Gender and HIV/AIDS scenario in the State of Gujarat.

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Abstract: Gender is an important dimension in understanding and creating control strategies for the HIV/AIDS epidemic. Gender inequality and discrimination against women has affected the course of the HIV epidemic. This paper gives an overview of HIV/AIDS epidemic in the state of Gujarat and outlines the importance of understanding gender equations to fight the epidemic. The paper is based on and supported by data from six districts of Gujarat which was collected from 151 respondents who are fighting the disease and undergoing treatment.

Keywords: Gender, HIV/AIDS, Vulnerabilities, Awareness, Challenges, Self- respect

1. Introduction

The importance of understanding Gender to tackle the epidemic of HIV/AIDS epidemic is crucial because women are many a times innocent victims as they do not have the social empowerment to say no to their partners who do not use protection while having sex. They do not have economic independence, decision making powers or authority in a hegemonic patriarchal society thereby increasing their chances of catching the disease. It is well known that 'Sex' is biological and 'Gender' is a social construct .One is born 'male' or 'female' but go on to learn to be 'men' or 'women'. This 'learnt' behaviour makes ones 'gender identity' and goes on to determine 'gender roles' which in turn decides who gets to have more power, which roles and responsibilities, privileges etc. and mostly men get the larger part of authority and decision making rather than women. This paper which is an outcome of an ICSSR research project titled, 'HIV Control Strategies: An Assessment of Self Concept, Gender Issues, Role of Government and Voluntary Sector in Gujarat State, India' is from research undertaken by the authors in six districts of the State of Gujarat wherein 151 respondents who were HIV/AIDS patients and 50 NGO staffers were interviewed by taking their consent and prior permissions from the relevant authorities. To understand the gender dimension it is also important to get an overview and the expanse of the epidemic.

Gender-related parameters related to HIV/AIDS in India

Gender has elements of a social construct that are based on sexuality. Understanding the individual risk factors of HIV/AIDS, free from gender, includes myriad behavioural, cognitive and lifestyle factors. Introducing gender to this interplay brings with it the attitudes and behaviours that are associated with individual sexual knowledge, cultural and societal acceptance (UNAIDS

factsheet, 1999). India has prevailed as a hegemonic patriarchal society. Its values, traditions, and norms often favour the male species and create hindrances for women at multi-faceted levels and forms (Shukla et. al, 2018). Studies suggest that HIV/AIDS-related deaths are the major cause of death amongst women that belong to the reproductive age group (UNICEF UK, 2010). Women diagnosed with HIV infection face extensive stigma, pressure from family, experience discrimination at workplace, communities, and schools (Mothi, Lala, &Tappuni, 2016). Research on the psychological effects of mothers living with HIV reported that the population reported elevated levels of depression when their lives at home and their roles as caretakers were considered. The pressure of increased household responsibilities and tasks, poor family sociability and the low ability of mothers with HIV to perform regular tasks was significantly associated with elevated levels of depression (Murphy, Marelich, Stritto, Swendeman&Witkin, 2002; Pradhan, Sundar, & Singh, 2006). Gender-sensitive interventions that address gender inequality amongst family and partners, stigma related to HIV for both, PLHIV and their families would support families to acknowledge care and treatment for women and overcome discrimination (Kohli, Purohit, Karve, Bhalerao, Karvande, Rangan, Reddy, Paranjape, &Sahay, 2012).

Gender is a strong determinant of an individual's response towards HIV, such that there are various instances in India where women are targeted and insulted as being impure and infecting the men, or removed from the households after widowed. Women are at a biological disadvantage when it comes to contracting the HIV infection as it is transmitted more easily from men to women than from women to men (UNICEF, 2005; Pradhan, Sundar, & Singh, 2006). Amongst certain scenarios in India such as economic dependence on men, limited access to property or control over it, unequal access to education, limited control taking decisions about their own body, limited opportunities to indulge in safe sex, lead to women being subjected to inequality that multiplies in its impact when paired with a chronic and life-threatening disease like HIV (Pradhan, Sundar, & Singh, 2006; Aggarwal, 2008; Shrinivassa, Cherian, Bhat, Chapman, Lukose, Patwardhan, Satyanarayan& Ramakrishna, 2015). In some regions, high prevalence of rape, intimate partner violence (IPV), domestic abuse, and forced sexual practices, put women at higher risk of contracting HIV (Silverman, Decker, Saggurti, Balaiah, & Raj, 2008). Additionally, a higher rate of women being affected by HIV increases the chances of pediatric HIV (Mothi et al., 2016). HIV from this route is highly preventable, irrespective of improvement in the services provided by the government, the basic issue of human rights needs to be addressed while combating widespread stigma in our culture. A large-scaled study on IPV and HIV for which the data from demographic and health surveys of 10 countries were analyzed found that almost 0.5% of women surveyed in India who reported IPV (physical and/or sexual violence) also tested positive for HIV (Harling, Msisha, & Subramanian, 2010). The analysis also indicates that women who reported any type of IPV appeared to be at an increased risk of HIV infection (Harling et al., 2010). A study focusing on married women in India found that 36% of married women reported having suffered from IPV - 28% reported experiencing physical IPV only, 7.68% reported experiencing both physical and sexual IPV - at the hands of their husbands and 0.22% of those women tested HIV-positive (Silverman et al., 2008). A facet of HIV infection for these women is the violation of rights and individuality. Specifically working with women and men on changing certain gender norms that promote IPV and abusive HIV-related sexual behaviours might reduce the risk of infection in abusive men and the partners of these men (Silverman at al., 2008).

In India, support groups have been formed for women, which work to challenge human rights violations, provide call for action for appropriate healthcare for women with HIV, and to curb the violence they face (UNAIDS, 2014; Mothi et al., 2016). NACO acknowledges HIV related risk to transgender people. While gender inequality, sexual roles, and norms, make women of HIV households more vulnerable to the increased psychological and physical burden, extended to include the perspective of self-diagnosis, relationships issues, risks & vulnerabilities, legal and economic position (Rathi, 2018; Grieg, Peacock,Jewkes, &Msimang, 2008).

To counteract the imbalances in society, there is particularly a strong need for specific gender tailored strategies.

A Brief Overview of the Government Strategies to combat HIV/AIDS

The Ministry of Health and Family Welfare established The National Aids Control Programme (NACP) which further led to the establishment of State AIDS Control Societies and collaborations with NGOs at the state level. The spread of the epidemic in India varies from state to state. The prevalence of HIV in the states of Maharashtra, Karnataka, Andhra Pradesh, Manipur, Mizoram and Nagaland is considered to be relatively high. States such as Gujarat, Tamil Nadu, West Bengal, Chandigarh, Kerala, Jharkhand Bihar, and Jharkhand have medium to low prevalence of the epidemic. The State HIV/AIDS control societies, NGOs and other international agencies work in the best interests of the patients along with the government conforming to the guidelines given by the centre. Targeted intervention for high risk population group, Blood safety programme, integrated counselling and testing centres, Strategic Information Management Unit, Condom promotion and Programmes related to information, communication and education (IEC) to combat the spread of the epidemic have been taken up by majority of the states across the nation.

