CHAPTER ONE

INTRODUCTION

1.1 Background of the study

There are different dimensions of human life. Among them health is also one of the dimension of human life and this investigation is also has been done on the ground of sociological health and issue by linking it with HIV/AIDS and COVID-19 because there is indirect relationship in between COVID-19 and HIV-infectious in my opinion. This study tries to address the problems and impact of COVID-19 in people living with HIV-AIDS as the main issue. Thus this study explains the social problems with regard to health issues. As we know that COVID-19 has been seeing as the burning issue s for sociological study since December 2019 and similarly HIV also continues to be a major global health issue. Thus HIV-AIDS and COVID-19 are not only the health issues but also the social problems.

Individual's health and diseases are not only the biological matter because diseases are produces and distributed socially as well. Thus COVID-19 and HIV-AIDS are not only biological but also the social products. It should be advocated on the basis of social aspects too because the spread and control of such types of diseases is determined through the way of interaction, action, habit, treatment process and behaviour of people with each other. HIV and AIDS are related but they are not same situation. They are different diagnoses. HIV is a virus that may cause infection whereas AIDS is a condition. According to Goffman and other symbolic interactionists, individuals actively participate in the construction of their own social worlds, including the construction of selfhood, via ongoing social interaction (Blumer,1969).

According to WHO (2022) the human immunodeficiency virus (HIV) targets the immune system and weakens people's defence against many infections and some types of cancer that people with healthy immune systems can more easily fight off. As the virus destroys and impairs the function of immune cells, infected individuals gradually become immune-deficient. Immune function is typically measured by CD4 cell count. The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS), which can take many years to develop if not treated, depending on the individual. AIDS is defined by the development of certain cancers, infections or other severe long-term clinical manifestations. Globally, 28.7 million people living with HIV

were receiving ART in 2021. Global ART coverage was 75% [66–85%] in 2021. However, more efforts are needed to scale up treatment, particularly for children and adolescents. Only 52% [42–65%] of children (0–14 years old) were receiving ART at the end of 2021.

NCASC (2020) reported that First HIV case was detected in 1988 in Nepal but HIV testing and counselling service was first started in Nepal in 1995. The data/fact sheet from January to June 2019 of National Centre for AIDS and STD Control (NCASC) shows that the total number of people with HIV (PWH) in Nepal who enrolled in previous year for the anti-retro viral treatment were 34,822 infectious and then at the end of the year the total number of PLHIV who enrolled for anti-retro viral treatment were only 19,085 people. This data shows the decrease in the people for coming to the hospital to test HIV and take anti-retro viral treatment (ART) due to lock down and with the fear of COVID-19 disease transmission. And other causes were 8,458 people living with HIV were transferred out among the total number of infectious, death had occurred of 3,956 people, the people living with HIV but loss to follow-up were in 3132 numbers, among the total population, 174 infectious are missing and who stopped treatment were 17 people in Nepal. As the argument of World Bank in 2009 the scenario of HIV in Nepal is also dangerous. By 2008 around 1750 cases of AIDS and around 11,000 cases of HIV had been reported. The first national AIDS prevention and control program was started in 1988 by government of Nepal. A National AIDS Coordinating Committee (NACC) was set up in 1992. The NACC now reports to a more recently set up unit, National AIDS Council (NAC). And WHO (2015) argued that there was a commitment to end the HIV epidemic globally by 2030. The global health sector strategy on HIV 2016–2021 has proposed the vision of zero new infections, zero new deaths and zero HIV-related discrimination in a world where people living with HIV are able to live long and healthy lives.

Furthermore, the human body can't get rid of HIV and no effective HIV cure exists. So, once you have HIV, you have it for life. However by taking HIV medicine (called antiretroviral therapy or ART), people with HIV can live long and healthy lives and prevent transmitting HIV to their sexual partners. The strategic information unit of the National Centre for AIDS and STD Control (NCASC) was consulted for routine programme data on epidemiology and services on the current status of HIV infections in different risk populations and control efforts of the programme in Nepal. ''Estimation of the number of HIV infections in 2015 has shown a trend of decreasing HIV incidence since 2008. The estimated prevalence of HIV in 2015 was 0.2%, and had progressively decreased since 2005. The estimated prevalence of HIV has shown a reverted trend as targeted by the programme but reported number of HIV cases did not show such trend.

Reports from ART centres show cumulative deaths due to HIV had reached 2204 in Nepal up-to 2015 (NCASC, 2016).

WHO (2022) stated "globally, the number of weekly cases decreased by 12% during the week of 29 August to 4 September 2022 as compared to the previous week, with just under 4.2 million new cases reported. The number of new weekly deaths decreased by 5% as compared to the previous week, with over 13 700 fatalities reported. As of 4 September 2022, over 600 million confirmed cases and over 6.4 million deaths have been reported globally.'' COVID-19 is caused by a virus officially named severe acute respiratory syndrome coronavirus-2 (SARS-Cov-2). It is a new pandemic that started in December 2019 in Wuhan, Hubei Province of China. The disease rapidly spread from Wuhan to the rest of Mainland China and other parts of the world, affecting at least 216 countries and territories. In this context, countries are reacting differently regarding the WHO-recommended preventive measures, lockdown, test-trace isolation, wearing masks and wearing them correctly, covering the mouth when coughing and sneezing, keeping at least one meter of social distance, frequent washing of hands and avoiding direct contact of the eyes, nose, and mouth, making some countries more affected than others. Therefore, the variation in the severity, frequency, and amplitude of this pandemic is due to the addition of several factors as well as government policies.

MOHP (2022) stated that the total cases of COVID-19 positive in Nepal are 998,542 the total number of recoveries are 984,082 and the total deaths are 12,012, the total PCR test are taken of 5,905,059 and there are 2448 people in the isolation in the country till the date of September 09, 2022 AD. The first COVID-19 case of COVID-19 positive in Nepal was confirmed on 23 January in a 32-year-old man who had returned from China on 9 January. Government of Nepal also announced lockdown for the first time in Nepal on 7 Chaitra, 2076 B.S. Since then Nepalese people have been facing full or partial lockdown till the month of Bhadra, 2077 BS. Almost six (6) months. Generally this COVID-19 disease and lockdown badly influenced in the lives of people throughout the world in many ways for example; it affected in the way of interaction and communication of people, in their behaviour, economic and social mobility, family and social gathering, lifestyle, culture, festival, health, education etc. and priority groups such as adolescents and pregnant women.

UNAIDS, (2015) argued that HIV/AIDS epidemic is reducing the average life expectancy of people in Eastern and Southern Africa by twenty years. The age range with the highest death rates, due to HIV, are those between the ages of 20 and 49 years. The fact that this age range is

when adults acquire most of their income they cannot afford to send their children to school, due to the high medication costs. It also removes the people who could help aid in responding to the epidemic''. After illness people experience social stigma and marginalization in the family and society. They feel isolation from others while they used to feel prestigious when they were healthy. The lines of inquiry (method of study and interaction in symbolic interactionism) is now focused in empirical study/real setting of life rather than focusing only in the doctor-patient interaction at hospital. This is how we know that we have to focus on the study of total or whole biography of an individual's contemporary life rather than focusing on historical background to know the self-image of a man.

Though COVID-19 and lock down influenced in many aspects of individual life of people all over the world, this study seeks to analyse that how the COVID-19 and lock down imposed by government of Nepal during six months from Chaitra, 2076 B.S to Bhadra,2077 B.S. affected. It also tries to find out whether the respondents impacted by COVID-19 or not. If they are affected then, it seeks that how and in which aspects of their lives it influenced and if not then, also it intends to find out that how and why not has its effects in them. This dissertation work mainly has attempt to study whether there are implications of COVID-19 or not in the interaction pattern, behaviour, mobility, education, lifestyle, medication and as a whole in the lives of people living with HIV-AIDS who are taking ART service from GPH (Garahun Primary Hospital), Waling, Syangja district.

