Poverty and Illness: Double Edged Sword Facing People Living With HIV/AIDS and HIV Discordant Couple

Nupur Tayal1 Subhasis Bhadra2
12Gautam Buddha University

Abstract— Study of awareness about health among HIV discordant couples (DCs), their problems and challenges, Govt. facilities available to them and the extent to which those facilities are being availed of by them. Data collected through socio-demographic tool, interpretative phenomenological analysis and case study method from 4 DCs. Famine, social issues and psychological issues deteriorate quality of life of people leading to their migration. Famine and migration are also factors in the spread of HIV as famine leads to migration and migrated persons are more vulnerable. Most of the People living with HIV/AIDS (PLWHA) and DCs are economically weak. PLWHA experience more mental health problems than general population as stigma and discrimination adversely affect their mental health. They change home and job due to discrimination at workplace, fear of discrimination against their kids in school and discrimination by their neighbours leading to poorer wages and worse economic condition. Thus, they become poorer than general population and lead a stressful life. In India, we are not likely to meet Millennium Development Goals (MDG) by 2015. In India, many programmes have been launched by National AIDS Control Organization for the betterment of PLWHA and DCs. Still, PLWHA and DCs suffer more in India than in other countries. Intervention is urgently required for improving their mental and physical health and to improve their quality of life. Government should focus on vocational training of affected person to enhance their livelihood opportunities to improve their economic condition and of their family.

Key words: HIV, Discordant couple, poverty, illness, discrimination, migration

I. INTRODUCTION

Poverty and illness are interrelated and might be leading to HIV or it may be vice versa. However, poverty was prevalent prior to HIV leading to a vicious cycle. HIV is becoming a bigger global problem despite best efforts to contain it since its first detection in 1981. People of HRGs (High Risk Groups) viz. FSW (female sex workers), MSM (men sex with men), IDU (injecting drug users), infected mother to child transmitters and it includes DCs are spreading HIV all over the world at a very fast pace. A DC is a married couple living in long term sexual relationship with one partner being HIV positive and another being HIV negative. Almost half of people infected with HIV are in discordant relationship. Uninfected partner becomes more vulnerable to HIV and infected partner continues to infect others without being aware of it or even after knowing about it. Stigma and discrimination are the biggest psychological issues for PLWHA and DC. Psychological distress adversely affects their quality of life and change of job, working place and family issues lead to spiraling. Life become awful for DC and also adversely affects the life of other people in their contact, leading to mental disturbance, conflicts and adjustment problems. There is an urgent need of psychosocial support to facilitate them to face their adverse life situation with a positive frame of mind.

Poverty and economic marginalization are the main causes of the spread of HIV. Poverty brings frustration which may lead to unprotected sex among DCs. According to studies- half of DCs are not using condom and thus MDGs (Millennium Development Goals) become unachievable. There is a big gap in facilities and services available for PLWHA in USA and those in India. Evaluation of available programmes reveals that these are not compatible with the aim leading to greater difficulties for PLWHA in India.

In the present article, qualitative approaches have been applied to analyse and interpret. Socio-demographic tool, interpretative phenomenological analysis and case study methods have been used to draw inferences. Convenient sampling method was used as the PLWHA were known population.

Denial of women’s rights was found quite evident. Among women, helplessness, stigma, discrimination, guilt, shame, worthlessness and social insecurities were found quite prevalent. Discrimination at work place, loss of employment, fear of discrimination with children in school, bad marital relationship and lack of social support were clearly evident. Govt. should take some firm steps for better future of PLWHA and DC. So many Govt. schemes are in existence but are not being implemented properly. Also, discontinuation of any Govt. scheme will further bring hopelessness among the affected people.

II. LITERATURE REVIEW

HIV was first identified in 1981 and since then PLWHA was described in Los Angeles and New York (Daar, 2013). By the mid of 2014, total number of people living with HIV was more than 35 million and among them 2.4 million are living in India (WORLD BANK, 2012). Worldwide, 2.5 million were detected newly infected in 2011 and 2.1 million in 2013 (WHO, UNAIDS, UNICEF, 2013). AIDS comes after eight to ten years of onset of HIV infection (if no treatment is given). According to NACO (National AIDS Control Organization), high risk of HIV is among injecting drug users, infected blood transfusion, infected mother to child transmission and main risk of HIV is unprotected sex (WORLD BANK, 2012).

