[47] While the Code does not specifically mention freedom of assembly and association, it does establish social dialogue as a fundamental principle that is impossible to have without these two components. In relation to this, it says:[48]

Employers, workers, and their representatives, along with the government, if applicable, must work together and have faith in one another for an HIV/AIDS policy and program to be implemented successfully. Employees who are HIV/AIDS positive must also take an active role.

3.12.3 The Right to Work

International agreements safeguarding human rights provide protection for the right to work.[49] " As stated in the International Guidelines on HIV/AIDS and Human

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[43] For further details see Appendix 1 of the Code on factors increasing the risk of infection.

[44] Sections 5.1 q) and 5.3.l)

[45] Sections 5.1 q), 7 and 7.2

[46] Articles 20 and 23.4 of the Universal Declaration on Human Rights; Article 8 of the International Covenant on Economic, Social and Cultural Rights; Articles 21 and 22 of the International Covenant on Civil and Political Rights; Article 15 of the International Convention on the Rights of the Child.

[47] Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87), and the Right to Organise and Collective Bargaining Convention, 1949. (No. 98).

[48] Section 4.5

[49] Article 23 of the Universal Declaration of Human Rights, Articles 6 and 7 of the International Covenant on Economic, Social and Cultural Rights, the Employment Policy Convention, 1964 (No. 122) and the Termination of Employment Convention, 1982 (No. 158), among others.

Rights, "the right to work includes everyone's right to access employment without any requirements other than the required occupational qualifications." When an employee or candidate is forced to take an HIV test and, should the test yield positive results, they are either fired, denied benefits, or denied employment opportunities, which is a violation of their right. States should make sure that people living with HIV/AIDS can work if they are capable of doing the job.[50]

Furthermore, the Code states that having an HIV infection is not a reason to be fired from a job. Like people with many other conditions, people with HIV-related illnesses should be able to work for as long as they are medically able in jobs that are suitable and available.[51] The Code requires employers to support employees living with HIV/AIDS to work for as long as they are medically fit for suitable work, in order to enable workers living with HIV/AIDS to continue in their current roles.[52] After consulting with the workers and their representatives, they should also take action to make reasonable accommodations for workers who are suffering from illnesses related to AIDS.[53] Modified work schedules, specialized equipment, opportunities for rest periods, time off for doctor's appointments, flexible sick leave, part-time employment, and return-to-work timelines are a few examples.[54]

3.12.4 Privacy Rights

Human rights law generally recognizes the right to privacy.[55] This right involves duties to uphold the confidentiality of all information pertaining to an individual's HIV

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[50] Op.cit. note 2, paragraph 127.

[51] Section 4.8; see also Section 8.1

[52] Section 5.2 e). Section 7.1 calls on management to be trained so that they can explain reasonable accommodations at the workplace.

[53] Section 5.2 j). Section 7.3 also calls for workers' representatives to be trained so that they can help and represent workers with AIDS-related illnesses to access reasonable accommodation when so requested.

[54] Section 5.2 j)

[55] Article 12 of the Universal Declaration of Human Rights, Article 17 of the International Covenant on Civil and Political Rights, and Article 16 of the International Convention on the Rights of the Child. The Occupational Health Services Recommendation, 1985 (No. 171) likewise recommends that provisions should be adopted to protect the privacy of the workers and to ensure that health surveillance is not used for discriminatory purposes or in any other manner prejudicial to their interests. The WHO/ILO Statement from the Consultation on AIDS and the workplace (Geneva, 27-29 June 1988), promotes the

status and to protect the privacy of one's physical surroundings, including obtaining informed consent for HIV testing.[56] Either way, the Code lays out specific guidelines to guarantee that employees administering tests are qualified and follow stringent policies about disclosure and confidentiality. If an individual's HIV status is discovered without their consent, they won't have to worry about being stigmatized or facing discrimination. This will ease their mind about getting tested. [57] The Code further states that HIV testing should not be a requirement for enrollment in national social security programs, occupational plans, health insurance, or general insurance policies.[58]

The following fundamental principle is stated in the Code regarding the confidentiality of HIV/AIDS data:

It is not appropriate to request private information about HIV from job candidates or staff members. Colleagues shouldn't have to divulge such private information to one another. According to the 1997 ILO Code of Practice on the Protection of Workers' Personal Data, confidentiality must be upheld by anybody who has access to a worker's personal information about their HIV status.[59]

Information on HIV/AIDS also covers counseling, care, and treatment options, as well as how to apply for benefits.[60] Governments, employers, private insurance providers, trustees, and managers of social security and employment programs are all subject to secrecy laws.[61] The Occupational Health Services Recommendation, 1985 (No. 171) is the only recommendation that should be followed when granting access to medical records, according to the Code. To be more specific, the Code mandates that employers make sure that all HIV/AIDS-related information is only retained in medical

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right of all workers to medical confidentiality with respect to all medical data, including HIV/AIDS-related information.

[56] International Guidelines on HIV/AIDS and Human rights, op.cit. note 2, paragraph 97.

[57] For more see the International Guidelines on HIV/AIDS and Human Rights, op.cit. note 2, para - 97.

[58] Section 8.2

[59] Section 4.7

[60] Section 9.7 a)

[61] Section 9.7

records and that worker organizations are not granted access to employee status information.[62]

3.12.5 Social Security rights

Numerous international agreements recognize the right to social protection as a fundamental human right.[63] Everybody has the right to a living standard that includes enough food, clothing, housing, health care, and basic social services to ensure their own and their families' well-being. According to Article 25 of the Universal Declaration of Human Rights, they also have the right to security in the event of unemployment, disease, disability, widowhood, old age, or any other loss of livelihood brought on by events beyond their control.

3.12.6 The Right to Partake in the Benefits of Scientific Advancement

The right to benefit from scientific advancement is acknowledged by the Universal Declaration of Human Rights, along with the International Covenant on Economic, Social, and Cultural Rights.[64] The International Guidelines on HIV/AIDS and Human Rights specify the following:

"It is critical that people have the freedom to benefit from scientific progress and its applications in the context of HIV/AIDS, given the rapid and continuous advancements in testing, treatment therapies, and the development of a vaccine. More basic scientific advancements related to HIV/AIDS include safeguarding the blood supply from HIV infection and implementing general precautions that prevent HIV transmission in a range of contexts, including healthcare. However, in this regard, developing countries face severe resource shortages that severely restrict access to necessary pain prophylaxis and antibiotics for the treatment of HIV-related conditions,

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[62] Access to information, the undertaking of trade union responsibilities, rules of confidentiality and the requirement for the concerned person's consent must be in accordance with ILO Occupational Health Services Recommendation, 1985 (No. 171) and strictly restricted to medical personnel. See Sections 5.2.g) and 5.3.j)

[63] Articles 22 and 25 of the Universal Declaration on Human Rights; Articles 9 and 11 of the International Covenant on Economic, Social and Cultural Rights; Articles 26 and 27 of the International Convention on the Rights of the Child.

[64] Article 15

in addition to the accessibility of such scientific benefits. Moreover, socially marginalized and/or economically disadvantaged groups might not have much access to HIV-related treatments or chances to participate in clinical and vaccine development trials. Serious concerns exist regarding the need to equally distribute more expensive and complex treatment therapies as well as basic medications and treatments among States and among all groups within States."[65]

3.12.7 The Right to Health

Many international instruments recognize the right to the best possible standard of physical and mental health, which is closely linked to the ability to benefit from scientific advancements.[66] States must take the necessary steps to prevent, treat, and control epidemic diseases as well as to set up the conditions that guarantee access to healthcare and medical care in the event of illness in order to ensure the full exercise of this right.[67]

The extent of this right in relation to HIV/AIDS is described as follows in the International Guidelines on HIV/AIDS and Human Rights:

States should "ensure the provision of appropriate HIV-related information, education, and support, including access to services for STDs, to preventive measures (like condoms and clean injection equipment), and to voluntary and confidential testing with pre- and post-test counseling" in order to empower people to protect themselves and others from infection."[68] One of the main tenets of the Code is to care for and assist those who are affected by HIV and AIDS. In regard to this, it makes the following claims:

In the face of HIV/AIDS, the workplace should respond with compassion, solidarity, and support. Every employee has a right to easily accessible healthcare, even

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[65] Paragraph 103.

[66] Article 25 of the Universal Declaration on Human Rights; Article 12 of the International Covenant on Economic, Social and Cultural Rights; Articles 24 and 25 of the International Convention on the Rights of the Child.

[67] Article 12.2 c) and d) of the International Covenant on Economic, Social and Cultural Rights.

[68] Paragraph 121.

those living with HIV. It should not be discriminatory for them or their dependents to access or receive benefits from occupational schemes or statutory social security programs.[69]

3.12.8 The Right to Education

Everyone has the right to an education.[70] Respect for human rights and fundamental freedoms, as well as the complete development of the human personality, must be the main goals of education.

The International Guidelines on HIV/AIDS and Human Rights state that[71] "This right consists of three major parts that are relevant to the HIV/AIDS situation. First of all, it is legal for both adults and children to receive HIV education, especially regarding prevention and care...

States should, secondly, make sure that neither children nor adults with HIV/AIDS are unfairly denied access to education because of their HIV status...

Thirdly, through education, governments should encourage tolerance, respect, and non-discrimination toward people who have HIV/AIDS."

3.12.9 The Fundamental Rights of Children

International human rights law recognizes the need to give children extra protection.[72] The core ILO Conventions on the Abolition of Child Labor serve as a safeguard against child labor exploitation in the workplace.[73] Children have the right to

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[69] Section 4.10

[70] Article 26 of the Universal Declaration on Human Rights; Article 13 of the International Covenant on Economic, Social and Cultural Rights; Articles 28 and 29 of the International Convention on the Rights of the Child.

[71] Paragraph 10.

[72] The Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights (especially Articles 23 and 24), the International Covenant on Economic, Social and Cultural Rights (especially Article 10), the statutes and instruments pertaining to specialized agencies and organizations concerned with child welfare. See on this subject the Preamble to the International Convention on the Rights of the Child.

[73] The Minimum Age Convention, 1973 (No. 138); the Worst Forms of Child Labour Convention, 1999 (No. 182). The 113 States which have ratified Convention No. 182 are under the obligation to take immediate measures to prohibit and eliminate the worst forms of child labour, whatever is their economic situation.

most of the same human rights as adults, in addition to those that are expressly stated in a number of international agreements. These programs should provide extra care to children who have lost one or both of their parents to AIDS because they may eventually be forced to drop out of school, find employment, and become more open to sexual exploitation.[74] This can be accomplished by giving direct or indirect financial assistance, as well as by offering apprenticeships and vocational training.[75]

3.13 The HIV & AIDS (P & C) Act, 2017[76]

A key piece of legislation that defends and advances the rights of those living with and impacted by HIV and AIDS is the HIV and AIDS (Prevention & Control) Act, 2017. With the intention of stopping the spread of HIV and AIDS and defending the legal and human rights of those who are infected with and impacted by the disease, the Act went into effect on September 10, 2018. The rights of healthcare providers are also intended to be safeguarded.

The Act aims to improve access to services by addressing stigma and discrimination and fostering an enabling environment. For those living with HIV and AIDS, it offers diagnostic services linked to antiretroviral therapy (ART) and opportunistic infection management. The Act also establishes a strong grievance redressal system with the goal of delivering prompt resolution, in the form of Ombudsman at the state level and Complaints Officer at the establishment level.

Following are the key provisions as to the rights of people living with HIV/AIDS under the Act:[77]

Consent to receive an HIV test or treatment:

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[74] Section 9.8 b)

[75] Section 9.8 c)

[76] https://naco.gov.in/hiv-aids-p-c-act-2017

[77] Dr. Renu Pal Sood. Rights of people living with HIV/AIDS in India in the light of the human immunodeficiency virus and acquired immunedeficiency syndrome (prevention and control) act,2017, *IJRAR- International Journal of Research and Analytical Reviews,* VOLUME 5, ISSUE 4, OCT.– DEC. 2018. Pp.615-616.

The Act, with some exceptions, requires informed consent. It aims to stipulate that no HIV test may be administered to any individual or subjected to medical treatment, interventions, or research without the individual's or his representative's informed consent and in a way that may be dictated by the guidelines. The person being tested or their representative must provide pre- and post-test counseling as part of their informed consent for an HIV test, in accordance with any guidelines that may be applicable. If an HIV test is anonymous and not intended to identify a person's HIV status, informed consent is not needed for screening by any licensed blood bank, court orders, medical research, or epidemiological purposes.[78]

Disclosure of HIV Status:

With some limitations, the Act protects an individual's right to confidentiality and privacy regarding their HIV status. It states that no one can be forced to reveal their HIV status unless an order from a court determines that doing so is necessary to resolve issues in the case at hand. Additionally, no one can be forced to reveal their HIV status or any other private information that has been disclosed to them in confidence or through a fiduciary relationship without the other person's informed consent or that of their representative. Organizations that maintain data on HIV-positive individuals must implement data protection protocols.[79]

Treatment accessibility:

The Act aims to outline the steps that the Central Government or State Governments must take to provide, to the greatest extent feasible, Anti-retroviral Therapy and Opportunistic Infection Management to individuals living with HIV or AIDS. The Central Government will also issue the necessary guidelines regarding HIV and AIDS protocols pertaining to Opportunistic Infection Management and Anti-

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[78] Sec 5,The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act,2017.

[79] Ibid, Sec 8 and 9

retroviral Therapy, which will be universally applicable and ensured to be widely disseminated.[80]

Encouragement of risk-reduction tactics for populations with elevated HIV infection risks:

It has been demonstrated that focused interventions, such as giving clean needles to drug injectors, stop the spread of HIV. However, some criminal laws make it difficult to provide these services by threatening to prosecute both recipients and providers. The Act gives risk-reduction initiatives legal immunity, bolstering HIV prevention efforts.[81]

Right of Residence:

Under the Act, every protected person—a woman or someone under the age of eighteen—shall have the right to live in a shared household, the right to remain in the shared household or any part of it, and the right to use and enjoy its amenities without facing discrimination.[82]

Individuals under state care or custody:

The Act aims to guarantee the right to HIV prevention, counseling, testing, and treatment services for all individuals under state care or custody, in compliance with the guidelines issued in this respect.[83]

Special Procedure in Court:

The court will handle cases pertaining to individuals who test positive for HIV in a priority manner. If a party to a legal proceeding is HIV-positive or affected, the court may order that the proceedings be conducted in camera, with the party's identity suppressed, and that no information be published that would reveal the applicant's identity.[84]

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[80] Id. Sec 14.
[81] Id. Sec 22.
[82] Id. Sec 29.
[83] Id. Sec31.
[84] Id. Sec 34

States all over the world have realized that the fight against the HIV/AIDS epidemic cannot be fully achieved if the human rights of those who are susceptible to the virus are not protected. When universal rights enshrined in international agreements have safeguarded and preserved human rights crucial to individuals afflicted with HIV/AIDS worldwide. In the absence of specific legislation regarding the rights of such individuals, the cause of HIV/AIDS patients in India is given new meaning and recognition by constitutional rights such as the right to equality and the various interpretations of the right to life under article 21. Under the auspices of international organizations like the World Health Organization and the Joint United Nations Programme on HIV and AIDS (UNAIDS), the Government of India in collaboration with the National Aids Control Organization has been formulating policies and guidelines pertaining to a range of topics that impact the situation of individuals living with HIV/AIDS in society. In addition, Indian courts have addressed claims made by HIV-positive individuals based on their rights. Courts have ensured that the law should be interpreted as liberally as possible to protect these people's various rights.

Section 34 of the HIV and AIDS (Prevention and Control) Act, 2017[85]

In any legal proceeding in which a protected person is a party or an applicant, the court may, upon application from that person or from another person acting on their behalf, grant any or all of the following orders in the interest of justice:

1) that the applicant's identity be suppressed in the proceedings, either entirely or in part, by replacing their name in the proceedings records with a pseudonym in a way that may be prescribed;
2) that the hearing, or any portion of it, may be held behind closed doors; (3) prohibiting anyone from disclosing the applicant's name, status, or identity through publication in any way.

The court will take up and handle any legal action pertaining to or involving an HIV-positive individual in a priority manner. Act Simplified Section 34 of the Human

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[85] https://kanoongpt.in/bare-acts/the-human-immunodeficiency-virus-and-acquired-immune-deficiency-syndrome-prevention-and-control-act-2017/section-34

Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 provides a simplified explanation of the law.

1) If a person covered by this law is a party or an applicant in a court proceeding, the court may, upon request, take specific actions to preserve the person's identity and privacy. These choices may consist of: (a) Using a pseudonym (false name) in court documents in a manner prescribed by law to conceal the true name of the individual. (b) Permitting the court case, or portions of it, to take place behind closed doors, unobserved by the public or media. (c) Preventing the dissemination of any information that might divulge the identity, health status, or name of the individual.
2) A court case involving an HIV-positive individual must be handled and resolved expeditiously, taking precedence over other cases.

Using an Example to Explain

Consider Jane makes the decision to file for divorce despite having HIV. She wants to make sure that her HIV status is kept private throughout the legal process because she is worried about the stigma and discrimination connected to her medical condition.

Jane or her legal representative may ask the court to: under Section 34 of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017:

a. To protect her identity, use a pseudonym in court documents instead of her real name.
b. Hold the divorce proceedings behind closed doors, in a private setting (in camera).
c. Forbid the media and other people from disclosing any information that would identify her or indicate that she is HIV positive.

Furthermore, because Jane is HIV-positive, the court must give her case top priority in order to expedite the proceedings.

Supreme Court Statement

Supreme Court directs Centre and states to ensure effective implementation of HIV Act. The court also directed all courts, tribunals, and quasi-judicial bodies to prioritise cases relating to HIV-infected persons for early disposal as per the mandate of Section 34(2) of the HIV Act.

3.14 Conclusion

In order to stop the spread of HIV/AIDS and lessen the impact the disease has on those who are already afflicted or infected, respect for human rights is crucial. The ILO Code of Practice on HIV/AIDS and the World of Work is another resource for protecting the rights of individuals living with HIV/AIDS. It specifically addresses workplace laws and the larger legal and policy framework that controls the workplace. The greatest strength of the Code is undoubtedly the fact that it exists at all, given that HIV/AIDS affects individuals, organizations, and governments, and that the ILO and its partners can assist local, national, and international efforts to combat the epidemic. This groundbreaking tool addresses the responsibilities of the social partners by giving them guidelines for effective action, in contrast to most international instruments that only address States.

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REFERENCES

1. Ambati BK, Ambati J, Rao AM (1997) Dynamics of knowledge and attitudes about AIDS among the educated in southern India. AIDS Care, 9 (3):319–330.
2. Ankrah EM (1993) The impact of HIV/AIDS on the family and other significant relation- ships: the African clan revisited. AIDS Care, 5:5–22.
3. Batra, T.S. : Human Rights : A Critique. Metropolitan, New Delhi, 1979.
4. Bermingham S, Kippax S (1998) HIV-related discrimination: a survey of New South Wales general practitioners. Australian and New Zealand Journal of Public Health, 22:92–97.
5. Bharat S (1996). Facing the challenge: household and community response to HIV/AIDS in Mumbai, India. Geneva, UNAIDS / Mumbai, TISS.
6. Bharat S, Aggleton P (1999) Facing the challenge: household responses to AIDS in Mumbai, India. AIDS Care, 11:31–44.
7. Bharat S, Singhanetra-Renard A, Aggleton P (1998) Household and community response to HIV/AIDS in Asia: the case of Thailand and India. In: Kaldor J et al., eds. AIDS in Asia and the Pacific, 2nd ed. PA: Lippincott-Raven: S117–S122.
8. Bhave G (1996) Trends of HIV 1 & 2 infection in STD patients and pattern of transmission to their spouses in Bombay, India. International Conference on AIDS, Vancouver, Canada, 7–12 July. 11:141 (Abstract No. Mo C 1496).
9. Brownlie, Ian (Ed.): Basic Documents on Human Rights (Clarendon Press, Oxford 1971)
10. Bakshi P. M, The Constitution of India,Universal Law Publishing Co., 2015
11. Basu D.D, Human Rights in Constitutional Law, 2010
12. Basu D.D, Constitutional Law of India,New Delhi : Prentice Hall of India, 2015,
13. Baxi, Upendra : Courage, Craft and Contention (N.M. Tripathi, Bombay, 1985)
14. Barowalia. J.N.Commentory on the Right to Information Act, Universal Law Publishing, Delhi, 2006.

15. Chinai R (1995) Linking jobs to HIV. Nexus. Aug.-Sept.:3–4.
16. Daniel H, Parker R (1990) Brazil, the goal of solidarity. In: The 3rd epidemic: repercussions of the fear of AIDS. London, Panos Institute.
17. Hira S, Gupta S, Godwin P (1998) HIV infection in the workforce and its perceived impact on industry. In: P Godwin, ed. The looming epidemic. New Delhi, Mosaic Books:139–149.
18. Karnataka State AIDS Prevention Society (1998).Monthly update on HIV infection in Karnataka. Directorate of Health and Family Welfare Services, Government of Karnataka. Nov.
19. Marie-Claude Chartier (2002). HIV/AIDS and Human Rights. ILO Programme on HIV/AIDS and the world of work Geneva, November 2002. Retrieved from https://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/documents/publication/wcms_117148.pdf
20. McGrath JW, Ankrah EM, Schumman DA, Nkumbi S, Lubega M (1993) AIDS and the urban family: its impact in Kampala, Uganda. AIDS Care 5:55–70.
21. Narasalah ML. Human Rights and Peace Discovery Publishing House, New Delhi.
22. Nangia R (1998) Corporate response to AIDS: policy guidelines. Mumbai, Bombay Chamber of Commerce and Industry.
23. National AIDS Control Organization (NACO) (1998–99) Country scenario. NACO, Ministry of Health and Family Welfare, Government of India, New Delhi.
24. National AIDS Control Organization (NACO) (1999) India responds to HIV/AIDS: a strategic response to the HIV epidemic by the Government of India, the UN, and its development partners in India, 1999–2000. NACO, Ministry of Health and Family Welfare, Government of India, New Delhi.
25. Nayak Bhikhubhai D. (2015). Criminal Law of India (Gujarati). University GranthNirman Board, Ahmadabad. Pp. 286-288.

26. New South Wales Anti-Discrimination Board (1992) Discrimination: the other epidemic. Sydney, NSW Anti-Discrimination Board.
27. Ogola H. (1990) Tanzania: hope in the extended family. In: The 3rd epidemic: repercussions of the fear of AIDS. London, Panos Institute.
28. Panos Institute (1990) The 3rd epidemic: repercussions of the fear of AIDS. London, Panos Institute.
29. Patel Manojkummar (ed.) (2010): 21 Century Human Rights and Education. Darpan Prakashan, Vallabh Vidhyanagar. Shisam K (1993) What AIDS policy options does India require now? CARC Calling, 6(2):29–32.
30. Shukla Gajendra B. (2015). Manavhakko (Gujarati), University Granth Nirman Board, Ahmedabad.
31. Singh Amitkumar. ‘Quest of Human Rights in Globalizing World’. *The Indian Journal of Political Science,* Jan-Mar 2009.
32. Tirelli U, Accurso V, Spina M, Vaccher E (1991) HIV and discrimination. British Medical Journal, 303:582.
33. UNAIDS (2000). Report on the global HIV/AIDS epidemic. June. Geneva, UNAIDS.
34. Warwick I, Bharat S, Castro R, Garcia R, Leshabari M, Singhanetra-Renard A., Aggleton P (1998) Household and community responses to AIDS in developing countries. Critical Public Health, 8 (4):291–310India: HIV and AIDS-related Discrimination, Stigmatization and Denial.

CHAPTER - 4

PUBLIC AWARENESS PROGRAM IN GUJARAT AND ROLE OF NGOs

4.1.1 Introduction

Every society is concerned about its health. Every human community also has unique customs and beliefs about illness, health, and treatment. Ever since the dawn of time, people have attempted to control illnesses. In an effort to provide solace by curing illnesses, herbalists, shamans, magicians, priests, and medicine men all made different attempts. In traditional culture and civilization, the bulk of beliefs in medicine were magical and religious. In modern society, medical sciences generally deal with health, medication, and treatment. However, for a variety of cultural, social, and economical reasons, people reject professional advice and modern medical procedures. As a result, social sciences surely have an interest in health.

HIV stands for "Human" (exclusive to the genus Human). Being immune deficient or unable to defend oneself against infectious agents AIDS is an acronym for acquired (requires action to contract) disease-causing agent known as a virus. being able to prevent infectious diseases (Syndrome); deficiency (absence); a set of symptoms and indicators of a disease. Since most nations have officially recognized the HIV/AIDS epidemic, no nation is exempt from the scourge of this illness at the moment. In the United States, AIDS was first scientifically recognized as a modern epidemic in 1981. The first confirmed case involving female sex workers (FSWs) was discovered in Madras, India, in April 1986. However, the first case of AIDS was discovered in 1987.

4.1.2 AIDS Awareness Program in Gujarat

Gujarat's industrial development has created a significant risk of HIV/AIDS transmission. People are moving to Gujarat in search of employment from all over India. In a similar vein, Gujaratis have a strong inclination to migrate overseas. In such cases, people may choose to have sex outside of marriage, which increases their risk of

HIV/AIDS. In 1986, the first recorded case of AIDS in Gujarat was at Ahmedabad Civil Hospital. Subsequently, as HIV/AIDS has become more common in various districts of Gujarat. The highest rate of HIV/AIDS is found in Gujarat's largest city, Ahmedabad, and is followed in order by Surat, Rajkot, Jamnagar, Vadodara, and Junagadh.

In order to carry out Phase-I of the National AIDS Control Programme in compliance with a state Family Welfare Department resolution dated July 13, 1993, and to evaluate the severity of HIV/AIDS, the government of Gujarat established the State AIDS Cell (SAC) in December 1992. SAC implemented the program in accordance with the guidelines set forth by the National AIDS Control Organization (NACO) and with the approval of the State Empowered Committee, which was established at the State level for the same purpose.

To guarantee the program's prompt and effective execution, the government asked NGOs to participate and cooperate in the fight against AIDS. The State AIDS Empowered Committee resolved to register the current State AIDS Cell as a society on August 27, 1998. The Indian government also recommended setting up a State AIDS Control Society to help carry out the program, especially the second phase that began in April 1999. The National AIDS Control Programme has been implemented since then by the State AIDS Control Society (GSACS). The Gujarat government manages several programs aimed at managing and preventing HIV/AIDS. Gujarat's primary initiatives are: 1. Targeted Intervention (TI), 2. ICTC, 3. STI Care Services, 4. Blood Safety Programme, 5. Information, Education & Communication, 6. Red Ribbon Club Programme, 7. Health Education and Life skill Programme (HELP), 8. Link Worker Scheme (LWS), 9. Care, Support and Treatment: Anti-Retroviral Therapy (ART) Centre and Link ART Centre (LAC) and 10. Community Care Centres (CCC). The goals of each of these initiatives are HIV/AIDS awareness, prevention, and control.

4.1.3 Public Awareness and HIV/AIDS

Medical sociology studies the ways in which culture and society influence health and illness. It also examines circumstances involving medical conditions. Without a doubt, a person's sociocultural environment has an impact on their morbid conditions. The emergence of the disease was once linked to natural, supernatural, religious, and magical factors. However, during the industrial revolution, people's faith in traditions, customs, and other folk practices began to wane and be replaced by more rational considerations as urbanization and the spread of Christianity increased. Consequently, medical science began to progress as an applied science.

Numerous studies have been conducted regarding the illness, its management, and its prognosis. Social science researchers are studying social dynamics, interactions, and behavior patterns concurrently in an attempt to identify risk behaviors that might make particular populations more vulnerable to HIV/AIDS and to encourage behavior modification. In this context, it becomes evident that human behavior can affect the path of the pandemic, despite the fact that this is a very broad and poorly understood concept.

David Mechanic (1968) discussed the prevalence of disease diffusion and socio-cultural reactions to the patient in his book Medical Sociology. Unaware of their status, HIV positive individuals can occasionally spread the virus to their partners, children, and other family members. When infected individuals move around and potentially infect others, they carry the infection, which is how the infection spreads from one geographic area to another. People who relocate from areas with a higher HIV prevalence to areas with a lower prevalence are generally more likely to get the virus than people who remain in the higher prevalence regions, according to studies on mobility and infectious diseases. If contagious, the infected individuals may also infect others, which is how they will spread the infection by carrying it with them. Migration has a big impact on high-risk sexual behavior.

The State AIDS Control Societies and the NACO both contribute significantly to the management and prevalence of HIV/AIDS through awareness campaigns. High Risk Groups (HRGs) such as Female Sex Workers (FSWs), Men Having Sex with Men (MSM), Truckers, Migrants, and Injected Drug Users (IDUs) are the main carriers of HIV/AIDS. Nevertheless, we are unable to identify the high-risk group's members. There is a significant chance that anyone could get HIV or AIDS. In order to prevent and manage HIV/AIDS, there must be public education. There is a lot of migration in society as a result of the urbanization and industrialization processes. It is not mobility per se that makes people more vulnerable; rather, it is the act of moving that puts people in circumstances where they are more likely to participate in high-risk behavior. From the source to the transit point to the destination and back to the starting point, there is a complex interaction of movement that must be understood in the context of the sociocultural meaning that people attribute to this physical movement. For example, it is important to understand people's origins, the reasons behind their migration, the ways in which they stay connected to the people they live with while they are away, the places they visit, the ways in which they maintain their health while traveling, the places they go, the living and working conditions at their destination, the social environment that is created there, the importance they place on returning to their place of origin, and the ways in which they adapt once more. People become more vulnerable to the infection as a result of being cut off from their families. The population that travels may encounter a variety of circumstances that could increase their susceptibility to infection. These could include a lack of access to health care, obstacles based on culture and language, the use of money to buy drugs or engage in sexual activity, prejudice related to immigration status, or HIV status that is real or believed. HIV and migration are not linearly related; rather, they are linked laterally, as a result of being removed from the conventional norms and restrictions that govern social behavior. Social and sexual behaviors that raise one's risk of contracting HIV/AIDS can be brought on by a hostile and isolating atmosphere, being away from family, and not having access to resources and support networks. The degree to which an individual is susceptible to contracting HIV, spreading the infection to others, or experiencing insufficient medical attention or social support depends on a variety of preconditions of a cognitive, behavioral, and social nature. Raising awareness is just one strategy to stop HIV/AIDS. This topic falls under the social sciences as well.

4.1.4 Disease and Society

Customs, beliefs, traditions, values, and ways of living vary among cultures. People in a society can be influenced by culture in both positive and negative ways. Whether the social environment is studied directly or indirectly, culture has a big impact on how diseases arise. For example, the disease known as atherosclerosis is brought on by eating fatty foods. This disease is more common in people whose culture involves eating animal fats.

Placing the disease and the human behavior that causes it within the sociocultural context helps to clarify the dynamics surrounding the disease's transmission and the subsequent behavior changes that would be the ultimate goal of the interventions. Therefore, it would be extremely constrained and inaccurate to solely view the epidemic as a medical and health problem. It needs to be understood in terms of social and cultural dimensions. AIDS is not just a medical condition; it also has important social components. Understanding what puts some people at a higher risk of contracting HIV has been the focus of anthropological research on risk and its social context. Everybody is biologically vulnerable to acquiring HIV if they are exposed to the virus through one of its modes of transmission. It becomes critical to recognize that the transmission necessitates a specific identifiable behavior. Understanding the social, economic, political, and cultural contexts in which the behavior takes place as well as the probability of such behavior within specific groups becomes essential.

Cultural taboos also indirectly contribute to the disease. A person disregards advice about a disease in order to uphold cultural taboos. An individual's knowledge of illnesses such as gonorrhea, syphilis, and HIV/AIDS is crucial for controlling and preventing these diseases. One can prevent the spread of contagious diseases by adopting personal security measures. There is still no public discussion of the sex-related issues. since it is thought to be offensive. However, it seems that knowledge and open communication are preventive steps to stop the spread of infectious diseases.

Organizational culture and social change can create some of the conditions that serve as catalysts or supports for the onset of disease. The nutrients are also impacted by changes in the economy. But it's not a given that someone who eats a lot of nutritious food won't get sick from these kinds of things. Social relationships within families have altered as a result of new occupational considerations and information-gathering initiatives aimed at lowering disease risk. Relief and relaxation are felt on the one hand, but tension has been created by the physical and emotional traits of children and teenagers on the other. Social change is putting pressure on the social structure. The concept of the illness is not included in this domain. Peter Conrad and Lavania contend that it is easier to draw a clear link between the illness and reason. Even now, some medical professionals do not believe that a person's lifestyle can cause a morbid condition. In cases of morbidity, the disease's immediate cause is considered to be important. But we also need to acknowledge our connection to human culture and its influences if we hope to stay disease-free for a very long time (Conrad, 1982:10-12 and Lavania, 2010: 58-65).

When these tasks are combined with HIV/AIDS, recent studies on the disease have revealed that unsafe sexual behavior is a contributing factor in 86% of cases of HIV/AIDS. HIV/AIDS-related problems that a person and his family face have an effect on social structure, either directly or indirectly. Consequently, the disease can be studied as a social fact. The socio-cultural structure of Indian society is still dominated by traditional norms and values. Sexuality-related norms are still rigorously upheld in Indian society. Indians tend to avoid having candid discussions about matters pertaining to sexuality. The majority of Indians still live in rural areas, and the nation continues to face challenges with low women's status, unemployment, poverty, superstition, and illiteracy. In a sociocultural setting like this, HIV/AIDS infections can also be caused by low literacy or education levels, as well as by not knowing how to use condoms properly.

Early on, it was thought that since risky behaviors such as homosexuality and having multiple partners were not seen as part of Indian socio-cultural norms, India would not be greatly affected by the epidemic. It was believed that the traditional sociocultural norms of mother goddess worship, universal marriage, and ensuing heterosexual relationships, along with social prohibitions against an explicit focus on sex and sexuality in public social interactions and discourse, provided the necessary protection against a disease that was primarily transmitted through sexual activity, according to Ramasubban (1998).

Due to the dissolution of the joint family system, the rise of the nuclear family, increasing urbanization, and the movement of people from rural to urban areas, traditional family structures have evolved over time. Due to differences in gender, class, and urban/rural development rates, people are more vulnerable to biological threats like the HIV/AIDS epidemic. The people's inability to obtain the resources necessary to maintain the bare minimum of housing, food, health, and livelihood is one of their biggest issues.

Under these conditions, the disadvantaged group may often engage in profitable or commercial activities that may increase their vulnerability to health problems, including HIV infection. Service and infrastructure development are hindered by insufficient social and economic development. The culture of silence surrounding sexuality prevents people from learning about the causes, symptoms, and prevention of health epidemics. In many cases, it also prevents people from receiving medical treatment. Women in Indian society are rarely involved in decisions that impact the institution of marriage and the family because of the patriarchal nature of the country. According to an epidemiological analysis of the data, HIV infection has two main characteristics: it spreads from urban to rural areas and from groups participating in risky behavior to the general population (NACO 2001). Because it demonstrates how the infection is spreading geographically and among various population groups, this pattern gives rise to grave concerns.

Lowering the risk of infection slows the spread of HIV by emphasizing behavioral changes and enacting change in circumstances where there is a risk of infectious disease. Reducing vulnerability lowers the risk of infection and the impact of the epidemic by focusing on access to health services, sexual behavior information, life skills-based HIV/AIDS education, addressing cultural practices and stereotypes, and providing services beyond legal and social norms to reduce stigma and discrimination. Vulnerability to HIV/IDS is decreased by focusing on improving the productive lives of those living with HIV/AIDS, lessening the stigma and poverty faced by surviving family members, increasing investment in care, education, and social support, and lessening the epidemic's impact. As a result, the community is better equipped to fight the epidemic.

In book Medical Sociology, Negal (1986), discussed the birth and development of medical sociology in India. As Indian society has evolved, so too have issues pertaining to therapy. Different people arrived at different times and brought different therapies with them to maintain their own health in Indian society. In India, the Ayurvedic method was used before the British arrived. When the British first arrived in India, they brought with them methods for treating and preventing allopathic diseases.

The Indian government has been monitoring the development of medical sociology since the decade that began in this century. Social scientists and anthropologists have received funding from the government to conduct research on public health-related topics. Numerous sociological techniques could be used to address some of the public health problems. for the reason that, in terms of medical sociology generally, India has not yet realized its full potential. On the other hand, initiatives to spread knowledge about HIV/AIDS have grown over time. A review of the literature indicates that the impact of HIV/AIDS over the past three decades has opened up new research directions for medical sociologists.

HIV/AIDS may not be treatable with medication or drugs, but it can be prevented and controlled in society with a better understanding of scientific knowledge and sociocultural structure. HIV/AIDS prevention and control are difficult in India because of the country's high rates of illiteracy, low educational attainment, strong traditionalism, and religious views on sexuality. Thus, in order to reduce the prevalence of HIV/AIDS in Indian society, NACO has concluded that it is crucial to spread scientific knowledge, with an emphasis on women's education in particular. Therefore, in societies where scientific knowledge is influential, HIV/AIDS prevention and control are made easier.

Prevention is always better than treatment, as there is currently no effective vaccine or treatment for the AIDS epidemic. One partner faithfulness, abstinence, and monogamy are common strategies to stop HIV transmission. Additional techniques include getting safe blood or blood products from blood banks, using sterile, disposable, or brand-new needles or syringes, and using condoms correctly and consistently. According to Mann M et al. (1994) propagating prevention efforts, a supportive social environment, health and social services, and education information were found to strengthen communities' and the nation's capacity to implement successful programs. These components need to be considered locally, tailored to the specific culture, and executed with the available means.

On one end of the spectrum are the "high risk groups" (HRG) or the "core group of high frequency transmitters." These comprise people who visit STD clinics, men who have sex with men (MSM), female sex workers (FSW), and drug injectors (IDU) (NACO 2009–10). These individuals are members of groups whose actions increase their risk of contracting HIV. On the other end of the continuum is the general population, which is thought to be "safe" from the epidemic because they are not engaged in high-risk activities. Studies and surveillance reports from the 1990s showed that the general population was becoming infected with HIV/AIDS at a rapid rate. These groups did not always behave in a way that was dangerous. The epidemic continued to spread to children and women. This disclosed a third category of subgroups called the "bridge population." Both male and female sex workers usually use them as partners or clients (NACO 2007). The bridge population is defined as active duty military personnel, migrant laborers, and truck drivers. Married men have frequently functioned as a conduit between HRGs and the broader public; consequently, women in relationships that they understand to be monogamous become contaminated by the knowledge that their husbands have multiple partners.

4.1.5 HIV/AIDS and Risk

Most people engage in some kind of risky activity on a daily basis, but they cease when they become aware that they are endangering themselves. There is a dearth of knowledge regarding people's interpretations of their sexual experiences and possible consequences of disease. Personal risks are perceived as being so small as to be overlooked or ignored, which can result in a range of thrilling or pleasurable activities that have the potential to be highly dangerous and damaging. Thus, it can be difficult to comprehend the rationality—or lack thereof—involved in different types of addictive behaviors. For example, smokers may be aware of the risk to others but believe they pose very little risk to themselves.

Because it is difficult for people to estimate and calculate risk based solely on factual information, people rely on "cultural heuristics" to understand how risk is perceived. When processing information, people employ heuristics—logical shortcuts—to make complex cognitive tasks simpler (Bailey, A., & Hutter, I., 2006). Heuristics that are derived from cultural meaning systems and deeply embedded in people's daily lives speed up decision-making when it comes to risk perception. The process of negotiating risks shows how people use social and cultural biases to create their reality and decide what to fear based on their lifestyle choices and accepted social and cultural norms. According to a Sub-Saharan African study, older men looking for women who are HIV-positive don't seem to consider the possibility that they could be infected as a viable or even acceptable risk when it comes to identity construction. But risk usually refers to personal risk, which means that it has more to do with personal accountability, decision-making, and blame than it does with societal accountability. Tsasis, P., and Nirupama, N. (2008) state that risk perception in the context of HIV/AIDS is influenced by an individual's inclination to be risk-averse or risk-seeking as well as their understanding of the particular situation. Because risks are unpredictable and access and knowledge are not distributed equally in societies, people are not always in a position to define and comprehend risk. Stated differently, individuals may lack the opportunity or capacity to determine the extent to which they are affected by the risk. Different risk perceptions are linked to different threats because different stakeholders and groups have competing interests at the public discourse level. It is therefore possible to affect how individuals perceive risk in both social structures and institutions.

Therefore, a deeper understanding of how people form their perceptions of risk requires an understanding of the relationship between social networks and risk perception. We can then use this knowledge to better understand how to influence people's behavior in order to slow the spread of HIV. People's behavior will change according to their comprehension of the behavior and how they feel about it. An individual's health behavior is influenced by how they perceive their actions. A person's beliefs about their perceived vulnerability to health issues, the severity of the illness, the efficacy of the new behavior, the benefits of taking preventive action, and the challenges of behavior modification will all influence how they behave. Knowledge and attitudes regarding health behavior are crucial for both understanding health practices and encouraging behavioral changes for improved health-seeking behaviors.

Social scientists have conducted numerous studies on the connection between HIV infection and human behavior. These studies have focused on risk behavior, or behaviors that are innate to human nature and raise the risk of infection. This alternative perspective allowed intervention efforts to shift from focusing on particular groups of people to focusing on specific behavior patterns. Barnett T. & Kadiyalal (2004) assert that the concept of risk evolved to be seen as a threat that "they" pose to "us," blatantly ignoring the fact that the behavior's riskiness is a feature of the environment rather than of particular individuals or practices, in order to support such an understanding of the epidemic. It's been said that discussing "risk categories" conveys the idea that the illness is someone else's. AIDS is not spread by high-risk "categories," but rather by high-risk behaviors like the exchange of bodily fluids.

4.1.6 HIV/AIDS Awareness Programs in Gujarat

In late 1985, the World Health Organization (WHO) started creating the Global Strategy for the prevention and control of AIDS in response to the consequences of HIV infection and the rise of AIDS. The first WHO anti-AIDS initiative was based on this strategy, which was thoroughly reviewed and discussed in 1986. Preventing HIV infection, reducing the social and personal effects of HIV infection, and coordinating national and international efforts to combat AIDS are the three main objectives of the Global AIDS Strategy (Rao D., 2000, pp. 207–208). India's response to the risks of HIV/AIDS is based on the global strategy proposed by the WHO.

HIV/AIDS is a major health concern in India. The people's social standing and quality of life have been impacted. India saw its first cases of AIDS in the mid-1980s (Pais, 1996). Since then, it appears that HIV infection has been spreading quickly in a number of places (NACO, 2001). The first HIV case was reported in Tamil Nadu, India, in 1986. Infection rates rose and defenses got stronger during the 1990s. The government created the NACO in 1992 in an effort to curb the spread of HIV and AIDS throughout the country. That same year, the government unveiled the National AIDS Control Program (NACP), a strategic plan for HIV prevention. This plan established State AIDS Control Societies (SACS) and provided administrative and technical program management in 25 states and 7 union territories. State AIDS Control Societies achieved several noteworthy strides in HIV prevention, especially in the area of blood safety (NACO 2007). In fact, India's fight against HIV/AIDS has shifted its focus to prevention and education since the early 1990s (NACO 2010, Ramasubban 1998).

Following the discovery of the first HIV infection in 1986, the Indian government initiated programs for prevention and awareness-building under the first and second Medium Term Plans (NACP-1, 1992–1999), respectively. Phase 1 only addressed blood safety. The Blood Safety Program's primary goal was to guarantee that there was enough safe blood available throughout the state of Gujarat. It's possible that the Blood Safety Program wasn't enough to stop and manage HIV/AIDS. Phase 2 of the National AIDS Control Programme (NACP) aimed to decrease HIV transmission through behavioral modification and strengthen India's ability to combat the infection. But as the epidemic's complexity has grown, so too have the NACP's approaches and policy frameworks. Here, the focus has moved from changing behavior to increasing awareness, from a small number of NGOs to an increasing number of networks of people living with HIV/AIDS, and from a centralized national response to a decentralized response.

Using the knowledge gained from Phases 1 and 2, India developed the Third National AIDS Programme (2007–2012). Over the next five years, NACP-3's primary goal was to integrate prevention, care, support, and treatment programs in order to halt and reverse the epidemic in India. To achieve the aforementioned goals, NACP-3 uses the following four strategies: 1. Preventing new infections in high-risk populations and the general public by: Expanding the use of targeted interventions (TIs) in high-risk groups; and stepping up interventions in the general public. 2. Offering more care, assistance, and therapy to a greater number of HIV/AIDS patients, 3. For prevention, care, support, and treatment programs, strengthening the systems, infrastructure, and human resources at the district, state, and federal levels; and 4. fortifying a Strategic Information Management System that spans the entire country.

It suggests that people outside of these groups are not concerned about HIV by concentrating on high-risk groups. Consequently, individuals who do not belong to high-risk groups (HRGs) often have their vulnerability disregarded (Craddock et al. 2004). To prevent and control HIV/AIDS, everyone in the community needs to be aware of the epidemic.

Individuals who would normally regard themselves as low risk often have an illusion of security and think they will never become infected with HIV. They frequently neglect testing as a result, unintentionally exposing themselves to the virus. Studies (like IIPS and ORC Macro 2008) indicate that the HIV/AIDS epidemic is not well known among low-risk populations. Furthermore, because the general public is unaware of the virus's modes of transmission and available defenses, it spreads swiftly among them once a member of a low-risk group contracts the infection. Thus, educating people about HIV transmission and prevention should help stop the virus from spreading among healthy people (Vandemoortele and Delamonica 2002). Accordingly, prevention efforts should not only focus on populations with low risk of HIV infection but also attempt to lower the risk of HIV diffusion in the general population (Craddock et al. 2004).

Given that over 400 languages are spoken throughout India, HIV/AIDS education and prevention are difficult. This suggests that while national efforts can be made to prevent and educate people about HIV/AIDS, state and local initiatives are often the most effective. India's vastness makes it difficult to evaluate the overall efficacy of HIV/AIDS prevention. A more comprehensive understanding of the crisis can be obtained by looking at each Indian state separately because most of them have larger populations than most African countries. In India, regional programs are carried out in collaboration with NACO by the state-level AIDS Prevention and Control Societies. Funding for youth outreach programs, blood safety checks, and HIV testing was given to state AIDS control societies under the second phase of the government's National AIDS Control Program (NACP-2), which ended in March 2006. Concurrently, the epidemic was brought to light through radio plays, TV commercials featuring a well-known Indian actor, concerts, and a day dedicated to voluntary blood donation. Schools provided HIV education to the youth. Active learning activities, such as debates and roleplaying, were used to teach students about AIDS, and peer educators and teachers received training in the subject (NACO 2009).

The State AIDS Cell (SAC) for the Prevention and Control of HIV in the State was founded in December 1992 to implement phase 1 of the National AIDS Control Program. The State AIDS Cell implemented the program in compliance with NACO guidelines and with the approval of the State Empowered Committee, which was established at the state level for that specific purpose. The State AIDS Empowered Committee made the decision to incorporate NGOs and to quickly and effectively implement the program through inter-sectoral coordination for AIDS prevention by registering the State AIDS Cell as a registered society. The Indian government has recommended that the State AIDS Control Society be formed for the program's second phase, which begins in April 1999. The National AIDS Control Program has been implemented since then by the State AIDS Control Society.

It is clear that this illness does not currently have a treatment. Preventing HIV infection is one of the most important strategies to decrease the effects of this health problem. Education is a crucial tactic for putting an end to this epidemic. People should have greater access to information about AIDS, STD (Sexual Transmitted Disease) treatment, and the illness's effects in order to stop it from spreading. There are times when the general public, medical professionals, friends, and even family mistreat people who are HIV positive. This frequently leads to personal suffering, which decreases the likelihood that people will take the necessary steps to seek treatment and care. If people's knowledge, attitudes, and behaviors regarding HIV/AIDS are assessed, we will be able to better understand people's current level of awareness. The ability to control the spread of disease through appropriate intervention will be highly advantageous for planners, health professionals, and researchers. The assessment would also be helpful in creating health programs that are customized to the demands of various communities' lifestyles. It will enhance peoples' health and act as a spur for the country's general development (James, 2010).

Rules pertaining to testing, informed consent, and privacy have been established by the NACO. The statement claims that in addition to biological considerations, HIV testing also takes human, ethical, and legal factors into account. NACO actually lacks the necessary framework to enforce these regulations. A legal framework and appropriate oversight are necessary to address the disintegration of laws and codes. It would remain difficult to put this philosophy into practice unless and until a system for monitoring the improper conduct of NGOs and medical professionals is created. Secrecy is crucial for HIV patients due to the extreme stigma associated with living with HIV/AIDS (Sharma, 2010).

Numerous initiatives are carried out by the Gujarat State Government to control and prevent HIV/AIDS in Gujarat. These programs followed NACO guidelines to the letter. Among these programs are: 1. ICTC, 2. Targeted Intervention (TI), 3. STI Care Services, 4. Blood Safety Programme, 5. Information, Education & Communication, 6. Red Ribbon Club Programme, 7. Health Education and Lifeskill Programme (HELP), 8.

Link Worker Scheme (LWS), 9. Care, Support and Treatment, ART Centre and LAC, 10. Community Care Centres (CCC) etc. and 11. Strategic Information Management Unit (SIMU).

4.1.7 Strategies of GSACS in Gujarat

Without an understanding of the biological and medical sciences, we are unable to fully comprehend HIV/AIDS. Since the world learned about the epidemic, people living with HIV/AIDS have faced social reactions from ignorant people that include fear, discrimination, and shame. HIV/AIDS has a reputation for being stigmatizing and discriminatory. Consequently, people with HIV/AIDS have been socially rejected by family, friends, and society at large.

The "State AIDS Cell" was founded by the Gujarati government in 1992 in an effort to stop the pandemic's spread. Industrialization and urbanization are two distinct aspects of the state. It leads to migration, which increased the rate of HIV/AIDS infection in the community. The first case of HIV/AIDS was identified in Gujarat state in 1986. The Health and Family Welfare Department (HFWD) of Gujarat state received guidance for the formation of the GSACS from the NACO, which oversaw the implementation of the AIDS Control Programme Phase 3. It seeks to provide integrated services in partnership, such as HIV/AIDS prevention, healthcare, and treatment. The cooperation of private organizations, educational, research, and training institutions, citizen associations, and HIV/AIDS patient groups has made these services possible. The GSACS's multifaceted strategy, activities, and accomplishments for HIV/AIDS prevention and control are listed below:

4.1.7.1 Integrated Counselling and Testing Services

In a discreet, encouraging environment, people can accept and learn about their HIV sero-status at the Vatsyayan Kendra & Mamta Clinic (VKMC). VKMC-ICTC is now an essential part of HIV prevention programs since it is a reasonably cheap intervention to prevent HIV transmission. As of the end of March 2014, Gujarat had 1621 ICTCs (Integrating Counselling and Testing Centers), comprising 309 mobile

ICTCs, 1309 facility-ICTCs (Private Partnership - PPP model, PHCs, CHCs, and Sub Center), and 309 stand-alone ICTCs. A total of 941582 general clients and 778639 pregnant women received testing and counseling at the ICTC in March 2014; 12282 of these people tested positive in the 2011–12 period. Seventeen pregnant women were identified as HIV positive out of the 11,282 individuals who underwent testing. In order to prevent the spread of HIV from mother to child, 681 mother-baby pairs received prophylaxis with nevirapine in the 785 live births.

At an ICTC, an individual may choose to receive HIV counseling and testing on his own initiative or at the advice of a medical professional. The principal duties of an ICTC are as follows: 1. Early identification of HIV infection; 2. Provision of basic information on HIV/AIDS prevention and modes of transmission to promote behavioral modification and reduce susceptibility; and 3. Facilitation of access to additional HIV prevention, care, and treatment resources.

Every demographic group should be served by a single ICTC at a healthcare facility. Nonetheless, an ICTC can be found in locations that serve specific demographics, such as expectant mothers. Because pregnant women make up the majority of clients who use the counseling and testing services provided by an ICTC, one can find one in a district hospital, maternity home, or the obstetrics and gynecology department of a medical college. The creation of such a facility is justified by the requirement for prophylaxis to prevent the transmission of HIV from infected pregnant women to their unborn children. In a similar vein, an ICTC may be housed in a tuberculosis microscopy facility or tuberculosis sanatorium where the majority of visitors are tuberculosis patients.

It is not necessary for an ICTC to evaluate and counsel every member of the public. Subpopulations that behave in a high-risk manner or are more susceptible exist. Generally speaking, these subpopulations have greater rates of HIV prevalence than the overall population. To identify populations that are vulnerable or at risk and ensure that they have access to HIV counseling and testing services, ICTC staff members must collaborate. Physicians who see patients who exhibit symptoms suggestive of

HIV/AIDS or who have a history of risky behavior can also refer them to an ICTC for testing and counseling.

The Employees' State Insurance Department (ESID), railroads, government-owned healthcare facilities, nonprofit and public sectors, and locations where non-governmental organizations (NGOs) operate are all potential places to find an ICTC. In the medical facility, the ICTC should collaborate effectively with the departments of medicine, microbiology, obstetrics and gynecology, pediatrics, psychiatry, dermatology, preventive, and social medicine, among others. Given the comparatively low cost of the HIV test and the general perception of low risk, traveling a considerable distance for testing could serve as a strong disincentive. Therefore, it's imperative to ensure that testing and counseling centers are located as close to the populace as feasible. The area where vulnerable and at-risk populations have the greatest access is the best choice for ICTCs. A few prerequisites for creating an ICTC are the government health sector, the private/not-for-profit sector, and non-governmental organizations. Although ICTCs can take many different forms, two main categories can be identified: fixed-facility ICTCs and mobile ICTCs. The three professionals that the ICTC needs on its skilled team are the manager (medical officer), the counselor, and the lab technician. An outreach worker would be necessary in districts where there is a high prevalence.

A private discussion between a client and a counsellor with the aim of educating the client about the disease and changing their behavior is known as HIV/AIDS counseling or education. It also seeks to assist the client in understanding the consequences of their decision and deciding whether to get tested for HIV. The steps in HIV counseling are HIV post-test counseling, HIV pre-test counseling, and HIV information. Basic HIV/AIDS education and risk assessment are provided to walk-in clients as part of HIV pre-test counseling and information. During HIV post-test counseling, the client is helped to comprehend and cope with the test results.