India's approach towards combating the disease has brought down its adult prevalence rate (Ages 15-49) from 0.91% in 2005 to 0.2% in 2018. The highest prevalence rate was found in Mizoram at 2.04%. This was followed by Manipur (1.43%), Nagaland (1.15%), Telangana (0.70%) and Andhra Pradesh (0.63%). The other states that have shown a prevalence rate greater than the overall rate are Karnataka (0.47%), Goa (0.42%), Maharashtra (0.33%) and Delhi (0.30%). Tamil Nadu had a rate of 0.22%, the same as the national average. All other States and Union Territories depicted levels below 0.22%. The estimation of the total number of HIV infected people in India came at 21.40 lakhs. Maharashtra ranked highest, with a population of 3.30 lakhs being affected by HIV. It was followed by Andhra Pradesh (2.70 Lakh), Karnataka (2.47 Lakh), Telangana (2.04 Lakh), West Bengal (1.44 Lakh), Tamil Nadu (1.42 Lakh), Uttar Pradesh (1.34 Lakh) and Bihar (1.15 Lakh). Other states and union territories showed less than 1 lakh people living with HIV**.**According to data, India reported over 26,000 cases of new infections of HIV in 1990 (GBD, 2017). The cases of new HIV infections almost doubled the following year in 1991, which doubled again to approximately 150,000 new cases of HIV infection in 1992 (GBD, 2017). From 1993 to 1997, the rate of increase in the cases of new HIV infections each year reduced. In 1998, new cases of HIV infection reached its peak, at over 290,000 (GBD, 2017). The next decade reported the annual number of new infections of HIV has declined from 289,799 to 100,488 in 2009 (GBD, 2017).

India has had large numbers of people infected with the disease. The prevalence of HIV in the nation could be discussed via social disparities. There is mixed evidence that suggests two lines of thought regarding the focus of the HIV epidemic. One suggests that socially disadvantaged groups (limited income, poverty, lack of access to education, employment, and healthcare) are deeply affected by HIV due to lack of fear of consequences, which increases exposure to risk-taking behaviours and susceptibility to indulge in risky sexual behaviour(Perkins, Khan , & Subramaniam, 2009). HIV prevalence in the economically and socially advantaged groups is attributed to them being enabled to heavily indulge in purchasing and indulging in sexual activities and maintaining multiple sexual relationships, as they possess resources greater than their needs (Perkins, Khan , & Subramaniam, 2009). In 2017, approximately 22.67 thousand women who had tested positive for HIV bore children. The state-wise Prevention to Mother to child transmission (PMTCT) need was found to be most in Maharashtra (2.41 thousand), followed by Uttar Pradesh (2.29 thousand), Bihar, Andhra Pradesh, Karnataka, Telangana, West Bengal, Gujarat, and Tamil Nadu. The need was found to be least in Sikkim. Reports support that the HIV disease is pointing towards a decline in India (Paranjape & Challacombe, 2016). However, there are critical concerns regarding the elevated level of the disease in high-risk population groups. HIV can further be managed when driven by a combination of strategies that move beyond policies and medical resources. The most recent Indian estimations reports indicate that the incidence rates are much higher in the high-risk groups as compared to the population, especially in states Mizoram, Nagaland, Telangana, Maharashtra, Manipur, Bihar, West Bengal and Uttar Pradesh (NACO & ICMR, 2018).The HIV/AIDS scenario in the heterogeneous states differ with varying culture, education levels, economic levels, gender-dynamics, geography, and occupation (Perkins, Khan , & Subramaniam, 2009)). These factors are reflected in the level of awareness and acceptance which prevails among the people residing there, in turn affecting the quality of life of people with HIV and people vulnerable in contracting HIV. Stigma and discrimination is a major challenge while dealing with HIV infection. Some newer ways to overcome these problems could involve going beyond conducting awareness and counselling campaigns for people infected and affected, by including awareness by sensitization and normality of uninfected and unaffected people. The plethora of information from research on HIV/AIDS is innumerable. Upon the first case being detected in India in 1986,in the following year, India promptly responded to combat the infection at the early stages itself, by setting up an AIDS task force and a National AIDS Committee (NACO, 2012). A Medium Term Plan from 1990-1992 was launched to establish a surveillance system and safe blood supply in 8 states – Tamil Nadu, Maharashtra, Manipur, West Bengal, Chennai, Kolkata, Mumbai and Delhi (NACO, 2012).To address the spread of HIV, a national response program called the National AIDS Control Program (NACP) was launched, in 1987. NACP addressed medical and blood screenings, surveillance, estimation, and creating awareness (Sharma, Zodpey, Quazi, Gaidhane, Sawleshwarkar, & Khaparde, 2011). It was quite later, in 1992, that an autonomous organization was founded, the National AIDS Control Organization (NACO), with an 84 million line of credit (The World Bank, 2004). It aimed to develop, regulate and execute HIV/AIDS-related strategies, programs, and policies in India, especially among key populations to understand the burden of the disease and the epidemiological trends (Sharma, Zodpey, Quazi, Gaidhane, Sawleshwarkar, & Khaparde, 2011); (Paranjape & Challacombe, 2016); (Tanwar, Dharma, Dharma Rao, & Seguy, 2016). The current estimate of the number of people with HIV receiving Antiretroviral therapy (ART) is reported to be over 1.2 million and estimated number of AIDS-related deaths is over 69,000 (Granich, Gupta, Hersh, Williams,

Montaner, Young, & Zuniga, 2015). According to the WHO estimates, the total HIV-related deaths have been recorded as 32 million globally in 2018 (WHO, 2018). A study on HIV infected patients reported women scoring significantly lower on the quality of life scale than men, despite suffering through a lesser advanced form of the disease (Kohli, Sane, Kumar, Paranjape, &Mehendale, 2005). Furthermore, the quality of life domains that were affected was significantly correlated with HIV patients; these were physical health, work and earnings, appetite and routine activities (Kohli et al., 2005). There is a need for psychological and social interventions for people living with HIV. Women scored lower on the quality of life domains as compared to men, despite having better CD4 counts than men further indicating towards a major influence of economic standing, societal awareness, acceptance, gender norms, and roles, on the impact of a physiological disease (Nirmal et.al, 2008; Shiradkar, MandeBapat, &Setia, 2016).HIV can further be managed when driven by a combination of strategies that move beyond policies and medical resources.

Regional Context: Gujarat

The latest NACO estimates of 2015 reveal that 1.66 lakh people in Gujarat live with HIV. The annual number of deaths has declined by 40% in the state. The state has remained at a moderate level of prevalence since the reporting of its first ever case in 1986. The main reasons behind the spread of HIV in the state are the presence of the large tribal population, massive industrialization, urbanization and migration. The Gujarat State Control AIDS Society (GSACS) was established in 1999 during the second phase of NACP. It now works towards the accelerating the reversal of HIV epidemic in the state and provide comprehensive care, support and treatment to all PLHIV. The decentralised module to prevent and control HIV has been implemented in Gujarat through District AIDS prevention and Control Unit (DAPCU) in 10 most affected districts. They carry out the required training and capacity building sessions at local level along with monitoring and coordination of HIV programme in the particular district. GSACS have leveraged the use of IEC in the recent years for disseminating right information and services to target population groups through the use of mass media, outdoor campaigns, a celebration of World Aids Day and carrying out mainstreaming training with multiple stakeholders.