1.2 Statement of Problems

This research study has been focused in the analysis about COVID-19 and its influence in the people living with HIV positive and taking ART service from Garahun Primary Hospital, Waling-9, Syangja especially during the lockdown time imposed by the government of Nepal from Chaitra 2076 B.S to Bhadra, 2077 B.S. though the people from all over the world are influenced by this COVID-19 disease in many ways. Health/illness of individuals is one of the main important issue for the social science because it affects indirectly to the society in general but individual self and mind in particular by guiding themselves. Besides this study is undertaken to find out whether there are any problems and difficulties in the individual and social life of people living with HIV or not during lock down. And similarly another reason of this investigation is to study whether there are any issues and impacts of COVID-19 or not regarding their medication and heath. So, through their interaction, behaviour, feelings, experience and

thinking towards oneself and others, sociology explores to interpret and understand the social linkage between COVID-19 and the people living with HIV-AIDS.

Lamontagne (2020) revealed that COVID-19 has an impact on HIV susceptibility, testing, prevention and treatment access. Beyond these four pillars, the COVID-19 pandemic is likely to have an impact on HIV susceptibility and risk, which may have decreased in the few months following the pandemic, but could increase due to adverse socioeconomic conditions resulting from the COVID-19 epidemic and widespread lockdowns. For instance, in a survey of 20,238 LGBTQ individuals from 138 countries in April-May, 2020 presented at the *AIDS 2020* meeting in July, 57.8% reported having either lost their job, at high risk of losing their job, or being unsure about employment in the near future. Moreover, 44% had experienced reductions in salary, 23% reported new food insecurity and 1% had exchanged sex for money or resources.

Goffman (1963) described about the four types of social stigma such as anticipated stigma, perceived stigma, experienced stigma and internalised stigma. In reality Goffman's theory of social stigma is still being used to understand reasons why individuals who are HIV positive abscond the drugs or spread the disease or refuse to embrace voluntary testing services. Moreover, the theory has been used to explain why individuals are not usually ready to reveal their status to others. This is because these individuals are more sensitive to social stigma.

Government of Nepal had also given the home stay order to the Nepalese people by imposing lockdown during six months from Chaitra 2076 B.S. to Bhadra 2077 B.S. The movement and gathering of people out of their house was like impossible apart from essential work. They faced problems and difficulties even in going to the hospital and take their anti-retroviral pills which they had to use daily as their regular medicine due to lock down, far distance and transportation.

This literature reviews with the above mentioned references, either that were done in Nepal or foreign territory show some gaps somewhere. And these studies give many information regarding social stigma, purity and impurity, inclusion and exclusion, self-looking views of individuals about self and others, HIV related issues, cancer etc. which are very significant but none of these above mentioned studies have found to be conducted in this Garahun Primary Hospital, Waling-9, Syangja on the one hand and on the other hand these above reference studies do not advocate about COVID-19 by relating with HIV-infectious. This study obviously addresses some issues and problems of between HIV and COVID-19 which are faced by the people living with HIV in this COVID pandemic time. Therefore this dissertation work here in this topic 'Impact of

COVID-19 in People Living with HIV-AIDS during Lockdown 2077 B.S.' is presented/prepared with the perspective of fulfilling this research gap. Eventually we can say that the statement of problems in this study is related with the following research questions which are designed to support the main purpose of this study.

- What are the impact of COVID-19 in people living with HIV-AIDS?
- How did they receive their anti-retroviral pills in this lockdown time?

1.3 Objectives of the study

- To study the impact of COVID-19 in people living with HIV-AIDS.
- To analyse about the influences in daily medication of people living with HIV during lock down.

1.4 Signification of the study

This study can be beneficial to analyse the experience and feeling of people about this COVID-19 disease and lock down. This research study may be useful to show how lock down impacted in social mobility, gathering and regular medications of people living with HIV Positive. It can add a brick in the study of diseases like Covid-19 and HIV-AIDS. This can be a proper foundational line in future for the further social researchers.

This study will be obviously helpful for giving information of alertness in upcoming pandemic situations. When we talk about the theory, symbolic interactionism is still relevant/influential, powerful as well as significant sociological approach/framework for better understanding how individuals think and interact with each other about health issues though it was developed around the middle of twentieth century and replaced by the other new theories and perspectives. Moreover this dissertation work significantly helps to add an academic contribution in the issue of Sociology of Health.

1.5 Limitations of the study

The respondents of this research study are the people living with HIV-AIDS who are taking ART service from Garahun Primary Hospital, Waling-9, Syangja Therefore the sample of the data was

taken from the total population of the people living with HIV-AIDS and taking anti-retroviral treatment service from Garahun Primary Hospital, Waling-9, Syangja. This study won't go beyond the HIV Positive people treating in this hospital while taking information for data collection and it is limited with the study of my respondents only.

1.6 Organisation of the Study

There are altogether seven chapters in this study. Every chapter has equal importance and value but defines about different parts of the study. The chapter one is about the introduction of the study and under this chapter, there is brief description about the background of the study, statement of the problems, objectives of the study, signification of the study, limitations of the study and organisation of the study. Chapter two deals with the overall literature reviews which includes theoretical review under which there are descriptions about the concept of social stigma, concept of social distancing, pure and impure and symbolic interactionism, review of previous studies and conceptual framework.

Chapter three describes about the overall research methods and methodology used in this study that includes rationale of the site selection, ethical consideration, research design, nature and sources of data, universe and sampling, data collection tools and data presentation and analysis. Chapter four is about the socio-demographic profile of the respondents which gives general information about study area and socio-economic traits of respondents such as their gender composition, caste and ethnicity, income, marital status, occupation, age, religion and education are presented in tables.

Chapter five is titled with " Impact of COVID-19 in People Living with HIV'' which deals with the influence of COVID-19 in people living with HIV, status of COVID-19 on respondents, safety measures used by respondents for the prevention of COVID, feeling of social stigma due to HIV during COVID-19 time, involvement of clients in the service to COVID patients and influence of COVID-19 in their tradition, culture and festivals due to this new disease by using tables, and pie chart and similarly this chapter also includes case studies to support additionally and strengthen the importance of this study.

Chapter six shows the overall study about the impact of COVID-19 in daily medication in PLWHIV during lock down which is focused on the discussion about the respondents self-

presence of respondents in hospital to fetch regular ART drugs during lock down, way of receiving anti-retroviral pills and status of accessibility for ART drug which are presented by using tables and bar graph. The last chapter of this study is chapter seven which deals with the summary, major findings and conclusion of the whole study.

CHAPTER TWO

LITERATURE REVIEW

This chapter includes the conceptual as well as theoretical literature reviews along with empirical review that are integrated in the field of health and disease or wellness and illness of people. Similarly we argue about COVID-19 and its influence on individuals living with HIV-AIDS and in their daily medication, cultural festivals, social and economic mobility and in the family and social gathering. The most importance of literature review is that it specifies the gap on the existing knowledge and provides the information with regards to what has been done and what is left undone in the concept under the investigation.

2.1 Theoretical Review

‘’The term looking glass self is described as our reflection of how we think we appear to others. Cooley takes into account three steps when using "the looking glass self". Step one is how one imagines and looks to other people. Step two is how one imagines the judgment of others based on how one thinks they view them. Step three is how one thinks of how the person views them based on their previous judgments’’ as descried by (Cooley, 1902).

