SOCIO-ECONOMIC AND PSYCHOLOGICAL IMPACT OF HIV/AIDS ON SOCIETY

By

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Subject: Submission of Ph.D Thesis

We, the supervisory committee, certify that the contents and form of the thesis submitted by Mr. Shahbaz Ahmed Khan, Reg. No. 2000-ag-493 have been found satisfactory and recommend that it be processed for evaluation by external examiners for the award of degree.

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ABSTRACT

Acquired Immunodeficiency Syndrome (AIDS) is a human viral disease that ravages the immune system, undermining the body’s ability to defend itself from infection and disease. The spread of epidemic at large scale may damage the socio-cultural fabric of society. The study was designed to estimate the past trend of HIV/AIDS spread and to forecast the HIV/AIDS in Pakistan. The information about the patients were taken from the national HIV/AIDS testing centers located in different hospitals as well as from the National Institute of Health, Islamabad. The study will explore the causative factors of HIV/AIDS along with socio-economic and psychological implications of disease on the patients, their families, and community as whole.

Qualitative and quantitative approaches were used to explore the research objectives. In qualitative approach focus group discussion was conducted with the patients, their families and health care providers. Well structured questionnaire consisting of open-ended and close-ended questions was prepared for exploring research objectives. Content analysis was also in the plan of analysis for exploration of research objectives.

Secondary data was taken from different Government and Non-government agencies. Descriptive analysis of the collected data carried out along with the development of model for future prediction. Policy recommendations which based on the findings suggested to the Government for framing a comprehensive national policy on the HIV/AIDS.
ACKNOWLEDGEMENTS

All praise is due to Allah, my creator, my fashioner omniscient of what I need, cognizant of my deeds, the one and only, who is nearer to me than my jugular vein, to whom are ascribed the traits of absolute perfection and beauty. Blessing and Peace Be Upon Him the one whom Allah has sent as a mercy to the world, Hazrat Muhammad (P.B.U.H), the illuminating torch and resource of humanity from going astray.

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Lastly, I would thank my parents, wife and my son for their patience, encouragement
and inspiration, which led to complete this study successfully.
GLOSSARY OF TERMS AND ABBREVIATIONS

Rs  
Pakistan Rupees = US$ 59.5 current rate in May 2005

ARV  
Antiretroviral

UNAIDS  
Joint United Nations Program on HIV/AIDS

UNICEF  
United Nations Children’s Fund

VSO  
Voluntary Services Overseas, UK

HIV  
Human Immune Deficiency Virus

AIDS  
Acquired Immune Deficiency Syndrome

NIH  
National Institute of Health

NACP  
National AIDS Control Program

MDG  
Millennium Development Goals

PIUs  
Provincial Implementation Units

WHO  
World Health Organization

T.B.  
Tuberculosis

IDU’s  
Injecting Drug Users

PLWHA  
People Living With HIV/AIDS

STD  
Sexually Transmitted Disease

UNDP  
United Nations Development Program

I/V  
Intera Vinous

CDC  
Centers for Disease Control

NGO  
Non-Governmental Organizers

SOPs  
Standard Operating Procedures

I/M  
Intera Muscular
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CHAPTER 1

INTRODUCTION

1.1 What is HIV/AIDS?

Among the challenges of present era, Acquired Immune Deficiency Syndrome (AIDS) is the leading enemy. This socio-medical problem has involved the whole globe breaking the boundaries of countries and continents. Electron microscopic virus of AIDS, called “Human Immune Deficiency Virus” has already infected million of people and the incidence is increasing alarmingly in the world (Bryon, 1990). AIDS is not simply a medical problem but due to its associated morbidity and mortality, every aspect of individual’s life is vulnerable to great damage. (Morrison, 2002)

Human Immune Deficiency Virus (HIV) destroys the defense system of human body. As a result, even the minor least lethal ailments may prove fatal for infected person (Walker et al, 1999). HIV infection may go unrecognized for many years as patients may remain symptom-free for prolonged period. The initial symptom free state of the sufferer is called “carrier state” as the person has AIDS virus in his/her blood and this is most dangerous phase in the disease process. Carriers, unknowingly and unintentionally, may transfer their virus to any healthy individual e.g. by donating blood.

A carrier of HIV may appear perfectly healthy and normal or one may suffer from minor negligible episodes of ill health, these minor episodes often go unrecognized except in high-risk population. Full blown AIDS is a late sequel of the disease process. Acquired Immune Deficiency Syndrome (AIDS) as name explains is not a single disease but is a complex of many associated pathologies which are strongly associated with
psychological and social disturbances. It may take on an average of seven to ten years for the development of full-blown AIDS. In spite of extensive medical research, there is no definite cure for AIDS yet. The available medication is just palliation to slow the speed of disease process and to improve the quality of life as much as possible.

The discovery of AIDS in early 1980’s and its global spread since then have shaken the entire world (Gottlieb et al, 1981). Genetic detail of HIV indicates that it is probably more than a century old. HIV infected cases were less than 0.001% of the world population until the mid 1970’s. After 1970, the virus surged because of rapid social changes, African urbanization, globalization and flood of intravenous drug users in America and Europe along with changing sexual practices accelerated the epidemic of HIV/AIDS in the world.

AIDS is characterized by the progressive loss of CD4+ helper/inducer cells are important subset of T.Lymphocytes which perform vital function in the immune system. AIDS is leading to severe immune suppression and constitutional disease, neurological complications, opportunistic infections and neoplasm that rarely occur in persons with intact healthy immune function (ACOG, 1992). Although the precise mechanism, leading to destruction of immune system has not been fully delineated, but abundant epidemiologic, virology and immunologic data support the conclusion that infection with the Human Immune Deficiency Virus (HIV) is the under lying cause of the AIDS.

HIV/AIDS has acquired the form of global epidemic. Responses to the HIV epidemic have increasingly focused global attention on dealing not only with the cause of the epidemic but also with its consequences, the better often referred to as the “impact” of the AIDS epidemic. The approach to handle both the causes and consequences of a development problem like the global AIDS epidemic has often been lacking in the past. However, keeping in view the spreading disaster of HIV, now the global strategy has
changed towards dealing with the impact and consequences of a large number of infections, while at the same time trying to prevent or slow down the spread of this virus. As HIV is becoming a major cause of adult mortality in many countries, the effects of the epidemic are psychological, social, economic deterioration (World Bank, 1993a).

1.2 Structure of Thesis

Chapter one is an introductory and describes the issue, severity of the issue at the national and international level, rationale and objectives of the study. In second chapter an overview of HIV/AIDS, characteristics of the disease, theories of origin of HIV, preventive policies for HIV/AIDS framed by the government of Pakistan, critical evaluation of government policies and literature review. Third chapter is comprised of the methodologies adopted for quantitative as well as qualitative study. The study design, study area, characteristics of the respondents, sequence of the questionnaire, reliability check, sample size, criteria for sample selection and techniques used for quantitative data analysis. The procedure and pattern of focus group, recording of discussions, video-filming along with photographs, personal observations and selection of moderators, observers and note-taker for qualitative study are described in the chapter.

In fourth chapter, there are in-depth case studies of patients, patient's families, peer group, panel discussion with health-care providers and religious leaders to describe the socio-economic and psychological implications of HIV/AIDS on individuals, community and society. In fifth chapter the descriptive findings about the impacts of HIV/AIDS, based on the analysis of the survey are presented. Sixth chapter deals with summary findings, discussions, conclusion, recommendations and proposals for future area of research.
1.3 Situation of HIV/AIDS in Pakistan

The history of HIV/AIDS in Pakistan is not very different from many other countries.

<table>
<thead>
<tr>
<th>Region</th>
<th>Total (HIV+AIDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Centres</td>
<td>408 (370+38)</td>
</tr>
<tr>
<td>Punjab</td>
<td>466 (414+52)</td>
</tr>
<tr>
<td>Sindh</td>
<td>666 (582+84)</td>
</tr>
<tr>
<td>NWFP</td>
<td>433 (377+56)</td>
</tr>
<tr>
<td>Balochistan</td>
<td>202 (190+12)</td>
</tr>
<tr>
<td>AJK</td>
<td>22 (18+04)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2197 (1951+246)</strong></td>
</tr>
</tbody>
</table>

(4.2 million Anti-HIV Tests carried out on recommended categories since 1986)

Source: National Institute of Health, Islamabad, Pakistan (December 2003)

According to latest information (UNAIDS, 2004), South East Asia shows around 7.1 million (4.4-10.6 million) out of total 39.4 million (35.9-44.3 million) HIV/AIDS cases globally. Adult prevalence in South East Asia region is around 0.6% (0.4-0.9). Pakistan is also one of those countries in South East Asian region where HIV/AIDS prevalence is considerably low. In Pakistan the number of HIV affected is comparatively lesser than other countries of even the same region like India. If we compare the high risk population like sex workers or intravenous drug users of other countries with Pakistan, the number of infected persons is still lesser and this situation reflects an opportunity to prevent a serious outbreak. Estimated HIV prevalence of HIV/AIDS in Pakistan is 0.07 percent (NACP, 2001).

The number of reported and estimated cases is still relatively low and the patterns of behavior which can rapidly facilitate an epidemic spread of the infection are wide
spread. Although at present, the situation of AIDS in Pakistan is not very horrible but Pakistan’s population high risk behavior has got the great potential to end up in epidemic form of disease situation.

As of September 2001, a total of 1639 cases of HIV infection and 216 cases of full blown AIDS had been reported by National AIDS program (NAP) in Pakistan, though it is estimated that real numbers of people living with HIV/AIDS in Pakistan at the end of 1999 was approximately 74,000 (UNAIDS/WHO, 2000). Relatively low numbers of reported infections may be the result of number of factors, including an actual low level of HIV infection due to early stages of epidemic; under-reporting of cases due to lack of surveillance system; restricted individual level care-seeking for possible HIV infection due to ignorance and/or stigma associated to HIV/AIDS.

According to the National AIDS Program (NAP), heterosexual transmission currently accounts for the majority (37%) reported HIV/AIDS cases. Transfusion of contaminated blood and blood products accounts for 18% of the cases. Repeated use of contaminated syringes contributes 4%, homosexual relationship 2%, bisexual behavior 1.5% and vertical transmission from infected mother to fetus 1.3% among reported cases of HIV/AIDS. In 35% of the reported cases, there is not a single mode of transmission which can be blamed exactly to be the cause of AIDS rather they indulged in multiple risk factors leading towards HIV/AIDS. The mode of transmission is not known but there is strong suspicion of sexual transmission (PNAR, 1999). There are approximately 60,000 sex workers throughout the country. There are 48 percent men who practice sex with men in Lahore (Go et al, 2004). Over 87 percent of reported cases in Pakistan have been detected in male population. Out of this 87 percent, 52 percent fall within age limit 20-40 years (UNAIDS/WHO, 2000) and 16 percent are in their forties. The age limit of 27 percent of reported cases is not known. Female population contributes to 13% in
reported cases of HIV/AIDS. In Pakistan ratio of HIV positive male to female is 7:1 (UNAIDS, 2002). HIV/AIDS cases have been reported from all provinces of the country and primarily from the major urban areas of the provinces. However, the continuous and rapid migration from rural to urban area might have contributed to a changed picture. Four hundred thirty cases have been reported from Federally Administred Territories and from Azad Jammu Kashmir (AJK) region too.

Although at present, Pakistan is regarded as a low prevalence and high-risk country for HIV/AIDS. The total cases reported from 1986 to December 2003 are 2197 and this includes 1951 HIV positive and 246 AIDS cases. The number of cases reported during the past 3 years is 130,135 HIV positive and 112 AIDS cases respectively. This is in contrast to the WHO/UNAIDS estimate of 70000 to 80000 HIV positive persons in Pakistan (UNAIDS, 2003). However, higher numbers of cases are being reported from some of the provinces among certain high risk groups like a recent investigation of HIV infected persons among intravenous drug users in Larkana created confusion as how to such a situation can be effectively dealt with.

1.4 Situation of HIV/AIDS in Asia

National HIV infection levels in Asia are low as compared with some other continents, notably Africa. But the populations of many Asian nations are so large that even low national HIV prevalence means large numbers of people are living with HIV.

In Asia, latest estimates show some 8.2 million (5.4m-11.8m) people, 2.3 million (1.5m-3.3m) adult women were living with HIV at the end of 2004, including the 1.2 million (720000-2.4m) people who become newly infected in the past years,(UNAIDS,2004). AIDS claimed some 540000(350000-810000) lives in 2004. Among young people of 15-24 years, 0.3% of women (0.2-0.6%) and 0.4% of men (0.3-0.8%) were living with HIV by the end of 2004 (Brown, 2004). Asia is not only vast
but diverse too and HIV epidemics in the region share that diversity. with the nature, pace and severity of epidemics differing across the region. Over all, Asian countries can be divided into several categories according to the epidemics they are experiencing.

While some countries were hit early (for example, Cambodia, Myanmar and Thailand), other are at the early stage of rapidly expanding epidemics. These include Indonesia, Nepal, Viet Nam and several provinces in China. In some parts of India and China, HIV has become well entrenched in some sections of the society. despite modest efforts to halt the virus spread. Other countries are at the low levels of HIV prevalence, even among people at high risk of exposure to HIV. These countries include Bangladesh, East Timor, Laos, Pakistan, and the Philippines. (MAP, 2004)

**Table 1.4/A HIV/AIDS Statistics And Features in Asia (2002-2004)**

<table>
<thead>
<tr>
<th></th>
<th>Adults &amp; children living with HIV</th>
<th>No. of women living with HIV</th>
<th>Adults &amp; children newly infected with HIV</th>
<th>Adult prevalence%</th>
<th>Adults &amp; child death with AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2002</strong></td>
<td>7.2 million</td>
<td>1.9 million</td>
<td>1.1 million</td>
<td>0.4</td>
<td>470000</td>
</tr>
<tr>
<td></td>
<td>(4.6-10.5 million)</td>
<td>(1.2-2.8 million)</td>
<td>(540000-2.5 million)</td>
<td>(0.2-0.5)</td>
<td>(300000-69000)</td>
</tr>
<tr>
<td><strong>2004</strong></td>
<td>3.2 million</td>
<td>2.3 million</td>
<td>1.2 million</td>
<td>0.4</td>
<td>540000</td>
</tr>
<tr>
<td></td>
<td>(5.4-11.8 million)</td>
<td>(1.5-3.3 million)</td>
<td>(720000-2.4 million)</td>
<td>(0.3-0.6)</td>
<td>(350000-810000)</td>
</tr>
</tbody>
</table>

**Source:** AIDS Epidemic Update, Publication of UNAIDS (2004)

Recognizing that the epidemics in the developing and developed world are interconnected, there has been a significant international response to the epidemic. Part of
this has come in the form of bilateral assistance between developed countries and specific developing countries. However, much of the collaboration between developed and developing countries have occurred through multilateral international agencies such as WHO, United Nations Development Program and Joint United Nation Program on HIV/AIDS.

1.5 Situation in India

India has a population of one billion; around half of it consists of adults in the sexually active age group. The first AIDS case in India was detected in 1986 and since then HIV infection has been reported in all states and Union Territories (Go et al, 2004).

The spread of HIV in India has been diverse, with much of India having a low rate of infection and the epidemic being most extreme in the Southern States. As of December 2004, 92 percent of all nationally reported AIDS cases have been found in ten of the twenty eight states and seven Union Territories. The greatest numbers were in Maharashtra and Gujarat in the west, Tamil Nadu and Andhra Pradesh in the South and Manipur in the North-East (NACO, 2004). In the Southern States of India, the infections are mostly due to heterosexual contact, while infections are mainly found amongst injecting drug users in Manipur and Nagaland (UNAIDS/WHO, 2004). In the Indian state of Andra Pradesh, ADB/UNAIDS estimated that 1 in 8 hospital beds are being used for people sick with HIV/AIDS, nearly five times the national average.(UNAIDS, 2000)

Table 1.5/A: AIDS data of India, December 2004

<table>
<thead>
<tr>
<th>Gender</th>
<th>Cumulative AIDS cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>69559</td>
</tr>
<tr>
<td>Female</td>
<td>27419</td>
</tr>
<tr>
<td>Total</td>
<td>96978</td>
</tr>
</tbody>
</table>

1.6 The global epidemic: HIV/AIDS on the MAP

Globally, there are now 18.7 million men and 17 million women between the ages of 15 and 49 living with HIV/AIDS since 2004. Nearly, one in 100 people worldwide is living with HIV/AIDS, rising to one in three in some parts of Southern Africa (VSO, 2003) Since 1985, the percentage of women among adults living with HIV/AIDS has risen from 35 percent to 48 percent.

Table 1.6/A: Estimated number of women and men (15-49) living with HIV/AIDS

![Chart showing the estimated number of women and men living with HIV/AIDS]

Source: UNAIDS, 2004

1.7 Sub-Saharan Africa:

In Sub-Saharan Africa, about 23 million adults aged 15 to 49 are infected, with 57% (13.1 million) of them are women and 43% (9.9 million) are men. In 1985, roughly half a million men and half a million women were living with HIV/AIDS. HIV is spreading predominantly through heterosexual contact, which has increased the risk for
women to be infected. In Botswana and Swaziland, there are 40% pregnant women suffering from HIV (Evian et al, 2004).

1.8 Latin America and Caribbean:

Some 2 million people between the ages of 15 and 49 are living with HIV/AIDS in Latin America and the Caribbean, with 36 percent women HIV/AIDS in Latin America, and 49 percent in the Caribbean (CAREC, 2004). In Latin America, One million young males living with HIV/AIDS and 560,000 females are the victim of HIV/AIDS (MAP, 2003). In Caribbean, the estimated number of men (15-49) living with HIV/AIDS are 200, 000 and 210,000 are young females.

Source: UNFPA, 2004

HIV prevalence has reached rates of 1 percent or higher in the general population in at least 12 Caribbean and Central American countries (Bahamas, Barbados, Belize, the Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Jamaica, Panama, Suriname and Trinidad and Tobago).
Source: UNIFEM, 2004

In the Caribbean, the main mode of transmission is heterosexual practice, however in Puerto Rico; injecting drug use appears to be the main source of the epidemic (Osimani, 2003).

1.9 **Middle East and North Africa:**

HIV prevalence in the Middle East and North Africa is still very low except Sudan. HIV infections are increasing among injecting drug users in Bahrain, Iran and Libya and to a lesser degree in Algeria, Egypt, Kuwait, Morocco, Oman and Tunisia (Jenkin et al, 2003). In this region, social and cultural norms limit the discussion on sexual and reproductive health issues (Kilani et al, 2003).

Source: UNAIDS, 2004
1.10 Western Europe:

In Western European Countries for the reported HIV cases, heterosexual intercourse is the most common mode of transmission and injecting drug use. In Western European countries heterosexual intercourse is the most common mode of transmission of HIV among reported cases. Injecting drug use is also a common mode in many western countries. A large share of the increase in new infections is among people who had acquired HIV while living in countries where prevalence of HIV was very high. (Euro HIV, 2003)

Source: UNAIDS, 2004

1.11 Australia and New Zealand:

It is estimated that 13,630 people were living with HIV infection in Australia at the end of 2003. From the start of the epidemic until the end of June 2004, there have been 23,758 diagnoses of HIV (or an estimated 20,955 after adjusting for multiple reports), 9,355 diagnoses of AIDS and 6,385 reported deaths of persons with AIDS (NCHECR, 2003). In Australia and New Zealand, the percentage of women among adults living with HIV/AIDS is 8 percent, one of the lowest in the world.
Table 1.11:


<table>
<thead>
<tr>
<th>Year</th>
<th>HIV Male</th>
<th>HIV Female</th>
<th>HIV Total</th>
<th>AIDS Male</th>
<th>AIDS Female</th>
<th>AIDS Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>1078</td>
<td>80</td>
<td>1162</td>
<td>775</td>
<td>26</td>
<td>804</td>
</tr>
<tr>
<td>1992</td>
<td>1051</td>
<td>88</td>
<td>1140</td>
<td>752</td>
<td>37</td>
<td>791</td>
</tr>
<tr>
<td>1993</td>
<td>912</td>
<td>67</td>
<td>986</td>
<td>799</td>
<td>41</td>
<td>845</td>
</tr>
<tr>
<td>1994</td>
<td>839</td>
<td>85</td>
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<tr>
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<td>618</td>
<td>73</td>
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<td>92</td>
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<td>186</td>
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<td>16</td>
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<tr>
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<td>83</td>
<td>782</td>
<td>279</td>
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<td>19010</td>
<td>1510</td>
<td>20580</td>
<td>8911</td>
<td>440</td>
<td>9380</td>
</tr>
</tbody>
</table>

Source: UNAIDS, 2004

1.12 North America:

The proportion of AIDS cases among adult and adolescent women in the United States has more than tripled since 1985 (US.CDC. 2004a). Twenty-five percent of all North Americans living with HIV/AIDS is women (Department of Health, UK, 2003). Women’s prevalence rates were jumped by 5 percent between 2001 and 2003, the largest increase among women in any region of the world.
1.13 Rationale of Study:

The current study is first ever study of its nature in Pakistan. People are really hesitant to talk about such sensitive issue. The current study will prove a landmark towards the HIV/AIDS awareness and creating enabling environment for HIV positive people. This study will motivate the high risk behavior people to get their tests done and develop the sense of care about themselves as well as about general community. The growing level of HIV/AIDS cases in Pakistan is of great concern for the country.

- It has been realized that demographic vulnerability (63% population of Pakistan is below 25 years of age); young people are at higher risk for HIV/AIDS.

- Prevalence of hepatitis-B and hepatitis-C, in Pakistan is one of highest in the world. HIV another blood borne pathogen has almost similar modes of transmission.

- Pakistan has large drug user population (more than five million). Recent studies indicate increasing number of drug users are shifting to intravenous drug use.
High risk sexual behaviors, such as sexual promiscuity, exchange of sex for money and homosexuality exist in the country. In some segments of population usage of condom for disease prevention is extremely low.

Overseas Pakistani workers have emerged as high risk group for HIV infection and majority of reported cases are deported Pakistanis who were working in Gulf countries.

Blood transfusion services both in public and private sector are still not hundred percent safe.

Only about 20% total blood transfusion in the country (1.5million units/year) is fully screened before transfusion. (Razzaq, 2004)

There is irrational use of injections, multiple uses of syringes and needles.

The sexual transmitted infections management services are not accessible, affordable and easily available.

HIV/AIDS is spreading at faster rates in south, and south East Asia than the rest of world.

Keeping in view the above mentioned facts, an attempt is made to explore the prevalence, causes and consequences of the HIV/AIDS epidemic in Pakistan with the following objectives.

1.14 Objectives of the study:

- To assess the socio-economics and psychological implications of HIV/AIDS on the patients, patients’ families and community.
- To estimate the past trend of HIV/AIDS spread in Pakistan.
- To forecast the HIV/AIDS.
• To examine the causative factors of HIV/AIDS.

• To study the role of family as an institution in the prevalence of HIV/AIDS.

• To evaluate the Government’s efforts and strategies in tackling the disease.

• To suggest policy measures to the government for framing an appropriate policy to address the issue.
CHAPTER 2
THEORETICAL PERSPECTIVE OF THE STUDY

2.1 Introduction

Nearly every major infectious disease had more than one epidemic: the illness itself and society's reaction to it. The fear of infection and the ignorance of its cause have often led to uncaring and even barbaric practices. HIV/AIDS has also been a subject of intense coverage in the fields of the popular media and of academic theory (Morrison, 2002). The HIV/AIDS epidemic has evoked a wide variety of responses with the reference of culture and society. Such powerful issues as illness and death, pain and loss, hope and despair have been particularly relevant for the creative arts and for religious groups.