If the test results are negative, the counselor helps the client adopt behaviors that reduce their risk of HIV infection in the future and goes over basic HIV information with them. If the client is within the window of opportunity, a repeat test is recommended. The closest microscopy facility is directed to clients who may have tuberculosis. In the event that the test is positive, the counselor offers support for coping and assists the client in understanding the implications of the result. The counselor guarantees access to care and treatment and supports sharing the spouse's HIV status. The significance of embracing safe behaviors to prevent the HIV infection from spreading to others is underlined once more in follow-up counseling. Follow-up counseling also includes establishing links and making recommendations to care and support services, including ART, nutrition, in-home care, and legal assistance.

This is the most common and direct method of diagnosing HIV infection based on the identification of HIV antibodies generated in the blood of an HIV-positive individual. Rapid test methods are widely used to identify HIV infection. They can provide the customer with fast results and are easy to use. There are numerous quick tests that apply diverse principles. Rapid HIV test kits are recommended by the NACO for use in ICTCs because the client receives results in 30 minutes after the test. Rapid test kits that identify more than 99.5% of all HIV-positive individuals and yield false-positive results in less than 2% of test subjects are recommended for use in an ICTC. Every client will receive free testing from all ICTCs in the government health sector as well as all "stand-alone" ICTCs funded by the NACO/SACS. If a single test yields a negative result, the client is considered HIV-negative. The client is considered HIV-positive if the same blood sample is tested three times using different kits that use different antigens or principles and the results are all positive. Rapid test kits that identify more than 99.5% of all HIV-positive individuals and yield false-positive results in less than 2% of test subjects are recommended for use in an ICTC. Every client will receive free testing from all ICTCs in the government health sector as well as all "stand-alone" ICTCs funded by the NACO/SACS. If a single test yields a negative result, the client is considered HIV-negative. The client is considered HIV-positive if the same blood sample is tested three times using different kits that use different antigens or principles and the results are all positive.

4.1.7.1.1 HIV Testing and the Window Period

The time interval (6–12 weeks) between the onset of HIV infection and the detection of HIV antibodies in the blood is known as the "window period." Blood drawn during the window period may test negative for HIV antibodies. In certain cases, further testing may be necessary after a 12-week period.

4.1.7.1.2 Emergency Testing

For laboring women who are HIV-unknown, the medical officer, resident physician, or labor room nurse can offer basic information about HIV/AIDS and HIV testing (NACO, 2005). Following that, a single HIV test will be given to ascertain the pregnant woman's status and determine whether starting antiretroviral therapy (ARV) is necessary to prevent HIV transmission from mother to child. The next working day, the ICTC Lab Technician will gather and examine a second sample to verify the existence of HIV. Sometimes the patient is unable to travel to the ICTC, so the blood sample is sent from another department or the hospital ward. In this case, the ICTC must ensure that the patient has received adequate medical advice and that a requisition slip was delivered with the blood sample. Post-test counseling will be provided by the ICTC counselor assigned to the patient's ward or department upon admission.

Testing for HIV is done in a different way than testing for other illnesses. The required counseling must be provided prior to pretesting and the reporting of HIV testing. HIV testing facilities are required by the Guidelines on HIV Testing (2007) to provide clients with counseling prior to and during the test, in addition to maintaining strict confidentiality. The results of their HIV tests are shared with the clients by the counselors. The facility acts as the first hub for HIV treatment and management. A total of 1621 ICTCs for integrated HIV/AIDS counseling and testing have been set up in the state of Gujarat. In Gujarat, free HIV/AIDS testing and counseling are provided by community health centers, nonprofit hospitals, district hospitals, municipal hospitals, and medical colleges.

4.1.7.2 Targeted Intervention

There has been a recent trend in the HIV/AIDS epidemic suggesting that it is also affecting the general population. Owing to these reasons, the main strategy for targeted intervention (TI) is the saturation of high risk groups (HRG) throughout the state. Targeted intervention efforts have been GSACS's primary method of halting the HIV/AIDS virus's transmission. Bridge populations, such as truck drivers and single male migrants (SMM), as well as high-risk groups, such as transgender individuals (TG), female sex workers (FSW), and men having sex with men (MSM), are the main targets of various preventive interventions. The primary driving forces behind the focused intervention efforts have been CBOs and NGOs.

4.1.7.3 Sexually Transmitted Infection Care (STI) Services

The goal of syndromic case management, private physicians' involvement in public-private partnership initiatives, and STI/RTI treatment facilities is to reduce the incidence of STIs. There are sixty active STI clinics spread across medical colleges, district hospitals, trust hospitals, and some sub-district hospitals. Coordinators have been assigned to each of these clinics to ensure appropriate STI counseling.

4.1.7.4 Blood Safety Programme

The main goal of blood safety programs is to ensure that there is an adequate supply of safe blood available throughout Gujarat. Gujarat has 143 operational blood banks in its network, which guarantees that blood is always available. The focus must be on promoting voluntary, repeat blood donation in order to lower the risk of complications from blood transfusions and other blood transfusion-related illnesses. Unsafe blood and its products are the cause of the HIV virus transition in 2% of all cases.

The availability of safe blood and its products is a concern for the NACP. The program's position is that enhancing the state's ability to exchange blood, assisting with testing each blood unit of voluntary blood banks, and pretesting exchanged blood for HIV in order to ensure safe blood are essential elements. To guarantee the safety of the blood, the GSACS has partnered with the Indian Red Cross Society and Charitable Blood Bank to exclusively provide testing kits out of Gujarat's 64 blood banks. As stated in the Annual Report 2013–14 (GSACS, 2015), the primary objective of this program is to make safe blood available to all those in need at the right time. This has been made feasible by a network that includes 139 Blood Banks. 632463 units (79.6%) of the 794056 units (98.3% achievement) were acquired through voluntary blood donation, compared to the target of 807880 units. There is a 0.05% sero-positivity rate, and the total number of separated components is 447760 units (56.4%).

4.1.7.5. Voluntary Blood Donation

The collection of healthy blood is the main objective of voluntary blood donation. The priceless gift of voluntary blood donation is available to both wealthy and underprivileged donors. Every healthy individual has the capacity to donate blood on a quarterly basis. The promotion of voluntary blood donation has progressed thanks to the government and an optional blood bank. Individuals with more education are passionate about volunteering their blood. In college, student organizations and the National Service Scheme (NSS) are usually the means by which students donate blood. Some people lack the motivation to give blood. Most students stop being interested in giving blood after finishing the study.

4.1.7.6. Information, Education and Communication

In addition to offering information, education, and communication to the general public, the state's primary tactics for the vulnerable population are mainstreaming and behavior change communication, or BCC. Gujarat has arranged several IEC events to promote HIV/AIDS prevention and control, such as the printing and distribution of pamphlets, posters, flip charts, and statements for the mass and mid-media. The belief held by authorities is that HIV/AIDS can be contained through vigorous public awareness campaigns that target key demographics such as women, youth, and migrants. Meetings, conversations in groups, and initiatives that advance people's awareness, sensitivity, and advocacy are just a few of the activities that make use of information, education, and communication (IEC). Among the IEC programs Gujarat state has been running are the Integrated Rural HIV/AIDS Program, Jivandeep Project, essay and catechism competitions, Red Ribbon Club, volunteer program, and proficiency education course. For a brief while, the IEC program has only been available on particular days. It does not fully address the need for HIV/AIDS education among the general public. IEC programs should be regularly offered to a range of social groups.

4.1.7.7. The Red Ribbon Club Programme

The Red Ribbon Clubs aim to improve access to safe and sufficient blood supplies for all those in need, foster healthy lifestyles, and instill in all students in educational institutions the values of service through regular voluntary blood donation. This program addresses important health issues such as drug addiction, stress-free environments, voluntary blood donation, HIV/AIDS, healthy eating habits, and reproductive and sexual health, including RTI/STI and HIV/AIDS.

4.1.7.8. The Health Education and Life-Skill Programme (HELP)

The Health Education and Life-skills Program (HELP) was approved by the State Coordination Committee (SCC), which is chaired by the Principal Secretary (Education), Government of Gujarat. The program's main objective is to promote the holistic development of adolescents while keeping health at its center. The Gujarat Council of Educational Research and Training (GCERT) is the program's Nodal Agency. A comprehensive HELP module has already been developed for teachers.

4.1.7.9 The Link Worker Scheme (LWS)

To address the following issues, the program is building a network of trained local staff members who will serve as Link Workers and volunteers: a. reach out to HRGs and vulnerable young people (men and women) in rural areas; b. reduce stigma and discrimination by working with already-existing community structures/groups, such as Village Health Committees, Self Help Groups (SHG), etc. c. draw links between HIV, gender, and sexual orientation and emphasize factors that increase the vulnerability of women and young people in both HRGs and the broader community, Encourage the regular and increased use of condoms as a means of preventing STIs and unplanned births. e. Promote the use of prevention, care, and support services and programs—especially those pertaining to STIs, ICTC, PPTCT, ART, and other health services—and raise public awareness of them. f. Make it easier for youth-friendly health and counseling services to be provided via the public health system's current service delivery channels. g. Assist HRGs in reintegrating into the community. Eleven districts in Gujarat are implementing the LWS: Dahod, Surendranagar, Navsari, Banaskantha, Mehsana, Ahmedabad, Rajkot, and Bhavnagar (funded by Global Fund Round 7) and Valsad, Surat, and Vadodara (funded by UNICEF).

4.1.7.10. Care, Support and Treatment

In Gujarat's 26 districts—six of which are Category A districts and four of which are Category B districts—there are an estimated 1,37,000 People Living with HIV/AIDS (PLHAs), whose ages range from 15 to 49. There was just one ART center in 2005, and it was situated at Ahmedabad's B.J. Medical College. It provided care for 1303 PLHAs.

4.1.7.10.1 The ART (Anti-Retro Viral Therapy) Centre

According to the Annual Report 2013-14 (GSACS, 2015) in Gujarat as on March 2014 there are 27[86] fully functional ART Centres, with a total of 79132 patients registered in HIV care at ART Centres, 52729 patients started on ART & a total of 39070 patients alive on ART. The state average for LFU of on ART patients is 3412. As on March-2014, 39070 PLHA are dependent on ART in Gujarat. Out of these 4093 are being treated in the BJMC Ahmedabad, 3908 in the NCH Surat, 2724 at the SMIMER

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[86] (1)B.J.Medical College, Ahmedabad, (2) New Civil Hospital, Surat, (3) PDU Hospital, Rajkot, (4) Sir T. Hospital, Bhavnagar, (5) General Hospital, Mahesana, (6) Reliance Industries Hazira, Surat, (7) SSG Medical College & Hospital, Vadodara, (8) Mahatma Gandhi Hospital, Surendranagar, (9) GG Hospital, Jamnagar, (10) General Hospital, Junagadh, (11) G.K. General Hospital, Bhuj, (12) SMIMER Hospital, Surat, (13) General Hospital, Palanpur, (14) V.S. Hospital, Ahmedabad, (15) Sir Pratap General Hospital, Himmatnagar, (16) General Hospital, Navsari, (17) General Hospital, Amreli, (18) General Hospital, Patan, (19) General Hospital, Porbandar, (20) General Hospital, Godhara, (21) General Hospital, Bharuch, (22) General Hospital, Valsad, (23) General Hospital, Dahod, (24) General Hospital, Nadiad, (25) General Hospital, Gandhinagar, (26) Sola Civil Hospital, Ahmedabad, (27) Vyara Civil Hospital, Tapi.

Surat, 847 at the Reliance Surat, 1776 at V.S. Ahmedabad, 3485 in Rajkot, 1981 in Bhavnagar, 1529 in Mahesana, 2776 in Vadodara, 1111 in Surendranagar, 1063 in Jamnagar, 829 in Amreli, 1444 in Palanpur, 850 in Patan, 422 in Porbandar, 887 in Navsari, 1459 in Junagadh, 494 in Godhra, 1289 in Himatnagar, 1185 in Bhuj, 1508 in Nadiad, 521 in Dahod ART, 691 in Bharuch, 1179 in Valsad, 226 at Sola Ahmedabad, 168 at vyara ART centre and 625 in Gandhinagar. Nearly five Hundred new patients are put on ART every month in the State.

4.1.7.10.2 The Link ART Centre (LAC)

ART at the Taluka Level is provided by the Link ART Centers, which are situated nearer to the patient's residence. 40 LACs were operational in Gujarat at the end of March 2012. People who test positive for HIV can lead long, healthy lives before developing the symptoms of AIDS. The last stage of the HIV virus's evolution is AIDS. It is controlled by ART, which increases an individual's defenses against its attacks. Naturally, not all HIV-positive people require it. 10% of HIV-positive individuals need to be on antiretroviral therapy (ART), which prolongs healthy life.

In Gujarat state, the first ART facility opened its doors in 2005. Subsequently, free treatment for HIV-positive individuals was established in the districts of Ahmedabad, Surat, Vadodara, Rajkot, and Bhavnagar. To guarantee that everyone could use the service, Gujarat is the only state that established the five link centers in the aforementioned five districts.

4.1.7.11 Suraksha Clinic (STD/STI Clinic)

By the end of March 2014, GSACS had provided support to 63 designated STI/RTI clinics at District hospitals, PHCs, and CHCs, as well as 135 STI Clinics in Targeted Interventions. Until the end of March 2014, patients had 119135 STI/RTI episodes managed, compared to the annual target of 234590 episodes. A greater number of clients are now covered by the STI program as a result of our year-round extension of STI facilities up to the CHC and PHC level. The availability of STI services is being increased through targeted intervention projects.

4.1.7.12 Strategic information management unit (SIMU)

SIMU Evidence-based planning has been identified as the key to halting and reversing the HIV epidemic under the National AIDS Control Program-3 (NACP-3). The state has created a Strategic Information Management Unit (SIMU) to utilize all available information and carry out evidence-based planning. All information sources are integrated by SIMU, which then delivers strategic, logical data that can be utilized in decision-making. The outcomes of SIMU's efforts in the domains of research, strategic planning, monitoring and evaluation, and surveillance assist GSACS in tracking the outbreak and the effectiveness of its response, as well as in determining how well GSACS and its partner organizations are contributing to the achievement of predetermined objectives.

4.1.7.13 Launch of Strategic Information Management System

During the implementation of NACP-3, it was felt that the data from the HIV Sentinel Surveillance and Computerized Management Information System (CMIS) are not sensitive enough to detect the emerging hot spots of the epidemic because the data entry is done offline. In order to tackle this issue, NACO has established the Strategic Information Management System (SIMS), an internet-based platform that centers on strategic planning, oversight, assessment, observation, and investigation at both the federal and state levels. Effective tracking and response to the HIV epidemic are the main objectives. The responsibilities of each program officer are made clearer by this system, which also facilitates data flow and feedback at various levels. Every level in SIMS that permits online data entry will also increase the data's accessibility. It will be extremely helpful for future HIV/AIDS prevention strategies.

4.1.7.14 Jivandeep Project

The Jivandeep Project aims to help individuals living with HIV/AIDS become more integrated into society as a whole. It attempts to establish a safe and encouraging environment for people living with HIV/AIDS at the state and district levels. in order to combat pervasive HIV/AIDS-related misconceptions, stigma, discrimination, and silent behavior. The main goal of the project is to expedite the program for HIV/AIDS control by involving persons living with the virus in advocacy, networking, and positive prevention. Every district in Gujarat has been involved in the Jivandeep Project. Among its primary activities are advocacy, delicate events, networking, Positive Speaker Bauru, counseling, and HIV/AIDS-related advice.

4.1.7.15 Mamta Clinic

Children under 15 who have grown up with HIV/AIDS through parental transmission. The risk of HIV transmission from mother to child is estimated to be between 30 and 40 percent; however, the risk can be reduced by nearly 7 percent by giving nevirapine to both the mother and the child during delivery. Mothers living with HIV have also advocated for HIV testing and prevention. Resources in the program can be used to locate and follow up with mothers who test positive for HIV. It has been ensured that the dosage of nevirapine for children and clinic delivery will not transmit HIV to unborn children. Mamta centers are designed to stop the HIV virus from spreading from mother to child. Mamta centers are run by medical colleges, district hospitals, municipal hospitals, nonprofit hospitals, and community health centers. These facilities provide developing children with a dose of nevirapine, a variety of prenatal tests, and free prenatal counseling.

4.1.7.16 Awareness Movement for Women

HIV infection is very common in women. Due to factors such as their biological makeup, lower social status, and ignorance of HIV/AIDS, women are more likely than men to get HIV. Forty percent of individuals living with HIV are female. In order to decrease the risk for women, the "National AIDS Control Society" has implemented a number of initiatives. In honor of "World Women Day," "Tejswini Week" has been observed throughout the state to support and increase awareness of women. Tejswini seeks to develop an immune system that combats the HIV virus.

4.1.7.17 Drop-in Centre

Social tension and psychological stress are common among HIV-positive individuals. There should be a few places they can go to feel safe and receive guidance. People living with HIV can express their emotions and provide support to one another at "Drop In Centers." The Centers were established under the National Aids Control Initiative. Most "Drop-in Centers" have been administered by individuals living with HIV/AIDS. A few of the largest cities in the state of Gujarat now have "Drop-in Centers" established. In 20 districts, the Jivandeep Project has also established comparable structures. The Gujarat State AIDS Control Society is a state-level organization that established the district-level "Gujarat State Network of Positive People."

4.1.7.18 The World AIDS Day

On December 1, we observe World AIDS Day. In order to demonstrate their steadfast commitment to the fight against HIV/AIDS, social workers, organizers, and legislators unite for a range of awareness-raising events on the day. There will be workshops, competitions, rallies, and demonstrations on this day. Students from high schools and colleges, as well as associations with health and medical authority and affiliated associations and a positive network of people, have all enthusiastically participated.

4.1.7.19 Introduction to Gujarat State Network of People Living with HIV/AIDS (G.S.N.P+)

The Gujarat State Network of People Living with HIV/AIDS is a powerful and inspiring state-level organization that is contributing to the prevention and treatment of the illness. HIV-positive people have contributed significantly to the fight against national HIV/AIDS resistance. The Gujarat State Network of People Living with AIDS was established on February 6, 2003, by seven HIV-positive people who wanted to raise awareness of their problems and types of discrimination. The goal of G.S.N.P.+ is to create a supportive and powerful environment where people living with HIV/AIDS can live, get the care they need without facing prejudice or stigma, and continue to be socially safe. At the district level, the 24 districts of Gujarat State are home to the G.S.N.P. plus.

The "Jatan Project" is being carried out by the 18 districts of Gujarat State. Its aim is to persuade HIV-positive individuals to have their children tested for the virus. Children who test positive for HIV receive attention, medical care, and antiretroviral therapy (ART). They also try to identify and address the problems that children who are HIV-positive and infected people face. The main functions of this organization are to provide special child care for HIV-positive orphans, Rs. 500 under the medical assistant scheme, a marriage bureau for HIV-positive individuals, educational support, grain assistance to the impoverished, counseling, organizing awareness programs, and a host of other services in partnership with governmental and nongovernmental organizations.

4.1.7.20 Government schemes for HIV positive people

- A 500-rupee monthly food subsidy for OBC and SEBC people living with HIV.
- HIV-positive widows with BPL ration cards are eligible for monthly assistance of Rs. 500, plus an extra Rs. 80 for each child under the age of 18.
- Adding BPL ration cards holders who are HIV-positive to the Antyodaya Scheme.
- Rs. 100 in cash, a transportation allowance for parents of HIV-positive children, and a transportation allowance for HIV-positive individuals traveling to ART clinics.
- Annually, the Social Welfare Department provides scholarships to HIV-positive and HIV-infected students valued at Rs. 27.42 lacs.
- For orphaned children who test positive for HIV, the Social Welfare Department established orphanages in Gandhinagar and Surat.
- Special plans have been made for students to visit A.R.T. centers and receive medical attention during their time off.
- As part of the new program to assist parents of orphaned children, a monthly payment of Rs. 1000.

- As part of the Jivandeep project, individuals living with HIV/AIDS have been working to increase public awareness of the virus.

HIV-positive SEBC and OBC individuals receive 500 rupees a month in food assistance from the government. Nevertheless, people's bank accounts aren't regularly credited with this help on a monthly basis. In addition, HIV-positive people do not have enough money to purchase wholesome food. HIV-positive people and their families should receive more assistance from the government.

4.1.7.21 Organization Adhar

The Adhar organization is run by HIV positive individuals. 2004 saw its founding. The Arabic word "adhar" means "support" or "shelter." In keeping with their name, Adhar members have shown affection and support for one another. The Adhar organization started out with just ten members and has since expanded to seventeen hundred. It was founded in 2005 as a charitable trust with the goal of promoting equality for all people and combating discrimination against HIV positive people. The Adhar organization is overseen by the AIDS Control Society, which is funded by the Ahmadabad Municipal Corporation, the Project Director, and physicians from civil hospitals. Since no one can live in isolation, the organization benefits from this concept. Each and every person is respected and cared for as a member of the Adhar family. She or he consequently assimilates into society's physical and social milieu. By promoting good behavior, the Adhar organization gives its members more power. The principal objective of the organization is to cultivate an atmosphere wherein individuals living with HIV can surmount their financial, social, and psychological challenges with the assistance of the community.

in order for them to live in harmony and have their human rights respected. They've planned a range of tasks with preset objectives. It aims to strengthen with a positive outlook on life through the organization of HIV/AIDS positive individuals. It seeks to empower them to take care of their physical, mental, and emotional needs; to establish educational support for the benefit of their children; to make them socially and economically acceptable; and to involve HIV-positive individuals in the processes of decision-making and execution.

4.1.7.22 Organization of people living with HIV/AIDS in Ahmedabad district

The Ahmedabad District Network of Positive People (ABAD N.P.+), a group of the district's HIV/AIDS-positive citizens, is supported by the GSACS. The group known as ABAD N.P.+ is made up of HIV-positive rural and urban residents of the Ahmedabad district. The "Kaira Social Service society" is the other Christian-focused organization. A few other businesses are involved in this industry.

The acronym for Ahmedabad Network of Positive People is ABAD N.P.+. It was established on May 5, 2005, and it is presently based in the district of Ahmedabad. HIV-positive residents of Ahmedabad's villages and cities make up the group that the GSACS supports. The organization's goals are to stop the spread of HIV/AIDS, assist people living with HIV in leading healthy, long lives, and to lessen their problems by doing away with stigma and discrimination.

One of ABAD N.P.+'s primary projects is to help HIV-positive people who are traveling to the A.R.T. center to receive medication as part of the Jatan Project with transportation. (b) Give groceries from the Antyodaya Scheme to a family of HIV-positive individuals who are impoverished. (c) Give HIV-positive people who are socially excluded Rs. 500 a month for nourishing food. (d) Provide HIV-positive widows living in poverty with a monthly allowance of Rs. 500 and Rs. 80 for each of their offspring. (e) Provide scholarships to HIV-positive students. (f) Students who test positive for HIV are eligible for special leave from the education department. (g) Orphans in Gandhinagar and Surat can receive care from orphanages following the death of their HIV-positive parents. (h) Under the Guardian scheme, provide a monthly assistance payment of Rs. 1000 to the guardian of an HIV-positive orphaned child. (i) The organization works to protect people living with HIV/AIDS from obstacles, stigma, and discrimination in accordance with the guarantee of human rights.

4.1.7.23 The Kaira Social Service Society

Without regard to a person's race, religion, sex, or caste, the Kaira Social Service Society has been giving special benefits and human rights to underprivileged and in needy people since 1974. The organization was driven by the principles of social work theory, which include creating social justice, establishing human kindness, eradicating poverty, and promoting peace in society. The group fights HIV/AIDS, empowers women, manages disasters, teaches kids, farms, protects girls from harm, and advances social justice and peace.

There are active Kaira Social Service societies in Anand, Kheda, Ahmedabad, and Panchmahal. The organization hopes that the programs will promote tolerance towards all religions. Children, women, young people, teachers, religious leaders, and dignitaries are among the participants in these activities. The organization was founded in 1967 and is registered under the Society Act as Guj/207/Kaira and the Trust Act as Kaira-F-109. The goal of the organization is to create a community that upholds ideals such as equality, social justice, peace, love, and a strong connection to the natural world.

4.1.8 Prevention and Control of HIV/AIDS and the Social System

Without a doubt, there is no permanent cure for HIV/AIDS. The prevention and management of HIV/AIDS can only be aided by a comprehensive understanding of the risks. Indians are hesitant and bashful when discussing their physical and sexual problems with other people. Such a scenario gives rise to numerous challenges and problems for society. People are afraid of stigma and discrimination, which makes them hesitant to take part in HIV/AIDS awareness campaigns. As a result, government initiatives to combat, prevent, and spread awareness of HIV/AIDS are doomed to failure. By dealing with the problem, society maintains the status quo. There have been initiatives to halt the spread of HIV/AIDS and promote an accepting environment for people living with the virus at the international, regional, and local levels. Consequently, initiatives have been taken on a number of social levels. HIV/AIDS is no longer just a medical problem; it is now a social problem that can be examined from a social science perspective. The information and comprehension of Indian society regarding HIV/AIDS are provided below, based on a review of the literature, fieldwork, and experiences obtained during the current study.

4.1.9 Informal Norms and Values

The conventional norms and values still have a strong hold on the modern Indian social structure that controls behavior. The sexual norms here are extremely rigid when compared to other societies worldwide. Women's sexuality and the concept of the sacred are related. Consequently, it became taboo to openly discuss sexuality in social circles, and sex education was not taught in the majority of Indian states' educational systems. As a result, India could not now develop the scientific way of thinking or ideas. Perceptions of sexual norms are unchanged in India. India's women are more likely to get HIV/AIDS and other STDs than men because they enjoy less freedom than men. Individuals living with HIV/AIDS, both men and women, face social rejection and scrutiny of their actions in relation to established sexual norms. The prevalent belief in Indian society is that an individual must have committed a wrongdoing for HIV/AIDS to strike. The sacredness of women is linked to the sexual values of Indian society. She has experienced discrimination and cruel treatment ever since receiving an HIV/AIDS diagnosis. The community is compassionate and supportive toward someone with diabetes or high blood pressure, but not toward someone living with HIV/AIDS. HIV/AIDS is a social problem because of perceptions of Indian society's sexual norms.

4.1.10 Family and HIV/AIDS

The family is the primary institution in Indian society that facilitates a child's socialization. A joint family member who gets HIV/AIDS has to live in a different house, which is found out while conducting fieldwork. HIV-positive people are excluded from the group when they genuinely need their family members' love, support, and cooperation. As a result, their social ties suffered. Among the many problems faced by the HIV-positive individuals living in separate households were not giving up their portion of the property and having to pay rent in order to reside there. India places a higher value on family than other countries do, and both nuclear and mixed families are examples of this. The highest degree of cooperation has been noted in both kinds of families. They collaborate to find solutions in trying circumstances, but an HIV-positive person cannot expect his family to act in the same manner. He or she felt isolated as a result. There is therefore a link between the HIV/AIDS problem and the family structure. It also didn't go unnoticed during the socialization process because of a lack of sex education. Consequently, family members end up contracting HIV/AIDS and hiding their actual knowledge of it. The individual also feels embarrassed and reluctant to talk to family members about their sexual illness. This kind of social environment has been seen in Indian society, especially in the family system. As such, Indian society can approach the HIV/AIDS crisis from a variety of perspectives.

4.1.11 Marriage and HIV/AIDS

The institution of marriage holds great significance in Indian society as it is closely linked to sexual norms. Marriage legitimizes sexual behavior in Indian culture. Premarital sex has been generally prohibited, and it is taboo to talk about sexual relations and sexual necessities in Indian society due to the belief that sexual relations are sacred because marriage rites are connected to religion. People were afraid to satisfy their sexual needs for fear of upsetting society, even in situations where they married too late or in inappropriate circumstances. Consequently, they sometimes initiate risky sexual relationships out of ignorance and fear of the society. In Indian society, true scientific knowledge can only be created if sexuality norms are divorced from marriage and religion and acknowledged as a biological necessity of human beings. It is imperative to adopt this mentality in order to stop the spread of HIV/AIDS.

4.1.12 Educational Institutions and HIV/AIDS

Both types of education in Indian society are deficient in their coverage of sexuality. There are limitations or controls on sexual education, including the teaching of scientific sexuality in schools, in the majority of Indian states, including Gujarat. Even though the curriculum needs to be based on the principles of scientific knowledge, Indian society and traditional religious beliefs have a clear influence on the current scientific education system. The family is no longer the primary social institution in any society; instead, the educational system is more important for socialization. Though the Indian educational system still upholds traditional sexual norms, in recent times there has been an increase in the value placed on education and scientific knowledge. Women and young people could not, therefore, get sex education at the right age. Thus, there has been a rise in the disease's spread due to a lack of scientific understanding regarding HIV/AIDS, safe sexual behavior, the use of condoms, and sexually transmitted infections. As a result, the Indian educational system needs to amass impartial and scientific knowledge. Not just HIV/AIDS but a host of other social issues will benefit from this kind of reform in India's school system.

4.1.13 Economic Institutions and HIV/AIDS

HIV and AIDS negatively impact the youth population in the area and depress the Indian economy. Therefore, if we want to see growth in our economy, we must put an end to the HIV/AIDS epidemic. People are unable to fully participate in their businesses or jobs as a result of these viral diseases that are preventing economic growth, which leads to dependency and a weakening of their financial situation. Thus, developing countries like India suffer from the HIV/AIDS epidemic.

4.1.14 Indian Community and HIV/AIDS

Though HIV-positive people are isolated because of the stigma and discrimination they face in society. Anomie, according to Durkheim (1897), is a state that eventually leads to risky behavior, such as suicide. Indians have always interacted with one another with empathy and compassion, but when these traits are absent from interactions with those who are HIV/AIDS positive, these people become isolated and bravely deficient. The primary groups suffer from mental disturbance and loneliness as a result of their inability to cooperate in these social situations. In actuality, they expect more from the principal groups than just collaboration. The primary groups' stigmatization and exclusion of HIV/AIDS sufferers, however, are unhealthy for Indian society.

4.1.15 Conclusion

Gujarat is implementing a number of programs in coordination with multiple departments, such as those that oversee labor, education, health and family welfare, home, and women's and children's development. As part of the third phase of the national AIDS control program, Gujarat is putting the aforementioned programs into action. These programs all promote management, prevention, and awareness of HIV/AIDS. There are still numerous societal barriers to the government's great efforts in the fight against HIV/AIDS.

Making sure that every citizen in Gujarat is aware of HIV/AIDS is the goal of the third phase of the state's national AIDS control program. To accomplish this, GSACS implemented a number of programs, such as ICTCs, Targeted Intervention, Blood Safety Program, Sexual Transmitted Infection Care Services, Information Education Communication, etc. Still, it is not enough to increase public awareness of HIV/AIDS. For example, the IEC program raises awareness among high school and college students. But a lot of children don't go to school or university. For this reason, the government ought to act swiftly to increase HIV/AIDS awareness among children who do not attend school or college.

State governments at all levels should take a leading role in the HIV/AIDS prevention and control program. Since the prevalence and consequences of HIV/AIDS differ from state to state, state governments should create their own HIV/AIDS prevention plans and initiatives. A curriculum-based approach should be used in educational institutions to teach about AIDS. A national HIV/AIDS education program in schools and universities should be implemented nationwide in order to mobilize sizable segments of the student body to educate one another and the rest of the community. It is also important to inform young people who are not students through the vast network across the country. Worker education programs and other social development initiatives ought to include education regarding AIDS prevention.

A major media campaign was initiated by the NACO in 1996, utilizing well-crafted generic materials. Posters, pamphlets, booklets, newspaper ads, movie clippings, TV spots, radio spots, wall paintings, and movie slides were made in Hindi in addition to all the regional languages. The government of Gujarat is trying to use the media to spread awareness about HIV/AIDS, but a large number of the state's villages are disconnected from the outside world and lack access to either rural or urban areas. A large portion of the state's population does not read newspapers, periodicals, posters, pamphlets, or watch television or listen to the radio. The messages presented in government advertisements are often too complex or unappealing for those who watch television or listen to the radio to comprehend or pay attention to. These issues can range from illiteracy or language barriers to these issues. The government should arrange street plays, puppet shows, folk dances, and other events that are more in line with the local sociocultural milieu in order to increase public awareness of the risks associated with HIV/AIDS.

Furthermore, HIV-positive individuals are viewed in a highly exclusive and discriminatory manner by the general public. To put an end to prejudice and stigma towards people living with HIV/AIDS, the GSACS has taken action. If people accept them, behave impartially, and express sympathy, those who are HIV positive will be less likely to put themselves through treatment. But it's very challenging. If such a friendly and accommodating environment is established, work for HIV/AIDS prevention and control will be extremely straightforward. To do this, the government should endeavor to disseminate accurate information about HIV/AIDS throughout society. To put it another way, if people could accept those who are HIV positive, they wouldn't have to worry about their social standing declining and would always be ready for treatment. This could contribute to a decrease in the quantity of new infections within society. People who donate blood for HIV testing at PHCs, CHCs, or district hospitals near to their homes do not return for follow-up care and counseling due to their fear of social stigma. He or she goes to a different neighborhood for a follow-up HIV test. In this instance, the government database contains two registrations for the same individual. Because of this, the government finds it challenging to plan programs and campaigns because it is unable to ascertain the actual number of HIV positive people. Discrimination and stigma should be eradicated from people's consciousness. These might be quite helpful in controlling and preventing HIV/AIDS.

As has been made very evident throughout the conversation, there is no foolproof way to manage or prevent HIV/AIDS. There are many things that work as barriers or hindrances to the goal of the government. Numerous initiatives are carried out by the government to increase awareness among all societal members. Still, a large number of people are left out of the government's campaign. As a result, the government ought to create laws that are applicable to all citizens. The government ought to accomplish this by educating individuals about HIV/AIDS in the community and at work. It is imperative to provide HIV/AIDS education to individuals engaged in farming, agricultural work, industrial work, and other related occupations. The government needs to do a better job of taking the involvement of capable leaders from all spheres of society very seriously.

Without a doubt, the HIV/AIDS awareness campaign is a social liability. The prevention and control of HIV/AIDS is not solely the job of medical professionals; it is the responsibility of every member of society. The campaign needs to involve as many people as possible in order to protect society from HIV/AIDS. To boost public involvement in awareness campaigns and citizen participation in them, the government should act more decisively. Developing sensitive awareness campaigns and programs that are considerate of micro-sociological contexts and sites requires a strong understanding of context.

4.2 Role and Functions of NGOs

4.2.1 Introduction

Voluntary organizations, or non-governmental organizations, are another name for non-governmental organizations (NGOs). Due to the fact that a voluntary organization is made up of either paid or unpaid social workers. Its participants are the ones who start it and set its rules. Its members participate voluntarily. No matter how many people shape it or if it comes from a single person, its activities always remain shared and form a structure of roles, status, norms, and values. Therefore, a non-governmental organization is a voluntary organization of this kind. The present chapter attempts to elaborate the role and functions of NGOs working in the field of HIV/AIDS in [A] Arvalli [B] Sabarkantha [C] Mehsana and [D] Banaskantha districts.

4.2.2 Non-Governmental Organizations (NGOs)[87] : Meaning, Nature and type

4.2.2.1 Meaning of Non-Governmental Organization (NGO)

A non-governmental organization is a voluntary social organization driven by humanitarian values such as love, kindness, compassion, philanthropy, and service, as opposed to a bureaucratic organization. Its creators are extremely sensitive people. NGO workers and founders must exercise extra caution when diseases such as HIV/AIDS are stigmatized by society and patients are treated unfairly.

A social worker, also known as a Karmasheel, is an individual who engages in social work activities. Social workers are people who use their knowledge and expertise in social work to help and support individuals, families, groups, communities, or society as a whole. Here in [A] Arvalli [B] Sabarkantha [C] Mehsana and [D] Banaskantha in four districts of North Gujarat, NGO workers work on prevention and control of HIV/AIDS, public awareness and discriminatory treatment of patients. The focus is on protection against.

According to H. S. Gore, the main focus of social work is on welfare initiatives that fall within preexisting moral frameworks. It aims to help underprivileged people and organizations in order to rescue them from disaster and establish circumstances that will enable them to carry out their tasks effectively. It aims to achieve social upliftment by assisting the community and needy groups in reaching the highest level of their physical, mental, and social welfare. By performing relief and service operations, it offers social insurance services to the less fortunate and weaker segments of society as well as to those impacted by disasters. People living with HIV/AIDS can receive direct psychological, social, economic, and legal assistance and services from NGO workers.

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[87] J. K. Dave (2014-15). Samajik Kannunikaran ane Samaj Kalyan (Gujarati). Anada Book Depo, Ahmedabad. Pp. 224-239.

4.2.2.2 Nature of Non-Governmental Organization

An organization that is voluntary and dedicated to providing social services or welfare is known as a non-governmental organization. voluntary activities that are organized. Social workers make up this organization. A number of humanistic values, including kindness, compassion, generosity, goodwill, service, and assistance, have contributed to the formation of non-governmental organizations. HIV/AIDS initiatives are aimed at preventing discriminatory treatment of positive patients by the general public and enabling them to lead respectable, dignified lives similar to those of any other citizen.

- An NGO's welfare operations are run by employees who are either paid or unpaid. In accordance with current legislation, non-governmental organizations are required to register in order to conduct welfare operations. Its scope and structure are unique.
- An NGO's norms, values, beliefs, and code of conduct comprise its ideology, which serves as the foundation for determining the structure, methodology, and strategy of its service delivery.
- An NGO makes decisions in a straightforward, expeditious, and informal manner. Grants and donations account for the majority of an NGO's revenue. Government grants and financial assistance are given to certain organizations.
- Non-Governmental Organizations work to enable those in need to develop to the fullest extent possible. It assists the community, needy individuals, and groups in understanding their issues, coming up with solutions, getting past them, and growing into their potential. Because of this, the social worker's job is to enable the underprivileged to develop their potential.

The goal of NGOs is to make the system of supplying people with resources and services more humane and sensitive. When it comes to telling people where services and support are located, NGOs serve as both informants and guides.

NGOs' objectives are to meet the needs of the underprivileged, improve the wellbeing of those living in challenging situations, and give them a sense of empowerment. Their core values are service, social justice, human dignity, the value of human relationships, honesty, and knowledge.

4.2.2.3 Types of Non-Governmental Organizations

Types of Non-Governmental Voluntary Organizations can be listed as follows:

1) National, international, regional, and local organizations.
2) Businesses operating in both urban and rural regions.
3) Groups that assist minorities, scheduled castes, tribal people, and other underprivileged groups.
4) Businesses engaged in environmental work.
5) Groups that assist women, kids, teenagers, the elderly, people with disabilities, drug addicts, and HIV/AIDS patients.
6) Secular and communal institutions.
7) Organizations receiving Government grants and self-supporting organizations not receiving Government grants.
8) Organizations offering one or more forms of targeted services, such as aid, education, or healthcare; additionally, these organizations may offer jobs, housing, family support, or legal assistance to marginalized and underprivileged populations. As a result, there are various reasons why non-governmental voluntary organizations might be founded.

The term "social welfare" refers to programs that provide security, safety, and empowerment to all citizens of the state, but particularly to the most marginalized and vulnerable groups within society. Governmental and semi-governmental organizations use their bureaucratic structures to carry out these kinds of operations. The bureaucratic structure functions as a rational tool for social welfare, carrying out regular welfare tasks under the direction and control of authority. Humanistic virtues like empathy, service, composure, kindness, compassion, and generosity are absent from it. He is organized and has finances. However, there is still a lack of values that are necessary for social welfare, such as sensitivity, equality, service, and the value of human relations. As a result, the successes of social welfare initiatives might be restricted.

Because of this, it is now accepted for non-governmental organizations or voluntary organizations to take part in a variety of government-sponsored social welfare initiatives. Through their inclusion in the vulnerable category list, patients with serious infectious diseases, such as HIV/AIDS, now have legal protections for their rights and a dignified life.

4.2.3 Acceptance of NGOs as public participation in social welfare

India is a democratic nation; thus social welfare participation is valued highly. In other words, voluntary or non-governmental organizations are what people's organizations and community-based organizations are known as. Social development will be equitable, as sustainable, useful, participatory, and movement-based as possible if such organizations start social welfare and development programs and use the welfare-development activities of the people, by the people, and for the people method. These programs will also assist the people in their welfare and development and create an environment where the people can achieve their development through cooperation. People's basic needs are satisfied, productivity rises, time and energy are saved, people have more choice, and welfare rises in this kind of development. Non-governmental organizations and volunteer groups have been approved for this reason in order to boost public involvement in social welfare and development initiatives.

Numerous non-governmental organizations engaged in socio-religious reform, including the Brahmo Samaj, Prathanna Samaj, Indian National Social Conference, Arya Samaj, Theosophical Society, and Ramakrishna Mission, made significant contributions to social welfare and social reform during the 19th century in India. Mahatma Gandhi founded voluntary organizations in the 20th century to carry out various social welfare initiatives, including the Swadeshi movement, village reconstruction, and the eradication of untouchability. One problem that today's society is dealing with is the HIV/AIDS epidemic. Government and non-government organizations are trying to control and prevent it as well as raise public awareness of it.

In order to accomplish the objectives of the welfare state, non-governmental and voluntary organizations were formally recognized after India gained its independence.

The nation's Central Social Welfare Board was founded in 1953, and Social Welfare Boards were also established in the nation's Union Territories and several states in 1954. This board's mission was to advance social welfare initiatives via non-governmental organizations and voluntary organizations. It was the first board to look for volunteer organizations from the general public to help carry out welfare programs. With the creation of this board, non-governmental organizations and voluntary organizations were accepted as forms of public participation.

Welfare programs are still carried out by the Central Social Welfare Board in conjunction with the Social Welfare Boards of the States and Union Territories. At the intersection of governmental and non-governmental organizations, these Boards carry out a range of welfare initiatives.

Since 1991, the liberalization, privatization, and globalization of the Indian economy have occurred, along with a shift in people's expectations for development, making non-governmental organizations' role in social welfare increasingly significant. These developments have also highlighted the limitations of governmental and semi-governmental organizations' bureaucratic structures in implementing social welfare schemes and programs.

Humanistic ideals like kindness, compassion, and sensitivity are crucial for the well-being of society's marginalized and weaker groups. In general, the bureaucratic structures of governments and semi-government organizations lack these values. Therefore, non-governmental organizations are better suited to carry out these groups' social welfare tasks than the government. Considering that non-governmental organizations driven by humanitarian principles are voluntary organizations. NGOs/Voluntary Organizations have a sufficient role to make participatory democracy meaningful and effective because they also have less responsibility and workload, which allows them to experiment, change the approach, and obtain the necessary information based on their fieldwork related to their field of work. are provided. This is made possible by the size and effectiveness of NGOs as well as the welfare initiatives and programs offered by the government, World Bank, and Central Bank.

4.2.4 Arrangements for participation of non-governmental organizations in social welfare

The Central Social Welfare Board, one Association, one Council, and five separate Ministries and departments have adopted the role of Non-Governmental Organizations/Voluntary Organizations in their various welfare schemes and programs. The Indian government has welcomed this development. With this arrangement, support from voluntary organizations and NGOs with a social work focus is sought for a variety of government-sponsored social welfare schemes and programs. Specialists in that field play a significant role in social welfare programs and schemes. Under various schemes, partnership arrangements with NGOs/Voluntary Organizations have been shaped in response to their demands. Under this arrangement, these organizations receive grants, or financial assistance for their programs, in accordance with government regulations. They are also assisted in various social welfare schemes and programs. These scheme programs include the following, to name a few.

(1) Welfare programs for tribes, other disadvantaged classes, and scheduled castes.

(2) Programs for the welfare and rehabilitation of the elderly, drug addicts, disabled people, and HIV/AIDS patients;

(3) Programs for the empowerment of women

(4) Employment-related programs

(5) Literacy, midday meal, and adult education programs

(6) Programs pertaining to youth and adolescent development;

(7) Programs pertaining to the establishment, instruction, and skill-building of self-help groups

(8) Initiatives aimed at providing the urban poor with basic services through the development of integrated housing and slums in housing schemes.

(9) Consumer education and environmental protection programs;

(10) Entrepreneurship programs;

(11) Rehab programsfor bonded laborers and child laborers;

(12) Rural development programs;

(13) Integrated watershed programs

(14) The Total Sanitation Campaign's related programs

(15) Town planning

(16) Legal aid

(17) Programs for family welfare and health

(18) Social Security programs

(19) Additional social welfare programs.

Thus, the participation of Voluntary Organizations (VOs) in various programs and schemes pertaining to social welfare and development is accepted. By doing this, efforts are made to increase the effectiveness and efficiency of social welfare programs and to strengthen public participation in the field.

4.2.5 Functioning and Role of Non-Governmental Organizations in Social Welfare

Social workers comprise non-governmental organizations (NGOs). A social worker, also known as a Karmasheel, is someone who engages in social work activities. Social workers are qualified, skilled, and knowledgeable in social work. Social work's main focus is on welfare initiatives. Professional social work is an all-encompassing endeavor. It is dedicated to helping the underprivileged, distressed, or suffering in all walks of life. Social workers are required to adhere to the Code of Conduct on Social Work when performing social welfare tasks. In addition to improving their circumstances and their upliftment in social welfare policy and legislation, they must also promote social welfare, aid in facilitating public participation in social welfare, and carry out activities to improve the social condition of the weak, deprived, marginalized, disaster-prone, and problem-prone in society. One of their responsibilities to society at large is to advocate for reforms that are necessary. In India, numerous non-governmental organizations and voluntary groups have grown to be active in a variety of spheres of society, providing social welfare services in accordance with their abilities and areas of interest.

From a historical standpoint, the belief that the state should prioritize the welfare of the people was prevalent in ancient India. Mahajan carries out a number of welfare tasks. It was believed that the king had a duty to provide for the needs of the elderly, the poor, victims of natural disasters, and destitute women. King Ashoka's reign saw a number of social welfare initiatives. Ashoka Raja created a complex social welfare system, and officials were chosen to carry out the welfare projects. During the Gupta administration, the welfare of the populace was regarded as a crucial state function. Some emperors, like Akbar, carried out charitable endeavors for the whole community. According to Akbar, a king ought to act in the interests of the populace.

Social welfare organizations in India started to emerge during the British colonial era, following the British model. Mumbai saw the founding of the Tata Graduate School of Social Work in 1936. This organization was the first to offer professional social work education and training. Other than this, other cities established institutions of a similar nature. Numerous socioreligious groups created initiatives for social welfare. To put an end to untouchability, Gandhiji provided innovative programs. As a result, before independence, social work and social welfare organizations in India were thriving. Various non-governmental and voluntary organizations proliferated in post-independence India and participated in state-run development and welfare initiatives.

4.2.6 Functioning of Non-Governmental Organizations in Social Welfare

As Kamal Taori points out, the charitable sector has historically been the exclusive focus of voluntary organizations' missions. However, it's getting more and more progressive these days. It is now imperative that nonprofit organizations run commercial, educational, and developmental initiatives. For voluntary organizations to fulfill the public's rising expectations, they must grow in strength. Various kinds of non-governmental organizations and voluntary organizations carry out social welfare programs based on their personnel, interests, and mentalities. They have also registered their participation in government-sponsored welfare programs that are presented. This was said earlier. However, he repeats the operational areas here, which is repetitive. The various areas that NGOs operate in are listed below.

Programs:

- Poverty alleviation and employment-self-employment programmes
- Welfare of Scheduled Castes, Tribes, Other Backward Classes, Minorities
- Literacy, Vocational Education
- Health care and the environment
- Rural development
- Town development
- Remediation of contaminated habitats
- Women and Child Development
- Child welfare and mother welfare
- Family welfare services
- Legal aid
- Rehabilitation of disabled, child labour, bonded labour
- Development of women working in the unorganized sector
- Homemaking
- Rescue, relief, rehabilitation disabled, destitute related welfare programs in the event of natural calamities.

In summary, non-governmental organizations (NGOs) that work in a variety of areas, such as child development, labor welfare, rural development, health, education, social security, family planning, environment, housing, and employment, support the needs of social welfare by means of social welfare-related initiatives. The government offers grants-in-aid to voluntary organizations (NGOs) that carry out social welfare activities. For non-governmental organizations to be eligible for such financial assistance, they must abide by government regulations. They must also carry out the program's implementation, which is funded by the government. Through their social welfare initiatives, a variety of non-governmental organizations support human development in a sustainable manner.

4.2.7 Role of Non-Governmental Organizations in Social Welfare

In a number of government-sponsored social welfare initiatives, non-governmental organizations and voluntary groups have been given sufficient space to improve the lot of people in India and act as a catalyst for the desired social transformations toward social justice, equality, and freedom. In government-sponsored programs that provide social welfare needs like employment, education, and health care, nongovernmental organizations are crucial. Here are descriptions of several facets of this role played by NGOs.

4.2.7.1 Contribution to Social Reconstruction

Non-governmental organizations work to address a variety of social welfare issues. Professor, as Masihi points out, the majority of volunteer organizations work to bring together the underprivileged, regressive, abused, and mistreated people and communities in order to help them escape their difficult circumstances. NGOs thus aid in social reconstruction by engaging in positive and developmental endeavors.

4.2.7.2 Empowerment

Non-Governmental Organizations place a strong emphasis on meeting social welfare needs for people. Non-governmental organizations work to enable people to access social services and facilities and complete life's tasks. He assumes the part of Shaktiman in it. In it, social workers take on the role of counselors, helping individuals change both their personal and external environments while also growing in their capacity for adaptation and intellectual orientation.

Self-help-like skills are part of empowerment. Through the development of decision-making skills related to both individual and group circumstances, social justice and welfare, the capacity to think positively in order to change one's circumstances, the capacity to blend in with society, the capacity to cultivate a positive self-image, and the capacity to discern between right and wrong with discretion, non-governmental organizations strive to empower people.

When a problem is empowered in this way, people are compelled to continue developing their basic human activities. For them, this form of development turns into sustainable development. Thus, the work that non-governmental organizations (NGOs) do to empower the affected population improves their quality of life, helps them rise up, and helps them become independent and growth-oriented individuals, all of which contribute to the prosperity and well-being of their offspring.

4.2.7.3 Eases the Government's Burden

The government has established partnerships with NGOs and accepted their role in social welfare and development across a range of fields. These partnerships include regulations governing the projects that NGOs may undertake in connection with government-sponsored welfare and socioeconomic development initiatives. Grants are given out in exchange for financial assistance, which lessens the government's administrative and financial burden. As a result, NGOs' involvement in government-sponsored initiatives for social reconstruction and empowerment lessens the administrative and financial strain on the state.

4.2.7.4 Role as a Safety Valve

Through their participation in a range of social welfare initiatives, non-governmental organizations function as a kind of safety valve in society. The problem and distressed people, as well as the weaker and more deprived segments of society, are unhappy with their circumstances and experience hopelessness and depression. Therefore, it's possible that they'll choose to fight their way out of this predicament. Non-Governmental Organizations serve as a social safety valve by removing agitation and conflict and providing a constructive outlet for people's resentment and frustration through social welfare initiatives.

Donations are a source of funding for non-governmental organizations engaged in social welfare initiatives. He appeases the people's philanthropic and spiritual spirits in this way. The donor feels satisfied that he has paid his debt to society and performed a good deed. Donation money is utilized for social welfare initiatives. Redistribution of wealth occurs in society in this way. Rich people's money helps the less fortunate meet their basic needs and become self-sufficient, serving as a safety valve to keep unhappiness from showing. As a result, NGOs function in society as a sort of safety net.

4.2.7.5 Providing Social Insurance Services

Through a variety of social welfare initiatives, non-governmental organizations help the elderly, the poor, the sick, the disabled, the victims of natural disasters or accidents, the displaced, the destitute, needy women and children, etc., get back to their regular lives. establishes a supportive environment. In this sense, NGOs satisfy the need for social insurance by offering disturbed and distressed people a semblance of security cover.

4.2.7.6 Social Awareness

NGOs' social welfare initiatives raise people's awareness of their predicament, inform them of their rights, and let them know what services are available. Inspires them to move in unison and organizes them to escape the circumstance. Engaging in such activities makes society and the government more aware and compels them to take the appropriate action. This kind of social awareness cultivation facilitates social action.

4.2.7.7 Social Actions

Some NGOs also carry out the essential tasks to enhance peoples' conditions. Social workers are the ones who organize these actions. Individual or group effort can be used as a form of social action. Such action could take the form of filing a lawsuit, staging a sit-in, or holding a demonstration in support of a government or semi-government organization. Enhancing social policy, enacting new legislation or reforming existing ones, or enhancing a range of welfare services are the objectives of such social measures. By educating the public, non-governmental organizations influence referendums through socialization. These actions are taken in opposition to the issues of child labor, child labor rehabilitation, the status of female workers, housing issues, slums, female genital mutilation, education of girl children, crimes against women, and rape. These actions are linked to improving those people's situation.

4.2.7.8 Role as Agents of Social Change

Through their various social welfare initiatives, non-governmental organizations work to change the lives of the most marginalized and vulnerable members of society in the direction that is desired. Non-Governmental Organizations try to implement new laws, develop sensitivity in the bureaucratic structure of Government and Semi-Government organizations, and address issues pertaining to housing, employment, health care, education, and other areas that affect the weaker and deprived groups. They also attempt to make necessary legal reforms. It makes an effort to eradicate the causes of inequality and injustice. Through efforts to empower individuals, families, and communities, it works to remove barriers from the path of life for the weaker and disadvantaged groups and also acts as an agent of change in the desired direction.

4.2.7.9 Role as a Facilitator in Human Development

Through their participation in a range of social welfare initiatives, non-governmental organizations contribute to human development. Evolution in humans is a series of transformations. Through social welfare initiatives run by NGOs, the underdeveloped developmental potentials of the weaker and disadvantaged groups start to show signs of life.