For instance during this study some of the respondents who are living with HIV are founded having no any difficulty and problems to expose themselves with their illness in the society because they think that they get love, affection and support from their family and other members of society and it also helps in their awareness if they are exposed whereas some of the others who also living with HIV are founded having hesitation, difficulty and problems to exposed in the society due to the fear of social stigma, discrimination and marginalization by people. So, it depends on individual perception, point of view and looking glass how the people take it and think about their illness.

Another example can be taken about smoking cigarette. The young and well-educated people also smoke cigarette and hookka even if knowing about its risk and harmfulness but they think that smoking is cool, that they will be safe from harm, and that smoking projects a positive image to their peers and they want to make hero like self-image/personality in the society and in front of others. Their judgement or looking glass about smoking is the reflection/imitation of hero by

seeing his act, performance and behaviour in cinema. So, the symbolic meaning of smoking overrides the facts regarding smoking and risk.

Goffman (1963) said that social stigma is an attribute which is deeply discrediting that reduces a person 'from a whole and usual person to a tainted, discounted one.' It creates a dichotomy between 'being normal and acceptable' versus 'being tainted and desirable.' Social stigma is commonly related to race, culture, gender, intelligence and health. The conceptualization of stigma identifies four elements which interact with each other: *anticipated, perceived, experienced and internalised stigma.*

Accordding to his idea HIV and COVID-19 have been associated with all these four elements of social stigma. People have modified their actions because of fear of being discriminated and isolated against, for example by avoiding testing for HIV and COVID diseases can be supposed as anticipated stigma, patients and their families felt judged by others can be supposed as a perceived stigma, infected and exposed persons were excluded, isolated and discriminated against by their household and the community members which can be taken as experienced stigma and some patients may have felt shame and self-rejection and it can be taken as internalised stigma.

Cooley (1998) argued that the mind is mental because the human mind is social. From the time they are born, humans define themselves within the context of their social interactions. Children learn that the symbol of their crying will elicit a response from their caregivers, not only when they are in need of necessities such as food or a diaper change, but also when they are in need of attention. Cooley best explains this interaction in *On Self and Social Organization*, noting that "a growing solidarity between mother and child parallels the child's increasing competence in using significant symbols. This simultaneous development is itself a necessary prerequisite for the child's ability to adopt the perspectives of other participants in social relationships and, thus, for the child's capacity to develop a social self."

An important statement from Cooley is that where there is no communication there can be no nomenclature and no developed thought. In a very large and interesting class of cases the social reference takes the form of a somewhat definite imagination of how one's-self – that is any idea he appropriates – appears in a particular mind, and the kind of self-feeling one has is determined by the attitude toward this attributed to that other mind. A social self of this sort might be called

the reflected or looking glass self: Each to each a looking glass – Reflects the other that doth pass.

WHO (1997) said that emerging infectious diseases (EIDs) are diseases recently identified or previously unknown infections that cause public health threats, either locally or internationally. In contrast, re-emerging infectious diseases are known diseases that reappear and increase in incidence but that in the past may have fallen to levels so low that they were no longer considered a public health problem.

It is evident that trade and international travel are essential to humankind. However, some preventive measures, such as travel restrictions and creation of awareness among trade and travel stakeholders, are paramount to flatten the curve. In recent years, trade embargoes or travel restrictions have been replaced with sensitive early warning surveillance, rapid verification procedures, and international response networks as well as epidemic preparedness through stockpiles of essential medicines (WTO, 2002).The risk of international spread of infectious diseases is increasing because of increased international travel. The process of globalization potentially influences a broad range of biological, environmental, and social factors that affect the burden of many critical human infections. Various international organizations and governments have been trying to establish better global systems to respond to EIDs. However, the SARS outbreak in 2003, the EVD outbreak in West Africa in 2014, and the current COVID-19 pandemic have highlighted that the current global system is still not fully ready for such (re)emerging infectious diseases. These EIDs threaten public health, as well as the global economy, and are sustained by increasing global trade and travel.

As we see our face, figure, and dress in the glass, and are interested in them because they are ours, and pleased or otherwise with them according as they do or do not answer to what we should like them to be; so in imagination we perceive in another's mind some thought of our appearance, manners, aims, deeds, character, friends, and so on, and are variously affected by it. A self-idea of this sort seems to have three principle elements: 1) the imagination of our appearance to the other person, 2) the imagination of his judgment of that appearance and 3) some sort of self-feeling such as pride or mortification.

The comparison with a looking glass hardly suggests the second element, the imagined judgment, which is quite essential. The thing that moves us to pride or shame is not the mere mechanical reflection of ourselves, but an imputed sentiment, the imagined effect of this reflection upon

another's mind. For example, we are ashamed to seem evasive in the presence of a straightforward man, cowardly in the presence of a brave one, gross in the eyes of a refined one, and so on. We always imagine and in imagining share the judgments of the other man.

COVID-19 has significantly altered everyday life for individuals worldwide. The presence of the virus has introduced physical distancing and closed schools and businesses, resulting in major disruptions to daily functioning. Given the social nature of human beings, people are finding ways to adjust to COVID-19 for the foreseeable future. In addition to the short-term effects of COVID-19, it is also critical for health care providers (e.g., doctors, psychologists, social workers, case managers, etc.) to consider how the impacts of COVID-19 may affect PWH, and the provision of health care treatment across time. For PWH, adjusting to COVID-19 may have significant effects on the biological, psychological and social aspects of their lives.

Bourdieu (1990) stated that habitus as an important factor contributing to social reproduction, because it is central to generating and regulating the practices that make up social life. Individuals learn to want what conditions make possible for them, and not to aspire to what is not available to them. The conditions in which the individual lives generate dispositions compatible with these conditions (including tastes in art, literature, food, and music), and in a sense pre-adapted to their demands. The most improbable practices are therefore excluded, as unthinkable, by a kind of immediate submission to order that inclines agents to make a virtue of necessity, that is, to refuse what is categorically denied and to will the inevitable. This theory seeks to show that social agents develop strategies which are adapted to the structures of the social worlds that they inhabit. These strategies are unconscious and act on the level of a bodily logic. In Bourdieu's perspective, each relatively autonomous field of modern life (such as economy, politics, arts, journalism, bureaucracy, science or education), ultimately engenders a specific complex of social relations where the agents will engage their everyday practice and language acts as a mechanism of power is through forms of mental representations it is acknowledged and noticed as objective representations: as a sign and/or symbol. These signs and symbols therefore transform language into an agency of power.

George Herbert Mead described the creation of the self as the outcome of taking the role of the other", the premise for which the self is actualized. Through interaction with others, we begin to develop an identity of our own as well as developing a capacity to empathize with others. As stated by Cooley, "The thing that moves us to pride or shame is not the mere mechanical

reflection of ourselves, but an imputed sentiment, the imagined effect of this reflection upon another's mind (Mead, 1934).

Bhattachan and et al., (2003) wrote that although the diverse groups are considered as equal by state law but in practice, and sanctioned to some extent by customary laws, the structural hierarchy of groups and genders remains. For example, Dalits, especially in rural areas, are still considered ritually polluting, and face numerous discriminations even from the Janjatis. These range from bans on entry into temples and homes, having to wash their dishes in restaurants, refusal by the 'upper' castes to eat or drink with them, and exclusionary practices faced while using common property resources such as springs and water taps, attending schools, selling milk to other castes, or even in several instances, being included in user groups or cooperatives.'' Dalits in western Nepal face more discrimination than in the east, which has a large ethnic population. The Madhesis, whose nationality and nationalism are questioned by the Pahadis, face difficulties in getting their citizenship certificates, without which they are unable to buy land, get loans from banks, apply for civil service jobs, study in universities, or vote during elections. While the Janjatis, in general, do not face such discriminations, they, like the Dalits and Madhesis, experience political and cultural exclusion, which in many cases translates into economic exclusion.