Cultural responses to the epidemic have been closely associated with gay men, the population that was earliest and perhaps most heavily impacted by HIV/AIDS (Silverstein et al, 2003). While much of the culture of AIDS is indistinguishable from that of gay male culture, however, many other voices have been heard and influences felt. Religious groups typically have extended existing general doctrines and beliefs about sexuality, drug use, illness, suffering, and death to the specific issue of HIV/AIDS, providing a wide range of responses. There are several academic/theoretical approaches to the study of the epidemic.
2.1.1 Feminism:

Feminism is theory that men and women should be politically, economically and socially equal.

This is the core of all feminism theories. Sometimes this definition is also referred to as "core feminism" or "core feminist theory." This theory does not subscribe to differences between men and women or similarities between men and women, nor does it refer to excluding men or only furthering women's causes. Most other branches of feminism do. Feminist theory made two very important contributions. The first is that feminist theory separated the social from the biological, insisting that we see a difference between what is the product of human ideas, hence something mutable and changeable, and what is the product of biology, hence something (relatively) stable and unchangeable. The second contribution is related to the first: by separating the social and the biological, the constructed and the innate, feminist theory insisted that gender was not something "essential" to an individual's identity. Sexuality is harder, though, in part because of the way, culture has always taught to think about sexuality. While gender may be a matter of style of dress, sexuality seems to be about biology, about how bodies operate on a basic level. Human sexual behavior is about pleasure and about pleasure mediated by all kinds of cultural categories.

Feminist theory is very much related with the behavior of human being, HIV/AIDS is a behavior disease. Consideration on equal basis female has the right to "Say No".
2.1.2 Queer Theory

The word "queer" in queer theory has some of these connotations, particularly its alignment with ideas about homosexuality (Rictor, 1997). Queer theory is a brand-new branch of study or theoretical speculation; it has only been named as an area since about 1991. Queer Theory assumes that "sexual identities are a function of representations." It assumes that representations pre-exist and define, as well as complicate and disrupt, sexual identities. It is an exclusive matter of choice and satisfaction. Rictor wrote the concept that gays are fundamentally different from straights and constitute a minority population that exists in all times and places. HIV/AIDS suggests an exaggerated tendency towards this particular behavioral segment.

2.2 Origin of HIV/AIDS

The issue of the origin of HIV could go beyond one of purely academic interest, as an understanding of where the virus originated and how it evolved could be crucial in developing a vaccine against HIV and more effective treatments in the future. Also, knowledge of how the AIDS epidemic emerged could be important in both mapping the future course of the epidemic and developing effective education and prevention program.

2.2.1 What type of virus is HIV?

HIV is part of a family or group of viruses called lentviruses (Matthews, 2003). Lentiviruses other than HIV have been found in a wide range of nonhuman primates.
These other lentiviruses are known collectively as simian (monkey) viruses (SIV) where a subscript is used to denote their species of origin.

2.2.2 How could HIV have crossed species?

It has been known for a long time that certain viruses can pass from animals to humans, and this process is referred to as zoonosis.

The researchers concluded that HIV could have crossed over from chimpanzees as a result of a human killing a chimp and eating it for food.

Some other rather controversial theories have contended that HIV was transferred iatrogenically i.e. via medical experiments. One particularly well publicized theory is that polio vaccines played a role in the transfer.

The journalist Hooper (1999) has suggested that HIV could be traced to the testing of an oral polio vaccine called Chat as batches of the Chat vaccine may have been grown in chimp kidney cells in the Congo, the Wistar Institute and Belgium. That could have resulted in the contamination of the vaccine with chimp SIV, the simian version of HIV-1. This vaccine was then given to about a million people in the Belgian Congo, Ruanda and Urundi in the late 1950s. However, in February 2000, the Wistar Institute in Philadelphia announced that it had discovered in its stores a phial of polio vaccine that had been used as part of this polio vaccination program. The vaccine was subsequently analyzed and in April 2001 it was announced that no trace had been found of either HIV or chimpanzee (Blanco, 2001). A second analysis confirmed that only macaque monkey kidney cells, which cannot be infected with SIV or HIV, were used to make Chat. What
is crucial in regard to the credibility of any theory is the question of when the transfer took place (Berry, 2001).

Although no one explanation for the origin of HIV/AIDS has been universally accepted, four theories provide some important lessons.

2.3 Theory 1: Tainted Polio Vaccine

In 1992, Tom Curtis, a renowned journalist, presented theory on the origin of HIV/AIDS. He traced the roots of HIV/AIDS from African Green Monkeys. According to him, contaminated polio vaccine was transferred from Green Monkeys to Human beings (Broxmeyer, 2003).

2.4 Theory 2: Contaminated Needle

A refinement of the cut-hunter theory comes from Preston A. Marx, a virologist who holds positions at Tulane University and at the Aaron Diamond AIDS Research Center. In the 1950s, with the worldwide introduction of disposable plastic syringes, injections became a popular way for doctors in the developing world to administer medicines, including vitamins, analgesics and other common drugs. According to Marx (1990), repeatedly utilization of unsterilized syringes became cause of spreading HIV/AIDS.

2.5 Theory 3: Heart of Darkness

In 1992, Joseph Conrad presented his theory about the origin of AIDS. According to him, during the early years of industrialization, there was massive movement from rural area to urban area with dramatic increase in population (Bauer, 2003). The problems
of poor sanitation, poor diet, limited health facilities and multiple sexual relations were the basis of immune deficiency disease which further links to HIV/AIDS (Edgerton, 2003).

2.6 Empirical Evidence of Literature Review

Although an HIV/AIDS epidemic is a relatively new phenomenon, substantial and committed efforts are needed to explore the epidemic of HIV/AIDS. But still, there are some studies and research work going on especially in the developing countries like Pakistan. Although in developed world, HIV/AIDS has been recognized as hot issue in the form of plague of present time, but in countries of third world where current status of HIV/AIDS is of low prevalence high risk; this volcano is still covered with ice of ignorance.

Ratzan (1993) in his book AIDS: Effective Health Communication for the 90's, has laid out the framework for effective health communication through an effective campaign of prevention message and strategies that are targeted at those evidences which are in the greatest need. An important aspect that has been neglected involves those individuals with impaired communication ability. Often they are ignored and the effective communication is needed for those individuals. Education is vital for breaking the viscous circle of HIV spread as it has observed in the study that general population especially of rural areas is not well aware of the nature & severity of the HIV/AIDS epidemic. They in general think that this is the disease of foreigners and they are spared of this lethal disease because of their religious, moral and social norms and life style. Effective communication has to be maintained for getting rid of this epidemic. Due to
rapidly growing HIV infected population there is intense need of attention of educators, counselors, physicians and health care providers as viewed Ratzan.

Edgar at el (1992) has mentioned in their essay, AIDS: A communication Perspective; that individuals will take necessary actions for prevention only when a) they are properly informed and b) they feel motivated to respond to the information they posses. The communication about HIV/AIDS is a continuous process because slowing the information for only a fraction result in individuals falling back into their old ways of unsafe sex. Edgar stressed on prevention, health risk communication, health behavior, safe sex; condoms and education for avoiding the lethal disease.

As is clear from the study there is very limited knowledge about HIV/AIDS in Pakistani society, people have no concept of safe sex, and most of population does not use condoms those who use them only for avoiding pregnancy. There is a considerable high risk population in the society which is endangering the life of others associated people because of their ignorance and negligence about the disease.

Muir (1991) has addressed the issue of education and information of specific groups of individual: general public homosexual and bisexual males, injection during users, adolescent and street youths, women, minorities and special needs groups. He focused on HIV prevention, particularly interventions involving education and information to the targeted groups. Among the at risk population: a special group is of women who sometime directly and indirectly are vulnerable to HIV infection. AIDS as it affects women has only recently gained attention. In the United Kingdom, the Scottish Women and HIV/AIDS Network is the major group that is trying to educate the young women in their teens, since 40 percent of the AIDS cases among women in the UK are
belonged to age group of 15-29 years and this group is the most resistant to adopt safe sex guidelines and measures.

Judy Bury et al (1992) said that although women with AIDS are relatively not in large number, their needs are special, especially if they are pregnant. Education directed at those who are positive and at greatest risk of getting pregnant is extremely important and needs to be developed in such a way that the women will understand how important it is. The female constitute 49% of total population, and share a great risk of developing HIV/AIDS, as females are with added risk of un-education, social deprivation and discrimination.

The prevalence of HIV infection in Asia on the rise but for variety of reasons, the government and health care authorities of Asian countries have for several years been underestimating the statistics and diverting attention away from this crisis.

Bonacci (1992) has examined the religious, cultural, social and economic reasons for the official suppression of the alarming data on HIV infection in Asia. He has discussed the religious and cultural barriers to some of the educational attempts including the religious prohibition against contraceptives and the cultural barriers in talking about safer sex techniques. This goes in comparison with study findings which show that religion is wrongly perceived regarding the issues of the contraceptive, safer sex and sex in general. To get through this supposed barrier is a critical problem for all of those working in the field of AIDS especially in the region where general public is not willing and hesitant to talk about such issue like AIDS publicly.

The relationship between sexually transmitted diseases, unsafe sex and AIDS has been established. McCauslin (1992) said that education about safe sex and awareness
about STDs is lacking. There are very limited numbers of health care providers who are particularly interested in the treatment of STDs, more over the patients are reluctant in the treatment from authorized personal due to stigmas associated with STDs and AIDS.

Elizabeth (1995) said that it was estimated in 1995 that by the year 2000, ninety percent of all new infections will occur in developing countries.

HIV/AIDS affects each and every aspects of individual’s life. Weeks (1995) proposed an ethics of love founded on four principles: care, responsibility, respect and knowledge. In case HIV/AIDS, keeping a positive outlook has proven to be more beneficial than some drugs indicating the importance of social aspects in addressing the issue of HIV/AIDS.

Brien (1995) described the successes and positive strategies those living with HIV employ to promote survival and positive quality of life. What is needed is to give courage and stamina to those who are positive so that they can lead lives more productively and excitingly.

Gonzales (1996) said that HIV does not care whether a person is heterosexual, a homosexual, bisexual or celibate (having no sex at all). It does not see whether a person is black or white, male or female, young or old. It does not ask a person’s financial status, moral beliefs or career path. The fact is HIV simply invades any body. It can reproduce itself, and eventually kills. Gonzales said that AIDS has touched thousands of individuals, some unknown and some well known. It has touched artists, athletes, scientists, writers, musicians, activists and doctors. It has been observed in the study that the sufferer of AIDS belonged to almost every field of life of every social status.
Among the routes of spread of HIV/AIDS, unsafe sex is one and transfusion of unscreened blood is another major route. Like Pakistani society became infected with HIV through unsafe blood transfusion is still a major concern in most developing countries, even though the blood banks claim one in a million chance of infection since 1985. Jenner et al (1995) has mentioned in their study that prior to 1985, it is estimated that some 25,000 American contracted HIV from blood transfusions with most of those being hemophiliacs. The researcher discussed liability of blood banks, hospitals, physicians and factor concentrate manufacturers for transmission of HIV. There are predicted to be many new blood-borne infectious diseases in the future, so having a safe blood is extremely important.

Roth (1998) said that the high risk population women are facing the increasingly serious threat of HIV/AIDS. According to Roth, females are the depressive segment of the community and having almost no rights to refuse unsafe sex in developing countries.

Gorna (1996) in his book “Vamps, Virgins and Victims: how can women fight against AIDS?” as focused on various burning issues like the epidemiology of AIDS and women, the psychosocial impacts of AIDS on women, the ways in which women’s sexualities are understood including economics of risk, sex for hire, marriage and sexual violence. All these issues are equally important as far as Pakistani society is concerned. It has been noted that women in Pakistani society are the main target of discrimination and stigma associated with AIDS. They are thought to be responsible for deeds of their male partner. They are being socially exploited by male dominant society. Even in marital sexual relationship they are not giving the courage to say “No”.

Campbell (1999) emphasized many facts why women are so vulnerable to become HIV positive. Women do not have control over condom use, gender roles and
gender power put women at risk because men are overpowering in developing societies like Pakistan and men’s behavior that is formed during adolescence increases women’s risk for AIDS.

As far as males are concerned, they face the social stigma and discrimination mainly outside their homes, mostly at their working places. When a male is identified as HIV positive ended up in unemployment, economic instability and financial deprivation. Businesses and trade people still have to be re-educated in order to understand what it means to be infected with AIDS virus and HIV/AIDS prevention strategies.

Christie (1995) has emphasized that as AIDS moves to become a chronic disease, and as people become more comfortable working with those who are infected, the better off this world will be.

Preventing the spread of AIDS is one of the most formidable and important challenges humanity has ever faced. Opinion among health care professionals, laypersons, religious leaders and gay rights activists on how to deal with this problem, ranging from mandatory AIDS testing to sexual abstinence to the implementation of programs to make high risk behavior safer. Leone (1997) said that responding to the control and prevention of AIDS especially in third world countries like Pakistan is very important.

Tulloch et al (1997) said that role of print and electronic media is very important in the prevention and control of HIV/AIDS. Television is a cultural product and it is through television that awareness can be created.

Jaccomord (1998) stated that how print media can play an important part in the prevention and control of HIV/AIDS. This is through television that awareness against
HIV/AIDS can be effectively produced and raised in the society where literary rate is very low. In societies like Pakistan, that print, electronic media can help to educate population, in the context of HIV/AIDS prevention. Interpersonal channels have been also proven successful to address the issue of HIV/AIDS.

HIV infection has brought about many changes in the psychological response over the last 15 years. From the start of the epidemic, efforts have been made to bring together the medical, psychological and social dimensions of HIV, in some ways providing a model for other medical diseases and for psychological interventions. Catulan, et al (1997) has looked into all areas of the psychological aspects of HIV infection and identified the psychological, social and economic implications of HIV/AIDS on individuals, community and nation.

Hunts (1998) said that death is always in the back of an individual’s mind when AIDS is mentioned. There is hope for more and more people who are HIV positive to live more. New drug treatments have extended life expectancy beyond what was ever thought to be not possible. Unfortunately, there are many for which the drug treatments are not as successful, resulting in premature death. Among the case studies of the thesis, it has been keenly observed the sufferings and problems of the left behind families after death of HIV positive male member. The consequences are not only faced by widows, her children, other family members, friends and colleagues but also health care providers.

### 2.7 Pakistan Government Efforts to Address the Epidemic

Pakistan’s government response to the HIV/AIDS crisis is a great dilemma, might be due to limited financial recourses and inconsistent political stability. In 1987, soon after the diagnoses of 1st HIV case in the country, the Ministry of Health, Govt. of
Pakistan established the Federal Committee on AIDS (FCA). Shortly afterwards in 1988, the National AIDS Program (NAP), based at Pakistan’s National Institute of Health, Islamabad was launched. Unfortunately, the FCA became dormant soon after its establishment and no meeting of the committee has been called for many years.

In 1990, the first govt. funded program plan for the NAP was developed and budgeted for a period of three years, and by 1994 the work of NAP was expanded through the approval of PC-1 for an increased commitment of Rs. 774.35 million for 1994-97. By the end of June 1997, however, a sum of only Rs. 129.20 million (about 15% of the actual requirement) had been made available to NAP and the duration of the original PC-1 was, therefore, extended up to 2003 and Rs. 288 million had been released against the originally committed amount.(NACP, Pakistan). The limited and reluctant release indicates the level of commitment of Government of Pakistan to address the issue.

**Table 2.7/A : Govt. of Pakistan’s Budget Allocation to NACP**

<table>
<thead>
<tr>
<th>Period</th>
<th>Allocated (US $)</th>
<th>Released (US $)</th>
<th>Released %</th>
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<td>2000-2001</td>
<td>3,045,349</td>
<td>744,786</td>
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</table>

*Source: NACP*
2.8 Achievement of NACP By 2002

According to HIV/AIDS Pakistan country profile 2002; the key features of NACP achievements by 2002 were:

- Provincial implementation units for AIDS control and safe blood transfusion has been established in four provinces. AJK and Federally Administered Northern areas.
- A comprehensive awareness raising strategy has been developed and implemented through electronic and print media campaigns, like 24 hour telephone hotlines; support to NGOs; district networking and imparting AIDS education to key influential persons.
- 46 countrywide surveillance and diagnosis centers have been established.
- Broad polices for the essential screening of blood before transfusion have been adopted for interrupting transmission of infectious diseases such as AIDS.
- National guidelines on safety of blood transfusion and standard operation procedures (SOPs) have been prepared.
- National guidelines on HIV antibody testing and quality control have been developed.
- National guidelines on Clinical Management of HIV/AIDS have been developed.
- National guidelines on counseling have been developed.
- National HIV/AIDS strategic framework has been developed.
- The ordinance for blood safety is in process.
- Four voluntary counseling and testing center have been established in the public sector.
- Four counseling centers have been established in the private sector (NGOs)
- Public sector blood banks screen blood for HIV and Hepatitis B virus.
• Approval of provincial PC-1 for Punjab by ECNEC costing rupees 223.6 million form July 2002-June 2007

• Approval of provincial PC-1 for NWFP for Rupees 72.8 millions for the period 2000-2003.

• Approval of provincial PC-1 for Balochistan for Rs.2.914 millions for the period 1999-2004.

• Approval of PC-1 for AJK for Rs. 14.44 millions for the period 1999-2003.

• Approval of 3rd PC-1 for Sindh for Rs. 9.67 millions for the period July 2000-June 2003.

According to a report from UNAIDS (report on HIV- infected Drug users in Pakistan), it is estimated that Rs. 2.85 billion will be needed for the next five years to ensure that Pakistan makes progress towards attaining Millennium Development Goals (MDG) targets and limits the spread of HIV/AIDS.

2.9 Provincial Implementation Units:

In 1995, the NAP established Provincial Implementation Units (PIUs) in each of the provinces. By May 2000, only provinces of Sindh and Balochistan managed to secure funding from their provincial health departments. With the possible exception of Sindh, no provincial government had illustrated its commitment to HIV/AIDS prevention through the allocation of significant human or financial resources by May 2000. Frequent changes in program management, additional assignments of HIV/AIDS issues to already overloaded health care workers and failure to get programs and budgets approved are some of the reasons that the PIUs have been largely ineffective to-date.
2.10 Other Government Ministries and Departments:

In 1997, the NAP and the Ministry of Labor and Manpower's Directorate of Worker Education collaborated to present a series of only 23 awareness raising seminars for factory workers in various regions of Pakistan.

In 1998, a new National Education policy was formulated, with input by the NAP, which included education at the secondary level about HIV/AIDS issue.

More recently the ministry of Labor and Manpower, in collaboration with ILO, has initiated a major project designed to provide HIV/AIDS education to organized workers throughout the country.

Anti-Narcotics Force (Central Division) has conducted workshops encouraging NGOs to develop community based drug demand reduction and HIV/AIDS prevention initiatives in Punjab and Sindh.

2.11 ROLE of NGOs & CBOs

The challenge posed by the HIV/AIDS epidemic cannot be countered without the close and effective co-ordinations between government and national as well as international NGOs along-with Community Based Organizations (CBOs). Inventory of NGOs involved in HIV/AIDS prevention in Pakistan has been produced by UNAIDS Pakistan. Revision 2002 includes information about the HIV/AIDS activities of 86 NGOs. Consortia of NGOs working on HIV/AIDS have been formed in the four provinces. These NGOs and CBOs are playing an important role in:
• HIV/AIDS prevention activities among groups at high risk of HIV transmission
• Counseling (telephone hotlines and person to person communications)
• Awareness raising through mass media
• Training of Health professional and educators
• HIV/AIDS preventive material production
• Peer education programs
• Sensitization of political and other influential leaders.
• Safe blood programs
• Condom promotion
• Street theatre
• Clinical and behavior research
• Intervention for reducing injection related HIV transmission among injecting drug users.

2.12 **International Agencies Working Against HIV/AIDS in Pakistan:**

The various international agencies including United Nations; WHO and World Bank are helping and working in collaboration with Pakistan Government against HIV/AIDS. Different divisions of United Nations, which are active in Pakistan, are: UNFPA, UNAIDS, UNICEF, UNDP, UNDCP, UNESCO, UNIC, ILO, WORLD BANK and WHO.

2.13 **Bilateral Donors Activities**

Some bilateral donors have responded to the need of a greater involvement in the nations struggle against the epidemic. These donors are as follows, Australian Agency for International Development (Aus.AID), Canadian High Commissio (CIDA), British High

2.14 Critical Evaluation of Government Programs

Reviewing the whole current situation of HIV/AIDS status and efforts against all visible aspects of the epidemic in Pakistan, it is obvious that fortunately Pakistan is the country with low prevalence but high risk profile. Whatever has been done by collectively (government; NGOs; CBOs; International agencies) is just the tip of the huge iceberg. There is a lot more to plan; to do and to review as yet.

HIV/AIDS awareness level in Pakistan is not up to the requirement especially in rural areas. In 1999, a Gallop Pakistan Survey of more than 1000 households in urban areas of all the four provinces revealed that 96% of urban Pakistan are aware about the AIDS.

In 2000, a pre intervention baseline KAP study of 350 industrial workers and 50 long distance truck drivers carried out through the Ministry of Labor and Manpower, Directorate of Workers Education in collaboration with ILO showed:

- More than 70% knew about the word “HIV/AIDS”.
- Two thirds of those who claimed to know about HIV/AIDS knew about three modes for HIV transmission.
- More than 60% knew that condoms can prevent transmission of HIV.
- One in three truck drivers have never heard of condoms.
- Nineteen out of twenty truck drivers who were indulged in illicit and unzipped sex with women did not use condoms (AIDS Epidemic Update Dec. 2004).
There are different myths prevailing in various communities. Resultantly, communities are practicing many unethical and illogical behaviors as a routine of their life. These factors lead them towards HIV/AIDS more rapidly. Here, the most common myths and realities have been mentioned as below:

**Perception:** HIV or AIDS can be cured

**Reality:** To date, there is no cure for HIV/AIDS and there is no vaccine to prevent HIV infection (Haley, 2003)

**Perception:** HIV/AIDS is a gay disease

**Reality:** Anyone can be susceptible to HIV/AIDS, regardless of their sexual orientation. Everyone is at risk of getting HIV from blood-to-blood contact, sharing needles or unsafe sex. World wide, HIV is spreading most often through heterosexual contact (Silverstein et al. 2003)

**Perception:** One can get HIV from breathing the air around an HIV infected person or from hugging or holding hands of HIV infected person.

**Reality:** HIV cannot be transmitted through:

- Toilet seats or door knob handle
- Touching, hugging, holding, or kissing the cheeks of an HIV infected person
- Sharing eating utensils with an HIV infected person
- Mosquito/insect bite

**Perception:**
One can get HIV by sharing exercise equipment or playing sports with an HIV positive person

**Reality:**
Contact with sweat or tears has never been shown to result in transmission of HIV

**Perception:**
One can get HIV by kissing an HIV infected person

**Reality:**
Casual contact through closed-mouth or social kissing is not a risk for transmission of HIV. Because of the theoretical potential for contact with blood during French or open mouthed kissing, the CDC recommends against engaging in this activity with an infected person. However, no cases of AIDS have been attributed to any kind of kissing (Kalichman, 2003).

