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"Beyond Stigma: Persons Living with HIV/AIDS and Their Problems"

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Background:

Acquired Immune Deficiency Syndrome (AIDS) caused by human immunodeficiency virus (HIV). In India, National AIDS Control and Organization (NACO) is primary concern Governmental agency which is deal with it in phase wise manner. During the all four phases of national AIDS control programme (NACP) concentration has been drawn on creation of amiable environment for persons living with HIV/AIDS (PLHA) by spreading awareness about different aspects of HIV/AIDS, reduction in high risk behaviour, (safe sex, usage of disposable syringes), free test of HIV infection and distribution of Anti- Retroviral Treatment (ART). All these efforts have their own advantage but still, the needs of PLHA are not fully met. They are many changes need to overcome yet, stigma is the biggest one and many others are increasing the problems of PLHA which have not been addressed adequately till date. This situation has been discussed in the paper.

Methodology:

Primary data has been collected from 213 respondents along with some secondary sources. Interview schedule and an interview guide were used as a tool.

Result:

This study reflects that despite the four complete phases of NACP the problem of PLHA has not been addressed in a holistic way. Concentration has been drawn mainly on the medical/clinical background of HIV/AIDS. The level of awareness among PLHA about ongoing programs is not very much good in condition. Particularly female PLHA and PLHA who were residing in remote areas like rural or slum had poor access to awareness. But the condition of PLHA who were well educated, belonging to a sound economic background, a resident of the urban or semi-urban area was also not better and had been found to be dissatisfied with arrangements.

Conclusion:

In the field of prevention and control of HIV/AIDS the role of NACO cannot be ignored. Because of the vigorous effort of NACO, the rate of new HIV infection has declined and in many parts has stabilized almost. This achievement

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does not permit us to ignore the diverse nature of needs, requirements and problems of the existing population of PLHA. In Indian health care system, in terms of a power relationship, PLHA share a subordinate position in which due to the absence of a bilateral interaction and unequal participation, they get less attention. Different nature of their problem has not been given adequate recognition but attention has been drawn on the medical/clinical background of HIV/AIDS. For that social difference, administrative negation is responsible. Therefore PLHA is the victim of poor pathological, biological condition and social arrangements that have victimized them in multiple ways.

Keywords: HIV/AIDS, Stigma, NACO

INTRODUCTION

As per World Health Organizing (WHO), "Since the beginning of the epidemic, more than 70 million people have been infected with the HIV virus and about 35 million people have died of HIV. Globally, 36.7 million (30.8–42.9 million) people were living with HIV at 2016." According to UNAIDS report 2013, India has the third largest HIV infected population.Although this figure seems quite small in front of the figures of countries like Thailand and African countries that have the largest number of PLHA. But, at the same time, in in our nation during 2013- 14, estimated 130,000 people have died from AIDS related illnesses.Surprisingly 57 percent slowing down in new HIV infections during 2000-11 and 29 percent decline in AIDS-related deaths during 2007-11 was also evidenced. Variation in HIV/AIDS related data according to geography is a very common thus responses against HIV/AIDS should also be flexible and effective as per changing socio-cultural and demographic circumstances.

During the early phase of infection in India, after knowing the mode of HIV infection, a high-powered committee was constituted under the Ministry of Health and Family Welfare, Government of India to handle HIV/AIDS related surveillance among the High-Risk Groups, screening of blood transfusion and monitoring of HIV/AIDS related Information Education and Counselling (IEC) material. After a brief gap, 1992 the first phase of National AIDS Control Program (NACP) was stared under NACO. This initiative can be acknowledged as the first institutionalized response against HIV/AIDS in which concentration was made on preventive activities, promotion of IEC material, blood safety measurement, safe sex, usage of disposable syringes and strengthening of clinical services. To slow down the increase of HIV infection and to control the AIDS deaths, the first phase of NACP was extended for next five years when issues like licensing of the blood bank, banning on the professional blood donation, collaboration with civil bodies and arrangements of ICTC were managed. At same time administrative responsibilities and resources were decentralized between the states and centre.

The second phase of NACP stated in 1999 with the help of WHO, World Bank and UNAIDS. When on the basis of the difference between prevalence rates, states in India were categories into high, moderate and low categories. Bringing down the rate of newly positive people below 5% through focusing on behaviour change strategy was the main concern at that time when poor attention was drawn on an awareness campaign. To achieve this target, the targeted

intervention was made among high-risk groups and bride population like Female Sex Workers (FSWs), Men who have Sex with Men (MSM), Injecting Drug Users (IDUs) and clients of sex workers. That time Anti-Retroviral Treatment (ART) and Prevention of Parent to Child Transmission (PPTCT) got a fresh attention along with the introduction of technical and managerial support to state AIDS control society (SACS) to ensure their quality of service.