As an example in the idea of Bhattachan about inclusion and exclusion also can be connected with this study as well because there was social discrimination and stigma in between people regarding COVID-19 disease rather there is high risk in people who are already living with HIV and they are treated that they are being as polluted as so called untouchable groups (Dalits) of the society. Hence they were in social exclusion in many aspects in that time such as they were not allowed to enter any one else home, they could not touch things and anyone else and they had to maintained physical distance etc. even in the work place by putting on face mask.

2.1.1 Concept of Social Stigma

A stigma is a negative attitude or prejudice toward people with a distinguishing characteristic, such as a physical or mental health condition whereas discrimination is considered as inequality and the state of being unequal which can be seen in the behaviours of people. Stigmas can be self-imposed, individual, or institutional and often lead to discrimination against people with that specific characteristic. Social stigma against people living with HIV can lead to gossip, rejection, bullying, and in some cases, even violence. Harmful HIV myths can also make intimacy a

difficult subject for people living with HIV. Individual and institutional stigmas can also have a huge negative impact on the mental health of people living with HIV. Stigmas can impact many aspects of mental health including self-esteem, depression and anxiety levels, avoidance and blame coping behaviours, social support and medication adherence (Daniel-Ulloa & Lockett, 2021). COVID-19 can be transmitted to anyone, regardless of their gender, ethnicity, or sexuality while the people living with HIV/AIDS have a greater chance of contracting this disease.

Logie (2020) said that stigma targeting people associated with COVID-19, particularly persons of Asian descent, has been reported in media spanning diverse global contexts. The United Nations described that "fear, rumours and stigma" are key challenges accompanying COVID-19. The convergence of its framing as a "foreign virus" and an "infodemic" enflamed/kindled this fear and stigma. This is not a new phenomenon. Blaming epidemics on a foreign "other" is a recurring historic narrative. We can leverage our four decades of HIV research to understand and address COVID-19 stigma.

For example; firstly he argued that HIV reflects the health, moral and racial dimensions of stigma theorized by Goffman and aligned with historical patterns of disease attribution. Stigma is produced in social processes of labelling that differentiate persons characterized as "normal" from the "abnormal'', racial and religious minorities as well as people labelled as physically unhealthy or "immoral" other. In the early 1980s the HIV epidemic – initially coined Gay-Related Immune Deficiency (GRID) – was conceptualized as a plague that impacted "at risk" populations in the US known as the "4-H's" (haemophiliacs, heroin users, homosexuals, Haitians). This framing blamed racial (Haitian) and "immoral" (e.g. gay men) others and positioned a foreign location (Haiti) as the origin of HIV in the US. The World Health Organization deliberately named COVID-19 to avoid conflation with a location of origin, yet referrals to it as the "Chinese" and "Wuhan" virus persist. The arrests of people for breaching COVID-19 public health measures – and subsequent labelling as "intentional murderers" and "super spreaders" – signal the creation of the "immoral" other. These arrests contradict UNAIDS recommendations to avoid criminal repercussions for breaching COVID-19 public health restrictions. Similar to HIV, we need to address several facets of COVID-19 stigma to effectively reduce it. These include exposing and eliminating racism and xenophobia and recognizing the social processes of othering already experienced by persons blamed for COVID-19 (including stigma and socio-economic exclusion experienced by immigrants.

Secondly in his opinion, HIV has taught us about the complexity of stigma. We are moving away from soloed stigma research on individual health conditions (e.g. HIV, mental health), social identities (e.g. race, sexual orientation) and practices (e.g., sex work, drug use) [. Instead, stigma is understood as intersectional, social ecological, and produced by drivers (e.g., misinformation) and facilitators (e.g., inequitable social norms). Intersecting stigma – such as racism and poverty – interact with HIV-related stigma to harm health engagement and outcomes and may present analogous barriers to COVID-19 testing and treatment.

2.1.2 Concept of Social distancing, pure and impure

Paul, Chakraborty & Anwari (2022) found that COVID-19 pandemic has been declared a major global public health issue by the World Health Organization (WHO). The outbreak not only affects human health but also disrupts the economy, social activities, mobility styles and habitual travel behaviours all over the world, aggravating people's living standards. To mitigate the virus transmission, a range of strategies involving lockdowns, restrictions on out-of-home activities and safety guidelines of maintaining physical distances have been implemented in many countries. Various studies show that males are making comparatively more daily trips than females are and are therefore at more risk of virus contagion. Consequently, males have higher infection and death rates. Interestingly, Khaddar and Fatmi noticed that individuals living in a high-income household are more likely to be working out of the home, whereas middle-aged people from low-income households are not working outside of the home. On the other hand, Beck and Hensher observed that younger respondents are more prone to having commuting trips, trips for education and childcare, food shopping and general shopping than middle-aged and older respondents are prone to. Hence, the younger respondents are at greater risk of infection than the middle-aged and older respondents. On the other hand, Anwari et al. observed that 51–60-year-olds are frequent travellers. People from low-income groups in several studies are not able to access work-from-home facilities, open spaces to maintain a safe distance in the workplace, or are unable to use private cars to make trips. As a result, low-income people face greater risks of virus contagion than higher-income groups do.

For example; in response to the pandemic, social distancing measures were taken by imposing lockdowns in many parts of the world including China, Italy, Spain and Bangladesh, while less-rigid social distancing measures were taken in other countries like the Netherlands, Sweden and Japan. However, the result of lockdowns and restrictions on movement may be ineffective in countries with high population density, poor transportation infrastructure and a large informal economy. Public transport is a major transport mode, accommodating many captive users. As

public transport has been associated with increased risk of viral transmission, the services have been reduced and users are facing constraints to use them as a travel mode. As a result, out-of-home activities and manual labour work become inaccessible to low-income people who do not own cars. Therefore with the indiscriminate spread of COVID-19 globally, many populations are experiencing negative consequences such as job loss, food insecurity, and inability to manage existing medical conditions and maintain preventive measures such as social distancing and personal preventative equipment. Some of the most disadvantaged in the COVID-19 era are people living with HIV/AIDS and other autoimmune diseases.

The risk of COVID-19 is also more significant for those that live in Low- and Middle-Income Countries, rural, and/or poverty-stricken areas. An additional concern for those living the HIV is the double stigma that may arise if they also test positive for COVID-19. As public health and health care workers try to tackle the needs of the populations that they serve, they are beginning to realize the need for a change in the infrastructure that will include more efficient partnerships between public health, health care, and HIV programs. The social support and community mobilization approaches for the management of HIV/AIDS, as opposed to individual-level approaches alone, have been shown to improve antiviral medication adherence. However, due to the enforcement of social distancing and other restrictions in the current pandemic, there has been a shift in the mechanism by which PLHIV receive such social support. A breakdown in social support would likely impact medication adherence as individuals with a low CD4 cell count and PLHIV not on ART are at a higher risk of becoming extremely sick with COVID-19 infection. It is imperative to explore and monitor the adequacy of the current guidelines for the management of PLHIV with other underlying comorbidities. However, ensuring PLHIV have access to their antiviral refills, as well as the maintenance of their social support including material and mental support from community, family, and friends may pose a challenge; hence, the need for the establishment of proper linkage to care during the current pandemic.