HIV can infect person of any age and sex. Mobile population, continue to spread the disease. Truck drivers, assistants, migrant labour workers, refugees, sex workers, men sex with men (MSM), injection drug users (IDUs), infected mother to child transmission and professional like surgeons, dentists and nurses are highly prone to HIV. Sexually transmitted infection (STI) increases the risk of HIV transmission three to five times. Younger people are more vulnerable to HIV infection creating even a bigger threat to socio economic development (Goldberg, 2011).
In India, transmission is unusual and it starts with sex workers. They infect others and thus it continues to spread in the society as these persons infect their wife. Also long distance truck drivers and single male migrants are other important sources of spread of the disease in the society. Truck drivers and single male migrants are a bridge population. They spread infection from sex workers to home and other low risk women in the society. In India, during 2011-12, the estimated population under High Risk Group was Female Sex Workers 12.63 lakh, MSMs and transgender 4.27 lakh, IDU’s 1.86 lakh, truckers 11.33 lakh and migrants 11.43 lakh. Most infections are spread through heterosexual mode. Infected mother to child transmission was 5.0 %, infection transmission among IDU’s was 1.7 %, homosexual transmission was 1.5 % and through contaminated blood and blood products was 1.0 % (NACO, 2011-12). An infected partner, who did not disclose or did not know about it, will continue to infect other partner. These people are called DC.

Discordant relationship is also a very high risk group. DC is a married couple living in long term sexual relationship with one partner being HIV positive and other HIV negative. Discordancy was recognized by UNAIDS in 2008 in developing countries. According to WHO up to 50 % of people infected with HIV are in discordant relationship. This ratio in African countries is more than 66 % (Zákumumpa, 2011). Discordancy is at higher risk.

Quality of life is reported not satisfactory even when one of the HIV infected partner is receiving ART. Psychological distress is additional onslaught. It is said that psychosocial support is needed with ART to improve the quality of life. Medical treatment of HIV alone is not sufficient. Psychological distress makes the life awful for DC and also affects the life of other people in their contact. There has been research in this field but very few studies were conducted in India. In Indian culture, the family ties are close and social status is important in public life. Therefore, disclosure of HIV positive status of DC causes stress among them leading to mental disturbance, conflicts, adjustment problems etc.

For a PLWHA, good health (mental and physical) is needed to extend their life span. Mental health and HIV/AIDS are closely connected as stigma and discrimination directly affects mental health. PLWHA experience more mental health problems than general population (Carter, 2012). Nearly 16.5 % of HIV infected people also suffer from mental disorders like depression, post-traumatic stress disorder and substance abuse disorder in South Africa (Goldberg, 2011). Among DC, psychological stress, excessive alcohol and drugs abuse is prevalent. Lack of emotional adjustment and other issues predominate the relationship leading to bad physical health, compulsion to migrate. They have to work harder for good food at other place for survival and they have less food to eat leading to malnutrition, deterioration of their health and leads to mortality. A study conducted in Botswana found that about 50 % of PLWHA are at the risk of malnutrition (Nnyepi, 2009). ‘Good diets and nutrition help many PLWHA feel healthier’ (Nelson Vergel, 2014). When PLWHA have to change their house to take care of health, they faces financial problems and are bound to live in far-off areas from the city leading to lack of transportation causing food insecurity and; as a result non-adherence of ART is also seen (Kalichman, 2014).

Due to health hazards (HIV) and economic down turns (loss of job due to stigma and discrimination), migration takes place. Migration depends on three things - famine, social issues and psychological issues which deteriorate their quality of life. Life events like illness and loss of livelihood have dreadful impacts and are major causes of poverty and famine brings migration. According to NACO report 29.24 lakh High Risk migrants found in 2013-14 (NACO, 2014).

Poverty brings frustration which may leads to unprotected sex among DC. Poverty and economic marginalization is the main cause of spread of HIV as mentioned by Crush. According to an Indian study, only 47 % of DC use condom (Mafatia, 2013). It reveals MDG (Millennium Development Goals) could not be met by 2015 in this area (Prasanna, 2013). MDG have 8 primary goals set by 189 Member States of United Nations at United Nations Headquarters in New York in September 2000 (UNDP, 2000).