The Strategies of GSACS in Gujarat

The “State AIDS Cell” was started in 1992 by the government of Gujarat for the prevention and control of the epidemic.The first case of the HIV/AIDS identified in the Gujarat state was in 1986. The GSACS by the Health and Family Welfare Department (HFWD)of the Gujarat state established under the guidance of the NACO ,implemented the AIDS Control Programme Phase-3.The Vatsyayan Kendra &Mamta Clinic (VKMC) provides people an opportunity to learn and accept their HIV sero-status in a confidential enabling environment. HIV counselling and testing services are a key entry point to prevention of HIV infection, and to treatment and care of people who are infected with HIV. When availing counselling and testing services, people can access accurate information about HIV prevention and care, and undergo an HIV test in a supportive and confidential environment.1621 ICTCs are established in the Gujarat state for the integrated counselling and testing of HIV/AIDS. Free of cost counselling and testing of HIV/AIDS is available at the medical colleges, districts hospitals, municipality hospitals, charity hospitals and community health centres of

Gujarat state.High risk population like Female Sex Worker (FSW), Man having Sex with Man (MSM), Transgender (TG) and bridge population like Truckers, Single Male Migrants (SMM) are main groups targeted for various preventive interventions. The Targeted Interference Project has been implementing with the cooperation of volunteer organizations. Commercial sex workers and homosexuals get medical treatment of sexual deceases, condom, and literature for awareness of HIV/AIDS etc. GSACS also carry out services such as that of Sexually Transmitted Infection Care (STIs) services, Blood Safety Programme, Voluntary blood donation, Information, Communication and Education, The red ribbon club programme, The health-education and life-skill programme (HELP), The link worker scheme (LWS) along with care and support treatment. Link Worker Scheme (LWS) has been established in 11 districts (Navsari, Surrendranagar, Dahod, Banaskantha, Ahmedabad, Rajkot, Bhavanagar and Mehsana under Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) round IV with the support of CARITAS-India UNICEF, The LWS has been established in Surat, Vadodara and Valsad Respectively). LWS facilitated the scattered the high risk group (HRG) or rural areas and involves youth and women in the villages to generate awareness and linkages with services. The LWS scheme aims at building a rural community model to address the complex needs of rural HIV prevention, care and support requirements in selected geographies, providing anon-stigmatized enabling environment. It aims at improving access to information materials, commodities (condoms, needles/syringes) through collaborating with nearest TI or government health facilities, testing and treatment services ensuring there is no duplication of services or resources, thereby improving linkage to other social and health benefits provided by other line departments in line with local norms, regulations suitable for vulnerable population.

Details of Government assistance for HIV positive people

- Monthly assistance of Rs. 500 to HIV positive SEBC and OBC people for nutritional food.

- Monthly assistance of Rs. 500 to HIV positive widow who possesses the BPL ration card and additional assistance for Rs. 80 for child till the age of 18 years.

- Including in the Antyodaya Scheme to HIV positive person who possesses the BPL ration card.

- Transport allowance to HIV positive person for going to ART centres and Rs. 100 cash assistance with transport allowance to parents of HIV positive child.

- Provision of scholarship of Rs. 27.42 lacs per year for HIV positive and HIV infected students by Social welfare Department.

- Established the orphanage at Surat and Gandhinagar by Social welfare Department for HIV positive orphaned children.

- There are special provision of leave for students to go the A.R.T. centres and medical treatment.

- Rs. 1000 monthly assistance under the new scheme of assistance to guardian of orphaned children.

The Jivandeep project has been operating for bring out the matter of HIV in the main stream of society by people living with HIV/AIDS. Government pay monthly assistance of Rs.500 to HIV positive SEBC and OBC people for nutritional food. Role of Non-Government Organizations in prevention and containment of HIV/AIDS

NGOs have been playinga key role in combating HIV/AIDS globally as well as in India. Their already formed network amongst the marginalized group provides tremendous support in working at community level. They act as a bridge between the people and the health administration and relentlessly work towards raising awareness and self-esteem amongst the people living with HIV/AIDS and other target groups. They have been instrumental in providing information, education and communication especially to the young, homosexuals, women of reproductive age, prostitutes, and intravenous drug users. Organisations such as National AIDS Control Organisation (NACO), Naz Foundation., Bill & Melinda Gates Foundation. , India HIV/AIDS Alliance, Solidarity and Action againstthe HIV Infection in India (SAATHII).

Gender dimensions of HIV/AIDS

Violence against women, particularly domestic violence and rape, is widespread, and rising numbers of women are at risk from AIDS and other sexually transmitted diseases as a result of high-risk sexual behaviour on the part of their partners ((UNFPA, 1995) There are various biological, social and cultural aspects that put women and adolescent girls at greater risk of HIV infection than men. Over the years, it has now become extremely critical to add gender dimension to the policy, advocacy and practice of the prevention of HIV/AIDS. Gender has elements of a social construct that are based on sexuality. Understanding the individual risk factors of HIV/AIDS, free from gender, includes myriad behavioural, cognitive and lifestyle factors. Introducing gender to this interplay brings with it the attitudes and behaviours that are associated with individual sexual knowledge, cultural and societal acceptance (UNAIDS factsheet, 1999). India has prevailed as a hegemonic patriarchal society. Its values, traditions, and norms often favor the male species and create hindrances for women at multi-faceted levels and forms (Shukla et. al, 2018). Studies suggest that HIV/AIDS-related deaths are the major cause of death amongst women that belong to the reproductive age group (UNICEF UK, 2010). Women diagnosed with HIV infection face extensive stigma, pressure from family, experience discrimination in the workplace, communities, and schools (Mothi, Lala, &Tappuni, 2016). Research on the psychological effects of mothers living with HIV reported that the population reported elevated levels of depression when their lives at home and their roles as caretakers were considered. The pressure of increased household responsibilities and tasks, poor family sociability and the low ability of mothers with HIV to perform regular tasks was significantly associated with elevated levels of depression (Murphy, Marelich, Stritto, Swendeman&Witkin, 2002; Pradhan, Sundar, & Singh, 2006). Gender-sensitive interventions that address gender inequality amongst family and partners, stigma related to HIV for both, PLHIV and their families would support families to acknowledge care and treatment for women and overcome discrimination (Kohli, Purohit, Karve, Bhalerao, Karvande, Rangan, Reddy, Paranjape, &Sahay,

2012).

The paper “Imaginative geographies of gender and HIV/AIDS: moving beyond neoliberalism” by Rachel Bezner Kerr and Paul Mkandawire studies the impact of neoliberal development discourse to the production and maintenance of problematic gendered hierarchies and spaces. It also draws perspectives from feminist geographies, arguing that by normalizing and privileging certain masculine identities, neoliberalism re-inscribes and legitimizes gendered power relations that are counterproductive to addressing HIV/AIDS. According to the study, the 'ideal' person fighting HIV/AIDS in the neoliberal framework needs to be competitive, rational and self-interested. However, these characteristics are complicit in worsening HIV prevalence and set off problematic gender roles and identities. The study proposes ways in which gender identities can be challenged and reshaped.