The third phase of NACP begun in 2007 with the goal to halt and reverse the epidemic in India in next 5 years. Hence fund was increased for NACO. Key targets of this phase of NACP were to prevent new infection among the High-Risk Groups and the people other than such groups. For that infrastructure was maximized in the field of care, support, treatment and human resources. Also to bring the national output under a single roof, national strategy information system was established under Department of AIDS Control. Now the fourth phase of NACP had begun along with the 12th five-year program. The main objectives of NACP four were the reduction of new infections by 50 per cent. Extension in care, support & treatment of PLHA and intensified, consolidated prevention services for high-risk groups. The vulnerable and general population was added once again in this phase of the program. Also, the extension was made in the field of IEC services in which the main focus was drawn on behaviour change strategy.

After a brief discussion, we got that NACP moved from centralized to the decentralized sphere in which various intervention programs and administrative experiments were made. Of such experiments, some of them were directly related to the welfare of PLHA. For example, condom promotion for prevention from the sexual transition of HIV and its free availability were arranged, simultaneously subsidy was provided on commercialized brands of the condom to increase their affordability among common people. For this purpose, social marketing was initiated and help was taken from different peer groups while condom vending machines were installed at the different locations also. During the same period, the initiative was taken for introduction of the female condom, to see the increasing number of FSW across the nation. Availability of safe blood was managed by improvement of infrastructure of blood storage units, blood banks and bringing them under licensing authority and regulation. Because of constructive efforts of NACO, in India, more than 5000 counselling and testing centres are working now that are mainly located in government hospitals and healthcare units which give their services to more than 2-3 million people. To increase effectiveness of patient care, under NACP-III, VCTCs was merged with antenatal treatment services and

tuberculosis, hence Voluntary Counselling and Testing Centre (VCTC) became Integrated Counselling and Testing Centres (ICTC). These units are very active in voluntary counselling & testing services, information about preventive steps related to HIV/AIDS and referral services. Extension of this service is also known as Prevention of Parent to Child Transmission of HIV/AIDS (PPTCT) which started in 2002. Along with above given arrangements the non-governmental and community based organizations were motivated for the care and support of PLHA for home-based care.

On the basis of the review of literature, we can say that the problems of PLHA are not uniform everywhere but tend to be heterogeneous because of which, despite a massive prevention

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and control program the situation is not very favourable. UNAIDS says that in the largest regions of the world where the prevalence rate of infection is high, around 9.5 million people immediately need life- saving drugs (ART) but only half of them – approximately four million manage to get them. Also, global deaths of 2 million people per year by HIV/AIDS have been recorded which is needed to be controlled. Even in our nation, the current situation of PLHA is still critical because the main activities of NACO move around specific points like awareness regarding HIV/AIDS, promotion of the use of condoms among the sexually active population to control the transmission of HIV, distribution of ART and behaviour change strategies. These arrangements do not address diverse problems and their weaknesses are quite glaring. For example, it is well known that ART is useless for the people who are only affected and are not living with the virus but are the family members of an infected person and also that a child is unable to protect himself/herself from the virus. The behaviour change strategies can't solve the problems like school dropouts, economic insecurity, loss of rearing & caring hands and absence of home care. Awareness campaigning has its own limitations in creating enabling environment for PLHA because print or electronic material promoting awareness has no value for poor, illiterate PLHA. Hence, in this paper, an effort has been made to assess the satisfaction points of PLHA in terms of facilities and services provided by NACO. Further enquiry has been made in the context of variables like sex, education, income and location of residence which directly affect the satisfaction level of PLHA.

METHODOLOGY

For primary data collection, drop-in-centre, community based care centre and other primary institutions situated in tri-city comprising Chandigarh, Mohali and Panchkula have been selected. Information was gathered from 213 respondents (male/female) using purposive sampling method with informed consent. Interview schedule and an interview guide were used as a tool. All respondents have been divided into six educational categories, five income groups and four residential locations to see the distribution of respondents. During this procedure, the focus was drawn on the observation of the gestures and body language of respondents to grab the hidden realities. For secondary data, help was taken from the publications, official records and documents of NGOs, CBOs, NACO, UNAIDS, electronic, print media and other international, national and regional bodies.