Dumont (1980) argued that this principle of the fundamental opposition of the pure and the impure permeates all the visible features of a caste system - hierarchy, separation and division of labour. There can be two levels of purity or impurity in Hinduism - permanent and temporary. In the hierarchy castes are rated by their level of permanent purity. Men are born in a certain caste with a certain permanent degree of purity or impurity, according to which his caste is rated in relation to the other castes of the system, between the two extremes - Brahmin castes at the one end and the untouchable outcaste groups at the other end. Dumont says that most manifestly

purity and impurity can be seen in the traditional occupations of the two extremes: Brahmans traditionally being priests or men of learning, knowledge, and Untouchables - cleaning, removing dead animals and serving the higher castes''. For instance untouchability was a common practice erupted from the Purity and Pollution concept. The so-called lower castes always found harassed by the names like Chandaals. B.R. Ambedkar also known as a popular anthropologist has given some examples which clears how purity and pollution concept was evolving in India. For example in the Peshwa Maharaja Kingdom, a Dalit was not allowed to use the public streets as his shadow over some upper caste human being is considered as an impure touch. Also, an upper caste person never had the food made by a lower caste claiming it to be a threat to their purity. Another sociologist Dipankar Gupta agreed that untouchability practice emerges from the norms of Purity and Pollution. Actually illness can be supposed to be the night side of the life. It means how the so-called Dalits are treated as impure, polluted and untouchables and so is the illness of COVID-19 treated in the society. This study can be linked with Dumont thought of hierarchy, purity and impurity because there is hierarchical order of healthy and unhealthy, normal and not normal, superior and inferior etc.in between people living with HIV and without HIV in terms of health and illness and so that PLWHIV are treated as inferiors, impures and untouchables and other normal people prefer to stay away of them by maintaining some physical distance.

2.1.3 Symbolic Interactionism

The symbolic interaction perspective, also called symbolic interactionism, is a major framework/approach of the sociological theory. This perspective relies on the symbolic meaning that people develop and build upon in the process of social interaction. Symbolic interaction theory analyses society by addressing the subjective meanings that people impose on objects, events, and behaviours. Although symbolic interactionism traces its origins to Max Weber's assertion that individuals act according to their interpretation of the meaning of their world, the American philosopher George Herbert Mead introduced this perspective to American sociology in the 1920s.

Symbolic interactionist perspective helps us to understand the relationship between the individual and the larger society as dynamic. This theoretical perspective views concepts of self, social situations and interactions. Through this concepts and guiding assumptions, symbolic interactionism fosters/encourages theoretically driven research with health and illness of people.

Cooley's most significant contribution was his idea of the "looking-glass-self." The concept of the looking glass self demonstrates that self-relation, or how one views oneself is not a solitary phenomenon, but rather includes others. Cooley states that society and individuals do not denote separable phenomena, but are simply collective and distributive aspects of the same thing. Developmentally, Cooley theorizes that human beings possess an inherent tendency to reach out, interact, or socialize with those people and objects that surround them. Therefore this investigation linkages and emphasizes with Cooley's idea of ''Looking glass self '' by applying the symbolic interactionism approach although this study includes the idea of many other sociological philosophers and sociologists.

Symbolic interactionism is a micro-level theory that focuses on the relationships among individuals within a society. Communication—the exchange of meaning through language and symbols—is believed to be the way in which people make sense of their social worlds. Theorists Herman and Reynolds (1994) note that this perspective sees people as being active in shaping the social world rather than simply being acted upon.

Symbolic interaction was conceived by George Herbert Mead (1863-1931). Symbolic interaction was conceived by George Herbert Mead and Charles Horton Cooley. Griffin (2015). argued that according to George Herbert Mead people's selves are social products, but that these selves are also purposive and creative, and believed that the true test of any theory was that it was "useful in solving complex social problems". Mead's influence was said to be so powerful that sociologists regard him as the one "true founder" of the symbolic interactionism tradition.

Mead's student, Herbert Blumer coined the term "symbolic interactionism" and outlined these basic premises: humans interact with things based on meanings ascribed to those things; the ascribed meaning of things comes from our interactions with others and society; the meanings of things are interpreted by a person when dealing with things in specific circumstances (Blumer, 1969).

''Mind, Self and Society is the book published by Mead's students based on his lectures and teaching, and the title of the book highlights the core concept of social interactionism. *Mind* refers to an individual's ability to use symbols to create meanings for the world around the individual – individuals use language and thought to accomplish this goal. *Self* refers to an individual's ability to reflect on the way that the individual is perceived by others. Finally, *society,* according to Mead, is where all of these interactions are taking place. A

general description of Mead's compositions portray how outside social structures, classes, and power and abuse affect the advancement of self, personality for gatherings verifiably denied of the ability to characterize themselves'' (Brewster, 2013).

According to Blumer (1969) ''human groups are created by people and it is only actions between them that define a society. He argued that with interaction and through interaction individuals are able to "produce common symbols by approving, arranging, and redefining them. Having said that, interaction is shaped by a mutual exchange of interpretation, the ground of socialization".

Goffman broke from George Herbert Mead and Herbert Blumer in that while he did not reject the way people perceive themselves, he was more interested in the actual physical proximity or the "interaction order" that moulds the self. In other words, Goffman believed that impression management can be achieved only if the audience is in sync with a person's self-perception. In '*The Presentation of Self in Everyday Life' that* was published in 1956, he describes the theatrical performances that occur in face-to-face interactions. He holds that when someone comes in contact with another person, he attempts to control or guide the impression the other person will form of him, by altering his own setting, appearance and manner. At the same time, the second person attempts to form an impression of, and obtain information about, the first person. Goffman also believes that participants in social interactions engage in certain practices to avoid embarrassing themselves or others. Society is not homogeneous; we must act differently in different settings. He saw a connection between the kinds of "acts" that people put on in their daily lives and theatrical performances. In a social interaction, as in a theatrical performance, there is an onstage area where actors (people) appear before the audience; this is where positive self-concepts and desired impressions are offered. But there is also a backstage—a hidden, private area where people can be themselves and drop their societal roles and identities. He defined "impression management" as a person's attempts to present an acceptable image to those around them, verbally or nonverbally. This definition is based on Goffman's idea that people see themselves as others view them, so they attempt to see themselves as if they are outside looking in. Goffman was also dedicated to discovering the subtle ways humans present acceptable images by concealing information that may conflict with the images for a particular situation, such as concealing tattoos when applying for a job in which tattoos would be inappropriate, or hiding a bizarre obsession such as collecting/interacting with dolls, which society may see as abnormal.

Lines of inquiry have generated new conceptual directions, as have areas of focus though early symbolic interactionist studies have used grounded theory methods to explore,describe and theorize individual life with chronic illness. Theoretical conceptions have become descriptions of illness experience. The central focus of symbolic interactionists has moved out of hospital and into home and society away from patient's role and into people's problematic lives. It means it has now turned to the analytical study from descriptive. In this way the lines of inquiry is shifted in macro interaction from micro level of interaction/study. It means the central focus of symbolic interactionism approach has moved from the doctor-patient's interaction to the live experience and real setting of family and society. It stresses on empirical study/real setting of the life. It's emphasis is in the study of total or whole biography of an individual contemporary life rather than focusing on historical background to know the self-image of the persons.