The institutionalization of laws pertaining to social welfare and education has been given priority in the current stage of human evolution. Non-governmental organizations that engage in welfare work help weak and disadvantaged groups build their capacity for development and strengthen their ability to overcome obstacles in life and obtain services. It is possible to enact new laws, reform existing ones, and ensure their enforcement through social action. In addition to participating in public policy-making, non-governmental organizations work to empower the illiterate by educating and empowering them with vocational skills. They also support the process of universalizing education. To accelerate human evolution, it becomes necessary to include those who are excluded from various spheres of social life, such as politics, employment, education, and other areas, because of their caste, sex, age, or gender. Society's ability to function can be improved by doing this. Non-Governmental Organizations (NGOs) engage in initiatives to break down barriers and encourage social inclusion of marginalized and vulnerable groups, as well as victims of particular circumstances. The process of social inclusion is evolutionary. As a result, non-governmental organizations' welfare initiatives that quicken social inclusion also facilitate and quicken human evolution, which is a prerequisite for sustainable development and becomes crucial to the globalization process. As a result, NGOs aid in the development of people.

4.2.7.10 Role as a Facilitator in Building a New Work Culture and Civil Society

Human rights protection is one of the missions of non-governmental organizations. Human rights advancement is greatly aided by activists. The ethical impact of non-governmental organizations operating in that domain can result in favorable attitude shifts within the bureaucracy, fostering the essential awareness within the bureaucracy for social welfare. Realizing human rights is social welfare's ultimate goal. Human rights are the foundational principles of liberal democracy.

Non-governmental organizations possess the capacity to significantly aid in the creation of a new workplace culture that is compliant with human rights. Non-governmental organization employees can help raise public awareness of India's status as a democratic society, a legal state, and a welfare state. A new, result-oriented work culture can only be established with this kind of awareness.

The core values of the new workplace culture are honesty, integrity, compassion, and a dedication to the freedoms and dignity of all people. Eliminating procrastination, rules and fair conduct, eliminating system weaknesses, reforming bureaucratic structures in accordance with human rights, and refraining from selfish activities. NGOs have a significant role to play in making sure that appropriate oversight and control, public outreach, a positive outlook, transparency in the workplace, and other factors become ingrained in the workplace culture and core values. In a democratic society, non-governmental organizations and voluntary groups are people's power and can help develop and support civil society by fostering a new workplace culture. The welfare of HIV/AIDS patients is the focus of non-governmental organizations working in the field. In order to give them the opportunity to live a life of dignity free from discrimination, efforts are made to safeguard their rights.

4.2.7.11 Contribution to Accumulation of Socio-Applicable Knowledge

Non-governmental organizations have a significant impact on the body of knowledge that is relevant to society. Employees of NGOs perform the functions of social scientists and researchers. Prof. As Masihi points out, voluntary organizations (NGOs) compile the data required by their industry to support and maintain innovative and developmental endeavors. There are NGOs that have their own documentation department, library, and research department. They maintain contact with local organizations that carry out comparable social welfare initiatives. He compiles knowledge from his professional experience and applies it to his social welfare work to make it more goal-oriented. Such knowledge also adds to the body of information that is beneficial to society and is published bibliographically as a book. Planners of government policy, social workers, and other social welfare organizations can all benefit from this accumulation of knowledge. Social sciences can advance via the same kind of information gathering. Social welfare organizations, social workers, the government, and policy makers can all benefit greatly from the information gathered through the efforts of various NGOs involved in the HIV/AIDS crisis.

Therefore, by collaborating on government-sponsored social welfare events and initiatives, NGOs/Voluntary Organizations can play a variety of roles in social welfare. According to Kamal Taori, in order to partner on a social welfare program, certain HIPPOO (Hidden Investable Potential Power of Organization) and KIPPOO (Known Investable Potential Power of Organization) elements must be chosen. That is, the non-governmental organization's covertness—that is, it is important to distinguish between known and unknown latent forces and choose the right non-governmental organization from among them. If this is done, the nation's great values—humanity, reason, justice, transparency, and equality—can be the cornerstone of development. Non-governmental organizations are the people's power in a democratic society, and they can help to build and support civil society.

4.2.8 Role of UNO

The Joint United Nations Programme on HIV and AIDS, or UNAIDS, is the main advocate for prompt, comprehensive, and coordinated international action against the HIV/AIDS pandemic. UNAIDS strives to lead, strengthen, and support an expanded response to HIV and AIDS in order to prevent HIV transmission, care for those who have the virus, reduce vulnerability of individuals and communities to HIV, and lessen the effects of the epidemic. UNAIDS aims to slow the rapid spread of the HIV/AIDS pandemic.[88]

4.2.9 Five Goals of UNAIDS

a. Strategic information and technical assistance to support efforts against AIDS globally;
b. Tracking, monitoring, and evaluation of the epidemic and of responses to it;
c. Engagement of civil society and the formation of strategic partnerships;
d. Mobilization of resources to support an effective response.
e. UNAIDS is headquartered in Geneva, Switzerland, and makes use of certain World Health Organization buildings there as well. It is a member of the United Nations Development Group. UNAIDS's first executive director was Peter Piot. UNAIDS's mission is to support and facilitate the development of a broader response to HIV/AIDS, involving numerous partners in both the public and private sectors.[89]

UNAIDS encourages cooperation between these many different kinds of non-state organizations. This calls for an increase in the number of new actors as well as

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[88] http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-india

[89] http://www.worldbank.org/projects/P078538/third-national-hivaids-control-project?lang=en)

creative working methods to enable increased capacity of non-state entities to respond to the epidemic at all levels in an effective manner.[90]

India is home to one of the greatest concentrations of HIV-positive individuals in the world. Even though it is generally accepted that prevention and treatment are complementary tactics in the fight against HIV/AIDS, the Indian government has prioritized prevention over treatment. Additionally, HIV/AIDS patients face severe discrimination and stigmatization. To support people living with HIV against all forms of discrimination, the HIV/AIDS and the Law Initiative at HRLN upholds their fundamental human rights, including their right to life, health, privacy, education, employment, housing, and other issues.[91]

With UNDP assistance, the Integrated Network for Sexual Minorities (INFOSEM) and 29 district-level PLHIV networks have been formed. 15.6 million people, including service providers, received information and training that improved their ability to protect themselves against HIV. UNDP India is currently focusing particularly on addressing punitive laws and environments that affect the inclusion of the criminalized and marginalized groups, in accordance with the joint UN Framework for Action. Working with networks of HIV-positive individuals and NACO, UNDP has been successful in enacting policy changes in 35 government programs that grant access to various entitlements for those affected by HIV. Free transportation, food aid, legal support, microgrants, short stays at home, livelihoods, education, and pensions are a few of these programs. As an example, Rajasthan was the first state to modify the widow pension program to cover widows with HIV who are widows regardless of age.[92]

He declared, "There is no doubt that we have made much more progress," citing, among other things, the fact that, at the time of the previous General Assembly special

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[90] http://www.un.org/apps/news/story.asp//html/realfile/story.asp?NewsID=38061&Cr=hiv&Cr1=#.Uqbn3NIW1_Q

[91] http://www.un.org/apps/news/story.asp//html/realfile/story.asp?NewsID=37950&Cr=HIV&Cr1=#.Uqbn_9IW1_Q

[92] http://www.undg.org/docs/9727/A-Resource-Guide-forTheme-Groups.pdf

session on the topic in 2001, less than 200,000 people were receiving treatment for AIDS. Currently, about six million people are receiving treatment for the disease. He went on, though, pointing out issues like defending the rights of men who have intergalactic sex, drug injectors, sex workers, migrants, and other marginalized groups.[93] The report highlights how brittle the progress is. Every patient starting antiretroviral therapy results in two new HIV infections, and there are 7,000 new infections every day, 1,000 of which are in children. [94]

The Secretary-General offers five suggestions in the report for bolstering the AIDS response, two of which are to revive the push for universal access to HIV prevention, treatment, care, and support by 2015 and to harness the energy of young people for a revolution in HIV prevention.[95]

Other suggestions he makes for cooperating with countries to enhance the affordability, effectiveness, and sustainability of HIV programs include the promotion of women's and girls' health, human rights, and dignity as well as making sure that commitments are kept in the AIDS response through mutual accountability.[96]

A global epidemic of this magnitude and complexity, which raises issues beyond health, requires action from an international organization. UNAIDS was established in 1996 as a result of the UN system taking action to address the HIV/AIDS problems. UNAIDS is a novel collaboration comprising seven co-sponsors, namely UNESCO, UNICEF, UNFPA, WHO, UNDP, UNCP, and the World Bank. The mission of UNAIDS is to advance global action against HIV/AIDS. A range of HIV/AIDS-related projects are funded by each partner organization in collaboration with governments, civil societies, and the private sector. A major turning point in the global effort to combat the AIDS crisis was the June 2001 special session of the UN General Assembly dedicated to HIV/AIDS. As stated in the United Nations, 2000 Millennium Development Goal 6, leaders of 189 Member States pledged in the United Nations,

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[93] http://www.ekh.lu.se/media/ekh/forskning/mfs/8.pdf
[94] www.globalaidspartnership.org/html/ngos.htmls#ngoii
[95] www.blogaids.gov/2012/09/nih-research-on-hiv-and-aging.html
[96] www.ngopulse.org/article/guide-hiv-aids-ngos-southafrica

2001 Declaration of Commitment on HIV/AIDS to a comprehensive set of time-bound HIV targets to halt and begin reversing the global epidemic by 2015.[97]

4.2.10 Increasing Our Efforts to End HIV and AIDS

Political Declaration on HIV and AIDS

a. From June 8 to June 10, 2011, heads of state and government, along with representatives from various states and governments, convened at the UN to assess the status of the implementation of the HIV/AIDS Political Declaration of 2006 and the 2001 Declaration of Commitment on HIV/AIDS. Our objective was to support leaders' ongoing political commitment to and involvement in a comprehensive response at the local, state, and federal levels in order to guide and bolster the global response to HIV and AIDS.
b. reaffirm that the UN Charter protects Member States' sovereign rights and that all countries must carry out the promises and commitments made in the current Declaration in line with domestic development priorities, international human rights, and national law;
c. Reaffirm the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, highlighting the critical need to step up efforts to ensure that everyone has access to comprehensive prevention programs, care, treatment, and support;
d. Although HIV and AIDS are global diseases, each country's epidemic is distinct in terms of its causes, susceptibilities, aggravating factors, and affected populations; therefore, responses to each unique scenario must be customized by the international community and the affected countries, taking into account the epidemiological and social context of each one;
f. Recognize the significance of this high-level meeting, which marks the tenth anniversary of the adoption of the Declaration of Commitment on HIV/AIDS, the fifth anniversary of the Political Declaration on HIV/AIDS, and the first anniversary of the first report on AIDS. It also honors the commitment to rapidly scale up

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[97] www.ncbi.nlm.nih.gov/pubmed/12284229

responses to ensure that everyone has access to comprehensive prevention programs, treatment, care, and support.[98]

4.2.11 Eliminating AIDS-Related Illness and Mortality Through Treatment, Care, and Support

a. promise to intensify efforts to raise everyone living with HIV/AIDS'squalityof life and life expectancy;

b. declares your determination to intensifying your efforts to fulfill the objective of providing everyone with access to antiretroviral treatment for those who meet the requirements in line with the WHO treatment guidelines, which demand the early start of high-quality care for the best results. By 2015, you want to have enrolled 15 million HIV-positive individuals in antiretroviral therapy;

c. Declare your commitment to assisting in the provision of high-quality, reasonably priced, highly effective, safer, and more straightforward treatment plans that avoid drug resistance; as well as straightforward, reasonably priced point-of-care diagnostics; cost savings for all essential components of treatment delivery; community mobilization and capacity building to assist treatment scaling up and patient retention; and initiatives that promote enhanced;

d. Assume responsibility for developing and putting into action plans to improve infant HTV diagnosis, including point-of-care diagnostic access; greatly expand and improve treatment options for children and adolescents living with HIV, including prophylaxis and treatments for opportunistic infections; raise the financial, social, and moral support systems for parents, guardians, and other caregivers; and enhance access to diagnostics at the point of care.

e. Become dedicated to promoting comprehensive, high-quality, reasonably priced primary health care and support services, including those that deal with the mental, emotional, physical, and social aspects of living with HIV; additionally, provide

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[98] www.iseac.ac.in/prc-abs17.pdf

services that integrate the prevention, treatment, and management of co-occurring conditions, such as hepatitis and tuberculosis;[99]

4.2.12 Resources for the AIDS response AIDS

a. Make sure that funds go through national finance systems when necessary, and make a commitment to working toward 2015 to close the $6 billion annual global HIV and AIDS resource gap, as estimated by the Joint United Nations Programme on HIV/AIDS. This will be accomplished by increasing strategic investment, continuing national and international funding to help nations access stable and sustainable financial resources, and finding creative sources of funding.

b. Ensure that synergies are tapped into between the HIV and AIDS response and the legal trade in generics and other inexpensive medications. Commit to enhancing the efficacy of prevention by concentrating interventions to deliver more creative, inventive, and long-lasting programs for the HIV and AIDS response, in line with national development plans and priorities.

c. To reach a significant level of annual global expenditure on HIV and AIDS, commit by 2015 to increasing national ownership of HIV and AIDS responses through greater allocations from national resources and traditional sources. Recognize that the Joint United Nations Programme on HIV/AIDS has set an overall target in low- and middle-income countries that is estimated to be between 22 and 24 billion dollars.[100]

4.2.13 Integrating HIV and AIDS with broader issues of health and development while bolstering health systems

a. With a focus on the nations most impacted by HIV and/or emigration, support and promote the significant development of human capital, the growth of national and international research infrastructures, laboratory capacity, enhanced surveillance systems, and the training of basic and clinical researchers, social

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[99] http://ekg.lu.se/media/ekh/forskning/mfs/8.pdf

[100] www.tnhealth.org/tsngo.htm

scientists, and technicians through domestic and foreign funding and technical assistance.

b. By 2015, make sure that funding is allocated to and the connections between HIV and tuberculosis responses, primary healthcare services, sexual and reproductive health, hepatitis B and C, drug dependence, non-communicable diseases, and maternal and child health are strengthened through collaboration with partners. HIV/AIDS prevention through the use of health care; enhancement of the interface between HIV services, related sexual and reproductive health care and services, and other health services, such as maternal and child health; elimination of parallel systems for HIV-related information and services where practicable; and fortifying ties between national and international initiatives pertaining to human and national development, including the eradication of poverty.[101]

4.2.14 Role of NGOs

NGOs play a critical role in HIV/AIDS prevention because of their close collaboration with individuals who participate in high-risk behavior. In addition to providing funding to numerous NGOs, the government is trying to create an effective network in order to alter behavior and increase public awareness. Promoting safe sexual behavior and educating marginalized populations about high-risk behavior are the objectives of NGO collaboration. Additionally, it helps grassroots NGOs that run population- and neighborhood-specific intervention programs. CBOs and NGOs that work on intervention projects make up the first group. The second category comprises organizations that support individuals living with HIV/AIDS, with a focus on initiatives for care and support aimed at mitigating its effects. It runs newspaper ads soliciting NGO proposals as part of its transparency policy. The selection of NGOs is done in three steps: 1) The proposal was given careful consideration by the Technical Advisory Committee and the NGO Advisor. 2) A zonal officer's pre-approval inspection conducted in the field. 3) The approval of the Executive Committee. The NGO Advisor

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[101] www.socialcapital.weebly.com/uploads/1/0/5/9/1059736/kabeba-social-capital-building-in-uganda.pdf

assesses all proposals from NGOs, and Zonal Officers visit the sites of recommended proposals to verify the organization's capabilities, operational status, and community perception. After the field inspection, the proposals and reports are brought before the Executive Committee. Subject to Committee approval and following the signing of the required contract, funds are disbursed to the NGOs in installments. Intervention programs try to encourage safe behavior by providing condoms, counseling, and STD treatment services to marginalized and vulnerable groups. NGOs have located and contacted 17 of these groups thus far. The groups identified for intervention programs include truck drivers, commercial sex workers, migrant labor, industrial workers, refugees, fishermen, slum dwellers, hotel and lodge employees, domestic help, students, street children, and MSMs. It also builds relationships with NGOs to guarantee that the HIV/AIDS situation is suitably and sufficiently addressed.

NGOs are asked to open house meetings each year so that the Hon. Health Minister can interact with them. It also hosts conferences where non-governmental organizations (NGOs) can share experiences and benefit from each other's domain knowledge and experience. NGOs can attend training sessions on project preparation and management in addition to workshops and seminars. Through NGOs, they back the following initiatives:

a. Counselling
b. STD treatment
c. Condom promotion
d. Treatment for opportunistic infections
e. Home care for people living with AIDS
f. Networking PLWH/A

Interventions with a priority focus for high-risk populations. The targeted intervention program aims to lower the rate of transmission among the most marginalized and vulnerable populations. One way to stop the disease from spreading further is to implement multi-pronged direct intervention programs among these groups. These programs should start with behavior change communication, counseling, health care support, treatment of STDs, and creating an environment that will facilitate behavior change. Targeted intervention is one of the most important components of the National AIDS Control Programme's Phase II. The National AIDS Control Program's Phase I, which ran from 1992 to 1999, gave environmental improvement projects and awareness-raising campaigns a lot of attention. Nonetheless, the focus of the National AIDS Control Programme, Phase II 1999–2004, has shifted from raising awareness to changing behavior through intervention, particularly for populations who are at a higher risk of HIV/AIDS. Plans from NACO state that NGOs are critical to stopping the HIV/AIDS epidemic. They are vital in the struggle against discrimination and stigma towards HIV/AIDS sufferers. The conventional method of persuading non-governmental organizations to endorse government programs has only been applied to non-health related fields. Consequently, well-established NGOs have stayed away from HIV/AIDS-related work.[102]

First, the condom promotion program was part of the state's Family Welfare Program. Furthermore, the condom promotion program is now overseen by the State AIDS Control Society via the District Health Offices, Municipal Corporations, and Civil Hospitals. This importance has been considered in the preparation of the condom distribution plan. The Family Welfare Program has made condom distribution free of charge in accordance with this plan. By the end of March 2004, 2,71,32,968 condoms had been distributed by the Family Planning, AIDS, and STD Control Program; during 2003–2004, a social marketing campaign distributed 36,000 condoms.[103]

The continuous and significant transition from a traditional, rural, and relatively stable social structure to a contemporary, competitive, and unstable urban environment must be considered in any HIV/AIDS prevention and control strategy. Globalization's effects on customary cultural practices and value systems have brought about advantages as well as annoyances.[104]

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[102] www.macrothink.org/journal/index.php/jpag/article/view/2732
[103] www.catholicrelief.org/hiv-aids/partners.cfm
[104] www.hivcode.org

Cultures aren't always the same. One constant feature is diversity. Culture is also never a frozen, fossilized, or monolithic system. On the other hand, culture is a dynamic product of evolution. It has internal dynamics that are part of its nature. At the same time, each culture appropriates aspects of the other. They appropriate ideas, viewpoints, and actions, whether they are traditional, contemporary, or concrete. A society or a specific population is constantly undergoing a wide range of external socio-economic transformation processes, which they participate in and are impacted by. Therefore, culture helps to revive, preserve, reinterpret, modify, and recreate traditions and ethos. These evolutionary variations, multiple dimensions, and modern cultural adaptations must be considered in the design, implementation, and evaluation of HIV/AIDS prevention and care strategies.[105]

For this reason, comprehensive, varied, cross-disciplinary, trans-institutional, and inter-sectoral strategies and policies for HIV/AIDS prevention and care are required. In conclusion, the following factors need to be considered in cultural approaches:

It is vital to respond to the epidemic with efficacious measures. The overarching goals of SANKALP's action plans are as follows: a. identify the relationships between the epidemic and its social surroundings; b. view social and cultural elements as both assets and obstacles in the process of development; and c. acknowledge the significance of considering a society's overall structure in addition to its cultural characteristics in general. d. guaranteeing the widespread mobilization of families, individuals, communities, and governmental and non-governmental organizations; e. increasing public awareness of the need for behavior modification; The main target groups for the organization's HIV/AIDS control and prevention programs are risk groups such as displaced individuals, commercial sex workers, people in mobile professions, segregated groups, homosexuals, and dysfunctional families.[106]

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[105] www.chinaperspectives.revues.org/498

[106] http://aids.gov/federal-resources/around-the-world/global-hiv-aids-organization

While some NGOs have concentrated on empowering individuals, especially through counseling, it's possible that they are unable to lessen the psychosocial problems and social stigma associated with HIV/AIDS. For example, the AIDS Information Centre (AIC) does not increase people's power through social capital initiatives, despite being the best organization for offering voluntary, high-quality HIV/AIDS counseling and testing. Thus, while AIC prioritizes disseminating broad information regarding HIV/AIDS, JSS prioritizes disseminating detailed information about the illness.[107]

However, it shouldn't be seen as an indication of AIC's shortcomings. Rather, it ought to be regarded in the context of the reality that each organization has a goal that it works toward. At AIC, we provide excellent voluntary HIV counseling and testing with the guiding principle of protecting clients' HIV/AIDS status. Therefore, we are speculating that these organizations might not be able to successfully mobilize the social capital needed to lessen the effects of HIV/AIDS.[108]

It will take more effort to effectively fight HIV/AIDS. Government grassroots programs, for example, are supposed to exist, but they have only existed on paper. Officials from the district directorate of health services claim that there isn't a response from the local level of government. These officials made the point that a significant percentage of local responses are handled by NGOs. NGOs are more effective than the government, despite their smaller size, according to a government official.[109]

4.2.15 NGOs, Solidarity and HIV/AIDS challenges

Social exclusion, stigmatization, self-denial, and self-exclusion brought on by HIV/AIDS had a divisive impact right away. These were the first difficulties that HIV/AIDS patients had to deal with. Paradoxically, these difficulties have come to define the PLWHA identity. The way society saw them—including discrimination and

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[107] http://www.humanrights.is/the-human-rights-project/humanrightscasesandmaterials/humanrightsconceptsideasandfora/theconceptsofhumanrightsanintroduction/definitionsandclassifications/(concept)

[108] http://www.humanrights.com/what-are-human-rights/brief-history/cyrus-cylinder.html

[109] http://www2.ohchr.org/english/issues/hiv/introhiv.htm

stigma—inspired these people to form solidarity groups and band together. Some of these organizations—some of which have grown to be fairly large—address a variety of HIV/AIDS-related issues, including care, support, counseling, sensitization, advocacy, and resource mobilization. These have continued to be the main pillars of the anti-HIV/AIDS movement since the late 1980s. People living with HIV/AIDS can now exchange experiences, contribute to development, and obtain information and resources (material and financial) through these vital channels.[110]

4.2.16 Institutional Competences of NGOs

NGOs possess the institutional expertise necessary to mitigate the effects of HIV/AIDS. We enumerate the competencies that NGOs possess in this section. One of the following skills is the capacity to create an identity in order to fight for a common cause: a. creating capacity; b. managing participatorily; c. creating policies; d. mobilizing resources;[111] The NGOs have partnered with one another and established mutually beneficial relationships with the government as a result of their connections. Consequently, there has been an improvement in the coordination of activities and programs, as well as between AIDS-affected individuals and NGO personnel. Two instances of organizational collaboration are the introduction of collaborative HIV/AIDS programs and the previously mentioned referral system. To assist in the execution of its programs, one organization may hire another in this regard. For example, Population Service International (PSI), a commercial services company, hired the TASO drama group in 2003 to notify the public on its behalf. There is no such group at PSI.[112]

4.2.17 Role of Government in Protection of HIV/AIDS

The Government of India (2009) estimates that 2.40 million Indians (1.93-3.04 million) are HIV positive, with an adult prevalence of 0.31%. 3.5% of individuals under the age of 15 and 83% of those between the ages of 15 and 49 are afflicted by

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[110] http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07
[111] http://www.equalpartners.info/Chapter2/ch2_1How.html
[112] http://csis.org/files/media/csis/pubs/071120-india-hivaids-public-health-strategy.pdf

infections. 39% (930,000) of HIV infections are in women. Mostly in the industrialized south and west as well as the northeast, a small number of states contain the majority of India's incredibly diverse epidemic. The country's HIV infections are concentrated in the 55%. 55% of all HIV infections in India are found in the four high prevalence states of South India: Andhra Pradesh (500,000 cases), Maharashtra (420,000 cases), Karnataka (250 000 cases), and Tamil Nadu (150 000 cases). With an estimated 100,000 or more PLHA each, West Bengal, Gujarat, Bihar, and Uttar Pradesh collectively account for 22% of HIV infections in India.

The HIV epidemic primarily affects populations at risk for the virus in India. The use of tainted injecting equipment for drug injection and unprotected sex between prostitutes and their clients are the primary causes of the concentrated epidemics. HIV prevalence rates are high and continue to be high in many of the most vulnerable populations. The main way that HIV is spread in India, according to the National AIDS Control Organization (NACO), is through unprotected heterosexual sex. The maturing of the epidemic has resulted in a greater proportion of HIV-positive individuals being women, particularly in rural areas. The population appears to have been protected thus far by the low prevalence of concurrent sexual relationships with multiple partners in the larger community. Even with relatively small increases in the rate of HIV infection, there are still a lot of new infections in a country with a population of over a billion people, even though overall prevalence is still low.[113]

4.2.18 Risk Factors

Many factors put India at risk of rapid HIV spread if effective prevention and control measures are not expanded nationwide. These danger factors include the following: The main causes of reported HIV cases in India are unsafe sex and low condom use. HIV prevalence is high among sex workers (male and female) and their

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[113] B. Ramesh, "Sex Work Typology and Risk for HIV in FSWs in Karnataka", paper presented at the XXI International AIDS Conference, Toronto, August 13- 18, 2006, http://www/aids2006.org/PAG/Abstracts.aspx?AID=9062

clients. In 87.4% of cases, sexual transmission is the cause as well. The majority of HIV-positive women seem to have gotten the virus from a regular partner who had paid sex and was exposed to it. Overall, there is a growing push in India to prevent HIV among sex workers. But the nature of sex work is complex, and the application of outdated laws frequently makes it more difficult to prevent and treat HIV. Despite recent data suggesting an increase, condom use is still limited in many places, particularly where business encounters take place in 'risky' areas where police tolerance for this activity is low. Furthermore, the minority of sex workers who work in brothels is often the focus of interventions. Particularly among those who work in the streets, sex workers are not well-informed about HIV. Certain preventive initiatives, for example, sponsored by sex workers' cooperatives in Sonagachi, Kolkata, have been associated with a decreased HIV prevalence by encouraging safe, paid sex practices (Kumar, 1998; Jana et al., 1998). According to recent HSS 2010–11 data, the three states with the highest HIV prevalence among FSWs are Karnataka (5.35%), Maharashtra (7%) and Mizoram (27%).[114]

Infection rates among expectant mothers and their babies have been rising in some states as the epidemic spreads through demographic groups that are bridging one another. Like in many other countries, women's low status and unequal power relations—which show up as limited access to human, financial, and economic resources—weaken women's ability to defend themselves and negotiate safer sex both inside and outside of marriage. Their susceptibility is heightened by this. Considerable Stigma: The stigma associated with being HIV positive is very strong. Preexisting discrimination is strengthened and supported by the myth that AIDS exclusively affects women who have sex with men, sex workers, and drug injectors.[115]

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[114] Rajesh Kumar, "Trends in HIV-1 Young Adults in South India from 2000 to 2004: A Prevalence Study, "The Lancet 367 (2006), pp. 1164-72, http://www.thelancet.com/journals/lancet/article/PIIS0140673606684353/fulltext

[115] Pramit Mitra, "AIDS Threatens India's Prosperity," http://yaleglobal.yale.edu/display.article?Id=8486

The second phase of the NACP concluded in March 2006, having started in 1999. During this phase, India continued to expand the program at the state level. Preventive interventions for the general public, targeted interventions for the populations most at risk, and the involvement of non-governmental organizations and other sectors and line departments, such as education, transportation, and law enforcement, were given more weight. Capacity and accountability at the state level continue to be major issues that require constant assistance. In order to reach a greater proportion of the population, interventions must be expanded and monitoring and evaluation must be improved.[116]

4.2.19 Numerous NGOs and CBOs

India is home to a considerable number of NGOs and CBOs that are involved in HIV/AIDS issues at the local, state, and federal levels. Projects include direct care for HIV-positive people, general awareness campaigns, targeted interventions with key populations, and care for children left orphaned by AIDS. Non-governmental and community-based organizations receive funding from a variety of sources, including the Indian federal and state governments, international donors, and local contributions. Furthermore, several Community-Based Organizations (CBOs) have experimented with innovative approaches to address the stigma and discrimination that hinder the most vulnerable populations from receiving efficient HIV prevention, treatment, and care services. Many sources provide India with funding and technical support. India receives financial and technical support from several bilateral donors and UN partners. NACO has partnered with DFID and the World Bank to finance NACP3. A few examples include the Clinton Health Access Initiative, UNAIDS, UNFPA, UNICEF, UNDP, and WHO; other organizations include the USG (USAID, CDC, and PEPFAR); the Bill and Melinda Gates Foundation's Avahan program; and DFID.[117]

In 1992, the World Bank provided a credit of 84 million dollars to establish the first National AIDS Control Project, marking an increase in collaboration between the

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[116] http://Tnhealth.org.tsngo.html

[117] http://Maha-arogya.gov.in/programs/nhp/aids/ngo.html

World Bank and the Indian government on programs aimed at combating infectious diseases since 1991. The project helped the government establish the institutions and procedures needed to halt the spread of HIV, as well as to expand prevention initiatives. In order to expand on the knowledge acquired from the first project, India approached the World Bank for funding for a follow-up project. The World Bank provided US$191 million to launch the Second National HIV/AIDS Control Project.[118]

Nonetheless, the state needs to realize that by carrying out its regular operations, it frequently directly influences the level of susceptibility to H1V infection, either rising or falling. For example, if the state is unable to sufficiently provide services like housing, electricity, water, and sanitation, it is not meeting its responsibility to provide the resources required to enable people to make "safe sexual choices."

The primary goal of the first National AIDS Control Programme (NACP), which ran from 1992 to 1999, was to monitor HIV infection rates among populations in certain urban areas that were considered at risk. During the second phase, which ran from 1999 to 2006, the original program was expanded at the state level with an emphasis on targeted interventions for high-risk groups and preventive interventions for the general public. The Prime Minister oversaw the National Council on AIDS, which was comprised of 31 ministries at this time. HIV/AIDS was acknowledged as a health concern as well as a development issue, leading to its mainstreaming into all ministries and departments. In order to reverse the epidemic, the third stage greatly expanded targeted interventions and included programs for care, treatment, and support. By the end of 2008, approximately 932,000 of the most vulnerable individuals—that is, 52% of the target groups—had gotten targeted interventions (49% of FSWs, 65% of IDUs, and 66% of MSM). India created a "National HIV and AIDS Policy and the World of Work" in 2009 to stop discrimination against employees based on their real or perceived HIV status. This policy encourages all public, private, formal, and informal businesses to create workplace policies and programs that are grounded in the values of non-

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[118] http://sankalp.org/hivaids

discrimination, gender equity, a healthy work environment, abstaining from screening applicants for jobs, confidentiality, prevention, care, and support.[119]

States in India also differ in their capacities to contain the pandemic. The southern states have the best health infrastructure, the highest levels of political awareness, and a seemingly greater willingness to fight the AIDS pandemic. The greatest level of HIV prevention efforts has been in southern India. However, certain northern states have notoriously subpar healthcare and governance systems. The most recent survey estimates that the prevalence is high in these 29 districts, some of which are in the states of West Bengal, Orissa, Rajasthan, and Bihar. They haven't gotten as much attention as those who do since they don't live in "high-prevalence states." Given that Bihar's high-prevalence districts are close to Nepal's infamously porous border, there's a chance the epidemic there will spread more quickly.[120]

The National Policy on HIV/AIDS and the World of Work was created by the Ministry of Labor & Employment and presented to the Standing Labor Committee during its 43rd session. The policy was developed by the Ministry of Labor and Employment following consultations with social partners, the National Aids Control Organization, and the International Labor Organization. Additional policies, guidelines, and groups providing protection to HIV/AIDS patients include:

- Daman, Diu Public Health Act, 1985 Goa, Amended in 1986
- Indian Penal Code, 1860
- Drugs and Cosmetic Act, 1940
- Juvenile Justice (Care and Protection of Children) Act, 2000 and 2006.
- Maharashtra Protection of Commercial Sex Workers, Bill, 1994. Antiviral Therapy Guidelines for HIV infected Adults and Adolescents including Post-exposure.

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[119] Vrajlal K., Sapovadia, “Controlling HIV/AIDS - A Judicial Measure, Recommen- dations by Supreme Court of India.”

[120] http://www.unicef.org/india/hivaids.html

- Condom Promotion by SACS - Operational Guidelines
- Data Sharing Guidelines
- Guidelines for HIV Care and Treatment in Infants and Children, Nov 2006
- Guidelines for HIV Testing, March 2007
- Guidelines for Network of Indian Institutions for HIV/AIDS Research (NIHAR)[121]

4.2.20 Role of Lawmakers in Battling the HIV/AIDS Epidemic

The scope of the Human Immunodeficiency Virus (HIV) pandemic has exceeded all expectations since the virus was discovered 24 years ago. Twenty-five million of the estimated 40 million HIV-positive individuals worldwide have already died. HIV/AIDS, more than any other health issue, is a primary cause of a country's development to stall since it affects people in the prime of their working lives and places an undue financial strain on the economy. Exactly half of the twenty countries (Bahamas, Belize, Botswana, Cameroon, Kenya, Lesotho, South Africa, Swaziland, Tanzania, and Zambia) that have suffered development reversals since 1990 are Commonwealth countries, according to the United Nations Development Programme's (UNDP) 2004 Human Development Report. Given this, the Commonwealth Parliamentary Association convened in New Delhi, India, to set up an experienced Commonwealth Parliamentarian Study Group.[122]

4.2.21 Specific Sessions Encompassed

v The responsibility and role of parliamentarians was explained by India's Minister of State for Statistics and Programme Implementation, Shri Oscar Fernandes, MP, who also provided a brief overview of the extent of the HIV epidemic in India. In order to reduce stigma and discrimination and to promote resource sharing among Commonwealth nations, he underlined the significance of open communication among legislators.

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[121] http://en.wikipedia.org/wiki/joint_united_nations_programme_on_HIV/AIDS

[122] http://c.ymcdn.com/sites/www/istr.org/resource/resmgr/working

v worldwide response to HIV/AIDS An overview of India's HIV response was given in this presentation by Mr. Anand Tiwari, Advocacy Advisor and Officer-in-Charge, UNAIDS, with an emphasis on the nation's current HIV infection rates and noted trends of spread.

v The effects of HIV/AIDS on women and children Ms. Vandana Mahajan of UNIFEM gave a presentation on issues of poverty, reproductive rights, and violence against women, specifically in the Indian subcontinent. It was also discussed how gender equality should be prioritized, with an emphasis on electing more women to Congress.

v The economic toll that HIV/AIDS has taken I discussed this via video conference with Mr. Shan-tayanan Devarajan, the Chief Economist for the South Asia Region at the World Bank. Myths and realities were emphasized. He stressed the effects of HIV on GDP growth as well as other ramifications, especially the costs to the economy and the urgency of taking prompt, decisive action to lower these costs.[123]

4.2.22 What ought lawmakers to do?

Ensure that they are informed about HIV/AIDS, act as advocates for those who are impacted by the disease, and have an accepting attitude toward managing it. You can speak out against stigmatization, social taboos, and discrimination by bringing HIV/AIDS to light and busting myths and misconceptions about the condition. v Take care of the poverty issues that are closely related to HIV/AIDS. v Openly demonstrate their political resolve and commitment to eradicating HIV/AIDS. Encourage legislators and other interested parties to join and support national HIV/AIDS organizations. [124]

4.2.23 What ought to lawmakers do?

Encourage the dissemination of HIV/AIDS education to schoolchildren, members of Congress, constituents, and communities, particularly by ensuring that HIV education is included in the national curriculum. v Establish a permanent or select committee on HIV/AIDS and require the group to submit a report at least once a year.

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[123] http://c.ymcdn.com/sites/www.istr.org/resource/resmgr/working_papers_toronto/jamil.ishtiaq.pdf
[124] www.cpqhg.org

Make certain that governments implement a multisectoral strategy to counteract the negative effects on the sustainability of social and economic development. Execute the mobilization of resources. Talk about gender-related issues such as the role of men and boys, women's empowerment, human trafficking and exploitation, and gender-based violence.[125]

4.2.24 NAPCP stands for National Aids Prevention and Control Policy

For fifteen years, India has been experiencing an AIDS (Acquired Immunodeficiency Syndrome/Human Immunodeficiency Virus) epidemic. It has swiftly grown to rank among the country's most important public health concerns. Injecting drug users in the northeastern State of Manipur and commercial sex workers in Mumbai and Chennai were identified as the initial cases of HIV/AIDS. Since then, the disease has rapidly spread in the areas surrounding these epicenters; by 1996, AIDS cases in the country had been reported from Maharashtra, Tamil Nadu, and Manipur combined, accounting for 77% of cases, with Maharashtra reporting close to half of all cases. Though the officially reported cases of HIV infections and full-blown AIDS cases are only in the thousands, it was found that there is a significant discrepancy between the reported and estimated figures due to the lack of epidemiological data in many regions of the country. The most recent estimate puts the number of adults in the country who had HIV/AIDS in 2000 at 3.8 million. Still, compared to many other Asian countries, the country's overall prevalence is relatively low.[126]

4.2.25 Program Administration

Traditionally, the Ministry of Health and Family Welfare has been in charge of managing public health matters, such as the AIDS control initiative. Because of the disease's behavioral nature and major socioeconomic ramifications, it must be treated as a developmental issue that impacts many economic and social sectors of governmental and non-governmental activity. The involvement of Ministries such as Railways, Surface Transport, Heavy Industry, Steel, Coal, Youth Affairs & Sports, and other

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[125] http://www.who.int/hiv/pub/idu/targetsetting/en/index.html

[126] http://www.naco.nic.in

public sector organizations with sizable workforces is necessary because the disease is more likely to affect the economically productive segments of the population. The organized and unorganized sectors of the industry must come together to ensure the well-being of their workforce's productive segments. Ministries such as Social Justice & Empowerment, Women and Child Welfare, Human Resource Development, etc. should design and oversee the HIV/AIDS control programs within their respective sectoral jurisdictions. These Ministries should provide strong financial and administrative support for these sectoral initiatives.[127]

4.2.26 Advocacy and Social Mobilization

In India, almost everyone uses print and electronic media to disseminate information. The remarkable rise in public awareness of HIV/AIDS can be partially attributed to the electronic media, which has disseminated this message all the way down to the village level. While the disease is generally understood, many people are still in the dark about certain aspects, such as the mode of transmission and ways to avoid infection, for example. Thus, there is a pressing need to create programs that prioritize interpersonal communication and are suitable for target groups such as women, migrant workers, children, students, and youth. The electronic media should create a well-coordinated media strategy in order to effectively disseminate information on all aspects of HIV/AIDS, including the promotion of positive cultural and social values like love, warmth, and affection within the family. Print media such as newspapers and magazines should be used for social mobilization efforts and information exchange in order to increase public awareness of prevention.[128]

4.2.27 Use of Condoms as a HIV/AIDS Prevention Measure

Condoms were previously marketed by the Family Welfare Program as a safe approach to population control. Since condom use is the only method of preventing HIV/AIDS through sexual contact, aside from complete abstinence, it has taken on special significance in the context of AIDS. The government feels that condom use

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[127] www.hsph.harvard.edu/population

[128] www.isec.ac.in/prc_abs17.pdf

should be encouraged for all sexually active individuals, especially those who participate in high-risk behavior, without regard to moral, ethical, or religious constraints. By means of social media marketing and a community-based distribution network, the government has established condom use as an intentional policy. The social marketing approach has led to a rise in the country's overall condom usage. Making sure condoms are accessible when and where they are needed is more crucial than ever. Hospitals, STD clinics, counseling services, assisted living facilities, and even private medical clinics ought to keep an adequate supply of condoms on hand for the benefit of their patients. Condoms should be easily available for use by sexually active individuals in public spaces, five-star hotels, major road and railroad intersections, neighborhood drug stores, etc. This will support the small family norm while also helping to achieve the dual goals of HIV prevention and control.[129]

4.2.28 Counseling

Counseling services for people with HIV/AIDS (PLWHAs) and suspected cases of HIV infection should be expanded in order to reach more people who need them. All hospitals, HIV testing centers, blood banks, STD clinics, and organizations started by PLWHAs should have counseling services manned by certified and trained counselors. The government has given these centers all the support they need to establish the infrastructure needed for them and to hire a large number of counselors to staff them. Offering PLWHAs the required monetary and non-monetary incentives will promote group counseling, which has been shown to be highly successful.[130]

4.2.29 Care and Support for People Living With HIV/AIDS (PLWHAs)

The number of HIV-positive individuals in society will rise dramatically as the disease spreads across the country; these individuals may come from a variety of social and economic backgrounds. In addition to providing counseling before disclosing their

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[129] http://www.hivlawandpolicy.org/resources/toolkit-scaling-hiv-related-legal-services-idlo-unaids-undp-2009

[130] http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/hivtoolkit.aspx

http://www.idlo.int/Publications/HIVtoolkit.pdf

HIV status, the government would seek to ensure these individuals' social and economic well-being by ensuring that (a) their right to privacy and other human rights were respected and (b) they received the necessary care and support in hospitals and the community. HIV-positive individuals ought to have equal access to the workforce and educational opportunities as the general public. HIV status should be kept secret and should not interfere with an individual's ability to get a job, keep a job, get married, or exercise other basic rights.[131]

4.2.30 Surveillance

Developing an appropriate surveillance system to assess the extent of HIV infections in the community is essential for selecting the most effective strategy for HIV/AIDS/STD prevention and management. The monitoring system is made up of:

v HIV Sentinel Surveillance: To track the trends of the epidemic, the government would enhance and broaden the current surveillance system's data collection on HIV infections in high-risk and low-risk populations in rural and urban areas.

v To determine the incidence of AIDS cases in the country, data will be collected from all hospitals with physicians who have received training and from a standard definition of an AIDS case in the Indian context. v STDs Surveillance: The institutional surveillance system of the National Venereal Disease Control Programme was put in place in the early 1950s, but it remained incomplete and patchy.

v Behavioral Sentinel Surveillance: The program will first employ behavioral sentinel surveillance on a pilot basis, and it will then be expanded as needed. Its goal is to evaluate how different risk groups within the population's behavior patterns are changing.[132]

4.2.31 Components of legal services

Social workers at the Legal Aid Clinics provide clients with basic legal information and referrals; they also serve as their first point of contact. The social

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[131] http://www.who.int/hiv/pub/surveillance/en/

[132] http://www.hrln.org/hrln/hiv-aids.html

worker might advise the client to make an appointment with the lawyer from the Legal Aid Clinic, law enforcement, or other legal aid providers. Legal advice: The lawyers provide legal advice, highlighting possible means of settling conflicts outside of court, such as Lok Adalat and alternative dispute resolution. Legal representation: Should it be required; the legal aid clinic will provide clients with ongoing support to settle conflicts through participation in ADR or Lok Adalat processes. Legal aid clinics usually suggest alternative dispute resolution (ADR) over formal court procedures. This not only saves money and time, but it also encourages confidentiality.[133]

4.2.32 Conclusion

NGOs are dependent on public donations, government support, and grants. However, relying on the government too much is not a good thing. NGOs will not lack donations from the public if they are known for their integrity, openness, and results-driven work cultures, as well as if they operate with a humane mindset. They must answer to society and be prepared for social audits at all times. However, the realization of human rights is the welfare state's ultimate objective. It is crucial that the government's governance and methods be in line with human rights, that the bureaucratic structure's actual work culture be in line with human rights, and that officials, officers, and employees carry out their duties in a humane manner. In a democratic country, the people's leaders have a unique role to play in accomplishing the welfare state's objectives. They have the obligation to lead the bureaucratic apparatus in accordance with the welfare state's objectives, manage to give the populace sufficient information, and exhibit a positive outlook.

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[133] http://www.who.int/hiv/topics/vct/toolkit/components/policy/introduction/en/index4.html

REFERENCES

1. Agrawal, H. K. et al. 1999. Knowledge and attitude on HIV/AIDS for senior secondary school pupils and trainee teachers in Udupi District, Karnataka, India, Ann Trop Paediatr. 1999 Jun; 19(2): 143-149.
2. Babbie & Mouton. 2001. HIV/AIDS in India; The UCSF Country AIDS Policy analysis Project. AIDS research Policy Centre, University of Californians San Francisco, http://ari.Vcsf.edu/Policy/Policy.htmlaccessed on 26-09-1012.
3. Bailey, A. and Hutter, I. 2006. "Cultural Heuristics in Risk Assessment of HIV/AIDS", Culture, Health & Sexuality,8 (5): 465-477.
4. Balk, D. et al. 1997, "Awareness and Knowledge of AIDS among Indian Woman: evidence from 13 states". 33: Health Transit Rev. 1997; 7 Suppl: 421-65. Honolulu.
5. Bakari, J. P. et al. 2000. "Rapid Voluntary Testing and Counseling for HIV, Acceptability and Feasibility in Zambian Antenatal Care Clinics", http://onlinelibrary.wiley.com/doi/10.1111/j.1749-6632.2000.tb05475.x/pdfaccessed on 26-09-1012.
6. Betteridge, Glenn. 2004. "Prisoners' Health and Human Rights in the HIV/AIDS Epidemic", HIV/AIDS Policy and Law Review, 9(3): 96-99.
7. Bronfman, M. et al. 2002. "HIV Prevention among Truck Drivers on Mexico's Southern Border", Culture, Health & Sexuality. 4 (4): 475-488.
8. Cameron, E. Miriam. 1993. Living with HIV/AIDS, New Delhi: Sage Publications.
9. Carelse, M. 1994. AIDS Prevention and High Risk Behaviour in Juvenile Correctional Institutions. Bellville: University of Western Cape.
10. Chowhury, Shankar. 1995. The AIDS Handbook, Bombay: Popular Prakashan.
11. Cohen, Jon. (2004, April). HIV/AIDS: "India's Many Epidemics", Science, New series 304 (5670): 504-509.
12. Earthtimes. 2007. NACO Bows to Activists' Pressure on AIDS Treatment in India, Says AHF, 22 November.
13. Esprza, Jose. 2001. "An HIV vaccine: how and when". Bulletin of the World Health Organization, 79(12): 1133.

14. Fact sheet. 2012. "National AIDS Control Organization. India resolves to defeat HIV/AIDS", New Delhi: Ministry of Health and Family welfare Government of India.
15. Glasser, G. B. & Strauss, A. 1964. "Awareness Contexts and Social Interaction", American Sociological Review, 29(5): 669-679.
16. Gosh, Health for million, "HIV/AIDS in south Asia", Feb-March- 2003, PN 4-9.
17. GSACS. 2010. Quaterly Bulletin. April to June- 2010.
18. GSACS. 2015. Annual Report 2013-14.
19. Health Vision and Research. 2005a. KABP study among injecting drug users. Kolkata: Society for Community Intervention and Research.
20. Health Vision and Research. 2005b. KABP report: PLWHA intervention. Kolkata: Society for Community Intervention and Research.
21. Iyengar, Sudarshan, Kumar, B. L. and Mistry, Ramkrishna. 2003. District-wise Mapping of Populations Vulnerable to HIV/AIDS in Gujarat State. Gujarat Institute of Development Research (Gota), Ahmedabad, Volume 1&2, 25th December 2003.
22. Joint United Nations Programme on HIV/AIDS. 1998. Expanding the global response to HIV/AIDS through focused action: Reducing risk and vulnerability: Definations, rationale and pathways. Geneva, Switzerland: Author.
23. Kuhn, et al. 1994. Literature review: Challenging HIV-related Stigma and Discrimination in Southeast Asia: Past successes and future priorities. The Population Council Inc.
24. Kumar R., Jha P. et al. 2006. "Trends in HIV in young adults in south India from 2000 to 2004: a prevalence study", The Lancet, 367: 1164-1172.
25. NACO. 1999. Specialists Training and Reference Module, Nov. 1999.
26. NACO. 2001. "National Baseline High Risk and Bridge Population Behavioural Surveillance Survey", In A. P. K.S. Jams, Population, Gender and Health in India. New Delhi: Academic Foundation.
27. NACO. 2006. HIV/AIDS in India: An update. Delhi: Ministry of Health and Family Welfare, Government of India.

28. NACO. 2006. National AIDS Control Programme Phase III (2006-2011): Ministry of health & Family Welfare. Government of India retrieved on March 12th 2010 from http://www.nacoonline.org accessed on 5-09-2009.
29. NACO. 2006. UNGASS India report: progress report on the declaration of commitment on HIV/AIDS.
30. NACO. (April 2006). HIV/AIDS epidemiological Surveillance and Estimation report for the year 2005.
31. NACO. 2007. Annual HIV Sentinel Surveillance Country Report 2006.
32. NACO. 2007. Guidelines on HIV Testing. National AIDS Control Organization.
33. NACO. 2007. HIV Sentinel Surveillance and HIV Estimation in India 2007. A Technical Brief Ministry Of Health and Family Welfare Government of India.
34. NACO. 2007. HIV/AIDS surveillance in India UNAIDS 2007 report on the global AIDS epidemic.
35. NACO. 2007. Operational Guidelines of Integrated Counseling and Testing Ceentres,http://nacoonline.org/upload/Policies%20&%20Guidelines/20,%20Operational%20Guidelines%20for%20Integrated%20Counseling%20and%20Testing%20Centres.pdf accessed on 22-09-2012.
36. NACO website, 'About NACO, National AIDS Control Programme Phase 1 (1992-1999)', accessed on 04-07-2012.
37. NACO. 2005. Annual Report 2002-2004.
38. NACO. 2008. HIV sentinel surveillance round 2008: National action plan September 2008 – June 2009. Delhi: Ministry of Health and Family Welfare, Government of India.
39. NACO. 2009. Annual Report (2008-09). New Delhi: Department of AIDS Control, Ministry of Health and Family Welfare, Government of India.
40. NACO. 2010. Annual report 2009-10: Ministry of Health & family Welfare. Government of India.
41. NACO. 2010. ‘Red ribbon express’: National AIDS control programme, phase III, India.

42. NACO. 2011. Refresher Training Programme for ICTC Counsellors, Second Edition, Trainee's Handouts.
43. NACO, 2012. Annual Report 2010-11.
44. Narain, P. J. (Ed.). 2004. AIDS In ASIA The Challenge Ahead. New Delhi: Sage Publication.
45. Nath, Anita. (2009, March). "HIV/AIDS and Indian Youth A review of the literature (1980- 2008)", Journal of Social Aspects of HIV/AIDS, 6(1): 2-8.
46. National Family Health Survey (NFHS-3) 2005-06, September 2007.
47. National Intelligence Council. 2002. The Next wave of HIV/AIDS: National Service Scheme, AIDS education for students youth, NSS: 2nd Revised edition, New Delhi, 1994.
48. National Science Foundation. 1991. "Attitudes towards Science and Technology", In Science and Engineering Indicators, 1991: 166-191. Washington, DC: Government Printing Office.
49. Nayar, M., Bhatnagar, N., & Arora, S. 2007. "Adolescents' knowledge and awareness about issues related to sexuality and HIV/AIDS", The Indian Journal of Industrial Relations, 43 (1): 69-86.
50. Pavri, K. M. 1992. Challenge of AIDS. New Delhi: National Book Trust.
51. Rama, Sridhar. 2011. Awareness Of HIV/AIDS among the Mathadi Workers and Truck Drivers in Mumbai: A Comparative Study, A Thesis Submitted for the Degree Of Doctor Of Philosophy in Sociology, Department Of P.G.S.R, S.N.D.T Women's University, Mumbai, December 2011.
52. UNAIDS. 1997. Prisons and AIDS: UNAIDS technical update, Geneva, Switzerland: Author.
53. UNAIDS. 2000. Consultation on STD interventions for preventing HIV: What is the evidence? Geneva, Switzerland: Author, http://www.unaids.orgaccessed on 12-09-2012.
54. UNAIDS. 2001. Population Mobility and AIDS: UNAIDS Technical Update, UNAIDS, Geneva Switzerland, http://www.unaids.orgaccessed on 12-09-2012.

55. UNAIDS. 2008. Report on the global AIDS epidemic, August 2008, Geneva Switzerland, http://www.unaids.orgaccessed on 12-09-2012.
56. United Nations Development Programme. 2004. HIV and Development Programme. Mapping made easy. A guide to understanding and responding to HIV vulnerability. UNDP. Bangkok.
57. UNGASS. 2010. India Country Progress report, March 31st 2010, http://wwwunaids.org accessed on 12-09-2012.
58. United Nations Development Programme. 2000. Population Mobility and HIV Vulnerability in South east Asia: An Assessment and Analysis by Skeldon Ronald. UNDP, http://www.unaids.orgaccessed on 16-12-2012.
59. WHO Global Programme on AIDS. "Recommendations for the Selection and use of HIV Antibody Tests", Weekly Epidemiological Record No. 20, 1992, Pp. 145-149.
60. World Health Organization. 2006. HIV/AIDS prevention, care, treatment and support in prison setting - A framework for an effective national response. Geneva: World Health Organization, Joint United Nations Programme on HIV/AIDS, United Nations Office on Drugs and Crime.
61. World Health Organization. 2007. Effectiveness of interventions to address HIV in prisons. Geneva: World Health Organization, Joint United Nations Programme on HIV/AIDS, United Nations Office on Drugs and Crime.
62. World Health Organization & Population Council. 2009. "HIV Testing, Treatment and Prevention Generic Tools for Operational Research" WHO, http://www.popcouncil.org/horizons/ortoolkit/aidsquest accessed on 20-09-2012.
63. Gujarati:
64. Aadhar, SangathitPrayasonaMadhyamathi Vikas TarafaniKooch (Activities story of year 2004 to 2010). Mithakhali Six Road, Ahmedabad, Gujarat.
65. AagalaavoJanakari Lo: HIV/AIDS Atakavo, Information Booklet, Year 2009-10, Gujarat State AIDS Control Society, Meghaninagar, Ahmedabad.
66. Aao Apane Pan NiyamitRakt Dan KarieJindagioBachavavamaSahabhagiBanie, Information booklet, 2010-11, Gujarat AIDS Control Society, Meghaninagar, Ahmedabad.