Poverty and illness are two major problems or we may call them curses, in India. A blend of Poverty and HIV/AIDS is not only in India but it is a worldwide issue. As WHO said, in Nigeria, poverty is prevalent issue among Nigerian PLWHA (Ezeokana, 2009). In Africa, PLWHA’s primary concerns are unemployment and poverty than HIV (Cloete, 2010). WHO believe that poverty is world’s most brutal killer and main cause of sufferings (Gupta, 2006). One third of World’s malnourished children are in India. It shows parents don’t have money or eatables to give their children so they want children to work and earn to survive. They send their children to work instead of to school or make sit at home the girl child, to look after their younger siblings and parents said no education was needed for household chores and agricultural work performed by most of the women in India. Only 39 % of women attend primary school. Women have equal rights as men according to Indian constitution. No equality even after 67 yrs of independence and 64 yrs old constitution. WHO has announced that India will miss its target of MDG-2015 with a big margin. Minority Affairs Minister Ms Najma Heptullah has said that; India has failed to achieve the goal of key parameters and is on the top of list of poor country on the globe (Roche & Mehta, 2014).

Most of the PLWHA and DC are economically weak. Strong bond is seen between poverty and HIV/AIDS.
United States take it as health emergency and launched a programme PEPFAR (President’s Emergency Plan for AIDS Relief) in 2003 to fight AIDS, Malaria and TB. In which 72% of the fund is for HIV/AIDS, fighting for AIDS free generation (USAIDS, 2012) (Foundation, 2014). US Government is providing houses to PLHWA. But in India, if a PLHWA migrates to Delhi, ART centre wants identity proof of being citizen of Delhi (migration is intra-country) otherwise they will not register the person for ART. It means PLHWA will not get ART. Hence, PLHWA is bound to struggle due to lack of ART. India faces difficulty due to lack of funds. Some projects were launched for the welfare of PLHWA and DC by WHO and NACO (WHO, 2012) (NACO, 2010). In Orissa and NCT (National Capital Territory) of Delhi, Government provided BPL (Below Poverty Line) card to PLHWA for food and housing (Nussbaum, 2010).

NACO provided a support system for the welfare of PLHWA, assigned Non-Government Organizations (NGOs), Community Care Centre (CCC) and Comprehensive Care and Support Centre to strengthen Community Care and Support Programs for PLHWA. Under NACP-III, NACO gave the following service model to CCC: - medical services like minor and major opportunistic infections (OI) management, post-exposure prophylaxis and anti-retroviral therapy, ART adherence, education on nutrition and hygiene, watch for side effects/complications, missed/ defaulter tracing and follow-up. Positive prevention like support positive attitude & disclosure of status, promote condom use, Sexually Transmitted Infection treatment, PPTCT for positive pregnant women, family planning education and home based care like Terminal Care/Care of bedridden patients, hygiene and sanitation, infection prevention and sign and symptoms of minor OIs, Referrals or linkage to ICTC/PPTCT/ART/DOTS/LAC, STI clinics, Government schemes, NGOs. District level network of people living with HIV for other support, Respite home/destitute care/extended family/ orphanages, linkages to legal support- property, workplace, Schools/ Shelter, linkages to schools, vocational training etc., link to Food programs, Social security (insurance, saving IGP), De addiction, Referral for psychological/ psychiatric treatment and support including counseling for self- disclosure, Counseling and Testing for family members, Family counseling, Bereavement counseling and Advocacy against stigma (NACO, 2010).

For the prevention of transmission some projects were launched like The Home-Based Care, Couples HIV Counseling and Testing, the Partner Project and Key Educational Messages etc. whereas WHO launched special programs like: (i) New ARV guidelines. (ii) New guidance for prevention and treatment of HIV in sex work settings in partnership with UNFPA, UNAIDS and Global Network of Sex Work Project to reduce the HIV infection among sex workers. (iii) World AIDS Day 2012: Getting to Zero® with the help of its partners globally. (iv) Helping to get 15 million people onto ART by 2015 (USAIDS, 2010) (WHO, 2012).

An evaluation of CCCs running by NGOs which are funded by NACO, found that either CCCs are for the holistic care of PLHWA. Some CCCs are linked to big private hospitals. In Gujarat (a high prevalent state) there is no CCC. Awareness about CCCs is very less among staff of health facility as well as PLHWA and awareness about CCCs facilities are not known even among the staff of CCCs. Awareness and sensitization programme about CCCs on health facility, at CCCs (for staff), facilities and funds provided to CCCs by the NACO should be strengthened (Independent Evaluation of NACP, 2013) (NACO, 2013). The evaluation of programmes reveals that the programmes are not running properly and thus programmes are not compatible to the aim.