Another example is according to Daniele Carricaburu and Janine Pierret's idea of 1995, they found that serious chronic illness may mean 'biographical reinforcement' rather than disruption among marginalized people. For instance an eminent actress Manisha Koirala before and after having cancer. After having victim of cancer she has had reinforcement in her life, she published her book and also appeared in literary festival as an invited literary figure. Actually there was and reinforcement in the life of Manisha Koirala after cancer. In this way the experience and feeling of being healthy and illness plays and great role in the biographic reinforcement or disruption and loss of self-image of and individual. Similarly the self-image or consciousness of Dr. Upendra Devkota towards his village during his illness time shows that there might be reinforcement/disruption if he recovered. This is how the feeling and experience of illness brings changes in the concepts and attitude of persons. Most of the people have feeling of prestigious in society before illness while after illness they feel to be marginalized by others and isolated from others. Hence illness brings change in the conception of social identity whether the illness is cancer or HIV-AIDS or COVID-19. In this investigation also some of the respondents are working as social activists in social organizations such as 'Sangkalpa Sahayog Samuha' for the awareness against HIV-AIDS. 'Sangkalpa Sahayog Samuha' is an INGO (International Non-Governmental Organization) which works in favour of HIV-infectious.

The symbolic interaction perspective, also called symbolic interactionism, is a major framework of Sociology.This perspective focuses on the symbolic meaning that people develop and rely upon in the process of social interaction. Humans act towards the things on the basis of the meaning they ascribe to those things. The meaning of such things is derived from, or arises out

of, the social interaction that one has with others and the society. This approach within the field of sociology that aims to reveal what role human awareness plays in the production of social action, social situations and social worlds. In essence, this theory has a belief that society is a human construction. It is a theory that attempts to explain socialization and its effect on the development of the self. It looks at the individual learning process, the formation of self, and the influence of society in socializing individuals. The main three assumption of this symbolic interactionism are:

- Individuals construct meaning via the communication process.
- Self-concept is a motivation for behavior
- A unique relationship exists between the individual and society.

The study is oriented to seek the social relationship of human action and interaction. Thus the major reasons behind applying this symbolic interactionism theory in this study are to advocate the respondents' individual feeling, thought, emotion, experience and perception about COVID pandemic, to show how they interact, behave with each other and work in the family and society, to find out how they received their medicines (ART pills) during this pandemic time and how was their social and economic mobility as well as family and social gathering in this time, it means how they presented themselves to control the spread of this COVID-19.

In other words this study represents common set of symbols, feelings and understanding possessed by individuals in a group that guide the individuals around them and according to the situation, it focuses on the individual interaction between person's internal thoughts, emotions and his or her social behaviour and it emphasizes on the processes by which individuals make decisions and forms opinions towards persons and things. In short this dissertation work revolves around the respondents' (the people living with HIV) individual thought, experience, interaction, symbols, gesture, language, meaning of the situation and interpretation of meaning and the behaviour of themselves and others in the family and society about this COVID-19 disease, their daily medication (ART drug) and measures of health and safety to control the spread of this disease that's why this symbolic interactionism theory is applied in this study.

2.2 Review of Previous Studies

Adhikari (2066) found that the respondents were discriminated and stigmatised in the society by other people after the HIV illness, they were treated as criminals and sinner. HIV-infection was

considered to be the consequence of crime and sin of previous birth of concerned individuals and they were totally marginalized, excluded, isolated and deprived from being participants in any cultural and religious functions with the fear of its transmission and due to the lack of enough knowledge, awareness and information about it. She concluded her thesis work by saying that the people living with HIV positive are not still accepted easily in the society, they are discriminated, stigmatised and marginalised by other members of the family and society. Actually they are considered/supposed to be criminal or sinner in the society and family. The study shows that there is gender discrimination in social stigma and marginalization too. Female members are more exploitative in social practice than that of male members out of the total infectious population. They are also compelled to live separately especially in shed or stay away of their family and other members due to lack of awareness and education about HIV.

For the linkage if we argue about self-image and marginalization then we can know that the feeling and experience of illness brings change in the concept of self-image. For example most of the people have lion like self-image before illness whereas after illness he/she has cat like self-image. It brings change in social identity. For instance a woman before being widow and after being widow is drastically changed because a woman after being a widow she has lost of self-image in Nepali society traditionally. Similarly the self-image is drastically different regardless of economic status i.e. Stephen Hawkins became one of the most intelligent scientist due to highly economic status society though he was disabled/paralyzed person but in Nepalese society it is not like that because it also depends in terms of the economic status of people and country as well. Furthermore there is no sameness/same lens towards others in looking, thinking, feeling and experience of people between those who belong to rich class family and those who belong to poor class family whether they are male or female.

Sapkota (2020) founded that there is change in the trend of new people living with HIV (PLHIV) on anti-retro viral treatment (ART) because the official report of government of Nepal i.e. National centre for AIDS and STD Control (NCASC) shows that before COVID-19 lock down the percentage of people changed in New PLHIV on ART between January and March 2020 was 4.4 % (i.e. in this time period there were maximum number with 225 and minimum with215 HIV-infectious were taking anti-retro viral treatment). Similarly during COVID-19 lock down the percentage of people changed in New PLHIV on ART between March and June 2020 was 39.5% (it means during this time period there were maximum number of 225 HIV-infectious and minimum number of 130 HIV-infectious in anti-retro viral treatment). Hence this data/report of

HIV-infectious of Nepal till this time frame shows that there was decreasement in the number of new people living with HIV on anti-retro viral treatment and it is because of fear of COVID-19 spread in people of different parts of the country.

UNAIDS (2020) report showed that in general, PLWH seem to experience similar clinical outcomes with COVID-19 infection than those without HIV in series from the U.S. and Europe. The majority of literature has not supported a higher risk for severe disease among people living with HIV in Europe and the United States, although a large population-based study in South Africa reported a higher rate of death due to COVID-19.COVID-19 is leading to decreased access to HIV prevention services and HIV testing, and worsening HIV treatment access and virologic suppression, which could lead to worsening HIV epidemic control.

Furthermore the above report also shows that one of the largest cohorts of COVID-19/HIV co-infection (n=253) reported from the U.S. to date. A multi-centre registry-based cohort of 286 PLWH from 36 institutions in 21 U.S. states and 3 international sites (2 in Spain and 1 in Singapore) found clinical outcomes of similar severity to those reported among HIV-negative individuals in the U.S .In a matched case-control study comparing 21 PLWH on ART to 42 HIV-uninfected patients hospitalized with COVID-19 in New York, PLWH had higher C-reactive protein (CRP) values and were more likely to have abnormal chest x-rays at admission. Compared to the control group, a higher proportion of PLWH required ICU admission (29% vs 18%) and mechanical ventilation (24% vs 12%), however these differences were not statistically significant, and there were no differences in mortality (29% vs 24%, $p = 0.7$). A small case series of 14 PLWH infected with COVID-19 in Wuhan observed a higher proportion of severe cases and higher mortality than the general population, however the median age and number of comorbidities was also higher among PLWH in that study compared to the general population of Wuhan. The largest study to address risk of death from COVID-19 among PLWH is a prospective cohort study in South Africa which includes 3,460,932 patients served by the public sector health care system in Western Cape Province, 3978 (16%) of whom are PLWH. In this province, 22,308 were diagnosed with COVID-19, from March 1 – June 9, 2020, of whom 625 died. Several factors could explain the differences in the findings of the South African cohort compared to the European and American cohorts. For instance, only 55% of the South African cohort were on ART and virologically suppressed, and comorbidity burden also differed when compared with European and U.S. cohort, with high numbers of PLWH having uncontrolled diabetes and active tuberculosis. The conclusion of all of these studies is that PLWH did not seem to be at increased

risk of severe outcomes with COVID-19 in studies to date within the U.S. and Europe, while HIV was associated with a higher mortality rate due to COVID-19 in a large cohort in South Africa.