67. AIDS aneJatiya Rog, Information booklet, Year 2010-11, Ahmedabad Municipal Corporation AIDS Control Society, Navarangpura, Ahmedabad.
68. AIDS Kevi Rite FelatoNathi, Information booklet, Year 2009-10, Ahmedabad Municipal Corporation AIDS Control Society, Navarangpura, Ahmedabad.
69. AIDS ne Samajie- AIDS ne Atakavie, Year 2009-10, Information Booklet. Samaj-karya Trust, Ahmedabad, Gujarat.
70. AIDS Pratikar, "AIDS Awareness Communication Letter of Samaj Karya Trust" December 2005. Satellite Road, Ahmedabad, Gujarat.
71. AIDS Pratikar, "AIDS Awareness Communication Letter of Samaj Karya Trust", Volume 2, December 2006. Satellite Road, Ahmedabad, Gujarat.
72. AIDS thiLadishuJarur. Information booklet, 2009-10, National AIDS Control Society, Vira Desai Marg, Mumbai (West), India.
73. JatiyaRogo ne Olakho. Information booklet, Year 2009-10. Gujarat AIDS Control Society, Meghaninagar, Ahmedabad.
74. Mane HIV/AIDS Vishe Satya HakikatJanavo, Information booklet, Year 2010-11, Gujarat AIDS Control Society, Meghaninagar, Ahmedabad.
75. Mamata (Arogya Karyakaro Mate HIV/AIDS AngeniMahiti). Information booklet, Year 2011-12, Gujarat AIDS Control Society, Meghaninagar, Ahmedabad.
76. Shu Tame JanoChhokeKshay-Rog ane HIV/AIDS Sathe Loko Jive Chhe. Information Booklet, Year 2009-10, Ahmedabad Municipal Corporation AIDS Control Society, Navarangpura, Ahmedabad.
77. Ujaas: Rajyama HIV/AIDS naAgyanata Rupi Andhakarane Door Karie. Information booklet for counselors, nurses, Para-medical staff under NACP, Year 2011-12, Gujarat AIDS Control Society, Meghaninagar, Ahmedabad.
78. YuvaMahiti Kendra. Information booklet, Year 2010-11, collaboration by UNICEF, Gujarat AIDS Control Society, Meghaninagar, Ahmedabad.
79. 40 Taka Kissaoma HIV no ChepYuvavasthama Lage Chhe. Information booklet, 2009-10, Gujarat AIDS Control Society, Meghaninagar, Ahmedabad.

Websites

(1) http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-india

(2) http://www.worldbank.org/projects/P078538/third-national-hivaids-control-project?lang=en)

(3) http://www.un.org/apps/news/story.asp//html/realfile/story.asp?NewsID=38061&Cr=hiv&Cr1=#.Uqbn3NIW1_Q

(4) http://www.un.org/apps/news/story.asp//html/realfile/story.asp?NewsID=37950&Cr=HIV&Cr1=#.Uqbn_9IW1_Q

(5) http://www.undg.org/docs/9727/A-Resource-Guide-forTheme-Groups.pdf (role of uno_01 file foot note)

(6) http://www.ekh.lu.se/media/ekh/forskning/mfs/8.pdf

(7) www.desiresociety.org

(8) www.globalaidspartnership.org/html/ngos.htmls#ngoii

(9) www.blogaids.gov/2012/09/nih-research-on-hiv-and-aging.html

(10) www.ngopulse.org/article/guide-hiv-aids-ngos-southafrica

(11) www.ncbi.nlm.nih.gov/pubmed/12284229

(12) www.iseac.ac.in/prc-abs17.pdf

(13) http://ekg.lu.se/media/ekh/forskning/mfs/8.pdf

(14) www.tnhealth.org/tsngo.htm

(15) www.socialcapital.weebly.com/uploads/1/0/5/9/1059736/kabeba-social-capital-building-in-uganda.pdf

(16) www.macrothink.org/journal/index.php/jpag/article/view/2732

(17) www.catholicrelief.org/hiv-aids/partners.cfm

(18) www.hivcode.org

(19) www.chinaperspectives.revues.org/498

(20) http://aids.gov/federal-resources/around-the-world/global-hiv-aids-organization

(21) http://www.humanrights.is/the-human-rights-project/humanrightscasesandmaterials/humanrightsconceptsideasandfora/theconceptsofhumanrightsanintroduction/definitionsandclassifications/(concept)

(22) http://www.humanrights.com/what-are-human-rights/brief-history/cyrus-cylinder.html (concept)

(23) http://www2.ohchr.org/english/issues/hiv/introhiv.htm (relations between hiv/aids/human rights)

(24) http://hivinsite.ucsf.edu/InSite?page=kb-08-01-07 (relations between hiv/aids/human rights)

(25) http://www.equalpartners.info/Chapter2/ch2_1How.html (relations between hiv/aids/human rights)

(26) http://csis.org/files/media/csis/pubs/071120-india-hivaids-public-health-strategy.pdf

(27) B. Ramesh, “Sex Work Typology and Risk for HIV in FSWs in Karnataka”, paper presented at the XXI International AIDS Conference, Toronto, August 13- 18, 2006, http://www/aids2006.org/PAG/Abstracts.aspx?AID=9062

(28) Rajesh Kumar, “Trends in HIV-1 Young Adults in South India from 2000 to 2004: A Prevalence Study, “The Lancet 367 (2006), pp. 1164-72, http://www.thelancet.com/journals/lancet/article/PIIS0140673606684353/fulltext

(29) Pramit Mitra, “AIDS Threatens India’s Prosperity,” http://yaleglobal.yale.edu/display.article?

(30) http://Tnhealth.org.tsngo.html

(31) http://Maha-arogya.gov.in/programs/nhp/aids/ngo.html

(32) http://sankalp.org/hivaids

(33) Vrajlal K., Sapovadia, “Controlling HIV/AIDS - A Judicial Measure, Recommendations by Supreme Court of India.”

(34) http://www,hrln.org/hrln/hiv-aids.html#ixzz2my2q8te1

(35) http://www.unicef.org/india/hiv_aids.html

(36) http://en.wikipedia.org/wiki/joint_united_nations_programme_on_HIV/AIDS

(37) http://c.ymcdn.com/sites/www/istr.org/resource/resmgr/working

(38) http://c.ymcdn.com/sites/www.istr.org/resource/resmgr/working_papers_toronto/jamil.ishtiaq.pdf

(39) www.cpqhg.org

(40) http://www.who.int/hiv/pub/idu/targetsetting/en/index.html

(41) http://www.naco.nic.in

(42) www.hsph.harvard.edu/population

(43) www.isec.ac.in/prc_abs17.pdf

(44) http://www.hivlawandpolicy.org/resources/toolkit-scaling-hiv-related-legal-services-idlo-unaids-undp-2009

(45) http://www.idlo.int/english/WhatWeDo/Programs/Health/Pages/hivtoolkit.aspx

(46) http://www.idlo.int/Publications/HIVtoolkit.pdf

(47) http://www.who.int/hiv/pub/surveillance/en/

(48) http://www.hrln.org/hrln/hiv-aids.html

(49) http://www.who.int/hiv/topics/vct/toolkit/components/policy/introduction/en/index4.html

CHAPTER - 5

THE PATIENT AND SOCIETY INTERACTION AND THE DISCRIMINATION PERCEPTION

5.1 Introduction

HIV/AIDS is one of the deadliest and worst epidemics to ever affect humanity. The virus affects not only the afflicted individual but also the entire family, the community, and the nation. In addition to the fact that mortality is a given, the stigma and discrimination surrounding it have made it the most feared epidemic of the century. Unfortunately, the health sector is one of the main places where people living with HIV face discrimination and stigma. A lot of medical professionals have negative attitudes towards individuals who are HIV/AIDS positive, and sometimes they even won't treat those who are known to be infected. Numerous organizations have contributed to public education regarding HIV/AIDS-related concerns and the importance of treating infected individuals with dignity. Despite being aware that HIV cannot be transmitted through casual contact, a sizable segment of the populace continues to shun those who are known to be seropositive.

On the other hand, the Indian government is acknowledging the urgent need and exhibiting concern for HIV/AIDS treatment and prevention. Additionally, the government has started offering all HIV-positive individuals free antiretroviral therapy. Nonetheless, this epidemic is stigmatized in the community.

Shame and fear combine to create a powerfully negative social stigma associated with HIV/AIDS (Piot, 2001). According to Mr. Zahir Uddin Swapon, Secretary General of the Parliamentary Group on HIV/AIDS, "people stigmatize due to fear stemming from ignorance" (UNAIDS, 2004). According to Agglet al. (2002), stigmatization can result from a lack of knowledge about the illness, misconceptions about how HIV spreads, and a lack of awareness of preventative measures. Such discrimination and stigma can lead to a host of detrimental outcomes, including social dysfunction such as strained relationships and feelings of melancholy, anxiety, and depression.

5.2 Consequences of Stigma and Discrimination

Stigma and discrimination are major contributors to the HIV/AIDS epidemic because they promote a culture of victimization, blaming, silence, ignorance, and secrecy (Taylor, 2001). This influences the health, behavior, and perception of the medical care received by PLHAs as individuals (Ganczak, 2007). Learning that one has been affected by such a disease causes unfathomable psychological suffering. Relationships are changed, both blatantly and subtly, and many people pull away from them. They also feel that the social support they had before getting sick has diminished. In addition to the direct effects the illness has on one's health, there is also the stigma associated with it to deal with. Managing the stigmatizing effects of the illness is one of the main challenges that study participants report facing in their daily interactions. In the discussion that follows, an effort is made to clarify the effects this discrimination has on them.

5.2.1 Stopped Working

The lives of those infected with HIV/AIDS are negatively impacted by the stigma surrounding the disease. The main consequence of HIV infection is the person's inability to work in a job that pays a salary on a regular basis. Like in the current study, the shock of their illness caused 18% of the respondents to resign from their jobs. The respondents said that the family's lack of financial resources was a major burden.

When asked about their decision to marry, about 86% of those surveyed stated they had already been married, divorced, separated, or widowed. About 5% of respondents wanted to get married, but only to positive people, with the exception of one who was willing to marry a girl who was not infected and they were both in love with each other. A little over 4% of participants expressed their desire to remain single, while the remaining 5% were unsure about their desire to tie the knot.

5.2.2 Feeling to Die

Being surrounded by friends, family, and loved ones is something that everyone enjoys. Although no one chooses to be alone or isolated, someone may begin to feel as though they are dying if they believe that their close friends and family are rejecting them. About 29% of respondents in the current study claimed to be waiting for death or to be praying to God to end their lives; however, about 59% of respondents claimed to have occasionally felt this way when they fell ill and had to visit the hospital on their own.

5.2.3 Don’t Want Further Treatment

Despite the fact that HIV/AIDS cannot be cured, there are drugs that can be taken to control the virus. However, a lot of PLHAs may experience worry and anxiety about who to tell, how to tell, and when to tell, which prevents them from receiving the necessary care and treatment.

The vast majority of respondents said it was very hard for them to tell people, they were positive. The majority of them said they would be interested in continuing their treatment when asked, but a small number of them also mentioned that they occasionally avoided using drugs, which resulted in problems with frequently falling ill. Overall, 17% of respondents stated that they did not want to receive any more medical care due to the unpleasant side effects of the medications and the fact that their doctors were not providing them with the recommended daily allowance of nutrients.

5.2.4 Avoided from Family/Friends and Relatives

Living with HIV has always involved coping with a progressive illness that could eventually be fatal. Despite recent medical advances, living with HIV still carries a lot of uncertainty about one's health. PLHAs have had to deal with challenges in their social relationships in addition to the physical health aspects of living with HIV. They make an effort to avoid their social circle in daily life because they feel that those who are infected are morally bankrupt and bear responsibility for the illness. They fear rejection (perceived stigma) or are experiencing rejection (felt stigma) from friends, family, and acquaintances. In line with the findings of the current study, more than half of the participants tried to keep their distance from friends and family, and more than 68% avoided seeing their relatives. They even said no to inviting their relatives and friends over for dinner. They avoid all social gatherings and thus cut themselves off from the outside world.

When asked why they didn't reveal their positive status when they saw friends and family, a sizable percentage of respondents who were visiting them said it was because they were afraid of their negative attitude.

5.2.5 Self-Blaming and Taking Revenge

Furthermore, because they feel they are to blame for contracting the virus, PLHAs could also hold themselves responsible for acquiring HIV. There are individuals who might feel driven to take revenge on those they suspect of having HIV. About 56% of respondents felt that people should accept responsibility for their actions, while 5% of respondents wanted to get revenge on those, they thought were the source of their infection.

The stigma associated with HIV/AIDS may negatively impact an affected person's health in a number of ways. For fear of rejection and stigma, some people might decline to have an HIV test. Those who try to hide their status out of such fear may experience poorer health and higher levels of stress when compared to those who seek appropriate treatment and express their emotions.

5.2.6 Other Consequences of Stigma and Discrimination

Individuals who experience stigma encounter a range of negative emotions, including depression, anxiety, and hatred. For someone living with HIV, it can be very upsetting to be rejected or turned away by others. Feelings of isolation, alienation, exclusion, and loneliness are common among PLHAs. There are positive effects of HIV/AIDS on relationships as well. Some affected individuals have also reported that their relationships with friends, family, and even medical professionals actually deepen when they show them their unwavering love and concern. However, a sizable portion of respondents indicated that they observed changes in their behaviour over time.

Stigma and isolation may manifest as symptoms of anxiety, depression, and suicidal thoughts, according to a small number of studies that have also examined how HIV infection affects patients' mental health (Chandra et al., 1998). According to Chandra et al. (2003), both men and women living with HIV express fear and embarrassment about tarnishing their family's reputation. Men with HIV expressed concerns about their growing reliance on others for care and the impact of their physical decline on the household income, while their spouses' expressed feelings of resentment, victimization, and helplessness (Bharat and Aggleton, 1999). (Chandra and Temoshok, 2000). Temoshok and Chandra (2000) posit that these women are unlikely to receive the necessary support to express their emotions, which may lead them to repress them or find coping mechanisms that are socially acceptable, such as seeking guidance and solace from religion.

5.2.7 Feelings of PLHAs about Meaning of Life

It makes sense that stigmatization occasionally leads to PLHAs experiencing negative changes in their self-perception and feelings about their lives. They usually internalize society's stigmatization and come to feel unworthy and corrupted. Just 14% of respondents said they thought life was worthwhile, with 6% strongly agreeing. Others said nothing or disagreed. About 35% and 58% of respondents, respectively, strongly agreed that their lives were special and purposeless.

5.2.8 Sadness and Unhappiness in Life

People experience a great deal of stress when they learn they are HIV positive. They begin to feel depressed and unsatisfied. Approximately 57% of the participants admitted that they were feeling unhappy and depressed as a result of their illness. About 45% said they didn't want to go anywhere because they were scared of meeting new people. Some of them, when left to their own devices, declared that they would rather die than live a life of suffering and terror.

5.2.9 Less Energy and Motivation

People living with HIV/AIDS face many challenges as the illness worsens and opportunistic infections occur. It was observed that the majority of respondents (about 51%) concurred that they lacked energy and motivation and had lost their confidence (about 53%).

Approximately 54% of the participants strongly agreed that this was the first time in their lives that they had experienced such self-pity. Nearly 64% of respondents strongly agreed that people should be educated about the issue when asked if they thought that was the case. The PLHA community should be encouraged and uplifted to make the most of their remaining years by being cautious and receiving the necessary care.

5.2.10 Feeling of Depression and Frustration

Receiving an HIV diagnosis is a traumatic event that frequently causes psychological distress. The respondents become extremely irate and depressed when people approach them with suspicion and ask a lot of questions. When they would leave their homes to go to the hospital, many of the women who responded said that they found it very difficult and frustrating when their neighbors would ask them questions like where they were going and when they would return. They also showed a great deal of rage, which they attribute to internalized frustration, at other people's ignorance of their illness. Much like in the current study, the majority of respondents (about 49%) agreed—and about 45 percent strongly agreed—that they get depressed and frustrated because of their illness.

5.2.11 Sexual Relationship with the Partner

It's common to experience anxiety when it comes to having sex after learning you have HIV. People ought to be informed about the risks involved in having sex. Many questions concerning the nature and number of sexual partners, the frequency of condom use, and the level of sexual satisfaction were asked about one's sexual life.

Most married PLHAs (men) said that their spouse is the only person they have sex with. They believed that they were unaware of the source of the virus. However, the vast majority of married women claimed that their husbands might have inherited it. A mere minority admitted to having more than one sexual partner.

About 53% of respondents strongly agreed that the illness was causing problems in their relationship, and 18% agreed that the illness was causing them a great deal of problems. They thought that sexuality had changed over time. Roughly 13% felt they had no need to reply to this.

"After learning my positive status, sexual closeness does not appeal to me; I get irritated easily on my wife who is not HIV-positive," stated a man who responded. I'm always afraid that I'll contaminate my spouse when we have sex because condom use isn't 100% foolproof.

"Even though I don't want to get closer to my husband because he cheated on me, I always give up because if I don't have sex with him, he might find someone else and spread the infection," a female respondent who tested positive for HIV told the researcher. I'm hoping he doesn't spread this virus to anyone else.

Many women said that having to deal with their partner's illness on top of their own was causing them great depression. They assume greater responsibility for child care, housework, and tending to the ailing spouse. When needed, they give their partner financial support.

The participants' sexual dissatisfaction with their partners is evident from the conversation, and some of them persisted in risky sexual behavior even after receiving professional counselling during the testing process. It's also conceivable that they weren't getting the proper counselling in relation to the dangerous behavior.

The decisional jurisprudence pertaining to dignity has been established by the constitutional courts. In the case of Naz Foundation,[134] "At the very least, it is evident that the constitutional protection of dignity requires us to acknowledge the value and

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[134] See Naz Foundation v/s Govt, of NCT Delhi and others, Writ Petition no.7455/2001.

worth of every individual as members of our society," the Delhi High Court noted. It acknowledges that each individual is a free being free to develop their body and mind however they see fit. A person's autonomy, or their freedom of choice and action, is the foundation of their dignity. The foundation of human dignity is the acceptance of a person's inherent worth, humanity, and physical and spiritual integrity—regardless of the benefit they may offer to others."

Earlier in case of Prem Chandar Shukla v/s Delhi Administration [135] the SC observed that dignity forms part of our constitutional culture and in Francis Coralie Mullin v/s Administration, U.T. of Delhi and others[136], "We think that the right to life includes the right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing, and shelter and facilities for reading, writing, and expressing oneself in diverse forms, freely moving about and mixing and commingling with fellow human beings," the SC noted through Bhagwati, J. Any action that violates or diminishes human dignity would be a denial of his right to life per se, and it would have to follow a lawful process that is reasonable, equitable, and just and that satisfies the requirements of other fundamental rights. As a result, it is clear from the aforementioned cases that the Indian judiciary recognizes the value and worth of every member of society, including those who are HIV/AIDS victims, and that maintaining one's human dignity entails expressing oneself in a variety of ways.

The first decision given to interpret the scope and meaning of life and personal liberty under article 21 of the Indian Constitution was the A.K. Gopalan v/s State of Madras[137] The Supreme Court interpreted the phrase "procedure established by law" in Article 21 to mean "due process of law" as specified by the U.S. Constitution, but only if it refers to state-made statutes laws. Any statutory law that specifies a process for taking away someone's rights or freedom must comply with Article 21's requirements.

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[135] 1980 1 SCC 529

[136] 993 1 SCC 645.

[137] AIR 1950 SC 27.

However, after two decades this was over ruled in the case of R.C. Cooper v/s Union of India[138] fter this there where a series of decisions by the apex court including that of Maneka Gandhi v/s. Union of India[139] where it was decided that a law must be just and fair if it takes away someone's life or liberty. It was said correctly by Krishna Iyer J. that "procedure in Article 21 means fair, not formal procedure law is reasonable law not any enacted pieces" It is now established that positive rights to life and liberty are granted by Article 21. In Article 21, "life" refers to a dignified life, not merely the survival of an animal.

In the 1978, by 44th amendment, Article 359 was amended and it provided that Article 20 and 21 could not be suspended even during declaration of an emergency. In the case of P.Rathinam[140] , The court ruled that both mental and physical health are regarded as essential components of the right to life, maintaining that one cannot enjoy one's civil or political rights—as guaranteed by the Constitution—without good health. The judiciary has been essential to understanding and applying article 21 correctly.

In case of C.Masilamani Mudaliar v/s. Idol of Sri Swami Nathaswami[141] The SC noted that every human being has the intrinsic right to equity, human dignity, and the right to development. Everything that gives a person's life purpose, such as culture, heritage, and traditions along with personal dignity, is included in life's enlarged horizons. The supreme court expanded the application of article 21 and provided the rights that article 21 encompasses in Unni Krishnan v. State of Andhra Pradesh.

They include freedom to travel, privacy, opposition to solitary confinement, opposition to postponed execution, right to housing, opposition to custodial death, right to a public trial, and opposition to medical assistance. It was also noted that the right to education would be incorporated into the right to life along with all previously mentioned rights

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[138] AIR 1970 SC 564.

[139] AIR 1978 SC 597.

[140] P Rathinam v/s UOI 1994 3SCC 394.

[141] 1996, 8 SCC 525, Paragraph 22.

In Naz Foundation Case[142], which is a prime example in the context of MSMs and HIV/AIDS It was argued that Articles 14, 19, and 21 of the Constitution's protections are violated by Section 377 of the IPC. An important turning point in Indian jurisprudence on diversity and pluralism has been reached by the case's ruling. Crucially, it introduces intersectional jurisprudence, which analyzes constitutionalism-related issues in relational terms that emphasize inclusivity. By this measure, the ruling is significant for more reasons than just the rights of LGBT (lesbian, gay, bisexual, and transgender) people. It turns the articulation of LGBT rights into a beacon for a broader comprehension of what freedom and dignity really mean, as well as of oppression, discrimination, social exclusion, and the denial of liberty.Morality according to the constitution is not an instinct. It needs to be 18 years old. We have to acknowledge that our people are still learning it. The court rejected the argument that homosexuality was against public and popular morality in India, citing Dr. Ambedkar. Instead, it upheld constitutional morality, the spread of which was dependent on Dr. Ambedkar's ideas of national change, as is clear from the lines quoted above. The ruling declared: "Diversity is acknowledged, safeguarded, and celebrated under the Indian Constitution. It is against constitutional morality to stigmatize or criminalize homosexuals based solely on their sexual orientation 1Q. [143] This is related to the Court's observation regarding the question of the horizontal application of rights, specifically referencing Article 15(2), a crucial but little-known provision of Article 15 that states that no citizen may prevent another from entering a public place on the basis of caste, sex, or any other specified ground. This intentional and intersectional interpretation of Article 15(2), which was previously primarily limited to untouchability practices against Dalits, provides a significant avenue for constitutional interpretation.

Judge P.N. Bhagwati's definition of the right to dignity in the Francis Coralie Mullins case serves as the foundation for the widely acknowledged national and international conversation about the value of privacy, self-worth, and self-respect in human social life. And when it comes to sexual relationships, privacy is especially

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[142] See Naz Foundation v/s Govt of NCT Delhi and others, Writ Petition no.7455/2001.

[143] Paragraph 80 of the Judgement.

crucial. As a general rule, "A breach of our privacy will occur if, in expressing our sexuality, we act consensually and without harming one another."[144]

5.3 Sources of Knowledge of PLHAs on HIV/AIDS

Healthcare professionals have a duty to educate and reassure the public about the likelihood of HIV infection as well as its impossibility. The patients look to the medical specialists each time they see them to provide an example of proper AIDS management.

The findings indicate that hospitals (about 96%) and non-governmental organizations (NGOs) provided the majority of the respondents' information regarding HIV/AIDS. It was found that sixteen percent of the participants learned things from posters, pamphlets, magazines, and newspapers. On the other hand, about 8% said that their primary information sources were friends and TV/radio (9%).

The study participants also stated that they had heard, seen, and heard advertisements for TV, radio, and other media on several occasions, but that they had initially ignored them because they were hard for them to understand.

Additionally, the respondents expressed dissatisfaction with the information provided by the medical professionals. They should be given more details about government assistance programs and avenues for reporting misbehavior or unfair treatment of medical personnel.

5.4 Problems faced by PLHAs in their day-to-day life

People who are HIV/AIDS positive are worried about future health issues and death. However, a person living with HIV/AIDS faces unique difficulties that a person with cancer or any other illness, like heart disease, does not usually encounter. People's reactions to those who are HIV-positive are often influenced by stereotypes about behaviors that are associated with the virus. This explains the problems that PLHAs face as a result of HIV/AIDS.

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[144] Paris Adult Theatre I v/s. Slaton, 413 US 49 (1973), page 63.

5.4.1 Physical Problems

According to the respondents, they were suffering from severe cases of exhaustion, frequent colds, diarrhea, coughing, headaches, fever, and other opportunistic infections.

A few respondents also brought up the fact that ART had disadvantages of its own. When they told the doctor about the problems they were having from those medications, he would often advise them to maintain a healthy diet. However, the majority of respondents said that, when living in rental housing, it was very difficult for them to maintain a healthy diet on an income of Rs. 12,000 or less per month. They added that, despite the fact that the organizations' nutritional packets were very beneficial to them, they weren't consistently provided with them.

Furthermore, the participants reported that these side effects occasionally caused them to discontinue the treatment. Some started drinking to help them forget the pain for a little while.

"What will happen to their children if they die soon?" was a question posed by respondents who had small children and were worried about their future. HIV-positive women added that, although they were there to support their husbands and kids (who were also positive), they were mainly in charge of looking after themselves when they became sick. In addition, they were worried about what would happen to them in the event that their spouse died.

5.4.2 Problem within the Relationships

Married research participants blamed each other for a variety of circumstances that led to decreased or nonexistent communication, which resulted in high levels of conflict between them. Still, some of them added in about how encouraging their spouse had been.

The respondents, whose relatives knew about the illness, added that because of their improved status, their relatives' viewpoints had changed. They tried not to talk to them as much, especially not to their siblings.

5.4.3 Financial Problems

Money is very important in life, especially when you are sick and have no one to help you financially. For most of the research participants, it was also a significant problem. When they fell ill, they had to take time off work to recuperate and get medical attention. The majority of respondents expressed concern regarding travel as well, believing it to be an additional financial burden due to their need to go to the hospital. Furthermore, a few respondents indicated that the cost of travelling from their villages to the nearby hospital for checkups is high. They also thought that the government ought to pay for these expenses.

Financial hardships can cause stress in people, which is something that doctors recommend against. Additionally, medical professionals have observed that stress directly lowers the function of the immune system and may speed up the onset of AIDS.

5.4.4 Stigma and Discrimination

A person who is subjected to discrimination and stigma usually fears rejection from others all the time, which can make them feel even more alone in society.

PLHAs were terrified that their friends, neighbors, family, coworkers, or even their jobs would reject them. For fear of similar reactions, they often withheld information about their condition from the public.

The woman who answered said, "My husband passed away from illness, leaving me and my son behind." If I told the truth, no one would believe me, even though I'm positive that he died of AIDS and that I contracted the illness from him as well. My in-laws will throw me out of the house and put the blame on me. I haven't disclosed my status to anyone as of yet.

The respondents, especially the women, also expressed how challenging it was for them to leave their houses in order to pick up their prescription medications from the hospital. Sometimes, if they were both positive and living in the same home, they would make up an excuse, or send their husbands to pick up their prescription medications.

There was a correlation found between HIV and participant fears of discrimination and isolation, which is consistent with previous research (Bharat 1995, 2000). The study's findings demonstrate that HIV stigma has a range of detrimental impacts, such as emotions of helplessness and loneliness, internalized anxiety, stress, and depression, as well as guilt and shame. People may also experience low self-esteem, self-dislike, difficulty communicating their positive status, and worry about the future of their children as a result of it. The women who contracted the virus also had to cope with feelings of guilt about losing their husbands and about becoming widows. Concerns about social isolation were also present.

5.5 Knowledge of HCPs on Universal Precautions

Universal precautions, sometimes referred to as standard precautions, are a recognized set of techniques and barriers to prevent the spread of pathogens. This refers to the use of barrier techniques in the context of HIV to prevent the virus from spreading between patients and healthcare providers.

According to the World Health Organization (WHO), the goal of standard precautions is to reduce the risk of infections spreading from both known and unknown sources, including blood-borne infections. These are the absolute minimum steps that should be taken to prevent infections in every patient.

To prevent the spread of blood-borne infections and other illnesses, it is essential to continuously implement universal precautions and infection control measures. It is imperative to apply these safety precautions and control measures to all patients, irrespective of their occupation, financial status, or HIV status. All staff members, including those in clinical, housekeeping, and other roles where they might have direct physical contact with waste, bodily fluids, linens, or spills, should undergo universal precautions training (NACO, 2007). One of the most important steps in reducing stigma and discrimination is to follow universal precautions. Diverse levels of awareness regarding the application of universal precaution, fear of infectivity, discriminatory behavior, and willingness to treat PLHAs have been noted among HCWs worldwide (Kowal & Taneja, 2010). Health care providers who implement universal precautions against PLHAs alone display discriminatory behavior and an infection fear in both developed and developing countries (Bermingham & Kippax, 1998 and Kotwal & Taneja, 2010).

The World Health Organization advises medical professionals to take the following general safety precautions:

Hand washing: As soon as you come into contact with blood, bodily fluids, secretions, excretions, or contaminated objects, take off your gloves and contact the next patient.

Gloves: for coming into contact with blood, bodily fluids, secretions, infected objects, and non-intact skin and mucous membranes.

Goggles, masks, and face masks: When it's likely that your mouth, nose, and eyes will come into contact with blood or other bodily fluids, protect those mucous membranes.

Gowns: Avoid getting blood or other body fluids on your skin. When performing procedures that may come into contact with bodily fluids or blood, try to avoid getting your clothes dirty.

Linen: Make sure to keep dirty linens away from skin and mucous membranes when handling them. Soapy sheets should not be rinsed beforehand.

Patient care equipment: Cleaning reusable equipment before each use will help prevent clothing and surrounding areas from becoming contaminated. Handling soiled equipment should be done so as to prevent skin or mucous membrane contact.

Environmental cleaning: routine cleaning and disinfection of the furniture and equipment in patient care areas.

Sharps: Needles should not be put back in needle dispensers or removed from single-use syringes. It is not appropriate to handle, bend, or break reusable needles by hand. Used sharps should be emptied into puncture-resistant containers.

Patient resuscitation: Use mouthpieces, resuscitation bags, or other ventilation tools to avoid mouth-to-mouth resuscitation.

Patient placement: Individuals who cause environmental pollution or lack the hygiene necessary to maintain good hygiene ought to be housed in private rooms (WHO, 2007).

It is evident from the above discussion that staff members lack knowledge about common sense precautions, despite them being an essential part of an effective and high-quality healthcare delivery system. Ignorance of these common-sense precautions could lead to stigma and discrimination. However, it is the hospital administration's responsibility to guarantee that each staff member receives top-notch training.

5.6 Exposure of HCPs to HIV/AIDS Training Program

In order to provide their patients with compassionate care, health care providers must possess both the necessary knowledge and an optimistic attitude.

Medical personnel may be unable to apply reason and the scientific method, which is crucial, if they have a negative attitude. It could also result in incoherent care, indifference, and discomfort throughout the course of treatment—none of which would be ideal for maximizing outcomes. Prejudices and biases can only be mediated through the socialization process during training, as opposed to factual knowledge acquired through didactic attitudes (Radecki et al., 1999). According to Mathew (2006), training is the process of gaining knowledge, skills, and attitudes through the teaching of practical skills and knowledge related to learning specific practical skills that will improve your performance at work.

Training and education on the distinctions between HIV and AIDS, HIV transmission, general preventive measures, and updates on treatment protocols for opportunistic infections and HIV/AIDS should be provided to health professionals. Other important themes include nutrition, drug use, stress, sexuality, and stigma and discrimination in health services (Morrison, 2004).

The study found that approximately 55% of the medical professionals had completed either short- or long-term training. Of the participants, about 45% said they had never taken part in an HIV/AIDS education program. The fact that none of them had any training before dealing with PLHAs is astounding.

Despite attending, a sizable portion of the respondents who participated in the training programme also stated that they did not find it to be very helpful. They felt that no training had been provided to them specifically on stigma and discrimination against PLHAs. Basic information about HIV/AIDS was among the materials being discussed.

However, those who had not attended the training claimed that only a select group of employees who had close ties to higher authorities had been granted access to the program.

A lack of universal precautions, high work pressure, poor training, and few promotions may all have an impact on health care workers' reluctance to treat HIV-positive patients.

5.7 Efforts by the institutions to create awareness on HIV/AIDS among general public

The primary course of action for prevention initiatives is comprised of Information, Education, and Communication (IEC) strategies. Mass media, such as radio, television, and newspapers, is used to inform the public. The epidemic, associated risk factors, and the importance of prevention are all well-known to and understood by the general public.

They also acknowledged the inadequate and unsatisfactory quality of the information they were getting from the medical staff. However, people must be adequately informed about the subject in order to avoid misunderstandings.

We asked the doctors about their efforts to increase public knowledge of HIV/AIDS-related concerns. They listed a range of communication techniques, such as flyers, brochures, periodicals, puppet performances, magic shows, skits, folk music, documentaries, films, and more, that are put up on department walls and used in the course of the department's community outreach initiatives. They also revealed that they hold a health lecture and exhibition in the neighborhood on World AIDS Day to increase awareness of HIV/AIDS. It was also mentioned that throughout the pre- and post-test counselling procedures, they provided all the information and answers to the people's questions.

5.8 The institutions' initiatives to educate medical professionals about HIV/AIDS

The public is expected to receive sufficient information about HIV/AIDS from healthcare providers. However, healthcare providers must possess sufficient knowledge about HIV infection in order to carry out this task. They should also be educated about doable measures to lower the risk of transmission, such as universal caution when handling bodily fluids like blood. It is imperative that healthcare professionals participate in multiple training programmes on these subjects in order to acquire the necessary knowledge.

The hospital hosts a number of internal conferences, workshops, and training program; works with other departments and institutions to host free faculty development series that cap the number of participants; and hosts skill-enhancement workshop sessions. These are just a few of the efforts being made to date to dispel myths and raise awareness among healthcare professionals about the fundamentals of HIV/AIDS, the researcher was informed. It was also mentioned that anyone who is curious about the epidemic can speak with their supervisors to get any information related to the areas they are worried about and to access the resources that are available both inside and outside the organization.

Many medical professionals who were asked about how they obtained this kind of information said that they had a hard time leaving the facility due to a staffing shortage. A few individuals had also stated that they felt the training programs lacked creativity, which made them less helpful in their opinion.

It is usually difficult to participate in many social and private activities when ill. Physiological anomalies such as nausea, headaches, and vomiting can strike healthy individuals occasionally. Because these illnesses are treatable, people who have them can lead very normal, happy lives. Their lives are not completely affected by the illness. They are living their normal lives and are in good health. However, HIV/IDS patients and their families experience significant financial and psychological hardship. On a social level, not even other people accept the person. The study illustrates the detrimental effects of HIV-related stigma on the lives of individuals living with HIV/AIDS. Among these consequences are the incapacity to work and make a living on a regular basis, the inclination to stay away from their social circle in day-to-day activities, the reluctance to reveal their positive status due to possible negative reactions from others, and so on.

In order to increase public awareness of the HIV/AIDS crisis, health care providers (HCPs) employ a range of communication techniques, such as posting posters on department walls, handing out flyers and magazines, and hosting puppet shows, magic shows, skits, folk music, documentaries, and movies. Health care organizations hold a range of internal conferences, workshops, and training sessions to educate medical professionals about HIV/AIDS and to debunk misconceptions about its basics. Additionally, they host several faculty development series in collaboration with other departments and organizations.

5.9 Social Work Intervention in the Context of HIV/AIDS in India

The western world is where social work was first acknowledged and developed as a profession. It started in England and then made its way to America. The field of social work originated in welfare, social services, reform, and charity. From a welfare approach to a development and empowerment approach, social work has come a long way. Individual rights protection and promotion, along with a right-based approach, are now priorities for the profession. Early in the 1930s, social work education made its way to India. The profession of social work gained recognition when the Royal Commission of 1831 recommended the appointment of labor welfare officers who held a degree in social science, social work, or labor welfare. This recommendation marked a significant turning point for the field of social work.

Through a variety of techniques, social work aims to support individuals, groups, and communities in promoting their well-being. Social work differs from other professions in that it uses both primary (social case work, social group work, and community organization) and secondary (social welfare administration, social action, and social work research) methods.

"Professional service, founded on scientific knowledge and skill in human relations, which helps individuals, alone or in groups, to obtain social and personal satisfaction and independence" is the definition of social work (Friedlander, 1958). "The professional activity of helping individual, groups, or communities to enhance or restore their capacity for social functioning and to create societal conditions favorable to this goal" is how the National Association of Social Workers (NASW), the largest professional association of social workers in North America, defines social work. The professional application of social work values, principles, and techniques towards one or more of the following goals constitutes social work practice: assisting individuals in receiving concrete services; offering individual, family, and group counselling and psychotherapy; supporting communities or groups; supplying or enhancing social and health services; and taking part in pertinent legislative processes. Understanding human behavior and development as well as the workings of social, economic, and cultural institutions is necessary for the practice of social work (NASW, 1973). Similarly, social work is described as "the applied science of helping people achieve an effective level of psychological functioning and effecting social changes to enhance the wellbeing of all people" in the Social Worker Dictionary (Barker, 1999).

According to the aforementioned definitions, social work has a scientific perspective and human relations abilities that assist individuals in enhancing their social functioning in order to achieve both social and personal fulfilment. It establishes social conditions that aim to improve people's wellbeing and avoid issues with social functioning.

An enormous accomplishment in the history of social work is the new international definition, which was approved by the International Federation of Social Workers (IFSW) General Meeting in Montreal, Canada, in June 2000. It emphasizes social work with a right-based approach and empowerment. The profession of social work "promotes social change, problem solving in human relationships, and the empowerment and liberation of people to enhance well-being," according to the revised definition. Social work intervenes where people interact with their environments by applying theories of human behavior and social systems. Social work is predicated on the concepts of social justice and human rights. (http://apaswe.com/attachments/article/125/workshop_part1.pdf)

5.10 Purpose of Social work

The goal of social work is to meet human needs and resolve interpersonal conflict by addressing social problems with vision, direction, and motivation. Enhancing the standard of living for people is considered to be one of the profession's clear objectives. The primary goal of social work is to support adaptive functioning in the interactions between people and social institutions. According to the CSWE (1988:120), "social work has historically contributed to the development of these relationships in such a way as to promote social and economic justice and protect the opportunities for all people to live with dignity and freedom."

Four goals of social work practice are listed by the Council on Social Work Education (CSWE, 1994): i) the support of individuals, families, groups, organizations, and communities in order to promote, restore, maintain, and improve their social functioning through task completion, the prevention and relief of distress, and the utilization of resources: the development and testing of professional knowledge and skills related to these goals (Thomas, 2009). ii) the planning, formulation, and implementation of social policies, services, resources, and programs needed to meet basic human needs and support the development of human capacities; iii) the pursuit of policies, services, resources, and programs through organizational and administrative advocacy and social or political action, in order to empower groups at risk and promote social and economic justice.

Through the application of professional social work values, principles, and practice methods, the goal of social work is accomplished. Social workers can, for instance, have conversations with people and families to help them manage stress and work through interpersonal issues. In addition, social workers support communities and society by preventing social problems and by delivering or enhancing social and health services. To create just and equitable social policies, they actively engage in advocacy for policies and legislative processes. In conclusion, social workers counsel people through difficult times, counsel decision-makers on important matters, and promote improved society. These social work initiatives show how the connections between individuals and society are the profession's primary area of concern. Social work is the only profession that takes into account people's interactions with their social and cultural environments to such an extent (Dubois, 1992:6).

5.11 Social Work in the Context of Health Care Setting

Health is harmed by inaccessible or insufficient medical care, and social issues like stress, unemployment, poverty, and a lack of social support systems aggravate health issues. Furthermore, difficulties with social functioning are frequently present in people who suffer from health issues. The five fundamental premises illustrate the close connection between social functioning and health: Social, cultural, and economic factors have a measurably positive impact on maintaining health as well as preventing and recovering from illness; ii) illness frequently upsets equilibrium and adaptive coping capacities; iii) institutionalization exacerbates all illness types, whether acute, chronic, or terminal; iv) community action and innovation are required to deal with issues related to accessing and using services appropriately; and collaborative efforts of a multi-professional team for both individual and community health problems address the complexities of socio-medical problems (Bracht, 1978a).

Social workers in the health care sector engage in activities related to "institutional, community, state, and federal health policy formation; program planning and administration; the educational preparation of social workers and the professionals practice in the health field; and social research" in addition to working with individuals, families, and groups (Carlton, 1984:5). Almost all specialization areas within the health system employ social workers, including emergency room services, public health, mental health, oncology, pediatrics, general medicine, surgery, intensive care, and rehabilitation (NASW, 1990). Specific settings include: (a) preventive-educational agencies, such as public health departments, maternal-and child health projects, crisis clinics, health referral agencies, and pregnancy prevention programs; (b) hospital-institutional care systems, such as community hospitals, veterans administration hospitals and clinic, rehabilitation centers, psychiatric hospitals, long-term care facilities, and hospital-based home-health care; (c) primary care programs such as individual and group medical practices, health-maintenance organizations, free clinics, outpatient clinics, community mental health centers, and community home health agencies; (d) community health-planning services, such as health system planning agencies, state developmental disability programs, mental health boards, and vocational rehabilitation offices; and (e) health professions education facilities, such as medical, public health, nursing, and allied health schools (Bracht, 1978a).

The discussion above makes clear that professional social workers are employed in every setting related to health care in western countries.

The field of social work has a great deal of room for expansion and growth in India as well. Professionals in social work have the chance to work in a variety of environments, including hospitals, classrooms, prisons, industrial settings, ageing services, family and child welfare, youth development programs, and numerous government development initiatives. In a variety of governmental and non-governmental organizations, they are referred to as social welfare officers, labor welfare officers, social workers, protection officers, assistant directors, and so forth. Even though there are many social workers working, the largest obstacle facing the field is that it is not as well-known and acknowledged as other professions like engineering, law, or medicine. Most people don't know if their organization employs social workers and mistake social work for sociology. The researcher encountered many healthcare professionals who were ignorant of the position of social worker in their organization and, moreover, of their qualifications, while gathering data from the healthcare setting.

5.12 Perception of PLHAs about Social Workers

Since the beginning, social workers have taken an active role in the HIV/AIDS epidemic. They have consistently responded with their expertise to assist individuals, families, and couples in understanding the illness and coping with the trauma. They collaborate with non-governmental and governmental organizations to advocate for the rights of individuals living with HIV/AIDS and to educate the public. Let's examine how the respondents (PLHAs) in this study felt about the social work profession.

When requesting services from the health care system, individuals living with HIV/AIDS were asked if they had interacted with any professional social workers. Overall, 66 percent of the study's participants—99 out of 150—reported positive experiences; these participants included social work students connected to the organization and researchers corresponding with them for their studies. On the other hand, 34% of the participants had no knowledge about social workers. They reported in an extremely positive way regarding the differences in dealings compared to other health care professionals.

Approximately 97% of respondents stated that they treat them with respect, accept them for who they are, regardless of their illness, and listen to them intently and patiently—qualities they said are rarely observed in other medical professionals. Additionally, they reported that social workers: (a) treat them as unique human beings (about 85%); (b) advocate on their behalf (about 35%); (c) maintain confidentiality about their positive status and any private information they discuss with them (nearly 79%); and (d) offer adequate referral services (about 38%) if necessary. In addition, they said that the social workers do not treat them unfairly and give them enough time to talk about any concerns they may have. They also educate them about the unknowable facts about HIV/AIDS and provide them with information about the organizations that offer nutritional support.

The HIV care environment should be free of stigma and discrimination in order to support the infected and affected and give them hope, as this will maximize the effectiveness of NACO and NGOs' efforts (Castro and Farmer, 2005). This is primarily due to the possibility that HIV care centers are the only settings in which both men and women recognize and talk about the effects of HIV infection on mental and physical health (Kermode et al., 2005a). As mentioned in the previous chapter, a significant portion of health care professionals were not exposed to the training, according to study results. As a result, the government needs to make sure that health care professionals are exposed to training programs on HIV/AIDS awareness and knowledge, providing high-quality care, universal precautions, and engaging in behavior and interactions that would challenge discrimination and stigma.

5.13 Role of Social workers/Medical Social Worker

In a medical team, a medical social worker's function is just as crucial as a doctor's. The social worker addresses the social, physical, and psychological aspects of the patient who is receiving treatment, whereas the medical professional's role is restricted to providing medical care. In actuality, the social worker's main responsibility is to oversee the patient's care or arrangements. The social worker serves as a friend, philosopher, and mentor to the patient and his family (Thomas, 2010). In the worldwide fight against the HIV epidemic and for the empowerment of individuals afflicted, social workers can be extremely effective. Social workers apply theory to practice while working in a variety of settings, such as HIV/AIDS, during their fieldwork placement. They work in a variety of hospitals as medical social workers as well. All social workers with professional qualifications possess the abilities, know-how, and mindset required to collaborate with afflicted and infected people. They provide patient care within a democratic and humanistic framework. A social worker assists the patient from the time they arrive at the hospital until they are able to adjust to their current circumstances. They support the patient in regaining their health and avoiding further personal decline brought on by the illness.

- A social worker prepares oneself by learning precise and specialized information about the illness, how it progresses, the range of tests available, prevention, treatment, care and management, moral dilemmas, patient rights, and the various resources both inside and outside of the hospital. Social workers, who have extensive knowledge of the subject, work directly with patients and their support system, particularly the family, to help them overcome feelings of stigma, discrimination, shame, and fear.

- The social workers engage in offering the PLHAs and their families counselling and educational services. Clearing up misunderstandings and improving understanding of the issue would be achieved by providing accurate information about HIV/AIDS. Social workers assist patients in regaining emotional stability and in making necessary situational adjustments. The only members of the medical team who can offer patients emotional support and satisfaction are social workers.
- Social workers have received extensive training in offering HIV/AIDS counselling to patients. They are knowledgeable about the syndrome and have the necessary abilities to offer pre- and post-test counselling, follow-up counselling, and counselling to those who are impacted, including spouses, family members, friends, carers, and significant others. Through counselling, social workers encourage behavior modification so that an individual can avoid contracting HIV or passing it on to others.
- Even though a patient is prepared during pre-test counselling, nobody can predict how they will react once they learn they are HIV positive. A patient may experience shock, rage, denial, fear, numbness, and other emotions. A social worker can assist the client in accepting their circumstances and making future plans, as well as handle the patient's information regarding a positive test result. Also, he offers the patient crisis counselling and complete support.
- To keep the family running smoothly, they assist family members in developing stronger coping mechanisms and problem-solving techniques to deal with the stressful circumstances.
- The patient becomes isolated due to their protracted illness. Friends and family might stop being friendly. Social workers help patients in these circumstances by offering social and emotional support as well as facilitating their access to other resources and help.
- Social workers establish a relationship based on trust and confidence in the patient by getting to know the PLHAs well. It aids in the patient's development

of sound decision-making skills and better coping mechanisms for an improved standard of living.

- Providing a client with genuine listening without passing judgement is one of the best treatments a social worker can provide. The social worker treats the patient with great respect and exhibits objectivity and friendliness.
- Everyone aspires to lead a life that is worthy of respect and dignity. They are entitled to health care, food, shelter, education, and protection from discrimination. In the context of HIV, the three most crucial rights are the following: the right to informed consent; the right to confidentiality; and the right to be free from discrimination. However, because they are ignorant of their fundamental rights, PLHAs' rights have been severely violated. The social worker informs them of their fundamental rights. Social workers advocate on their behalf to uphold their rights and enable them to lead dignified lives.
- The social workers are quite knowledgeable about how health organizations operate. Additionally, they keep them well-informed about the various programs available to PLHAs and teach them how to use these services and programs for both preventive and curative purposes. Additionally, they offer PLHAs referral services to other community care facilities, Positive People Network, and other organizations that assist PLHAs.
- Social workers are also involved in the hospital's policy-making and program planning. Since they interact directly with PLHAs, they might suggest changes to deliver better and more efficient care.
- As members of a team of professionals, social workers perform the roles of coordinators of services, facilitators, mobilizers of resources, and mediators. In order to use the hospital's facilities that are only available to patients, he or she can mediate or facilitate interactions between patients and doctors as well as between administration and patients.

5.14 Application of Social work methods in HIV/AIDS care setting

There exist six widely recognized and widely applied social work approaches: social casework, social group work, community organization, social welfare administration, social action, and social work research. Based on the twenty-plus years of work that professor Gracious Thomas has dedicated to raising public awareness and educating the public about HIV/AIDS, six additional social work techniques are being advocated. These include networking, public interest litigation, advocacy, awareness campaigns, resource mobilization, and strengths-based practice (G. Thomas, personal communication, April 6, 2013). These are the approaches that can be used to practice social work. Eliminating these techniques would be equivalent to removing the soul from the body. In actuality, the special qualities of the social work profession are the aforementioned techniques. Social workers in a variety of settings are able to apply these techniques with skill. Let's examine the application of social work techniques to the HIV/AIDS domain.

5.14.1 Social Casework

Social casework is the practice of doing various tasks for various individuals while working together to improve both their own lives and society as a whole (Richmond, 1922).

People's needs go beyond their material desires since material gains by themselves cannot guarantee happiness for humans. When emotional needs are met in addition to material comforts, happiness is attained. Individuals living with HIV/AIDS experience not only their physical illness but also emotional trauma. The family plays a crucial role in these kinds of circumstances. A caseworker visits the sick person's home, holds discussions with the family, and organizes family support to provide care during the patient's critical moments. Additionally, the caseworker gives the family the support they need and assists them in understanding the needs of the HIV/AIDS patient.

One of the methods used in social casework is counselling. Because casework is client-oriented, while counselling is problem-oriented, it offers relief on the periphery.

A social caseworker works to help a client find a long-term solution to their issue by boosting their self-esteem. A caseworker examines the client holistically, taking into account the client's surroundings, prior experiences, relationships with important people, comprehension of the issue and ability to solve it, as well as the client's need for self-understanding.

Social caseworkers improve their clients' knowledge and information about the disease, their rights, prevention, and other topics that can cause new problems or exacerbate pre-existing ones. A caseworker also deals with the stigma and discrimination that the patient and family experience on a variety of levels.

After learning of their positive status, PLHAs frequently experience shock, feelings of rage, guilt, grief, despair, taking revenge, suicidal thoughts, and similar emotions. It is imperative to relieve the client of these emotions in such circumstances. The caseworker helps the client express repressed feelings by paying close attention to what they are saying and accepting them for who they are. He or she values and respects each person for who they are as a unique human being. A caseworker encourages the patient to connect with other PLHAs groups and assists the patient in adjusting to reality. Additionally, he or she provides referral services to other appropriate resources. A caseworker can assist a person in achieving a higher degree of integration by presenting them with novel concepts and lifestyle options.

5.14.2 Social Group work

Through social group work, people in groups in social agency settings receive assistance from a worker who facilitates their interaction in program activities so they can relate to others and experience opportunities for growth according to their needs and capacities for the purpose of the development of the individual, the group, and the community (Trecker, 1955).

Hospitals play a significant role in social work practice. There is a connection between psychological issues and physical health. Patients' health conditions may deteriorate due to adverse psychological factors. In India, and especially in developed nations, there is a widespread understanding that the healing process involves more than what the medical model recommended (Garvin, 2004). Group work allows for the holistic care of a client. A social worker facilitates the process of group work and plays a key role in setting up the HIV support and education groups. Knowledge regarding the illness, its prevention, and its treatment is shared in the educational groups. They impart knowledge to the group members regarding the pattern of progression and its impending debilitating effects. Additionally, they learn how to follow the prescribed course of action, such as taking their medications on time, and they are trained to abstain from behaviours that could exacerbate their condition.

The patients in the support groups receive the essential emotional and social support from the group members. For HIV/AIDS patients, it is a vital forum where they can openly express themselves and discuss their issues in order to support one another. HIV-positive people are assisted in changing their mindset for the rest of their lives through social group work, which helps them live a happy life and deal with their circumstances.

5.14.3 Community Organization

Through the process of identifying its needs and goals, ranking them, finding the resources (internal and/or external) to address them, taking action towards them, and developing the confidence and will to work towards them, a community can become more organized. In doing so, the community fosters and grows cooperative and collaborative attitudes and practices (Ross, 1955).

In social work, community organization is a macro method. The community organizer has the necessary traits and abilities to interact with people and effectively disseminate information to them. The community organizer applies their fundamental knowledge and abilities of the concepts, procedures, and processes of community organizing while working in the community.

Regarding HIV/AIDS, this approach is used to spread knowledge about the illness, its modes of transmission, preventative measures, and the range of services and programmes available to those who are living with the virus. The role of the community organiser is to mobilise members of a community to take the necessary steps to stop the spread of HIV/AIDS. He or she plans awareness campaigns about human rights, government initiatives, and health in order to increase people's knowledge and comprehension. He or she performs street plays, puppet shows, lectures, and other events to get the word out to the broader audience. In addition, the community organiser informs the populace about HIV/AIDS while taking into account social stigmas, religious convictions, and general community sentiment. They are the most qualified to collaborate closely with and influence community members' attitudes in order to lessen stigma and discrimination against individuals living with HIV/AIDS. This is something that someone without experience in social work could never accomplish.

5.14.4 Social welfare administration

"Administration of social agencies translates the provisions of social legislation of social agencies and the goals of private philanthropy and religious charities into the dynamics of services and benefits for humanity," according to Walter A. Friedlander (1958).

Social welfare organisations are essential in providing HIV/AIDS patients with services. HIV/AIDS is a very delicate topic, and in order to accomplish desired goals, the service provider organisation must demonstrate professional competence. Social workers with professional training are employed by the social welfare organisations. With their extensive knowledge and active involvement in the community, the social workers utilise all available resources to effectively accomplish the program's objective.

5.14.5 Social action

Within the parameters of social work philosophy and practice, social action is any individual, collective, or community endeavour with the goal of advancing social justice, changing social policies, and enhancing social laws, health care, and welfare services (Friedlander, 1977).