III. METHODOLOGY

Chose qualitative approaches to draw analysis under the socio-demographic tool, interpretative phenomenological analysis and case study methods were used as a methodology of qualitative analysis to draw deep inferences.

Socio-demographic tool used to find basic information about individual’s education, occupation, income, spouse, children, family, relatives, friends and neighbours etc.

Interpretive phenomenological analysis is a qualitative approach which is recently used in psychology to draw deep inferences from the field of health, human and social sciences. Through this approach individual’s personal perception and lived experiences can be experienced (Birkbeck, 2011). Under this approach, participant tells real life experiences and analysis is to find the common theme, situation and condition from those experiences. Not only one rather multiple interviews are necessary to achieve depth meaning from statements and quotes. It is used in psychology by Moustakas in 1994 (Padgett, 2008).

Case study is a qualitative technique to draw deep inferences about the individual or community. Case study is of two types- individual case study and community case study, as the name suggests in individual case study, an individual or person is a social unit. In community case study, community or society is a social unit, it may includes location, economic activity, climate and natural resources, historical development, social structure, life values, health education, religious expression, recreation, impact of outside world (Singh, 2004) (Anastasi, 1968).

Case study data can be drawn through several modes such as interviews, questionnaires, analysis of recorded data, conferences, dramatic productions, tests of abilities, social reactions to frustration, imagined productions etc. The purpose of case study is to draw deep inferences from studying unit and reason of its cause. The main element to focus in it is typically not uniqueness.

Meron Paulos (2011) used case study method as a tool of investigation in a study conducted on HIV DCs (Paulos, 2011) and also used in Nepal to see social support, hope and quality of life of PLHWA (Yadav, 2009). It is very common and important type of non-experimental research or descriptive research, a useful study method. It is mainly used in social science study to organize social data to view the social reality. In this a social unit is studied as whole, a social unit can be a person, family, group, institution or a community.

Used convenient sampling method, because DC / PLHWA is known population.

The author is giving clear and real picture about the situation considering confidentiality and ethics, without
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revealing any name. Author worked with DSACS (Delhi State AIDS Control Society), a unit under NACO.

PLWHA and DC faces so many difficulties in their life viz. fear of discrimination in school, discrimination at workplace leading to loss of job and frustration and bitterness in relation with spouse, family and neighbours. The situation could be better understood with the help of the following four case stories-

A. Case Story:
This story is of a DC in which male is infected and female is affected. Before infection they were enjoying a happy life with a daughter. Infection brought disastrous change in their life. It seems as if this is the end of their life. The person got infection (nature of job gives cuts in hands) while helping one of his coworkers (good deed) and was shocked at the time of detection. In disbelief, he got himself tested 13 times at different places and was found to be positive. Wife could not bear the shock and became ill. The workplace was disclosed and when his boss came to know about his infection, he was kicked out from job (job loss). Due to loss of job and increased household expenses, he faced financial hardships and had to sell his house to take care of family chores. His wife scolded him and a discord in relationship started and they stopped talking to each other. He thought death is near due lack of proper scientific information. He planned to marry his daughter at age earlier than he was planning prior to HIV status change. He sold his house and money was used for the treatment of self and marriage of daughter. Neighbours came to know about it, but no one came to help. They changed the place of residence and did not disclose the status to anyone at the new place. They did not even disclose to school teacher of her daughter (fear of discrimination in school). For livelihood, he started to work with HIV positive people. They got associated with NGO which provided Rs100/month for kids and Rs1000/month from ART, which providing a ray of hope to live better but governmental schemes were discontinued due to unavailability of funds.

B. Case Story:
In this case of DC, male is infected and female is affected. The scenario is same as above but the set up is different. In this case, male is not very much stressed about the earning for livelihood. Even in the poor economic condition, all the need for survivals was fulfilled by female member of the family. The lady mistrusted her husband regarding transmission of infection. They have a family of four kids, two elder children wanted to earn for livelihood and were pursuing vocational training. However they had to leave training due to lack of resources and so lost both school as well as training. Mother is depressed about the future of their children. Among the four, two were attending school, but their status is not disclosed to the school. She said, “We don’t tell to teacher of our children, what is the need to tell them, they will not help us in anyway rather they will not entertain our children or may kick out them from school”. She is the only one, earning for six people family. She told that from last 15 days she was not well and can’t go for work (worst financial condition). Marital and family relationship are also bad, “he does not bother about me for infection, earning, food for family, study of children and thus anything about me and family, I am the only person who takes care about all this”. They don’t have any social circle. Any new information provided by their only friend.

