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Being alive for children: A qualitative investigation into the lives of people living with HIV/AIDS (PLHA) in an urban town of India

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Abstract*---Background:*** HIV/AIDS is a complex disease affecting not only an individual, but families, communities and social ties creating fragile social networks, marginalized and discriminated people. India has the world's third largest population suffering from HIV/AIDS.Women and children are the worst sufferers,. Many continue to look at HIV positive-patient as 'deviant', 'immoral', socially 'intolerable'. HIV has subdivided the already divided Indian society; it has given rise to a new minority, a new marginalized class. The social reaction to people with AIDS in India has been overwhelmingly negative. *Methods:* The study was conducted in Delhi during 2018-19. The organizations working for PLHA welfare were approached, which facilitated interviews/FGDs with 39 PLHA. This paper tries to explore the stigma and discrimination faced by the PLHA. at different levels of their interaction and also explore their strategies through which PLHA negotiate and navigate through their sufferings in everyday life. *Results:* The participants reveal that being HIV positive has made them feel different and perceive life differently. Upon diagnosis, the participants experienced psychological crisis and even had suicidal tendencies, as they could not face the judgement of people. The tendency to self-discipline was also experienced in interactions with children and other family members at home. To prevent their HIV-infection transmission to others, most married participants retreated from sexual activity after diagnosis. Ensuring well-being and securing future of their children is a main preoccupation of PLHA. *Conclusions:* The disclosure of the positive status upon themselves had initially been quite disturbing having suicidal tendencies. The disclosure had

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initially resulted in conflict with relationships, but with time relationship with close family members proved to be the primary source of care them. Participants tended not to disclose their sero-status to people outside their families.Fear of discrimination also made participants reluctant to disclose status to health workers outside AIDS-specific institutions. The HIV infection had serious economic implications that also affects social status, livelihood, nutrition, and other family responsibilities. The loss of productivity and resources due to the infection negatively influenced their businesses, and forced many to sell their assets. However, the PLHA mostly see their children as primary motivation to live more.

***Keywords*---**being alive, children, qualitative investigation, HIV/AIDS (PLHA).

Introduction

Illness and disease are social constructions and these do not come forth unless these are proposed, described and recogned in society. Intermittent outbreaks of infectious diseases have had profound and lasting effects on societies throughout history. Human life has been greatly shaped in terms of its economic, political and social aspects that have long lasting implications (Huremovic, 2019). AIDS is a terminal disease affecting not only an individual, but families, communities and their social ties (creating Fragile social networks); creating scores of marginalized, discriminated and neglected people (Castro, Orozco, Aggleton, Eroza, & Hernandez, 1998; Adelman & Frey, 2020). It takes million lives every year, infects thousands, orphans many and plagues the left ones physically, emotionally and psychologically (Huremovic, 2019). After Tuberculosis, it amounts for the highest number of deaths world-over and will continue to remain one of the ten leading causes of death globally over few decades (UNAIDS, 2009). Moreover, HIV has led to the resurgence of TB mainly in Africa, and TB is a leading cause of death for people with HIV worldwide (WHO, n.d). It has undone the improvments that were made in helth and wellbeing indicators in regions that are in grip of HIV infection. It has created an unending challenge and a tiring task for the third world countries, which are still in the infancy of their development and are bearing the brunt of the pandemic. Besides poverty, malnutrition, hunger, illiteracy, they now have a new enemy to fight and defeat, which would otherwise defeat them permanently (Grant & De Cock,1998; Gill,2010; Jha, 2010). It is an incurable disease spreading through unsafe sexual practices, blood transfusion, organ transplants, breast milk, etc, STIs and some other situations and practices act as catalysts for the transmission (Vaillant, & Sticco, 2021). However there are many social, economic, political & cultural factors that create risk & vulnerability. HIV/AIDS is a complex phenomenon and not merely a global health issue. It ia pandemic composed of diverse local contexts which is shaped by complicated relationship of numeirous forces, factors and structurues across nations, societies and human pupulations which exhibit varied but similar human behaviors and societal conditions and practices (Poku, 2005).

