

CHAPTER IX

CONCLUSIONS AND POLICY IMPLICATIONS

9.1 CONCLUSIONS

This thesis is based on a primary research survey of 401 HIV positive individuals in Pune city and sub urban area, conducted in order to investigate the impact of HIV infection at the various dimensions (social, economical and psychological) at household and individual level. HIV affects not only the individual living with HIV, but also the life of the entire household economically, socially and emotionally. HIV poses a significant development challenge to developing and poor nations of world. Detrimental impact of HIV infection at macro and micro level is already felt in Sub-Saharan African Region (SSAR), which accounts sixty-eight percent of total HIV infection all over the world (UNAIDS). However, a country like India with low HIV prevalence in country as a whole and high absolute number of people living with HIV (because of population size), at macro level impact of HIV infection is not much visible. But it leads to hazardous consequences to household economy. In India, 2.4 million people were living with HIV in 2009 and 0.17 million died due to HIV related illness. In the South-East Asian Region (SEAR) India at large accommodates sixty percent of people living with HIV. In India, like any other country of world, HIV infection was first reported in groups of society living at marginal ends, considered to be high risk groups. It was believed to be the problem of someone else. With the passage of time, HIV infection through the bridge population has surpassed caste, creed, region, gender, economic, race and religion barriers in India. HIV cases are reported from all states of India; however, the majority of cases are concentrated at Southern and North-eastern end of nation. In India, eight-five percent cases of HIV are believed to occur due to unsafe sexual practices and more than half of India's population is young (15-49 years), considered to be at escalated risk of HIV. Twenty-six percent of total population is living below poverty line, a group of society which is most economically vulnerable and destitute to information, education and awareness. In the urban region, slum dwellers and their health priority is closely associated with HIV infection. Taking into consideration these mentioned facts, it was realized that in India, economic and social conditions of households with people living with HIV is not much explored. In recent years, initiatives have been taken by some research

institutes and international bodies to assess socio-economic impact of HIV in India. In these initiatives, in 2003, International Labour Organization (ILO), in collaboration with networks of people living with HIV conducted a study to assess socio-economic impact of HIV/AIDS on people living with HIV/AIDS and their families in Delhi, Maharashtra, Tamilnadu and Manipur. In 2005, United Nation Development Programme (UNDP), along with National Council of Applied Economic Research (NCAER) and National AIDS Control Organization (NACO), conducted a study in six high HIV prevalence states of India (Tamilnadu, Karnataka, Andhra Pradesh, Maharashtra, Manipur and Nagaland). These studies were focused on general population rather than groups of population at high risk. However, in majority of studies, major emphasis is still on groups of society at high risk. This thesis particularly, emphasizes the needs of households of people living with HIV, their socio-economic conditions and consequences of HIV at household level and psychological and emotional wellbeing of PLHIV to live a healthy life.

In this thesis, an attempt is made to explore multifaceted issues related to HIV infection, affecting various dimensions of life of household in general and an individual in particular. Specifically the objectives of the thesis were:

1. To assess the background characteristics of households with PLHIV.
2. To examine / assess the economic burden of HIV infection at household level.
3. To examine the differentials in the economic burden at different stages of HIV infection.
4. To acquaint with coping up strategies.
5. To assess the impact on the social status of the household in general and HIV positive individual in particular and impact on the quality of life enjoyed by PLHIV.

These are the specific objectives of the thesis, which are explored / assessed empirically in the different chapters of the thesis. This thesis is divided into nine chapters. Introductory chapter, comments on the rationale and specific objectives of the study apart from commenting on the different dimensions of HIV infection. Trends and latest estimates of HIV infection in world, Asia, India and different states is explored in Chapter II of the thesis. Chapter III of thesis throws light on the voluminous literature on HIV/AIDS and its impact on different sections of society. Chapter IV articulates the methodology adopted to conduct primary research survey in Pune city among households with PLHIV. The economic profile of PLHIV with a

range of impacts of HIV infection on household was assessed in Chapters V and VI. Social implications of HIV infection are clearly demonstrated through stigma and discrimination against PLHIV at various levels (family, neighbourhood, workplace and health facilities) in Chapter VII. Further, probability of acceptance of PLHIV within the family is also observed. Implication of HIV at emotional and psychological ground is assessed in Chapter VIII. Chapter IX suggests some policy implications in the light of current policies and intervention strategies.