Social action was defined as "a process of bringing about the desired changes by deliberate group and community efforts" by Nanawati (1965). The true test of whether social action is successful or unsuccessful is not the adoption and signing of social legislation, but rather the way the policies are carried out. According to Singh (1986), social action is defined broadly as the process through which certain elites or the people themselves make deliberate, methodical, and organised efforts to change the system in order to address issues and enhance conditions that restrict the social functioning of weaker and vulnerable groups. Since intimate behaviour patterns are the primary means of HIV infection transmission, health authorities frequently encounter obstacles in providing services to these high-risk behavioural groups. If the government and non-governmental organisations (NGOs) have good working relationships and their social workers are professionally trained, then this gap can be closed (Thomas, 2010).

A social worker tackles HIV/AIDS-related issues through community action. They act as advocates by speaking out on behalf of those who are HIV/AIDS positive. It is commonly acknowledged that there is a serious violation of the PLHAs' rights. They are the targets of discrimination and stigma in the healthcare industry. Social workers use advocacy to persuade, inspire, and encourage democratic authorities to make decisions that will best serve the interests of PLHAs. They struggle to enact the necessary policy changes in order to guarantee the social system's fair distribution of resources, uphold their rights, and administer justice. One of the best strategies for social work is social action, which social workers can employ to advance the rights of PLHAs.

5.14.6 Social work research

A methodical, critical, and meticulous examination of a social phenomenon is known as social work research. The results of social work research can assist policy makers, agencies, and social workers in developing programmes that are effective and tailored to the needs of a specific community (Thomas, 2010).

For any HIV/AIDS-related programme initiative to be implemented effectively, social work research plays a critical role. Research studies help with effective programme planning, policy formulation, and implementation by offering helpful information about the various facets of issues like HIV/AIDS. Since HIV/AIDS is such a delicate topic, social workers evaluate it from a wider perspective, using their professional expertise to make recommendations for appropriate action plans.

5.14.7 Advocacy

Three main principles—independence, empowerment, and inclusion—are the foundation of the ethical activity of advocacy (Dunning, 2010). "Generally involves people making a case for themselves and advancing their own interests, or representing others and supporting them to secure and exercise their rights on an individual or collective basis," according to Dunning (2005), is how advocacy is defined. Cohen defines advocacy as the process of trying to change things that have an immediate impact on people's lives, such as public policy and resource allocation decisions made within political, economic, and social systems and institutions (Cohen, 2001).

It is the process of speaking up for the underprivileged people who do not have access to financial or political resources. One of the key strategies employed by social workers to advance social justice, equality, and PLHA social inclusion is advocacy. In order to effectively address the members' unmet needs, social workers can act as their advocates, representing or persuading them to present their case to the relevant authorities. They can advocate on behalf of PLHAs in order to increase service quality or gain access to resources. Social workers can tackle the underlying causes of issues, defend the rights of PLHAs, and bring up discrimination and stigma through advocacy.

5.14.8 Awareness campaigns

In regards to HIV/AIDS, professional social workers have a significant task ahead of them. Social workers are deeply involved in their communities, so they have firsthand knowledge of their norms, customs, cultural practices, and behavioural patterns.

The general public can be educated about the fundamentals of HIV/AIDS, modes of transmission, prevention, and the care and treatment of people living with

HIV/AIDS. PLHAs can be educated about their rights and how to exercise them by means of awareness campaigns. PLHAs can be supported and encouraged by social workers to advocate for themselves.

HIV-positive individuals frequently face discrimination due to their fears of infection and the negative associations that HIV has with unacceptable behaviours like drug addiction, homosexuality, and promiscuity. Social workers can bring up the subject of discrimination and stigma through awareness campaigns and by sharing information with relevant authorities. PLHAs can be made aware of the different government initiatives and programmes. With their expanded knowledge, they can effectively disseminate the message of risk reduction through a range of media. To raise awareness of HIV/AIDS, one can use print, radio, television, dance, and folk theatre, in addition to other media. These are the most efficient ways to raise public awareness of such a delicate subject.

5.14.9 Networking

An association of groups that get together to share resources, information, knowledge, and skills is referred to as a network. Each member's strengths and skills can be enhanced and sharpened through networking. They can share services and information with people and groups who share interests, and they can react to injustice more effectively. PLHAs rely on networking to support their effective self-management.

The worldwide network for and by individuals living with HIV/AIDS is called the Global Network of People Living with HIV/AIDS (GNP+). The GNP+ represents all HIV/AIDS-positive individuals. They bring up concerns about human rights, health rights, and the empowerment of HIV/AIDS patients. They can get assistance from a social worker in bringing to light issues that they are ignorant of. Social workers can build coordinated and cooperative relationships through networking to gain access to the resources of different social systems. They can establish connections with powerful community leaders, human services organisations, and other social structures like business and industry.

5.14.10 Resource Mobilization

The necessary resources must be gathered in order to carry out the suggested course of action. The resources could be external (funding, expert advice, other technical assistance, etc.) or internal (material, space, money, manpower, etc.).

The social worker can organize the necessary resources to deliver services to PLHAs in an efficient manner and with high-quality care. Resources for HIV/AIDS patients could be created, particularly since the majority of patients are unable to pay for their care. In addition to offering financial assistance for patient care, funders may be contacted to support other crucial tasks like organizing and managing training programmes, conducting research, and disseminating information. It's critical to mobilize resources from outside sources in these circumstances.

5.14.11 Public Interest Litigation (PIL)

A Public Interest Litigation (PIL) is a type of legal action brought in a court of law to enforce a general or public interest in which the general public, or a class of the community, has a financial interest or some other interest that affects their legal rights or obligations. PILs, then, are legal proceedings in which a person \requests relief for the benefit of the public at large rather than for personal gain (Mathew, 2010).

Justice can be served to those who, because of their ignorance or socioeconomic limitations, are unable to defend their rights through Public Interest Litigation (PIL). Individuals who are denied their legal and constitutional rights can receive assistance from social workers. If they believe that PLHAs are being discriminated against because of their positive status and that their human rights are being violated, they can file a case with the constitutional courts to seek justice on their behalf.

5.14.12 Strength based practice

Put simply, strength-based practices highlight strategies that build resilience rather than addressing deficiencies (Pulla V., 2006). The focus of strengths-based practices (SBPs) is on utilising people's innate strengths as individuals, families, groups and organizations to support their healing and empowerment. When it comes to working with individuals, groups, and organizations, SBPs are empowering substitutes for conventional methods. SBPs avoid using dehumanizing, stigmatizing, or labelling language. SBPs provide a constructive means of challenging pathologies and descriptions held by individuals, groups, and organizations that imply acceptance of their condition as hopeless or helpless to change (Pulla. V., 2012).

Each person has certain assets and capabilities that they can use to further their own empowerment. A social worker can assist PLHAs in recognizing and leveraging their strengths through SBPs, enabling them to maintain or regain their independence in day-to-day living. By using this strategy, PLHAs can strengthen their capacity for self-care and boost their self-worth and confidence, all of which will enable them to independently perform their daily activities.

5.15 Conclusion

In the care and treatment of individuals living with HIV/AIDS, the role of health care professionals is crucial. However, since they provide the best services to the PLHAs, professional social workers play an important role that cannot be undervalued. To find a solution, they bring up the problems of discrimination and stigma. Social workers advocate for PLHAs' rights and advance social justice in addition to their other roles. Throughout their studies at different colleges and universities, professional social workers with master's degrees in social work receive both theoretical knowledge and hands-on experience in the field. Working with PLHAs allows them to offer social, psychological, and emotional support that medical professionals might not be able to.

The chapter has covered the function of social workers in healthcare environments. The conclusions of this chapter show how professional social workers and other health care professionals interact differently. According to the respondents, social workers provide them with adequate referral services, advocate on their behalf, respect them for who they are, accept them as they are, listen to them carefully and patiently, and maintain confidentiality about their positive status. They also mentioned that social workers rarely saw them with other medical professionals. The chapter has also covered the use of social work techniques in HIV/AIDS care environments.

REFERENCES

1. Aggleton, P., Parker, R., & UNAIDS. (2002). World AIDS Campaign 2002-2003: A
   Conceptual Framework and basis for Action: HIV/AIDS Stigma and Discrimination.
   Retrieved from http://www.eldis.org/static/DOC10145.htm on 3/4/2012.
2. Barker, Robert L. (1999). The Social Work Dictionary (4th ed.). Washington, DC: NASW Press.
3. Bermingham, S., and Kippax, S. (1998). Infection Control and HIV-Related Discrimination and Anxiety, Glove Use during Venipuncture. Australian Family Physician, 27 (2), 655-69.
4. Bharat, S. and Aggleton, P. (1999). Facing the Challenge: Household Responses to HIV/AIDS in Mumbai, India. AIDS Care, 11, 31-34.
5. Bracht, N. F. (1978a). Social Work in Health Care: A Guide to Professional Practice. New York: Haworth Press.
6. Carlton, T. O. (1984). Clinical Social Work in Health Settings. New York: Springer.
7. Castro, A. and Farmer, P. (2005). Understanding and Addressing AIDS-related Stigma: From Anthropological Theory to Clinical Practice in Haiti. American Journal of Public Health, 95, 53-59.
8. Cohen, D., De La Vega, R., Watson, G. (2001). Advocacy for Social Justice. Bloomfield, CT: Kumarian Press Inc. Council on Social Work Education (1988). Curriculum Policy for the Master’s Degree and Baccalaureate Degree Programs in Social Work Education. Handbook of Accreditation Standards and Procedures, Washington, D C.
9. Chandra, P. S., Deepthivarma, S. and Manjula, V. (2003). Disclosure of HIV Infection in South India: Patterns, Reasons and Reactions. AIDS Care, 15, 207-215.

10. Chandra, P. S., Ravi, V., Desai, A. and Subbakrishna, K.K. (1998). Anxiety and Depression among HIV-infected Heterosexuals: A Report from India. Journal of Psychosomatic Research, 45, 401-409.
11. Dubois, B. L. and karlak Miley (1992). Social Work and Empowering Profession. USA: Allyn and Bacon.
12. Dunning, A. (2005). Information, Advice and Advocacy for Older People: Defining and Developing Services. York: Joseph Rowntree Foundation.
13. Dunning, A. (2010). A Scoping Study of Advocacy with Older People in Wales for the Older People's Commissioner for Wales. Older People's Commissioner for Wales, Cardiff.
14. Friedlander, W.A. (1955). Introduction to Social Welfare. New York: Prentice Hall, Inc.
15. Friedlander, W.A. (1958). Concepts and Methods of Social work. New Delhi: Prentice Hall.
16. Friedlander, W.A. (1977). Introduction to Social Welfare. NewDelhi: Prentice Hall.
17. Ganczak, Maria (2007). Stigma and Discrimination for HIV/AIDS in the Health Sector: A Polish Perspective. Interamerican Journal of Psychology, 41(1), 57.
18. Garvin et al. (2004). Handbook of Social Work with Groups. Jaipur: Rawat Publications. http://www.nimhans.kar.nic.in/psw/default.htm
19. International Definition of Social Work, Retrieved from http://apaswe.com/attachments/article/125/workshop_part1.pdf
20. Jenkins, R., Northway, R. (2002). Advocacy and the Learning Disability Nurse. British Journal of Learning Disabilities, 30 (1), 8-12.
21. Kermode, M., Holmes, W., Langkham, B., Thomas, M. S. and Gifford, S. (2005a). Safer Injections, Fewer Infections: Injection Safety in Rural North India. Tropical Medicine & International Health, 10, 423-432.
22. Kotwal, A., and Taneja, A. (2010). Health Care Workers and Universal Precautions:
    Perceptions and Determinants of Non-Compliance. Indian journal of Community Medicine, 35(4), 526-528.

23. Mathew, A. (2006). A Study on the Factors Related to the Attitudes of Health and Social Care Professionals towards HIV/AIDS Patients in Select hospitals of Hyderabad (Unpublished Doctoral Thesis). Osmania University, Hyderabad.
24. Mathew, P.D. (2010). Public Interest Litigation. In G. Thomas (Ed.), Social Work Intervention with Individuals and Groups. New Delhi, IGNOU.
25. Morrison Ken, Cuadra, and Silvia Magali (2004). HIV-related Stigma and Discrimination in Mexican Healthcare Services. Journal of Sexual health Exchange-2.
26. NACO (2007). Operational Guidelines for Programme Managers and Service Providers for Strengthening STI/RTI Services. Retrieved from http://nacoonline.org/upload/Policies%20&%20Guidelines/21,%20Operational%20 Guidelines%20STI%20RTI.pdf
27. NASW (1990). Social Work Practice in Health Field. In Aurther, 1991. Social Work Speaks: NASW Policy Statement, Silver Spring, M. D, National Association of Social Work, 172-174.
28. Nanavati, M.C., (1965). Social Action and the Professional Social Work. Social Work Forum, III (2), 26-29.
29. Nimbiakkim, Rose (2010). Social Work Intervention in Prevention and Control of HIV/AIDS. In G. Thomas (Ed.) HIV/AIDS: Stigma, Discrimination and Prevention, IGNOU, New Delhi.
30. Pincus, Allen and Minaham, Anna (1978). A Model of Social Work Practice. In Specht, Henry and Vickery, Anna (ed.), Integrating Social Work Methods (p.78). London: George Allen and Unwin.
31. Piot, P. (2001). World Conference against Racism, Racial Discrimination, Xenophobia and related Intolerance, Durban South Africa. Retrieved from http://www.unaids.org/whatsnew/speeches/eng/piot040901racism.htm
32. Pulla, V. (2012). What are Strengths Based Practices all About? In Venkat Pulla, Leseley Chenoweth, Abraham Francis and Stefan Bakaj (Eds.), Papers in Strengths Based Practice. Allied Publishers, Pvt. Ltd.

33. Radecki, S., Shapiro, J., Thrupp, L. D., Gandhi, S. M., Sangha, S.S., Miller, R. B. (1999). Willingness to Treat HIV-positive Patients at Different Stages of Medical Education and Experience. AIDS Patients Care and STDs, 13, 403-4.
34. Richmond, Marry (1922). What is Social Casework? New York: Russel Sage Foundation.
35. Ross, M. G. (1955). Community Organization: Theory and Principles. New York: Harper and Brothers.
36. Singh, Surender (1986). Social Action in Horizons of Social Work. In Surender S. & K. S Soodan. (ed). Harnam Publications.
37. The National Association of Social Workers (1973). Retrieved from http://socialwork.iu.edu/about iussw/what is social work.php
38. Thomas, Gracious (2009). Social Work Practicum: The practitioner’s Guide. New Delhi, IGNOU.
39. Thomas, Gracious (2010). Existing Trends in Counselling Services in India. In G. Thomas (Ed.), Substance Abuse and Counselling, IGNOU, New Delhi.
40. Taylor, B. (2001). HIV, Stigma and Health: Integration of Theoretical Concepts and the Lived Experiences of Individuals. Journal of Advanced Nursing, 35, 792-798.
41. Temoshok, L. R. and Chandra, P. S. (2000). The Meaning of Forgiveness in a Specific Situational and Cultural Context: Persons Living with HIV/AIDS in India. In M.E. McCullough, K. I. Pargament and C. E. Thoresen (eds.), Forgiveness: Theory, Research, and Practice (pp.41-64). New York: The Guilford Press.
42. Trecker, G. (1955). Social Group Work: Principles and Practices. New York: Association Press.
43. UNAIDS (2004). Press Release, Stigma biggest Hurdle to AIDS Prevention in South Asia. Satellite Session at XV International AIDS Conference on Critical Themes for AIDS in South Asia. Bankock.
44. WHO (2007). Standard Precautions in Health Care. Retrieved from http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf

CHAPTER - 6

RESEARCH METHODOLOGY

This chapter includes the methodology of research which is used to conduct study on Legal Awareness Study on Legal Rights of HIV/AIDS Victims in North Gujarat. This chapter includes the research design, statement of problem, need of the study, hypothesis to be tested and various components of methodology which helps in conducting a survey by collecting primary data with the help of a structured questionnaire. The tools and techniques used to test the hypothesis are explained in the chapter which helped in carrying out data analysis and infer interpretations to support the theoretical base of the research.

6.1 Need & Significance of Research

The researcher conducted the research work in the field to ascertain the Legal **Awareness Study on Legal Rights of HIV/AIDS Victims in North Gujarat**. Researcher interacted with various Counsellors of Integrated Counseling and Testing Centers (ICTCs) and Anti-Retroviral Therapy (ART) Centers, Doctors, Non-Governmental Organization (NGO) workers, nurses, patients and relatives of the patients on issues of discrimination, awareness, risk behavior and risk perception. This brought up certain pertinent questions in the mind of the researcher. The need of research was to gain knowledge as awareness is an important indicator that affected the discriminatory behavior of the society towards Human Immuno Deficiency Virus/ Acquire Immuno Deficiency Syndrome (HIV/AIDS) infected persons.

For future intervention or otherwise programmatic response to the epidemic would entail measurement of the knowledge of HIV/AIDS in society. National surveys have brought out this aspect and have presented data on knowledge level among the general population regarding this pertinent issue. It reports that nationwide only 17 percent of women and 33 percent of men have comprehensive knowledge of HIV/AIDS. Misconceptions about the disease are common and so the research is undertaken to explore this area. It is important to study the about HIV/AIDS as it will equip people to fight against stigma and discrimination associated with this epidemic and encourage safe and secured societal practices. Lack of proper understanding of HIV/AIDS can sometimes lead to discriminatory behavior towards the patients which is a violation of the human rights of an HIV infected person.

6.1.1 Research process flowchart

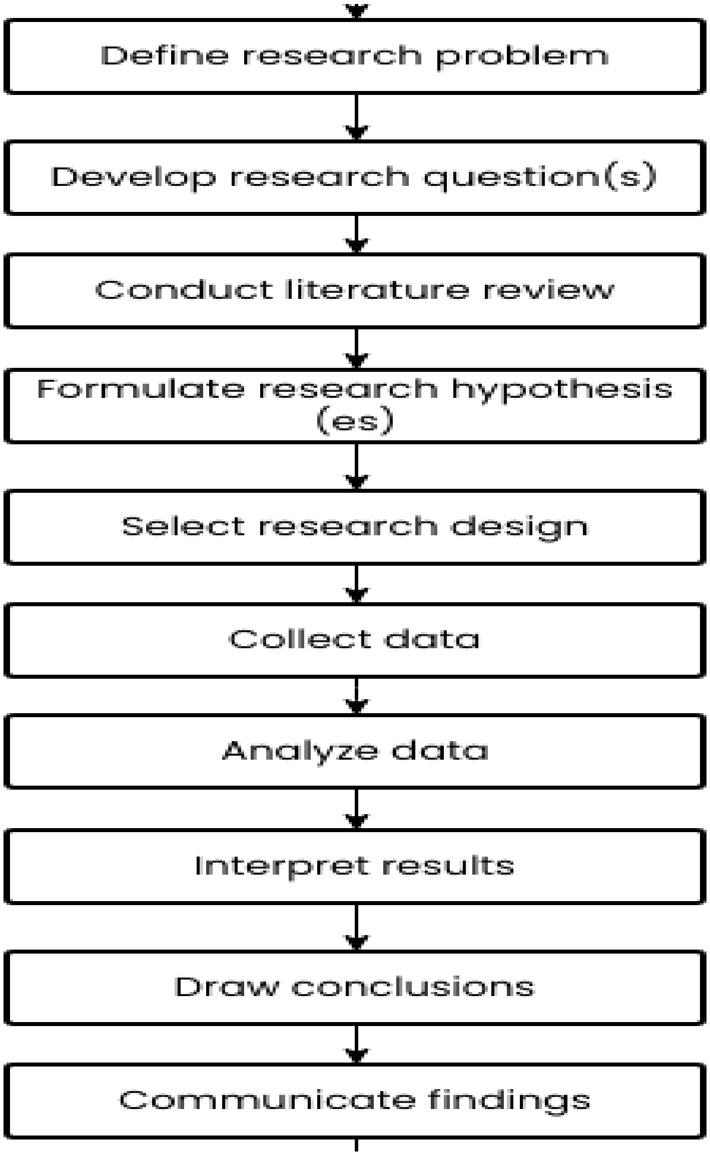

Fig 6.1: Flowchart of the Research Process

The research process flowchart outlines the steps involved in conducting the research study. The first step was to define the research problem and developing the research questions. An extensive literature review was conducted to identify the gaps in knowledge and provide a foundation for the research study. In the next step research hypotheses were formulated to predict the relationship between the independent and dependent variables in the study.

A quantitative and descriptive research design was formulated to conduct a valuable research and provide a clear answer to the research questions. The primary data was collected and analyzed using appropriate statistical methods, to find interpretation and find the results, and draw conclusions.

6.1.2 Scope of the Study

The broad objective of the study is **in the context of Legal Rights awareness of the HIV/AIDS patients in North Gujarat**. The study aims to bring out descriptive information regarding the discrimination with HIV/AIDS infected person. The study focused on the NGO workers who work with such individuals and try to uplift their position in the society.

6.1.3 Location of the Study

Four districts **(Aravalli, Mehsana, Patan, Palanpur)** of the Gujarat state were selected for the study

6.2 Objectives of the Study

1. To critically asses the Legal Rights and state-mediated HIV/AIDS awareness programs in Gujarat.
2. To examine the role of law in protecting against discriminatory behavior with HIV positive individuals.
3. To understand the perspectives of the society regarding the HIV/AIDS.
4. To examinewhat kind of discriminatory behavior is done by people with positive persons.

6.3 Hypothesis

H_{O1}: **There is no significant relationship between gender of** HIV patients **and their** awareness towards legal rights

H_{A1}: **There is a significant relationship between gender of** HIV patients **and their** awareness towards legal rights

H_{O2}: The **role of law** to protect the **legal rights of patients** with HIV is **not significant**

H_{A2}: The **role of law** to protect the **legal rights of patients** with HIV **is significant**

6.4 Research Design

A research design is a framework or blueprint for conducting the research. It details the procedure necessary for obtaining the information needed to structure or solve the research problem.

The researcher has implied descriptive research design to analyses the qualitative and quantitative data with appropriate statistical techniques.

The research design used by the researcher is in accordance with the quantitative study requirements. As such, it covers the type of data collected, the methodology of data collection and the various statistical tools and techniques used for analysis of data and hypotheses - testing.

Being a survey, it is based on primary data collected by the researcher through well designed, structured and comprehensive questionnaire developed in view of the theoretical literature and existing research findings, personal interview and discussions. The questionnaire was administered on the patients to know what kind of behavior is exhibited by others at family and workplace with them and another questionnaire was administered on NGO workers who work in the field to safeguard the lives of positive patients and help them to cope up with the negative behavior and role of the society

The tool for primary data collection is structured with various statements showing relationship with the research objective. The questionnaires were distributed for data collection to the sampled respondents to study the Legal Awareness Study on Legal Rights of HIV/AIDS Victims in North Gujarat.

The data selected through the survey was coded and tabulated in accordance with the research objectives in the form of bivariate and multivariate representation of tables. The data was analyzed by the researcher by applying statistical tools and techniques to test the hypothesis and draw inferences by using exploratory factor analysis, ANOVA and Chi square.

6.5 Type of Research

6.5.1 Descriptive Research

Descriptive research is a research method used to try and determine the characteristics of a population or particular phenomenon. This type of design aims to describe or document the characteristics, behaviors, attitudes, opinions, or perceptions of a group or population being studied.

Descriptive research design does not attempt to establish cause-and-effect relationships between variables or make predictions about future outcomes. Instead, it focuses on providing a detailed and accurate representation of the data collected, which can be useful for generating hypotheses, exploring trends, and identifying patterns in the data. Survey research is ideal if you’re using descriptive research as your primary research.

6.5.2 Sampling Plan

The sampling plan constitutes of the method of selecting sample units for the study in the sample from the target population. This study includes the non- probability sampling plan to select sample units from the population. The sampling technique used to select the sample is multistage random sampling where the first stage of sample processing is carried by selection of districts in north Gujarat and then at second stage selection of NGO from these districts.

The next stage of sampling was carried to select the sample to act as respondents for the further research and the respondents were segregated on the basis of different districts. The later stage of sampling includes survey of the selected sample through survey questionnaire. The tool of data collection is used to collect primary data from the selected respondents and secondary data is collected through published works.

6.5.3 Population

The population of the research study includes patients from four selected districts and all the employees who are working in the NGO also located in the four selected districts of north Gujarat.

6.5.4 Sample Size

The sample size constitutes of 400 Patients from the 4 districts and 200 employees who are working in the NGO located in the four selected districts of north Gujarat. From each district 100 and 50 sample units are selected respectively for the study.

6.5.5 Period of Study

The study covers a period of 3 years.

6.6 Research Methodology

The method of research is quantitative and the data is collected through survey questionnaire. The response rate of questionnaire filling is 80%, 20% of the respondents did not complete the questionnaire.

6.6.1 Tool of Data Collection

A primary questionnaire was designed to collect the responses from NGO workers and HIV positive patients who were selected randomly to test the survey tool

Once the response from 50 respondents were received, the questionnaire was improved by the researcher to remove the unnecessary questions and those who were difficult to be answered by the respondents. Cleaning and purifying, is the most common way of guaranteeing that your information is right, steady, and usable for the research purpose. Rectification, addition, deletion etc. was done on a case by case basis to keep the mistake from reoccurring.

Reverse scaling was done during the pilot study, to check the biasness of respondents. The researcher asked a few open-ended questions to know the view of respondents on the mentioned parameters and after corrections the tool of data collection was finalized to collect data from the large sample.

6.6.2 Validity and Reliability Test

Reliability is the consistency of the measurement; the results will not change every time when testing in the same way with the same subject. “A measure is considered reliable if a person's score on the same test given twice is similar.” Reliability cannot be measured only can be estimated.

Validity suggests that if the measure measures what it supposed to analyze. In short, validity is about the accuracy of the measurement. It is vital for a test to be valid in order for the results to be accurately applied and interpreted. Validity is not determined by a single statistic, but by a body of research that demonstrates the relationship between the test and the behaviour it is intended to measure.

The value of Cronbach's alpha test for the final questionnaire with a sample of 400 respondents is .852 which is excellent, according to different theory of reliability value above 0.6 is appropriate, low value below the 0.5 implies that reliability may not be appropriate.

Thus, the final questionnaire was used for gathering primary information that has been enclosed as Appendix I.

6.6.3 Statistical Tool Applied

Statistical tools like,ANOVA test, Correlation and Chi-square test are used for the analysis of the data Table, Graphs and Diagrams are also used to present the processed data.

Chi- square Test

The hypothesis was tested by applying a non- parametric test **Chi-square (x^2test).** The quantity **x^2**describes the magnitude of discrepancy between theory and observation.

The formula

$$x^2 = \frac{\sum(F_o - F_e)^2}{F_e}$$

Fo= Observed frequency

Fe = expected frequency

Steps for Calculation of (x^2) Chi-Square

i) Compute the expected frequencies (Fe)

ii) (Fo-Fe) is computed.

iii) $(Fo\text{-}Fe)^2$ is calculated.

iv) The squared differences between frequencies $(Fo\text{-}Fe)^2$ are divided by expected frequency (Fe) that is $(Fo\text{-}Fe)^2$ / Fe is calculated.

v) These quotients are added together to obtain the total of computed of x^2 values that is Σ $(Fo\text{-}Fe)^2$ /Fe is obtained.

vi) The degrees of freedom (d.f.) are calculated from the frequency table called contingency table by using the formula.

d.f. = (c-1) (r-1)

c = number of cell frequencies in columns

r = number of cell frequencies in rows

vii) The computed value is then compared to the tabular value of x^2

viii) If the computed value is lesser than tabular value the null hypothesis is accepted.

Conditions for using x^2 test

- The experimental data or sample observations must be independent of each other.
- The data collected must be drawn at random from the universe or population.
- The data must be presented in original units.

Correlation

The statistical tool with the help of which relationship between two or more than two variables is studied is correlation.

The Karl Pearson's method, popularly known as Pearsonian coefficient of correlation, is most widely used. The coefficient of correlation is denoted by r. this symbol is used for describing the degree and direction of relationship between two variables.

$$r = \frac{N\sum xy - (\sum x)(\sum y)}{\sqrt{[N\sum x^2 - (\sum x)]^2\,[N\sum y^2 - (\sum y)^2}}$$

Where,

N = Number of pairs of scores

$\sum xy$ = sum of the products of paired scores

$\sum x$ = Sum of x scores

$\sum y$ = sum of y scores

ANOVA

Analysis of variance, also called ANOVA, is a collection of methods for comparing multiple means across different groups. The "analysis of variance" procedure or "F" test is used for the significance of the difference among more than two sample means.

Assumptions in Analysis of Variance

The analysis of variance technique is based on the following assumptions:

1. Each sample is drawn randomly from a normal population and the sample statistics tend to reflect the characteristics of the population
2. The population from which the samples are drawn have identical means and variances

Computation of Analysis of Variance

The null hypothesis while applying analysis of variance technique is that the means of different samples do not differ significantly. It can be calculated in two ways-

<u>One -way classification, and Two -way classification</u>

Anova is a statistical test which analyzes variance. It is helpful in making comparison of two or more means which enables a researcher to draw various results and predictions about two or more sets of data. Anova test includes one-way anova, two-way anova or multiple anova depending upon the type and arrangement of the data. One-way anova has the following test statistics:

$$F = \frac{\mathrm{MST}}{\mathrm{MSE}}$$

Where,

F = Anova Coefficient

MST = Mean sum of squares due to treatment (**Formula is given below)**

MSE = Mean sum of squares due to error. (**Formula is given below)**

$$\mathrm{MST} = \frac{\mathrm{MSE}}{\mathrm{p} - 1}$$

$$\boldsymbol{SST} = \sum \boldsymbol{n}(\boldsymbol{X} - \overline{\boldsymbol{X}})^{\mathbf{2}}$$

Where,

SST = Sum of squares due to treatment

p = Total number of populations

n = Total number of samples in a population.

And Formula for MSE is:

$$MSE = \frac{SSE}{N - p}$$

$$S = \sum (n-1)S^2$$

Where,

SSE = Sum of squares due to error

S = Standard deviation of the samples

N = Total number of observations.

ANOVA is used to test the significance of group differences between two or more groups when the IV has two or more categories and it only determines that there is a difference between groups, but doesn't tell which is different.

6.7 Limitations of the Research

- The study is limited to selected districts of north Gujarat region and with some HIV patients and employees of NGO in selected region only.
- The study is limited to only one aspect, i.e., legal awareness of HIV patients
- The sample size remains limited
- Some of the conclusions are based on the estimates, assumptions, observations and informal interviews
- Primary data collection was difficult and so the responses may be biased.

CHAPTER - 7

DATA ANALYSIS AND INTERPRETATION

This chapter is one of the most important chapters of the thesis as it incorporates the analysis of the data collected from the respondents. The previous chapter discussed the research methodology and research design, data collection tool and other aspects of analysis and in this section the implementation of research methodology is presented wherein the data collected is coded and tabulated along with statistical analysis.

The demographic profile of respondents is presented in this chapter and tables and graphs are used to depict the collected data which is further analyzed by testing the formulated hypothesis. The chapter spreads over sections, each section is dedicated to a specific objective and hypothesis. Hypothesis testing is done to establish the objectives of the research.

Demographic profiling is a key tool in market research, social analysis, and public policy formulation, enabling a deeper understanding of the diversity within a given population

In the chapter on Data Analysis and Interpretation, the focus is on extracting meaningful insights from collected data, transforming raw information into actionable knowledge. This crucial phase involves employing statistical methods, visualization techniques, and analytical tools to uncover patterns, trends, and correlations within the dataset. The chapter delves into the application of appropriate statistical tests, data cleaning processes, and data transformation methods to ensure accuracy and reliability. Furthermore, it addresses the importance of presenting findings through clear and impactful visualizations, aiding in the effective communication of results.

Ultimately, the chapter emphasizes the significance of thoughtful interpretation, guiding readers through the process of drawing meaningful conclusions and implications from the analyzed data. This stage is pivotal in bridging the gap between raw data and informed decision-making, contributing to the overall validity and relevance of the study.

7.1 Section1 Demographic Profile

A demographic profile provides a concise overview of the characteristics of a population or a specific group, typically including information such as age, gender, race, ethnicity, education, income, and other relevant factors. This profile is essential for understanding the composition of a population, allowing researchers, policymakers, and businesses to tailor their strategies, products, or services to meet the specific needs and preferences of different demographic segments.

Table 6.1: Gender of the Patients

Gender	Respondents
Male	244
Female	156
Total	400

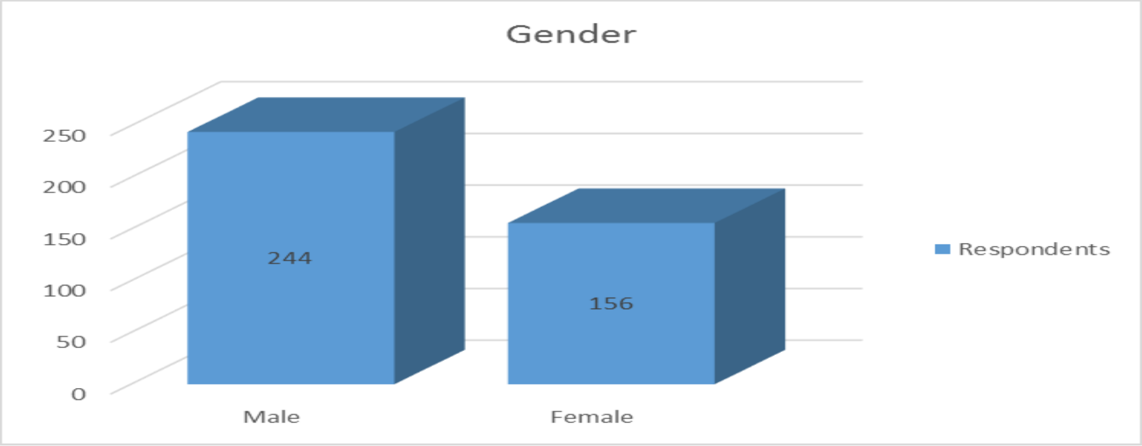

Fig. 6.1: Gender distribution

Interpretation

The above table clearly shows that The respondents were classified into two groups on the basis of their Gender. Maximum respondents 244 out of 400 were male whereas only 156 respondents were females.

Table 6.2: Category of the Patients

Category	**Respondents**
General	104
SEBC	75
EWS	24
ST	87
SC	78
Others	32
Total	400

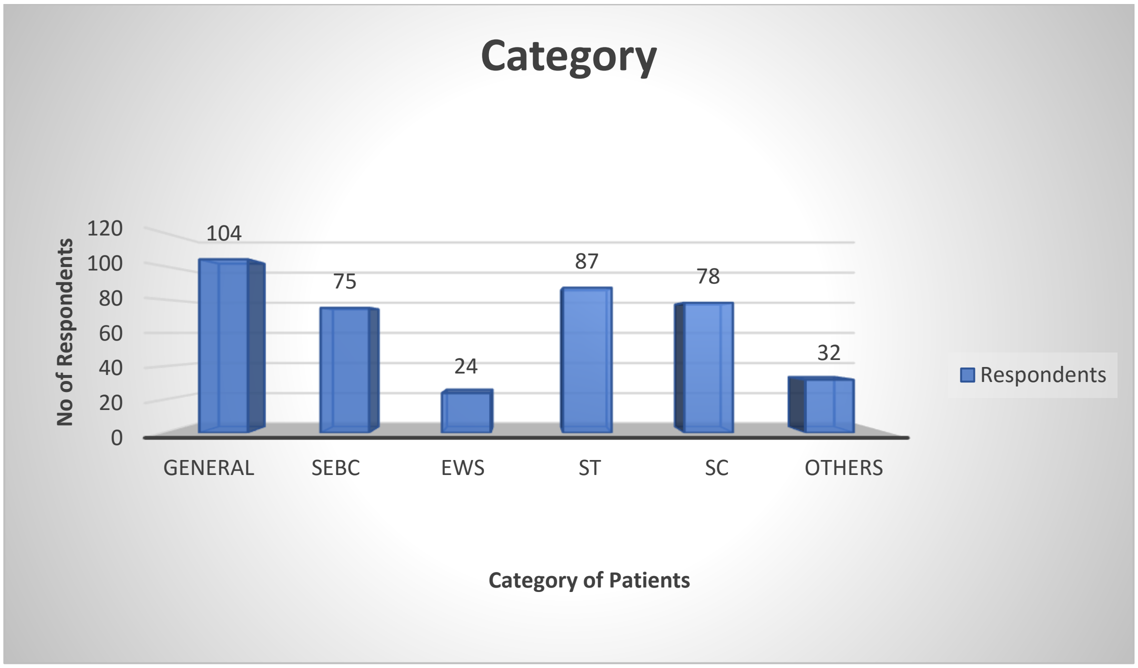

Fig. 6.2: Category distribution of the Patients

Interpretation

The above table clearly shows that the respondents were classified into six groups on the basis of their category Maximum respondents 104 out of 400 were falling in the general category and minimum 24 were falling in the EWS category.87 in the ST category and 78 in the SC category were recorded.

Table 6.3: Religion of the Patients

Religion	**Respondents**
Hindu	202
Muslim	53
Christian	84
Sikh	24
Others	37
Total	400

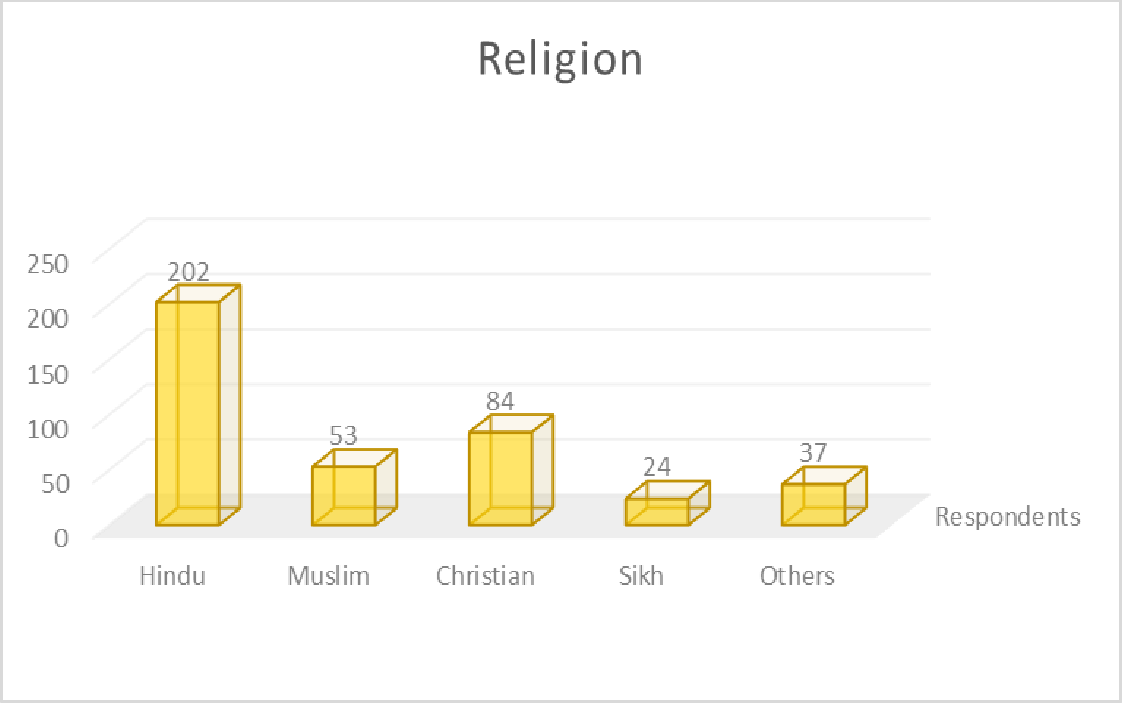

Fig. 6.3: Distribution of the Religion

Interpretation

The above table clearly shows that The respondents were classified into five groups on the basis of their religion. Maximum respondents 202 out of 400 was falling in the category Hindu and minimum 24 were falling in the Sikh religion category, 53 were Muslim and 84 were Christians while some of them fall in the others category.

Table 6.4: Location of the workplace of the Patients

Working area	**Respondents**
Rural	237
Tribal	18
Urban	145
Total	400

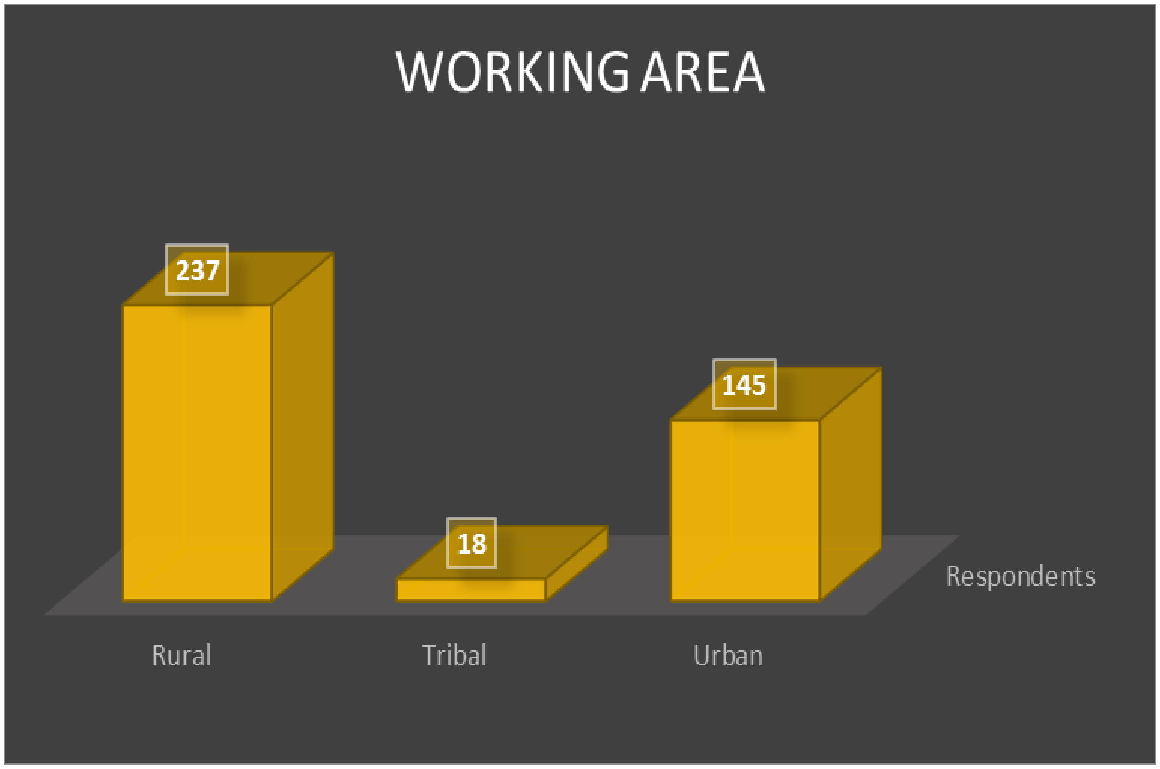

Fig. 6.4: Workplace Area Distribution

Interpretation

The above table clearly shows that out of 400 sampled respondents 237 are working in the rural area and 145 in urban area. Only 18 of them are working in the tribal area.

7.2 Section 2 Bivariate and Multivariate Representation

Table 6.5: Gender likely to be victim of discriminatory behavior

Gender likely to be victim of discriminatory behavior	**Respondents**
Male	257
Female	143
Total	400

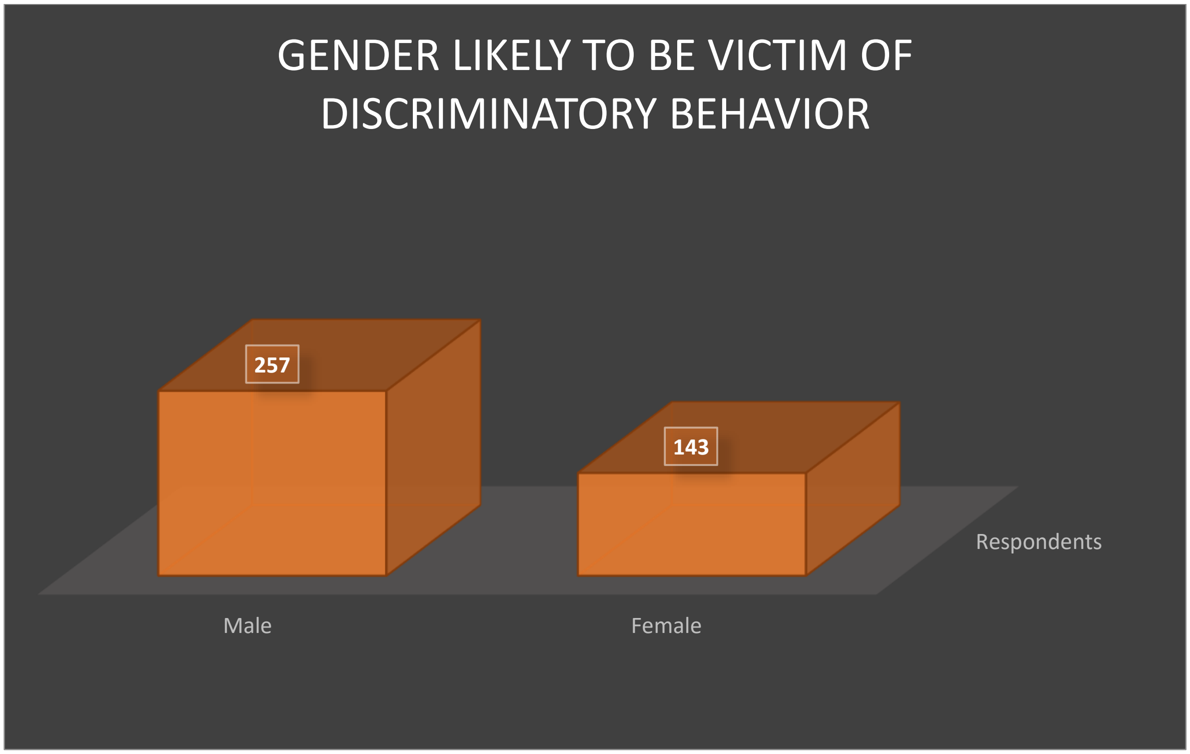

Fig. 6.5: Gender likely to be victim of discriminatory behavior

Interpretation

The above table clearly shows that male as well as female Gender is likely to be victim of discriminatory behavior. Out of 400 respondents 257 males and 143 females Patients of HIV/AIDS agree that they have to face discriminatory behaviour in the society.

Table 6.6: Relative engaged in discriminatory behavior

Relative engaged in discriminatory behavior	**Respondents**
Husband/Wife	99
Family Members	80
Relatives	101
Village People	84
Others	36
Total	400

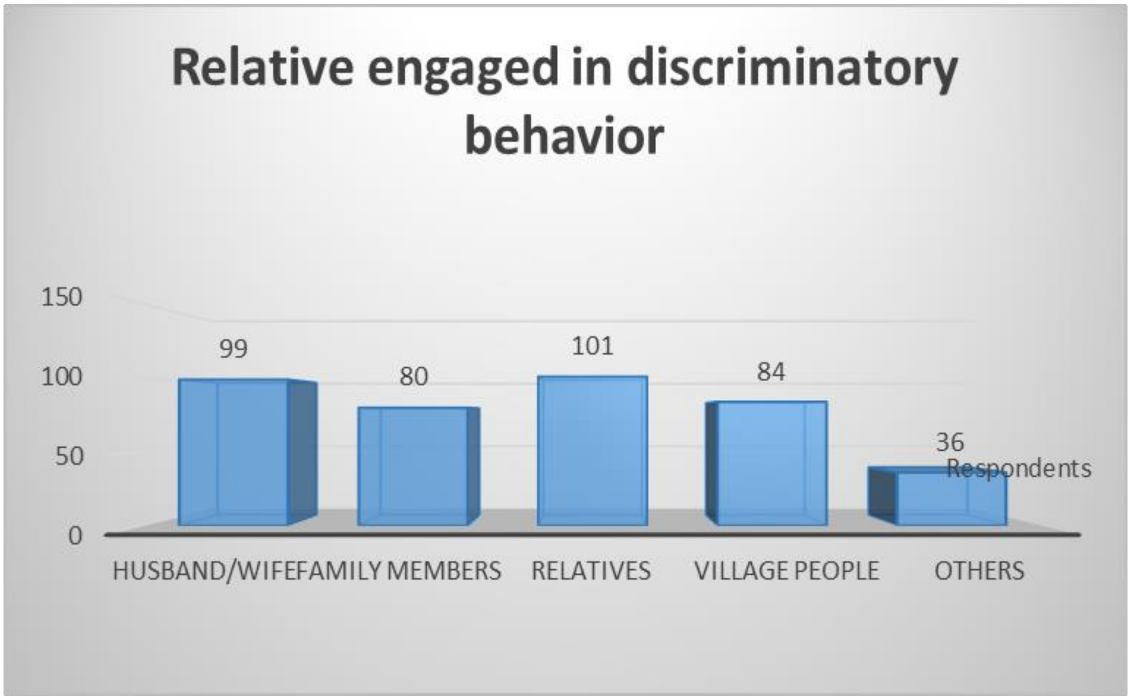

Fig. 6.6: Relative engaged in discriminatory behavior

Interpretation

The above table clearly shows that discrimination is generally done by Relatives and by spouse. it is also found that family members and village people are also engage in such type of behavioral bias.

Table 6.7: Area of discriminatory behavior

Area of discriminatory behavior	**Respondents**
At work place	317
At Home	83
Total	400

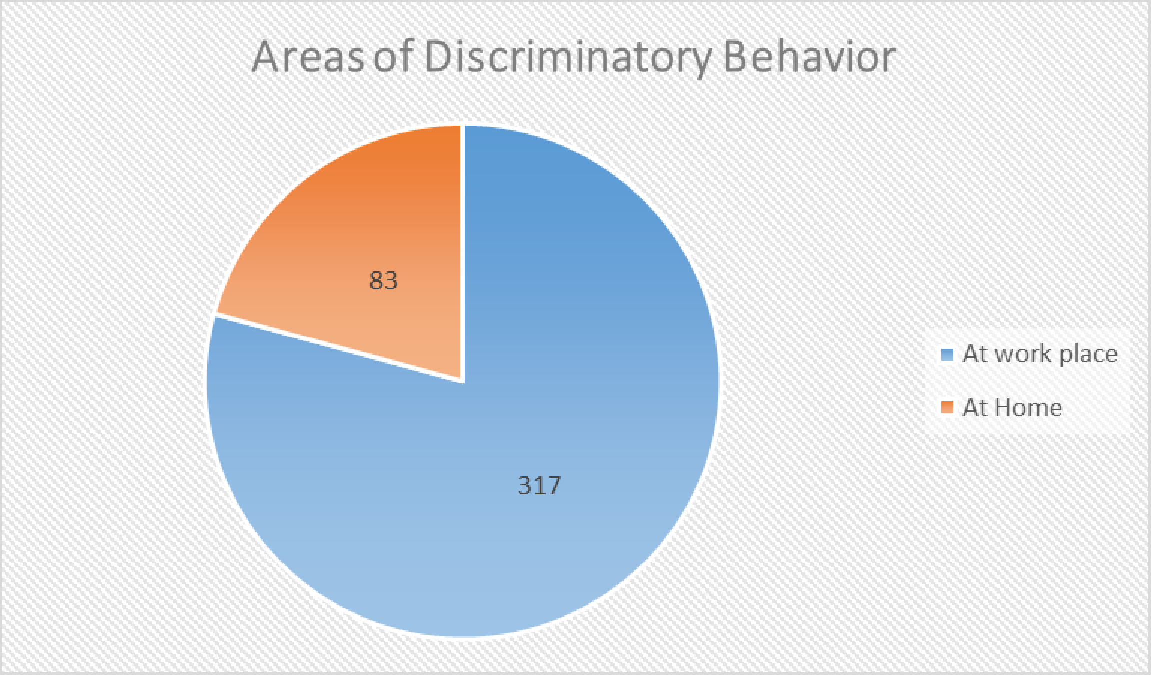

Fig. 6.7: Area of discriminatory behavior

Interpretation

The above table clearly shows that discriminatory behavior is more common at workplace. Out of 400 respondents 317 reveal that they face discrimination at work place more and 83 opined that it is more at home.