From the disease of certain stigmatized groups like sex workers, people-with-same-sex-relations, drug users, immigrants and refugees (Avert, 2019), as initially thought; it has crossed all potential barriers and engulfed the general population through complex behavioral interactions and now is the disease of young adults, expecting mothers and unborn babies (Avert, 2019; Hivinfo, 2019). With no proper cure discovered so far (WHO, 2020; Jehangir, 2013), the combination of drug therapies provide for management of the syndrome (Volberding et al, 1990; WHO, 2020; Medlineplus, 2021), only delaying the inevitable end of the sufferers (Average survival in the absence of treatment is around 10 years after infection). Antiretroviral drugs, education campaigns, funded interventions, international investments, large-scale awareness programmes, national prevention programs and projects, celebrity involvements have contributed their part, but much more remains to be planned and implemented. Certainly, it is an extraordinary development challenge that requires an extraordinary multi-sectoral response.

Globally, around 11% of children living with HIV acquire the virus through their mothers during child bearing, labor or delivery, or through breast milk; drug use thgough injections contributes 10%, same-sex relationships amount to 5-10%; healthcare settings contribute 5-10% in and heterogenous sex accounts for the remaining proportion – around 2/3rd of new cases. The developing world seems to be the capital of HIV infections and the same is boud to grow hugely due to poor economic conditions, dwafed health care and little efforts from the governments regarding prevention and care. While as displacement, high levels of illiteracy, low social status of women, exacerbate the already worsened situation.
If one critically analyzes the affliction and the havoc it has subjected people to, the fact comes to the surface that HIV/AIDS is, largely, preventable. The pandemic could be contained if people are informed with the relevant and useful information; if people don't resort to denial that they can't be infected; if countries expand their social spending; and if health and health system is prioritized in the national planning. Perhaps the foremost bottleneck to HIV care continuum of prevention is the ignorance of among high-level policy makers and decision authorities to deny the existence of increased risk among their populations and regions. Without the support of policy makers, HIV prevention cannot be put into place on a meaningful scale. Thus, it becomes imperative for the researchers to focalize, contextualize and represent the facts in their research before the policymakers, and before the epidemic reaches the stage of rapid expansion in their part of the world. People in emergencies, conflicts and post-war situations, including vulnerable children, women and other at-risk groups also need improved interventions and programmes that increase their access to prevention, health care, information and comprehensive services. It demands a professional and informed approach based on good epidemiological and behavioural information, strong political policy, pragmatic and effective mobilization and utilization of resources.

HIV/AIDS in India

India is at third position in term of having population living with HIV/AIDS, after South Africa and Nigeria (Reuters, July4 2007; Padyana, Bhat, Dinesha & Nawaz, 2013; Leslie, 2019). India's prevalence rate in 2016 was found to be 0.3% which is 80th highest in the world (The World Factbook, 2019), too alarming for a

country with a population of around a billion (UNAIDS, 2008). There is no single 'group' or section of population affected by HIV. Infact, the number of people living with HIV is mainly high among certain groups. It is estimated that in these at-risk groups the prevanlence of HIV is 6 to 8 times higher than that of the general population (NACO, 2005; Avert, 2020). The deep-rooted stigma against HIV infected people and their family- members continue to undermine the efforts made to combat the affliction . People who are infected face extreme inhuman treatment, rejection and irrational prejudice every day (Avert, 2019). Women and children are the worst sufferers of this scourge (Jan, 2021). Many continue to look at HIV positive-patient as one who has indulged in deviant, 'immoral', socially 'intolerable' and 'unacceptable' behaviour like homosexuality, drug addiction, prostitution, and promiscuity, whose life styles are 'perverted and sinful'(Olaore & Olaore, 2014). AIDS prevalence has further subdivided the already divided Indian society; it has given rise to a new minority, a new marginalized class. It has widened the socio-economic gap leading to ever-increasing inequality and injustice. It has created a disadvantaged group who face worst form of discrimination and rejection from the society.

Rationale of the Study

The social reaction to people with AIDS in India has been overwhelmingly negative. The people's identification of HIV as an ailment of certain marginalized groups further complicates the lives of persons with HIV (Skinner & Mfecane, 2004). A qualitative research study on the difficulties faced by parents, caring for adult children with HIV, reveals the pervasive effects of stigma in rural areas with little or no awareness on HIV (Haney, 1988; Nyblade, Stockton, Nyato & Wamoyi, 2017). Results indicated that stigma limited access to health services, cut people with HIV off from extended families and friends and ostracized them in their communities and places of employment (Suwisith, 1996; Laltlinzo, 2011; Jan, 2021). The present study was an attempt in the same direction, with its focus on the issues concerning people living with HIV/AIDS. It tried to explore the discrimination faced by infected people at different levels of their interaction. Primarily, the literature on socio-economic inequalities in health and its implications on the status of the afflicted-people, with special focus on the people living with HIV/AIDS, will be reviewed to guide the research process in this study. Moreover, the literature that has documented the issues of stigma and discrimination in relation to HIV/AIDS would also be in the focus of the study.