Introduction begins with highlighting the problem of HIV from social and economic dimensions and discusses the specific objectives of study in detail. Preliminary investigation comments on the rationale for the study and multifaceted aspects of HIV infection.

Next an attempt is made to analyze the trends in the HIV epidemic world at large. The latest estimates of HIV/AIDS, people living with HIV, prevalence of HIV and deaths due to HIV related illness in the world and different regions of world are important indicators of the trend of HIV pandemic. An attempt is made to accentuate detailed analysis of situation of HIV in Asian region and India. Indian estimates of HIV infection, AIDS cases and HIV prevalence discussed with specific consideration to Maharashtra state. Maharashtra is one of the high HIV prevalence states in India. National Family Health Survey (NFHS-III, 2005-06), found an infection rate of 0.62 percent in the general population of Maharashtra. Latest estimates of NACO found 0.55 percent (0.44-0.71) estimated adult HIV prevalence in Maharashtra in 2009 and 419,789 people were estimated to be living with HIV in Maharashtra in 2009. Mumbai, which is the capital of Maharashtra, accommodates most of the cases of HIV. Pune is another mega city of Maharashtra and Pune district is one of the high HIV prevalence districts in India. Majority of cases in Pune district are concentrated in Pune city and Pimpri Chinchwad Municipal Region (PCMC). NACO estimates show 0.5 percent HIV prevalence among ANC attendees in Pune urban in 2007. Pune ranked among top five HIV prevalence cities in Maharashtra state. The official figure reported that Jan-Oct 2007, 18,039 people in the city were tested for HIV at government testing centers. Of these, 12.27 percent tested positive for HIV. These figures exclude the thousands of people already living with HIV in the city, along with those who are yet unaware about their HIV status. High HIV prevalence among HRG in Pune (23.6 % among MSM and 50% among FSW who were tested for HIV, NACO) also poses a serious threat to development aspect. These facts and figures

emphasize the careful analysis of needs, aspirations and socio-economic conditions of people living with HIV in a high HIV prevalence setup like Pune city. Considering these facts, various studies conducted in the past on socio-economic dimensions of HIV infection were explored and extensively studied during the course of this PhD endeavor.

An effort to explore the initiative of different organizations and government to address social and economic conditions of PLHIV is made. A huge amount of literature is available on different aspects of HIV/AIDS. HIV/AIDS literature reveals clearly that HIV/AIDS is basically a social problem. However, once this problem occurs and people start getting affected, it crosses its boundary of social and cultural routes and gradually enters into Bio-medical researches for the purpose of some treatment by using the latest medicines which are available but very costly. In India, studies related to general population and impact of HIV infection at household level is limited in number and recently, some international bodies in collaboration with national research bodies came forward to study the impact of HIV infection in India. In this aspect, a study by Pradhan (Pradhan *et.al.* 2006), is a prominent one. This study is also taken as a benchmark for our study. Before that ILO (ILO, 2003) studied the socio-economic impact of HIV at family level. A. Mahal and B. Rao (2005) gave an overview of economic perspective of HIV/AIDS epidemic in India. This review gave a hunch of economic impact of HIV at household level in India. This thesis, has added to an expanding literature on HIV/AIDS and economic wellbeing of PLHIV households. It is a contribution to limited empirical studies with respect to India, which is the third most populous nation, where people living with HIV reside. Hence, it could be modestly claimed that this thesis is an important contribution to literature on HIV/ AIDS, socio-economic consequences of HIV and psychological and emotional implication of HIV infection. Considering the fact of limited number of studies in India, particularly related to general population, this study is based on a primary research survey of households with HIV positive members.