Table 6.8: HIV cases having cohabitation breakdown

HIV cases having cohabitation breakdown	Respondents
Yes	252
No	148
Total	400

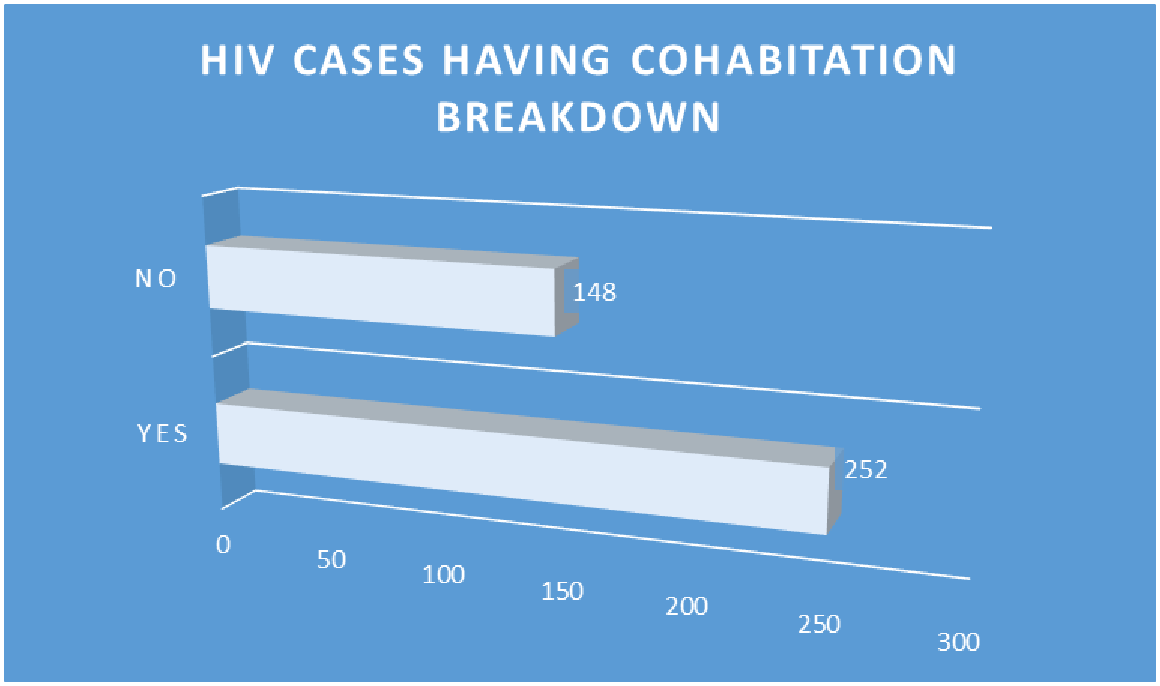

Fig. 6.8: HIV cases having cohabitation breakdowns

Interpretation

The above table clearly shows that out of 400 respondents 252 said yes to HIV cases having cohabitation breakdown and 148 say no to such practice

Table 6.9: HIV patients complaining against defamation or injustice

HIV patients complaining against defamation or injustice	**Respondents**
Yes	302
No	98
Total	400

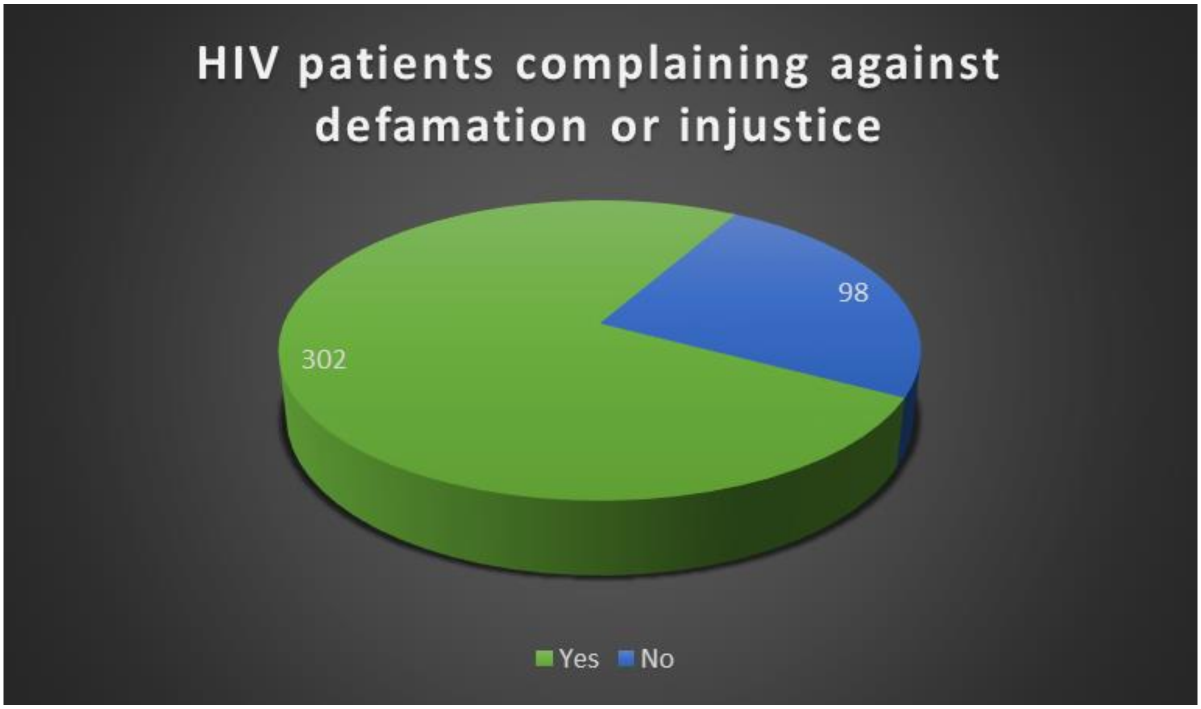

Fig. 6.9: HIV patients complaining against defamation or injustice

Interpretation

The above table clearly shows that HIV patients complaining against defamation or injustice is increasing and 302 agree that they are now open to complain about any wrong practice or behavior.

Table 6.10: HIV patients requiring legal assistance

HIV patients requiring legal assistance	**Respondents**
Yes	286
No	114
Total	400

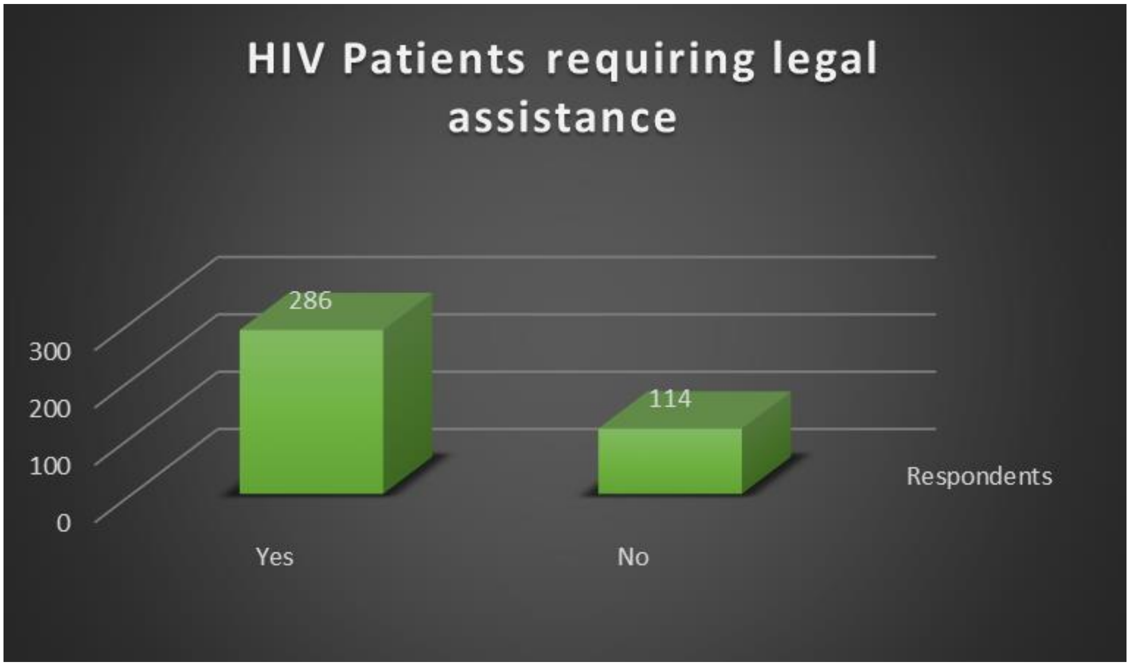

Fig. 6.10: HIV patients requiring legal assistance

Interpretation

The above table clearly shows that out of 400 respondents 286 agree that HIV patients require legal assistance for malpractices against them

Table 6.11: Patients Aware About Laws Related to HIV

Patients Aware About Laws Related to HIV	**Respondents**
Yes	39
No	361
Total	400

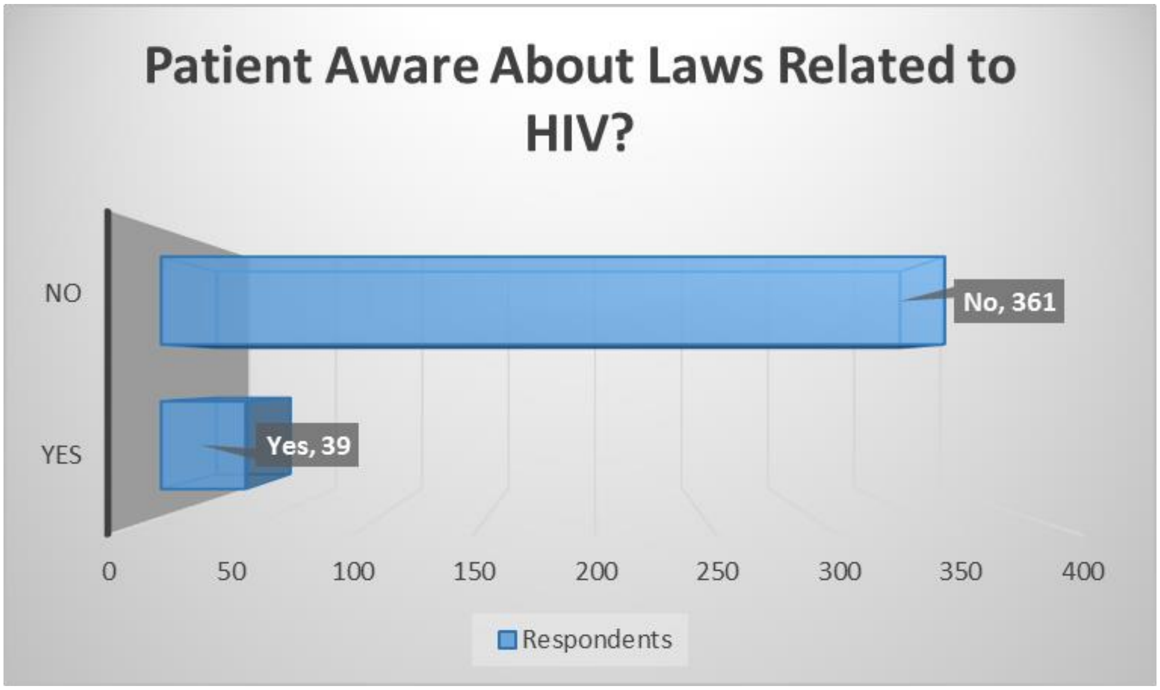

Fig. 6.11: Patients Aware About Laws Related to HIV

Interpretation

The above table clearly shows that awareness of Patients About Laws Related to HIV is very low only 39 say yes that they are aware but majority 361 say that they are not aware about their legal rights.

Table 6.12: Are HIV protection laws appropriate

Are HIV protection laws appropriate	**Respondents**
Yes	314
No	86
Total	400

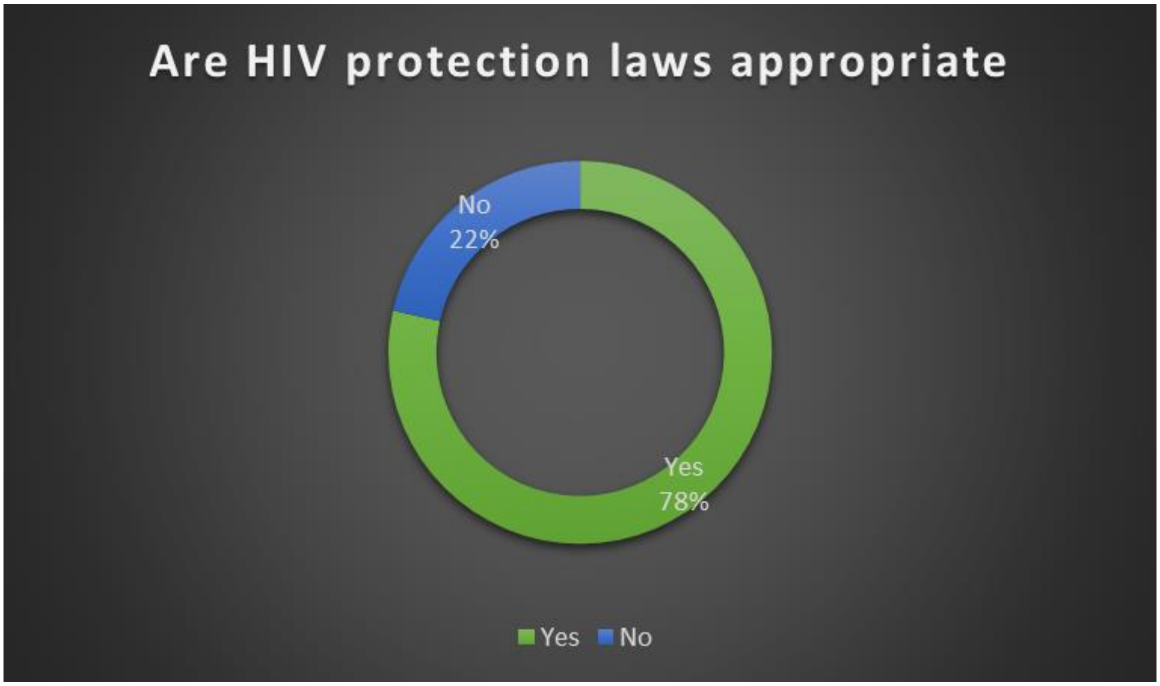

Fig. 6.12: Are HIV protection laws appropriate

Interpretation

The above table clearly shows that majority 314 out of 400 respondents say that HIV protection laws are appropriate and only 86 respondents deny that these laws are sufficient.

Table 6. 13: Gender of Respondents

Gender	**Respondents**
Male	244
Female	156
Total	400

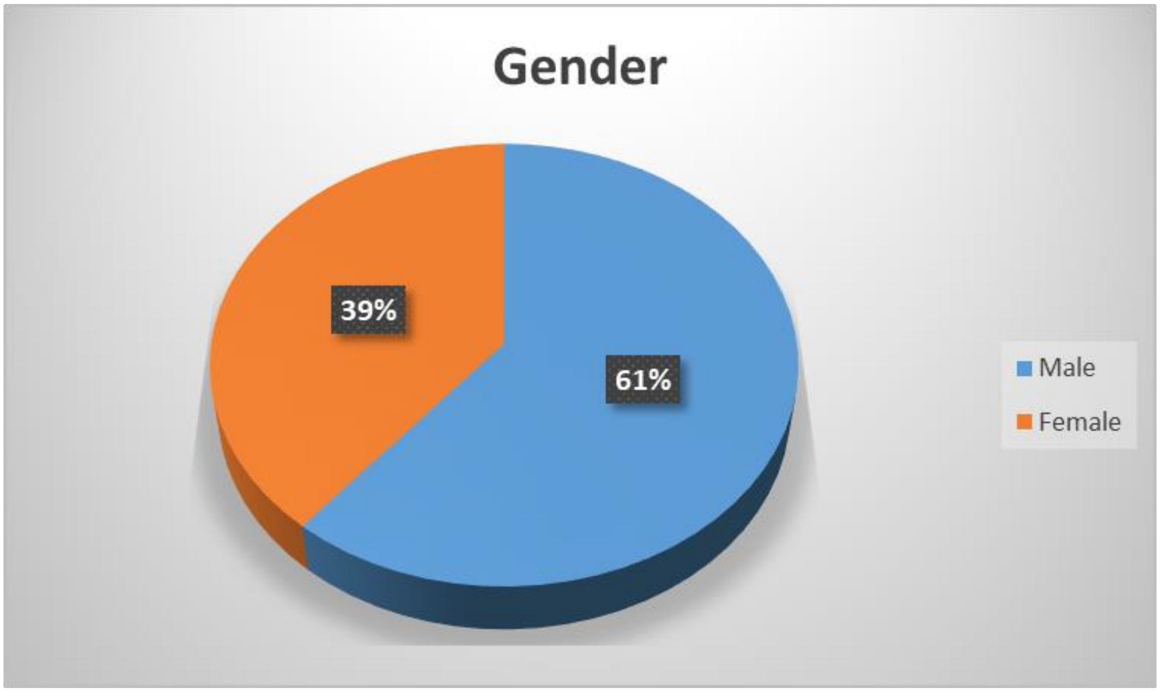

Fig. 6.13: Gender of respondents

Interpretation

The above table clearly shows that The respondents were classified into two groups on the basis of their Gender. Maximum respondents 244 out of 400 were male whereas only 156 respondents were females.

Table 6. 14: Category of respondents

Category	**Respondents**
General	104
SEBC	75
EWS	24
ST	87
SC	78
Others	32
Total	400

Fig. 6.14: Category of respondents

Interpretation

The dataset categorizes 400 respondents into various groups, reflecting the demographic diversity within the sample. Among these, 104 respondents are classified as General, 75 as SEBC (Socially and Economically Backward Classes), 24 as EWS (Economically Weaker Sections), 87 as ST (Scheduled Tribes), 78 as SC (Scheduled Castes), and 32 respondents fall under the "Others" category. This categorization provides a snapshot of the social and economic composition of the surveyed population, offering valuable insights into the distribution of respondents across different classifications. Understanding these demographics is essential for gaining a nuanced perspective on the experiences and opinions of individuals from various social backgrounds.

Table 6. 15: Types of Family

Types of Family	Respondents
Joint	298
Nuclear	102
Total	400

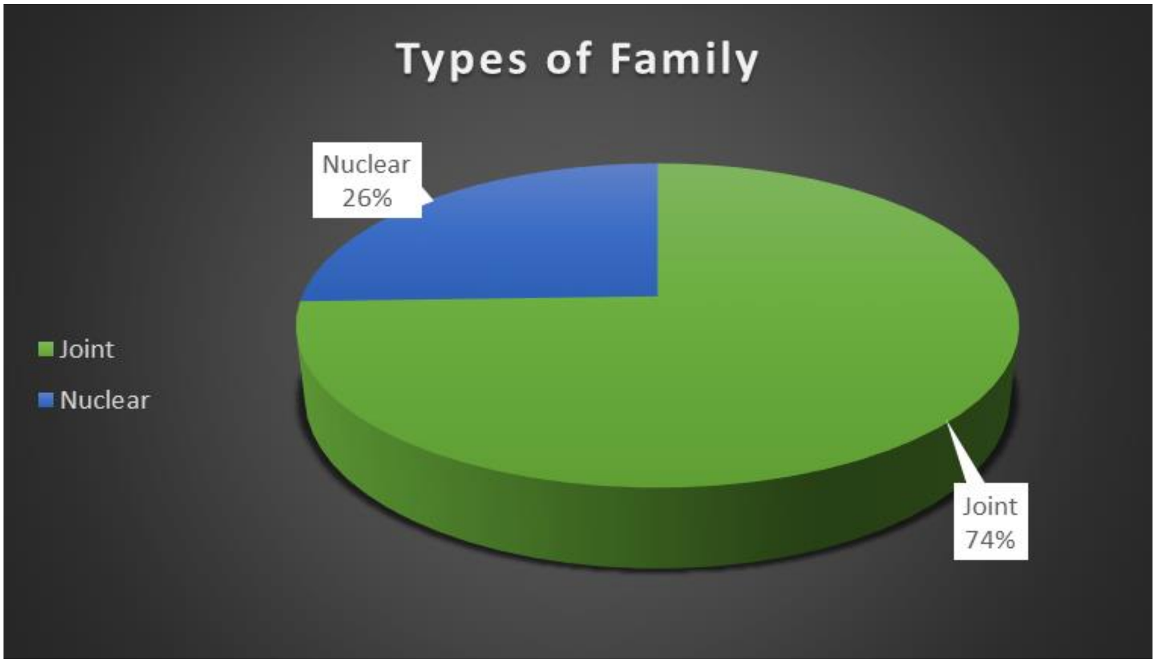

Fig. 6.15: Types of Family

Interpretation

The above table clearly shows that The respondents were classified into two groups on the basis of their family type. Maximum respondents 298 out of 400 were living in joint family whereas only 102 respondents were having a nuclear family.

Table 6. 16: Education Status

Education	Respondents
Uneducated	162
Primary	43
Secondary	72
Sen. Secondary	63
UG	32
PG	28
Total	400

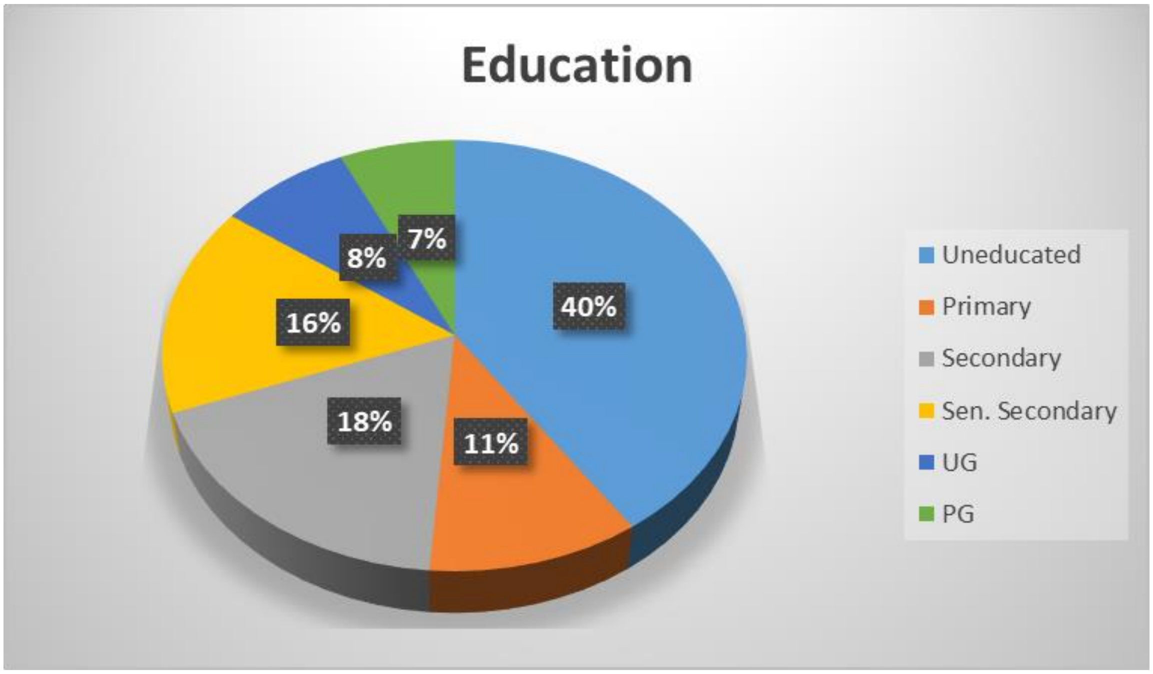

Fig. 6.16: Education Status

Interpretation

The above table clearly shows the educational qualification of the respondents The respondents were classified into six groups on the basis of their highest education. Maximum respondents 162 out of 400 were uneducated whereas 72 were having secondary education and only 28 were PG and 28 were UG.

Table 6. 17: Marital Status

Marital Status	**Respondents**
Single	81
Married	253
Widowed	29
Divorced	37
Total	400

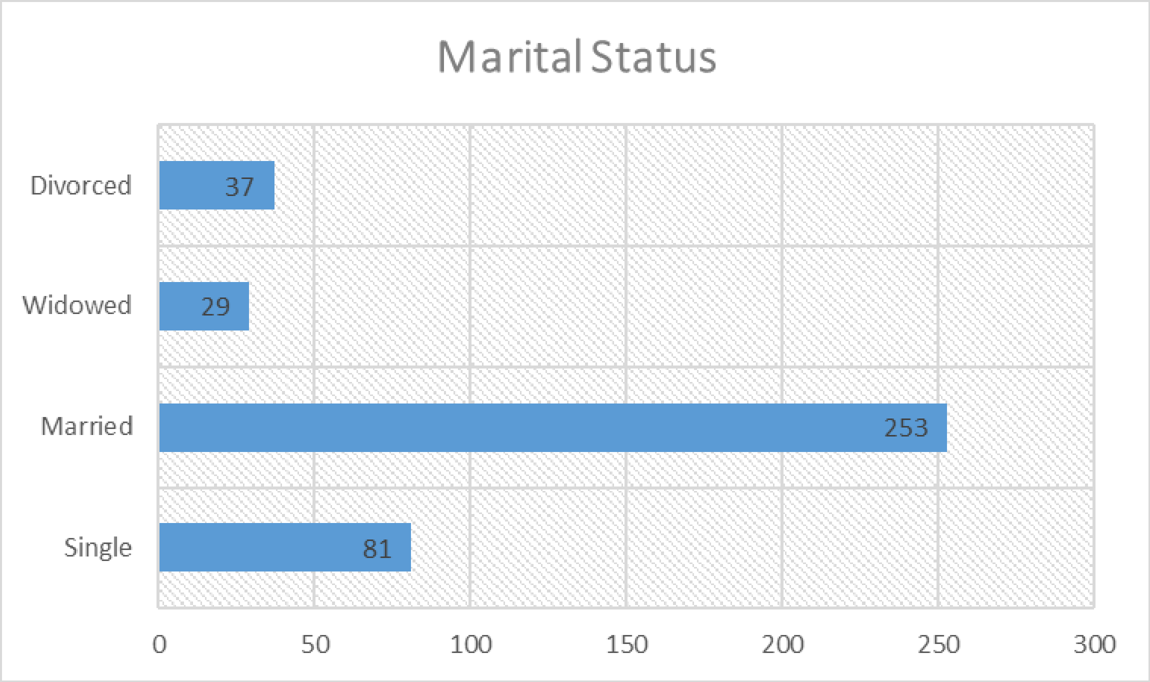

Fig. 6.17: Marital Status

Interpretation

The above table clearly shows the marital status. The respondents were classified into four groups on the basis of their status. Maximum respondents 253 out of 400 were married only 81 were single whereas 27 were divorced.

Table 6. 18: Source of HIV related information

Source of HIV related information	**Respondents**
News Paper	11
Books	7
Posters	49
Magazines	2
Radio	24
TV	31
Friends	77
Health Workers	87
Doctors	26
HIV positive patient	11
attending work-shop	4
Through NGO	58
Others	13
Total	400

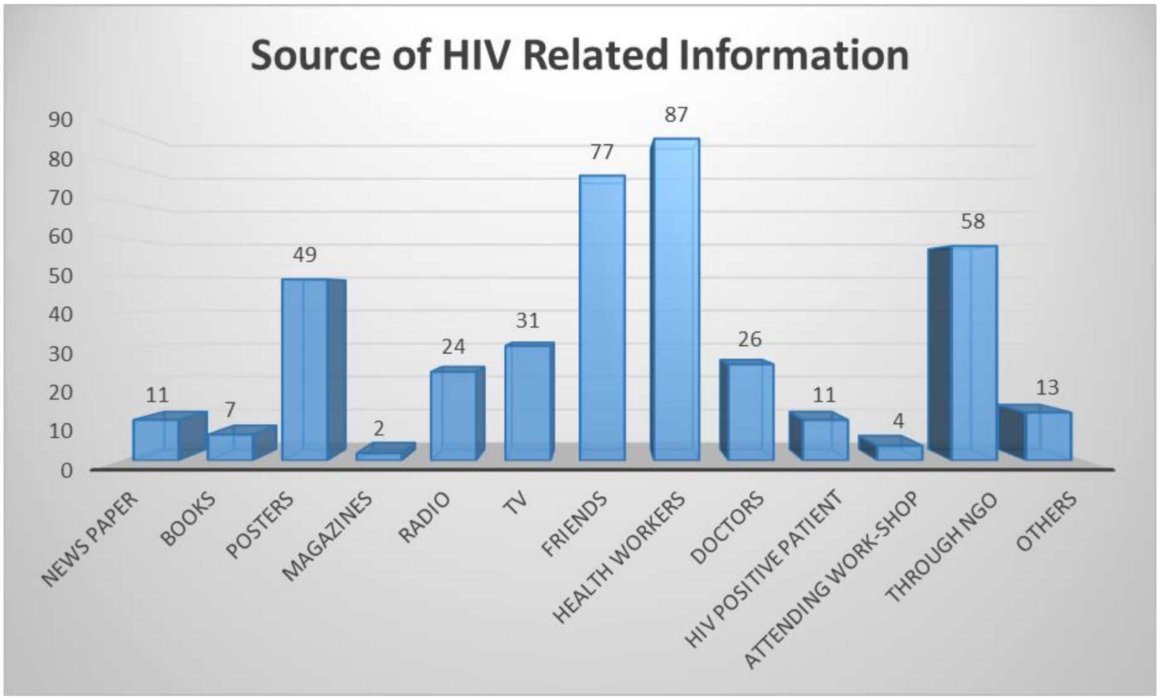

Fig. 6.18: Source of HIV related information

Interpretation:

The above table shows the s**ource of HIV related information** to the respondents. Maximum respondents 87 out of 400 received information through health workers and 77 from friends and 58 from NGO workers.

Table 6. 19: Reason behind getting affected to HIV

How did you got affected to HIV	**Respondents**
Through interpersonal relationship with HIV infected person	19
Through HIV infected Blood transfusion	146
Through Mother got transmitted to Child	14
Through the use of a unsterilized needle	194
Other	27
Total	400

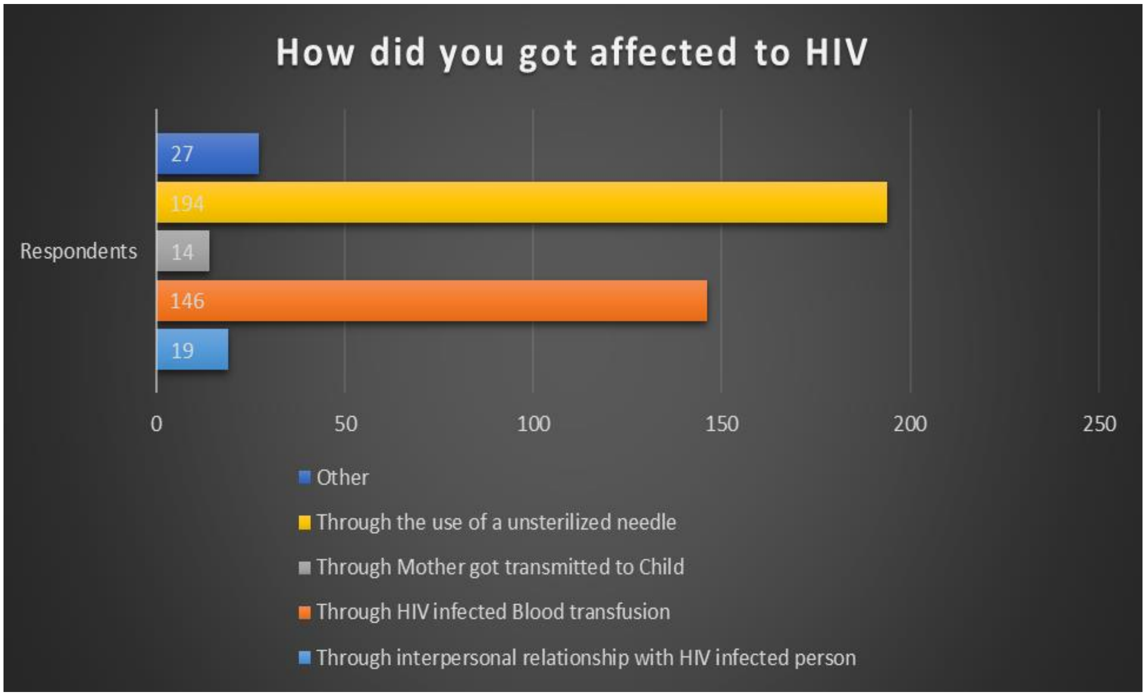

Fig. 6.19: Reason behind getting affected to HIV

Interpretation

The above table shows the means **of HIV infection**. Maximum respondents 194 out of 400 received Through the use of unsterilized needle and 146 Through the use of a unsterilized needle ,19 Through interpersonal relationship with HIV infected person and 14 through infected mother, rest of them were infected by other means

Table 6. 20: Advise to get check-up of problems was received from

Who advised you to get check-up of problems?	**Respondents**
Doctor	41
NGO worker	137
Friend	94
Family member	93
Relative	16
Other	19
Total	400

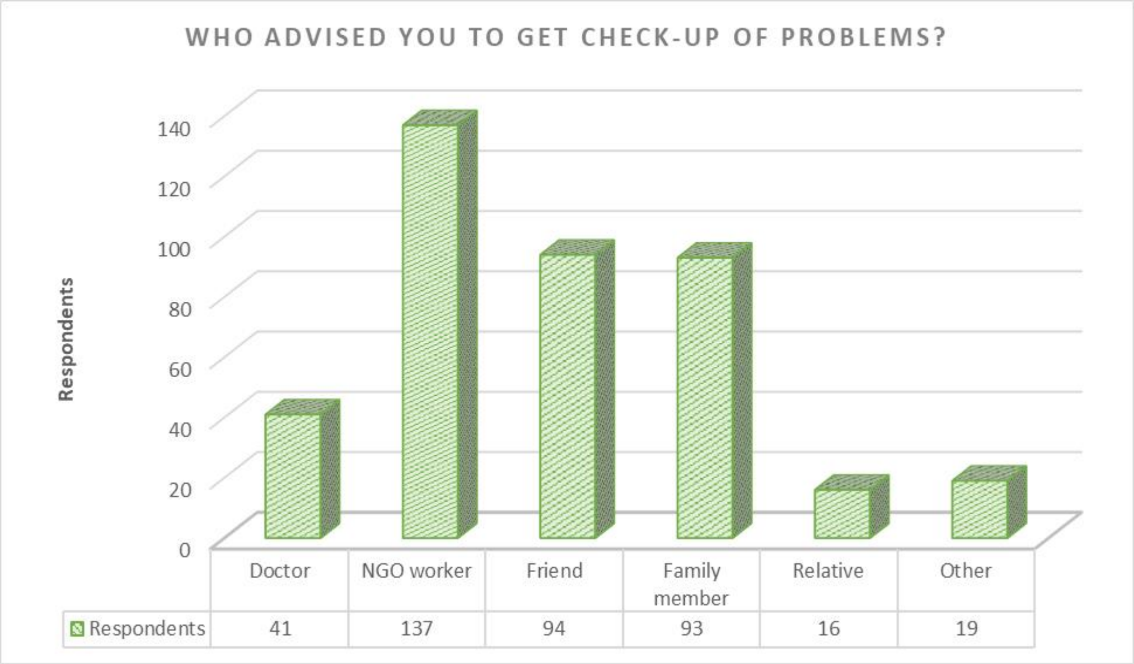

Fig. 6.20: Advise to get check-up of problems was received from

Interpretation

The above table shows that maximum patients 137 were advised by NGO workers to get check-up of problems followed by 94 friends ,93 and family members.

Table 6. 21: Response towards HIV Positive Report

What was your response to your HIV positive report?	**Respondents**
Got confused	12
Got worried about future	203
Got worried about family member	107
Felt uncertainty about life	22
Thought of report being incorrect	46
No hard feelings	10
Total	400

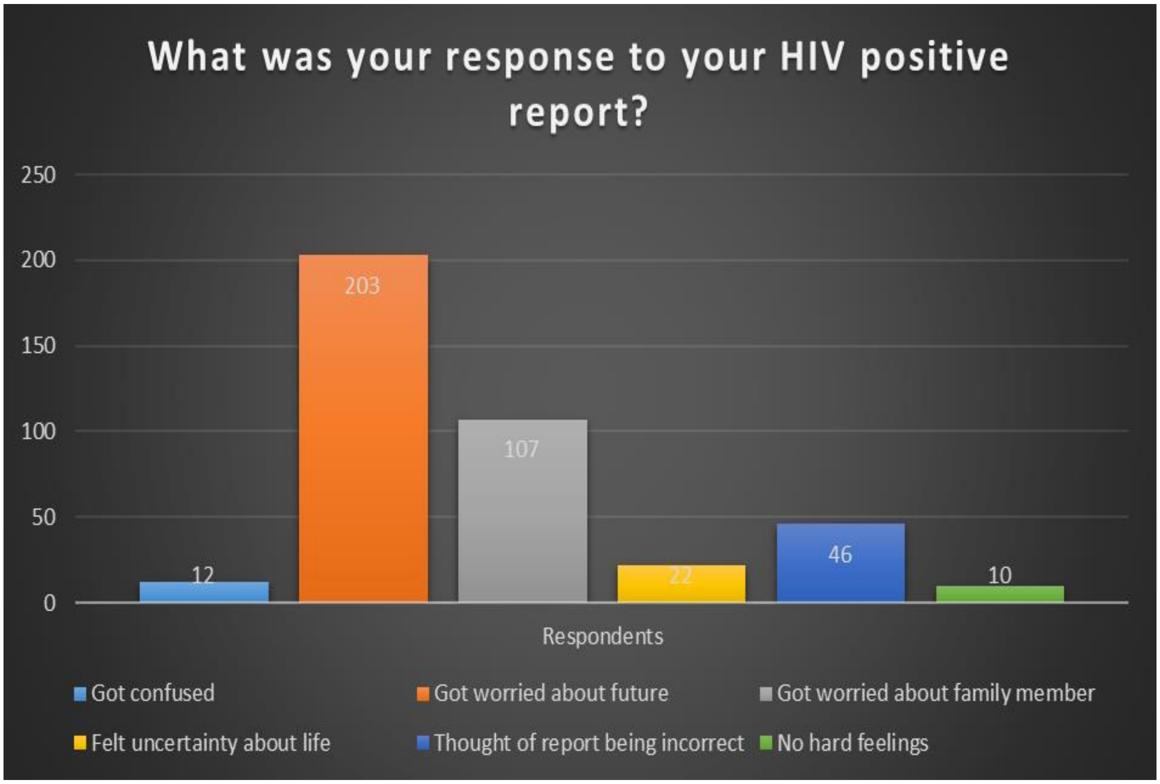

Fig. 6.21: Response towards HIV Positive Report

Interpretation

The above table reveals the response when the respondent first time received a HIV positive report. Maximum 203 were worried about future followed by 107 who got worried about family.

Table 6. 22: Did your colleagues behavior got changed?

Did you felt difference in your colleagues behavior ?	**Respondents**
Yes	378
No	22
Total	400

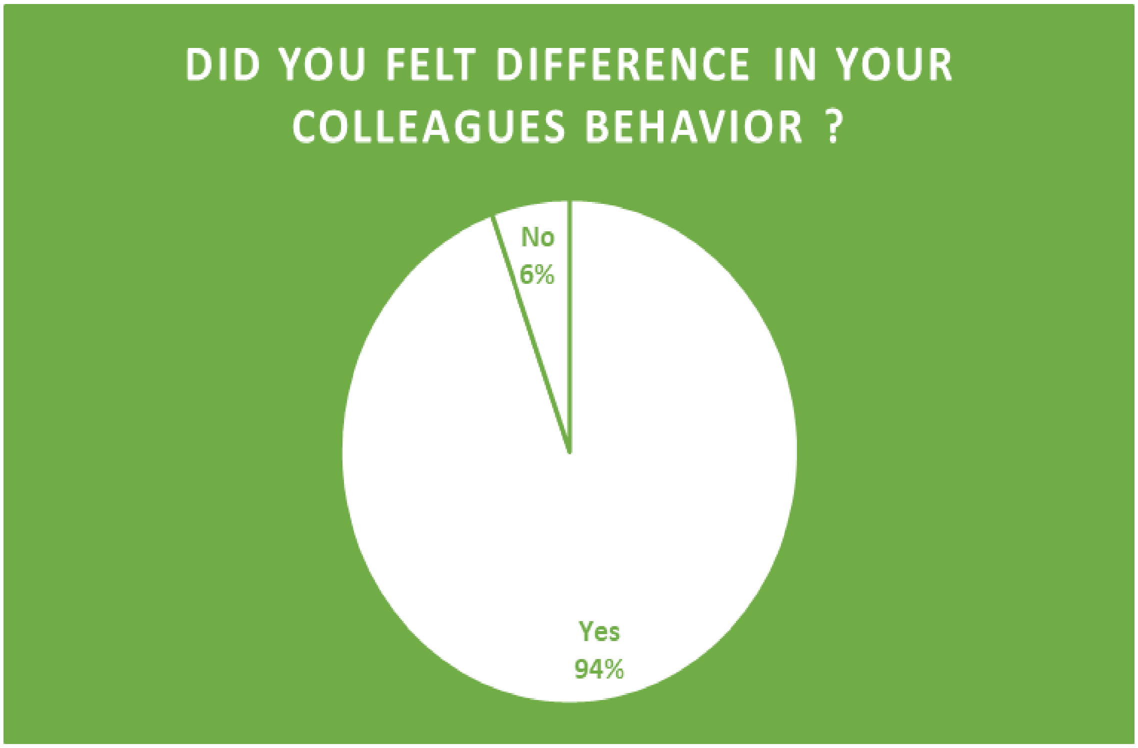

Fig. 6.22: Did your colleagues behavior got changed

Interpretation

The above table shows that maximum of them felt that difference in the behavior of the colleagues towards them after infected by HIV. Only 22 respondents said that it does not matter and had no change in their behavior.

Table 6. 23: Did you find difference in your working capability after HIV infection

Did you felt any difference in your working capability after HIV infection?	Respondents
Yes	65
No	335
Total	400

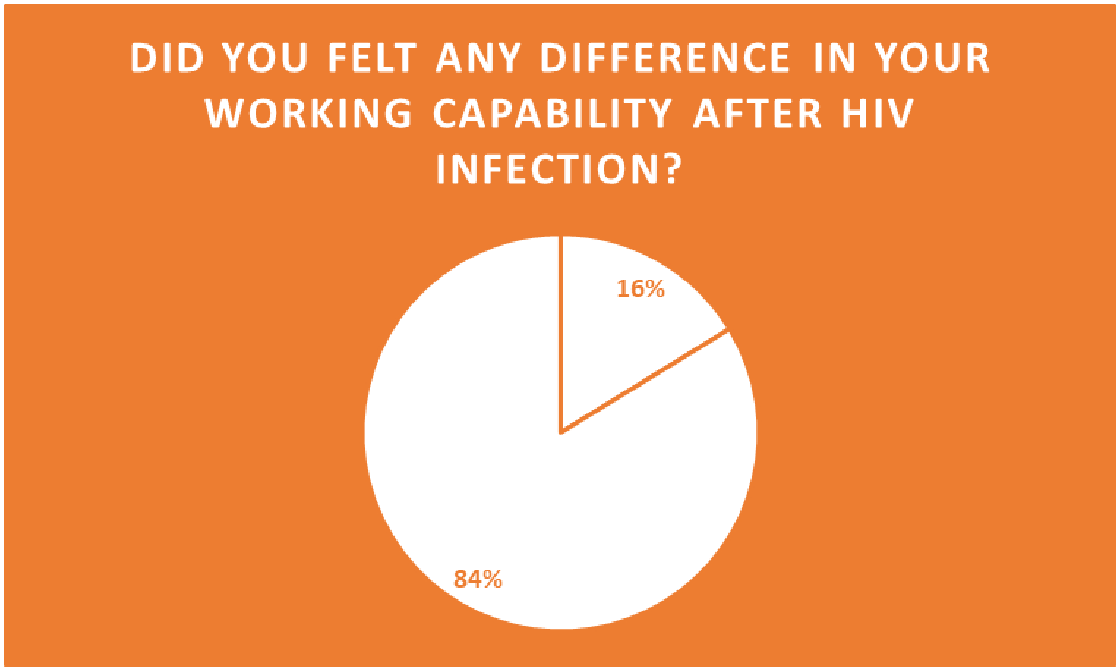

Fig. 6.23: Did you find difference in your working capability after HIV infection

Interpretation

The above table shows the difference in respondents working capability after HIV infection. And to a surprise only 65 out of 400 said that it was affected but 335 said that it was not affected

Table 6. 24: Got engaged in any programmes related to HIV

Did you engaged yourself in any programmes related to HIV?	**Respondents**
Yes	164
No	236
Total	400

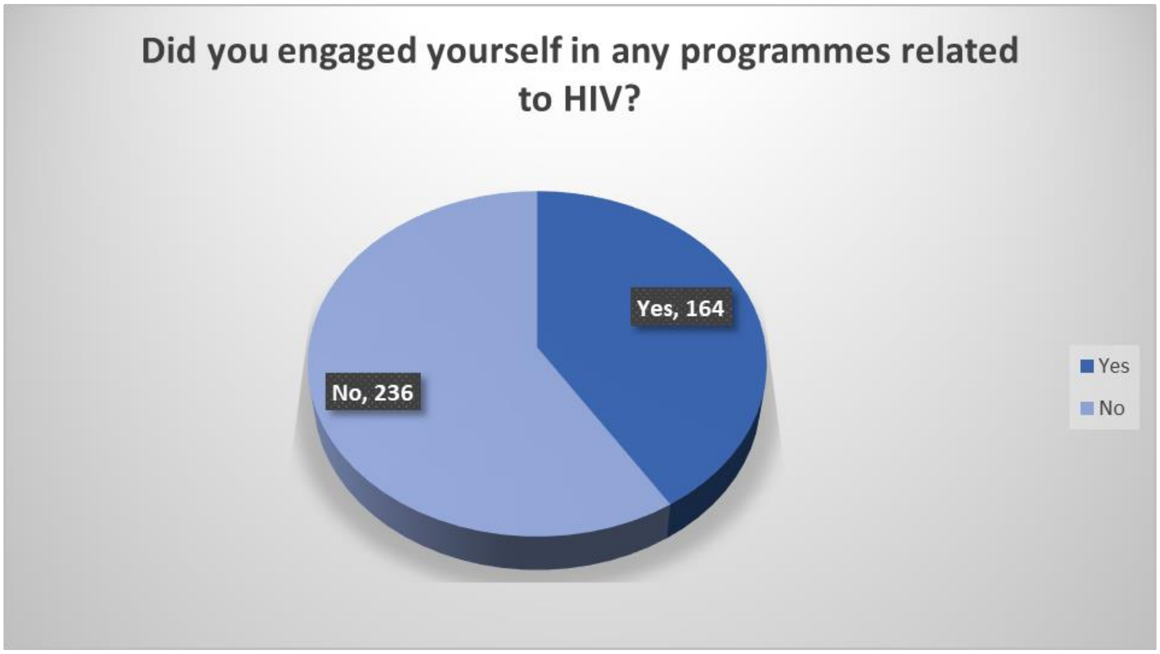

Fig. 6.24: Got engaged in any programmes related to HIV

Interpretation

The above table shows response to get engaged in any programmes related to HIV. it showed that 164 out of 400 were agree to it and rest of them were not engaged in any such program.

Table 6. 25: Attendance towards social occasions

Do you attend social occasions?	**Respondents**
Yes	43
No	357
Total	400

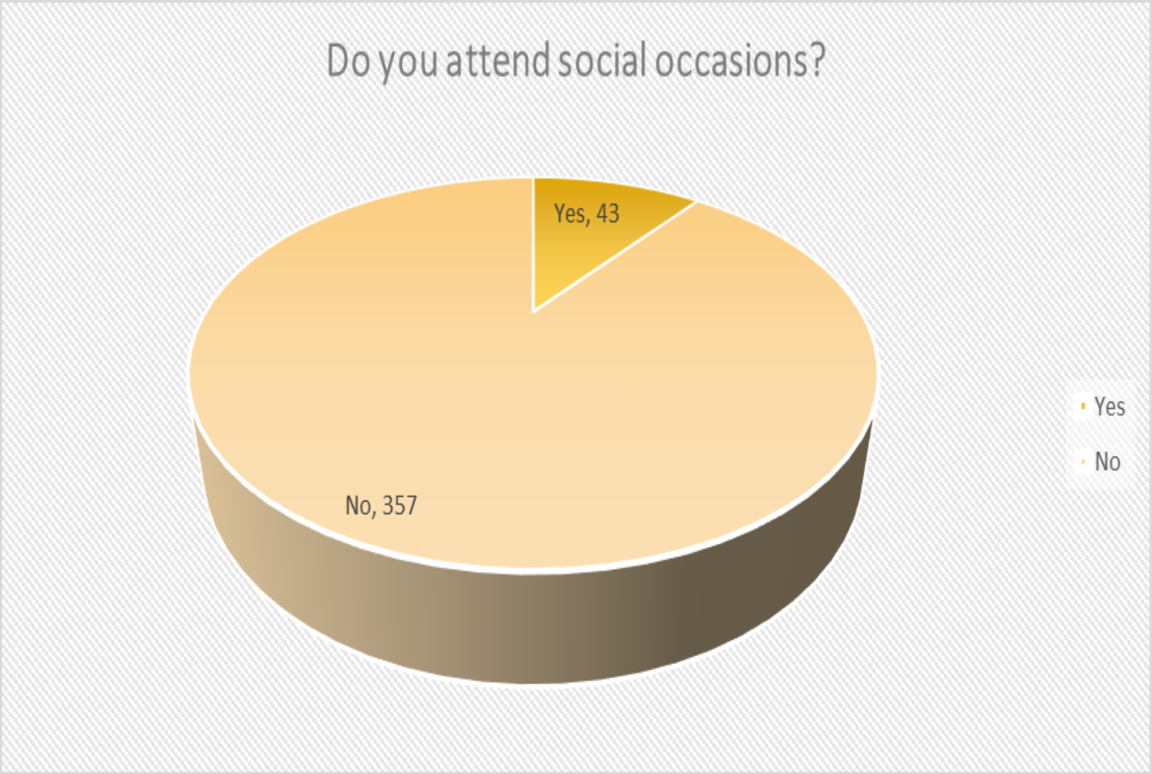

Fig. 6.25: Attendance towards social occasions

Interpretation

The above table shows that out of 400 a high percentage that goes around almost equals 90% of the total respondents of HIV patients did not attended any social occasions.

Table 6. 26: Awareness of people in your society about your HIV infection

The people of society know about your HIV infection?	**Respondents**
Yes	134
No	266
Total	400

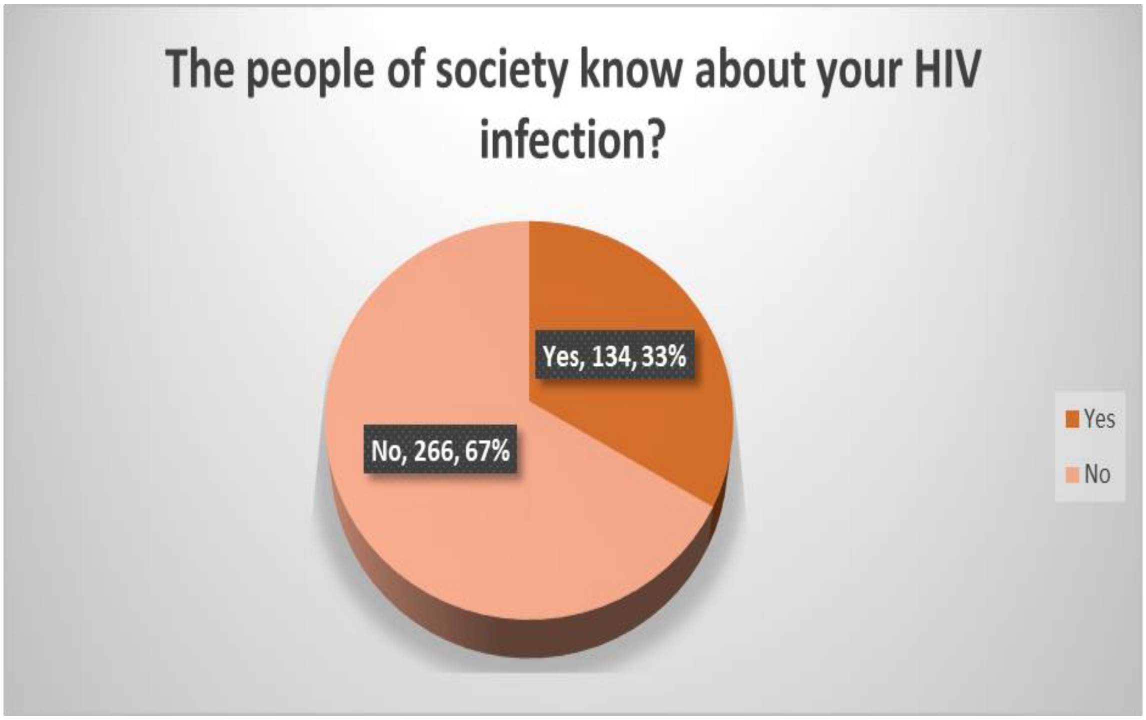

Fig. 6.26: awareness of people in your society about your HIV infection

Interpretation

Out of 400 maximum i.e. 67% did not tell about their illness to the people of society and 134 said that people of society know about their HIV infection.

Table 6. 27: Does HIV have created problems for your social status?

Does HIV have created problems for your social status?	**Respondents**
Yes	333
No	67
Total	400

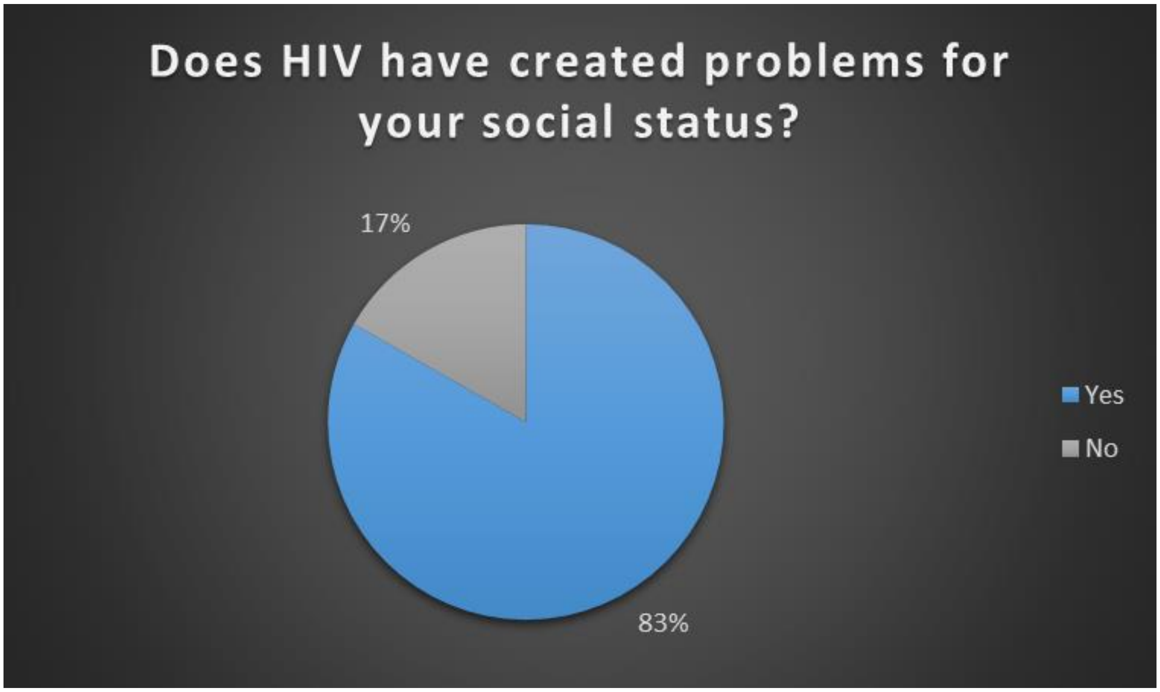

Fig. 6.27: Does HIV have created problems for your social status?