The paper “It's really a hard life: Love, gender and HIV risk among male-to-female transgender persons” by Rita M. Melendez' &Rogerio Pinto sheds light on the contribution of gender roles towards the spread of HIV/AIDS. Little research has been done on the spread of the infection among male to female (MTF) transgender and the stigma and discrimination associated with it. This study was based on in-depth interviews conducted with MTFs who attend a community clinic. According the data that was collected, the MTFs showed a higher need to be loved by their partners, which made them more vulnerable to the disease. This stems from their willingness to engage with sexual partners who, even though might provide a sense of love, but engage risky and unsafe sex. The study built a model illustrating how HIV risk is generated from stigma and discrimination.

The article “HIV And Domestic Violence: Intersections in the Lives of Married Women in India” by Sapna Desai aims at establishing a connection between HIV/AIDS and domestic violence in order to identify potential areas for a state-led response. It lays emphasis on the vulnerability of women, saying, “Lack of knowledge, combined with their inability to negotiate condom use, places women whose husbands have multiple partners at risk of HIV infection” (pg. 145). By assessing women’s vulnerability, this article analyses the factors associated with the risk of the infection among them. It identifies three areas as opportunities for a state-led response - strengthen HIV and domestic violence strategies and address their overlap; mainstream gender; and improve data and research.

A lot of HIV prevention literature shows women as especially vulnerable to HIV because of biological susceptibility and men's sexual power and privilege. On the other hand, heterosexual men are perceived as active transmitters of HIV but not active agents in prevention. Even though the paradigm of women's vulnerability was a major revision of earlier views of women in the epidemic, mounting challenges undermine its current usefulness. The study “Rethinking Gender, Heterosexual Men, and Women's Vulnerability to HIV/AIDS” by Jenny A. Higgins, Susie Hoffman, and Shari L. DworkinAm J reviews both the etiology and success of the paradigm and its limitations. It suggests a better model that not only acknowledges biology, gender inequality, and gendered power relations but also directly examines social structure, gender, and HIV risk for both heterosexual women and men.

The paper “Concerns and experiences of women participating in a short-term AZT intervention feasibility study for prevention of HIV transmission from mother-to-child” by Nita Mawar, Pyare L. Joshi, SeemaSahay, Rajani D. Bagul, and Ramesh S. Paranjape describes the concerns and experiences of women who have participated in a short-term AZT intervention feasibility study to prevent mother-to-child HIV transmission at three sites in India. Zidovudine (AZT, Retrovir) is an anti-HIV drug that slows down the disease and prevents damage to the immune system, reducing the risk of developing AIDS-related illnesses. The research was conducted on 19 healthcare providers and 31 women who were in the later stage of pregnancy. It was found that one of the major concerns was the HIV status of the new-born and the women's understanding of the long-term implications of participating in the intervention study was poor. In conclusion, the authors suggested providing psychosocial support on an ongoing basis. They also suggested networking with women-centered support groups.

The study “Coping, social support, stigma, and gender difference among people living with HIV in Guangxi, China” by Zhiwen Xiao, Xiaoming Li, Shan Qiao, Yuejiao Zhou and ZhiyongShen, analysed the association of gender, HIV-related stigma, social support among PLWHA, in Guangxi, China. The sample of 2987 showed significant effects of factors like emotional social support, functional social support, and informational social support on various coping strategies. The interaction between gender and informational social support, and internalized stigma and perceived stigma were associated with various coping strategies. The results lay emphasis on the importance of HIV-related stigma and social support differences in the coping strategies.

In India, support groups have been created for women, that work to challenge human rights violations, call for action for appropriate healthcare for women with HIV, and to curb the violence they face (UNAIDS, 2014; Mothi et al, 2016). NACO acknowledges HIV related risk to transgender people. While gender inequality, sexual roles, and norms, make women of HIV households more vulnerable to the increased psychological and physical burden, extended to include the perspective of self-diagnosis, relationships issues, risks & vulnerabilities, legal and economic position (Rathi, 2018; Grieg, Peacock, Jewkes, &Msimang, 2008).

This article attempts to present the crucial aspects of gender and HIV/AIDS with a major focus on studies in the Indian context. To fulfil this purpose, it primarily focuses on literature from the Indian cultural context, and wherever necessary, from other cultures and takes into account women’s vulnerability to HIV: biological, social and cultural aspects. It explores the problems faced by women inapproaching the treatment facilities, awareness among women, beliefs and attitude towards HIV and perception of risk. This article focuses on issues of stigma, discrimination, mental health, coping and quality of life among women living with HIV. It reports the literature which explores factors affecting the life of women living with HIV. Finally, based on the results of the review, the article provides inputs for future research and suggestions for intervention targeting the challenges encountered by women living with HIV.

2. Method

Published literature relevant for this article was searched through electronic medium using JStor, Science Direct, EBSCO Connections and Google Scholar. To perform a broad search, the keywords used were 'HIV' and 'Gender'. After initial readings of the selected articles, the issues faced by women were identified. In the second phase, the collected data from the 6 districts consisted of 151 patients and 50 NGO staff in the 6 districts of Gujarat that included Palanpur, Surendranagar, Mehsana, Surat, Navsari, and Dahod. Out of these 37 patient questionnaires and 10 NGO staffs were completely or partially incomplete so we were unable to include them in the analysis. Furthermore, as a result of various administrative and population characteristic reasons, we received zero responses for the doctor population sample. The report includes a discussion based on the experiences of the administrator who interacted with the potential respondents and the administration personnel and office.

The collected data from the 6 districts consisted of 151 patients and 50 NGO staff in the 6 districts of Gujarat that included Palanpur, Surendranagar, Mehsana, Surat, Navsari, and Dahod. Out of these 37 patient questionnaires and 10 NGO staff were completely or partially incomplete so we were unable to include them in the analysis.

Table 1: Demographic Profile of Patient Participants.