The methodology adopted to assess socio-economic conditions of PLHIV in Pune city is discussed next in the thesis. A detailed discussion was made on the criterion based on which the sample is drawn, research tools used, data entering, editing, analysis and background characteristics of HIV households and PLHIV individuals. To conduct a study on this topic both quantitative and qualitative methodologies were applied. Household survey could be conducted at community level or from the direct sample

of people living with HIV/AIDS. Looking at the level of prevalence, it was not possible to conduct community level study. Hence, a survey was conducted on identified people living with HIV/AIDS. Network of Maharashtra People Positive (NMP+), a state level organization was contacted and consent was obtained after taking into consideration of all ethical issues involved. District level Network of NMP+ was contacted to get the list of PLHIV registered till December 2007. Out of total fourteen hundred enrolled with DLN, four hundred adult PLHIV were selected on the basis of two dimensions- average monthly household income and CD4 count. Four hundred and one PLHIV individuals were contacted and interviewed in the time span of six months. On the basis of interview schedule, information was collected on economic aspects, social aspects of life of household in general and emotional and psychological aspects of life of HIV positive individual in particular. Statistical analysis and econometric tools were applied to get a better insight to the issue concerned.

Next an attempt is made to estimate economic profile and consumption pattern of households with people living with HIV. In order to analyze the socio-economic well-being of HIV household, a wealth index based on the principal component analysis was constructed. Wealth index depicts the possession of durable goods and access to basic amenities to the household. Similarly, standard of living index based on the weight given to individual durable goods and basic amenities was constructed as an alternative measure of socio-economic status. The economic differentials were analyzed among HIV households and compared with Pune urban Households (RCH-III), on the basis of these two indices. It was evident that economically, general Pune urban households are better off than that of HIV study group households. HIV households are more disadvantageous than Pune Urban Households. Forty percent of HIV households are categorized as poorest, whereas as per RCH-III, merely 4.6 percent are categorized as poorest among Pune urban households. This marked difference is visible in SLI categories as well.

It is evident from the analysis that female headed household in general and HIV positive female headed household in particular are economically and socially more destitute than their male counterparts. More than 90 percent of female headed households are categorized below middle category of socio-economic status and about 85 percent of female headed households are categorized as poorest/poor household as per wealth index score categories of socio-economic status. On the contrary, around

30 percent of male headed households are categorized as poorest as per wealth index score categories of socio-economic status. HIV positive female headed households are most socially and economically vulnerable. A mere, one percent of them reach the rich wealth index score categories of socio-economic status compared to 10 percent in HIV negative female headed households and 5 and 11 percent in case of HIV positive and negative male headed households respectively. This is particularly important, to identify the needs and to draft intervention strategies. In a patriarchal society like India, where women are more socially and economically deprived, HIV infection further escalates their vulnerability and condition. Secondly, similar differentials were observed as per the headship of household. Difference in pattern and level of consumption between HIV households and that of an average Urban Maharashtra household is depicting the economic condition of HIV households due to HIV infection. It was evident that HIV households spent more on medical care than that of an average urban Maharashtra household. In the households studied nearly 10 percent of total consumption expenditure is devoted to medical expenditure as compared 5 percent for Maharashtra Urban non HIV HHs (UNDP, 2005) and 6 percent as per the sample from NSS urban Maharashtra. HIV households spend more on food items than non food items as compared to general urban Maharashtra HH. This is because of frequent ailments and HHs have to cope mostly with the medical expenses related with HIV related illness on their own, because of lack of any social security scheme or support from government. Out of pocket spending on health care, puts extra burden on the limited resources of HIV household.

HIV/AIDS has bearing on the economic wellbeing of the household. Economic burden of HIV related illness analyzes economic impact and impoverishment due to HIV related illness. Frequent illness associated with HIV infection can undermine livelihood and contribute to impoverishment. It becomes catastrophic for certain households and pushes many households into poverty. Secondly, it has bearing on the intensity of poverty among already defined poor households. Hence, it leads to Medical Poverty Trap. Most of the PLHIV rely on private doctors or private health care to seek treatment for non- hospitalized and hospitalized ailments, leaving spending a high amount on health care. This is because of feeble public health care facilities. Another dimension of economic consequences /economic burden of HIV related illness is investigated by applying methodology adopted by World Health Organization (WHO), expert group in defining and analyzing the distribution of

health payments and catastrophic OOP health spending. On the basis of that methodology, it was observed that, 10 percent of total HIV households were incurring the catastrophic OOP health spending. The average monthly household health payments (Private, public institutional and HIV, non HIV health care spending) were Rs. 426. Households with symptomatic and asymptomatic HIV stage of an adult member of household, spent more than that of household with an adult member having AIDS symptoms. It may be attributed to increase the life span of PLHIV individual in the household who does not have AIDS related symptoms. Individuals with visible AIDS conditions have very limited life span, so it is quite possible that household decision maker becomes neutral to spend on medical expenditure of that individual. Household health payments were 9.6 percent of the total (including food and non food) household expenditure and 16.2 percent of capacity to pay (effective income). Incidence of catastrophic health payment was higher among households, with a symptomatic HIV infected adult member.