Objectives

The broad objective of the study was to explore the social implications of HIV/AIDS on the infected-people.

- Issues of stigma and discrimination at various levels of their interaction in the society.
- Economic implications of HIV/AIDS infections.

Research Methodology

The study was done in an Urban Town of Delhi. The organizations/NGOs working with PLHA welfare were approached, which facilitated the interaction and meetings with the participants of the study. Five cases among these participants were focused and selected for further indepth interviews keeping in view the efficiency, demands and requirements of the research. The research approach was moulded to include the ways people make sense of, and socially construct, meanings HIV/AIDS. Thus, a social interpretative approach was used in the study to analyze the data and it was premised that particiapants' accounts are not seen as revealing any generic 'truth', rather they are treated as stories whose meanings are situationally located and require to be discovered (Berger & Luckmann, 1990). The particpants involved theselves voluntairily and quite proactively with this research after they were assured of confidentiality and anonymity. They were also informed and encouraged to terminate the discussions at any point during the conversation or at any stage of this research.

Research Techniques and Tools

The Narratives, Interviews, Checklists, Observation, etc were used to collect the data.

Analytical Plan

All the data including interview transcripts, narratives, observatory notes and inferences were interpreted in the light of the relevant literature; where-in nuanced conclusions were drawn so as to get an in-depth understanding of the underpinning issues concerning people-living with HIV/AIDS.

Ethical Issues

There is multiplicity of ethical concerns in relation to HIV/AIDS. Research questions pertaining to the study often place the researcher and the subject in difficult situations. An invasion into the 'private affairs' of people often results in diminishing of self respect. Due care was taken by the researcher to protect the rights of the research participants and minimize their physical and emotional discomfort as far as possible. The principle of confidentiality was taken care of.

Major Research Findings – Analysis and Interpretation

People with HIV face numerous difficulties in their everyday lives. The difficulties are compounded by unpredictable nature of the affliction (Adelman & Frey, 2020). Very often people face existential or spiritual issues that involve dealing with and finding meaning in their lives, and searching for value and meaning in their suffering and death (Siegel & Lekas, 2002). People with HIV experience an overpowering cumulative sense of loss that is not typical of their development stage; like the losses related to disfigurement, physical limitations and self-esteem. Physical changes often precipitate a mourning process to deal with the loss of attractiveness and desirability (Taylor-Brown, 1995; Lichtenstein, Laska & Clair, 2002). HIV-positive people also suffer from extreme psychological

impairments in case of loss of interpersonal relationships, death of partners, friends, and family members or due to withdrawal of significant people from social support networks (Priya, 2004; Jan, 2021).

Changes Perceived by the Individuals within Themselves

The study participants reveal that being HIV positive has made them feel different and they perceive different changes with-in themselves. Upon diagnosis, the participants experienced psychological crisis and even had suicidal tendencies, as they could not face the judgement of people and their families. The tendency to self-discipline and to self-police was also experienced in interactions with children and other family members at home. To prevent their HIV-infection transmission to others, most married participants retreated from sexual activity after diagnosis. However, working with an NGO and being associated with other positive people had helped the participants feel empowered. They feel all the more confident and at the same time responsible. All the participants reported that they are hopeful that they can contribute to the lives of other people living with the infection.

One of the participants, R1 (42) revealed:

"When my doctor informed me of the infection I was shattered. I started crying and sobbing. I couldn't believe that I can have HIV. I was scared; I thought that I will die in a day or so. But, today things are different. When I introspect I feel HIV infection has made me more responsible. I have become more mature and understanding in the last five years of my infection. I spent all the time earning for my family and children, besides working for the other HIV positive people."

In a somewhat nervous stance, the other participant, R2 (35) opined:

"*No doubt I have adjusted to this life; but the fact that I am HIV positive and belong to a population, which is often stigmatized and discriminated, disheartens me every now and then. At times a mild cold or cough reminds me that my death is hovering over my head!"*

R3 (31) narrates:

"Before I came to know about my positive status, I used to enjoy my life; roam around with friends and would live in a very unhygienic way. But now a lot has changed in my life. I am more conscious about cleanliness and try to maintain hygiene. I no more consume any food on roadsides, etc... or anything that is not hygienic. As I know that any minor infection could cost my life."