**Perception:**
You cannot get HIV if you are using birth control methods like diaphragms, cervical caps, sponges, spermicides, depo provera, norplant or birth control pills

**Reality:**
These contraceptive methods do not prevent the transmission of sexually transmitted disease (STD) such as HIV. These only aim to prevent pregnancy. The surest way to prevent both pregnancy and an STD infection is through abstinence. Good quality condoms are only contraceptive
method which can prevent transmission of HIV. Spermicide monoxynol-9 (found in most contraceptive creams, gels, suppositions, foams, films and sponges) help to prevent pregnancy but may increase the risk of HIV infection (Macphail, 2003)

**Perception:** One cannot has more than one sexually transmitted diseases (STD) at a time

**Reality:** A person can suffer from more then one STD at a time. A person with an untreated STD may also be 6-10 times more likely to pass on or acquire HIV during sex. Risk for infection increase 10 to 300 fold in the presence of a genital ulcer, such as in syphilis or genital herpes (Gerdes, 2003)

**Perception:** There is no such thing as safer sex

**Reality:** Safer sex is sexual activity without penetration or sex with a latex condom or latex barriers (in case of oral sex)

**Perception:** Since one only has oral sex, I am not at risk for HIV/AIDS

**Reality:** One can get HIV by having oral sex with a man or a woman. That is why it is important to use a latex barrier during oral sex, vaginal or anal sex (Bellis, 2003)

**Perception:** A person will come to know automatically if he himself or his beloved one had HIV.
**Reality:** A person with HIV may not show any symptoms for up to 10 years. Since HIV affects each person differently, many people with HIV can look and feel healthy for years. The only sure way to know is to get tested.

**Perception:** To get diagnostic tests for HIV is not needed.

**Reality:** Knowing if one is HIV positive will allow him to seek early treatment that can help him to stay healthy longer and enable one not to pass on the virus to someone else. Regardless of your HIV status, you can learn how to prevent future infection from HIV or other STDs through counseling offered at HIV testing centers (Scott, 2003)

**Perception:** when one is on anti HIV therapy you can’t transmit the virus to any one else.

**Reality:** Antiretroviral drugs don’t keep you from passing the virus to others. Therapy can keep the viral load down to undetectable levels, but HIV is still present in the body and can still be transmitted to others (Dolin R. at el, 2003).

**2.16 Historical background:**

In 1981, an immunologist from Los Angeles and a dermatologist from New York reported some unusual findings in the center for Disease control’s morbidity and mortality weekly report. The articles, hinted at a puzzling new syndrome affecting homosexual male patients that began showing up around 1979. These two doctors, as
well as other in several American cities with significant gay populations, observed the

Twenty years ago, AIDS was called the “The Gay Plague”, gay cancer, or gay-related immune disorder (GRID). Sadly, because AIDS was first detected in homosexual males, it was largely dismissed because gay men circa 1980 were viewed as dispensable. The medical community considered this a homosexual disease, neither fashionable nor prestigious, and consequently unworthy of serious attention.

1980: A mysterious outbreak of fatal pneumonia among gay men had occurred in San Francisco and in several other major cities of USA. The centers for disease control (CDC) noted an alarming rate of a new cancer (Kaposi Sarcoma) in other wise healthy gay men.

1982: The CDC linked the new disease to blood and sexual transmission, calling it acquired immune deficiency syndrome, or AIDS. Over 1600 cases of AIDS were diagnosed in USA and over 600 people were already dead.

1983: AIDS, first in homosexual communities has spread to 35 states of USA and 16 foreign countries including France, Germany & Denmark. Although gay men still account for 72% of cases, AIDS seems to be moving into the population at large. “The head of the US public health service claims AIDS is no threat to “Public” because only 1450 people are infected, all of them gay and bisexual men and I/V drug users. Meanwhile, scientists at pastern Institute in France discovered HIV in blood.

1984: Dr. Robert Galle, a US researcher claims for discovery of causative retrovirus of AIDS, Blood test was developed to detect the presence of HIV, two months later
Luc Montagnier & his French colleague published details of isolation of retrovirus Lymphadenopathy Associated virus (LAV) from culture of

1985: Food & Drug Administration (FDA) of US approved the first HIV antibody test in March 1985.

1986: Acknowledgement of presence of HIV and AIDS in Africa, where it was called as slim disease.

1987: Two years after the development of HIV antibody test, conflicting opinion about testing reached a shrill pitch. Azathioprim (AZT), a failed cancer drug developed by Glaxo-Wellcome becomes the first HIV drug approved by the FDA-recommended dose: one 100 mg capsule every four hours round the clock.

1988: Nearly, 107000 cases of AIDS have been diagnosed in the US and over 62000 deaths had been recorded.

1989: Safe sex information inundates the population from AIDS and social service organizations, the medical community and HIV activists and educators.

1990: Pediatric AIDS Foundation came into being.

1991: Call for mandatory testing of all healthcare providers.

1992: 333000 AIDS cases diagnosed in the US and over 198000 dead.

1993: The "female condom" marketed with the name Reality, won the approval from FDA.
1996: Dr. David Ho, Scientific Director of the Aaron Diamond AIDS Research Center in New York suggested that “cocktail” of anti-viral drugs, costing as much as $20,000 a year might just lead to a cure.

1997: The center for disease control that an HIV positive man most likely passed the virus to his female partner through deep kissing after brushing and his teeth until his gums bleed. It remains the first and only case of transmission attributed to deep kissing.

1998: Phase III efficacy trials of first human AIDS vaccine (AIDS vex)

1999: Study after study suggest that nonoxynol-9, a spermicidal added to condoms and lubricants in 1980s to kill HIV, may actually sabotage safe sex by irritating the skin, creating scars or ulcers that facilitates transmission of the virus.

2000: FDA refused to halt the production, sale and marketing of condoms or lubricants containing nonoxynol-9 despite the research. The “Durban declaration” restated that HIV cause AIDS.

2001: World wide 36 million people were infected with HIV; 24 millions of those infected live in Africa. In US over 300,000 deaths have been recorded since 1980s, and new HIV infections have held steady at roughly 40,000 a year for the past decade.

For all practical reasons, AIDS is still a new disease among humankind. Keeping the perspective of newness is important especially for those working to develop preventive interventions for a disease that cannot be controlled, using traditional
technological methods: vaccines are not yet available, treatment is limited, and a complete cure is still a vision for future.

There are still much confusion about HIV/AIDS among the general community in different segments based on their culture, norms, values and educational background.

2.17 Implications of HIV/AIDS

The risk-factors of HIV/AIDS and its mode of transmission are the principal determinants of its impact on society. HIV/AIDS affects the population in a number of ways. There will be increased morbidity and many of these people will be in their reproductive years. This could reduce fertility rates. The impact can be divided into three broad areas, namely:

- Social Implications
- Economic Implications
- Psychological Implications

These three major factors are very much interdependence on each other, the relationship between these factors can be illustrated by the “Tri-Fold Implications of HIV/AIDS”.

2.17.1 Social Implications

Stigma and discrimination is one of the basic problems that a person has to face after being identified as an HIV positive. The discrimination starts from the Laboratory, and then doctors and other medical staff treat these persons as untouchables. This discrimination extends to family members and then among social sector.
The social implications of HIV infection will result from the illness and death of individuals and the consequent effect on the family, community and broader society. Obviously, it is also vital to observe who falls ill and dies in terms of their role in the family and community. The death of an adult male, who is an income earner, will affect the family's access to resources. The people who fall ill and die are the parents and
leaders in society, which means a generation of children, may grow up without the care
and role models they would normally have. The death of an adult female may result in
children receiving less care and females being taken out of school. A few attempts have
been made to look at this at community level, but research is very limited.

2.17.2 Economic Implications

At the household level the effects of HIV infection are obvious; the cost of
medical care and related areas will increase. In addition, if the infected person is an adult,
than production and income of the household will be reduced. It is not easy for a common
person to get treatment of HIV/AIDS, it cost him/her a lot and if a person is the only
earning hand, it is always difficult to survive. In addition, poverty pushes some women
into risky behavior or dangerous situations. With no other options in sight, they may
resort to sex work to feed their families.

The epidemic may also affect national economy through the illness and death of
producers and the diversion of resources from savings to care. The impact of the
epidemic will be felt first and worst with reference to GDP per capita and includes
aspects such as longevity, standard of living, infant, child and maternal mortality and
distribution of income. An additional problem is that HIV/AIDS is only one of a member
of pressing problems faced by policy makers in developing countries like Pakistan.

2.17.3 Psychological Implications

An HIV positive person has to go through intense mental pressure, after being
identified as an infected person. One becomes easy victim of tension, fatigue and
isolation which leads towards frustration and even to commit suicide. Widows in
Pakistan are exceptionally disadvantaged, as culturally they tend to be regarded as having very low status in household. A woman whose husband has died in the first year of marriage may be regarded as particularly unlucky. Women widowed by HIV and AIDS are doubly marginalized as a result of stigma. They may be thrown out of their homes or sent back to their parents’ homes without their dowry or jewellery in the abnormal state of mind. They are poorly equipped to counsel children in this way. Children become depressive and frightened all the time. Resultantly, they ran away from schools and indulge in crimes and begging. These psychic children become the spoiled kids of the community and usually involved in drug trafficking.
CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction:

The topic is highly sensitive and touching the behavior aspects of the society. For conducting the study, both qualitative as well as quantitative methodologies were employed. This chapter describes the procedures and techniques used in both, qualitative and quantitative studies. No doubt, the most important and uphill task was to reach the HIV positive people and to take them in confidence as far as Pakistani religious and cultural values are concerned so ethical issues which were taken in care are described in this chapter.

3.2 Study Design:

To get the best result by utilizing scarce resources, both qualitative and quantitative studies were combined. As discussed by Bamberger, there are several benefits of using integrated approaches in research to get the optimum result particularly in the sensitive case studies where data availability, economic constraints and time frame really matter. For conducting the research work, several meetings were arranged for developing the patient’s confidence and preparing them to share their views. There was a great help of two major NGO’s who were working for the counseling of People Living with HIV/AIDS (PLWHA).

The major factors to be taken into account were socio-economic and psychological implications. The focus was set, “how general community took those people and the attitude of different stakeholders towards patients and their families.” The main causes of HIV/AIDS were discussed with PLWHA and tried to discuss the life pattern of those marginalized people as well. National Institute of Health, Islamabad and
Punjab AIDS Control Program were continuously visited to get the comprehensive and valid information of HIV positive people. For testing the reliability and authenticity of the targeted people, male and female doctors were also included as part of research team to examine the CD4 level reports along with brief history of patients. The major variables like age, gender, visit to abroad and source of transmission were compared with the secondary source of data recorded by NIH, Islamabad since 1987.

A number of methods were used to collect data. These were questionnaire schedules, focus group discussions, participant observation, personal interviews with different personalities and affected household members, community meetings and case studies.

In addition to strengthen the study design, Focus group interviews were conducted with patients, patient’s families, peer’s groups, health care providers and religious leaders.

3.3 Study Area:

The most populous province of Pakistan i.e. “Punjab” is selected to investigate the influence of socio-economic and psychological impact of HIV/AIDS on society. The cultural values, socio-economic status and mode of living all over the province are almost the same. Religion and language which are the powerful forces influencing the lifestyle of people (Hull, 1983) are almost same in all cities of Punjab. The first reported case was also diagnosed in the major city “Lahore” in the Punjab. The major reason to select this particular segment was its richness in various types of professions, multiple businesses and migrants, which might be the true representative of the whole population of Pakistan.

3.4 Characteristics of the Respondents:

It was carefully examined the status of patients by their CD4 level, only those respondents were interviewed who were HIV positive. Before conducting the interview,
several visits were paid respondents were provide with some multi-vitamins in the form of supplementary food as a token of care. At last, they were confident self-assured to share their views because they were really scared of the attitude of society. Once the felt love, affection and care from research team, their response was very encouraging and they feeling free to talk about each aspect of their HIV positive status and its consequences. They were ready to make photographs with the researchers and were behaving as friends rather than as some wonder.

3.5 Features to Improve Data Quality:

Almost all aspects were focused as suggested by Fisher et al (1983) for design and administration of the interview schedule to enhance the data quality, e.g. coding scheme, the sequence of the questionnaire, sensitive questions, mixing of open ended and dichotomous questions, pilot study, criteria of interviewer selection and editing of data.

3.6 Questionnaire and Sensitive questions:

No doubt, the development of questionnaire is really uphill task especially in social science research. Questionnaire should be designed in such a way that researcher should get maximum co-operation from respondents for getting the reliable and true picture of the issue. Double barreled and embarrassing questions should not be part of questionnaire for the validity of the answers. While designing the questionnaire, maximum care was exercised to use very common and easy words according to the ideology of the people. In this perspective, one question was dropped from the questionnaire after the protest because it was observed that respondents were feeling hesitant and embarrassment in response to that question.

3.7 Sequence of the Questions

The order of the questions in the questionnaire is really significant for getting the fair and supportive response from the respondents. For avoiding the discomfort and
confusion of respondents, the mixing of questions on different topics was also evaded. Therefore, separate segments like general information, social implications, economic implication and psychological implications were designed. Moreover, in each section a funnel technique was followed. A great exercise was practiced on the formatting of questionnaire i.e. from positive to negative or negative to positive. Great emphasis was laid to get the involvement and creating interest among the respondents.

3.8 Check Reliability

Validity refers to the measuring instrument’s ability to provide consistent results in repeated uses. It is argued that same question may be asked twice for checking the reliability but it is not an appropriate approach (Zafar, 1993). As thus way the respondents feel as if interviewer is not listening and it is just wastage of time. In the current study, the response reliability was established to ask some questions that provide a check for the questions that were asked earlier. For example, one question was “Have you visited abroad”? The question that provides a check on the response to that question is “if yes, visited alone or along with family.” The same respondents would reply to the second question who replied positively in the response of first question.

3.9 Coding

For maintaining the interest of respondents, there was mixing of close-ended as well as open ended questions throughout questionnaire. For saving the time, maximum questions were pre-coded for data collection, processing and analysis. The collected data were transferred to coding sheets in order to maintain the accuracy.

3.10 Time and Relevant Questions

Time is really a vital as far as the administration of the questionnaire is concerned. Fisher et al (1983) argued that shortest questionnaire proved more effective for collection of meaningful response. Face-to-face interviews were conducted for an
hour whereas half an hour was consumed to administer the questionnaire and almost all questions were used in the data analysis.

3.11 Training and Field Supervision

The qualification and background of the interviewers are the main elements for collecting the quality data. The interviewing team was comprised of one person from NGO, a psychiatrist, male and female medical doctor along with sociologist. First of all, before going to the respondents, all the team members and researcher himself sat together and reviewed the severity and sensitivity of the study in detail is the light of direction from the chairman of the supervisory committee.

3.12 Pre-test Technique

The pilot test should mimic the actual field work as closely as possible. The main objective of pre-testing was to examine the sensitivity and workability of the questionnaire. One question was dropped from the questionnaire in the piloting exercise.

3.13 Data Editing

Editing procedures were conducted to make the data ready for coding and transfer to data storage. There was complete checking of the questionnaire for errors, omissions and discrepancies soon after the interview is a key step to ensure completeness and accuracy which are important component of quality data (Fisher, 1983). The editor “should bring to light all the hidden values and extract all possible information from a questionnaire, while adding nothing extraneous” (Erdos, 1970).

3.14 Threats to Validity

Maximum care was made to minimize the possible errors for obtaining the validity of the data. All the respondents were examined by their CD4 levels, blood test for ensuring the status of respondents as HIV positive.
3.15 Selection of Interviewers, Training and field Supervision

The services of eight interviewers were hired to interview the respondents within prescribed frame of time. These interviewers were having the different professional back ground like two of them were professional doctors i.e. one male medical specialist and another was female gynecologist, two were sociologists, one psychologist, one person from NGO, a friend of the respondent and researcher himself.

3.15.1 Training

Theoretical and practical training was conducted to groom the interviewers. The interview techniques were discussed in detail. A special lecture was arranged and delivered on the demographic situation of Pakistan, stigma attached with AIDS, communication theory, probing techniques for causative factors of disease and the cultural environment. The significance of the accuracy of socio-economic, demographic and cultural variables and need for reliable and correct data was discussed. There was complete dress rehearsal and practice for conducting the interview.

3.15.2 Field Experience

The social science research is mainly focusing on the human beings and their behavior which varies from person to person. In this particular study, it was essential to develop the confidence among the respondents prior to ask any question. Because of highly sensitive issue, respondents were reluctant to disclose their status publicly due to the fear of society rejection and stigmatization. For developing the intimacy, they were served with multivitamins, symptomatic treatments, and small gifts in the shape of garments. The respondents were belonging to very desperate and poor socio-economic back ground. After developing good relation, their cooperation was really remarkable.
3.16 Data Analysis Techniques

The study was quite sensitive. A descriptive analysis was done with the help of simple statistical techniques to examine the study objectives. Mean, central tendency, average, frequency distribution and range techniques were used to interpret the results. With the help of these techniques, comparison between different values became very convenient to analyze the conclusion.
CHAPTER 4

QUALITATIVE STUDY

4.1 Introduction

This chapter is comprised of the focus group discussions with patients, views of their family members, observations of their peer group, experience of health care providers and comments of religious leaders.

4.2 Focus Group Discussion

A focus group interview is an unstructured, free-flowing interview with a small group of people. It is not a rigidly constructed question and answer session, but a flexible format that encourages discussion. The non-directive and open ended questions allow individuals to respond without setting boundaries and also to explain and share experiences and attitudes as opposed to the structured and directive interview (Krueger, 1988). The Focus group interview is so popular that many research agencies consider it to be the “only” exploratory research tool (John, 1968).

4.3 Selection of Moderator

The moderator’s job is to develop a rapport with the group and to promote interaction among the members. The moderator’s role is also to focus the discussion on the problem areas of concern. The selection procedure is important so as to obtain, consistent and unbiased information from respondents. Careful recruitment of the moderator is the key element for the properly conducted discussion. In the study, a female health care provider and a psychologist from Lady Willingdon Hospital,
Lahore were selected as moderator, observer and note-taker. The selection of moderator was equally good for conduction of discussion with patients, patient’s family members, patient’s peer group, doctors and religious leaders. Every effort was exercised to establish an enabling atmosphere in which participants may express and exchange their views.

4.4 Findings of the Qualitative Study

There were 15 HIV positive patients, including 4 females and 11 males who were interviewed in depth after mending complete enabling environment of love, care and privacy. In-depth interview of each patient was conducted by providing complete enabling environment.

Qualitative Case Studies of PLWHA
(People living with HIV/AIDS)
Profile 1

Muhammad Aasim, 26 years of age, a young victim of HIV/AIDS.

He was working as an organiser at Multan office of an NGO working against HIV/AIDS.

How he infected:

Aasim has cheerful personality with an attractive smiling face. When he was asked how he was infected by HIV, he started narrating his story in a very politely way. According to him, he was engaged with the automobile spare parts business at Misri-Shah, (a locality) Lahore. He had his own shop. One unfortunate day, he was unloading the goods from a truck carrying the waste of hospital, like used syringes, lincon etc. He slipped and fell on that heap of syringes and got multiple pricks all over his body. Following this event, he developed fever for quite a few days and was cured completely, but at that time, he was totally unaware of his future destination.

About the diagnoses of his sero-positive state, Aasim told that like every young Muslim he was very keen to go to Saudi Arabia to serve the pilgrims (Hajjis) as “Khadim” (voluntary servant). For this purpose in 1999 he underwent a screening process at Islamabad. The result of his screening report was shocking, as he was suspected to be HIV positive and this suspicion was confirmed with certain other diagnostic tests.

Feeling after Diagnosis:

What was the response of his family and friends when they came to know about his HIV status? Aasim replied that “this news was a shock not only for me but also
for my family. Neither I nor any member of my family was ready to believe that I was HIV positive. Same was the response of my friends."

To Asim, "there was quite a marked change in the family attitude towards me. Being youngest of four brothers and sisters, I was very dear to my family, but now all of my family members looked upon me as if I was very risky to them."

**Effects or Implications:**

There were few immediate effects of this bad news. Aasim narrated that he left his spare parts business as he was afraid of rejection. He did not want to be rejected and ignored. My fellow shopkeepers were reluctant to even talk to him as if he would transfer his infection to them by sound waves. So he changed his track and now he had very few friends, true friends indeed.

When Aasim came to know about his HIV positive status, he announced the breakage of his engagement. The only reason Aasim knew about his strange decision was that his fiancé was very dear to him and he didn’t want to hurt his loved one as he had got no misconception about his future life.

**Society’s Attitude:**

Aasim was very annoyed of behavior of health care providers including doctor, nurses and paramedics. He said that in initial days when he was very sick with almost no immunity, he was admitted in MAYO Hospital Lahore. He was labeled as a "showpiece" there. Every body wanted to see me, but no body wanted to touch me. He was in miserable condition and was crying for help but no body was paying attention. Recalling, Aasim said that those were worst days of my life. He was about to die when Allah helped him and gave him new light and hope of life. People from
an NGO rescued in time and now he was spending almost near normal life, working and helping PLWHA.

Aasim said that PLWHA only need a little more care and attention a loving attitude, a caring behavior of their loved ones. This is the only life saving “drug” in the form of love, which can add few more beautiful and comfortable moments in the life of PLWHA.

Profile 2

Mrs. Azra Masood, a young lady of 30 years, was HIV positive for the last four years. While she was being interviewed, she appeared calm contented and satisfied. She told that she had undergone multiple surgical procedures for different problems at various main hospitals of Lahore. According to her, probably she got HIV infection while she was hospitalized during surgery. When further inquired she refused for having any blood transfusions during any of her operation.

Answering the questions about when she was diagnosed to be HIV positive? Azra told. “About four years back, she started loosing weight and became an easy prey of even mild and benign infection like common cold and flue in spite of supportive management, when she was screened for her HIV status, she was found to be positive.” On further diagnostic test, her CD4 level turned out to be remarkably low. This was amazing for her as well as for her family, told Azra, she was not ready for such bad news. She remained very much depressed for initial few weeks after diagnosis. She would have died with depression if her innocent children were not supportive.
Discussing her HIV positive status and family behavior, Azra explained that she was quiet disturbed due to the behavior of her husband and her family initially. No doubt medicines played vital role in saving life, but medicines would have been useless if there was discouraging behavior and rejection from family.

Azra was so much so depressed that she offered her husband to leave her instead of continuous physical as well as mental torture. About the attitude of her friends and neighborhood, Azra told that most of her friends and neighborhood understood her problem but they were not convinced about her innocence in that regard. Those who were reluctant to meet her, she solved their problem herself and left them before they did the same.

Azra was an uneducated house wife. Although she was still on ARV drugs but felt better now. She wanted to live for her kids and husband but it seemed very difficult. The only thing that she wanted from society was basic understanding of the disease. According to her, “this is cruelty to reject the poor infected persons badly.”

Profile 3

Mr. Muhammad Nawaz, was 38 years old and got HIV infection while he was in Kuwait. Mr. Nawaz was basically an electronic technician by his profession and engaged with the business of electronics. He was in Kuwait, when for a very mild ailment he was needed to get his blood tests done.

To Nawaz, when lab reports arrived, health personals in Kuwait made him limited to one isolated bed. They chained his arm and one leg. He was very much anxious and worried about the situation and was continuously thinking what wrong I had done? But he could not recall any crime or sin for which he was being punished. Then
he requested a doctor to inform him what went wrong with him? The doctor disclosed
the news of him, being HIV positive. Nawaz said that this news was as astonishing,
for him as for any body else there. After that they made arrangement to deport him
back to Pakistan within next few days. He was taken to plane in chains and no body
was ready to touch him. They even did not touch his passport without gloves. They
dropped his papers on the seat and asked him to pick them up. So he was sent back to
Pakistan without being given any chance to explain his position or to windup his
business. So this was not only a psychological trauma for him but also a big financial
loss as his investment and money was left in Kuwait. Nawaz told sadly.