Interpretation

The above table shows response to whether HIV have created problems for their social status and the data reveals that 333 i.e. 83% agree to it and were sad that this has created a difference in their social life

Table 6. 28: Awareness about legal provisions for protection of HIV/AIDS patients

Are you aware of the legal provisions for the protection of HIV/AIDS patients?	**Respondents**
Yes	39
No	361
Total	400

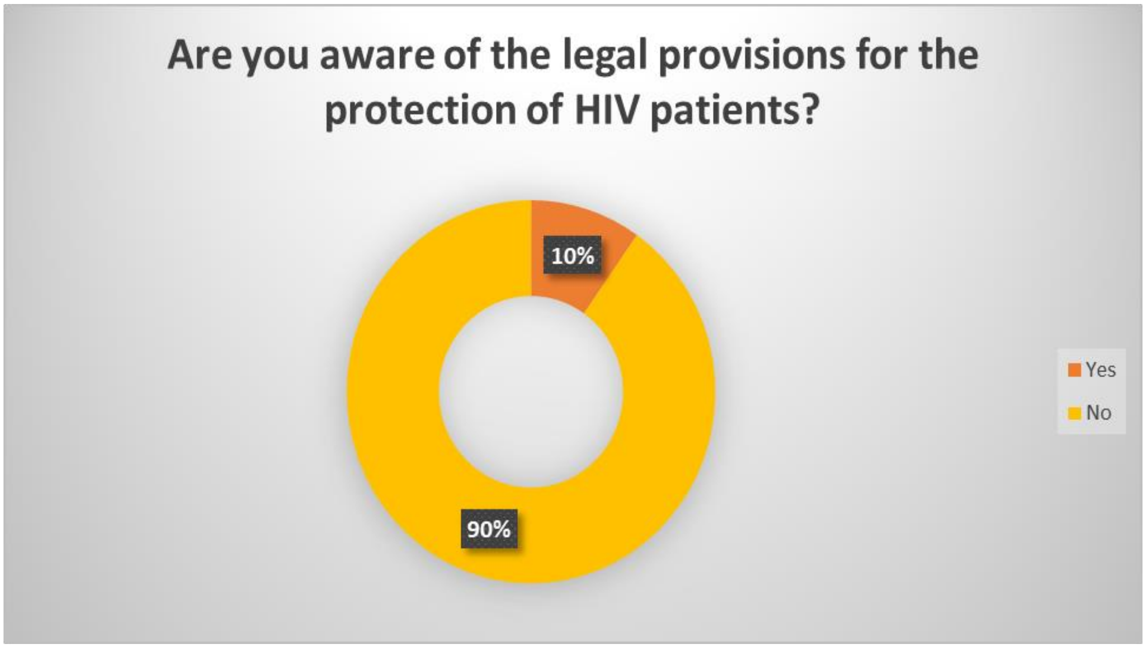

Fig. 6.28: Awareness about legal provisions for protection of HIV/AIDS patients

Interpretation

The dataset reveals a notable lack of awareness among respondents regarding legal provisions for the protection of HIV/AIDS patients. The majority, represented by 361 respondents, answered negatively, indicating a substantial portion of the surveyed population is not aware of the existing legal safeguards for individuals affected by HIV/AIDS. Conversely, only 39 respondents acknowledged awareness of such legal provisions. The data implies a need for increased awareness campaigns, education, and dissemination of information regarding the legal rights and protections afforded to those living with HIV/AIDS, highlighting a potential gap in knowledge that could impact the well-being and rights of this vulnerable population.

Table 6. 29: Feeling towards usage of legal provisions to protect HIV patients?

Have you ever felt that legal provisions should be used to protect HIV patients?	**Respondents**
Yes	94
No	66
No Idea	240
Total	400

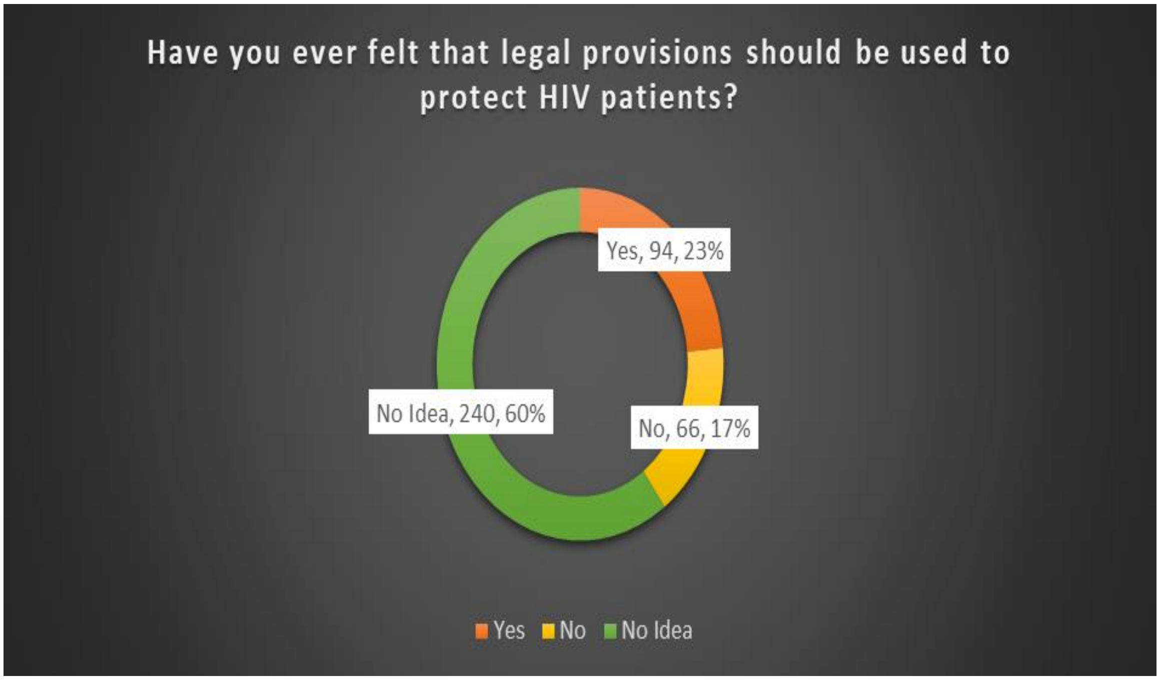

Fig. 6.29: Feeling towards usage of legal provisions to protect HIV patients?

Interpretation

The above table shows response towards importance of legal provisions felt by the patients to protect them. Majority i.e. 240 out of 400 have no idea about this legal rights of HIV patients or how laws can protect them.

Table 6. 30: Are the laws appropriate and sufficient to protect anyone from HIV?

Are the laws to protect anyone from HIV are appropriate and sufficient?	**Respondents**
Yes	84
No	13
No Idea	303
Total	400

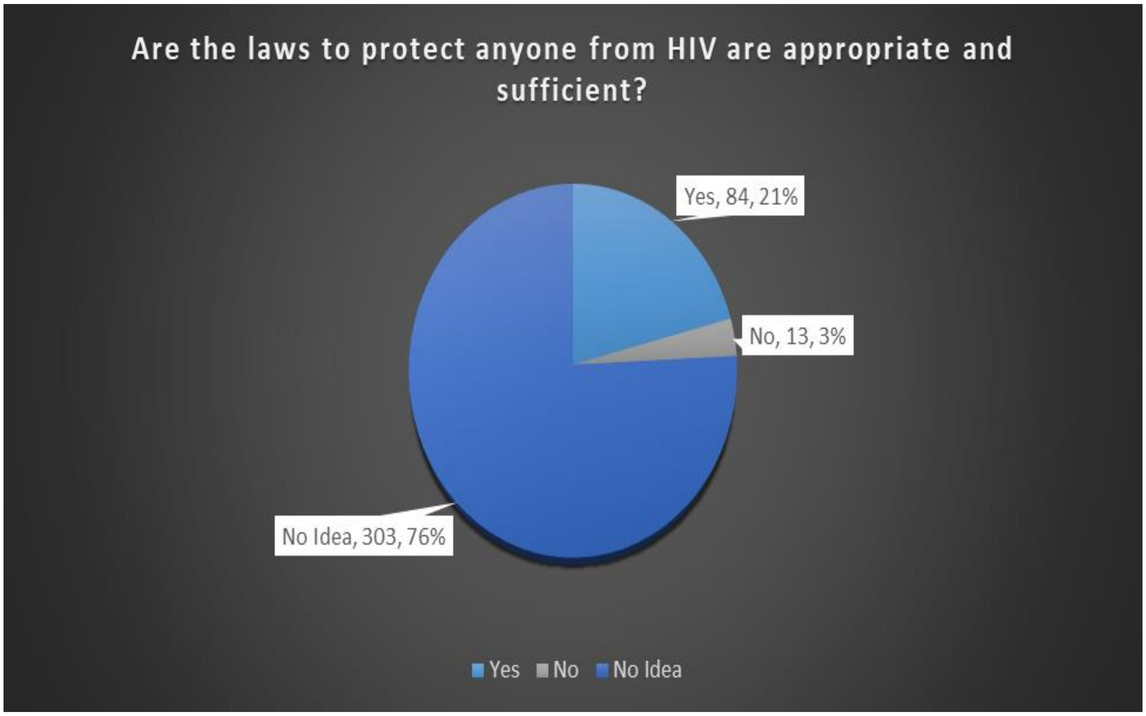

Fig. 6.30: Are the laws appropriate and sufficient to protect anyone from HIV?

Interpretation

The above table shows response towards appropriateness and sufficient laws to protect anyone from HIV and to a surprise majority i.e. 76% have no idea about this legal rights of HIV patients or whether these laws can protect them or not.

Table 6. 31: Expecting any kind of benefits from government side

Do you expect any kind of benefits from government side	**Respondents**
Yes	291
No	57
No Idea	52
Total	400

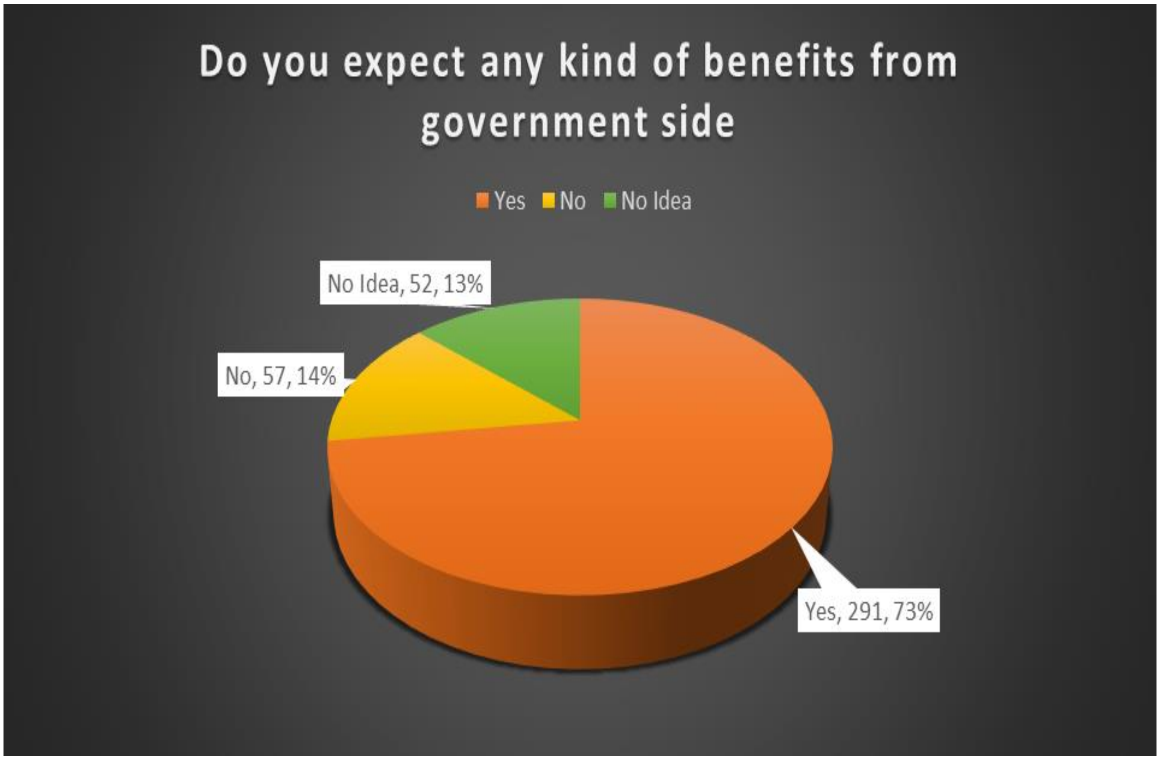

Fig. 6.31: Expecting any kind of benefits from government side

Interpretation

The above table showed the expectations of any kind of benefits from government side.13 % have no idea about this,14 % said no but maximum 73% said that they have assurance that government can work for their benefits.

Section 3 Responses of NGO Workers

Table 6.32: Experience of NGO Workers

Years of Experience	**Number of Participants**
Less than 5	67
5 to 10 years	43
10 to 15 years	72
More than 15	18

Fig. 6.32: Experience of NGO Workers

Interpretation:

The majority of participants (72) have 10 to 15 years of experience working with HIV patients, indicating a significant presence of mid-career professionals in the sample. There is a substantial representation of individuals with less than 5 years (67) and 5 to 10 years (43) of experience. A smaller proportion of participants (18) have more than 15 years of experience in this context.

Table 6.33: Patient Response to NGO Workers

Patient Response to NGO Workers	**Respondents**
Positive	332
Negative	68
Total	400

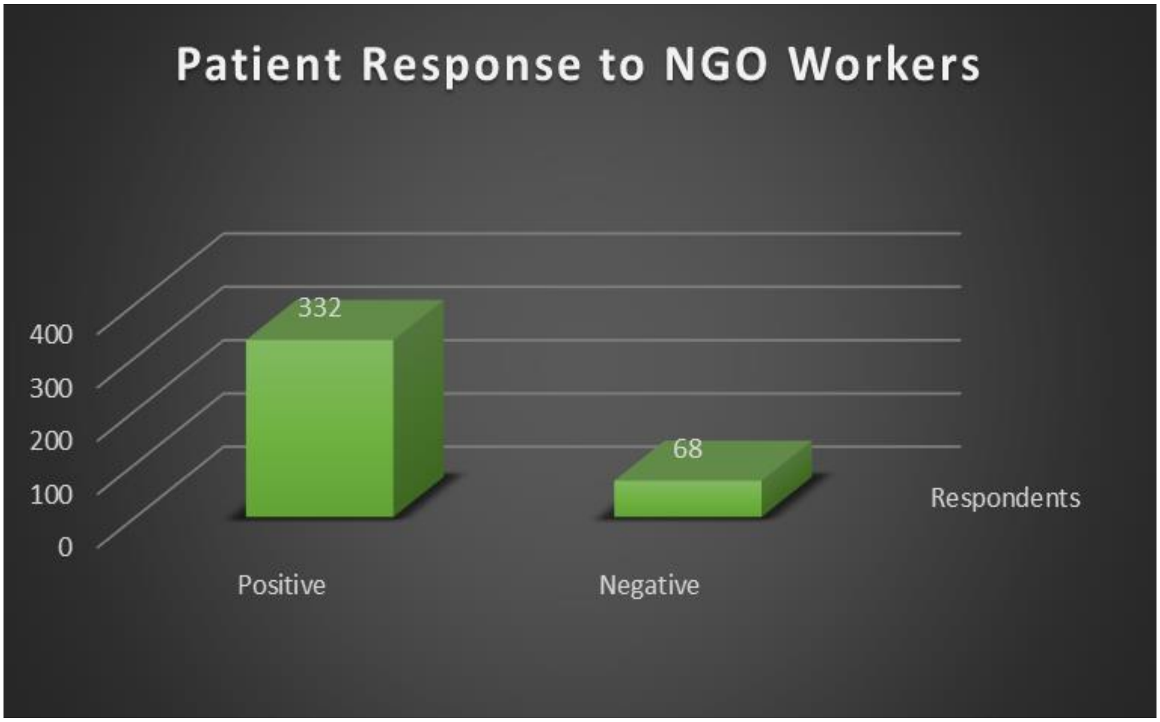

Fig. 6.33: Patient Response to NGO Workers

Interpretation

The above table clearly shows that only 332 Patient Response positively to NGO Workers for any type of details and questions asked related to any of the incident occurred while a certain group of people comprising of about 68 around 15% of them do not responded to the NGO workers.

Table 6.34: Participation level of patient in discussion

Participation level of patient in discussion	**Respondents**
Low	372
Medium	15
High	13
Total	400

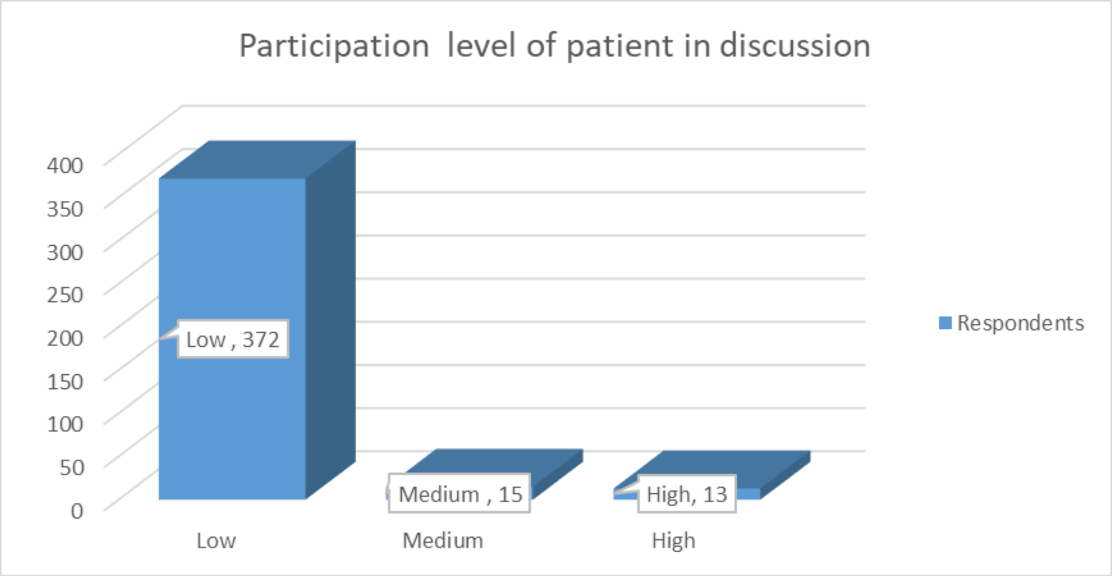

Fig. 6.34: Participation level of patient in discussion

Interpretation

The above table clearly shows that Patients ask questions to the NGO workers but the data revealed that 121 do not ask any question or discuss their issues with the NGO workers but a significant number of patients 279 are asking and conversant with the workers that shows that they are open to conversations.

Table 6.35: Patient curiosity in knowing about laws and rights related to HIV/AIDS

Patient curiosity in knowing about HIV/AIDS related laws and their rights	Respondents
Low	321
Medium	48
High	31
Total	400

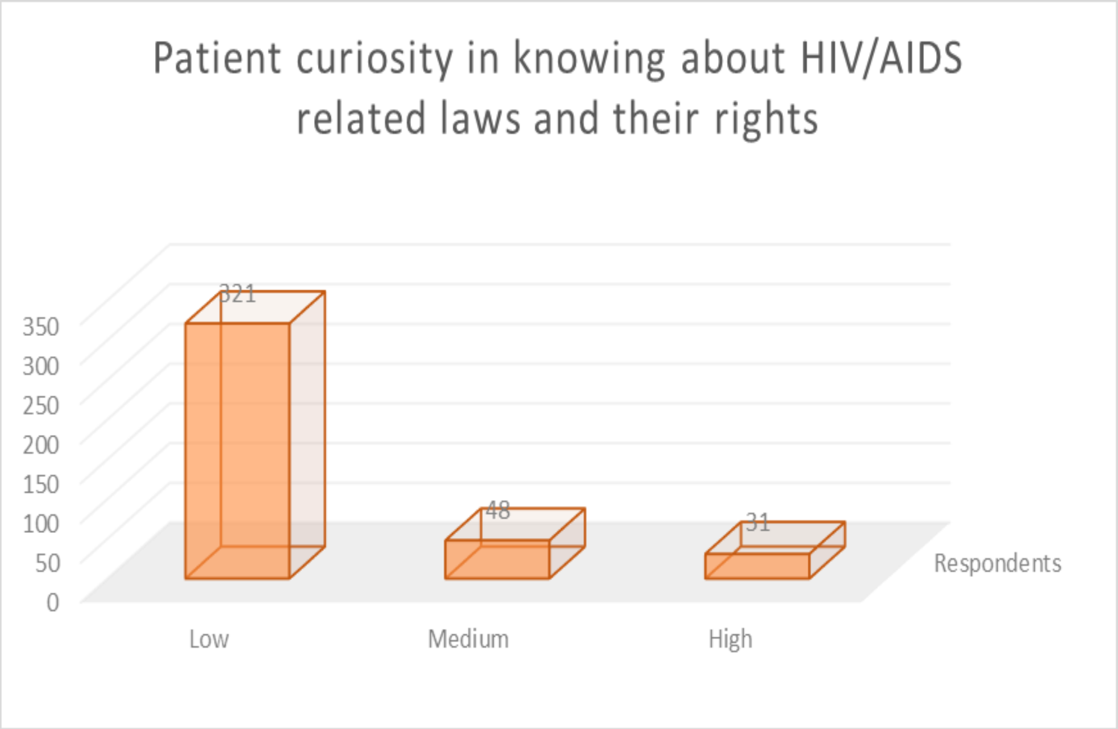

Fig. 6.35: Patient curiosity in knowing about laws and rights related to HIV/AIDS

Interpretation

The above table clearly shows that Patient interest to know about HIV/AIDS related laws and their rights. Out of 400 respondents 352 agree to this and are showing willingness to get awareness about legal rights.

Table 6.36: Options supported to control HIV and raise awareness

What is done to control HIV and raise awareness	**Respondents**
Campaigning	21
Targeting and message	92
Public education	27
Promoting openness	4
Counselling and testing	34
Focus on young people	22
Total	200

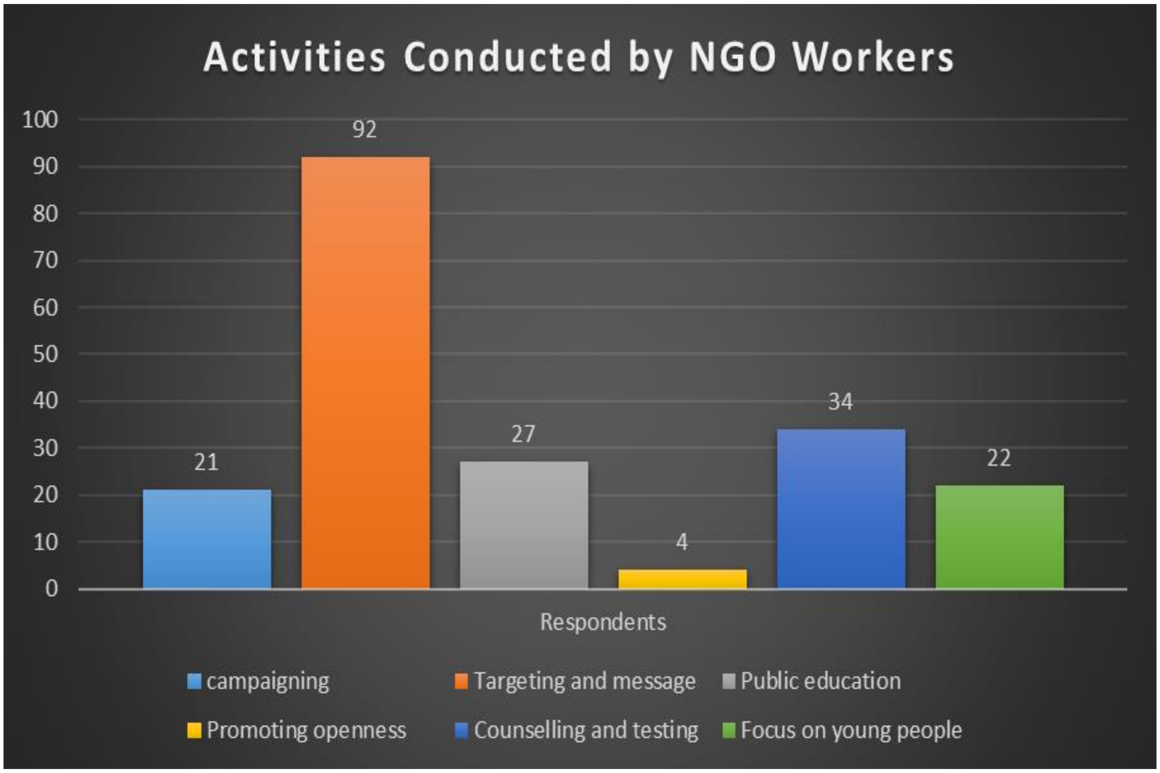

Fig. 6.36: Options supported to control HIV and raise awareness

Interpretation

The tabular data reveals insights into respondents' perspectives on strategies for controlling HIV/AIDS and raising awareness. The predominant response, with 92 respondents, underscores the perceived significance of tailored messaging and targeted interventions. Following closely, 34 respondents emphasize the importance of counseling and testing in HIV/AIDS control. Public education is recognized by 27 respondents, highlighting the value of disseminating information widely. The focus on young people is acknowledged by 22 respondents, suggesting a recognition of the need for age-specific interventions. Campaigning receives a response from 21 participants, indicating a role for broad awareness initiatives. Notably, promoting openness is the least emphasized, with only 4 respondents. The data collectively suggests a nuanced approach to HIV/AIDS control, emphasizing targeted communication and varied strategies to address specific demographics.

Table 6.37: Patent understanding the NGO worker’s explanations

Does the patent understand the NGO workers explanations?	**Respondents**
Yes	139
No	56
May be	5
Total	200

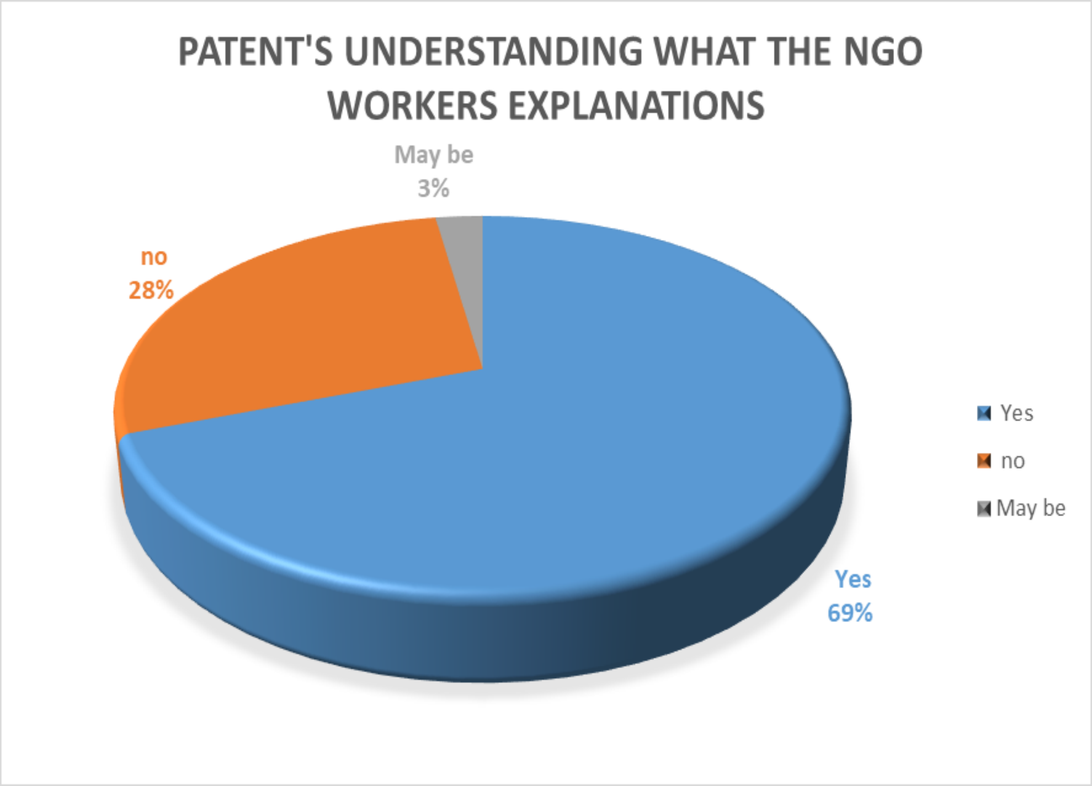

Fig. 6.37: Patent understanding the NGO worker’s explanations

Interpretation

The provided data offers insights into the level of comprehension among respondents regarding explanations provided by NGO workers. The majority, with 139 respondents, indicated a positive understanding, suggesting that a significant portion of the surveyed individuals comprehends the explanations put forth by NGO workers. On the contrary, 56 respondents answered negatively, indicating a segment of the population that does not understand the explanations. The response "May be" is the least frequent, with only 5 respondents. Overall, this data implies that there is room for improvement in communication or clarity from NGO workers to enhance understanding among the surveyed individuals, given the proportion of respondents who expressed uncertainty or lack of comprehension.

Table 6. 38: Supportive Techniques Used in the Awareness Program

Supportive Techniques Used in the Awareness Program	Respondents
Encourage and support people living with HIV and AIDS	64
Motivate HIV and AIDS patients to speak at meetings	55
Encourage testing by organising testing drives	36
Create role models for how to cope with HIV and AIDS,	27
Identifying influential people who are HIV positive to raise awareness	18
Total	200

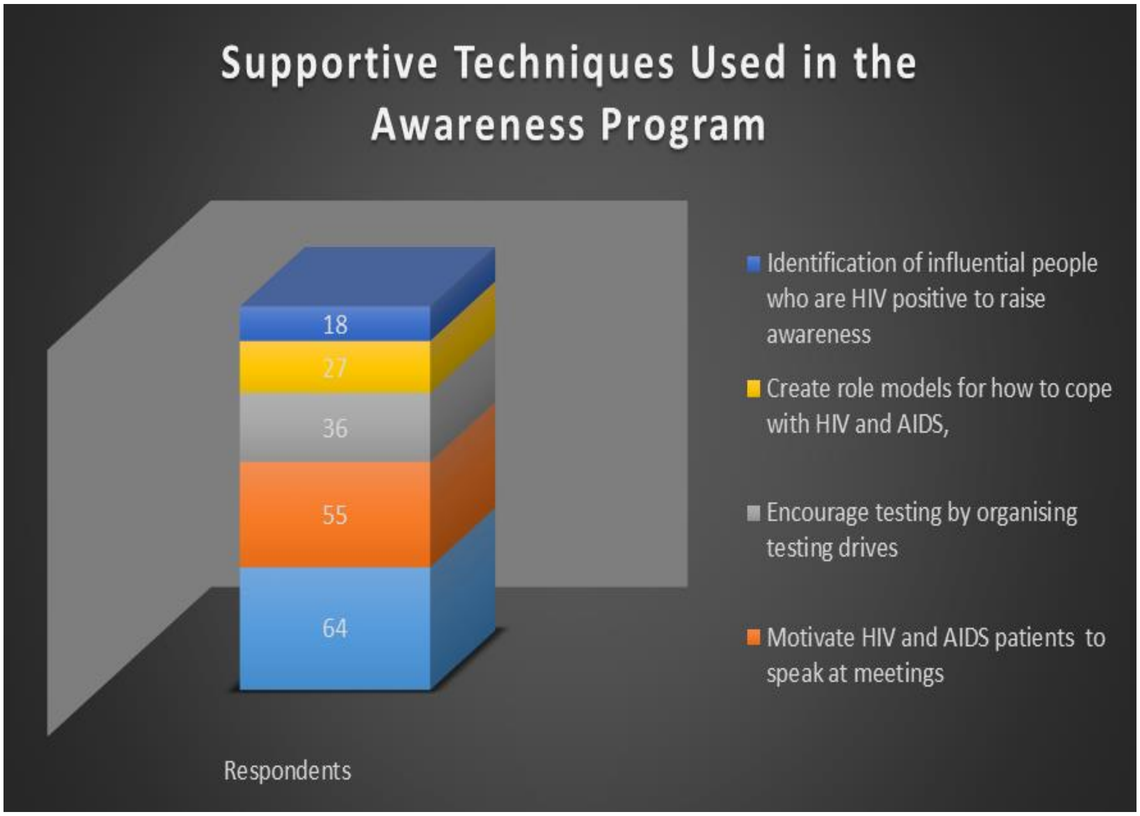

Fig. 6.38: Supportive Techniques Used in the Awareness Program

Interpretation

The presented data sheds light on the supportive techniques perceived as effective in HIV/AIDS awareness programs, as indicated by the respondents. The most frequently endorsed technique is "Encourage and support people living with HIV and AIDS," with 64 respondents expressing its importance. Following closely is the strategy of "Motivating HIV and AIDS patients to speak at meetings," endorsed by 55 respondents, emphasizing the significance of personal narratives in awareness efforts. "Encouraging testing by organizing testing drives" is considered essential by 36 respondents, highlighting the importance of accessible testing initiatives. Creating role models for coping with HIV and AIDS is acknowledged by 27 respondents, suggesting the value of exemplars in awareness programs. Lastly, the identification of influential people who are HIV positive to raise awareness is noted by 18 respondents. The cumulative data suggests a recognition of diverse and multi-faceted approaches to support and enhance HIV/AIDS awareness efforts.

Table 6.39: Participation level of patient in discussion

Participation level of patient in discussion	**Respondents**
Low	43
Medium	101
High	56
Total	200

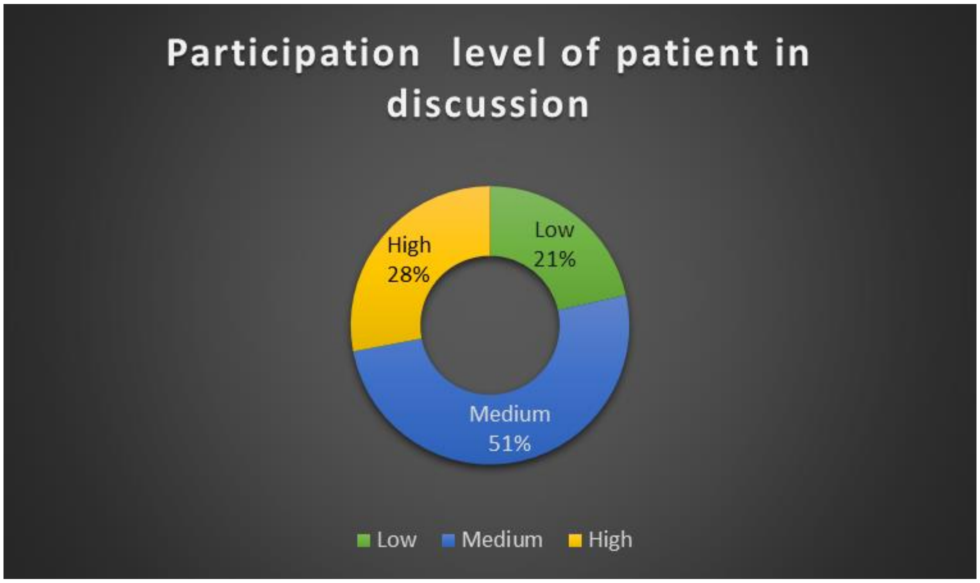

Fig. 6.39: Participation level of patient in discussion

Interpretation

The provided data illuminates the participation levels of patients in discussions, as perceived by the respondents. The largest group, consisting of 101 respondents, indicates a medium level of patient participation, suggesting a substantial portion of participants perceives patients as moderately engaged in discussions. The high participation level is recognized by 56 respondents, signifying a noteworthy segment acknowledging active and involved patient contributions. Conversely, 43 respondents perceive a low level of patient participation, indicating a proportion of individuals who perceive patients as less engaged in discussions. Overall, the data implies varying perceptions of patient involvement in discussions, with a considerable number of respondents recognizing a moderate to high level of participation.

Table 6.40: Difficulties faced by the NGO workers during the field work

What kinds of difficulties are faced by the NGO workers during the field work?	**Respondents**
Limited government funding	9
Pressure on nonprofits to show results and strategic solutions	32

A significant increase in the need for nonprofit services	11
No Strategic Planning	48
Absence of networking	5
Poor networking and communication system	21
Mismanage their resources	28
Lack of accountability and transparency.	17
Inadequate HR management activities	4
No standardized legal model available for NGOs	25
Total	**200**

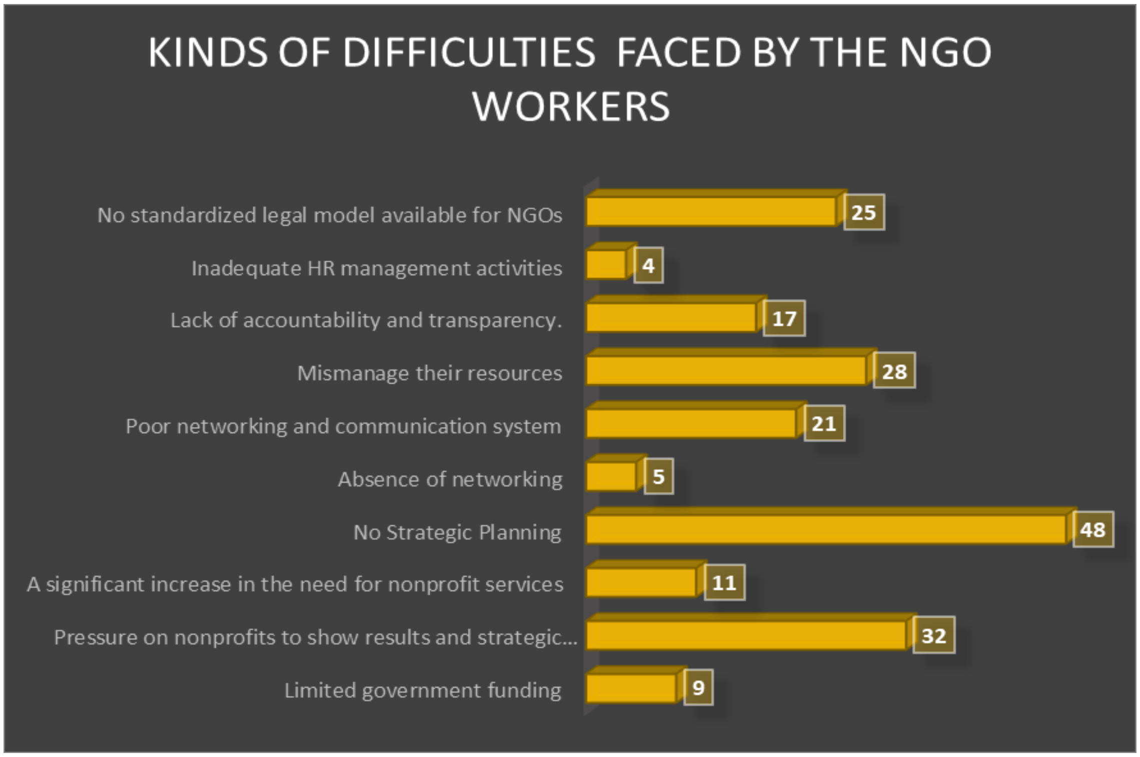

Fig. 6.40: Difficulties faced by the NGO workers during the field work

Interpretation

The data provides insights into the challenges encountered by NGO workers during fieldwork, as perceived by the respondents. The most frequently identified difficulty is the absence of strategic planning, with 48 respondents highlighting the need for a more structured approach. Following closely, pressure on nonprofits to demonstrate results and strategic solutions is acknowledged by 32 respondents, indicating the challenges associated with expectations and accountability. Other noteworthy challenges include limited government funding (9 respondents), a significant increase in the need for nonprofit services (11 respondents), and poor networking and communication systems (21 respondents). The data collectively underscores the multifaceted nature of challenges faced by NGO workers, ranging from financial constraints and organizational planning to issues related to networking, communication, and resource management.

Table 6.41: Patient's trust on the NGO Worker

How much trust the patient has on the NGO Worker?	**Respondents**
Low	36
Medium	139
High	25
Total	200

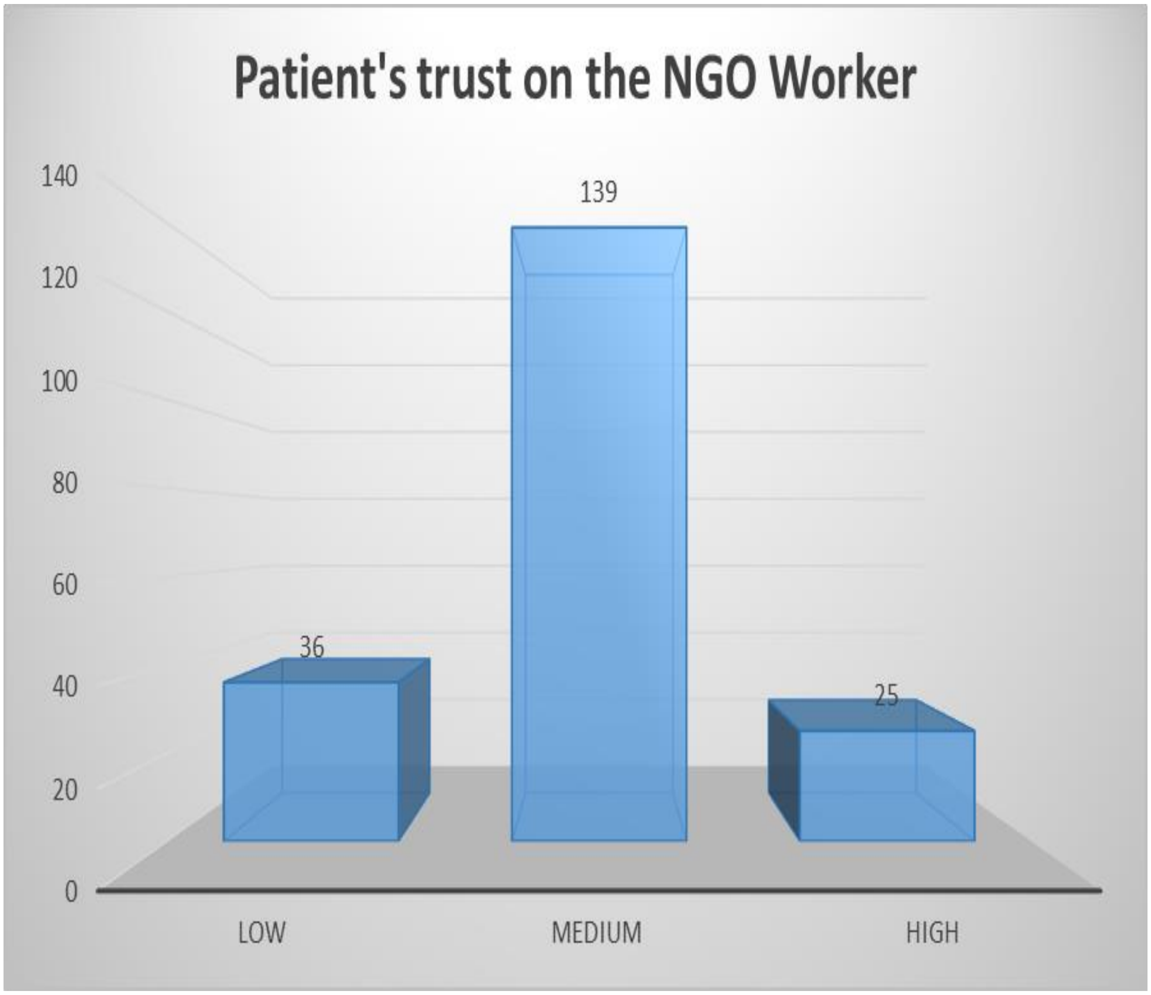

Fig. 6.41: Patient’s trust on the NGO Workers

Interpretation

The table indicates the level of trust patients have in NGO workers, with 36 respondents reporting low trust, 139 respondents expressing medium trust, and 25 respondents indicating high trust, summing up to a total of 200 respondents. The majority of patients fall into the medium trust category, suggesting a substantial level of confidence in NGO workers. However, the presence of respondents with low trust highlights a segment of the population that may have reservations. Understanding the factors influencing trust levels, addressing concerns, and enhancing communication between patients and NGO workers could contribute to fostering a higher level of trust within the community served by the NGO

Table 6. 42: Expectations of the patient

What are the expectations of the patient?	**Respondent's**
Peer education on HIV and AIDS	5
School programmes dealing with both health n emotional side of life skills.	7
Youth groups that offer support to young people with problems.	3
Youth-friendly health services,	23
Legal awareness programs	6
Health checkups	43
Distribution of preventive materials	46
Communal support	67
Total	200

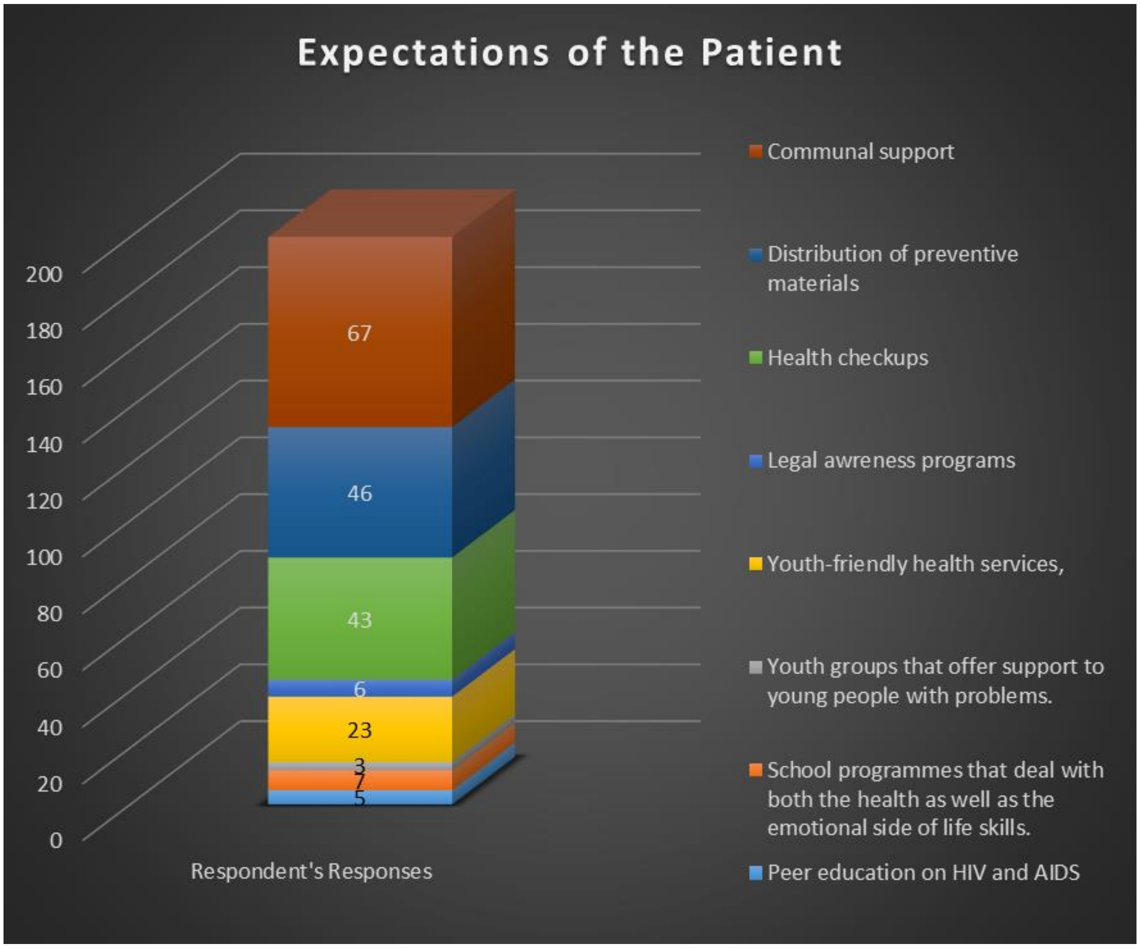

Fig. 6.42: Expectations of the patient

Interpretation

The responses from patients regarding their expectations reveal diverse needs and priorities. A significant emphasis is placed on communal support, with 67 respondents expressing a desire for a supportive community environment. Health-related expectations are prominent, with 43 respondents indicating a need for health checkups and 46 respondents emphasizing the distribution of preventive materials. The demand for youth-friendly health services (23 respondents) suggests a recognition of the specific healthcare requirements of young individuals. Additionally, the interest in legal awareness programs (6 respondents) underscores the acknowledgment of broader socio-legal aspects impacting health. The smaller but noteworthy mentions of peer education, school programs addressing both health and emotional skills, and youth support groups indicate a multifaceted approach to patient expectations. Recognizing and addressing this spectrum of needs can enhance the effectiveness of healthcare programs and support services provided by the NGO.

<u>Section 4 Hypothesis Testing and Objectives Outcomes</u>

Objective 1 and

Hypothesis testing

The HIV patient's awareness towards their legal rights and their demographic characteristics

H_{O1}: There is no significant relationship between gender of HIV patients **and their** awareness towards legal rights

H_{A1}: There is a significant relationship between gender of HIV patients **and their** awareness towards legal rights

	Patients Awareness About their legal rights		
Gender of patients	Yes	No	Total
Male	35	209	244
Female	4	152	156
Total	39	361	400

Interpretation: To study the association between gender and awareness a cross tabulation is done. Out of 244 male respondents 35 are aware and 209 are not aware about the legal rights of HIV patients and out of 156 females only 4 are aware and 152 females are unaware. Total 0nly 39 out of 400 are aware about legal rights and 361 are unaware.

Table for Chi Square Output

Calculated Value	Tabular Value	Degree of Freedom	Hypothesis (H0)
8.01	5.99	2	Rejected

To statistically test the association between the two variables chi square is applied. The test results are showing that the calculated value at 95% level of significance and 2 degree of freedom is 8.01 as compared to the tabular value which is 5.99. Since the calculated value is much higher than the tabulated value, we reject the null hypothesis and conclude that the respondents gender has a significant relationship with its awareness towards legal rights.

Objective 2

H$_{O2}$: The **role of law** to protect the **legal rights of patients** with HIV is **not significant**

H$_{A2}$: The **role of law** to protect the **legal rights of patients** with HIV **is significant**

Table for ANOVA

Anova: Single Factor						
SUMMARY						
Groups	*Count*	*Sum*	*Average*	*Variance*		
Column 1	8	412	52.855	1802.68		
Column 2	8	83	10.565	36.26		
ANOVA						

Source of Variation	*SS*	*df*	*MS*	*F*	*P-value*	*F crit*
Between Groups	6203.25	1	6206.22	6.0241	0.01692	4.60011
Within Groups	12448.75	14	943.471			
Total		15				

Inference: The comparison of calculated and tabulated value of F shows whether the difference is significant or not. The F critical at 5% level of significance and (1, 14) degree of freedom is 4.600 which is much lower than the calculated value of F which is 6.02. Since the computed value of F is high than critical value, therefore we reject our null hypothesis. Hence, the difference is significant which is also shown by p value which is lower than 0.05 and we can infer that **The role of law to protect the legal rights of patients with HIV is significant**.

So finishing the analysis conveys that,

HYPOTHESIS	**RESULTANT**
There is no significant relationship between HIV patients and their awareness towards legal rights.	**REJECTED**
The role of law to protect the legal rights of patients with HIV is significant.	**ACCEPTED**

CHAPTER - 8

SUMMARY AND CONCLUSIONS

This chapter is one of the most important chapters of the thesis as it is the essence of the entire thesis. The chapter emphasizes the importance of thoughtful interpretation, guiding readers through the process of drawing meaningful conclusions and implications from analyzed data. This phase is critical in bridging the gap between raw data and informed decision-making, contributing to the overall validity and relevance of the study.

8.1 Major Findings of the Research:

- The respondents were classified into two groups based on their gender. Out of 400 maximum respondents 244 were male while only 156 respondents were female.
- The respondents were classified into six groups based on their categories. Maximum respondents out of 400 were 104 falling under general category and minimum 24 falling under EWS category. 87 respondents in ST category and 78 respondents in SC category were recorded.
- The respondents were classified into five groups based on their religion. Maximum respondents out of 400 were 202 belonging to Hindu category and minimum 24 belonging to Sikhism category, 53 Muslims and 84 Christians while some of them were belonging to other categories.
- Out of 400 sampled respondents 237 are working in rural areas and 145 in urban areas. Only 18 of them are operating in tribal areas.
- Men and women are more likely to be victims of gender discriminatory treatment. Out of 400 respondents 257 male and 143 female HIV/AIDS patients agree that they face discriminatory behavior in the society.
- Discrimination is usually done by relatives and spouses. It is also known that family members and village people are also involved in this type of behavioral bias.

- Discriminatory behavior is more common in the workplace. 317 of the 400 respondents declared that they face more discrimination at the workplace and 83 opined that it is more at home.
- Out of 400 respondents 252 said yes to HIV cases having cohabitation separation and 148 said no to such practice.
- HIV patients complaining against defamation or injustice are increasing and 302 agree that they are now open to complain about any wrongful practice or behaviour.
- 286 out of 400 respondents agree that HIV patients need legal assistance for wrongs against them.
- Awareness of patients about laws related to HIV is very low only 39 say yes they are aware but majority 361 say they are not aware of their legal rights.
- A majority of 314 out of 400 respondents say that HIV protection laws are adequate and only 86 respondents deny that these laws are sufficient.
- Respondents were classified into two groups based on their gender. Out of 400 maximum respondents 244 were male while only 156 respondents were female.
- dataset categorizes 400 respondents into different groups, reflecting the demographic diversity within the sample. Among these, 104 respondents are classified as General, 75 as SEBC (Socially and Economically Backward Classes), 24 as EWS (Economically Weaker Classes), 87 as ST (Scheduled Tribe), 78 as SC (Scheduled Caste) and 32 respondents as is Under the "Other" category. These classifications provide a snapshot of the social and economic composition of the population surveyed, providing valuable insights into the distribution of respondents across different classifications. Understanding these demographics is essential to gain a nuanced perspective on the experiences and opinions of individuals from different social backgrounds.
- Respondents were classified into two groups based on their family type. A maximum of 298 out of 400 respondents lived in a joint family while only 102 respondents had a nuclear family.