RESULTS

Availability of ICTC/ FICTC Close to Home

ICTC/FICTC provides clinical facilities and socio-psychological support to PLHA without any charges, which also performs the role of a mediator between PLHA and NACO/SACS/health care system. In our pilot study, it came to light that many people do not visit such centres due to different reasons like stigma, shortage of time and employability etc. Among such reasons, inaccessible locations (very far from residential areas) of these units have also been identified. To get the empirical proof of this situation, we asked all our respondents if there is any ICTC/FICTC nearby their homes.

From Table 1, we learn that out of the 213 respondents only 46 (21.6%) said that the

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ICTC/FICTC is located near their homes while a very large proportion of as many as 167 (78.40%) respondents have answered that there is no ICTC/FICTC near their residences.

Table 1 Availability of ICTC/FICTC Close to Home

Responses					
Available	%	Unavailable	%	Total	%
46	**21.60**	**167**	**78.40**	**213**	**100**

An analysis of this variable in terms of sex, educational qualification and income was not deemed necessary as accessibility to the ICTCs is not directly associated with or affected by either the sex, educational or income levels of the respondents but is a matter of administrative concern. However, there is a direct relation to this issue with the residential location of a person, which we have analyzed further.

Residential Area Wise Availability of ICTC/FICTC

Table 1.a Residential Area Wise Availability of ICTC/FICTC

Residential Area	Responses		
	Available (%)	Unavailable (%)	Total (%)
Rural	**4 (8.70)**	**40 (23.95)**	**44 (20.66)**
Semi- Urban	**12 (26.09)**	**40 (23.95)**	**62 (29.11)**
Slum	**6 (13.04)**	**49 (29.34)**	**55 (25.82)**
Urban	**24 (52.17)**	**28 (16.76)**	**52 (24.41)**
Total	**46 (100)**	**167 (100)**	**213 (100)**

From Table 1.a, Residential location wise analysis shows expected results, as of those 46 persons who do have ICTC/FICTC available near their homes, 24 (52.17%) come from urban areas and 12 (26.09%) from semi-urban areas whereas those living in slums and rural settings are very few 6 (13.04%) in number.

Awareness about the location of ART Centre (Medical Facility)

The role of life-saving drugs in the case of HIV/AIDS is a proven fact as they increase the length of the life of the infected person. According to UNAIDS report 2008, only 42% of the total global population of PLHA is getting ART while every year 2 million AIDS patients die due to unavailability of life-saving drugs.

From the initial phase of HIV infection in India, the distribution of ART was started at the selected locations and institutions in a centralized form. In this system, doctors perform the role of an administrator while the experts of different fields work under them. In view of the rising rate of PLHA in surrounding states/Union Territory of Chandigarh, ART centre has been established in the Post Graduate Institute of Medical Education and Research Chandigarh, commonly known as PGI, from where across the region, PLHA visit and take advantage of medical assistance. But whether or not all PLHA of the region get ART or know the exact

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location of the centre, where it is available, is the important question. Hence, we asked our respondents whether or not they know where ART is available in their city/region.

Table 2 Awareness about the Location of ART Centre

Responses				Total	%
Aware	%	Unaware	%		
153	71.83	60	28.17	213	100

Table no. 2 tells us that of the 213 respondents, overall a vast majority of 153 (71.83%) were aware of the existence of the ART centre and 60 (28.17%) knew nothing about it. Thus, although it is heartening to learn that a large number of PLHA in our sample are aware of the existence and location of the ART centre, still almost 30% are ignorant of the fact. For better result in this direction bilateral steps are expected from the society and administration. For example, recently ART centre has been set up in the GMCH-32 of Chandigarh. Such types of steps are needed to be taken in the other part of this country by establishing such units at the different location.

Gender Difference in Awareness about the Location of ART Centre

Table 2.a Gender Difference in Awareness about the Location of ART Centre

Sex	Responses		Total (%)
	Aware (%)	Unaware (%)	
Male	117 (76.47)	13 (21.67)	130 (61.03)
Female	36 (23.53)	47 (77.33)	83 (39.97)
Total	153 (100)	60 (100)	213 (100)

According to Table 2.a, a majority of nearly 76% of males have claimed that they know the location of the ART centre while very few (only 23%) women are aware of the same. On the other hand, the percentage of women unaware of this information is much higher than their male counterparts. The difference in Awareness About the location of ART Centre based on Educational Qualification.The analysis of responses in terms of their educational qualifications throws up very interesting results.