Next, an attempt is made to assess the impact of OOP health payments on the impoverishment among HIV households. Based on the operational guidelines entitled “Analyzing Health Equity Using Household Survey Data (O’ Donnell *et al*, 2008) given by an expert team led by World Bank institute, we had attempted to estimate the impoverishment among HIV study group households due to out of pocket health spending. On the basis of these operational guidelines, it was observed that, poverty increased by 20% in the study for HIV households, when OOP spending is adjusted for. Additional Rs 59 per capita per month have to be transferred to the poor to bring their expenditure up to poverty line. An attempt is also made to estimate and identify the determinants of catastrophic OOP health spending among HIV households. Logistic regression analysis was applied to determine the probability of a HIV household incurring catastrophic OOP health payments. Likewise, multiple linear regression analysis was applied to estimate and identify the various predictors of OOP health payments among PLHIV households. Various individual and household level predictors based on the socio-economic, demographic and health related conditions were identified. Results of multiple linear regression analysis reveal that household size, socio-economic status of HH and hospitalized illness episodes have bearing on economic conditions of household.

Logistic regression estimates that incidence of catastrophic-I (10% or more OOP share to total consumption expenditure), is significantly influenced by caste,

hospitalized illness among PLHIV adult; occupation and educational status of Head of household. Other variables although not statistically significant, demonstrate a largely expected direction of association with the regressand. Similarly, incidence of catastrophic –II (40% or more OOP share to capacity to pay), is significantly influenced by age of head of household, hospitalized illness episodes among HIV infected individual and socio-economic status. Both the analyses support the hypothesis that the economic burden increases as the severity of disease increases.

Qualitative results revealed that PLHIV relied on a variety of sources for mental support, advice, treatment and care. However, they experience pain and discomfort in this respect at different stages. It was experienced that HIV positive women are more disadvantageous and at a compromised stage than that of male HIV positive. They are cursed at their in-laws' house to bring "*misfortune*" to family and often are deprived of economic support and dragged out from the house after the death of the husband. This has questioned economic and social security of HIV positive women. Qualitative analysis also observes the important proposition of linkage between migration and HIV infection and its detrimental impacts on origin household.

Along with economic consequences, social dimensions also have important role, as HIV infection is a social problem at first hand. In the next attempt in the thesis, the social implications of HIV/AIDS at various setups of society are discussed. PLHIV have been discriminated against in the family, when they disclosed their HIV status. However, with the passage of time, more accepting attitude towards male PLHIV member was observed in the family. It is evident from the discussions, that HIV positive women are being discriminated more in the family (results are supported by the earlier studies) and despite their own HIV status, at times they have to take up jobs apart from attending to household chores and taking care of other ailing members of household. This highlights socially and economically compromised status of women living with HIV (WLHIV). Apart from commenting on the instances of stigma and discrimination at various setups of society, against PLHIV, an attempt is made to analyze the determining factors associated with probability of a PLHIV individual being accepted in the family setup. Probit regression analysis was applied to estimate the probability of a PLHIV individual, being accepted in family setup. Sex and age of PLHIV individual observed to be important predictor of probability of PLHIV being accepted in family. Likewise, it was observed that the denial of PLHIV in family set up is found to be more in lower economic strata of society. Death in the

family due to HIV related illness also significantly influences the acceptance of PLHIV in family.

What emerged from the probit analysis is that denial is more prevalent in case of female PLHIV member of household. PLHIV Women are often cursed to bring misfortune in the family and after the death of their husband they are mal-treated in their in-laws' house. HIV illness related death in the family, significantly leads to denial of current PLHIV member of the family. Myths and ignorance about the correct knowledge about HIV infection significantly promote the denial of PLHIV member in the family.