About the attitude and reaction of his family, Nawaz told, “I was not willing to
come to Pakistan as I was afraid of possible response of my family. I never wanted to
hurt my family including his Mother, Brothers, Sister and above all my wife and
kids.” He didn’t want to harm them, so when he talked to his wife on phone and
wanted to tell his future plans, she insisted to come back. She was a big support and
motivation for him. When he arrived at Lahore airport, she received him along with
her mother. Nawaz told that “it was the spirit of his life partner”. About rest of the
family and friends, Nawaz explained, the response of other family members was
different. Out of his five brothers, one brother and his family left home, while rest of
them had changed the relationship completely. Nawaz told most of his friends were
not aware of his true picture, and they knew him, as if he was a patient of Hepatitis.
Mr. Nawaz is jobless now a day. At present he was on ARV drugs and still he could
not speak fluently which was a disability due to his sever tension and mental stress.
According to Mr. Nawaz he was in a very bad state of health a few months ago but
now with psychological, medical and spiritual support, he was feeling much better.
Mr. Nawaz's wife is a beautician by profession and is running her own beauty salon. She is HIV negative and is very careful in handling her clients. All of kids (five sons) of Mr. Nawaz are also fortunately sero-negative for HIV.

To Mr. Nawaz, he had to depend upon barber for his shave, but now he was trying to learn how to shave. Soon he would be expert in making his shave himself. At present, he fixed his barber and he was keeping a separate shaving kit at barbershop. He disposed off used blades himself and off and on he gave advices to his barber about precautionary measures about HIV/AIDS and Hepatitis.” According to Mr. Nawaz, “caring attitude proved him to be a responsible citizen.”

Mr. Nawaz said that one should hate HIV/AIDS but not the sufferer. He again insisted on improvement in positive attitude of general public towards HIV/AIDS patients. He said, “Only love and care can cure.”

Profile 4

Mr. Jahangir, a middle-aged man of 45 years, who is HIV positive, narrated his story that he worked abroad (Dubai) about 22 years. During his stay, he earned a lot and sent the whole money to his family in Pakistan. He said, “I was away from my family for quite a long time, I had sexual relations with professional sex workers (prostitutes) quite often.” Mr. Jahangir said, “This was a natural need and instinct of human, so I was helpless. I probably got infected by HIV through unsafe sex.” His general health deteriorated rapidly when he was diagnosed to be HIV positive. He turned back to his home and family in search of true love and care. Mr. Jahangir was very sad to tell that his loved ones for whom he had spent golden days of his life away from his home working hard, when he needed them, they became white
blooded. There was such a strong rejection and repulsion of hate from his family especially his wife that he didn't want to live more. His wife did not tolerate him for even a single day and she left his home with her kids saying that from now on, "she had no relation with him and he should not dare to contact her again."

Although, Mr. Jahangir was being treated with ARV drugs now a days but his condition was miserable. He was having no hope for his life. He was more deprived emotionally. Moreover, he got no financial support on permanent basis, so his prognosis was not very bright.

**Profile 5**

Mr. Salman, a young chap was resident of Faisalabad, suburb area. He did his middle level education from Faisalabad. He was diagnosed to be HIV positive when he went to donate blood to one of his relative. During screening process of blood bank, he was found to be HIV positive and his HIV status was confirmed by certain diagnostic tests.

Mr. Salman was very much afraid of disease and stigma associated with AIDS. He was very much depressed due to social rejection and repulsion. So out of all fears, he made all the efforts for going abroad. He was well-aware about the fact, that "with his HIV positive reports, nobody would allow him to enter into any foreign country."

So by hook or by crook, he managed to get fake report of medical clearance, he got the visa and left the homeland for Saudi Arabia. Now a day, he is there in Saudia Arab and playing a very silent role of HIV carrier. He might transmit the disease to so many innocent community members.
All facts and figures about Mr. Salman, were recorded during the interview in the presence of his close friend for creating conducive atmosphere, who requested not to disclose his identity. What happened to Mr. Salman after reaching Saudi Arabia is not known as no body could contact him.

Profile 6

This interview was conducted in Lady Wallingdon Hospital in the presence of concerned duty gynecologist with the consent of patient. Mrs. Shazia Azhar, a young charming lady of 25 years, presented in out-patient department of Lady Willingdon Hospital with complaint of some growth on genital region. According to patient, she was married about 6 months ago, but the couple could not match each other. Her husband was very annoyed of this situation and he was not satisfied with her. On inquiry about reason of this dissatisfaction among partners, same “vulval growth” turned out as bone of contention.

Shazia told that she had few warty growths on vulva before marriage, but she ignored them and had not consulted any gynecologists for it. After marriage, her problem got aggravated and it proved to be a cause of breakage of her marriage.

Now as she was planning for remarriage she thought it would be better to get treatment of her problem before starting a new life.

Although, the story of patient appeared vague, on examination by gynecologist, the growth was diagnosed provisionally to be viral warts. A minor surgery was planned, and her biopsy of warts was taken and specimen was sent for histopathology. At the same time, her two blood samples were taken and subjected to HIV screening at two different authentic laboratories.
According to gynecologist, vulval warts were many in number and complete cure was not possible in one sitting, so it was postponed till next session after two weeks. Meanwhile, her biopsy report was available and diagnosis was confirmed to be HIV positive. Her blood screening reports turned out according to expectation, she was HIV positive. Mrs. Shazia Azhar’s residential address was incorrect which she had given on admission forms.

What is her present status, nobody knows probably she might be transmitting the death silently to so many. There is a strong suspicion that she may belong to red light area adjacent to Lady Willington Hospital, but this is just a supposition. According to interview panel, “the warty growth gives a clue towards unsafe sexual behavior of the affected person. Shazia might have concealed certain information out of fear or shame.”

Profile 7 & 8

Aslam Masih & Sughran Bibi, a couple acquired HIV/AIDS on their way to life innocently. When the couple was interviewed, Aslam Masih was 35 years old and belonged to Kasur city (Punjab). He said that he belonged to a poor Christian family with three brothers and two sisters.

He had a poor and illiterate family background that has further suppressed his financial and social status. Aslam had been running a donkey cart which was the only source of income for the family.

Aslam acquired this lethal infection from his partner Sughran to whom he had married after a long struggle. This was the first marriage of Aslam while second marriage of her wife.
About his life partner, Aslam Masih told that Sughran was also from the same village. Sughran was formally married to an army man, named Iqbal, under social and emotional pressure. Her husband went to Somalia on an army mission; there he had sexual relations with multiples sex workers to fulfill his natural desire and to compensate his home sickness. When Iqbal turned back home, he transferred that infection to his poor wife without telling his HIV status to her, this transmission was no doubt, through sexual route.

After few years, he died because of complications of AIDS. After death of Iqbal, Sughran was diagnosed to be HIV positive. Six years ago since the death of her first husband, Sughran had to pass through a real crucial time. She was the target of social rejection and hate, as everybody in the village knew her HIV status. Meanwhile, Aslam Masih was attracted towards Sughran, and in spite of knowing her HIV status, he proposed her. Initially she refused his proposal, as she was reluctant. But on continuous and persistent request, she explained her HIV status to Aslam and possible future consequences.

Aslam said, “I am ready to bear all the consequences, I ensured you about my support and care, I know it is not your fault, I do not want you face the pain of this problem alone, I want to share the pain.” He further said, “I am human being, a human being must help other human being in the needy hour. I think this is the right time to save humanity.”

He expressed these views emotionally, he knew that he had received HIV from his wife, but she was innocent and that was not her fault. She also innocently and unknowingly got the virus from her ex-husband who did not care and inform her. She
sacrificed for her married life and became victim of HIV/AIDS. Now why should she suffer alone a dark future, he sacrificed for her and they were leading a happy life.

Aslam Masih told.” His immediate family members reacted negatively in the beginning but with the passage of time, things improved and now they were really supporting and caring them.”

Regarding their friends, Aslam explained that, “when his friends came to know about their HIV status they started hating and ignoring them. That was really very painful and they were very upset about their attitude. We locked ourselves at home as social rejection was very difficult to bear. Then one of our friend, Nazir Masih, who himself was HIV positive, visited them and encouraged them to face the realities of life. His personal example was in front of them. Afterward, they started convincing their friends about the fact that HIV/AIDS does not spread by greeting, meeting and taking care of PLWHA. As a result of all these efforts, now all the friends were our supporting hands. About Sughran HIV status, she told, “It is more than 6 years now when she was infected with HIV. During the last few months she was permanently suffering from fever, diarrhea and cough. Her CD4 level was checked which turned out to be 281 only. Very minor ailments were proving very serious for her, so she started taking Antiretroviral (ARV) drugs. Since Sughran was using ARV now she was not only healthy but was active in other family affairs.”

Seeing the interest, honesty and confidence, one of their sincere friend helped Aslam to buy his own donkey cart. Due to that rehabilitation step, now Aslam and Sughran were very happy and contented with their life. In their special message, Aslam and Sughran said, “PLWHA should take courage and came out because AIDS is not a sin but a disease like so many other diseases. Still there are many ways to
coop up with life’s ups and downs. They need to advocate for rights and needs. Let’s get together for the noble cause.”

Profile 9

Nazir Masih was a middle-aged man who faced discrimination, social rejection and mental torture due to his HIV positive status for the last more than one decade.

Narrating his story, Mr. Nazir Masih told, “He was diagnosed to be HIV positive when he was in Dubai in 1990. There he was engaged with the business of tires and spare parts. Doctor performed his confirmatory blood tests, and he was diagnosed to be HIV positive. He was promptly arrested there in Dubai and was kept in solitary confinement before being deported to Pakistan.” He further said “When his status was disclosed, people ostracized him. He was hated.”

Recalling the behavior and attitude of his family and friends on his arrival in Pakistan, Mr. Nazir Masih told, “I was afraid as I loved my family very much. I didn’t ever want to hurt them. But when I was deported back to Pakistan only my wife was there to receive me with open arms. As I was the first person in Pakistan to have his HIV status publicly disclosed, journalists took pictures of my wife along with children and published them in local press. It was a horrible experience. I was thinking, it would be better to die than spoil the lives of my family members. I felt isolated and alone.”

He further added that no body was ready to talk to him or even look at him. He often felt seriously sick and when he was taken to hospital most educated class of society, doctors and nurses, were reluctant to treat him. They behaved badly with him. They even cursed him and every body wanted to see him once as if he was a
monument. He didn’t want to recall even those painful days when he was thrown into hell. It was fortunate that his wife and children are HIV negative. They were the biggest support to him.

Mr. Nazir Masih kept on struggling for PLWHA. He had worked very hard for last one decade to increase awareness about HIV. He found an organization with the name of “New Light”. This organization has been working a lot in Pakistan for PLWHA. Mr. Nazir Masih was contented with his efforts.

He said that he was thankful to God, for giving him the courage and ability to help those poor victims who received this infection. He said that HIV positive people are still hiding themselves. They should come forward because sickness is not a sin. They have to live a positive and meaningful life. Doctors and medical staff need to be trained properly. Medical institutes must include special feature of HIV/AIDS treatment in training program and Government should strictly check."

Profile 10

Shukria Gul, a 37 years old well groomed and maintained lady, resident of Lahore having three kids, got affected with this disease due to her husband. She was diagnosed HIV positive three years back. She was an educated lady who had gotten complete information about the disease but her husband kept her in dark and didn’t inform her about the disease. She got affected in innocence and due to the blind trust that eastern women have in their husbands. Her husband came from Middle East with HIV/AIDS. He was goldsmith in UAE. He stayed in Middle East for quite some time and he indulged in the malpractices of illicit sexual encounters with commercial sex workers.
After she was diagnosed positive she said that the attitude of relatives, friends and community was very pessimistic. It was difficult to tolerate it. She added that time was more painful than disease and she was compelled by the social pressure to shift her residence.

Despite the fact that both husband and wife were HIV positive, their kids are HIV negative. She was a good social worker and now working for the awareness, betterment and uplift of the PLWHA. She was getting ARV’s but she was appealing to Government of Pakistan that there should be easy and proper supplies of medicine for PLWHA, like in India.

Profile 11

Mr. Zahid, a middle aged poor man, who was a victim of HIV/AIDS. He was a tailor by profession. When he was asked how he got HIV infection, he was not very sure about it. To him, in 1990 he consulted a local quack (who claims himself to be a doctor) for flu and fever. Mr. Zahid was given an intravenous injection for his fever as per routine of that “doctor”. After 24 hours of this injection; he developed severe jaundice. Again jaundice was treated by the same “doctor” and during the treatment many injections and intravenous infusion were given to him. After few months, he was found to be hepatitis-C positive. His hepatitis status passed through phases of remission and relapses and every time he took treatment from the same self assumed doctor. According to Mr. Zahid, repeated use of un-sterilized syringes and pricks by infected needles was the source of transmission of HIV/AIDS to him and probably he was right to say so.
Answering the question, how was he was diagnosed to be HIV positive? Mr. Zahid said that over the period of time, he started feeling quite lethargic and generalized weakness. He also got oral herpes and vitiligo, which is progressive in nature. He got his different blood tests done and was found to be HIV positive.

Narrating his family life as an HIV-positive person, Mr. Zahid told that he was living a very happy and satisfied family life. He was father of two sons. His wife was a very cooperative lady and she became even more loving and caring since Mr. Zahid is diagnosed to be HIV positive.

When Mr. Zahid was inquired about the HIV status of his family members he told that his wife and both sons were tested for HIV/AIDS and by the grace of Allah they were found negative.

Describing the attitude of his friends and neighborhood Mr. Zahid told that most of his friends did not know about his HIV status and those who knew the disease show variable behavior. He was more hurt from the educated community and according to him; the educated persons behave more rudely as compared to uneducated poor fellows.

Mr. Zahid was a tailor by profession. To him, his business situation fluctuated with fluctuations in status of his health. He earned a reasonable amount when his general health was good and his family suffered an economic crisis, when he was not feeling well in general.

At present, Mr. Zahid was taking ARV drugs and his present CD4 level has improved a lot since he was on drugs. These drugs were provided to him by a local NGO "New light" who was providing services particularly to PLWHA.
Giving his conclusive message, Mr. Zahid said that awareness regarding HIV/AIDS really the need of the time. For this purpose, main target should be educational institutes where students should be told all facts and figures about AIDS so that worsening condition of AIDS and PLWHA could be given a powerful support. Moreover, he said that PLWHA should be encouraged to discuss their problems with general population and the fear of rejection and curse from their fellows, family and friends is needed to be eliminated so that PLWHA could spend their remaining life in peace.

Profile 12

Muhammad Afzal, 31 years old unmarried, was HIV positive. He belonged to the slums area of Lahore (red light area). He was involved in sex-working community as sex agent. From the bad company, he indulged in addiction of “Heroin”. He had been arrested many times by police. To get escape from police, he found that injecting drug was more convenient and easy to carry from one place to another. To him, availability of tranquilizer was also very easy and cheap as compared to powder.

He shifted from powder to injecting drug for the last three years. He used injecting drug in the company of his fellows. They, usually, used the same syringe for multiple times for multiple companions. In January 2004, he was hit by the motorcycle on the road while he was addicted. He was taken to the hospital emergency and made some essential tests for cross matching. He, accidentally, diagnosed as HIV positive. Due to continuous usage of drugs, he could not even realize how much serious disease he got. He was living very wretched life because he
was already a member of marginalized community. Now a day, he was fully dependent on a group working against injecting drug users.

Profile 13

Muhammad Naeem Afzal, 33 years, a resident of Lahore slums area, was attached with entertaining party for the last 10 years. The party was providing entertainment on the various events like dancing on marriages and sometime sexual facilities as well. He was bachelor and making used to get sexual satisfaction from a female member of his party.

Naeem was detected very accidentally on the death of his young colleague (partner) by liver cirrhosis. She was a commercial sex worker. Mr Naeem, being a good companion, went to MAYO Hospital for blood donation. His screening report was surprising for all, he was HIV positive.

Mr Naeem told it was really very odd time while doctors declared his status as HIV positive. Everybody considered him as a dangerous person and reflected a lot of hate and rejection. He said, “he realized his entire mistakes and was repenting on all his activities and feeling regret. He further said, “God might forgive the person but people never give the chance of forgiveness.”

Naeem was living in a very miserable condition. He was isolated and completely depressed. Now he was dependent on old parents who were having no interaction previously due to his company and activities. Other than parents, his family members just hated him and they had no relation with him. Naeem declared himself a spoiled member of his family. He was not financially able to get medicine for even
opportunistic diseases. His state of mind was not completely sound and seemed as a psychic patient.

He was repeatedly saying, “Love your life and never indulge in evil practices which led towards hell.” But he got the real point after a very long time while the things were beyond his limits.

**Profile 14**

Kashif, 35 years, was diagnosed HIV positive. To Kashif, the first thing he did was to take his wife into confidence and get her and his daughter tested. By the grace of God, they were negative. But since that day, Kashif was subjected to blame, anger, and bitterness. His wife walked away from his life with their only child.

Kashif initially did not disclose his status for fear of rejection by colleagues. But as AIDS progressed, he was compelled to take off from work from time to time and finally he disclosed the disease. No one used to sit with him in the cafeteria and within days of knowing it, colleagues pressurized the cafeteria in-charge to separate his plate and the crockery he used. But it did not last long as Kashif was fired without any valid reason saying “he is medically not fit for work.”

Kashif while answering the question about possible cause of infection said that a man is an easy victim of mistakes. He was repenting on having multiple sex partners in the red light area. Basically, he visited a hospital with the problem of STI (Sexually Transmitted Infection) five years back. His relevant investigations showed his HIV positive status. He was not expecting this. Now, he was alone and spending days in
despondent condition. Kashif was forcing on the issue, “Breach of confidentiality remained one of the key concerns of PI.WHA.”

Profile 15

Mr. Karamat, 41 years old, diagnosed accidentally while donating the blood to his family member. He kept on weeping while describing his tragedy. He was working in Saudi-Arab for 10 years without family. He was quite unfamiliar about the reason of transferring the disease.

He was spending very uneasy life due to social and family pressure. His parents were blaming his wife for causing the lethal disease. His wife was living very desperately. She was unable to announce his status publicly. He was waiting for the ARVs and suffering skin problems adversely.

He had three daughters, one was college going but all of them did not know about the status of disease. Mr. Karamat remained fearful from the society. He was living in the village in very close-knitted community. He could not afford the rejection and repulsion from his nears. He said, “Fear of war is more than war”. He further said, “Health is big blessing and one should care about himself”.

4.5 Summary of in-depth interviews of Patients

After going through all the interviews, the major findings are as follows:

- All the infected respondents belonged to a socially depressed class of the society.
- Most of the infected respondents were illiterate.
- Majority of infected respondents were unaware of the disease.
• More than half of the respondents got this infection from abroad through blood transfusion and illegal sexual behavior.

• Along with the ARV drugs, family love, care, and support proved to be a vital factor in their survival.

• Social rejection is considered to be the biggest stigma for the patients.

• All the infected were from the blue collar jobs.

• Weaker purchasing capacity leads them to consult quakes, unqualified dentists for the medical needs which are the biggest potential threat for transmitting this disease.

• Pessimistic attitude of the educational class of the community towards the patient is also a great factor to aggravate this disease.

• Doctors who are supposed to be appointed for their treatment do not bother to see them and touch them for checkup.

• Patients are displayed in the hospitals like “showpiece” that is quite unethical.

• Wife in most cases prove to be the loyal partner of the patients while other relatives left them when they needed the care and love of the family.

• Most of the patients felt intense deprivation, lack of security and protection.

4.6 Panel discussion with health-care providers

As it is quite obvious that HIV/AIDS infection is not a simple disease but it is a complex of different disease processes based on paralysis of immune system. So the infected person may not die of HIV/AIDS but may lose his life due to complications of infections. Although doctors of different specialties are involved in the care of these patients but general physicians and gynecologists are two main concerned specialties who deal with patients of HIV/AIDS in general and for specific
gynecological and obstetric concerns of female patients here are the views of some of
doctors who deal with patients for HIV/AIDS.

Dr. Naveed Aslam

A dedicated physician of MAYO hospital when asked about the attitude of
doctors towards HIV infected patients he replied, “Being the part of same society the
doctors, despite of knowledge of disease process and its mode of spread, do not spare
the HIV positive patients from discrimination. Several incidents of stigmatization
have been reported in the health care sector as neglect and denial of treatment”

Dr. Naveed said, “Being honest, HIV/AIDS patients are not given the same services
because the doctors know they are going to die, so less time is spent on them”. Although this is against medical ethics and human rights but being the part of same
fearful society, they are helpless.

Doctors are also afraid of getting HIV/AIDS infection through handling of infected
patients. The basis of this fear is non availability of precautionary facilities in all
government hospitals. Specialized disposable surgical kits are not available in
hospitals and wherever are used in private sector these are very expensive and out of
reach of common men. During surgery of all high risk cases including AIDS, Hepatitis B, C according to international standards, the surgeons and assisting staff
should wear special kits, goggles, to prevent splash of body fluids in the eyes. But
these standards are not met in our hospital setups mostly. Moreover, doctors dealing
the patients in emergency department are at greater risks, as patients are not screened
and most of times need immediate intervention.
Dr. Nauman Alam

Dr. Nauman Alam, when asked about his views about HIV/AIDS patients, he replied, "Policy of universal precautions may bring down the fear element, staff capacity and skill building for HIV positive patient care, but all this is still lacking in Pakistan. Health professionals are needed to be trained in this particular specialty both in public and the private sector.

For better control of this epidemic, not only the public health staff but private practicing professionals of all types—allopaths, homeopaths and hakeems should be trained for HIV/AIDS care and for an orientation to human rights principles like patients conscent, confidentiality and respect for privacy. Lack of recent knowledge, fear for personal safety and uncertainty about treatment procedures explain why many doctors find it more convenient to refer their HIV positive patients to HIV "experts". These factors also explain why many of them are not supportive for their own colleagues who treat HIV positive patients.

Dr. Bushra Rehman

Dr. Bushra Rehman, a busy medical consultant of CMH Lahore, expressed her views about HIV/AIDS current status and behavior of health care providers towards PLWHA.

"In spite of all stigma and taboos associated with AIDS patient, doctors are much better in their attitude towards this particular group of patients. Most of the doctors, who come across the patients, do want to help them but at the same time we are also helpless and bound as no definite treatment is available. Whatever treatment can be offered, the essential medicines for opportunistic infections, antiretroviral medicine
and counseling service to PLWHA in all settings are not available. So in such circumstances, when it is obvious, that in spite of all efforts, patient is going to die, sometimes doctors also lose hope as the patients themselves."

Dr. Bushra added that to improve the doctor patient relationship, there is need to develop and implement professional codes of conduct and ethical guidelines as means of accountability of health professionals, employers and other professionals engaged in AIDS related work.

**Dr. Rubab Khalid**

Dr. Rubab Khalid has been working in the specialty of obstetrics and gynecology in Lady Willingdon Hospital Lahore since 2001. When she was inquired about the attitude of female doctors particularly obstetricians and gynecologist towards female patients of HIV/AIDS, she told if already suppressed female in male dominant society get infected by HIV, they hesitate to seek care for the fear that health care providers will discover their sero-positive status. Those who reveal their status to health care providers may be turned away, they are offered care but in an isolated place and are treated badly. In September 2003 at a local hospital of Lahore, a 17 year old HIV positive mother gave birth to a baby. According to doctor who delivered the baby, the delivery room had been closed for fumigation to protect other patients from being infected with the AIDS virus. She added that towel, gloves and bed sheets used by the women were burnt whereas instruments have been discarded soon after the delivery.