The participants' accounts clearly revealed how they perceived the differences in their lives immediately after they were diagnosed positive, and how with time they have adjusted and adapted to their seropositive status. Even though there have been a good number of perceived positive changes in their lives, nonetheless, the fear of an anticipated death dominated their narratives. The disclosure of the positive status upon themselves had initially been quite disturbing and traumatizing for most of the participants, as most of them thought of ending their lives and concealing their status. But with time all the participants expressed to

have restarted their lives with the hope that they can serve their fellow people and do something for their families especially children.

Changes perceived in the interpersonal relationships

Living with HIV also affected the participants' interpersonal relationships, particularly with their families. In general, participants expressed gratitude for the moral support, financial assistance and other instrumental support they received from their family members.

R1 expressed:

"After my wife came to know about my infection her behaviour towards me changed. Although she would take care of me, accompany me to the doctor, provided me medicines on time. But I could feel her anger, though she never expressed it".

R3 relates his wife's reactions when he disclosed his positive status:

"Though my wife was initially shocked to know about my positive status, later she was very supportive and helping. She understood my situation and provided me with all the care. Today I feel she is all the more concerned about me. She takes care of every little thing of mine. I think we understand and care about each other more than we ever did".

The narratives of the study participants clearly revealed the impact of HIV/AIDS infection on their interpersonal relations. The disclosure in many cases had initially resulted in conflict in relationships, but with time relationship with close family members proved to be the primary source of care for the participants.

Disclosure of HIV-positive Status

For HIV infected people disclosure of the positive status remains a serious issue. Fearing stigma and discrimination from society infected people try to conceal their status. However in most of the cases, it is the close family members to whom people reveal their status to. Family is seen as a source of support and care. Study participants revealed that their positive status was known to their spouses. Only in one of the cases had the doctor revealed the status of the male respondent to his wife without taking his consent, in all other cases respondents had themselves disclosed their positive status. Besides this four out of five respondents had disclosed their positive status to their close family members. One of the respondents, R3 says:

"We had to disclose our status to our family members, there was no other way. Besides, they are ones who would take care of my children when I am dead. There was no point in not telling them the truth. Sooner or later they would know it. I thought it is better to tell them before they get to know it from other source..... They provided me with the moral strength to cope up with the stress and frustration. My father and brothers helped me financially."

Similarly, the other participant, R1, revealed:

"I had to reveal my status to my wife. How could I do without that? I was filled with guilt and shame. I disclosed my status the same day I got to know about it as my doctor advised me to get my wife and son tested as soon as possible. I was scared that my wife would also test positive. I was praying to god to save her and when she tested negative I was filled with joy. I felt as if god has given me another life."

R4 (40) had concealed her and her husband's status from the family. She narrates:

"I knew what would be their reaction. They would have surely thrown me out of their house. All they knew was that my husband and I were suffering from some infection for which we both were taking treatment. My mother-in law was already spreading rumours about me that I am character less and had bought ill fate to the house. She was holding me responsible for her son's illness. In such circumstances it was impossible to tell her that we both are suffering from HIV. She would have surely spread the news around and it would have been difficult for me and my husband to survive in the neighbourhood."

It was apparent from the respondent's account that disclosure remained more or less confined to close family members. Participants tended not to disclose their serostatus to people outside their families, such as friends, co-workers, neighbours, and/or health workers to reduce the odds of unexpected breach. Fear of discrimination also made participants reluctant to disclose their serostatus to health workers outside AIDS-specific health institutions.

Response of the family

All those respondents whose HIV status was known to their families expressed that their families had proved to be a great source of strength for them. Participants, however revealed that they had to bear the immediate reaction of dejection from their families on the disclosure of their status. As having a HIV positive member in the family was considered unacceptable and a matter of shame and disgrace for the family. Moreover, many family members believed that an infected member can spread the infection to other members. However, as the time passed and families started understanding the infection and its modes of transmission they provided all care and needed support.

R5 (38) relates her ordeal:

"As soon as my family came to know that my husband has died of AIDS and I too am infected with HIV, they broke all their contact with me. My brothers stopped visiting me they thought I am disgrace for the family and I might infect their children. Even my parents would not enquire about me. For about a year I was living alone with my four year old son. I had nowhere to go and no one to look after me and my child. But soon I got work, I restarted my life and slowly my relations with my family members started improving. They started understanding me, my infection; they would accompany me to the doctor and meet the counselors. With

time my brothers also started caring for me they would often send me money and helped me in whatever way they could. However their wives continued with their indifferences towards me. The re-association with the family has helped me bear the burden of the disease. At least my son will have someone to look after him when I am no more around.''