Items	n	%
Age:		
20-30.5 years	22	19.30
30.5-50.8 years	73	64.03
50.8-70 years	19	16.67
Gender:		
Male	69	60.52
Female	44	38.60
Other: Transgender	1	0.88
Occupation		
Job:	44	38.59
Private Job	4	3.51
Farmer	24	21.05
Truck Driver	1	0.88
Business	24	21.05
Household Work	10	8.77
Housewife	2	1.75
Prawn Farmer	1	0.88
Machine Operator	1	0.88
Technician	1	0.88

Self-Employed	1	0.88
Artisan	1	0.88
Educational Qualification:		
5th Grade	1	0.88
6th Grade	2	1.75
7th Grade	6	5.26
8th Grade	15	13.16
9th Grade	5	4.39
10th Grade	37	32.46
11th Grade	3	2.63
12th Grade	23	20.17
BA	12	10.53
Bcom	1	0.88
Bsc	1	0.88
Graduate	3	2.63
MA	1	0.88
Diploma	2	1.75
Dropout	2	1.75
District of Current Residence:		
Banaskantha	6	5.26
Surat	21	18.42
Mehsana	23	20.17
Navsari	11	9.65
Dahod	30	26.32
Surendranagar	23	20.18
Monthly Family Expenditure:		
Less than Rs. 5,000	4	3.51
Rs. 5,000 – Rs. 10,000	23	20.17
Rs. 10,000 – Rs. 20,000	42	36.84
Rs. 20,000 –Rs. 50,000	44	38.60
More than Rs. 50,000	1	0.88
Marital Status:		
Married	49	42.98
Single (Never Married)	25	21.93
Divorced	8	7.02
Separated	17	14.91
Widowed	13	11.40
Other	2	1.76
Sexual Orientation:		
Straight	59	51.75
Bisexual	36	31.58

Homosexual	19	16.67
Other	0	0
Not sure	0	0
Engaged in Homosexual or Bisexual Relations:		
Yes	57	50
No	57	50
Location of HIV Diagnostic Testing:		
ICTC	46	40.35
Private Practitioners	19	16.67
NGO	29	25.44
ICTC, NGO	18	15.79
ICTC, Private Practitioners, NGO	2	1.75
Source of knowledge about ICTC:		
Public campaign referral	52	45.62
Private practitioners	38	33.34
Self-Referral	9	7.89
Public campaign referral, Private practitioners	10	8.77
Public campaign referral, Self-Referral	3	2.63
Private practitioners, Self-Referral	2	1.75
Treatment forms:		
Combination of HIV medications	29	25.44
ART medications (antiretroviral)	75	65.79
Drug Therapy	6	5.26
Other	4	3.51
None	0	0
Monthly Treatment Expenditure (in Rupees):		
Rs.10,000	2	1.75
Rs.5,000	26	22.81
None (Free of Cost)	86	75.44
Source of medication		
ART Center	88	77.19
Private Hospitals	4	3.51
NGO	9	7.89
ART Center, Private Hospitals	1	0.88
ART Center, NGO	12	10.53
Follow Treatment Programme:		
Yes	114	100
No	0	0
Financial assistance received by the government of HIV/AIDS support organization	17	14.91
Food assistance received by the government of	21	18.42

HIV/AIDS support organization		
Emotional/Social assistance received by the government of HIV/AIDS support organization	110	96.49
Family awareness of HIV/AIDS diagnosis	101	88.60
Friends awareness of HIV/AIDS diagnosis	85	74.56
Workplace awareness of HIV/AIDS diagnosis	81	71.05

The data collected from the 6 districts in Gujarat, India reported that 40.35% of the sample was tested at the ICTC (Integrated Counseling and Testing Centers) in their districts, 25.45% were tested at NGOs, 16.67% were tested by private practitioners, 15.79% went to ICTC and NGOs for their diagnostic testing, and 1.75% of the patient sample went to all 3, the ICTC, private practitioners, and NGOs for diagnosis. The most commonly visited centers for diagnosis and testing services are reported to be ICTC and NGOs. There are over 309 pure ICTC centers in Gujarat, 1309 Facility ICTC i.e. PPP model, and 3 mobile ICTCs. ICTC network is the first point of contact between a person wanting to get tested for HIV and the public health system. These centers become an ideal point for prevention as HIV negative individuals can gather knowledge and awareness about HIV and the existing services provided at the ICTC, and the positives could engage in adopting protecting behaviours, avoiding further transmission, and avoid re-infection (Sharma, 2009). The source of knowledge about ICTC was reported to be highest via public campaign referrals for 45.62% of the patient sample and 33.34% of the patient sample reported their source as private practitioners. Self-referrals were the source of information for 7.89% of the patients. Voluntary Counselling and Testing Center (VCTC) were remodeled as the Integrated Counseling and Testing Center (ICTC) to focus on the holistic healthcare model (Sharma, 2009). It was reported in the study of 811 registered clients, conducted in Ahmedabad, Gujarat, that 75% of attendees at the ICTC were referred there by doctors and only 19% were walk-ins (self-referrals) (Sharma, 2009).

Some people usually consider themselves as belonging to the low-risk group of individual who lives under a false sense of security, with the notion that HIV couldn't affect them as they fall outside the high-risk groups, often do not get examined and are exposed to the HIV without being aware of its possibility and their vulnerability (Craddock, 2004; IIPS and ORC Macro, 2008).

It is essential to spread information about prevention and control of HIV/AIDS to all the people of the society, to keep the epidemic from spreading.

ART therapies and medications accounts for 65.79% of the patient sample's medical treatment, while treatment via a combination of HIV medications accounts for 25.44% of patients. Furthermore, ART centers are the source of medication for 77.19% of the patient sample, and NGOs are next with providing HIV medications to 7.89& of the patient sample.

ART Centers provide a comprehensive set of the Care, Support & Treatment services program to the PLHIV. They register, provide care to, and monitor PLHIV; they identify PLHIV who require ART and deliver ART effectively as per NACO guidelines; they also provide HIV drugs to eligible PLIV, provides treatment and counseling services pre and post-diagnosis and treatment of drug

adherence, and provides anti-tuberculosis treatment and IPT for the prevention of TB in PLHIV. ART centers follow up on HIV positive referrals from ICTC and provide them with basic HIV services (National Report: NACO, 2015).

ICTC is a place where people can receive counselling and testing services for HIV, on their own free will, or the advisement of their medical provider. The main functions of ICTCs include early HIV detection, providing basic information on the modes of HIV/AIDS transmission and prevention, promoting behavioural change, linking people with other relevant centers for care, prevention, and treatment services. Programs like Targeted Interventions, STI Care services, Blood Safety Program, Red Ribbon Club Programme, Link Worker Scheme (LWS), Health Education and Lifeskill Programme (HELP), Community Care Centers, and Care, Support and Treatment: Anti-Retroviral Therapy (ART) Center; are all programs are focused at awareness, prevention, and control of HIV/AIDS. ICTC is often more focused on awareness, prevention, and control of HIV/AIDS.

The financial support schemes by the government and other HIV/AIDS support organizations help PLHIV from remote areas, low income, and poor economic background to get treatment and manage their lives. 75.44% of our patient sample reported receiving treatments free of cost. A couple of patients reported that even though they received the treatments for free (no cost), the cost of traveling to the ART center is still existent. 14.9% of the patient sample reported that they have received financial support and 18.42% of the patient same received food assistance from the government or other HIV/AIDS-related support organizations. It is important to note that the patients were open about their sexual orientation and were aware about their gender and sexuality.57% were either bi-sexual or homosexual.

Table 1: Patient Response: Services, Treatment and Policy

Items	Low	Average	High	Value Range
Initial Diagnosis (in the year)	2002-2008 27 23.68%	2008-2016 64 56.14%	2016-2019 23 20.18%	1-18
Undergone HIV diagnostic testing (in number of times)	0.31-2.36 19 16.67%	2.36-6.44 79 69.30%	6.44-10.5 16 14.03%	1-10
CD4 count	73-391.30 22 19.30%	391.30-1026.42 75 65.80%	1026.42-1345 17 14.90%	110-1299

Table 2: Perception amongst Patients

Patient Perception	N	Mean	SD
Total	114	34.35	2.70
Male	69	34.13	3.38
Female	44	34.75	0.87
Other: Transgender	1	32	0

The descriptive analysis of patient perception for the overall patient sample is reported as *M*=34.35, *SD*=2.70. The maximum possible score was 35 and the minimum was 7. The higher the score, the more positive the patient perception is about the medical and treatment experiences they have had at the NGOs and GSACS authorized clinics.