**Dr. Riffat Iqbal**

Dr. Riffat Iqbal, specialist of obstetric and gynecology of Lady Willingdon Hospital Lahore, also expressed her views about HIV positive patients. To her, they
are working in this particular specialty and in the hospital which is surrounded by high risk population area (red light area) are at increased risk of acquiring this lethal infection. In hospital, they have to deal with commercial sex workers for their gynecological problems and most of the time, the patients are taken for granted to be HIV positive (even if they may not) due to their high risk profession. So as a result, like general public, she added, “Women in sex work are thought to deserve to get infected because of their occupation. Although, some married women who contract the infection through their husbands may be viewed as victims, others may be blamed as the cause of infections.

Dr. Riffat iqbal told that the attitude of doctors, nurses and the lower staff including aayas and sweepers towards HIV/AIDS positive patients is not positive. Even they would not bother about the help and assistance they need from them. Sweepers hesitate to handle the urine, vomits and drainage bags of such patients which add to their agony and misery.

**Dr. Zopash Bilal (private practioner)**

Delivering her views about HIV/AIDS and health care providers she said, “As far as care- giving is concerned, they are stigmatized as being one of the immoral persons. If they have the courage to even touch such patients, they are considered as misfit for society. As a consequence, those who have the strength to face these accusations will stick on, but those who cannot handle the daily torment would just give up resulting in lack of enough and competent care givers. There is also a definite anger among care givers towards PLWHA because of these positive people they have to put their career at risk.”
Dr. Zopash further explained that the doctors who dare to help their HIV positive patients have to keep a secret identity as to what work they do; otherwise they will lose their other sero-negative patients. If the people will come to know that this particular doctor is treating HIV positive and negative patients side by side, they will take it a potential danger and risk to get HIV infection from the clinic or hospital setting of that particular doctor. Resultantly, doctor would have to pay the price in the form of a ruined future.

**Dr. Shakeel ur Rehman**

He is a medical consultant. He said expressing his views, even after knowing all the basic knowledge about the disease; doctors are still fearful and reluctant to treat HIV/AIDS patients.

Answering the question of a participant he said that he was saying sorry on behalf of medical profession as there is no authority to monitor the standard of sterilization of instruments and proper monitoring of complete blood screening in Pakistan.

**Dr. Major Munawar Wattoo**

He is a professional classified surgeon. He was having his own reservation on HIV/AIDS disease. To him, surgeons are at greatest risk; they are just a prick away from the lethal disease. He had handsome experience of practice in rural area. According to him, rural people are more illiterate and unaware about HIV/AIDS so they can be easy victim of such lethal diseases. He further condemned the unethical role of quakes and medical stores especially in poor socio-economic areas.
Dr. Haroon Rashid

Dr. Haroon Rashid is a consultant psychiatrist at Sir Ganga Ram Hospital Lahore. When consulted about his views on the psychological aspect of HIV positive patients, he told that counselors and others who provide psychological support or psychiatric care face tremendous stress because their clients face stigma and discrimination, affecting their mental and physical health. They have to be careful about how they disclose patients about their HIV status and they have to be prepared for patients' negative reactions.

When Dr. Haroon inquired about the behavior of health care providers towards AIDS patients in hospital settings, he said that AIDS stigma affects care providers in two major ways making it much harder for them to provide care. Although it is realized that PLWHA may be treated along with other patients and need not be isolated, but even then in many hospitals, HIV/AIDS services are located in isolated ill-equipped parts of the hospital lacking basic facilities. In other places, where PLWHA are treated with other sero-negative patients, they are kept at the end of the ward, often next to the toilet. Their sero-positive status is mentioned at the top of their files and bed side, visible to all. Care providers take elaborate precautions, many times unwanted, while providing care to these patients. He told that some care providers do not provide services even if they want to because their unstated hospital policies may not allow them to treat positive persons.

Laboratory Staff

Being the important part of health care system, laboratory staff of two major hospitals of Lahore was interviewed about HIV/AIDS positive patients and their care.
Mr. Younas, working as laboratory technicians in Lady Willingdon Hospital Lahore replied, “Accidental exposure to HIV is an important and serious issue in health care settings. Health care workers are not only concerned about acquiring the infection but also what others will think of them if they get the infection. They fear that it will destroy their families and limit their career opportunities. This fear is obviously due to associations of this horrible disease with abnormal sexual relations and addiction.”

Mr. Younas added that while handling the body secretions of patients and often they don’t know the sero-status of the patients, so they are at greatest risk of getting infected. And if God forbid, any of them get this infection, nobody will believe in his innocence, everybody will be suspicious about his characters. This whole picture may endanger their job without considering their hard work and talent.

Considering all these consequences without any benefit, most of laboratories refuse to help HIV positive patients. Younas added that staff should be ensured about their own safety and security.

**Nursing Staff**

Nursing staff is directly involved in the care of HIV positive patients along with doctors and sometimes even closer than doctors. Miss Nasim Zohra, a dedicated staff nurse in a busy government hospital when asked about HIV positive patients and their nursing care, she said, like all other diseases, sometime, HIV/AIDS patients come for treatment only when complications arise and there is very little which can be done for them. Probably, this hesitation is mainly due to stigma associated with HIV/AIDS.
To her, HIV positive patients are often being ignored by them but they also have families, children and parents how they can pick this lethal infection with them from hospital to our houses? Why should they endanger the lives of their loved ones when they know that there is no cure?

Staff Nasim Zahra added that she herself also does not want to disclose the sero-positive status of HIV patients on the top of their files and on their bed side but it is done keeping in mind the safety of other patients and working staff. Nurse takes care of all sorts of deadly serious and infectious patients day and night but she does not feel herself willing to the extent that she can take better care of HIV positive patients. Basically, like all other members of society she is afraid of the lethal nature of disease, not the diseased ones.

**Blood Bank Staff**

Transmission of HIV/AIDS, through blood as well as blood products, is a known route. Blood banks along with staff, both in private and government sector are involved in this route indirectly. To know about the possible role of blood bank staff, Mr. Arshad was interviewed, working as blood bank technician, in Sir Ganga Ram hospital, Lahore. To him, since the implementation of safe blood transmission service in the government hospitals, the chances of blood borne transmission of HIV has reduced to a considerable extent, but still they are not 100 percent sure all the time that the blood which we are providing in emergency situation is safe. In emergency situations, we have no time for screening and blood is immediately needed to save the life of the patient. In such situations, sometimes, even cross matching of blood group is not waited.
About the concerns of blood bank staff, he said, they are also at constant risk of acquiring the infection, as they have to prick the donor. While preparing the donors, they can also get pricks of same needle with which they have pricked the donors, and if donors turns out to be HIV positive, after screening, where do they stand? Mr. Arshad during his talk criticized the certain commercial blood banks which endanger the life of patients for money and provide the blood taken from high risk donors like intravenous drug users and addicts. He insisted that Government should use electronic and print media for proper awareness about safety of donation of blood so that all misconceptions about blood donations can be removed from society. Only in this way, blood transfusion will be 100% safe and transmission of HIV/AIDS and other fatal infections can be effectively checked.

4.7 Summary Findings

The rapidly progressing epidemic of HIV/AIDS is a major health challenge of present era and health care providers are related to this epidemic in number of ways. Almost each and every member of health care system, including doctors, nurses, paramedics, laboratory staff, blood bank staff and lower staff like sweepers, “Aayas” in one way or other are involved in the care and treatment of HIV/AIDS infected patients. Due to this mandatory relationship both partners namely health care recipients and providers face certain problems due to stigmas associated with the HIV/AIDS.

Still doctors are feeling great fear and threat while dealing the patients. There should be well-arranged trainings and counseling sessions for the continuous improvements of doctors and all health care providers. Efforts should be made to
create enabling environment for the health care providers to handle the HIV/AIDS patients in ethical ways.

4.8 Peer Group Discussion

Mr. Aasher is a good friend of Mr. Nazir Masih (HIV positive). He is presently working as Coordinator for PLWHA activities. He was frightened initially of AIDS and tried to remain away from the patients affected with this disease. After awareness, all his fear has disappeared. And now he is working for PLWHA. He stressed, “Awareness campaigns should be launched at macro level.”

Aashar said, “PLWHA really deserve love, care and affection.” He further gave his message to Government; that there should be proper wards in the hospitals like other diseases. He said, “PLWHA are human like normal people.”

4.9 Patient’s Family Views

Mrs. Nighat Aalam wife of Mr. Aalam (who was AIDS patient), have two sons and two daughters. Her husband died about four year back. After her husband death, she has gone through very tough time and her survival was difficult and support of family was her main priority. At present she is working as in-charge Rawalpindi Region for an NGO working for PLWHA. While giving her message, she shared different experiences and said, “Patients should disclose themselves and take care if they got some injury. They must have separate shaving kit and properly dispose the blades after shave.” She faced lot of problems from her family during the life of her husband and even after the death. She is spending very isolated and depressed life. Her relatives assume her HIV/AIDS patient; while she is HIV negative.
4.10 Views of Religious Leaders

Regarding different aspects of AIDS spread and prevention, in Punjab, Pakistan, interviews were conducted from religious leaders of two major religions (Islam & Christianity). Both religions give great importance to marriage and marital relationships.

When asked about prevention of AIDS, Qazi Tajweed ud din, a muslim leader, said, that the religious teachings encourage and advocate marriage and prohibited all other alternates for sexual enjoyment. He further added that Islam has restricted sex to marriage and considered any sexual activity outside it a forbidden transgression. Qazi quoted the reference of the Last Holy Prophet Muhammad (PBUH) urges those who can afford marriage not to delay it. He said, “Young man! Who ever has sufficient means should get married. It would help him to lower his gaze and protect his chastity. But those who can not, should resort to fasting, as fasting is a good restraint of the sexual drive” (Nerated by Al-Bukhari and Muslim on the authority of Abdullah ibn Massoud). Emphasizing that chastity is one of the aims of marriage, the Prophet (PBUH) says: “When one of you looks at a woman (in a sexual sense), he should go to his wife for what would satisfy his desire” (Nerated by Muslim on authority of Jabir ibn Abdulah).

Qazi said that not only does Islam pronounce homosexuality as forbidden, but it also prohibits unnatural sexual activity between men and women. Several Hadiths have reliably reported the Prophet (Peace Be Upon Him), as having strictly forbidden anal intercourse. One such hadith says, “God shall not look at a man who has an anal
intercourse with his wife”. Islam has also prohibited sexual intercourse during menstruation.

On discussion of drug and intoxication substances, Qazi quoted the saying of Holy Prophet (PBUH), “Every intoxicant is unlawful. If a substance intoxicates when taken in large quantities then every small quantity of it is forbidden. Whatever influences the functioning of the mind is forbidden.”

Father Rakib Patrick Joseph, Catholic Church, Faisalabad, explained “Christianity encourages marriages. It is well documented in both the “Old and New Testaments of the Holy Bible”. He added the reference from Old Testament, it is said: “Then the Lord God said, ‘it is not good that the man (Adam) should be alone, I will make him a helper fit for him.” (Genesis: 2, 18). Saint Paul says in his First letter of Corinthian, “Now concerning the matters upon which you wrote. It is well for a man not to touch a woman. But because of the temptation, each man should have his own wife, and each women her own husband” (7, 1-2).

Father Rakib told, “Adultery is strictly forbidden in Christianity as well, as both the Old and New Testaments make absolutely clear.” The seventh commandment given to Moses states: “You shall not commit adultery”, while the Old Testament says, “He who commits adultery has no sense,” (proverb: 32). In the book of Mathew, Jesus is quoted as saying, “But I say to you that every one who looks at a woman lustfully has already had adultery with her in his heart” (Matthew: 5, 28).

He quoted, Christianity, as it forbids adultery, also prohibits all kinds of unnatural sexual relationships, as it forbids adultery, also prohibits all kinds of unnatural sexual relationships, including homosexuality of men and women (Leviticus: 20, 13).
Christianity also prohibits the use of such substances that clearly affect the functioning of the mind. It is given in the Old Testament that, “Whoredom, wine and new wine take away the fear” (Hosea: 4, 11), quoted Father Patrick, when asked about prohibition of drugs and intoxicants in Christianity.

4.11 Summary findings

Every religion gives the lesson of peace, reality of life and logical decision for spending happy life. In cases of HIV/AIDS, avoiding the risk factors prove to be the only weapon available in combating this disease and this can be achieved by adopting responsible, sensible and rational behavior. Since the modes of transmission of the AIDS infection mostly revolve around human pleasures and the types of behavior within which men seek their pleasures, it is important to identify which sexual pleasures are permissible and which are not, in order to make sure that by following religious teachings, people would effectively steer away from behavior patterns through which this individually and collectively devastating epidemic can spread.

As AIDS mainly spreads through heterosexual, homosexual activities and among drug addicts, especially intravenous drug users or those who use contaminated needles, the exposition of religious teachings relating to such types of behavior is essential in building protective barriers against infection and disease.

4.12 Main Findings of the Study

Gender inequality, which increases a woman’s vulnerability to HIV/AIDS, is what puts them at unjustifiable risk. Sexual, social, economic and political inequality has made women the new prime targets of infection.
There is quite non-availability of treatment centre.

Non-availability of “ARV drugs” (antiretroviral) is also big problem which leads towards more opportunistic diseases.

- High risk sexual behavior among affected partner for transmitting the HIV virus is very common.
- HIV/AIDS education within the family is almost non-existent.
- Non-Availability of VCT (Vaccination, Counseling & Treatment) centers for general population, family and HIV positive persons.
- Lack of specialist doctors regarding HIV/AIDS treatment
- Due to discriminatory attitude of medical and para-medical staff at Government hospitals, people avoid disclosing themselves.

**Mode of Transmission**

![Mode of Transmission Diagram]

<table>
<thead>
<tr>
<th>Mode</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syringes &amp; injections</td>
<td>7</td>
</tr>
<tr>
<td>Barber</td>
<td>1</td>
</tr>
<tr>
<td>Sexual</td>
<td>1</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>2</td>
</tr>
<tr>
<td>unknown</td>
<td></td>
</tr>
</tbody>
</table>
Epidemiological Data (NIH)

<table>
<thead>
<tr>
<th>Mode of Transmission of HIV Carriers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Carriers</td>
</tr>
</tbody>
</table>

- Diagnostic and prognostic tests of HIV/AIDS are very expensive.
- Lack of awareness among general public regarding HIV/AIDS.
- Faith-based organizations have an integral role to play in the battle against HIV/AIDS.
- HIV/AIDS patients and their families do not have a safe and supportive environment.
- ABC (Abstain from sex, Be faithful and Condomize), approach is insufficient to a certain extent, there must be some other policies as well to face this incurable challenge.
Chapter 5

Findings of Quantitative study

5.1 Introduction

The HIV epidemic and its associated socio-economic and psychological consequences are relatively new phenomenon and have, so far, not been serious consideration given in development planning by most of the affected countries. HIV/AIDS is silently becoming a major cause of adult mortality in many countries. The rapid and hidden spread of the epidemic is affecting the suffering societies psychologically, socially and economically. These are impacts are personal, community-related, social and national simultaneously.

5.2 Demographic Characteristics of Respondents

5.2.1 Age

Punjab, the most populous province of Pakistan reflects that most of the affected were lying in the peak age of their earning. Thirty-five percent of this population was falling in the range of (30-34) year’s age group. Because, virus takes 3-month for incubation so, after 3 to 9 years, the signs and symptoms are going to appear among the patients and they live for 1-3 years after developing AIDS (GOP, 2003). So more concentration is required towards the youth when they get this lethal virus due to unawareness about the consequences of the disease. Lot of attention should be focused on behavior change in the teen ages because 63 percentage of Pakistani population is below 25 years of age (Haider, 2004). “Over 5.2 million people in South
Asia are estimated to be infected with HIV/AIDS at the end 2003, up to one-quarter are aged under 25 years" (Rasheed, 2004). It is very much evident from the data that young population is at more risk. But a very large proportion of those at risk of HIV infection in South Asian Countries are drug injectors, sex workers and their clients, and men, who have sex with males, are in their teens or early twenties (MAP, 2004). In Manipur state of India, over 40 percent of the males who injected drugs included in the surveillance system in 2002 were under the age of 25. In Katmandu valley (Nepal), where injecting drugs is a long established practice, some 44 percent of new injectors were under 25 years

Table: 5.1

Age wise distribution of the respondents

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>25-29</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>30-34</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>35-39</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>40-44</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>45-49</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Fig (5.1)
5.2.2 Gender Distribution

Bury et al. (1992) quoted the study conducted in UK, "The Scottish Women and HIV/AIDS Network is the major group that is trying to educate the young women in their teens, since 40 percent of the AIDS cases among women in the UK are in the 15-29 age group. With the rapid increase of HIV infection among women, Ciambrone (2003) introduced modern techniques, for avoiding and safety measures against HIV/AIDS focusing towards gender discrimination. "Strategically, women must be at the centre of the response to HIV and AIDS; tactically, men have to be involved to address both HIV/AIDS and gender inequalities" (Sarkar, India).

Table 5.2

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>28</td>
<td>70</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Pakistan is one of the very few countries in the world where female population is less than the male. The sex ratio in the year 1998 was calculated at 92.5 females per 100 males (GOP, 1998). HIV/AIDS is more common among males as compare to females. Females are playing a role of vector. In data analysis, it is very much obvious that 70 percent were males whereas 30 percent are females. In Pakistan, 86 percent of all reported cases of HIV/AIDS were males whereas 14 percent cases were of females. Andhra Pradesh in India is estimated to have the second highest prevalence of HIV/AIDS with 473,250 HIV positive people, among adults, males are infected 3 times as compared to females. (Andhra Pradesh, 2004).
5.2.3 Educational Attainment

A study from 32 countries found that women with post-primary education were five times more likely than illiterate women to know facts about HIV/AIDS (Vandermoortele and Delamonica, 2000). In Zambia, during the 1990s, HIV infection rates fell by almost half among educated women but showed little decline for women with no formal schooling. (UNICEF, 2004)

Table 5.3

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>17</td>
<td>42.5</td>
</tr>
<tr>
<td>Primary &amp; below</td>
<td>13</td>
<td>32.5</td>
</tr>
<tr>
<td>Middle</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Matriculation</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Higher Secondary</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

No doubt, education is the key to an effective response to HIV/AIDS. In Pakistan, the overall literacy rate is dismally low at 40 percent. Female literacy is particularly low, around 28 percent as against 51 percent for males. The situation is worse in the rural areas with female literacy rate of about 12 percent. The educational enrolment and attainment levels are also rather unsatisfactory, especially for females (Pakistan Economic Survey, 1998). Table 5.3 reveals that 42.5 percent are illiterate and 47.5 percent are literate. In Pakistan, the definition of literacy “Any person who can write and read a paragraph in any local language is considered as literate.”
So, the literate people are also quite unaware about the penalty of getting HIV/AIDS. According to some studies, all over the world, 150 million children were currently enrolled in schools and drop out before completing primary school, and at least two thirds of them were girls (World Bank, 2002).

The literacy break-down shows 32.5 percent of total respondents were below primary or primary education, 12.5 percent of them were only middle, whereas 5 percent, 7.5
percent were metric and higher respectively. But it's really hard luck, till to date, HIV/AIDS has never been specific of curriculum of “Medical Education”, what to talk about to discussion of such a sensitive and touchy issue, in general education.

5.2.4 Profession of the Respondents

National AIDS Control program, Islamabad reminded, “70 percent of all confirmed cases of HIV/AIDS are deported workers from Gulf while many of the women inflicted with it happen to be those who contracted it from their husbands.” Women and men working as sex-workers are particularly vulnerable to HIV transmission. A representative from Jagruti, India, an organization working with sex workers said,” If a women could not feed herself, why would she worry about a disease that might kill her in ten years’ time? If a client offers to pay twice as much for sex without a condom, the need for money might overtake everything.” Rushing (1995) said, “The risk of young girls’ contracting HIV/AIDS is higher than that of adults, and especially for those girls entering the sex industry.” The importance of the prevention of sexually transmitted diseases generally in the fight against AIDS increases when it is realized that the presence of a sexually transmitted disease raises the chances of having the AIDS infection by more than 300 percent (Wahdan, 1993). In Pakistan, sex-work is illegal but it is practiced in all major cities of the country, in the title of dancing, singing and entertainment shows in various hotels and guest houses in the guise of companionship (Zeenat, 2004).

Most of the respondents belonged to very depressed and marginalized communities. As table 5.4 reflects, 35 percent of the total respondents were laborers. They had very poor socio-economic background. Twenty-five percent of all respondents (all females) were indulged in sex-working with a high risk behavior,
while 20 percent of them were involved in sex-brokerage and became easy victim of HIV/AIDS.

Table 5.4

Profession wise distribution of the respondents

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shipping</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Drug Trafficker</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Laborer</td>
<td>14</td>
<td>35.0</td>
</tr>
<tr>
<td>Shop keeper</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Farmer</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Sex Worker</td>
<td>10</td>
<td>25.0</td>
</tr>
<tr>
<td>Sex Agent</td>
<td>8</td>
<td>20.0</td>
</tr>
<tr>
<td>House Wife</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Over 7 percent of the respondents were from shipping companies, who were working abroad, away from their families, mostly involved in hetero-sexual activities. A very few number of respondents, 2.5 percent from agriculture, shop keeping & drug trafficking each and 5 percent of them are from house-hold activities.

5.2.5 Religion of the Respondents

It does not make any difference, either Muslim or Christian; it is just a disease of deviant behavior.

Table: 5.5

Religion wise distribution of the respondents

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muslims</td>
<td>30</td>
<td>75.0</td>
</tr>
<tr>
<td>Christians</td>
<td>10</td>
<td>25.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>
In the study, 75 percent were Muslims and only 25 percent are Christians including males & females. No religion in the world, is giving the message of mal-practices but its always circumstances and situations which divert the persons towards high risk deviant behavior.

5.2.6 Residence of the Respondents

The number of reported HIV infections and AIDS cases has been steadily rising in Pakistan, and affects all geographical regions of the country. Several large cities and towns are home to historically famous red light districts like Lahore, Sargodha and Multan. Poverty, illiteracy, politics, social repression, exploitation, crime and unemployment are the casual problems of slums.

Table: 5.6

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Urban</td>
<td>7</td>
<td>17.5</td>
</tr>
<tr>
<td>Slum</td>
<td>28</td>
<td>70.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5.6 reveals that 70 percent of the respondents were residing in the slum whereas 17.5 percent were dwellers of urban areas. It is very much obvious, still the percentage of rural area victims are as low as 12.5 percent. In rural area, family binding, religious institutions and values are very strong yet. In urban area, mobility of people especially from abroad makes the place more vulnerable for HIV/AIDS. The key factor for high prevalence of HIV/AIDS in slums is that the, “High risk behavior people feel more protected in congested areas and purely urban as well as purely rural areas going to shrink for them.” In slums high risk behavior people can
prolong their activities like sex-working, injecting drug and drug trafficking more confidently.

5.2.7 Marital Status of the Respondents

In India, “Marriage is actually women’ primary risk factor” (Krishnan, 2004). On Colombia’s Atlantic Coast, 25 percent of all HIV cases were among women, about 50 percent of them were either married or in a stable relationship. Another study, at a health clinic in Puna, India, found that out of 400 women, 93 percent of them were married, 25 percent had sexually transmitted infections (STIs) and 14 percent were HIV positive. Ninety-one percent have never had sex with anyone but their husbands (WHO, 2004).

Table: 5.7

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>28</td>
<td>70</td>
</tr>
<tr>
<td>Unmarried</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Widow</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5.7 reflects that 70 percent of all the respondents were married, 25 percent of respondents were unmarried and only 5 percent of respondents were widowed. It shows that disease is more common among married respondents.