Stigma and discrimination are important negative social effects. These social impacts demonstrate the difficulties that PLHIV and their households' experience in developing and maintaining the social capital that is necessary for protecting against negative shocks. Stigma and discrimination against PLHIV is driven by the behavioural aspects in a society like India. Empirical findings of are substantiated by the qualitative analysis of case studies. Qualitative analysis highlights the sexual and physical assault of women in marriage and threat to HIV infection, high risk sexual behavior among MSM, who face double stigma and economic and social vulnerability of widows living with HIV.

After examining the economic and social dimensions of households with PLHIV, one comes to analyse the quality of life, which encompasses all the dimensions related to living a comfortable life. This thesis attempts to examine the impact of HIV infection on the quality of life among PLHIV. HIV infection affects the different dimensions of life of an individual and deteriorates the quality of life. An ordered probit model was applied to estimate the negative impact of HIV infection on the quality of life among PLHIV individuals. QoL was estimated based on the methodology proposed by WHO *i.e.* WHOQoL HIV BREF, which is a questionnaire series based on the various dimensions of life and all the responses are recorded in likert scale. On the basis of WHOQoL HIV BREF, overall QoL score for the whole sample was (2.67). Among the 29 facets, the highest scores were for the health and social care (3.61), new information and skills (3.56) and death and dying (3.38). Lowest score were for physical environment (2.3), positive feelings (2.19) and financial resources (1.71). Most of the facets have mean score below the mid-scale point of 3 excepting health and social care facet, new information and skill, death and dying and forgiveness and blame facet. In the study group, no significant gender difference was reported in the

overall QoL and overall health status among PLHIV respondents. Men reported significantly higher QoL in following facets Positive feelings, negative attitude, personal relations, social support, sexual activities, social inclusion, physical safety and security, home environment, financial resources, new information and skills, physical environment, recreation transport and death and dying. Females reported significantly higher QoL in spiritual, religious and personal beliefs facet. Of the six domain of QoL, men reported better QoL in environment and social relationship domain. In Ordered Probit Regression (OPR) analysis, most important among predictor variables are wealth index score and CD4 count (clinical indicator of progression of HIV infection). Age, gender, education status, employment status, migration status, social class and locality are other significant variables in respective domains.

Hence it describes the quality of life and factors associated with QoL of people living with HIV in Pune city. We sought to examine QoL among Pune HIV positive individuals and impact of demographic, socio-economic and clinical factors on QoL in order to suggest public health policy and services. Effective intervention is required in this aspect to enhance quality of life among PLHIV.

These are the specific findings of the thesis. Considering above mentioned findings, some policy implications are suggested in the light of current policies of government, combating HIV infection.

9.2 CURRENT POLICIES AND SUGGESTED POLICY IMPLICATIONS

Conclusions of this thesis suggest many policy implications that should be further explored. These policy implications are suggestive only and their impacts have not been and could not be tested with available data. Any policy derived from the analysis and conclusions from the thesis should be subjected to thorough piloting and empirical testing to verify its effectiveness. These policy measures are suggested in the light of HIV intervention strategies, initiatives of government. After the first HIV case was reported in 1986, the Government of India initiated programmes of prevention and raising awareness, disseminating correct information about HIV/AIDS under medium term plans (1990-92), first National AIDS Control Programme (NACP-I, 1992-99) and the second NACP (NACP-II, 1999-2006). NACP (NACP-III, 2006-2011) is the third programme in the series. In the last twenty years, with the growing complexity of the epidemic, there have been shifts in policy frameworks and

approaches of NACP. Focus has shifted from raising awareness to behavior change, from a national response to decentralized response and an increasing engagement of NGOs and Network of people living with HIV. To strengthen the response to HIV, the National AIDS Prevention and Control Policy was formulated in 2002 and the National Council on AIDS (NCA), chaired by the Prime Minister was organized to provide policy guidelines and political leadership to HIV response.