Vizcarra MD (2020) argued that an outbreak of pneumonia of unknown origin was first reported in Wuhan, China, on Dec 31, 2019. After a week, the cause had been identified as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). With a persistently increasing number of cases of COVID-19 worldwide, WHO declared a pandemic on March 11, 2020. Spain has been one of the most affected countries worldwide with 203,715 confirmed cases as of April 30, 2020. Particularly, the Community of Madrid has documented the highest number of cases within the country. In this study, mortality was 4%, which is lower than that reported in the general population in the Community of Madrid (20%). However, in the age strata of 50–59 years, the mortality of cohort is double that of the mortality in the general population (8% *vs* 4%). Despite the low mortality rate, 25% of HIV-infected individuals with COVID-19 had severe disease and 12% were admitted to an ICU, which is a higher rate than that observed in cohorts of the general population, of whom 17–21% have severe disease and 3–5% are admitted to an ICU. These data suggest that HIV-infected individuals might have worse outcomes than previously speculated. Hence HIV-infected individuals should not be considered to be protected from SARS-CoV-2 infection or to have lower risk of severe disease. Generally, they should receive the same treatment approach applied to the general population. this finding highlights the increased prevalence of comorbidities in HIV–SARS-CoV-2 co-infected individuals, particularly hypertension, high BMI, diabetes, chronic kidney disease, and chronic liver disease, compared with people with SARS-CoV-2 monoinfection or people with HIV monoinfection.

For instance the transmission of COVID-19 infection, seems to be indiscriminate. The negative consequences of COVID-19 for some populations are more severe than others, including job loss, food insecurity, inability to manage existing conditions, and inability to maintain preventive measures such as social distancing and use of personal protective equipment (PPE). Those who live in poverty have less control of their living arrangements and their immediate environment, thus the barriers that they are facing when trying to protect themselves and their families are greater than those that are not living in poverty. Among the most disenfranchised and most disadvantaged in the COVID-19 era are people living with HIV/AIDS, people at risk of contracting HIV such as sex workers, people who inject drugs, and men who have sex with men, and people with other autoimmune diseases. As the pandemic has led to significant changes in

health service delivery and amplified fears of increased death and illness, the health inequities and the consequences of these changes among various subgroups of those living in HIV/AIDS, or at risk of contracting HIV must be reviewed through the lens of social determinants of health.

2.3 Conceptual Framework

Leshem and Tradfford (2007) stated ‘’Conceptual Framework is alluded to most serious texts on research, described in some and fully explained in few. However examiners of doctoral theses devote considerable attention to exploring its function within social science doctoral vivas. A literature survey explores how the conceptual framework is itself conceptualised and explained. Drawing upon experience of conducting programmes for doctoral candidates and supervisors, field-tested models illustrate how conceptual frameworks may be devised and used’’.

Conceptual framework actually provide a clear vision about the study and establish linkage among the variables. The structure or the framework of the study is set up through the relationship among the different variables and such types of related variables can be visualised through the conceptual framework. In this topic ‘ Impact of COVID-19 in People Living with HIV-AIDS’, there are some key variables.

Conceptual Framework of Theoretical Linkage among Variables

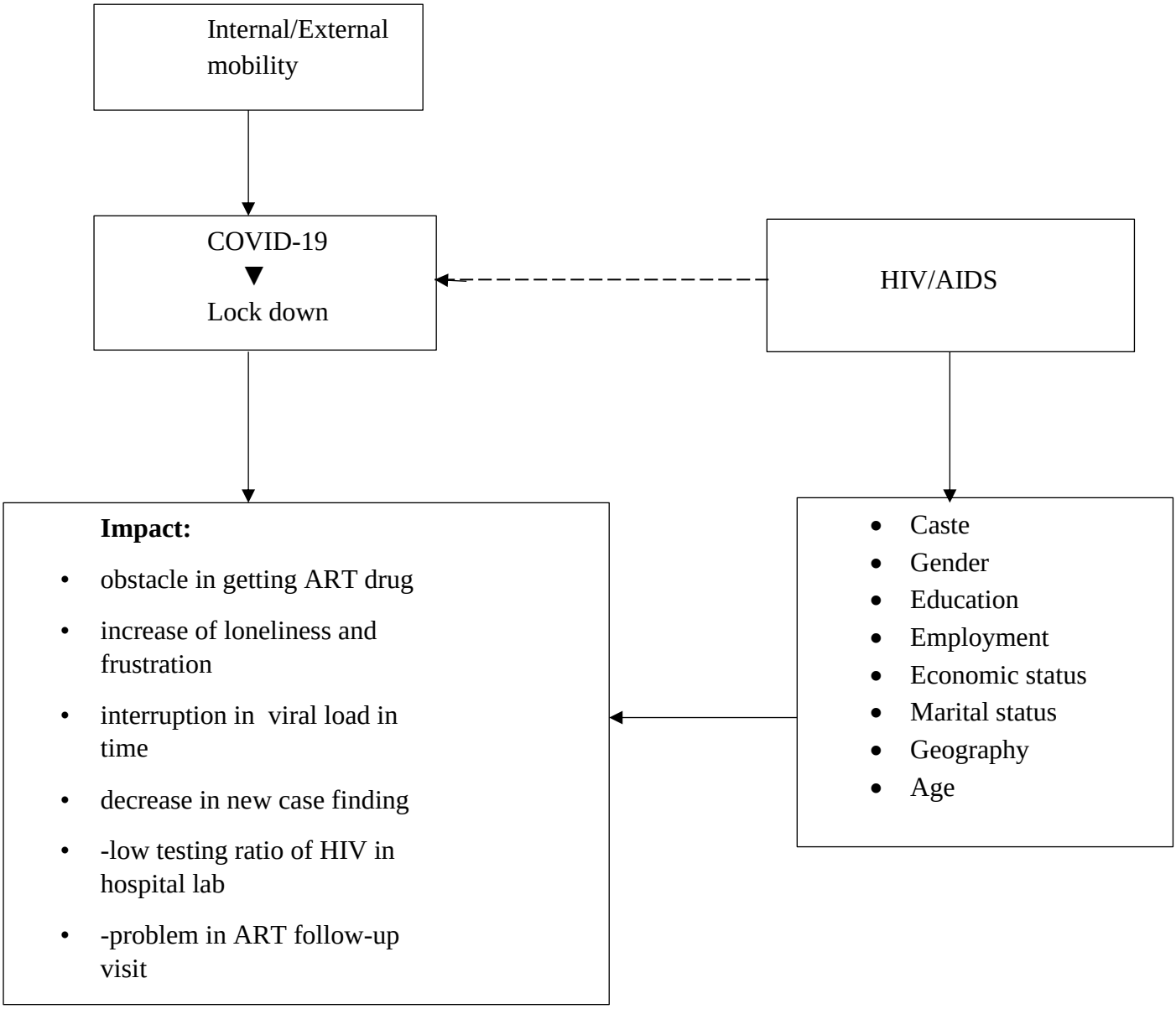


Figure 2.1: Theoretical Linkage among Variables

The persons belonging to different castes and gender of people, income status of individuals, level of education, age, occupation for livelihood and the people using and not using daily medication also affected in the interaction, communication and behaviour with each other in the family and society because there is change in the verbal speech, in their activities and behaviour of people towards others before and after illness, economic status also becomes poorer than previous due to lack of work and job in pandemic time, there is like stagnation in the market and

business besides necessities because of restriction in movement, transportation and gathering of people and it badly affected to the traditional culture, social values and religious norms of people living in a particular place in general, the education pattern is transmitted into virtual form from physical. Eventually individual health of people also is badly affected in the COVID pandemic time due to the lack of treatment and medication.