5.2.8 Family Size of the Respondents

In slums, due to lack of basic infra-structure and limited entertaining facilities, family size is comparatively bigger than rural and urban areas. In slums, people have only available cheap enjoyment is to have unsafe sex.
Table: 5.8

Average Family Size of the Respondents

<table>
<thead>
<tr>
<th>Locality</th>
<th>Family Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Areas</td>
<td>7.8(39/5)</td>
</tr>
<tr>
<td>Urban Areas</td>
<td>6.4(45/7)</td>
</tr>
<tr>
<td>Slum Areas</td>
<td>8.4(235/28)</td>
</tr>
<tr>
<td>Overall</td>
<td>8.0(319/40)</td>
</tr>
</tbody>
</table>

Table 5.8 indicates the average family size is reasonably big, may be due to high illiteracy rate and poor knowledge about reproductive health. Big family size compels the dwellers of slums to involve in illicit sex and evil practices for feeding whole family. Mostly, in those areas, only one person is earning and rest of all just depending upon a single earning person.

5.3 General Characteristics of the Respondents

5.3.1 Respondents Visited Abroad

The purpose of visiting abroad was only to have better life far their poor family but all were in vain. The first HIV positive case reported in Pakistan was also deported from Gulf.

Table: 5.9

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Areas</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Urban Areas</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Slum Areas</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Not applicable</td>
<td>29</td>
<td>72.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 5.9 reveals that 72.5 percent of the respondents did not visit abroad ever in their life. Out of 27.5 percent respondents who visited abroad, 12.5 percent were living in urban areas and having bit good standard of life. About twelve percent of the respondents who visited abroad belonged to rural areas and one respondent resided in slums.

5.3.2 Duration of Stay Abroad of the Respondents

Longevity of the stay created more risk among the people towards the HIV/AIDS. Almost all the respondents stayed abroad without their spouses.

<table>
<thead>
<tr>
<th>Table: 5.10 Duration of stay at abroad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years</td>
</tr>
<tr>
<td>&lt; 5</td>
</tr>
<tr>
<td>5 to &lt; 10</td>
</tr>
<tr>
<td>10 to &lt; 15</td>
</tr>
<tr>
<td>15 to &lt; 20</td>
</tr>
<tr>
<td>20 to &lt; 25</td>
</tr>
<tr>
<td>Overall</td>
</tr>
</tbody>
</table>

Table 5.10 indicates that 100 percent respondents visited alone, without their families. A significant number of Pakistanis are employed overseas or serve in international armed forces. Away from their homes for extended periods of time, they become vulnerable to HIV infection and are at higher risk for having unprotected sex and/or abusing drugs. Those infected bring STDs and HIV back to their spouses, partners, or contacts. HIV-positive Pakistanis who were repatriated from the Gulf countries have received public attention, largely because this group is systematically tested.
5.3.3 Smoker Respondents

The data, basically, reflects the chances of people who may shift themselves in future towards drug addiction through cigarettes primarily and switch over their status towards injecting drug users laterally. So the sharing of needles among injecting drug users is very precarious behavior, which becomes a cause of so many communicable diseases as HIV/AIDS.

**Table: 5.11**

Percentage Distribution of Smokers

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smokers</td>
<td>28</td>
<td>70</td>
</tr>
<tr>
<td>Non Smokers</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

The question was asked from all respondents: overall 70 percent respondents were smoker as shown in the table 5.11. Thirty percent of the respondents were non smokers because most of the rural people and in slums areas, smoke “Huqa”, a traditional pipe.

5.4 Medical Characteristics of the Respondents

5.4.1 Mode of Diagnosis of HIV/AIDS Status of Respondents

**Table: 5.12**

Mode of diagnosing the HIV/AIDS

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidentally discovered</td>
<td>29</td>
<td>72.5</td>
</tr>
<tr>
<td>Doctor diagnosed</td>
<td>11</td>
<td>27.5</td>
</tr>
<tr>
<td>Overall</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>
A general question was asked by the respondents about their diagnosis regarding HIV/AIDS. There were two possibilities, either a sick person diagnosed during his treatment with the help of signs and symptoms or he/she got any accident, blood screening and deported on seropositive status on annual checkup. Table 5.12 points out that 72.5 percent of the respondents were quite unaware of their seropositive status. They came to know about disease suddenly and accidentally. But 27.5 percent of the respondents were diagnosed as HIV positive after laboratory test on the recommendation of doctors.

### 5.4.2 Respondents getting Medicines for treatment.

According to many studies, a very few HIV positive people take medicine. Poverty, discrimination, lack of resources, unemployment and lack of family support make them unable to get medicine against opportunistic infections instead of antiretroviral drugs (ARV). In Zambia, in one rural town out of 40 people on antiretroviral treatment (ART), only three were women (IRIN, 2004). A study in Rwanda found that many women who were receiving medication for opportunistic diseases had to stop because they could not afford transportation to the hospital (Africa Rights, 2004).

### Table: 5.13

**Percentage distribution of Respondents using medicine against opportunistic diseases**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>21</td>
<td>52.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>
As Table 5.13 reveals, out of all respondents, about 12.5 percent go for medication against opportunistic diseases where as 35 percent male respondents got medicine. There are about 52 percent of respondents unable to get medicine against opportunistic diseases. The study reflects that more women than men had financial problems to pay for monthly medicine.

5.4.3 Purpose of Medicine

Studies in Brazil and South Africa show that intensive counseling, coupled with support from other HIV positive patients, makes it more likely that AIDS patients stay on drug therapy (Attawell, et al, 2003).

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>For sedation</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>For TB</td>
<td>2</td>
<td>5.00</td>
</tr>
<tr>
<td>For STD</td>
<td>9</td>
<td>22.5</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>21</td>
<td>52.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

While question was asked from respondents, about 22 percent of the respondents were indulged in sexually transmitted diseases (STD). This high percentage of respondents is clearly medicating their living styles and behavior. Ten percent of the respondents just took the medicine as “sleeping pills”. They were getting these tranquilizers to remain isolated and sedative for maximum time. On inquiring the respondents, they told, “They mostly used valium, Avil, Xanax and lexotanil, which
are easily available from local medical stores without any prescription.” They were quiet and calm. Just five percent of the respondents were getting medicine for “Tuberculosis” (T.B) which is very much common among the HIV/AIDS patients. But there is continuous need of counseling of HIV/AIDS patients for proper treatment against opportunistic diseases. About 10 percent of respondents were victim of casually occurring diseases like influenza, cough and fever. There were about 52 percent of the respondents unable to take medicine due to their poor socio-economic situation.

5.5 Characteristics of Drug Using Respondents

5.5.1 Drug Users Respondents

The word “Drug” proposed by the World Health Organization (WHO) is defined as “any substance, when taken into a living organism may modify its perception, mood, cognitive behavior or motor function” (WHO, 1993).

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>17</td>
<td>42.5</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>5.0</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>21</td>
<td>52.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5.15 shows, out of total respondents, about 52.5 percent of the respondents were not using drugs. About 42 percent of them were males and only 5 percent were females. These people completely depend on the drugs. One thing is very evident that females as compared to males, in Pakistan, are very few who involve in drug
addiction. In fact, drug using women are likely to be more stigmatized than their male counterparts because their activities are regarded by society as “double deviance”.

5.5.2 Mode of using drugs

In Europe, the dominant mode of transmission since 1989 has been injecting drug use. Patterns in Asia are changing rapidly, with an increasing share attributable to Injecting Drug Users (IDU) (UNDCP, 1992). When asked, the respondents said, “To carry injection is easier as compared to take “Heroin” and there is no legal constraint as well.” Easy availability and no legal restriction has supported the drug users to switch over their track from cigarettes to injections. It is difficult to give a rationale for the spread of injecting drug use independent of continent, culture, religion, social class and urban or rural circumstances. (Jarlais, 1993) To date, 80 percent of the HIV infections in Malaysia seem to be related to injecting drug use. (Tsuchie et al. 1995)

<table>
<thead>
<tr>
<th>Mode</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarette</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Sneezing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inhaling</td>
<td>3</td>
<td>7.5</td>
</tr>
<tr>
<td>Injectable(I/M)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Injectable(I/V)</td>
<td>11</td>
<td>27.5</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>21</td>
<td>52.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

According to table 5.16, about 27 percent drug user respondents were using drugs through intravenous rate. Those people are very risky and more vulnerable to get any communicable disease. Rate of usage of narcotics via cigarettes is higher than
inhaling. As table reflects, about 12 percent of the respondents were administrating drug by smoking whereas about 7 percent of the respondents were inhaling the drugs as smoke.

5.5.3 IDU’s Respondents

According to a study in Denmark, seroprevalence was found in 31.8 percent and 1.5 percent in IDUs and non-IDUs female sex workers respectively (Alary et al, 1994).

Table: 5.17
Percentage of respondents using drugs (through IV) with sharing of needles

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>25.0</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>2.50</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>29</td>
<td>72.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

All the respondents, IVDU (Intravenous Drug Users) were frequently sharing their needles. To them, drug is more important than the needles. Among all respondents, there was one female whereas 25 percent were male IVDU’s respondents. Information is presented in table 5.17.

5.6 Respondents Undergone Through Hospitalization and Blood Transfusion

5.6.1 Blood Transfusion

No doubt, blood is the essence of resuscitation but contaminated blood leads to horrible health problem. Females usually undergo minor and major surgical procedures during deliveries and are generally anemic as well. It is said that females
are more at risk to get virus through blood or blood contaminated products used during gynecological and obstetric procedures.

| Table: 5.18 |
| Percentage of respondents involve in blood transfusion |
| **Sex** | **Number** | **Percentage** |
| Male | 4 | 10.0 |
| Female | 3 | 7.50 |
| Not Applicable | 33 | 82.5 |
| Total | 40 | 100 |

Table 5.18 indicates that 17.5 percent of the respondents were involved in surgical or blood transfusion process. Among those respondents got blood transfusion, ten percent were males while as about 7 percent were females.

5.6.2 Source of Blood Transfusion

Every healthy individual in the age group of (18-50) years, maintaining weight of 50 kg and who never had hepatitis B & C or HIV may donate blood after necessary cross-matching. (NACP, 2004)

| Table: 5.19 |
| Percentage distribution of source of blood transfusion |
| **Main Source** | **Number** | **Percentage** |
| Relatives | 0 | 0 |
| Friends | 0 | 0 |
| Purchased from professional Donors | 7 | 17.5 |
| Blood Bank | 0 | 0 |
| Not Applicable | 33 | 82.5 |
| Total | 40 | 100 |

Table 5.19 reveals that blood was purchased from professional donors who were the main source of deadly disease. New IDU’s might be the big source of spreading HIV because their seropositive status can not be detected by blood test immediately due to long incubation period of HIV(Shah, 2002).
5.6.3 Hospital Experience of the Respondents

The slums or peripheral areas of big cities very poor infra-structure and they lack basic health facilities. There are so many health care centers in Punjab slum areas where patients have to bring their brought bed with them from home what to talk about proper laboratory facilities.

<table>
<thead>
<tr>
<th>Hospital appraisal</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied</td>
<td>3</td>
<td>7.50</td>
</tr>
<tr>
<td>Unsatisfied</td>
<td>4</td>
<td>10.0</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>33</td>
<td>82.5</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5.20 reflects those respondents who got experience of surgery. Out of all respondents, about 7 percent of the respondents were satisfied from health center equipments where as 10 percent were even satisfied with the health facilities provided to them during their hospital stay.

5.7 Main Sources of HIV/AIDS

When questions were asked to conclude their views about the sources of HIV/AIDS, many respondents were agreed for more than one source.

<table>
<thead>
<tr>
<th>Main sources</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use drugs with same needle</td>
<td>11</td>
<td>27.5</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>7</td>
<td>17.5</td>
</tr>
<tr>
<td>Through dentist/surgeons</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Through barber</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Multiple sex partners</td>
<td>38</td>
<td>95</td>
</tr>
<tr>
<td>Homosexuality</td>
<td>22</td>
<td>55</td>
</tr>
</tbody>
</table>
Ninety five percent were of the views that “Multiple sex partners are the big source of spreading HIV/AIDS”. Fifty five percent of the respondents were of the views that “Homosexuality might be a cause of HIV/ADS as well.” About twenty eight percent thought that sharing of needles might be a big source of HIV/AIDS. Twenty five percent were of the view that dentists might be the one of the reasons for spreading of virus. Whereas 17.5 percent and 12.5 percent of the respondents viewed that unsafe blood transfusion and barbers might play a vital role in spreading this poison, named “HIV/AIDS”.

There is comparison with Pakistan epidemiological data of HIV carrier given by NIH, Islamabad in the Fig 5.4.

**Fig (5.4) Epidemiological Data (NIH) 2003**

<table>
<thead>
<tr>
<th>Mode of Transmission of HIV Carriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
</tr>
<tr>
<td>819</td>
</tr>
<tr>
<td>644</td>
</tr>
<tr>
<td>295</td>
</tr>
<tr>
<td>100</td>
</tr>
<tr>
<td>25</td>
</tr>
<tr>
<td>25</td>
</tr>
<tr>
<td>35</td>
</tr>
<tr>
<td><strong>Carriers</strong></td>
</tr>
<tr>
<td>819</td>
</tr>
<tr>
<td>35</td>
</tr>
<tr>
<td>25</td>
</tr>
<tr>
<td>295</td>
</tr>
<tr>
<td>100</td>
</tr>
<tr>
<td>29</td>
</tr>
<tr>
<td>644</td>
</tr>
<tr>
<td><strong>Het-Sex</strong></td>
</tr>
<tr>
<td><strong>MSM</strong></td>
</tr>
<tr>
<td><strong>Bi-Sex</strong></td>
</tr>
<tr>
<td><strong>Blood</strong></td>
</tr>
<tr>
<td><strong>IDUs</strong></td>
</tr>
<tr>
<td><strong>MTC</strong></td>
</tr>
<tr>
<td><strong>?</strong></td>
</tr>
</tbody>
</table>

**5.8 Social Implications**

Social implications of HIV/AIDS are perhaps the serious most threat and hurdle to human development. As the roots of epidemics penetrate deeply among
individuals, families, communities and nations which have to face deaths on a scale which is not acceptable in modern era. In situations where quick social change is already posing shocks to traditional family and social structures, these costs might be enormous affecting gender roles, fertility, household patterns, and perhaps offsetting many of the achievements made in these areas in the near past. A particularly concerned and insightful analysis of effects which are challenged by the epidemics is given by Reid et al (1993). She explains, “Five sets of relationships, or ‘social contrasts’ which might be addressed if communities and nations are to survive for quality life.”

These are the relationships between.

a) Men and women
b) Individuals and communities
c) Communities and government
d) The infected and the uninfected
e) The present generation and the next.

In each of these relationships power imbalance, lack of trust, faith and confidence and failure to handle problems equally and honestly contribute to the rapid spread of this dangerous epidemic. Along with all these problems and pressure, confusion and complications within these relationships will be amplified and stretched to breaking point by the HIV prevalence rates and widespread presence of the virus.

5.8.1 Family System of the Respondents

People who marry have in fact two families. One is the “family of orientation”, the family in which one grows up, consisting of oneself and one’s parents and
siblings. The other is the "family of procreation", the family that one establishes through marriage, consisting of oneself and one's partner and siblings (Thio, 1996).

In Pakistan, "Joint family", bindings are very strong and more generally recognized as popular mode of living. HIV/AIDS patients are stigmatized by the general community and they became badly rejected even by their own families. No one wants to get paralyzed due to someone else problem. They live mostly alone, isolated and family does not accept them as a part.

Table: 5.22

<table>
<thead>
<tr>
<th>Family system</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuclear</td>
<td>28</td>
<td>70</td>
</tr>
<tr>
<td>Joint</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Overall</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5.22 indicates that 70 percent of the respondents were living at their own, so many respondents were having no accommodation and they kept on sleeping on the paved path in the slums areas. Ultimately, these marginalized people use to live very 0miserable and isolated life. Thirty percent of the respondents were living in joint family system.

5.8.2 Status of Respondent’s Family Regarding HIV/AIDS

The common situations where a man has become infected from outside, and he then put his wife at risk of silent infections, create severe tensions and stresses within the families. Few women insist that their spouse should use condoms when having sex. And yet, failure to do so, if they have suspicion that their husband could be infected, put not only a wife’s own life at risk, but also threatens the survival of the children and family.
Every one was well aware that how a wife has the right to comment upon her husband’s sexual behavior. This is an important and difficult question to answer for many cultures including Pakistani social setup. In the male dominating society like Pakistan, how far men re-evaluate their own values and needs with respect to sexual behavior and attitude in the form of threats to their sexual partners (wives in most of the cases in Pakistani social setup), children and families? Should they all evaluate the risk that their infection produces? Many infected people remain unaware of their HIV positive status, because testing system are far from being available everywhere. When detected, the short and long-term social and cultural effects are generally disastrous for them and their families.

Due to possible social problems, infected people often tend not to inform their spouses or regular sexual/emotional partner. In other cases, people are not concerned with HIV/AIDS infection due to more pressing concerns associated with their “under privileged” socio-economic” situation. As for people in economically and socially superior positions, they tend to regard themselves as “immune” from the disease because of their socio-economic status. Many of those with professions that involve frequent mobility do not assume their responsibility towards occasional sexual partners. Thus the HIV/AIDS epidemic and prostitution are highly concentrated in activity zones, related to these professions especially along national borders.

Table: 5.23

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall From All</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>38</td>
<td>95</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>
There were only 5 percent of the respondents whose family members were affected. It is noticeable that all respondents in this category were coupled and they got transmission of virus from each other innocently. It was all happened just due to lack of information and illiteracy among the respondents.

5.8.3 Attitude towards Respondents

No doubt, attitude of the various segments of people play a vital role in the smooth life of HIV positive people. As Fig 2.1, in chapter 2 is the reflection of the tri dimensional relationship i.e. social, economic and psychological factors are inter-related and inter-dependent and having great impact on the victimized people. Only optimistic attitude and normal behavior can prove to be “life blood” for the HIV/AIDS people.

Table: 5.24

Attitude toward respondents after diagnosis of HIV/AIDS

<table>
<thead>
<tr>
<th>Category</th>
<th>Sympathetic</th>
<th>Just Normal</th>
<th>Harsh/ Hated</th>
<th>Indifferent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Neighbours</td>
<td>10</td>
<td>25.0</td>
<td>8</td>
<td>20.0</td>
</tr>
<tr>
<td>Family members</td>
<td>18</td>
<td>45</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Relatives</td>
<td>2</td>
<td>5.0</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Friends</td>
<td>17</td>
<td>42.5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community members</td>
<td>1</td>
<td>2.5</td>
<td>3</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Table 5.24 indicates four variables on the basis of which attitude of different segments were analyzed towards patients.
Neighbors

Very rubbing and harsh attitude was observed by 42.5 percent of the respondents from their neighbors. Twenty five percent of the respondents were those who got sympathetic attitude from their neighbors after being diagnosed as HIV positive, who were unfamiliar about consequences of the disease. There were 20 percent respondents who observed that their neighbors were just taking HIV/AIDS as a normal disease like cancer or tuberculosis. While discussing the dealings of neighborhood, 12.5 percent of the respondents felt the reasonable difference between the behavior and dealings before and after declaration of their sero-positive status.

Family Members

According to Walker (1991), how a family copes with any illness, including HIV depends on both the nature of the family organization and the belief systems that govern the family’s response to illness. The impact on the family also varies with their ethnicity, religion, race and social class, family’s developmental level, and the family’s relationship with the treatment providers (Rait, et al, 1997).

HIV/AIDS is not only a single medical disorder but its associated stigma adds in the complexity of AIDS. The shame, blame, fear, distrust, disgust and dangers that surround these issues and the problems of discussing them in present-day cultures, are major hurdles facing family of PLWHA today. The point which makes it even worse is that there are very few channels in our present societies through which they can be tackled and faced.

Table 5.24 divulges that 45 percent respondents got sympathies from their families. Mostly, in Pakistani society, “mother and wife” prove to be the most sincere and caring for their patients. But they used to face lot of criticism and social pressure from
the community. The UN Secretary General’s report on South Africa revealed that two-thirds of caregivers in the household surveyed were females, with almost a quarter of them over the age of 60 (UN Secretary General, 2004).

About 33 percent of the respondents were of the view that they had felt apparent difference among the family members. Many of the respondents were complaining that their brothers left their home or compelled the patient to leave the home. About 13 percent of the respondents were gloomy to express that they faced hateful and harsh activities from their family members after diagnoses. Just 10 percent of the respondents shared their views that their family did not know the severity of HIV/AIDS, so the family members deal them normally.

**Relatives**

The behavior and interaction of relatives was remarkably changed. To 50 percent of the respondents, their relatives did not even accept them. About 43 percent of respondents were found angry on the response of their relatives. They even denied to see them. Five percent of the respondents declared that they got sympathies from their relatives. They were mostly from marginalized community and most of the family and relatives were involved in illicit sex working. STIs (Sexual Transmitted Infections) were very common among the relatives of the respondents of this group. About 3 percent of the respondents considered their relatives are normal in attitude towards them.

**Friends**

All the respondents unanimously had the same viewpoint that their friends were changed in either ways optimistically as well as pessimistically. But there was not a single respondent who said that his friend’s behavior was as normal as before, after declaration of his/her HIV positive status. About forty three percent of the
respondents told that their friends became more sympathetic with them. Friends of PLWH were having the same risk behavior and same living styles as PLWHA. They had very limited friends as they were rejected people of the society. Those friends were also IDU’s and involved in sex working activities. Thirty percent of the respondents were of the view point that their friends showed hateful behavior because of the fear, that PLWHA may disclose the name of their company of friends. They were all involved in the deviant behavior. Over 27 percent of the respondents were of the view that their friends just have changed. They said, “When they had enough money with them, they were having a lot of friends.” Now they are deprived and helpless, no one was ready to have any relation with them.

Community Members

Sixty Five percent of the respondents were depressed that no one was ready to have any interaction from the locality (Mohallha) with them. They felt that community people just pointed out their HIV seropositive status among the general public. Twenty five percent of the respondents said that there was an inadequate behavior of the general community with them. People from their locality were not even bothering to say “Hello” (Salam). Most of the respondents were assuming themselves as a symbol of rejection and isolation. Over 7 percent of the respondents told that people were feeling just normal. They belonged to poor socio-economic class of the society, quite unknown about the disease. Only one respondent replied for the question about the behavior of community people that they were sympathetic and considering them a casual patient.

5.8.4 Change of the Residence

Due to social pressure, it is very hard to face the community by the HIV positive people. PLWHA are considered rejected and isolated people of the society. Many of the
HIV positive people are compelled to change their residence due to negative response of the neighborhood.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>17</td>
<td>42.5</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td>22.5</td>
</tr>
<tr>
<td>Not</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>Applicable</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Table: 5.25
Percentage of respondents who changed their residence after HIV/AIDS

Regarding the change of residence, overall 65 percent of the respondents were compelled to change their residential place due to unbelievable peer and community pressure. To them every one was after them and even people were informing the residents of a new colony about their status after changing their residence. About twenty two percent of the respondents who changed their place were females and about 42 percent respondents were from male segment. Females were more wretched and depressed that they were considering themselves “the evil of the society”.

5.9 Psychological Implications

Stigma and discrimination associated with HIV/AIDS have disastrous psychological and emotional impacts, strong social rejection, blame of doing something very unethical, breaking the trust and faith, dishonesty; self guilt and shame, disgusting attitude of loved one’s, avoidance by the companions, isolation and so on, are the total output of this stigma and discrimination. All these factors affect the psychology of the affected persons in such a strong way that whole personality of a person is changed all together.
In some cases, due to self stigma, the persons with HIV/AIDS isolated which destroy personal and community ties resulting in deep emotional shock (Welbourn, 1995). The person surrounded by deep feeling of guilt and anxiety. As a result he/she thinks about suicidal attempts.