Table 2.b Awareness About the location of ART Centre based on Educational Qualification

Educational Qualification	Responses		Total (%)
	Aware (%)	Unaware (%)	
Uneducated	28 (18.31)	35 (58.33)	63 (29.58)
Primary Educated	38 (24.84)	16 (26.67)	54 (25.35)
Matriculate	40 (26.14)	6 (10.0)	46 (21.60)
Intermediate	18 (11.76)	3 (5.0)	21 (09.86)
Graduate	15 (9.80)	0 (00)	15 (07.04)
Post Graduate	14 (9.15)	0 (00)	14 (06.57)

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Total	**153 (100)**	**60 (100)**	**213 (100)**

From Table 2.b it appears that of the 153 persons who are aware of the existence of the ART centre, it is those with either no education at all or those with very basic education, who show greater awareness of the medical facilities. While respondents with graduate and postgraduate degrees seem to be less aware of the existence of ART centres. An in-depth investigation proved that during the phases of counselling it is usually the counsellor of the concerned ICTC/FICTC who enlightens the positive patients about the availability of ART. But in many cases, the positive persons do not come for post counselling. Hence, neither do they collect their test reports nor do they become aware of the availability of ART centres and the importance of such drugs. Also, this medicine is started as per the number of CD4 cells. In many cases, ART is not stared due to the presence of an adequate number of CD4 cell in the body of an infected person. Hence, the positive person is not guided about this facility. So it is possible that the CD4 cells among the graduate and postgraduate respondents might not have been below as per the guidelines to start ART hence they were not found to be aware.

Consequently, they were not counselled about such services. But ignorance of this issue among the positive persons is a very risky proposition and information regarding it should always be disseminated to the PLHA from day one. Awareness About the location of ART Centre: Income Wise Analysis

An income wise analysis of respondents showed unexpected results. We find that it is those who fall into the lesser income groups who from a majority of those who are aware of the existence of the ART centre. Those with incomes between Rs. 20001/- and Rs. 40000/- form a minority among the aware respondents.

Table 2.c Income Wise Distribution of Respondents on Awareness about the Location of ART Centre

Monthly Income	Responses (%)		Total (%)
	Aware	Unaware	
Up to Rs. 10000	74 (61.16)	9 (42.86)	83 (58.45)
Rs. 10001-20000	26 (21.49)	5 (23.81)	31 (21.83)
Rs. 20001-30000	10 (8.26)	7 (33.33)	17 (11.97)
Rs. 30001-40000	11 (9.09)	0 (00)	11 (7.75)
Total	121 (100)	21 (100)	142 (100)

As it is mentioned, ART is required when the CD4 cells of positive persons decrease below 250. But this does not happen if one has good health and balanced lifestyle followed by a good diet and exercise, which depends a lot on income. For example, those who have the better economic condition can purchase nutritious food and medicine. Thus, it makes sense to see that the PLHA from higher income groups have better health in general and do not need ART treatment while the opposite is true for the lower income groups. Obviously then, the lower

income groups become more aware of the existence and location of ART centre due to their need for this treatment. Awareness about the Location of ART Centre: Residential Location Wise Analysis In terms of residential location, it appears that among the 153 respondents showing awareness of the existence of the ART centres, a large proportion of those living in urban (33.99%) and semi-urban (40.52%) areas have reported that they are aware of the ART centre of their city, while respondents from rural and slum areas do not show high figures in this regard (13.73% and 11.76%, respectively). It means awareness about the location of the ART centre is poor among the respondents of

Table 2.d Residential Location Wise Distribution of Respondents on Awareness about the Location of ART Centre

Residential Location	Responses		Total (%)
	Aware (%)	Not Unaware (%)	
Rural	21 (13.73)	23 (38.33)	44 (20.66)
Semi- Urban	62 (40.52)	0 (00)	62 (29.11)
Slum	18 (11.76)	37 (61.67)	55 (25.82)
Urban	52 (33.99)	0 (00)	52 (24.41)
Total	153 (100)	60 (100)	213 (100)

backward locations such as rural areas and slums. It thus, appears that the PLHA from these areas do not visit these medical centres, which is not a good sign as these are the areas where now HIV/AIDS is spreading very fast.

After conducting this analysis it has been realized that in this study the awareness of respondents regarding the site of the ART centre is much influenced by the factors like gender and location of respondents than the other factors like income and education.