C. Case Story:
This is another story of a DC where male is infected and female is affected. They are extremely afraid of disclosure; don’t talk to any friend, neighbour, relatives etc. after infection. Being a joint family and very much conscious about disclosure, they didn’t disclose anything to other family members. He kept on changing his job due to fear of disclosure. Due to weak financial condition, she wants to go out from house to overcome the stress and to earn for family but being a joint family she is not allowed to go out. They ask her, “why you want to work, tell us what the problem is” (fear of stigma and discrimination). He was depressed and said,” I am about to die or will commit suicide”, and was eager to join PLWHA group to see the condition (physical and mental) of those people who are having HIV for more than 10 yrs, whether they are about to die or living properly . PLWHA don’t want to disclose their status to anyone including, to the teacher of their child. Both of them were in depression. Marital life is not satisfactory as she does not want to live with him but she has to. She does not talk to anyone due to fear of disclosure.

D. Case Story:
Among this DC male is infected and female is affected. Earlier, they didn’t heard about the word HIV. When detected, they came to know about it. When his status was disclosed to wife first, she cried a lot and didn’t want to stay with him. After some time, she accepts it. Felt discriminated by family members—neighbours, relatives, school, workplace everywhere, as family members stopped talking, stayed away, did not allowed to touch anything, relatives stopped to talk, neighbours went inside their house when they came out, teacher stuck off the name of their children from school and coworkers started behaving unexpectedly. So they left that place and moved to other city. Worst economic condition, having a large family with five kids they have to earn their livelihood to survive, both of them do work for survival, lady is doing household chores in different houses and male is doing work as a labourer. He is too weak to do this work, sometimes he can’t go for it and faces lack of food for family. Children are still drop outs.

IV. DISCUSSION ABOUT THE CASES
In Indian society, few things have their own outcomes. It is somewhat a male dominated society, although law provides equal rights to female in society but in real world the things are somewhat different. If a male does wrong things it is acceptable and the female is bound to live with that partner. On the other hand, if a female goes wrong, it is very shameful and unexpected deed, then a male member have right to expel that lady without asking any reason. In India, 5.5 % female were asked to leave home as compare to 1 % male (Pradhan & Sundar, 2006). In above mentioned studies, problems were being faced by both male and female members but author experienced that the ladies were the worst sufferers.

PLWHA and DC change their house and work place due to discrimination at workplace, fear of discrimination with their kids in school, neighborhood issue
and may be poorer due to poorer wages received at other place. Usually, they remain poorer than general population and lead a stressful life. Problems and challenges evidently came through in case study method.

A. Marital Relationship:
In the cases went through by author, it was found that females don’t want to live with their infected male partner but they have to do so. One of them said “my husband wants a baby boy that’s why he becomes irritated”. In another case of mistrust where husband is infected, husband and wife told different reasons of infection. In another case, wife actually doesn’t want to live with husband but she has to stay with husband otherwise her parents will feel guilty in society.

A study conducted in India reveals that DCs are facing unique socio-cultural problems like marital and fertility pressure (Solomon & Solomon, 2011). Family relations are bad in most of the cases. Husbands physically injure their wives (Michele Cascardi, 1992). Strained relationship is also reported (Rispel, Metcalf, Moody, & Cloette, 2009). About 7% of DC reported violence after the disclosure of the status (World-bank, 2010).

B. Discrimination at School:
Author talked to many persons, nobody revealed their HIV status to school teacher or peer. This is only because of fear of discrimination. They think that teacher will not provide proper services or stuck off their child from school roll call.

A study conducted by UNICEF in Kerala reveals that 88% of infected children did not disclose their status to school because of fear of discrimination and those who told faced so many different problems. According to a study, children may be treated badly (UNAIDS, 2003). Discrimination is seen all around with infected and affected persons. It is very common with school age children and fear of discrimination worries parents and they do not wish to disclose their status.

C. Discrimination at Workplace:
No one wants to share infected person’s food or people don’t even want that an infected person touch their food at the time of lunch or tea break. People look at them with sympathy only (bechara). Even educated people who understand that HIV cannot be transmitted via touch have sense of discrimination. They don’t even want to touch their papers or documents. Because of discrimination people feel guilt, shame and worthlessness and have to leave their job.