R3 happily added:

"My family has always supported me. I never felt any difference in their behaviour after I disclosed my status. My mother and my wife have been very much understanding."

Respondent's narratives clearly reflect that in most of the cases families continue to remain a primary source of care and support for people living with HIV infection. However it is the close members of the family who prove to be more accepting and caring. The acceptance seems to be lesser with those members who are new to the family and don't share any blood relationship with the infected person.

Discrimination within the family

Many studies have shown close association of HIV/AIDS infection with stigma and discrimination. People who are infected often tend to be discriminated and stigmatized by other people in the family, neighbourhood, work place and in health care settings. Much of the discrimination occurs due to the ill information of the disease and the misconceptions around its transmission. However, infected people report less discrimination from close family members, infected women though suffer discrimination and ill treatment from their in-laws.

R5 narrates her ordeal right after the disclosure of her infection to in-laws:

"As soon as my in-laws came to know about my HIV positive status, they separated everything in the house that I would use. My utensils were kept apart from others; I was time and again scolded for washing my clothes in the common laundry (bathroom). I was given food in separate room, and my towel, soap, etc were kept outside the house. I could not understand their behaviour. Whosoever came to our house, my mother-in-law would tell them about my infection, and advise them to keep distance from me. Everyone in the village came to know about my infection. It became unbearable to live in that community and neighbourhood. I was looked upon as an outcast; a witch! And when my husband died of AIDS in hospital, I was blamed for his death, and asked to leave the house, immediately, with my two children. My own parents could not support me for long. My brothers and sister-in-laws would abuse me and call me names."

Discrimination at work place, neighbourhood and healthcare setting

Since the respondents had not disclosed their status to anyone besides their family members they did not report any episode of stigmatization and discrimination (enacted stigma). However the fear of stigmatization and discrimination (felt stigma) was quite apparent in their accounts. The dominant

research in the subjects of stigma and the related issues, has emphatically argued that the 'enacted stigma' (the direct confronting of any discriminatory or stigmatizing behaviour) rarely comes in the narratives of the people living with HIV. On the other hand, the felt stigma (the fear of stigmatization or discrimination on their disclosure of HIV positive status) generally overwhelms and preoccupies the same narratives. The circulating stories of HIV-related discrimination and ill treatment among the HIV positive people potentially proves to determine their own apprehensions about their disclosure of seropositive status to others in their community. In such circumstances, they tend to be reluctant in disclosing their positive status, and most of them live a 'double-life'. In our study, all the participants had quitted their earlier jobs for the same reason- the 'danger' of being known to the employers and colleagues that they are HIV positive. For instance, one of our participants, R4 was due to get promotions in the company she was working. But she quitted the job, as the company had necessitated a complete medical examination before one could avail that promotion. She narrates:

"I thought my 'secret' (being HIV positive) would have been taken quite negatively by my employers and colleagues. Had they come to know of HIV positive status, I would in that case have not only lost the job, but my dignity and respect too."

The participants revealed that hiding their serostatus in the community, at the workplace, etc turned out to be difficult and psychologically overwhelming. The expressions of them "having two faces" and "living a double life" was full of burdens or battles, which they negotiate at every step of their life and interaction with the society. Moreover, the fear of stigma in health care settings forces the HIV positive people to seek health care from that doctor or health personnel who is aware of their positive status; or to seek it at those health centres that are far off from their neighbourhood. Our participants' access to health care services has tremendously got impacted in such a scenario.

Economic Implication of Infection

Owing to their physical weakness and deteriorating health, the people living with HIV/AIDS suffer serious economic hardships in their day to day life. In our participants, the HIV infection had serious economic implication that in turn affected their social status, livelihood, nutrition, and other family responsibilities. The loss of productivity and other resources due to the infection negatively influenced their established businesses. The HIV-related medical expenses, on the other hand, forced many to sell their assets that heavily weighed on their family budgets. Reflecting the same, R2, says:

"Before diagnosis, I was quite satisfied with my life, as my whole-sale cloth business was quite established. But after my diagnosis, with-in a short period my body failed me; I had no energy to work. I lost my business. As I could not work to feed my family, I had to sell my accumulated assets ... even a gas cylinder! The life of the people living with HIV/AIDS is full of challenges and miseries!"