Awareness about Services Provided by NACO

Since 1987 various arrangements have been made in India as the response to HIV/AIDS. About such efforts, comprehensive explanation has been made in National AIDS Control Program (NACP) which has completed three phases and now the fourth is going on. Popular activities of NACO revolve around awareness campaign, distribution of ART, behaviour change strategies, counselling, free testing of HIV and free distribution of condoms among sexually active people. Awareness of PLHA about all these ongoing facilities and arrangements can promote their rehabilitation in society, personal and public life. But it has been found that usually, the weaker sections that lack awareness about the different arrangements or intervention plans become the prominent victims of HIV infection.

Table 3 Distribution of Respondents on Awareness about Services Provided by NACO

Responses				Total	%
Aware	%	Unaware	%		

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74	**34.74**	**139**	**65.26**	**213**	**100**

Hence, the awareness about these programs has been assessed in given table asking our respondents whether or not they know about all the arrangements made for them. From Table Number 3 it has been clarified that out of total 213 respondents only 74 (34.74%) have replied that they are aware of the various arrangements made for PLHA, while a very large number, 139 (65%) have answered that they don't know anything about such arrangements. Clearly then, a large majority among our respondents is not aware of the facilities available to them in their status as PLHA.

Awareness about Services Provided by NACO: Sex Wise Analysis From Table 3.a it is clear to us that the male respondents are much more aware of the arrangements made for PLHA in their city as compared to the women as of the 74 aware persons 82.43% are male while only 17.57% are females. Thus, the awareness level of the men is greater probably because they have better opportunities to get an education and avail the benefits of the information system.

Table 3.a Sex Wise Distribution of Respondents on Awareness about Services Provided by NACO

Sex	Responses		Total (%)
	Aware (%)	Unaware (%)	
Male	61 (82.43)	69 (49.64)	130 (61.03)
Female	13 (17.57)	70 (50.36)	83 (39.97)
Total	74 (100)	139 (100)	213 (100)

Awareness about Services Provided by NACO: Educational Qualification Wise Analysis Educational qualification wise analysis in Table 3.b shows that the awareness level of respondents, who are uneducated or have studied up to only primary level, is dismal as all of them have replied that they don't know anything about these arrangements made for them in their city. On the other hand, all of the respondents who are better educated are aware of such arrangements. Interestingly, however, it is not the graduate or postgraduate respondents who show greater awareness but those with intermediate and matriculate qualifications.

Table 3.b Educational Qualification Wise Distribution of Respondents on Awareness about Services Provided by NACO

Educational Qualification	**Responses (%)**		**Total (%)**
	Aware	**Unaware**	
Uneducated	**0 (00)**	**63 (45.32)**	**63 (29.58)**
Primary Educated	**0 (00)**	**54 (38.85)**	**54 (25.35)**
Matriculate	**27 (36.49)**	**19 (13.67)**	**46 (21.60)**
Intermediate	**18 (24.32)**	**3 (2.16)**	**21 (09.86)**
Graduate	**15 (20.27)**	**0 (00)**	**15 (07.04)**
Post Graduate	**14 (18.92)**	**0 (00)**	**14 (06.57)**

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Total	**74 (100)**	**139 (100)**	**213 (100)**

But overall from the table it becomes clear that education does play a role in creating awareness regarding provisions made for PLHA, as among those who have no awareness of HIV/AIDS related facilities, the largest proportion of respondents are either uneducated (45.32%) or have had only primary level education (38.85%).

Awareness about Services Provided by NACO: Income Wise Analysis

From Table 3.c it becomes obvious that of the 213 total respondents 71 (33.33%) did not disclose their income. Hence, all income wise analysis in this chapter would be done keeping in view the 142 respondents who revealed their earnings. The data show that the awareness regarding facilities available for PLHA among the respondents earning up to Rs.10000/- is quite low as less than 23% of them showed any knowledge regarding these services. The situation is slightly better among the respondents in the other income categories as 20 (32.26%) of those in the Rs.10001- 20000/- category and 17 (27.42%) from the Rs.20001-30000/- category do show some awareness regarding this issue. But surprisingly, only 11 (17.74%) from the income category of Rs.30001-40000/- have shown such awareness. Thus, no clear picture emerges when we look at the awareness of PLHA in terms of their incomes. But things become clearer when we see that of the 80 persons who are not aware of the facilities for PLHA, the largest proportion (86.25%) comes from the lowest income group while no person in this category comes from the higher income respondents.