9.2-A. NACP-I (1992-99)

NACP-I was launched with an IDA credit of USD 84 million, with an objective to slow down the spread of HIV infection so as to reduce morbidity, mortality and impact of AIDS in the country. To strengthen the management capacity, a National AIDS Control Board (NACB) was constituted and an autonomous National AIDS Control Organization (NACO) was setup to implement the project. The key outcome of the project includes, capacity development at the state level in the form of setting up State AIDS Cells (SAC) in 25 States and 7 UTs; a well functioning blood safety programme, expansion of HIV sentinel surveillance system; collaboration with NGOs, During this period, bilateral partners like USAID (Tamil Nadu), DFID (Andhra Pradesh, Gujarat, Kerala, Orissa and West Bengal) and CIDA (Karnataka and Rajasthan) also implemented focused programmes successfully and contributed to the state and national level efforts.

9.2-B. NACP –II (1999-2006)

In November 1999, the second National AIDS Control Project (NACP-II) was launched with World Bank credit support of USD 191 million, with an objective to shift the focus from raising awareness to changing behavior, decentralization of programme implementation at state level and greater involvement of NGOs. Policy initiatives taken during NACP-II include, adaption of National AIDS Prevention and Control Policy (2002), National Blood Policy, a strategy for greater involvement of people living with HIV/AIDS (GIPA), launching of National Rural Health Mission (NRHM), launching of National Adolescent Education Programme, provision of ART, formation of inter ministerial group for mainstreaming and setting up of NCA chaired by Prime Minister.

9.2- B (1). National AIDS Prevention and Control Policy (2002)

National AIDS Prevention and Control Policy was formulated during the 2nd National AIDS Control Programme with the general objective to prevent the epidemic from spreading further and to reduce the impact of the epidemic not only upon the infected persons but also upon the health and socio-economic status of general population at all level. It was targeted to achieve zero-level of new infections by 2007. Specifically, it was focused to active participation of government, NGOs, GIPA and other international bodies to combat HIV and other opportunistic infection (e.g. TB), to provide greater care, support and treatment to PLHIV at large and disseminate information, education and communication regarding HIV and sexual issues at large. University Talk AIDS (UTA) programme was initiated to target youth at large. Government of India looked at HIV/AIDS prevention and control as developmental issue with deep socio-economic implications. It touches all sections of the population, both infected and affected, irrespective of their regional, economic or social status. By following a concerted policy and an action plan that emerges out of it, Government hoped to control the epidemic and slow down its spread in the general population within the shortest possible time.

9.2-C. NACP-III (2006-2011)

Keeping the prevalent social context, concerns and the emerging HIV/AIDS scenario as well as drawing from the experience of the earlier two phases, NACO initiated NACP-III with objectives to prevent new infections in the HRGs and general population, providing greater care, support and treatment to large number of PLHIV, strengthening the infrastructure, system and human resources in prevention, care, support and treatment programmes at the district, state and national level, strengthening the nationwide strategic information management system. NACP-III decentralizes its organizational structure further to implement the programme at district level to combat HIV spread in rural regions. Accordingly, based on the epidemiological and vulnerability criteria, all the 611 districts in the country have been classified into four categories: Category A–163 districts – *high prevalence*; Category B–59 districts – *concentrated epidemic*; Category C–278 districts – *increased presence of vulnerable population* and Category D–111 districts – *low/unknown vulnerability*. Differential packages of services have been developed for

each category of districts. Institutional arrangements and capacities of the SACS as well as the proposed District AIDS Prevention and Control Units (DAPCUs) will be strengthened. To address special vulnerabilities of the North-Eastern States, a Regional AIDS Control Unit (RACU) will be established as a sub-office of NACO but embedded in the governance structure of NRHM. NACP-III has also developed an HRD plan to continuously update and improve the competency and skills of the programme personnel. In order to implement wide range of interventions, a financial resource plan has been worked out. Resources required for NACP-III are estimated to be Rs. 11,585 crore.

In the light of current policy intervention, initiatives taken by Government of India at large; this thesis brings into notice the following points into consideration.