The descriptive analysis of patient perception for the male patient sample is reported as (*M*=34.13, *SD*=3.38) and that of patient perception for the female patient sample (*M*=34.75, *SD*=0.87). While the mean for both male and female samples is high, suggesting that both reported a positive perception of the overall quality of services received at the NGO and government centers in Gujarat. The standard deviation of the male sample is much higher, suggesting a wider measure of the spread of data than the female sample.

The experiences included the information doctors, nurses, and health care providers provided to the patients about the examinations they undergo, safeguarding their privacy, communicating in a language they understand, explain the risk of reinfection, and prepare them for news related to their diagnosis. Understanding patient perception provides an insight into the quality of care of patients based on actual experiences, as well as information on the quality and aspects that patients consider in high regard.

Patient perception is a reflection of the experiences that they have during the process of diagnosis and care, and reflects on the quality and suggests about the performance of the health care workers.

Research on ART centers has previously indicated that to provide specific needs-based care to HIV-patients it is essential to understand patient perception and experiences (Yoder, Mkhize, and Nzimande, 2016). Patient experiences and perceptions are often linked to the quality of future care,

health-seeking behaviour after discharge, treatment follow up, and revisiting the same ART centre (Wilde-Larsson, & Larsson, 2009).

The patient sample reported that 100% of the sample followed the medication and treatment program provided to them by their doctors. A previous study conducted on PLWHA in Gujarat reported that adherence to medication was given utmost importance by the combination antiretroviral therapy (cART). Patients and providers acknowledged the counsel and treatment of doctors and the emotional support of counsellors (Patel, Baxi, Patel, Golin, Mehta, Bakshi, Shingrapure, Modi, Coonor, and Mehta, 2012). Research allows us to identify the factors that influence the patients' consumption of medicines and following treatments that are, relationship and rapport with doctors and counsellors, support from other in the family and society and others living with HIV, and belief in the properties of the treatments (Patel et al, 2012). Qualitative factors such as interactions, social support, emotional support, rapport with counsellor, perception, and beliefs, affect the patient experience.

In a study in South Africa, themes of the perceptions of care of HIV patients that they received at the treatment clinics include the perception of experiences related to the environment and attitudes of health professionals. The patients' views and perceptions have to guide and shape the design and delivery of health care service processes. Successful implementation of the same would promote the usage of available health care services and provide motivation and confidence to continue seeking health care.

Table Error! No text of specified style in document.**: Patient Stigma**

Patient Stigma	N	Mean	SD
Total	114	12.5	3.85
Male	69	6.75	3.61
Female	44	13.11	4.21
Other: Transgender	1	11	0

The descriptive analysis of patient stigma for the overall patient sample is reported as *M*=12.5, *SD*=2.85. The maximum possible score was 45 and the minimum was 9. The higher the score, the higher is the HIV-related stigma experienced by the individual in their healthcare settings, family, and society. The overall stigma is reported to be quite low for the sample, and the variability i.e. the

spread is wide. Due to the direct and secondary experiences of the stigma that is often attached with HIV/AIDS, PLHIV and their family and friends often face social and medical issues including discrimination in healthcare or employment, disturbed personal relationships with spouse, partners or others, psychological troubles such anxiety, overwhelming feelings of guilt and shame, that could manifest as physical and or stress-related problems (Dixit et al., 2017). 96.49% of the patient sample reported that they were receiving emotional or social support and assistance by the government of HIV/AIDS support organization.

The descriptive analysis of patient stigma for the male patient sample is reported as (M=6.75, SD=4.21) and that of patient stigma for the female patient sample (M=13.11, SD=3.61). The average stigma for the female patient is higher than both the overall sample and the male sample. Women are often more likely to be treated more badly than men or children with HIV/AIDS. According to a study, more than 90% of widows with HIV/AIDS have forced to leaves the homes they were married after their husbands died (Bharat, 1999). A study based in New Delhi reported the stigma and discrimination are manifested in the forms of unreliable or unwarranted references to other facilities and organizations, condescending and judgmental behaviour, segregation and labelling of patients (Mahendra, 2006).

A study based in Patna, Bihar, reported that enacted stigma and discrimination interfere with every process of HIV care for PLHIV in the state (Nair, Kumar, Pandey, Harshana, Kazmi, Moreto-Planas, Burza, 2019). The continued presence of discriminatory practices and stigmatization of PLHIV and it has negative effects on PLHIV care-seeking behaviour and disclosure of HIV status, impacting their and access to care and treatment (Nair et al., 2019).88.60% of the patient sample in our study report having informed their family of their HIV status, 74.56% reported having informed their friends of their HIV status, and 71.05% of the patient sample reported having informed their colleagues at the workplace of their HIV status. Some patients reported having informed selective friends due to the fear of rejection.

Table 3: Enacted Patient Stigma

Enacted Patient Stigma	N	Mean	SD
Total	114	6.86	2.15
Male	69	6.67	2.08
Female	44	7.16	2.28
Other: Transgender	1	7	0

Table 4: Felt Normative Stigma

Felt-Normative Patient Stigma	N	Mean	SD
Total	114	5.64	2.17
Male	69	5.45	1.76
Female	44	5.96	2.69
Other: Transgender	1	5	0

Enacted stigma refers to the external stigma that is associated with unfair or discriminatory treatments by others or the awareness of social stigma on the grounds of 'being imperfect' or immoral behavior. Felt-normative stigma is an internalized stigma that subjectively captures the interpersonal aspects of stigma and anticipation of enacted stigma (Scambler, 2009). The descriptive analysis of enacted patient stigma for the overall patient sample is reported as (*M*=6.86, *SD*=2.15). The maximum possible score was 25 and the minimum was 5. The descriptive analysis of enacted patient stigma for the male patient sample is reported as (*M*=6.67, *SD*=2.08) and that of enacted patient stigma for the female patient sample (*M*=7.16, *SD*=2.28). The variable of external stigma for our patient sample suggests a similar pattern like overall patient stigma, such that it is low scoring and females have reported an overall low score, but slightly higher than males. External stigma or enacted stigma here is marked by the patient's experiences with health care workers and their family or society.The descriptive analysis of felt-normative patient stigma for the overall patient sample is reported as (*M*=5.640, *SD*=2.17). The maximum possible score was 20 and the minimum was 4. The descriptive analysis of felt-normative patient stigma for the male patient sample is reported as (*M*=5.45, *SD*=1.76) and that of felt-normative patient stigma for the female patient sample (*M*=5.96, *SD*=2.69). Similar to enacted stigma, felt-normative scores are low scoring and closer to the minimum score as average. The efficiency and impact of positive and supportive counseling are essential to quality health care and effective patient management (Chippindale& French, 2001).