In less severe cases there is intense hopelessness towards every aspect of life. The whole picture of life turns black in case of infected person. He thinks negative about every thing. This effect not only affects the particular person but the associated family members: especially children and friends are also encircling by his wave of helplessness.

5.9.1 Impact on School Going Children

Many children suffer multiple losses - a father, a mother, siblings, grandparents, uncles, aunts, and other relatives. In addition, they may lose friends, familiar surroundings, schooling, hope for future, and their remaining childhood. The impact of HIV and AIDS on a child starts well before the death of a parent or caretaker. Children living in household where a member is HIV positive are at risk of other infectious diseases. He or she may have to care for ill and dying family members and face the trauma of seeing someone they love is slowly dieing. Their distress amplifies by the stigma often associated with HIV/AIDS.

Table 5.26, reveals the psychological implications on school going children of HIV positive patient. A study in Zambia found that 82 percent of those caring for children noted changes in their behavior during parental illness. Caretakers noted that children became worried, sad and that they tried to help more at home and stopped playing so as to stay close to their parents (Poulter, 1997).
### Table: 5.26
Psychological impact of the society on the respondent’s school going children

<table>
<thead>
<tr>
<th>Category</th>
<th>Sympathetic</th>
<th>Just normal</th>
<th>Harsh / Hated</th>
<th>Indifference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Teachers</td>
<td>10</td>
<td>33.3</td>
<td>5</td>
<td>17.0</td>
</tr>
<tr>
<td>Friends</td>
<td>1</td>
<td>3.0</td>
<td>19</td>
<td>63.0</td>
</tr>
<tr>
<td>Relatives</td>
<td>2</td>
<td>7.0</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Family members</td>
<td>15</td>
<td>50.0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community members</td>
<td>1</td>
<td>3.0</td>
<td>3</td>
<td>10.0</td>
</tr>
</tbody>
</table>

There are five different stakeholder of the society. On the basis of their significance, implications were measured on the school going children.

**Teachers**

Teachers are really the backbone of any society. But one should not forget that they are human beings too. Forty seven percent of the respondents were of the view that their children’s teachers’ behavior was entirely changed. Teachers were having fear that children might be carrier of HIV and they might transfer to others. They remained at an arm’s length from them. Thirty three percent of the respondents said that teachers were feeling pity for children and reflecting their sympathies whereas 17 percent of the respondents said that teachers were considering their kids a part of stigma. During classes, teachers tried to point out the children of patients (Malaney, 2000). Children were feeling quite disgraced and humiliated.
Only one respondent was of the view that behavior of teachers was just normal, because they were not told about the parents' status of disease. Resultantly, those poor dishearten kids could not complete even primary education because of psychological de-motivation and economic burden. Parents were also unable to pay even a very meager amount in the lower standard schools. Globally, 115 million children do not attend primary school, and 57 percent of them are girls. According to same studies, 150 million children currently enrolled in school will drop out before completing primary school and at least two thirds will be girls (Filmer and Pritchett, 1999).
Friends

Friends of the PLWHA’s children were innocent and really had no knowledge about the HIV/AIDS. Those who showed in-different behavior, it was due to poor information from their parents and teachers. Table reveals that 63 percent of the respondents were of the view that the friends of their kids up to school atmosphere are just normal. 27 percent of the respondents were of the view that the friends of their kids were reserved due to their parents and teachers indication. Seven percent of the respondents were of the views that friends were avoiding their kids, whereas 3 percent of the respondents described about the emotional and empathetic behavior with their kids.

Relatives

The behavior of relatives with the kids was as it was shown with their parents. They even did not want to see them and felt kids would be burden after the death of patients. They were having pessimistic attitude towards the victimized family. According to the table 5.25, there were 50 percent of the respondents who were complaining about the adverse behavior of their relatives. Forty percent of the respondents had the observation that their relative hated their children. Seven percent of the respondents were optimistic and said that their relatives had concern with their kids, where as one respondent informed that his relatives are still normal with kids due to unawareness of their HIV positive status.

Family

The behavior of the family for the children of HIV positive was not as normal as it should be. Stigmatization, discrimination and social isolation, dropping out of school, moving away from friends, and bearing an increased workload in the home all increase the stress and trauma that accompanies the death of a parent (Foster et al,
1997). According to the table 5.25, 50 percent of the respondents were of the views that relatives were having sympathetic behavior towards children. They were feeling pity on the fate of their children. Over 27 percent of the respondents were observing that family members (uncles of patient’s children) were not allowing their kids to play and even talk to the patient’s children. They might be doing this a safety measures for their own children but respondents were feeling their hateful behavior towards their kids. Twenty three percent of the respondents were of the opinion that dealings of family with their children were entirely different as compared to their previous behavior. Such type of behavior involves the children in inferiority complex and distrust atmosphere.

Community Members

Fear, worries, observing and caring for ill parents in pain, stigmatization, hospital visits, shattered hope and eventual loss are all experienced by children affected by HIV/AIDS at various times over several years. Along with all, it is observed by 57 percent of the respondents, according to table 5.25, that people from the surrounding always pointed out them along with their kids. This segment of respondents was of the view that their kids were more neglected and punished by the unethical behavior of the general community. Thirty percent of the respondents were of the view that there was indifferent behavior of the community towards their children. Children were not in the position to play in the streets due to strong community rejection. Ultimately, children were quite depressed and lethargic regarding the fearful environment prevailing around them. To 10 percent of the respondents, the community people were normal at least with their children. But those people in the surrounding were not aware of the implications of HIV/AIDS. Only one respondent
was of the view that the children got sympathetic behavior from community members.

5.9.2 Psychological State of Mind of the Respondents

Families may experience a range of emotional reactions including, fear of contagion, anticipatory grief, shame and helplessness, which can impede coping and create disruptions and relationship problems.

Table: 5.26
Percentage of respondents families shocked after the declaration of HIV/AIDS

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>28</td>
<td>70.0</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>30.0</td>
</tr>
<tr>
<td>Overall</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

According to table 5.26, hundred percent of the respondents declared that their families felt distress after diagnoses of their status as HIV positive. Individuals affected by HIV may be influenced by psychosocial stresses common to other chronic or life-threatening illnesses, such as cancer or heart disease. But families of the patients along with them were quite uncomfortable, agonizing, hurting and painful due to social, peer and employers reactions as well.

5.9.3 Psychological states of mind of the respondents

Depression results from abnormal functioning of the brain. Depression is a major contributor to fatigue in patients with HIV/AIDS. Feelings of hopelessness, pessimism, feelings of guilt, worthlessness, helplessness are the major symptoms of
depression. “One in three persons with HIV may suffer from depression” (Bing et al, 2002).

Table: 5.27

**Psychological states of mind of the respondents**

<table>
<thead>
<tr>
<th>Type</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>23</td>
<td>57.5</td>
<td>17</td>
<td>42.5</td>
<td>40</td>
</tr>
<tr>
<td>Tension</td>
<td>09</td>
<td>22.5</td>
<td>31</td>
<td>77.5</td>
<td>40</td>
</tr>
<tr>
<td>Depression</td>
<td>29</td>
<td>72.5</td>
<td>11</td>
<td>27.5</td>
<td>40</td>
</tr>
<tr>
<td>Aggression</td>
<td>17</td>
<td>42.5</td>
<td>23</td>
<td>57.5</td>
<td>40</td>
</tr>
<tr>
<td>Regression</td>
<td>05</td>
<td>12.5</td>
<td>35</td>
<td>87.5</td>
<td>40</td>
</tr>
<tr>
<td>Fixation</td>
<td>08</td>
<td>20</td>
<td>32</td>
<td>80</td>
<td>40</td>
</tr>
<tr>
<td>Resignation</td>
<td>18</td>
<td>45</td>
<td>22</td>
<td>55</td>
<td>40</td>
</tr>
</tbody>
</table>

While explaining the different terms regarding the psychological states of mind to the respondents, they expressed their views as reflected in the table 5.28. In the table, it is apparent that 72.5 percent respondents who were really in the phase of depression. There were 57.5 percent respondents were very much anxious about the future of life and curious about the status of their disease. Forty five percent respondents were so frustrated that they tried to commit suicide. In fact, ignorance about HIV/AIDS means that people are frightened. And frightened people do not behave rationally. There were 42.5 percent respondents whose behavior was aggressive. Aggression is the out come when the person is attempting to accomplish something that he or she is not capable of achieving and aggressive people may keep on abusing without any logic (Flippo, 1987). 22.5 percent respondents were found to
be hypertensive, due to irritating behavior of community. PLWHA become hypertensive and reflect ridiculous behavior. There were 20 percent respondents who were behaving in fixation segment, fixation means redundancy of the same practice without any realistic significance. In fixation stage, PLWHA kept on doing the same activity again and again impractically. 12.5 percent respondents were in the regression state of mind and resorted to act an immature behavior. Those respondents were involved in unreasonable complaining and crying for help to relieve some frustration.

5.9.4 Psychological impact of HIV/AIDS on respondent’s children

According to McKelvy (1995), children with HIV positive parents may feel helplessness, abandonment, resentment, sadness, anxiety and anger. They may take parental roles in early age as their parents suffer with this social stigma. If the family is not conscious about their HIV status, these children may lack confidence and other psychological sources of support that help them in the grooming of their future. Children may struggle to come to terms with information about their parents that was disclosed along with HIV status (sexual orientation, drug use and sex trade work) from others.

From the table 5.28, a high percentage, about 62 percent respondents said that they felt poorly, about their children who felt deprivation and deep inferiority complex in every sphere of life. About 52 percent of the respondents felt that there was a prevalent sense of insecurity among their children. They assumed that their kids were shelter-less and direction-less in each matter of life. These kids felt insecure atmosphere around them. Forty five percent of the respondents said that they felt very badly, about their children who felt deprivation in the basic essentials of life.
Table: 5.28

Psychological impact of HIV/AIDS on respondent’s children

<table>
<thead>
<tr>
<th>Impacts</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
<th>N/A</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental retardation</td>
<td>17</td>
<td>42.5</td>
<td>13</td>
<td>32.5</td>
<td>10</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>Inferiority complex</td>
<td>25</td>
<td>62.5</td>
<td>05</td>
<td>12.5</td>
<td>10</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>Isolation</td>
<td>11</td>
<td>27.5</td>
<td>19</td>
<td>47.5</td>
<td>10</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>Sense of deprivation</td>
<td>18</td>
<td>45.0</td>
<td>12</td>
<td>30.0</td>
<td>10</td>
<td>25</td>
<td>40</td>
</tr>
<tr>
<td>Insecurity/ unprotected</td>
<td>21</td>
<td>52.5</td>
<td>09</td>
<td>22.5</td>
<td>10</td>
<td>25</td>
<td>40</td>
</tr>
</tbody>
</table>

N/A—stands for not applicable.

It is very much clear, about 42 percent respondents were very poignant to express that their children got mental retardation and they were feeling irrational fear and sense of phobia. About 27 percent of the affected person narrate that their kids actually cut off from all the social pillars of the society that strengthen the sense of isolation in them. When they lacked company they tend to follow the evil practices like drug, looting and violence. They always let down in every aspect of life and never been considered part of normal society at all.

5.10 Economic Impact on Respondents

5.10.1 Monthly Average Income of the Respondents (Before Diagnosis)

The economic impact of AIDS was most severely felt by developing countries. In 1990 these countries accounted for more than 80 percent of the world’s infection; by 2000 this disproportionate burden reached 95 percent (World Development Report,
1993). PLWHA kept on working until their HIV positive status revealed to the workplace. Irrational and pessimistic behavior from their colleagues really compelled them to leave their work. During the current study, some of the respondents admitted that they felt lethargic, tired and fatigued during their working. Due to the weak immune system, they felt themselves physically unfit at work (Silverstein, 1992).

Table 5.29

<table>
<thead>
<tr>
<th>Locality</th>
<th>Number of Respondents</th>
<th>Male income (Rs.)</th>
<th>% Income</th>
<th>Female income (Rs.)</th>
<th>% Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Areas</td>
<td>(3+2) 5</td>
<td>6767</td>
<td>77</td>
<td>2000</td>
<td>23</td>
</tr>
<tr>
<td>Urban Areas</td>
<td>(7+0) 7</td>
<td>16714</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Slum Areas</td>
<td>(18+10) 28</td>
<td>7450</td>
<td>60</td>
<td>5050</td>
<td>40</td>
</tr>
<tr>
<td>Overall</td>
<td>40</td>
<td>30931</td>
<td>81</td>
<td>7050</td>
<td>19</td>
</tr>
</tbody>
</table>

Table 5.29 reveals that income of the male respondents is reasonably high as compared to females. Seventy seven percent income of rural area was composed by male respondents whereas 23 percent of the total rural area income was comprised of the female segment. Among the respondents from urban area, there were all male members so hundred percent of the urban area respondents income was comprised over male respondents. Sixty percent of the income of slums area was consists of male respondents whereas 40 percent of the total slum area income was contained by female respondents. Two female respondents from slums declared their status of house wives and not indulged in commercial working for earning money.
5.10.2 Adverse impact on the Respondents Income

The most alarming situation is faced by the respondents when they were misplaced from their jobs. Their socio-economic condition goes towards decline day by day. Ultimately, the adverse impact affects the family of the respondents very badly.

Table: 5.30
Average Adversely Impact of HIV/AIDS on Income

<table>
<thead>
<tr>
<th>Locality</th>
<th>Average Income of Respondents before Disease</th>
<th>Average Income of Respondents after Disease</th>
<th>Average Adverse Impact on Income of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>16714</td>
<td>571</td>
<td>96.6</td>
</tr>
<tr>
<td>Rural</td>
<td>4860</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Slums</td>
<td>6593</td>
<td>2319</td>
<td>64.8</td>
</tr>
</tbody>
</table>

Most of the respondents from urban area were deported from different countries. Those overseas laborers were just de-recruited from their jobs and were compelled to leave the country. They were facing complete loss because they could not find any room of sympathies in their homeland too. As table 5.30 reflected that there was 96.6 percent adverse impact on the income of respondents living in the urban area. In the rural area, there were no opportunities for jobs and rate of illiteracy was very high. Resultantly, there was 100 percent respondents lost the employment and were facing complete disaster. About 64.8 percent negative impact on the income of the respondents dwelled in slums. Due to poor income and lack of resources these respondents expressed that they were not been able to purchase the basic medicines against opportunistic diseases and how they can survive expressed no respondents.
5.10.3 Monthly Average Expenditure on Treatment

The costs for a prolonged illness family include additional expenditures particularly on health, lost income, and re-allocation of work and domestic responsibilities. As one would expect, those with fewest assets are the most vulnerable. There is evidence that poor households incur debt in order to meet additional health costs. That they try, as far as possible, to hold on to productive assets, such as land, cattle in Pakistani rural society, for as long as possible to protect the existence of the family. Death itself imposes additional economic stress, which in many societies like Pakistan further drain the resources available to households.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Areas</td>
<td>325.0</td>
<td>215.0</td>
</tr>
<tr>
<td>Urban Areas</td>
<td>921.0</td>
<td>NA</td>
</tr>
<tr>
<td>Slum Areas</td>
<td>482.0</td>
<td>322.0</td>
</tr>
<tr>
<td>Overall</td>
<td>490.0</td>
<td>304.0</td>
</tr>
</tbody>
</table>

Table 5.31 reflects the monthly expenditure on medical treatment of rural area of the male respondents was Rs. 325 whereas female respondents just had medical expense of Rs. 215 per month against opportunistic diseases. Nine hundred and twenty one rupees was the expense of the male respondents per month in account of medical treatment. Male respondents of the slums reported that medical expense was Rs 482 and female respondents of the slums spent Rs 322 per month on the medical treatment.

5.10.4 HIV/AIDS as Cause of Unemployment

Unawareness, illiteracy and un-conducive atmosphere compelled the HIV positive people to leave their jobs. There are no opportunities to get job for PLWHA at present.
Table 5.32
Percentage distribution of respondents who reported the main cause of unemployment is HIV/AIDS

<table>
<thead>
<tr>
<th>Locality</th>
<th>Frequency (Yes)</th>
<th>Frequency (No)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Areas</td>
<td>5</td>
<td>0</td>
<td>12.5</td>
</tr>
<tr>
<td>Urban Areas</td>
<td>7</td>
<td>0</td>
<td>17.5</td>
</tr>
<tr>
<td>Slum Areas</td>
<td>28</td>
<td>0</td>
<td>70.0</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

While replying the question about the views about HIV/AIDS is cause of unemployment, all the respondents positively declared HIV/AIDS is the major cause of unemployment.

5.11.1 **Awareness and Role of Pakistan Government**

Proper awareness is the only way-out to fight against HIV/AIDS. Due to religious bindings and cultural implications, it is an uphill task to create awareness among youth especially about their unsafe sexual behavior. Most of the people are still unaware about the causative factor of HIV/AIDS and are becoming easy victim of this lethal disease.

Government should focus all its efforts on grass root level of the community instead of addressing the elite class of the society. Majority of people one not aware of the unfamiliar about the Government efforts and infected people completely dissatisfied regarding Government policies for care and treatment of the PLWHA.
Table: 5.33
Satisfaction of respondents regarding Government facilities provided to HIV/AIDS patients

<table>
<thead>
<tr>
<th>Locality</th>
<th>Satisfied from Govt. Facilities</th>
<th>Un-satisfied from Govt. Facilities</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Areas</td>
<td>0</td>
<td>5</td>
<td>12.5</td>
</tr>
<tr>
<td>Urban Areas</td>
<td>0</td>
<td>7</td>
<td>17.5</td>
</tr>
<tr>
<td>Slum Areas</td>
<td>0</td>
<td>28</td>
<td>70.0</td>
</tr>
<tr>
<td>Overall</td>
<td>0</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5.34 reflects that hundred percent of the respondents are dissatisfied from the Government facilities whereas PLWHIA are still waiting for ARVs since long.

5.11.2 Source of Awareness about HIV/AIDS
Media is really playing an essential role in creating awareness among the community. A great attention is required to select the media according to the target community. Language of the message should be simple, easy and very common in the general public as expressed by the respondents.

Table: 5.34
Media from where the respondents get awareness about HIV/AIDS

<table>
<thead>
<tr>
<th>Media</th>
<th>Yes</th>
<th>Percent</th>
<th>No</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newspaper</td>
<td>6</td>
<td>15.0</td>
<td>34</td>
<td>85.0</td>
</tr>
<tr>
<td>Radio</td>
<td>9</td>
<td>22.5</td>
<td>31</td>
<td>77.5</td>
</tr>
<tr>
<td>Television</td>
<td>24</td>
<td>60.0</td>
<td>16</td>
<td>40.0</td>
</tr>
<tr>
<td>Any other</td>
<td>5</td>
<td>12.5</td>
<td>35</td>
<td>88.5</td>
</tr>
</tbody>
</table>

Table 5.34 indicates that only 15 percent of the respondents knew about HIV/AIDS through newspaper. About twenty three percent of the respondents said
that radio was the main source of information about HIV/AIDS. There was encouraging response from 60 percent of the respondents got the awareness about this fatal disease from television. Just five percent of the respondents obtained information through miscellaneous sources.

5.11.3 Response towards HIV/AIDS Help Line

The AIDS Helpline provides a free national telephone counseling, information and referral service for those affected by and infected with HIV/AIDS. Social attitudes and perceptions about HIV/AIDS are highly discriminative and therefore can force people to live in fear and isolation with the knowledge of their status. The ongoing support from the Helpline, as well as from other sources assists in not only promoting disclosure, but also improving the quality of life for the caller. During the session the caller is given relevant information to cope with both the physical and emotional issues of being HIV positive or living with AIDS.

<table>
<thead>
<tr>
<th>Locality</th>
<th>Yes</th>
<th>Percentage</th>
<th>No</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness about HIV/AIDS Helpline</td>
<td>12</td>
<td>30</td>
<td>28</td>
<td>70</td>
</tr>
</tbody>
</table>

The HIV/AIDS hot line is providing multiple services but general public is quite unaware about the hot line number. Only 30 percent respondents were familiar about the hotline providing services regarding HIV/AIDS. All the respondents were expressing lack of confidence and need to have a very enabling environment to move ahead for getting facilities, information and counseling.
5.11.4 **Health care facilities provided by the Government at work place**

The Pakistani Government did not take the catastrophic as seriously as it is need of time. All the respondents were unhappy about the policies of Government. While asking about their routine tests, all the respondents burst off by saying that they never even got the status of patient what to talk about treatment. All the respondents were depressed due to non-availability of ARV drugs; they got the medicine from other countries after a very long and tedious procedure. In contrast, in India, medicine is being provided to patient on regular basis from open market and Indian Government is intending to introduce the ARV drugs to the patients free of cost in next coming years.
Chapter No.6

Summary Findings, Conclusions and Recommendations

6.1 Summary of Major Findings

Quantitative and Qualitative (in-depth focus group interviews) approaches are used in the study to explore the research objectives. The summary findings of quantitative study are as fellows:

6.1.1 Summary Findings of the Quantitative Study

Forty HIV/AIDS patients were interviewed by using a structured questionnaire. Most of the patients were suffering from lethal infection, falling in the age group of 30 to 34 years (35 percent) which is the most productive age of an individual from all aspects. As far as gender issue is concerned, it is obvious from the study that HIV/AIDS is more common in males (70 percent) as compared to females (30 percent).

The study established that majority of affected respondents (42 percent) was illiterate or just had primary level of education (32.5 percent). Most of the respondents were from very depressed or marginalized communities. Thirty five percent of respondents were manual workers and the second commonest profession was female sex work which was 25 percent. Drug traffickers, shopkeepers and farmers share the smallest percentage of 2.5 percent of each. As far as religious believes were concerned, the study revealed that out of all respondents, 75 percent were Muslims and remaining 25 percent were Christians. It is apparent from the survey that seventy percent of the respondents were residing in slum areas. Rural area
shared the lowest proportion about twelve percent (12.5 percent). The majority of
affected population was living in slum areas had average family size of 8.4 which is
the highest figure among all affected areas. The study showed that most of the
affected people (70 percent) were married, 25 percent unmarried and 5 percent were
widows.

It is generally observed that HIV/AIDS has been hardbound from abroad,
conversely it is evident from this study that majority of respondents (72 percent) did
not visit abroad ever in their lives and those who (12.5 percent) stayed in the foreign
countries without their spouses, out of them almost fifty four percent (54.5%) of the
affected respondents stayed abroad for 5 to less than 10 years. The foreign visitors
who got affected belonged to urban areas (12.5 percent); slum areas (12.5 percent) and
2.5 percent were from rural areas.

Regarding the medical status of the study population, 72.5 percent (29)
were diagnosed incidentally and they were quite unfamiliar about their sero-positive
status before. The remaining percentage was diagnosed on recommendation of health
care providers.

About 52 percent of respondents were unable to get treatment of
opportunistic infections and out of those who could afford these medicines (47.5
percent) 35 percent were males and 12.5 percent were females. Among 47.5 percent
of affected patients, 22.5 percent were using medicine for treatment of sexually
transmitted diseases, which are major cause of HIV/AIDS.