A study was conducted by International Labour Organization (ILO) in Vietnam on a sample of 200 factory workers and it was found that HIV infected had been ostracized by their co-worker (Family foundation, 2003). Discrimination at work is remarkable. Many people are facing this difficulty even while the government is spreading awareness through media.

D. Loss of Employment:
In some cases, where co-workers found out the status about their infected colleagues, they quit their job because of shame and fear of discrimination. One person told, ‘I got infection from one of my co-worker. I had already got cracks in my hand due to nature of job. One day, a co-worker got a cut in his hand and started bleeding. That blood came in contact with my cracks and I got infection and owner asked me to leave the job’. Some infected persons have to leave their job because of work load and doctors said not to take too much exertion, live life tension free (can you just imagine a tension free life without earning). Once you leave a job it is quite difficult to get another job in India.

One UNDP study tells that 74% of HIV infected people did not disclose their HIV status due to fear of losing job (UNICEF, 2007). Loss of employment is very common among HIV infected persons. It can be because of discrimination, work load, shame or any other.

E. Neighbourhood:
Both types of neighbours are there in our society i.e. good and bad. Those who are helpful in need and those who close the door at your face in need. A tag of HIV infected or affected brings stigma and discrimination in our society.

According to a study people don’t allow their children to be friend with HIV infected or affected children. In the same study an infected person doesn’t want to disclose his status to the neighbour. He thinks the onslaught may be people will throw stones on him until death (UNAIDS, 2003). According to a study, 18.3% of people are victim of neighborhood discrimination (DNPP, MNPLAWH, NMPLWH, PWNSI, 2003).

Most of the people did not disclose their HIV status to their neighbours because of associated stigma and discrimination. What will they think about us? Will they talk to us? Will they allow their children to play with our children? Some of them told that no one is helpful these days, as society may just make them a laughing stock. They also told that they tried to feel the response from the society and the response received was very distasteful. Some said we don’t share personal things with neighbours where as some told that they change their house after infection because neighborhood comes to know about their status.

V. Conclusion:
For this research, choose cases where males are infected and females are affected and not infected. Discrimination at work place, loss of employment, fear of discrimination with children in school, bad marital relationship, and lack of social support is clearly seen in above mentioned cases. Discontinuation of governmental and non-governmental schemes worsens the situation further and can generate psychological issues like hopelessness. Government has a major role to play and many psychosocial issues can be taken care of by proper and timely government intervention.

Based on the cases discussion it is found that some NGO provided Rs. 100/ per month for kids for few months and then discontinued indicating lack of funds. A scheme launched by the departments of Delhi Govt. to pay Rs. 1000/ to every individual who is registered in ART centre from more than one year (DSACS, 2012). This provided a ray of hope and some poor people took a sigh of relief. This provided them good food (it is required for their body) but after 3-4 months the scheme was discontinued due to lack of funds.

Lack of awareness in masses is rampant. Govt. should work properly and honestly in this field. Counselors should provide them, at least basic information otherwise...
these patients become burden for the society. NGOs and related agencies should help people as well as Govt. without any personal interest. The officials should do sincere efforts in this field so that maximum number of people can take benefit. VCT, condom and risk reductions are available but use is still slow (solomon & solomon, 2011).

Some private hospitals and laboratories provide wrong test reports. A person tested HIV positive from one lab and received ARV for two years. After two years, he was tested for HIV and was found uninfected thus the previous diagnosis was wrong and he took medicines for 2 yrs in vain. One person diagnosed HIV positive at one ICTC went for another laboratory in disbelief and was found to be not infected. He did not believe and got tested privately and was found uninfected. Came, talked and got again tested at a different centre and was found infected then believed. Another person tested 13 times in disbelief. This shows that the data available with NACO is not perfect. There shall be labs run by government which people can rely upon. Labs in the private sector are unreliable and shall be legally liable for wrong test results. WHO inform to retest before ART initiation (WHO, 2014) but what about private labs.

A service model (NACO, 2010) provided by the NACO is not working properly so intervention programmes are needed for betterment of physical and mental health (complete health) of PLWHA and DC. A service model is required for affected children like vocational training programme to earn their livelihood and thus their economic condition can be improved.

Infected people are afraid about the future generation and contemplate the incidence of infection to uninfected children. People say what will happen to their kids after them. They are too young to earn so the government should start some program for this group of population.

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