Table 5: Patient Knowledge and Awareness about HIV/AIDS Infection

Descriptive	N	%	N	%
	Yes		No	
Abstain from sex	14	12.28	100	87.72
Stay faithful to one partner	109	95.61	5	4.39
Avoid sex with commercial sex workers	102	89.47	12	10.53
Use condoms	102	89.47	12	10.53
Avoid kissing	13	11.41	101	88.59
Limit number of sexual partners	87	76.32	27	23.68
Avoid sharing razors, blades or any sharp object	101	88.60	13	11.40
Avoid transfusions with blood that has not been tested for HIV	107	93.86	7	6.14
Avoid sex with persons who inject illegal	102	89.47	12	10.53

drugs intravenously				
Avoid sex with homosexuals	77	67.54	37	32.46
Seek protection from traditional healers	33	28.95	81	71.05
Avoid mosquito bites	8	7.02	106	92.98
Avoid unsterilized needles and injections	105	92.10	9	7.90
Require partner to take HIV test	101	88.60	13	11.40
Avoid sex with persons who have many partners	99	86.84	15	13.16
Other	0	0	100	100

Table 6: Patient Knowledge and Awareness about HIV/AIDS infection

	Low	Average	High	Value Range
Correct Answers	3-7.149	7.149-10.659	10.659-12.412	3-10
	19	95	0	
	16.67%	83.34%	0%	
Wrong Answers	-0.778 – 0.248	0.248-2.296	2.296-3.321	0-4
	26	72	16	
	22.81%	63.16%	14.03%	

The large population base of our India requires the contribution towards curbing the spread to vulnerable populations that contribute to any inadequacy and inaccuracy that promotes information that further promotes awareness, in-awareness, stigmas, and discrimination.

The vulnerable factors include low levels of education, poverty, early age of sexual experiences, limited access to health, inadequate information on modes of HIV transmission, and misconception about HIV/AIDS (Mehra, Bhattar, Bhalla, and Rawat, 2014). The patient sample also reported some misconceptions such as 7.02% thought that mosquito bites were a mode of HIV transmission, 88.60% thought they should require their spouse to take HIV test, 11.41% reported that they thought HIV is transmitted through kissing. Certain other behaviours that participants reported, that are also healthy, less risky behaviour, and lifestyle choices such as 12.28% said they thought abstaining from sex would avoid transmitting HIV, 95.61% thought staying faithful to one partner would avoid transmitting HIV, 89.47% believed that avoiding sexual intercourse with sex workers would avoid transmitting HIV, 76.32% thought that limiting the number of sexual partners would avoid transmitting HIV, 88.60% thought that avoiding sharp objects (razors, blades, etc.) would avoid

transmitting HIV, 67.54% believed avoiding sex with homosexuals would avoid HIV transmission, and 86.64% reported avoiding sex with multiple partners as a way of avoiding HIV transmission. The evolution of creative and novel techniques to improve existing knowledge and bust the myths and misconceptions would help enhance the positive direction of education and awareness about HIV/AIDS. Positive attitude towards life for PLHIV and their families is to hear their problems without stigma and discrimination. Human rights and rights to education, health, security, and employment are very relevant and critical to good quality for HIV patients and for preventing future cases (Dixit, Thakor, Goswami, and Verma, 2017).

A study in Delhi about awareness among VCT HIV positive clients reported that the knowledge and awareness about modes of HIV transmission and unsafe sexual practices were high amongst married participants. It also reported a significant positive correlation between knowledge of unsterile needles and syringes as a mode of transmission and education level and urban residence (Mehra, 2014). Further, the study explored some misconceptions about the modes of HIV transmission as well and 32.9% reported a false perception that HIV is potentially transmitted by sneezing or coughing, 34.4% reported they believed that HIV could be transmitted by a mosquito bite, 14.6% thought it could be transmitted by working with an infected person, and 23.3% and 29.9% respectively stated that they thought HIV could be transmitted by eating with sharing towels/handkerchief/clothes of a person with HIV/AIDS (Mehra, 2014). The highest factors according to the patient samples' awareness and knowledge that they think to contribute to the HIV infection. The factors were reported as 89.47% for using condoms, 76.32% for limiting the number of sexual partners, 93.86% for avoiding untested blood transfusions, 98.47% as avoiding sexual intercourse with individuals who inject drugs intravenously, 67.54% as avoiding sexual intercourse with homosexuals, and 92.10% for avoiding using unsterilized needles and injections (Mehra et al., 2014).

Table 9: Perception of Sexual Intercourse

Perception of Sexual Intercourse	N	Mean	SD
Total	114	0.02	1.46
Male	69	-0.29	1.39
Female	44	0.52	1.44

The descriptive statistics of the perception of sexual behaviour of the overall patient sample is reported as (M=0.02, SD=1.46). The descriptive statistics of the perception of sexual behaviour of the male patient sample is reported as (M=-0.29, SD=1.39) and that of the female patient sample is reported as (M=0.52, SD=1.44). The average score for the sample is reflective of the general perception about sexual intercourse. A higher score reflects a more rigid set of perception regarding sexual intercourse. While the overall patient sample reports a slightly positive score; there is a difference of direction for the male and female patient samples. The results suggest that the male patient sample reports more liberal and less judgmental perceptions about sexual intercourse, where the female patient sample reports rigid perceptions regarding sexual intercourse.

A qualitative study conducted in Gujarat reported that all the female participants were infected by their husbands, while only a few males reported that they were infected by their wives (Patel et al., 2012). The other male participants reported that they were infected through their extramarital or premarital relationships or commercial sex workers (Patel et al., 2012). Further, there were some females who believed that their husbands' extramarital or premarital relationships were the cause of their HIV infection.

Table 10: Perceptions about Men's Sexual Behaviour

Perceptions about Men's Sexual Behaviors	N	Mean	SD
Total	114	0.83	1.95
Male	69	0.73	2.09
Female	44	0.98	1.76

The descriptive statistics of the perceptions about men's sexual behaviour of the overall patient sample is reported as (M=0.83, *SD*=1.95). The descriptive statistics of the perceptions about men's sexual behaviour of the male patient sample is reported as (*M*=0.73, *SD*=2.09) and that of the female patient sample is reported as (*M*=0.98, *SD*=1.76). The score is reported as positive for the overall, male and female patient samples suggesting a more liberal and less prejudiced perceptions about the sexual role of men.

Table 11: Perceptions about Women's Sexual Behaviour

Perceptions about Women's Sexual Behaviour	N	Mean	SD
Total	114	-0.35	1.30
Male	69	-0.34	1.21
Female	44	-0.39	1.45

The descriptive statistics of the perceptions about women's sexual behaviour of the overall patient sample is reported as (M=-0.35, *SD*=1.30). The descriptive statistics of the perceptions about women's sexual behaviour of the male patient sample is reported as (*M*=-0.34, *SD*=1.23) and that of the female patient sample is reported as (*M*=-1.49, *SD*=1.97). As opposed to the score of the male patient sample, the score for the female patient sample is negative, suggesting perception about the

sexual role of women that are more rigid and prejudiced.