Quite interestingly, the children and their future remained the central and the primary reason for most of the participants to live. From the interviews with the

participants, it emphatically surfaced that their children are their only 'hopes' and 'reasons' in this world. In order to guarantee proper care and upbringing of their children, and considering their weak economic conditions, most of them preferred orphanages or Govt./NGO hostels suitable and affordable for their children.

Moreover, the economic adversities of the participants seriously affected their nutritional requirements, as advised in HIV infection. They argued that doctors, counsellors, etc, advise them to take healthy and nutritious food and supplements; but they expressed their inability to afford such food, as the expenses for control and treatment of opportunistic infections already weighs our family budgets.

Conclusion

All over the world, the epidemics of HIV and AIDS have been capable of bringing out the best and the worst in people: the best, when, in solidarity, people join together to combat government, community, and individual denial, and to offer support and care to people living with HIV and AIDS; the worst, when people are stigmatized and ostracized by their loved ones, their families, and their communities, and discriminated against individually as well as institutionally.

It was quite clear from the interviews of the participants that the 'felt stigma' (Goffman, 1963) dominated their post-HIV lives. All the participants expressed fear of confronting stigmatizing and discriminatory behaviour if people in their neighbourhood, community, health care setting, workplace, etc get to know about their HIV positive status. This fear revolved round their understanding that HIV is still perceived in their society as a disease associated with 'deviance' and 'moral degradation'. These revelations bring into focus that the dominant discourses of HIV/AIDS in India are still morality-centred, and HIV positive people are constructed as morally problematic others (Priya, 2002). The earlier epidemiological discourses on "high-risk groups" (e.g., "promiscuous" people and drug users) that over-emphasized the "causal relationship" between moral degeneration and HIV infection had profound and lasting impacts in the way that this disease is understood and responded to by the public, including people living with HIV themselves. Being viewed as an "indecent" disease, HIV/AIDS has severely stigmatized people, families, and communities that are associated with it. To protect themselves and their families from stigmas and discrimination, many HIV positive people made a conscious decision of nondisclosure. However, living with secrets creates more challenges in their daily lives and, thus may further compromise their health and wellbeing. Moreover, the non-disclosure bereaves them of the HIV-related health care and other social supports (Daniel et al 1993). The silence and invisibility of people living with HIV/AIDS has made this group hard to reach and intervene with, which in turn may create a greater risk of HIV transmission and exacerbate the situation (Altman, 1994). However, the participants emphasized the fact that much of the stigma and discrimination which people practice is due to their lack of awareness with respect to HIV and its modes of transmission. They argued that proper and efficient awareness could tremendously help to overcome their prejudice and stereotypical apprehensions, and simultaneously make them positively more responsive to the concerns and issues of people living with HIV/AIDS.

One of the interesting conclusions to be drawn from the interaction with the study-participants was the importance HIV positive people attach to their families, especially children. The families tend to be viewed as the sole source of support and care. In all participants, the close family members had proven to be quite helpful and supportive, that enhanced participants to capacity to cope with the burdens of HIV and its social consequences. More interesting was the central position assumed by children in the lives of the HIV positive people. The participants revealed that children have become their reference points, to which they attach all their aspirations and purpose of being alive. Most of the participants expressed that they are surviving only to see their children grow in an environment that guarantees them prosperity and enriching lives.

Moreover, the participants attributed their present positive attitude towards life to their association with other HIV positive people. The association with an NGO has helped them to regain confidence and self-determination in their lives. Their activities of conducting various awareness programmes and involving and sensitizing other stakeholders are aimed to create a more responsive environment for other HIV positive people. Thus, the findings of this study also illustrate that the positive interactions between HIV positive people and others were not only helpful for them to constructively understand this disease, but also significant for building a supportive environment for people affected by this disease in the long term. The significance of their association with the NGO was quite evident from their accounts of last month's activities in various localities. A few of them, especially those whose families have rejected or discriminated them, consider the relationship with this NGO more valuable than their family and relatives.

The issues of stigma and discrimination confronted by the HIV positive people and other social responses to HIV-infected bodies in practice suggest the importance of understanding the non-biomedical dimensions of HIV/AIDS constructions and their impacts on social and interpersonal interactions. Thus, in the end it is strongly emphasized that the creation of a supportive social environment is indispensably imperative. It is determined by the achievement of social justice for various groups who have been disproportionately affected by HIV/AIDS due to their gender, socioeconomic status, sexual preference, and lifestyle.

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