Table 3.c Income Wise Distribution of Respondents on Awareness about Services Provided by NACO

Monthly Income	Responses		Total (%)
	Aware (%)	Unaware (%)	
Up to Rs. 10000	14 (22.58)	69 (86.25)	83 (38.97)
Rs. 10001-20000	20 (32.26)	11 (13.75)	31 (14.55)
Rs. 20001-30000	17 (27.42)	0 (00) 17	(07.98)
Rs. 30001-40000	11 (17.74)	0 (00)	11 (05.16)
Total	62 (100)	80 (100)	142 (100)

Awareness about Services Provided by NACO: Residential Location Wise Analysis

From Table 3.d it becomes clear that the proportion of aware respondents from urban areas is much higher than those who live in other locations. We found that among the 74 respondents who had some awareness regarding the facilities for PLHA, 36 (48.65%) came from the urban areas, 18 (24.32%) respondents came from semi-urban areas, 11 (14.87%) came from rural areas and only 9 (12.16%) came from slums. Thus, the poorest awareness is found among the respondents living in slums.

Table 3.d Residential Location Wise Distribution of Respondents on Awareness about Services Provided by NACO

Residential Location	Responses		Total (%)
	Aware (%)	Unaware (%)	
Rural	11 (14.87)	33 (23.74)	44 (20.66)
Semi-Urban	18 (24.32)	44 (31.65)	62 (29.11)
Slum	9 (12.16)	46 (33.1)	55 (25.82)
Urban	36 (48.65)	16 (11.51)	52 (24.41)
Total	74 (100)	139 (100)	213 (100)

DISCUSSION

NACO is considered the prime apex agency working in the field of HIV/AIDS control and prevention whose state level units are called State AIDS Control Societies (SACS) that exercises control on the district and sub- district units. Till date, NACO has completed three phases of the National AIDS Control Program (NACP) and the high impact of this agency has been highlighted and lauded by various agencies. However, after our field experiences, it seems that the efficiency and effectiveness of NACO have been overestimated. Most of the activities of NACO follow traditional styles to address the situations. Moreover, nearly 50-60 per cent of NACO funds is used for awareness campaigns which are either not useful to PLHA or have very limited utility for them as the PLHA need physical, vocational and psychological rehabilitation that is not achieved by such events and activities. In addition, the bureaucratic setup of this agency has also been criticized. In spite of this the tremendous effort of NACO in the field of response to HIV/AIDS cannot be ignored because due to the extensive effort of this agency the prevalence rate of HIV has almost stabilized or has declined, guarantee of the transfusion of safe blood has become possible, people have started realizing the importance of condom for prevention from HIV infection. This is the effort of NACO which has mobilized the population to discuss this issue in public domain.

The services related to HIV/AIDS for PLHA start from counselling Centres popularly known as Integrated Counselling and Testing Centres (ICTCs)/Facilitated Integrated Counselling and Testing Centres (FICTC). At such places arrangement are made for counselling and free HIV tests under a team containing professionals of the different field. When the person is identified to be HIV positive after different phases of clinical trials, he/she is attached with the Antiretroviral Therapy (ART) centre, where the life-saving drugs are given as per the guidelines and count of CD4 cells. Hence, this is the prime duty of administration to introduce and popularized such facilities among the people to halt the effects of HIV/AIDS on human body and society.

After conducting this study it has been realized that in this study the awareness among respondents regarding the site of the ART centre is much influenced by the factors like gender and location of respondents than the other factors like income and education. Hence there is a need to decentralized this service by introducing them among the localities of the infected population. By that PLHA can be facilitated and empowered without disclosing their identity.

CONCLUSION

In power relationships, PLHA shares a subordinate position in which due to the absence

of a bilateral interaction and unequal participation they get less opportunity to be the agent of their own welfare. Despite the four popular phases of NACP and various massive steps the problems of PLHA could not be solved at the holistic level. Attention has been given mainly on the medical/clinical background of HIV/AIDS. In this study, we got that the level of awareness among PLHA about ongoing programs is poor particularly in female and who are residing in rural or slum areas. But overall we got that condition of PLHA who were well educated, belonging to a sound economic background; a resident of the urban or semi-urban area was also not good. For that social difference, administrative negation is reasons because of that PLHA have not achieved equal participation in the arrangements made for their betterment. So they are the victim of poor pathological, biological condition, unfair social arrangements, representation and participation.

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