- Intervention should be gender sensitive as there are vast differentials within the study group of PLHIV itself. Element of gender should be incorporated with due consideration while formulating policies regarding combating HIV.
- HIV infection puts extra burden on the financial resources of the household due to frequent or continuous ailing or hospitalized illness among PLHIV members of household. This could be catastrophic for certain households and can impoverish them. In a country like India, out of pocket health spending in case of HIV infection at household level could be disastrous for household economy. Expected policy response should comprise of a suitable blend of targeted health insurance intervention or some social security scheme to save the HIV household from economic catastrophe due to HIV related illness. One medical health insurance scheme⁴⁰ is already implemented in Southern India as a part of an initiative program for wellbeing of PLHIV.
- Public health care facilities should be made more accessible and affordable. To combat HIV infection, it is required that public health policies with respect to HIV should be active. There is a greater need to address the sensitivity of the issue in the community at large. People should be informed and encouraged to practice safer sexual practices.
- HIV households need much greater support from the government in terms of accessibility and affordability of health care. The thesis comments on the

⁴⁰ An initiative taken by Population Service International (PSI), Karnataka Network of People Living with HIV (KNP+), Star Health and Allied Insurance supported by UNAIDS.

expenditure incurred to avail health care at a public setup. Special attention should be directed to households with catastrophic OOP health spending.

- Anti-Retroviral Treatment (ART) is provided at government hospitals free of cost to PLHIV. This initiative needs to be focused on with greater care and implemented rigorously, so that the benefit could reach maximum number of PLHIV. In this respect, NGOs working in this field can be of greater help, in bringing PLHIV at a common platform.
- HIV campaigns should be more demonstrative. Mere advertisement regarding HIV would not help to curb spread of HIV infection. Street plays at the local level particularly at slums, are an important means to disseminate knowledge and awareness regarding HIV. NGOs and other public bodies or educational institutions can be of immense help in this regard. Educating people regarding HIV transmission would solve two main objectives: 1. accurate knowledge of mode of transmission can prevent further spread of HIV infection. 2. Attitude of people towards PLHIV is likely to change the scenario and may lead to greater acceptance of PLHIV with in the family and society, building social capital and acquainting the mainstream of society about PLHIV.
- At the workplace, policies should be chalked out taking into account the possibilities of HIV employees. PLHIV at workplace should be given all due respect. In this regards ILO code of conducts should be followed with due consideration regarding HIV.
- Special focus should be on widowed women living with HIV. Some social security measures should be made to provide a comfortable and respectful life to them. On the other hand, NGOs with the motive and commitment for a better life for them should come forward with support from government and international bodies, to provide vocational skills to them or to set up some self-finance group or micro-enterprise to live a respectful life. A targeted intervention is required to improve income generation for PLHIV.

These are the suggested policy implications in the radiance of current policies, which can further be explored. Incorporating these dimensions in the current policies can make them more effective and for betterment of PLHIV.

9.3 LOOKING FORWARD

Curbing spread of HIV/AIDS is the need of the day, along with maintaining a comfortable and respectful life for PLHIV. HIV is one of the greatest public health and development challenges that the global community is facing. Cost of care and treatment which any individual living with HIV has to bear, is enormously exorbitant and beyond the reach of masses. Any country primarily focusing on the treatment dimension of HIV/AIDS would not be able to sustain its cost and for a longer period, no matter what economic and technical support are provided by donor agencies. Therefore, the trivial issue is how to address the issue of HIV/AIDS and what sort of management devices need to be made which will be efficient, cost effective and culturally viable in a huge country like India. This thesis provides empirical evidence of socially and economically deprived status of PLHIV in the society and the impoverishment of HIV household due to HIV infection and also examined the issues of stigma and discrimination against PLHIV at various level of social hierarchy. Impact of HIV infection at various dimensions of life of an individual was also explored. Overall, the thesis emphasizes that, to successfully address HIV/AIDS; policy planners must also address the problems of inequality, poverty and gender gap. The thesis comments on the potential link between gender inequality and poverty and HIV infection, and empirically investigated the same. It is only by recognizing these causal relationships we can find effective solutions to curb HIV infection. The welfare of those who are living with HIV or likely to suffer, their future is the greatest challenge that the contemporary world is facing today.

Lastly,

"The global HIV/AIDS epidemic is an unprecedented crisis that requires an unprecedented response. In particular, it requires solidarity -- between the healthy and the sick, between rich and poor, and above all, between richer and poorer nations. We have 30 million orphans already. How many more do we have to get, to wake up?"

-Kofi Annan
(Former secretary UN)