As usage of illicit drugs is a well-known mode of transmission of
HIV/AIDS. Out of total 40 respondents, 19 (47.5 percent) patients were engaged in
drug abuse and among those 47.5 percent were drug users, majority (27.5 percent including 25% males and 2.5% females) were intravenous drug users who shared the same needle for injecting drug. Second commonest (12.5 percent) mode of drug was smoking (cigarettes). The study showed that 17.5 percent of the respondents had blood from professional donors so visibly it was not properly screened out from some laboratory. Among the respondents who had blood transfusion, 10 percent were not satisfied with the screening process of hospitals and they blamed the unscreened/wrongly screened blood to the cause of their positive status. As it is identified that there could be multiple source of transmission of HIV/AIDS, and there can be more than one source in a single patient. The study explored that probable mode of transmission of HIV/AIDS was sexual contacts with multiple partners (95 percent of respondents were using of needle for intravenous drugs, 27.5 percent used of un-sterilized instruments and irrational use of injections by dentists/surgeons contributed to 25 percent share. Almost all respondents were agreed with multiple modes of transmission of HIV/AIDS. Turning towards the second implication of HIV/AIDS, 70 percent were having joint family setup. Only two respondents were living in separate family system while 30 percent were having affected family members who were HIV positive.

The study findings revealed that 42.5 percent of respondents faced harsh/hated attitude from their neighbors and relatives. Behavior of relatives of 50 percent of the respondents was indifferent while friends of 27.5 percent of the patients remained indifferent. Sixty five percent of respondents were forced to change their residential places to after disclosure of their HIV positive status as they faced strong social rejection and discrimination.
The psychological implication of HIV/AIDS, the study revealed that AIDS has not only influenced the psychology of the affected person but the family members, children, parents and care takers equally. They all more or less suffered from stigma and discrimination along with the patients. The school going children of HIV positive persons faced harsh and hated behavior from the community (75 percent) and from their relatives (40 percent). The teachers showed changing behavior e.g. sympathetic (33 percent), just normal (17 percent), harshness/hated (3 percent) and indifferent (47 percent) towards these children. Friends of their kids showed mostly normal behavior (17 percent) and stayed in different (27 percent). Over all the feelings of rejection and hatred of varying degree was received from all the segments of society including family, relatives, friends, neighbors, teachers and general community.

Families of all respondents (100 percent) who shocked to hear the news of their loved one had HIV positive status. The kids of the most of respondents suffered from inferiority complex, isolation, sense of deprivation, insecurity and un-protection.

Psychological status of respondents was observed and it was turned out that 25 percent of patients felt anxiety, 09 percent tension, 29 percent depression, 17 percent aggression, 05 percent regression, 08 percent fixation and 18 percent showed resignation. All these psychological impacts were sufficient enough to change the personality of a person completely.

While seeking the economic implications of HIV/AIDS on society, the study illustrated that monthly income of all the respondents was badly affected after the diagnosis and disclosure of HIV positive status. All the respondents of rural areas, 96.6 percent of the respondents of urban areas and 64.8 percent from slums reported a
substantial decline in income after diagnosis. Overall Rs.490/month (US$ 8.16) were being spent on treatment for opportunistic infection on male respondents and Rs.304/month (US$ 5.05) on female patients which was noticeably very insufficient. HIV/AIDS appeared as cause of unemployment in 100 percent cases irrespective of their localities they were residing (rural, urban, slums). All of the respondents were unsatisfied regarding the facilities provided by the government of Pakistan to PLWHA. The major share of this unrest was contributed by the respondents living in slums (70 percent).

As awareness was concerned, television was the main source (60 percent), second major source was radio (22.5 percent) and newspaper was considered as third large source of information (15 percent). Only 30 percent of respondents were familiar about national HIV/AIDS helpline while 70 percent were not aware of any such service. All the respondents (100 percent) were unhappy and unsatisfied about the policies of government regarding HIV/AIDS, PLWHA and their future.

6.1.2 Findings of the Focus Group Interviews with the Patients

During the focus group interviews, fifteen (100%) respondents were found depressed, disappointed and the miserable condition. They were feeling themselves as useless, ineffective and abandoned part of the society. Almost all the respondents were spending their lives desperately. Most of the family members did not know the real status of their disease but those knew they hated them. All the respondents faced the social, economic and psychological pressure.

Almost all the respondents were uneducated. They lacked of knowledge and information about basic health. There were serious misconceptions and
misunderstandings about the disease. They were deficient in knowledge about their rights and responsibilities in the context of HIV/AIDS. They were not confident how to negotiate different situations (whether to refuse unsafe or unwanted sex or resisting peer pressure to use alcohol or drugs). They were not having a safe and supportive environment to express their feelings and emotions. They were bearing the loss of their families, identity, and affection. Economic hardships and psycho-social distress were almost faced by all the respondents.

The major findings are as follows:

- All the infected were from the working class i.e. small laborers.
- Social rejection was considered as a big setback to the patients.
- Majority of the patients never heard about the disease before their diagnosis.
- Almost all the respondents were belonged to a socially depressed class of the society.
- Attitude of the educated people towards them was really unethical and quite pessimistic.
- Sixty five percent respondents got the infection from abroad through blood transfusion and illicit sex.
- In most of the cases, wife was observed as a loyal partner of the patients.
- All the patients were economically so week that they were unable to purchase the casual medicine or consult with a doctor.
- The dealings of the doctors with the patients were below the standard of humanity. It seemed that doctors were fearful and reluctant to check them up the patients.
• All the patients were complaining of non-availability of the ARV drugs from market.

Most of the patients were in the shock, they were feeling the sense of deprivation, lack of security and rejection. All the male respondents were unemployed after diagnosis of their status publicly.

6.1.3 Findings of the Discussion with Health Personals

There were twelve health care providers who were interviewed regarding the progressing epidemic of HIV/AIDS. Out of twelve, nine were qualified doctors, one was nursing staff, one was laboratory staff and one was blood bank staff. It was observed that doctors and paramedics were not mentally well-prepared to handle HIV/AIDS patients. They were unwilling to treat them and feeling great fear.

There was no special unit for HIV/AIDS patients in hospitals. Doctors and paramedics were not trained and technically sound to handle the patients. They were having unknown fear in their mind which was a big hurdle to treat them in proper manner.

6.1.4 Findings of the Families Views of the Patients

No doubt, HIV/AIDS is a lethal disease but attached stigma with the disease is more fatal than disease. Its implications destroy the all family bindings and family members hate the patient. The associated embarrassment, distrust, fear, blame and shame with disease made the family members annoyed from the patients. In some cases, only wife was considered as a most sincere member from the whole family.
Due to isolation and rejection of the family, the patients were compelled to change their residences. Children of the patients were the most panelized members of the family; they had to face a lot of psychological stress and strain from the surroundings. Their education was almost stopped. Almost all the families of the patients were indulged in the economic crises very badly. Most of them were unable to meet their basic need of the life.

6.2 CONCLUSION

It is very much apparent whatever have been done up till now against HIV/AIDS for PLWHA and general public are quite insufficient. Females and youth are although less in number among affected people but they are at major risk and are potential future targets of HIV/AIDS. Illiteracy and unawareness is very much prevalent among sufferers. High risk social behavior like unzipped sex work is the major contributing factor among sufferers for transmission of HIV/AIDS. Family setup is not as strong as it should be considered. Religious and moral teachings are not playing their ideal role against this lethal infection.

Overseas citizens are not provided with proper and adequate opportunities to stay with their families. Screening facilities for HIV/AIDS are not only insufficient but also thought to be unreliable at all levels.

Healthy and save sexual practice is lacking in society like use of condoms etc. Prevalence of intra drug users by sharing needle is considerably high, one of the biggest sources of HIV/AIDS transmission.
Health sector is neither adequately equipped nor ideally trained to provide health care facilities to HIV positive patients and is quite expensive. Blood transfusion services are although claimed to be safe but there are still loopholes so that safe blood transfusion is still not totally possible. There are no facilities for psychiatric and psychological support of the diseased and their depressed family members. Stigma, discrimination and social rejection are common in the society.

Unemployment and economic deprivation created serious problems for HIV positive persons. Standards of social, moral and ethical values are set for below than normal expectation for PLWHA and their families.

Media is although working against HIV/AIDS but its role is not as penetrative and effective as it could be. The study established that electronic especially visual awareness can prove more helpful in creating awareness about HIV/AIDS. Government, whatever is doing neither enough nor serious. Probably, government is not anticipating the volcano, which can ruin the whole establishment if not taken care in time.

6.3 Recommendations

This section presents suggested options for policy making and programmatic actions based on the study’s principle, research findings and particularly on the choice available to the persons once they are diagnosed as HIV positive. It has been concluded that HIV/AIDS has adversely affecting the entire individual’s life and consequently the society. So recommendations are divided into seven subheadings.
6.3.1 For People Living with HIV/AIDS

- Provision of accurate and first hand information about contraceptives, safe sex, risk of mother-to-child transmission, antiretroviral therapy; and the consequences of unsafe abortion are necessary for HIV positive women to make informed choices about pregnancy and childbearing.

- Increased accessibility of information to the pregnant women and the couples who are planning for pregnancy regarding HIV/AIDS are needed. The preventive measures against mother-to-child transmission and through breast milk during neonatal period should be observed.

- To establish programs for provision of accurate information about benefits and risks of disclosure that enable HIV positive persons to make informed choice regarding disclosing their HIV status.

- STDs (Sexually Transmitted Diseases) and HIV/AIDS services should be widely available and accessible.

- The social insurance policy for HIV positive persons should be made available to cover their medical care costs. This is very important as HIV positive people face multidimensional problems in addition to HIV including unemployment, rejection and stigma. After declaration of their positive status, patients are surrounded by unhealthy and unwanted environment.

- Develop health service policies and programs designed to provide the equal standard of care and service for all the clients irrespective of their HIV status. For overcoming the financial problems, there should be a proper planning to bear the expenses of their treatment.
• There should be a comprehensive policy for HIV/AIDS patients to continue with their jobs. If it is really impossible, there must be reasonable alternate arrangement for avoiding economic crisis.

• There is a need to increase the availability and accessibility of special AIDS care clinics for HIV positive persons with well-equipped and well-versed health care providers who should be specially trained to take care of such patients.

• To establish conducive arrangements for accessible maternal and family counseling services for the betterment of HIV positive persons.

• Antiretroviral (ARV) drugs at affordable prices should be available.

• There is a need to organize training for HIV support groups; AIDS service organizations, and health care providers to give accurate, comprehensive, up-to-date and easy to understand information on treatment of this lethal disease.

• Arrangements of strong and informative mass media campaign for care and treatment of HIV positive persons should be advocated.

• Provision of safe powdered milk to new born babies and scholarship to school going children of HIV positive persons to facilitate their education is vitally important.

• Provision of medical care and psychosocial support to the concerned individuals and their families on issues such as protecting identity, relocation to a safer place if so required, provision of enabling environment and logistic arrangement should be ensured.
• The assistance that is required from relevant authorities, NGOs, civil society to ensure adequate care and support along with follow up actions should be made available.

• Creation of awareness among HIV positive persons about the availability of voluntary counseling and testing (VCT) will be of paramount importance.

• To educate and create awareness about legal right of marginalized so as to empower them to seek justice and legal protection, for example, women be made aware of their legal rights of inheritance, matrimonial home and maintenance will be an important step addressing the issue of HIV/AIDS.

\textbf{6.3.2 For the General Public}

• Increase access to information related to safe sex, family planning, safe pregnancy and safe abortions as preventive measure for the general population, including adolescents, the elderly and people living with HIV/AIDS should be ensured.

• Increase access to information on voluntary and confidential HIV testing and counseling for the general population should be made available.

• Undertake innovative sex education programs and those designed to address gender issues among male and female adolescents; engaged as well as married couples.

• Provision of intensive education campaign programs for families, communities, schools, workplaces, health service providers and the mass media people so they have clear understanding of HIV/AIDS which can reduce stigmatization, discrimination, and cases of abandonment.
• Raising community awareness and acceptance of HIV positive persons as well as their family members is essentially needed.

• Conduct intensive education campaigns to change attitudes towards use of condom use and the image of condoms as a sign of “caring” should be advocated.

• Provision of information on the prevention of mother-to-child transmission program to all potential mothers is recommended.

• Addressing of myths and misconceptions related with HIV/AIDS to reduce fear and anxiety among general public.

• There is need to provide correct, factual, evidence based information about HIV/AIDS to general public is of key significance.

• There is need to change the social barrier and create the conducive environment for women so that they can negotiate for safer sex practices and to find relevant information easier and even to say “NO” against unsafe sex.

• Ensure protection of sexual and reproductive health rights of all partners including wives of homosexual persons (men who have sex with men), injecting drug users and female sex workers is needed.

6.3.3 For Health Care Providers

• Developing and implementation of firm policy regulation to ensure the confidentiality of HIV/AIDS patients among health care providers and their staff is recommended.

• Provision of specialized training of medical and paramedical workforce in the treatment and care of HIV positive patients should be ensured.
• Providing training programs to health workers for improving communication skills (including body language) to change attitude and increasing awareness about the reproductive rights and choice of HIV positive persons will be an important strategy to address the issue of HIV/AIDS.

• Provision of training in pre and post-test counseling, specialized psychological and psychiatric support should be encouraged.

• Developing and implementation of policy for ethical, safe blood transfusion and careful disposal of hospital waste is advocated.

6.3.4 For the Work Place

• Developing and enforcing regulations regarding the ethical treatment of HIV positive persons within business establishments (Public and Private sectors) are recommended.

• Developing and enforcing policies regarding provision of job security, employment benefits and post-retirement benefits to HIV positive persons in their lives as well as to protect family members and dependents after their death are advocated.

• Developing and implementation of workplace policies as well as undertake training programs for workers aimed at ensuring the secrecy and rights of HIV positive persons will be encouraging step.
6.3.5 For the Mass Media

- Promotion of mass media programs in national as well as local languages aimed at general public to raise their knowledge of HIV/AIDS; rights of HIV positive persons, preventive measures and change of behavior is essentially needed.

- Use of print as well as electronic media extensively for promotion of PLWHA support groups is advocated.

- Provision of briefing to media to ensure that the identity of the concerned HIV positive individual is not disclosed in media reports without his/ her consent is very important.

- A well-designed strategy should be developed for media sensitization regarding all aspects of HIV/AIDS. Mass media should adopt responsible and ethical attitude towards the rights of HIV positive patients. There should be strict instruction to the media people for maintaining the anonymity and confidentiality of HIV/AIDS patients.

- Training programs for media should include session on moral and human right aspects.

- Concrete effort should be made to raise financial and technical resources required for the effective operation of such services. The sustainability of such services should be ensured especially when projects are funded through external resources.

- Ethical review committees should be established to screen HIV related research nation wide.
- The practices related to reuse and disposal of needles and syringes must be studied and appropriate measures should be recommended to check misuse.

6.3.6 **For the Government:**

- Formulation and strict implementation of legislation about preventive measure of HIV/AIDS and rights of HIV positive persons are advocated.
- Allocation and release of adequate funding for effective and comprehensive programs against HIV/AIDS epidemic compatible to social and cultural demands are recommended.
- There is need to establish HIV/AIDS and IV Drug use task forces at federal and provincial levels.
- There should be well-structured frame of work for HIV/AIDS patients. The span of work, duty roaster and working procedure should be chalked out with the consent of health care provider.
- The members of task forces should be made alert and well prepared to manage the civil situation in those districts which are more vulnerable to the HIV/AIDS. They should establish adequate and quick channel of communication among themselves and higher authorities.
- Availability of comprehensive drug treatment and rehabilitation services at district level should be ensured.
- Standard protocols should be developed to ensure that the voluntary counseling & testing (VCT) services meet the specifications.
- There should be legal provision to ensure confidentiality of HIV test result with penal sanction for non-compliance.
• Administrative measures to ensure confidentiality including use of an index or coded number instead of individual's full name when samples are submitted for HIV testing should be taken.

• Government should be committed to tackle the stigma and discrimination associated with HIV/AIDS at the highest level by involving the leadership of the country and ensuring the political will of this leadership.

• Governments of South East Asian countries should go hand in hand against HIV/AIDS as these countries are having the similar socio-cultural background. It is hoped that combined efforts of the region will play a remarkable role.

• Religious instructions must be introduced into school curricula at all levels of education. Mosques and churches should improve their fundamental role in educating society on the issue of safe sex and HIV/AIDS.

• Screening of blood and blood products should be made cheap and reliable at all hospitals blood banks.

6.3.7 Recommendations for Future Studies

In future studies, other implications of HIV/AIDS on society like religious, political and impacts on health care system specifically should be evaluated in details. More over further studies are needed to identify age and gender related implications of HIV/AIDS. For example study with HIV positive men in order to understand their sexual and reproductive decisions, choices, and needs as well as to highest important gender differences and similarities. These studies will also provide important information for AIDS services organizations and policy makers to develop the better set up for patients and their families.
Advance studies should target all aspects of discrimination and stigmas associated with HIV/AIDS and affected people. Studies should be conducted to search for better ways to tackle all associated stigmas with HIV/AIDS. Supplementary studies should be conducted to develop appropriate and innovative educational programs on safe sexual practices, reproductive rights of women, to raise the awareness and acceptance of HIV/AIDS patients in all spheres of society. All those factors which expose a person to high risk of getting HIV/AIDS infection should be explored in future studies.

Further research studied should be planned to investigate in-depth to cope up mechanism and survival strategies that HIV positive men and women employ to facilitate child and family survival. Further research studies should be conducted to disclose the factors that encourage and sustain stigma and discrimination in society.

Moreover, what are the various ways and means by which HIV/AIDS associated stigma impact those living with the virus? How does AIDS stigma impact those involved in providing care, support and other services to PLWHA (e.g. family members, doctors, nurses, social counselors, NGO workers and activists, community workers, researchers, media persons etc)? How does HIV/AIDS stigma differentially impact the marginalized groups in society (women, sex workers, MSM, IDUs, eunuchs)? All these questions should be answered in future studies. Such studies as well as others should use a participatory approach and involve HIV positive persons in all stages of the research process. Intensive training services for the HIV positive persons teams on research methodology and AIDS counseling should be an important part of future studies.
In addition, several research projects should be conducted with the following objectives:

- To develop appropriate, innovative education programs on sexuality and contraception for different target groups, such as the general population, youth and people living with HIV.
- To develop gender sensitization program.

(a) To empower women and make them more aware about their sexual and reproductive rights.

(b) To improve respect for women’s reproductive rights and their access to reproductive services.

- To raise community and family members awareness and acceptance of HIV positive persons.
- To raise health provider’s acceptance of HIV positive persons and awareness of their right.
- To implement the available legal support to HIV positive persons and their families plus identification of potential for new legislation.
- To create better and acceptable working environment for PLWHA with security of all financial rights and after death economic benefits to the affected widow children and other dependent family members.
- To minimize social, economic and psychological implications of HIV/AIDS.
- To enhances the role of religions and ethics in prevention and control of HIV/AIDS and other sexually transmitted diseases.
• To change the attitude of men and women that condom use is a care oriented action not only simply related to disease control.

• To check, the reuse of already used syringes, other hospital equipment, to ensure safe & ethical blood transfusion and control of drug addiction and rehabilitation.

• To identify and eliminate the factors exposing the individuals regarding the high risk of getting HIV/AIDS infection.
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Questionnaire

City: ___________________________  Locality: ___________________________

Date of Interview: __________

Name: _______________________________

1. Age (Years): ______________________

2. Gender: □ Male □ Female

3. Education (Years of Schooling): ______________________

4. Profession: ______________________

5. Religion: □ Islam □ Christianity

6. Place of residence: □ Urban □ Rural □ Slums

7. Monthly income From all sources in Pak Rs.: ____________

8. Marital Status: □ Married □ Unmarried □ Widowed
   □ Divorced
   If married, number of children
   a) Male ______ b) Female _______
   Their ages ___________ ___________
   Number of dependents: _________

9. Visited Overseas: □ YES □ NO
   If yes, how many times _______________
   Which countries/country ____________________________
   Duration of stay ____________________________
   Visited abroad alone: □ YES □ NO
   If no, along with how many family members__________
10. Do you smoke? □ YES □ NO
   □ Frequently □ Now & then □ When need desired
   If yes, how often in a day_________ how many cigarettes___________

11. Do you use any drug? □ YES □ NO
   If yes, please mention the name of drug: ___________________________
   a) Drug for sedation_________ b) Drug for TB.___________
   c) Drug for STD___________ d) Any other______________

12. Do you think? You are suffering from?
   □ Anxiety    □ Hypertension □ Depression
   □ Aggression □ Regression □ Fixation □ Resignation

13. Route of drug use
   I) Oral
      □ By cigarette □ By sneezing □ By inhaling
   II) If inject able then:
      □ Through IM □ Through IV
      If IV, which vain mostly do you use for injection______________

   Do you use drug in the company, with same needle/syringe? □ Yes □ No
   If yes, how? □ Often □ Frequently □ Now & then

14. Do you have any major surgery? □ Yes □ No
   If yes, please mention the name of surgery: ________________

15. Did you have blood transfusion? If yes, please mention the source of blood
donation:
    □ Relatives □ Friends
Purchased from professional  Free blood bank

Were the hospital / place of surgery well-equipped for testing / screening of blood before transfusion?  YES  NO

Did the doctor tested / screened the blood before transfusion?  YES  NO

16. Have you ever visited dentist
If yes?
   a) Examined by qualified dentist  YES  NO

If No, Who
   b) Examined _______________________

17. Do you shave?  YES  NO
If yes, who make your shave?  Yourself  Barber

18. Do you have multiple sex partners?  YES  NO
If Yes, How many: _______________________

Do you use condoms during sex  YES  NO
If yes, who told you? _______________________
If No, please explain: _______________________

SOCIAL

19. Do you live in joint family system?  YES  NO
How many brothers and sisters you have? Brother___ Sisters_____
Has any member of your family are HIV+ ve  YES  NO
If yes,
How it is diagnosed
   Accidentally discovered  Doctor Diagnosed
20. What was the attitude after diagnosis of HIV/AIDS?

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<thead>
<tr>
<th>S/No</th>
<th>Category</th>
<th>(1) Sympathetic</th>
<th>(2) Just Normal</th>
<th>(3) Harsh/Hated</th>
<th>(4) Indifferent</th>
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<td>General Friends</td>
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<td>5</td>
<td>Community members</td>
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</table>

21. Have you changed your residence?  
☐ YES  ☐ NO

If yes, please mention the reason: ____________________________

22. What was the impact on your school going children? How you can describe the treatment of following with your children?

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<tr>
<th>S/No</th>
<th>Category</th>
<th>(1) Sympathetic</th>
<th>(2) Just Normal</th>
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<td>Family Members</td>
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<td>5</td>
<td>Community</td>
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</tbody>
</table>

Psychological
23. How many members of your family deeply shocked after the declaration of HIV/AIDS____________?

24. What was impact on children?
   - Inferiority complex
   - Isolation
   - Sense of deprivation
   - Lack of security & protection

Economics

25. Did HIV/AIDS impact on your earning adversely [ ] YES [ ] NO

If yes, how much____________

26. How increase in much expenditure is on treatment of the opportunistic diseases____________

27. How will you describe the impact of HIV/AIDS on Socio-Economic and psychological life

<table>
<thead>
<tr>
<th></th>
<th>To a great Extent</th>
<th>To Some Extent</th>
<th>Harsh/Hated</th>
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<tr>
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<td>Stress</td>
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28. Do you think that HIV/AIDS is a cause of unemployment of other family members as well? [ ] YES [ ] NO
29. Dependability after death of person/head of family

☐ YES  ☐ NO

Govt. Efforts

30. Are there enough facilities provided to PLWHA by Government?

☐ YES  ☐ NO

31. Are there any screening systems of overseas return at port of entry?

☐ YES  ☐ NO

32. Are you already aware of the disease before the present incident?

☐ YES  ☐ NO

If yes, by which source you got awareness

- Newspapers
- Radio
- Television
- Any others

33. Is there any AIDS help line or any toll free number for HIV/AIDS awareness?

☐ YES  ☐ NO

34. What health care facilities are provided by the Government at work place?

- Casual tests
- Monthly tests
- Biannual tests
- Annual tests