According to a study conducted on HIV patients in Mumbai most of the participants reported traditional attitudes towards gender norms, women reported more misconception about sexual transmission than men, and an association of avoidance and denial of rights (Bharat, Ramakrishna, Heylen, &Ekstrand, 2014). The dual norms of men and women lead to marginalization of groups to reinforce gender-biased norms and values.

Women often face trouble in getting proper treatment because they lack financial freedom. In many cases, women are forcibly exposed to this infection. For instance, when the husband has been sleeping with various other women, and refuses to use condoms, he might get infected, and, in turn, spread the infection to the wife. According to an ICSSR report, men who buy sex form a major part of the infected population of HIV/AIDS. Due to this, their wives are exposed to the disease as well, since she does not have a say in monogamy on part of the husband, or the use of precautions like condoms.

Another instance of a woman's vulnerability is when she is raped. Other groups that are affected by this virus are transgender, bisexuals and male sex workers.

Table 12: Risky Sexual Behaviour

Risky Sexual Behaviors	N	Mean	SD
Total	114	-5.61	3.20
Male	69	-6.10	2.83
Female	44	-4.77	3.27

The descriptive statistics of the risky sexual behaviour of the overall patient sample is reported as (*M*=-5.61, *SD*=3.20). The descriptive statistics of the risky sexual behaviour of the male patient sample is reported as (*M*=-6.10, *SD*=2.83) and that of the female patient sample is (*M*=-4.77, *SD*= 3.27). Often many HIV-infected individuals avoid risky sexual behaviours, but some continue to make substantial changes, or variations to stop or engage in risky sexual behaviour. Other studies have previously reported that HIV infected individuals 10% to 60% of PLHIVcontinued to engage in risky sexual behaviour(Mehta, Baxi, Chavda, Patel, & Mazumdar, 2016). A study conducted in Jamnagar, Gujarat, reported that risky sexual behaviour amongst undergraduate students were increasing, consequently increasing the incidences of HIV &STDs, unsafe abortions, adolescent pregnancies, juvenile delinquencies, and many more consequences (Dave, Makwana, Yadav, &Yadav, 2013).

Table 13: Risky Sexual Behaviour- Only women factors

Risky Sexual Behaviour	N	Mean	SD
Female	44	-0.91	0.87

The descriptive statistics of the risky sexual behaviour of the female patient sample is reported as (*M*=-0.91, *SD*=0.87). The average of the patient sample is negative, suggesting the reduction in pregnancy related risky behaviour. Women related factors are pregnancy and breastfeeding related. The education and awareness programs provided to HIV patients, along with the detailed treatment and counselling allows patients to identify risky sexual behaviour and comply with preventive measures

Table 14: Acceptance of Sexual Practices

Acceptance of Sexual Practices	N	Mean	SD
Total	114	0.90	1.77
Male	69	1.04	1.72
Female	44	0.84	1.74

The descriptive statistics of the acceptance of sexual practices of the overall patient sample is reported as (*M*=0.90, *SD*=1.77). The descriptive statistics of the acceptance of sexual practices of the male patient sample is reported as (*M*=1.04, *SD*=1.72) and that of the female patient sample is reported as (*M*=0.84, *SD*=1.74). The sexual practices referred to here are gay and lesbian, or homosexual relationships. The last couple of decades have been essential in the recognition of relative and different sexual norms. The concepts of sexuality differ from place to place, in a complex place like India, where the social constructs discriminate against certain sexual partnerships and practices. (Asthana, 1996).

Table 15: Gender Roles regarding Sexual Behaviour

Gender Roles regarding Sexual Behaviors	N	Mean	SD
Total	114	0.18	1.94
Male	69	-0.30	1.54
Female	44	0.36	2.00

The descriptive statistics of the gender roles regarding sexual behaviour of the overall patient sample is reported as (*M*=0.18, *SD*=1.94). The descriptive statistics of the awareness of sexual practices of the male patient sample is reported as (*M*=-0.30, *SD*=1.54) and that of the female patient sample is reported as (*M*=0.36, *SD*=2.00). Gender inequality is reflected in the sexual relationships between couples, where men are often more likely to play the dominant role in terms of initiating and controlling the sexual interactions. In an Indian context, women often lose the control over the rights and are unable to negotiate the terms of safe sex or usage of condoms (UNDP, 2006). The cultural norms and attitudes towards acceptance of sexual pleasure or the discrimination of sexual affairs combined with liberal perceptions of men's sexual behaviour leads to increased risk of women being infected with the virus (UNDP, 2006).

3. Conclusion

The bridge populations such as the migrant populations have been a major contributor to the spread of the HIV infection in India and in Gujarat. A boost in the sexually active migration of people from rural and poor areas to urban areas was a leading cause in the global spread of HIV. From a macro perspective, substantial efforts are required for the progress of every individual and the community to minimize negative societal pressures towards HIV/AIDS and aim at improving the quality of life. From a micro perspective, enhancing efficiency and efficacy of units and staff through training, focus resources on preventing new infections, promote holistic and targeted interventions for high-risk groups and bride populations, prioritize local and district management to enhance ground response, explore behaviour and lifestyle-related problems, and further medical research. Effective and specialized health care settings need to address the mental health of HIV-infected patients and their families in contexts that reduce concern regarding chronic pain, stigma related to mental health, HIV, substance use and treatment. The effectiveness of treatment programs is assessed through the outcomes, for which plan for the development of operational and functional skills sets that strengthen the positive health of the individuals.

Important findings that need to be addressed are that women and young girls continue to be disproportionally affected by HIV as autonomy over body is still not available to women. Economic dependence, poverty and intimate partner violence in relationships hinders the woman's ability to negotiate condom use and protect herself from HIV. Stigma and discrimination associated with the disease increases the trauma for the patient and undermines the response to the epidemic. The efforts of the State government was well appreciated by the respondents and the positive outcome which was observed was that the society is accepting of the patients and the patients have started confiding and informing people about their medical state, so openness in society is a sign of hope.

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List of Abbreviations

1. AIDS: Acquired Immune Deficiency Syndrome
2. ART: Antiretroviral Therapy
3. AZT: Azido-Thymidine
4. CDC: Centers for Disease Control and Prevention
5. FDA: Food and Drug Administration
6. FSW: Female Sex Workers
7. GRID: Gay-Related Immune Deficiency

8. HIV: Human Immunodeficiency Virus
9. HSS: HIV Sentinel Surveillance
10. ICTC: Integrated Counseling and Testing Centre
11. IPV: Intimate Partner Violence
12. MSM: Men who have Sex with Men
13. NACB: National AIDS Control Board
14. NACO: National AIDS Control Organization
15. NACP I: National AIDS Control Program I
16. NACP II: National AIDS Control Program II
17. NACP III: National AIDS Control Program III
18. NACP IV: National AIDS Control Program IV
19. NACP: National AIDS Control Program
20. PCP: Pneumocystis Pneumonia
21. PLHIV: People Living with HIV
22. STI / STD: Sexually Transmitted Infection/Sexually Transmitted Disease
23. TV: Television
24. US: United States of America
25. VCTC: Voluntary Counseling and Testing Centre