- The respondents were classified into six groups based on their higher education. Out of maximum 400 respondents 162 were uneducated while 72 had secondary education and only 28 PG and 28 UG.
- Respondents were classified into four groups based on their status. Out of maximum 400 respondents 253 were married only 81 were single while 27 were divorced.
- The highest number of 137 patients were advised to get check-ups for problems by NGO workers, followed by 94 friends, 93 and family members.
- The respondent received an HIV positive report for the first time. A maximum of 203 were worried about future followed by 107 worried about family.
- Maximum people experienced a difference in the behavior of colleagues towards them after being infected by HIV. Only 22 respondents said it did not matter and there was no change in their behavior.
- Response to joining any HIV related programs showed that 164 out of 400 agreed to it and the rest were not involved in any such program.
- A high percentage of 400 which is about 90% of the total respondents of HIV patients did not attend any social events.
- A maximum of 400 ie 67% did not tell the community about their illness and 134 said that the community knew about their HIV infection.
- The majority of participants (72) have 10 to 15 years of experience working with HIV patients, indicating a significant presence of mid-career professionals in the sample. There is a substantial representation of individuals with less than 5 years (67) and 5 to 10 years (43) of experience. A smaller proportion of participants (18) have more than 15 years of experience in this context.
- The patient is interested in knowing about HIV/AIDS related laws and their rights. 352 out of 400 respondents agree with this and are willing to get awareness about legal rights.
- The provided data illuminates the participation levels of patients in discussions, as perceived by the respondents. The largest group, consisting of 101 respondents, indicates a medium level of patient participation, suggesting a

substantial portion of participants perceives patients as moderately engaged in discussions. The high participation level is recognized by 56 respondents, signifying a noteworthy segment acknowledging active and involved patient contributions. Conversely, 43 respondents perceive a low level of patient participation, indicating a proportion of individuals who perceive patients as less engaged in discussions. Overall, the data implies varying perceptions of patient involvement in discussions, with a considerable number of respondents recognizing a moderate to high level of participation.

- The data provides insights into the challenges encountered by NGO workers during fieldwork, as perceived by the respondents. The most frequently identified difficulty is the absence of strategic planning, with 48 respondents highlighting the need for a more structured approach. Following closely, pressure on nonprofits to demonstrate results and strategic solutions is acknowledged by 32 respondents, indicating the challenges associated with expectations and accountability. Other noteworthy challenges include limited government funding (9 respondents), a significant increase in the need for nonprofit services (11 respondents), and poor networking and communication systems (21 respondents). The data collectively underscores the multifaceted nature of challenges faced by NGO workers, ranging from financial constraints and organizational planning to issues related to networking, communication, and resource management.
- The presence of respondents with low trust highlights a segment of the population that may have reservations. Understanding the factors influencing trust levels, addressing concerns, and enhancing communication between patients and NGO workers could contribute to fostering a higher level of trust within the community served by the NGO.
- The responses from patients regarding their expectations reveal diverse needs and priorities. A significant emphasis is placed on communal support, with 67 respondents expressing a desire for a supportive community environment. Health-related expectations are prominent, with 43 respondents indicating a

need for health checkups and 46 respondents emphasizing the distribution of preventive materials. The demand for youth-friendly health services (23 respondents) suggests a recognition of the specific healthcare requirements of young individuals. Additionally, the interest in legal awareness programs (6 respondents) underscores the acknowledgment of broader socio-legal aspects impacting health. The smaller but noteworthy mentions of peer education, school programs addressing both health and emotional skills, and youth support groups indicate a multifaceted approach to patient expectations. Recognizing and addressing this spectrum of needs can enhance the effectiveness of healthcare programs and support services provided by the NGO.

- There is no significant relationship between gender of HIV patients and their awareness towards legal rights.
- There is a significant relationship between gender of HIV patients and their awareness towards legal rights.
- There is no significant relationship between gender of HIV patients and their response towards appropriateness of HIV protection Laws.
- There is a significant relationship between gender of HIV patients and their response towards appropriateness of HIV protection Laws.
- There is no significant relationship between gender of HIV patients and their response towards area of discriminatory behavior.
- There is a significant relationship between gender of HIV patients and their response towards area of discriminatory behavior.
- To study the association between gender and Area of Discriminatory Behavior a cross tabulation is done. Out of 244 male respondents 218 say that Area of Discriminatory Behavior is more at work place than at home and out of 156 females 99 also agree that Discriminatory Behavior is more at work place. Total 317 out of 400 are saying yes to workplace as Area of Discriminatory Behavior and 83 are saying home as the Area of Discriminatory Behavior.
- The rejection of the null hypothesis suggests that there is a statistically significant association or difference between the observed and expected

frequencies in the data and conclude that the There is a significant relationship between gender of HIV patients and their response towards area of discriminatory behavior.

- There is no significant relationship between gender of HIV patients and their complaining against defamation or injustice.
- There is a significant relationship between gender of HIV patients and their complaining against defamation or injustice.
- To study the association between gender and HIV Patients Complaining Against Defamation or Injustice the data is cross tabulated and out of 244 male respondents 188 agreed to the statement and 56 disagree to it. In case of females 114 said yes and 42 said no to Complaining Against Defamation or Injustice by HIV patients. Total 302 out of 400 are saying yes and 98 are saying that HIV Patients do not complain against defamation or injustice.
- Rejection of the null hypothesis indicates that there is a statistically significant association or difference between the observed and expected frequencies in the data and concludes that there is a significant relationship between the gender of HIV patients and their complaint against defamation or injustice.

8.2 Suggestions based on primary and secondary data

- Social workers have the ability to raise awareness by using print, broadcast, and social media platforms such as Facebook and Twitter, particularly with younger audiences.
- Increasing the ability of individuals living with HIV and AIDS (PLHAs) to confront stigma in their daily lives;
- It is imperative for social workers to establish a methodology for ascertaining suitable and workable individual and community reactions to stigma and discrimination.
- Social workers must give organisations all-inclusive, adaptable tools to build staff competencies and create or improve interventions to lessen stigma associated with HIV.

- Social workers ought to advocate for and provide culturally sensitive, comprehensive sexuality education for adults and youth. A social worker should be adequately informed about the cultural competencies of each individual client.
- Social workers should support the government and non-governmental organisations in promoting skill development training for healthcare providers, and they should push for adequate and sufficient staffing, particularly in the field of HIV/AIDS.
- Social workers ought to advocate for, conduct, and apply research in order to prevent HIV/AIDS based on heterosexuality, HIV/AIDS transmission mechanisms, and human resource guidelines.
- Academic institutions offering social work education as a core discipline ought to develop and implement impactful curricula on HIV/AIDS from the standpoint of the social work profession, taking into account its ethics and values, in order to encourage novel approaches, treatment models, medications, and policies.
- HIV/AIDS social workers should act as networking officials between concerned government authorities and NGOs to improve the quality of partnership work in the health field.
- Social workers should uphold fundamental values like individual autonomy, dignity, and worth when providing professional interventions, as this fosters a strong sense of partnership with those living with HIV/AIDS.
- Social workers ought to prioritise understanding the client's strengths, or the areas in which they feel most at ease receiving services.
- Collaborating with PLWHA and AIDS service organisations, it can create programmes that promote transparency, fact-disclosure when necessary, and the exchange of ideas and experiences from those impacted by the illness.
- Social workers have the ability to foster global strategic alliances between various non-governmental organisations at the international level, providing referral services related to HIV/AIDS.

8.3 Recommendations

- NGOs only work with HRGs, such as transgender and IDU people, truck drivers, and FSWs, and their intervention is very limited to the general public. Therefore, the government ought to support these initiatives and services for the general public.
- It is anticipated that non-governmental organisations (NGOs) will foster more efficient connections between the local government, stakeholders, and beneficiaries. Additionally, they will establish networks with technical and resource institutions.
- A proper, sufficient, and timely allocation of funds is necessary to fortify and ensure the long-term viability of the collaboration between NGOs and GO.
- To implement services under partnership, adequate manpower, training for skill development, and resource allocation are most important. Thus, GOs ought to give their partner organisation access to all of these resources.
- Achieving the target under the partnership process requires NGOs to plan, implement, and execute the programme properly.
- The government must update appropriate curricula and educate formal and informal groups, government officials, and the public about family life, including AIDS.
- It is necessary for GOs and NGOs to act responsibly in order to respect the human rights of individuals living with HIV/AIDS.

Scope for Further Study:

As a result, the study is limited to the Arvalli, Sabarkantha, Mehsana and Banaskantha districts. As a result, more research on the GO-NGOs partnership can be conducted at a higher level, including the national and international levels. Research on NGOs' obligations to reduce discrimination and stigma against PLWHA.

BIBLIOGRAPHY

1. Aggleton, P., Parker, R., & UNAIDS. (2002). World AIDS Campaign 2002-2003: A Conceptual Framework and basis for Action: HIV/AIDS Stigma and Discrimination. Retrieved from http://www.eldis.org/static/DOC10145.htm
2. Ambati BK, Ambati J, Rao AM (1997) Dynamics of knowledge and attitudes about AIDS among the educated in southern India. AIDS Care, 9 (3):319–330.
3. Ankrah EM (1993) The impact of HIV/AIDS on the family and other significant relation-
ships: the African clan revisited. AIDS Care, 5:5–22.
4. Bakshi P. M, The Constitution of India,Universal Law Publishing Co., 2015
5. Barbara Clow and Linda Snyder. Gender and HIV/AIDS: Understanding and Addressing Stigma and Discrimination Among Women and Girls. Book Title: Confronting Discrimination and Inequality in China, Book Editor(s): Erroi P. Mendes and Sakunthala Srighanthan, Published by: University of Ottawa Press. Retrieved from https://www.jstor.org/stable/j.ctt1ckpdk1.18
6. Barker, Robert L. (1999). The Social Work Dictionary (4th ed.). Washington, DC: NASW Press.
7. Barowalia. J.N.Commentory on the Right to Information Act, Universal Law Publishing, Delhi, 2006.
8. Basu D.D, Human Rights in Constitutional Law, 2010
9. Basu D.D, Constitutional Law of India,New Delhi : Prentice Hall of India, 2015,
10. Batra, T.S. Human Rights: A Critique. Metropolitan, New Delhi, 1979.
11. Baxi, Upendra: Courage, Craft and Contention (N.M. Tripathi, Bombay, 1985)
12. BDD Radipati (1993). HIV/AIDS and employment law: a comparative synopsis. The Comparative and International Law Journal of Southern Africa, Vol. 26, No. 3 (NOVEMBER 1993), pp. 396-409. Retrieved from https://www.jstor.org/stable/23249472

13. Bermingham, S., and Kippax, S. (1998). Infection Control and HIV-Related Discrimination and Anxiety, Glove Use during Venipuncture. Australian Family Physician, 27 (2), 655-69.
14. Bermingham S, Kippax S (1998) HIV-related discrimination: a survey of New South Wales general practitioners. Australian and New Zealand Journal of Public Health.
15. Bharat S (1996). Facing the challenge: household and community response to HIV/AIDS
in Mumbai, India. Geneva, UNAIDS / Mumbai, TISS.
16. Bharat S, Singhanetra-Renard A, Aggleton P (1998) Household and community response
to HIV/AIDS in Asia: the case of Thailand and India. In: Kaldor J et al., eds. AIDS in Asia and the Pacific, 2nd ed. PA: Lippincott-Raven: S117–S122.
17. Bharat, S. and Aggleton, P. (1999). Facing the Challenge: Household Responses to
HIV/AIDS in Mumbai, India. AIDS Care, 11, 31-34.
18. Bhave G (1996) Trends of HIV 1 & 2 infection in STD patients and pattern of transmis-
sion to their spouses in Bombay, India. International Conference on AIDS, Vancouver, Canada, 7–12 July. 11:141 (Abstract No. Mo C 1496).
19. Bracht, N. F. (1978a). Social Work in Health Care: A Guide to Professional Practice. New York: Haworth Press.
20. Bronwen Lichtenstein and Jamie DeCoster (2014). Lessons on Stigma: Teaching about HIV/AIDS. Teaching Sociology, APRIL 2014, Vol. 42, No. 2 (APRIL 2014), pp. 140-150. Retrieved from https://www.jstor.org/stable/43187474
21. Brownlie, Ian (Ed.): Basic Documents on Human Rights(Clarendon Press, Oxford 1971)
22. Carlton, T. O. (1984). Clinical Social Work in Health Settings. New York: Springer.

23. Castro, A. and Farmer, P. (2005). Understanding and Addressing AIDS-related Stigma: From Anthropological Theory to Clinical Practice in Haiti. American Journal of Public Health, 95, 53-59.

24. Chandra, P. S., Ravi, V., Desai, A. and Subbakrishna, K.K. (1998). Anxiety and Depression among HIV-infected Heterosexuals: A Report from India. Journal of Psychosomatic Research, 45, 401-409.

25. Chandra, P. S., Deepthivarma, S. and Manjula, V. (2003). Disclosure of HIV Infection in South India: Patterns, Reasons and Reactions. AIDS Care, 15, 207-215.

26. Charles Ngwena (2000). HIV/AIDS and equal opportunities in the workplace: the implications of the Employment Equity Act. The Comparative and International Law Journal of Southern Africa, MARCH 2000, Vol. 33, No. 1 (MARCH 2000), pp. 96-113. Retrieved from https://www.jstor.org/stable/23251120

27. Chandreyee Roy (2005) Human Rights and HIV/AIDS with Special Reference to Women, *Indian Anthropologist*, March & Sept. 2005, Vol. 35, No. 1/2 (March & Sept. 2005), pp. 97-110. Retrieved from https://www.jstor.org/stable/41919981

28. Chinai R (1995) Linking jobs to HIV. Nexus. Aug.-Sept.:3–4.

29. Cohen, D., De La Vega, R., Watson, G. (2001). Advocacy for Social Justice. Bloomfield, CT: Kumarian Press Inc. Council on Social Work Education (1988). Curriculum Policy for the Master's Degree and Baccalaureate Degree Programs in Social Work Education. Handbook of Accreditation Standards and Procedures, Washington, D C.

30. Dubois, B. L. and karlak Miley (1992). Social Work and Empowering Profession. USA: Allyn and Bacon.

31. Dunning, A. (2005). Information, Advice and Advocacy for Older People: Defining and Developing Services. York: Joseph Rowntree Foundation.

32. Dunning, A. (2010). A Scoping Study of Advocacy with Older People in Wales for the Older People's Commissioner for Wales. Older People's Commissioner for Wales, Cardiff.

33. Daniel H, Parker R (1990) Brazil, the goal of solidarity. In: The 3rd epidemic: repercussions of the fear of AIDS. London, Panos Institute.

34. Don C. Des Jarlais and Samuel R. Friedman. AIDS and Legal Access to Sterile Drug Injection Equipment. The Annals of the American Academy of Political and Social Science, May, 1992, Vol. 521, Drug Abuse: Linking Policy and Research (May, 1992), pp. 42-65. Retrieved from https://www.jstor.org/stable/1046542

35. Elizabeth Fee and Manon Parry (2008). Jonathan Mann, HIV/AIDS, and Human Rights. Journal of Public Health Policy , Apr., 2008, Vol. 29, No. 1 (Apr., 2008), pp. 54-71. https://www.jstor.org/stable/40207166

36. Friedlander, W.A. (1955). Introduction to Social Welfare. New York: Prentice Hall, Inc.

37. Friedlander, W.A. (1958). Concepts and Methods of Social work. New Delhi: Prentice Hall.

38. Friedlander, W.A. (1977). Introduction to Social Welfare. New Delhi: Prentice Hall.

39. Ganczak, Maria (2007). Stigma and Discrimination for HIV/AIDS in the Health Sector: A Polish Perspective. Interamerican Journal of Psychology, 41(1), 57.

40. Garvin et al. (2004). Handbook of Social Work with Groups. Jaipur: Rawat Publications.
    http://www.nimhans.kar.nic.in/psw/default.htm

41. Ginny O’Brien, Jane Carrier and David Ward (1995). Housing Law and People with HIV Infection. Book Chapter-4. AIDS: A Guide to The Law (second Edition), edited by Richard Haigh and Dai Harris for the Terrence Higgins Trust, London and New York: Routledge.

42. Gobopamang Letamo (2003). Prevalence of, and Factors Associated with, HIV/AIDS-related Stigma and Discriminatory Attitudes in Botswana. Journal of Health, Population and Nutrition, December 2003, Vol. 21, No. 4 (December 2003), pp. 347-357. Retrived from http://www.jstor.com/stable/23499343

43. Gryk Wesley (1995). AIDS and Immigration. Book Chapter-5. AIDS: A Guide to The Law (second Edition), edited by Richard Haigh and Dai Harris for the Terrence Higgins Trust, London and New York: Routledge.

44. Hira S, Gupta S, Godwin P (1998) HIV infection in the workforce and its perceived impact on industry. In: P Godwin, ed. The looming epidemic.Delhi, Mosaic Books:139–149.

45. International Definition of Social Work, Retrieved from http://apaswe.com/attachments/article/125/workshop_part1.pdf

Iyengar, Sudarshan, Kumar, B. L. and Mistry, Ramkrishna. 2003. *District-wise Mapping of Populations Vulnerable to HIV/AIDS in Gujarat State*. Gujarat Institute of Development Research (Gota), Ahmedabad, Volume 1&2, 25th December 2003.

46. Jenkins, R., Northway, R. (2002). Advocacy and the Learning Disability Nurse. British Journal of Learning Disabilities, 30 (1), 8-12.

47. JAMIE ENOCH and PETER PIOT (2017). Human Rights in the Fourth Decade of the HIV/AIDS Response: An Inspiring Legacy and Urgent Imperative. Health and Human Rights, Vol. 19, No. 2, Special Sections: Romani People and the Right to Health HIV and Human Rights (DECEMBER 2017), pp. 117-122. Retrieved from https://www.jstor.org/stable/10.2307/90016119

48. Jennifer, Kipgen. 2012. *Utilization Patterns of Health Services by Widows Living With HIV/AIDS: A Study in Manipur*. A thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy in Social Work, School of Social Work, Tata Institute of Social Sciences, Mumbai, 2012.

49. Jesus Ramirez-Valles, Lisa M. Kuhns, Richard T. Campbell and Rafael M. Diaz (2010). Journal of Health and Social Behavior , MARCH 2010, Vol. 51, No. 1 (MARCH 2010), pp. 30-47. Retrieved from https://www.jstor.org/stable/27800367

50. Joshua Amo-Adjei and Eugene KM Darteh (2013). Drivers of Young People's Attitudes towards HIV/AIDS Stigma and Discrimination: Evidence from Ghana. African Journal of Reproductive Health / La Revue Africaine de la Sante

Reproductive , December 2013, Vol. 17, No. 4, Special Edition on HIV/AIDS (December 2013), pp. 51-59. Retrieved from https://www.jstor.org/stable/24362086

51. Jothivenkatesan, D. (December -2009). *Vulnerability of Prostitutes to HIV/AIDS and other Health Hazards- A Sociological study in Pudukkottai District*, Thesis submitted to Bharathidasan University for the award of Doctor of Philosophy in Sociology, Bharathidasan University, Tiruchirappalli, December -2009.

52. Karnataka State AIDS Prevention Society (1998). Monthly update on HIV infection in Karnataka. Directorate of Health and Family Welfare Services, Government
of Karnataka. Nov.

53. Kermode, M., Holmes, W., Langkham, B., Thomas, M. S. and Gifford, S. (2005a). Safer Injections, Fewer Infections: Injection Safety in Rural North India. Tropical Medicine & International Health, 10, 423-432.

54. Kotwal, A., and Taneja, A. (2010). Health Care Workers and Universal Precautions: Perceptions and Determinants of Non-Compliance. Indian journal of Community Medicine, 35(4), 526-528.

55. Lance Gable, Lawrence O. Gostin, and James G. Hodge, HIV/AIDS, Reproductive and Sexual Health, and the Law, Am J Public Health. 2008 October; 98(10): 1779–1786. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636460/

56. Maman, Suzanne et al. 2002. "HIV-Positive Women Report More Lifetime Partner Violence: Findings from a Voluntary Counseling and Testing Clinic in Dar es Salaam, Tanzania", *American Journal of Public Health*, 92 (8).

57. Marie-Claude Chartier (2002). HIV/AIDS and Human Rights. ILO Programme on HIV/AIDS and the world of work Geneva, November 2002. Retrieved from https://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/documents/publication/wcms_117148.pdf

58. Mark D. Regnerus and Viviana Salinas (2007). Religious Affiliation and Aids-Based Discrimination in Sub-Saharan Africa. Review of Religious Research, Jun.,

2007, Vol. 48, No. 4 (Jun., 2007), pp. 385-400. Retrieved from https://www.jstor.org/stable/20447458

59. Mathew, A. (2006). A Study on the Factors Related to the Attitudes of Health and Social Care Professionals towards HIV/AIDS Patients in Select hospitals of Hyderabad (Unpublished Doctoral Thesis). Osmania University, Hyderabad.

60. Mathew, P.D. (2010). Public Interest Litigation. In G. Thomas (Ed.), Social Work Intervention with Individuals and Groups. New Delhi, IGNOU.

61. McGrath JW, Ankrah EM, Schumman DA, Nkumbi S, Lubega M (1993) AIDS and the urban family: its impact in Kampala, Uganda. AIDS Care 5:55–70.

62. Michael, Mike. 1996. “Ignoring science: discourses of ignorance in the public understanding of science”, In *misunderstanding science?* edited by Alan Irwin, Brian Wynne, 107-125. South Africa: Cambridge University Press, 1996.

63. Miriam Maluwa, Peter Aggleton and Richard Parker (2002). HIV- and AIDS-Related Stigma, Discrimination, and Human Rights: A Critical Overview. Health and Human Rights, 2002, Vol. 6, No. 1 (2002), pp. 1-18. Retrieved from http://www.jstor.com/stable/4065311

64. Morrison Ken, Cuadra, and Silvia Magali (2004). HIV-related Stigma and Discrimination in Mexican Healthcare Services. Journal of Sexual health Exchange-2.

65. NACO (2007). Operational Guidelines for Programme Managers and Service Providers for Strengthening STI/RTI Services. Retrieved from http://nacoonline.org/upload/Policies%20&%20Guidelines/21,%20Operational%20Guidelines%20STI%20RTI.pdf

66. Nanavati, M.C., (1965). Social Action and the Professional Social Work. Social Work Forum, III (2), 26-29.

67. Nanda, Satyajeet and Pramanik, Aparimita. 2010. “Media Exposure, Gender Stereotype and Contextual Stigma Perceptions about HIV and AIDS: Evidences from Gujarat, India”, *Journal of Health Management*. 12 (4): 461-481.

68. Nangia R (1998). Corporate response to AIDS: policy guidelines. Mumbai, Bombay Chamber of Commerce and Industry.

69. Narasalah ML. Human Rights and Peace Discovery Publishing House, New Delhi.

70. NASW (1990). Social Work Practice in Health Field. In Aurther, 1991. Social Work Speaks: NASW Policy Statement, Silver Spring, M. D, National Association of Social Work, 172-174.

71. National AIDS Control Organization (NACO) (1998–99) Country scenario. NACO, Ministry of Health and Family Welfare, Government of India, New Delhi.

72. National AIDS Control Organization (NACO) (1999) India responds to HIV/AIDS: a strategic response to the HIV epidemic by the Government of India, the UN, and its development partners in India, 1999–2000. NACO, Ministry of Health and Family Welfare, Government of India, New Delhi.

73. Nayak Bhikhubhai D. (2015). Criminal Law of India (Gujarati). University GranthNirman Board, Ahmadabad. Pp. 286-288.

74. Nimbiakkim, Rose (2010). Social Work Intervention in Prevention and Control of
HIV/AIDS. In G. Thomas (Ed.) HIV/AIDS: Stigma, Discrimination and Prevention, IGNOU, New Delhi.

75. Nthabiseng Phaladze and Sheila Tlou (2006). Gender and HIV/AIDS in Botswana: A Focus on Inequalities and Discrimination. Gender and Development , Mar., 2006, Vol. 14, No. 1, HIV / AIDS (Mar., 2006), pp. 23-35. Retrieved from https://www.jstor.org/stable/20461113

76. Ogola H. (1990) Tanzania: hope in the extended family. In: The 3rd epidemic: repercussions of the fear of AIDS. London, Panos Institute.

77. Panos Institute (1990) The 3rd epidemic: repercussions of the fear of AIDS. London, Panos Institute.

78. Patel Manojkummar (ed.) (2010): 21 Century Human Rights and Education. Darpan Prakashan, Vallabh Vidhyanagar.

79. Patel, Hiteshkumar N. 2005. *Gyana nu Samajashastra* (Gujarati), Ahmedabad, Gujarat, India: Parshwa Publication.

80. Patel, Twinkal. 2008. *Counseling ma Aachaar Sanhitaa: Vyaavasaayik Sthiti ane Prashno*, unpublished M.Phil Dissertation in M.S.W., Gujarat Vidyapith, Ahmedabad.

81. Peter Moszynski (2009). Discrimination risks derailing progress against HIV and AIDS. BMJ: British Medical Journal, Vol. 339, No. 7733 (5 December 2009), p. 1281 Published by: BMJ. Retrieved from https://www.jstor.org/stable/25673404

82. Peter Baume (1999). Chapter Titled AIDS AND DISCRIMINATION (1999) in book A Dissident Liberal. Retrieved from https://www.jstor.org/stable/j.ctt183q3f4.43

83. Pincus, Allen and Minaham, Anna (1978). A Model of Social Work Practice. In Specht, Henry and Vickery, Anna (ed.), Integrating Social Work Methods (p.78). London: George Allen and Unwin.

84. Piot, P. (2001). World Conference against Racism, Racial Discrimination, Xenophobia and related Intolerance, Durban South Africa. Retrieved from http://www.unaids.org/whatsnew/speeches/eng/piot040901racism.htm

85. Pulla, V. (2012). What are Strengths Based Practices all About? In Venkat Pulla, Leseley Chenoweth, Abraham Francis and Stefan Bakaj (Eds.), Papers in Strengths Based Practice. Allied Publishers, Pvt. Ltd.

86. Radecki, S., Shapiro, J., Thrupp, L. D., Gandhi, S. M., Sangha, S.S., Miller, R. B. (1999). Willingness to Treat HIV-positive Patients at Different Stages of Medical Education and Experience. AIDS Patients Care & STDs, 13, 403-4.

87. Rebecca Tiessen, Jane Parpart and Miriam Grant (2010). Gender, HIV/AIDS, and Human Security in Africa. Canadian Journal of African Studies / Revue Canadienne des Études Africaines, 2010, Vol. 44, No. 3, Gender, HIV/AIDS, and Human Security in Africa / Les sexes, le VIH/SIDA, et la securite humaine en Afrique (2010), pp. 449-456. https://www.jstor.org/stable/23236804

88. Renee Danziger (1994). Discrimination Against People with HIV and AIDS in Poland. British Medical Journal, Apr. 30, 1994, Vol. 308, No. 6937 (Apr. 30, 1994), pp. 1145-1147. Retrieved from https://www.jstor.org/stable/29723396

89. Richard Lewis Siegel (1996). AIDS and Human Rights, *Human Rights Quaterly*, Vol. 18, No.3 Aug 1996, Retrieved from https://www.jstor.org/stable/762474

90. Richmond, Marry (1922). What is Social Casework? New York: Russel Sage Foundation.

91. Ross, M. G. (1955). Community Organization: Theory and Principles. New York: Harper and Brothers.

92. Sarkar, Debnarayan (2011). "Social and Economic Implications of HIV/AIDS Evidence from West Bengal", *Man and Development,* March 2011, 19-38.

93. Sharon, Macdonald. 1996. "Authorising science: public understanding of science in museums", In *misunderstanding science?* edited by Alan Irwin, Brian Wynne, 152-171. South Africa: Cambridge University Press, 1996.

94. Shisam K (1993) What AIDS policy options does India require now? CARC Calling, 6(2):29–32.

95. Shukla Gajendra B. (2015). Manavhakko (Gujarati), UniversityGranthNirman Board, Ahmedabad.

96. Singh Amitkumar. 'Quest of Human Rights in Globalizing World'. *The Indian Journal of Political Science*, Jan-Mar 2009.

97. Singh Surender (1986). Social Action in Horizons of Social Work. In Surender S. & K. S Soodan. (ed). Harnam Publications.

98. Susan J. Klein, William D. Karchner and Daniel A. O'Connell (2002). Interventions to Prevent HIV-Related Stigma and Discrimination: Findings and Recommendations for Public Health Practice. Journal of Public Health Management and Practice, Vol. 8, No. 6, Issue Focus: HIV and STD Prevention (November 2002), pp. 44-53. Retrieved from https://www.jstor.org/stable/44968209

99. Taylor, B. (2001). HIV, Stigma and Health: Integration of Theoretical Concepts and the Lived Experiences of Individuals. Journal of Advanced Nursing, 35, 792-798.

100. Temoshok, L. R. and Chandra, P. S. (2000). The Meaning of Forgiveness in a Specific Situational and Cultural Context: Persons Living with HIV/AIDS in

India. In M.E. McCullough, K. I. Pargament and C. E. Thoresen (eds.), Forgiveness: Theory, Research, and Practice (pp.41-64). New York: The Guilford Press.

101. The National Association of Social Workers (1973). Retrieved from http://socialwork.iu.edu/about iussw/what is social work.php

102. Thomas, Gracious (2009). Social Work Practicum: The practitioner's Guide. New Delhi, IGNOU.

103. Thomas, Gracious (2010). Existing Trends in Counselling Services in India. In G. Thomas (Ed.), Substance Abuse and Counselling, IGNOU, New Delhi.

104. Tinny Dawar and Sarita Anand (2009). Narratives of Women Living with HIV/AIDS: An Exploration. Indian Anthropologist, Jan - Dec 2009, Vol. 39, No. 1/2 (Jan - Dec 2009), pp. 35-48. Retrieved from https://www.jstor.org/stable/41920089

105. Tirelli U, Accurso V, Spina M, Vaccher E (1991) HIV and discrimination. British Medical Journal, 303:582.

106. Trecker, G. (1955). Social Group Work: Principles and Practices. New York: Association Press.

107. UNAIDS (2000). Report on the global HIV/AIDS epidemic. June. Geneva, UNAIDS.

108. UNAIDS (2004). Press Release, Stigma biggest Hurdle to AIDS Prevention in South Asia. Satellite Session at XV International AIDS Conference on Critical Themes for AIDS in South Asia. Bankock.

109. Warwick I, Bharat S, Castro R, Garcia R, Leshabari M, Singhanetra-Renard A., Aggleton P (1998) Household and community responses to AIDS in developing countries. Critical Public Health, 8 (4):291–310India: HIV and AIDS-related Discrimination, Stigmatization and Denial.

110. WHO (2007). Standard Precautions in Health Care. Retrieved from http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf

APPENDICES

ANNEXURE 1

Questionnaire

TITLE OF THE THESIS: LEGAL AWARENESS STUDY ON LEGAL RIGHTS OF HIV/AIDS VICTIMS IN NORTH GUJARAT

Questionnaire: Patients

1. Name: …………………. (Optional)
2. Age: ……………. (in year)
3. Gender:
    - Male
    - Female
4. Caste:
    - SC
    - ST
    - EBC
    - GEN
5. Religion:
    - Hindu
    - Islam
    - Sikh
    - Christian
    - Other
6. Location of the work place:
    - Rural
    - Tribal
    - Urban
7. Types of family:
    - Joint
    - Nuclear
8. Education:
    - Illiterate
    - Primary
    - Secondary
    - High. Secondary
    - College
    - Professional
    - Other
9. Marital Status
    - Single
    - Married
    - Widowed
    - Divorced
10. Relative engaged in discriminatory behavior

- Husband/Wife
- Family Members
- Relatives
- Village People
- Others
- Total

11. Area of discriminatory behavior

- At work place
- At Home

12. HIV cases having cohabitation breakdown

- Yes
- No

13. HIV patients complaining against defamation or injustice

- Yes
- No

14. HIV patients requiring legal assistance

- Yes
- No

15. Patients Aware About Laws Related to HIV

- Yes
- No

16. Are HIV protection laws appropriate?

- Yes
- No

17. Source of HIV related information

- News Paper
- Books
- Posters
- Magazines
- Radio
- TV
- Friends
- Health Workers
- Doctors
- HIV positive patient
- attending work-shop
- Through NGO
- Others

18. How did you got affected to HIV News Paper?

- Through interpersonal relationship with HIV infected person
- Through HIV infected Blood transfusion
- Through Mother got transmitted to Child

- Through the use of a unsterilized needle
- Other

19. Who advised you to get for check-up of problems?

- Doctor
- NGO worker
- Friend
- Family member
- Relative
- Other

20. What was your response to your HIV positive report?

- Got confused
- Got worried about future
- Got worried about family member
- Felt uncertainty about life
- Thought of report being incorrect
- No hard feelings

21. Did you felt difference in your colleague's behavior?

- Yes
- No

22. Did you felt any difference in your working capability after HIV infection?

- Yes
- No

23. Did you engaged yourself in any programmes related to HIV?

- Yes
- No

24. Do you attend social occasions?

- Yes
- No

25. The people of society know about your HIV infection?

- Yes
- No

26. Does HIV have created problems for your social status?

- Yes
- No

27. Are you aware of the legal provisions for the protection of HIV/AIDS patients?

- Yes
- No

28. Have you ever felt that legal provisions should be used to protect HIV patients?

- Yes
- No

29. Are the laws to protect anyone from HIV are appropriate and sufficient?

- Yes
- No

30. Do you expect any kind of benefits from government side?

- Yes
- No

TITLE OF THE THESIS: LEGAL AWARENESS STUDY ON LEGAL RIGHTS OF HIV/AIDS VICTIMS IN NORTH GUJARAT

Questionnaire: NGO Workers

1. Years of Experience
    - Less than 5
    - 5 to 10 years
    - 10 to 15 years
    - More than 15

2. Patient Response to NGO Workers
    - Positive
    - Negative

3. Participation level of patient in discussion
    - Low
    - Medium
    - High

4. Patient curiosity in knowing about HIV/AIDS related laws and their rights
    - Low
    - Medium
    - High

5. What is done to control HIV and raise awareness
    - Campaigning
    - Targeting and message
    - Public education
    - Promoting openness
    - Counselling and testing
    - Focus on young people

6. Does the patent understand the NGO worker's explanations?
    - Yes
    - No
    - May be

7. Supportive Techniques Used in the Awareness Program
    - Encourage and support people living with HIV and AIDS

- Motivate HIV and AIDS patients to speak at meetings
- Encourage testing by organizing testing drives
- Create role models for how to cope with HIV and AIDS,
- Identification of influential people who are HIV positive to raise awareness

8. Participation level of patient in discussion
    - Low
    - Medium
    - High

9. What kinds of difficulties are faced by the NGO workers during the field work?
    - Limited government funding
    - Pressure on nonprofits to show results and strategic solutions
    - A significant increase in the need for nonprofit services
    - No Strategic Planning
    - Absence of networking
    - Poor networking and communication system
    - Mismanage their resources
    - Lack of accountability and transparency.
    - Inadequate HR management activities
    - No standardized legal model available for NGOs

10. How much trust the patient has on the NGO Worker?
    - Low
    - Medium
    - High

11. What are the expectations of the patient?
    - Peer education on HIV and AIDS
    - School programmes that deal with both the health as well as the emotional side of life skills.
    - Youth groups that offer support to young people with problems.
    - Youth-friendly health services,
    - Legal awareness programs
    - Health checkups
    - Distribution of preventive materials
    - Communal support

ANNEXURE 2

Publications Details

List of Published Papers

S. No	Author	Journal	Title	Vol.	ISSN/ ISBN no.	Year
1	**1.** Anant Upadhyay **2.** Dr. Manoj Joshi	Research Matrix	Problem of Prostitutions in India	Volume 1 Issue 2	ISSN: 2321-7073	Sep. 2023
2	**1.** Anant Upadhyay **2.** Dr. Manoj Joshi	Research Matrix	Rights of the people living with HIV/AIDS	Volume 4 Issue 11	ISSN: 2321-7073	Jun. 2023

ANNEXURE 3

Plagiarism Report

Legal Awareness Study on Legal Rights of HIV/AIDS Victims in North Gujarat

ORIGINALITY REPORT

9%	6%	5%	3%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Submitted to Pacific University Student Paper	2%
2	hateamongstus.net Internet Source	<1%
3	vdoc.pub Internet Source	<1%
4	ijrar.com Internet Source	<1%
5	egyankosh.ac.in Internet Source	<1%
6	Public Health Aspects of HIV/AIDS in Low and Middle Income Countries, 2009. Publication	<1%
7	www.jrnrvu.edu.in Internet Source	<1%
8	www.science.gov Internet Source	<1%

ANNEXURE 4

Certificate of Publication and Presentation

FACULTY OF MANAGEMENT
Pacific Academy of Higher Education and Research University, Udaipur

PACIFIC SCHOOL OF LAW
Pacific Academy of Higher Education and Research University, Udaipur

13th International Conference

The Next Normal : Strategies For Sustainable Future

Knowledge Partners
IARA WWA LPU-Laguna

Certificate of Participation

22-23 April, 2022

This certificate has been awarded to

Anant Kumar Rameschndra Upadhyay, Research Scholar

of

PAHER University, Udaipur

for presenting the paper titted

Evolution of human Rights

in the 13th International Conference held on 22-23 April, 2022.
The organizers wish the participant a great success.

Prof. Mahima Birla
Conference Director

Dr. Pallavi Mehta
Organizing Secretary

Dr. Subhash Sharma
Convener

Dr. Ashish Adholiya
Co-convener

12th INTERNATIONAL CONFERENCE

SUSTAINABLE GLOBAL TRENDS : PLANET, PEOPLE AND PROFIT

CERTIFICATE OF PARTICIPATION
16-17 April 2021

PACIFIC INSTITUTE OF MANAGEMENT
PACIFIC ACADEMY OF HIGHER EDUCATION AND RESEARCH UNIVERSITY, UDAIPUR

&

PACIFIC BUSINESS SCHOOL
RAJASTHAN TECHNICAL UNIVERSITY, KOTA

This is to certify that **Anantkumar Rameschndra Upadhyay**

of PAHER University, Udaipur (Research Scholar)

has presented his/her paper entitled Spiritual Lifestyle and Health

during the two-day International Conference jointly organized by Pacific Institute of Management & Pacific Business School, Udaipur in online mode. The Organizers wish his/her success in future endeavors.

Prof Mahima Birla
Conference Chair

Prof Dipin Mathur
Director Conference

Dr Shivoham Singh
Organizing Secretary

ANNEXURE 5

Published Papers

RESEARCH MATRIX :2321-7073
Peer Reviewed & Refereed | International Multidisciplinary journal of applied research

PROBLEM OF PROSTITUTION IN INDIA

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GUIDE NAME : DR MANOJ JOSHI

ABSTRACT

Women have traditionally had a lower social status than men in Indian society. Women have always been socially and economically subordinated to men. Men have always forced women to be under their control. Women also find themselves in a situation where they seem to have accepted the dominance of men due to widespread illiteracy and economic dependence. Men have taken advantage of such economic dependence, illiteracy and ignorance of women and exploited them in various ways. Among such various forms of exploitation, physical and sexual exploitation of women is the extreme situation. Physical and sexual abuse of women by men has resulted in problems like prostitution and Devadasi practice. In many big cities of India like Mumbai, Calcutta, Delhi, a very large number of women earn their living by selling their bodies in brothels and live a life full of torture. Devadasi practice is also a religious form of prostitution, but this practice is not prevalent throughout India. In Maharashtra and some states of South India, the practice of offering daughters at the feet of God, i.e.Devdasi, is still prevalent. After the Devadasi Prohibitory Act, the practice continued in secret, but it did not die out completely. The women offered as devadasis in the temple are actually engaged in prostitution apart from dancing and from time to time some of these devadasis walk in the brothels of Mumbai, Lakatta, Bangalore, Delhi. In the present article we will get an explanation about the problems of prostitution which culminates in physical and sexual exploitation of women.

KEYWORDS: PROBLEM, PROSTITUTION, INDIA

INTRODUCTION

A report by the National Committee on the Status of Women identified prostitution as a symbol of exploitation of the poor by the rich and of women by men. Prostitution is on the rise in metros and urban areas. This profession presents the demand and supply situation regarding sex life satisfaction. On the one hand, there is a demand for sex life satisfaction from men who live alone in cities and urban areas for business, single and married men who frequently visit such cities for long or short periods of time, men who live with families but are attracted to richness and variety. On the other hand, conditions like poverty, lust for luxury life provide supply to satisfy this demand to get money. Due to the commercialization of this business, brokers who profit from the prostitution business, as well as alcohol and gambling communities have also come into being. According to the prevailing norms and values of the society, prostitution is known as an unethical trade.

MEANING OF PROSTITUTION

According to the Prohibition of Indecent Traffic in Women and Girls Act of 1956, "Any woman who engages in renting out her body for the purpose of uncontrolled sexual intercourse is guilty of prostitution." The 1987 Act changed the definition of prostitution as this law proved ineffective in controlling prostitution. According to the Prohibition of Unlawful Trade Act 1987 "Prostitution is defined as the sexual exploitation or abuse of persons for commercial purposes. Prostitution is not an illegal activity under this law. But exploitation of women through prostitution is a crime and is illegal.

It is difficult to estimate the number of legal and illegal prostitution activities in small and large cities of

India. Dr.Gilada[2] notes, a study of 800 women engaged in prostitution found the following: About 120 of the 800 women were under 18 years of age. As many as 120 women entered prostitution through Devadasi practice. Each woman satisfied 4customers a day and her monthly income was around Rs 300.Interviews with these women revealed that women working in prostitution were in need of medical and social support. Women working in prostitution also had children. The living conditions of these women were extremely miserable and pitiful and difficult to describe. 10to 12girls were housed in a single room. Mostof these girls bought food from dirty hotels and ferias and ate. Most of the young girls consumed alcohol, cigarettes or drugs. During the treatment it was found that 80percent of the women were suffering from sexually transmitted diseases. After the experimental test, it was found that 90percent of the women were affected by this disease. 50percent of these women had two or more such diseases simultaneously. Such diseases included syphilis, choroid, gonorrhoea, donovanosis etc. Apart from this, some women also got AIDS disease. As male consumers frequently switch to females, such diseases increase progressively.

ADVERSE EFFECTS OF PROSTITUTION

Some of the negative effects of prostitution can be deduced from the details of the above study, in which the physical exploitation of women can be seen. Some of the significant effects are as follows:

(1)Women may be financially and physically exploited. Women who work as prostitutes in brothels are paid very little. A large part of the money taken from the customer is taken by the agents and persons running the brothels. Such women earn an average of Rs 300, in exchange for which they have to satisfy four customers. Their food is undernourished and light. They usually resort to dirty hotels and ready-made food from trucks, where they are overcharged. Besides, they have to go into debt to spend on beauty products. Many prostitutes are in debt, unable to afford nutritious food due to low income and debt, resulting in poor health.

(2)Women in brothels suffer from sexually transmitted diseases. Also suffer from diseases like AIDS. Not only that, but brothels play an important role in the spread of such diseases.

(3)The question of the location of children born to women in brothels arises. Usually they end up being illegitimate children. Their female children become part of the brothel in future.

(4)The position and dignity of a woman in a brothel is undermined. Their living conditions are pitiable and inferior.

(5)Prostitution fosters other unethical businesses. As it feeds the vices of alcohol and gambling.

(6)Kidnapping and rape of minors is encouraged to obtain minors required for prostitution. An unscrupulous business of raping and abducting young women has developed to provide such women to brothel agents for huge sums of money. There are many cases of rape victims being forced into prostitution. As the committee noted, the lure of profit from this trade has fueled the rape and exploitation of women from tribal communities and other groups who have never taken up the profession.

CAUSES OF PROSTITUTION

Some of the significant reasons responsible for prostitution are as follows:

(1)Factors like child marriage, social prohibition on widow remarriage, dowry system and inadequate opportunity for women to work, attachment system, bride fee can be considered responsible for boosting prostitution.

(2)Industrialization and urbanization have made this profession a highly profitable industry.

(3)In some castes, the traditional form of this profession, sanctioned by social and religious customs, has changed into an unethical trade. Studies on prostitution have shown that most prostitutes come from traditional groups.

(4)Many women join this profession due to poverty and social injustice. Sometimes not only poor families but also middle class people are forced to engage their women in prostitution due to lack of sufficient earning opportunities.

(5)Men engaged in vetha and agricultural labor have to resort to prostitution to free their wives and

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[2] Shah A.G. and Dave J.K. (1993): Social Problems. Anada Book Depot, Ahmedabad. Pp. 196.

their families from debt.

(6)The Committee notes that in some parts of the country girls are encouraged to take up this profession in order to manage their dowry amount.

(7)There have been cases of girls from middle class families taking up this profession due to financial necessity and in some cases to attain wealth.

(8)Kidnapping has also become a common cause of prostitution in modern times. A young girl is trapped by a woman or a couple taking advantage of her naivety. Such a girl is lured to watch a movie, go on a city tour, travel, become a film star, give a job or get married in a good place. In this way, they are kidnapped and sent to a brothel. This kind of kidnapping has become a business. The kidnapper receives a large sum of money from the agents of the brothels.

(9)Devadasi practice is an important cause of prostitution. This practice is especially prevalent in Karnataka and Maharashtra. Every year thousands of girls perform the ritual of offering gifts at the feet of the goddess. After this ritual some girls are sometimes diverted to brothels. Dr. As Gilada notes, 10 percent of the total prostitutes in India are recruited from these devadasis. 15 to 20 percent of brothels in Mumbai, 10 percent in Nagpur, Delhi and Hyderabad, 50 percent in Pune and 80 percent in Belgaon district are recruited from Devadasis.

(10)Rape is a contributing factor to prostitution. Dr.Gilada notes, 6percent of girls were raped and joined prostitution. A rape victim takes refuge in a brothel when she cannot find a safe place in the society.

REMEDIAL MEASURES

(a) Legal Remedy: The Suppression of Immoral Traffic in Women and Girls Act, 1956 was enacted in 1956 to control the problem of prostitution. The purpose of this law was not to penalize individual prostitutes and prostitution businesses, but to prevent the commercialization of this business. Only when a prostitute plies her trade in public places and around religious places is she legally punished. To remove such deficiency in the law, this Act has been amended and replaced by the Unfair Trade Detention Act, 1987, which came into effect from January 1987. The Act provides for severe punishment for offenses related to prostitution.

(b) Other Remedies: The Committee on the Status of Women has suggested some of the following remedial measures to address the problem of prostitution:

(1) Shelters should be constructed for illegitimate and abandoned children.

(2) Counselingcenters should be established for women in moral and social danger.

(3) Rehabilitation facilities should be provided to women released from prostitution.

Apart from this, the following measures should be taken considering the causes of prostitution:

(4) Devadasi practice should be strictly prohibited. Devadasi Detention Act should be strictly followed.

(5) Kidnappers, rapists etc. should be exposed.

(6) Proper arrangements should be made for the upbringing of children of prostitutes, so that they are not likely to turn to prostitution.

(7) To provide protection to women victims of abduction or rape.

(8) To take care of the health of women engaged in prostitution. The Indian Health Association is one such organization, which tries to address issues related to prostitution.

(9) To rehabilitate women victims of prostitution i.e. to create conditions in the society where they can lead a dignified and independent life.

(10) Effective enforcement of laws prohibiting unethical trade.

(11) To make effective measures to solve problems related to women's marriage institution like child marriage, widowhood, dowry system.

(12) Increase employment opportunities for women.

(13) To present information through mass media about the prevalence of prostitution, its causes, its adverse effects and especially the diseases spread by it and AIDS disease and its seriousness and thereby try to develop social awareness.

REFERENCES:

Ditmore. Joint United Nations Programme on HIV/AIDS. UNAIDS; 2008.

Shah A.G. and Dave J.K. (1993): Social Problems. Anada Book Depot, Ahmedabad. Pp. 195-200.

Shah A.G. and Dave J.K. (2010): Women and Society. Anada Book Depot, Ahmedabad.

World Health Organization. WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. Geneva: World Health Organization; 2019.

World Health Organization. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Geneva: World Health Organization; 2009.

RESEARCH MATRIX :2321-7073
Peer Reviewed & Refereed | International Multidisciplinary journal of applied research

THE RIGHTS OF THE PEOPLE LIVING WITH HIV /AIDS

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ABSTRACT

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

— **Preamble to the Constitution of the World Health Organization**

The system of treaties, convention, gives formal recognition to certain rights for all human beings that states have a duty to protect their right .HIVpatient fall within the bounds of all human rights treaties but, because of their severity of illness, discrimination, social exclusion and incurable disease need extra care and protection and these are enshrined by the United nation with the form of different Instruments.Like Article14,16,21 19(1) (g) of the Indian constitution and **Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017**This paper studies the various rights made for the people living with HIV at the various Instruments.An attempt has been made to understand the rights of status of HIV patients , this paper tries to know whether these rights actually works for HIV patients or not. If not, what other efforts can be made?

KEY WORDS : HIV/AIDS, RIGHTS, ACT,2017,INDIAN CONSTITUTION .

INTRODUCTION

More than four decades after the first clinical evidence of acquired immunodeficiency syndrome was reported, AIDS remains one of the most devastating diseases humankinds has ever faced.

Since the epidemic began, more than 60 million people have been infected with the virus and nearly 30 million people have died of HIV-related causes. AIDS is the sixth-largest cause of death worldwide. 1.5 Million people were newly infected with HIV in 2021. 38.4 Millionpeople were living with HIV in 2021. 650 THOUSAND people died of AIDS-related illnesses in 2021[1] Several fundamental/legal rights are threatened in the context of HIV/AIDS including –

THE RIGHT TO NON-DISCRIMINATION

Discrimination with HIV-AIDS victims is widespread. It not only violates the rights of those affected but also further disables them by limiting their access to employment, housing, health care and vitally needed social support systems.[2]Sec.-3 Of this Act[3] prohibits any kind of discrimination against people suffering from HIV and AIDS.People fighting with HIV/AIDS cannot be mistreated in any way in common facilities like educational institutes, health centers, shops, hotels.Now HIV-AIDS victims will get property rights. His family members cannot evict him from the property.Every patient will have the

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[1] https://www.unaids.org/en

[2] Report of the Secretary-General on international and domestic measures taken to protect human rights and prevent discrimination in the context of HIV/AIDS, Commission on Human Rights,

[3] THE HIV & AIDS (P & C) ACT, 2017

right to HIV prevention, testing, treatment eg.LX versus Union of India and counseling services ,They will also get priority in legal matters. From now on, cases related to HIV positive people will be dealt with on priority basis in the court.HIV patients will be given free treatment and the cost will be borne by the central government.

RIGHT TO CONFIDENTIALITY

Right to Confidentiality[4] Special care has been taken for the privacy of HIV/AIDS patients. In court cases, during treatment and in government records, full care will be taken about the privacy of the patients. Making any information public in this matter will be considered a crime.No person can be forced to reveal his HIV status. Institutions having information about HIV victims have been required to adopt data security measures. So that their information does not come in the public domain in any way. If necessary, an HIV positive person can be forced to reveal his status only on the orders of the court.

RIGHT TO RESIDENCE

The HIV/AIDS (P&C) Act 2017 Sec.-29 says that every protected person shall have right to reside in a shared household.

RIGHT TO INFORMED CONSENT

National AIDS Control Organization has issued a comprehensive HIV testing policy. According to the HIV testing policy, mandatory HIV testing should not be imposed as a precondition for employment or for providing healthcare services in private firms. Testing should be done after obtaining informed consent, with pre and post-test counseling and should be voluntary.Sec-5 of this Act.[5]

RIGHT TO MARRY AND FOUND A FAMILY

Article 23 of the International Covenant on Civil and Political Rights recognizes the right of men and women to marry and found a family. Mandatory premarital testing as a precondition for marriage, or forced abortions or sterilization of women living with HIV would violate these (and other) rights.

RIGHT TO EDUCATION

also encompasses the obligation of States to promote understanding, respect, tolerance and non-discrimination in relation to people living with HIV. Furthermore, it provides that individuals have the right to receive HIVrelated education.

RIGHT TO DISCLOSURE OF HIV STATUS

Sec-8 of The HIV&AIDS(P&C)Act 2017 says that no person shall be compelled disclose his HIV status except by an order of the court that the discloser of such information is necessary in the interest of justice.disclosure of HIV status is also violet the article 12 of UDHR,1948

RIGHT TO TREATMENT ANDREMEDY

In cases of discrimination or denial of facilities- eg.LX versus Union of India[6]

RIGHT TO EMPLOYMENT

MX of Bombay Indian Inhabitant Versus ZY and Ors.[7] in this case Bombay High Court has held that no person could be deprived on his or her livelihood except by procedure established by law. A public sector employer can not deny a person employment solely because he is HIV Positive. In another case G Versus New India Assurance Co.Ltd.Writ Petition No.1562 of 1999 the Bombay High Court has held that a person who is otherwise fit, could not be denied employment only on the ground that He or She is HIV Positive.

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[4] MR.X VsHospital Z(2003)1 S.S.C.500

[5] THE HIV & AIDS (P & C) ACT, 2017

[6] Delhi High Court(Order Dated 5 May2004

[7] A.I.R1997BOM.406

CONCLUSION AND SUGGESSION

HIV/ADIS was not simply a medical issue but an issue of social justice. In todays century HIV/AIDS petients still suffer a hugh amount of discrimination every day .Discrimination can be seen In every places Decriminalization is a critical element to end AIDS by 2030. However, despite the compelling evidence, many discriminatory and punitive laws remain. States are under the obligation to promote and protect all universally recognized fundamental rights and individual freedoms, in accordance with international human rights instruments The government has implemented the HIV/AIDS(P&C) Act 2017 to protect the rights of such patients. The protection of fundamental rights must constitute an integral part of the fight against HIV/AIDS.There is a need to make HIV patients aware and educated about their rightsSo that they can fight against the violation of their rightsAnd the society will also have to change its thinking only then these victims will be able to use their rights in the true sense. Communities are advocating for change, and are helping to build a growing movement for decriminalization.