Figure 2.1 reveals that internal and external movement of people is the main cause for the spread of COVID-19 which affected to the HIV-infectious including with other healthy people. This COVID-19 pandemic invited lock down in the country and lock down was imposed for restriction in the movement and transportation and to control COVID-19 infection in people. Generally family and social interaction pattern, individual behaviour, social and economic mobility, family and social gathering, culture and festivals, income, education and occupation are guided and influenced by COVID-19 and particularly COVID-19 impacted in new test, enrolment and case finding of HIV, in their medication, follow-up visit and added frustration and loneliness in their lives because they have been existing with HIV previously.

In this study internal and external mobility of people is taken as independent variable while the outcomes or the impacts are taken as the dependent variables and these impacts are obstacle in getting their regular medication, increase in loneliness and frustration, interruption in viral load in proper time, decrease in HIV testing and new case finding ratio and problem in ART follow-up visit of individuals living with HIV/AIDS. The variables like caste, gender, education, employment, economic status, geography, age and marital status are supposed to be the intervening variables. The increase in the mobility of people causes the increase in the COVID-19 transmission and the decrease in the mobility decreases its transmission in people living with/without HIV but there is higher risk of COVID-19 transmission to HIV-infectious in the comparison to other healthy people because they have weak immunity power to fight against other diseases like cancer, tuberculosis and COVID-19. So, there is direct or indirect relationship in between HIV/AIDS and COVID-19.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter argues about the research methodology, tools and technique used in this study as the data collection methods, rationale of site selection, research design, nature and sources of data, universe and sampling and eventually data presentation and analysis process. Similarly non-probability purposive sampling will be used while collecting data for this study.

3.1 Rationale of the Site Selection

This study was undertaken in this Garahun Primary Hospital, Waling-9, Syangja and this place is being purposively selected for this study because more or less in comparison to Western Regional Hospital, Pokhara this kind of study was not undertaken/conducted in this hospital taking cases of HIV and COVID-19 till now. Most probably being a little far from Pokhara or whatever and COVID-19 is just a new burning issue but the stress and focus of this investigation is to reach there and address the issues of HIV-infectious because such kinds of studies haven't undertaken yet and this is the main reason behind this site selection. And the most important reason behind this site selection is that there are sufficient number respondents/cases of HIV-infectious in this hospital for my study.

There are five municipalities and six rural municipalities (gaon palika) in Syangja district whereas among these cities and gaon palika this research study had been done by collecting data information with the respondents who belongs to one rural municipality and four municipalities such as Kaligandaki rural municipality, Chapakot, Bhirkor, Galyang and Waling municipalties because the respondent who are taking ART service from GPH are from these five places only. Waling is also known as *' Pink City'* of Nepal as most of the houses can be seen to be painted with pink color and it is growing/developing to be smart city. It is one of the beautiful cities of Nepal and neighbouring district of Kaski. It also lies in Gandaki Province. The people living with HIV-AIDS and taking ART from this hospital were my respondents.

3.2 Ethical Consideration

Initial approval for my data collection was taken from the respondents who are living with HIV Positive and getting ART service from Garahun Primary Hospital, Waling-9, Syangja. And only then with that approval the field work data collection task was started. The participants/respondents were informed that it is voluntary job and they are free to participate or not to participate in it. Respondent's secrecy and privacy are maintained and kept confidential, there is well considerations of their respect, dignity and prestige in the study. The words, speech and activities which can hurt them are not used by the researcher while collecting data information.

3.3 Research Design

The research design is the complete framework for the research study. It serves not only as a framework for the research but also guides for the collection and analysis of data, it dives instructions which research instruments/tools to be utilized and which sampling plans to be followed as described by Wolf, (2008). This is an academic research. Similarly this study is based on both qualitative and quantitative research method. Similarly descriptive and exploratory research designs are applied for the purpose of this research study because the most of the data and information taken by the respondents for this investigation are qualitative in nature .

This work goes on exploring the impacts and consequences of COVID-19 pandemic upon the cultural and religious festivals, family and social gathering and social and economic mobility of respondents. Furthermore this investigation is focally concerned to find out how this disease is socializing and controlling the overall behavioural pattern. Interaction, mobility, gathering and regular medication of the people living with HIV-AIDS.

3.4 Nature and sources of data

This work has included both the qualitative and quantitative base research methodology. The data were mainly collected from the primary source however some of the data were also collected from the secondary sources as well in this study. Therefore as the sources of data collection both the primary and secondary sources have been applied in this report.

i) Primary Sources :

In this study Key Informant Interview (KII), interview schedule and case study are used for the primary data collection because the primary data in this study were collected by taking interview with key informant, doing case study of respondents and taking face to face interview directly with the respondents of this study who are the people living with HIV-AIDS and taking ART service from this Garahun Primary Hospital, Waling-9, Syangja. In this process the check lists of open ended questions were prepared for primary data collection through interview with KII and respondents.

ii) Secondary Sources :

In this investigation the secondary data were collected by searching in google, internet, website and studying already published reports, journals, articles and books.

3.5 Universe and Sampling

For the investigation ***'Census Method'*** is used. The data were collected from the people living with HIV Positive who are taking ART from this Garahun Primary Hospital, Waling-9, Syangja. The total number of population of the respondents are all the patients living with HIV and taking anti retro-viral treatment were ***eighty (81)*** in this hospital that's why they all are the total number of respondents in this analysis of study. In this way the whole population of respondents is considered as the ***universe*** and each and every respondent is the ***unit*** for this study. And the attempt of this study was to obtain data for and from each and every unit of population. Therefore the data information were taken and collected from the whole population of respondents in this study.

3.6 Data Collection Tools

In this study the tools like ***interview schedule***, ***Key Informant Interview (KII) and Case Study*** are used in this investigation. Interview schedule was used to collect data from all eighty-one (81) respondents and the interview schedule of questions was prepared for taking interview with them is attached in Appendix-I .

As a Key Informant (KI), ART Counsellor of Garahun Primary Hospital was taken. The check list of the questions was prepared for taking interview with him and the check list for Key Informant interview (KII) is attached in Appendix-II.

Besides these the case study of three (3) respected respondents are also kept in required places of this dissertation work. Some questions were made to ask them as the guideline and the guideline for Case Study is attached in the sheet of Appendix-II.

3.7 Data Presentation and Analysis

After the data collection, on the basis of their feature the data are grouped, classified, categorized and analysed. Data was random in initiation. The quantitative data are directly presented in the form of table and the qualitative data are presented by providing with numerical values. And then only necessary data are chosen and unnecessary data are removed from them. After the process of cleaning, transforming, transcribing and modelling with the objective of discovering useful information we arrive at conclusion and data analysis. As the part of the data analysis, data collected from whole population are shown in form of tables and the narratives of the data narrated by ART Counsellor and other three respondents (by doing their case study) were in Nepali language but later it was transcribed into English language and attached in required places in this study in the form of narration by key informant and case study of respondents. Every table is analysed in terms of characterstics of the data. The computer software like Micro-soft Word, Micro-soft Excel and SPSS are used for finalizing of the data.

CHAPTER FOUR

SOCIO-DEMOGRAPHIC PROFILE OF THE RESPONDENTS

This chapter includes the demographic information about the respondents of this study who takes anti-retro viral treatment service from this Garahun Primary Hospital, Waling-9, Syangja district till the date. Geographically this hospital is located in the Hilly region of Nepal and the respondents also belong to the same region like they are from Waling Municipality, Chapakot Municipality, Bhirkot Municipality, Galyang Municipality and Kaligandaki Rural Municipality. The respondents in this investigation belong to Brahmin, Kshetri, Thakuri, Newar, Magar, Gurung, Bishwokarma and Nepali although the different castes and ethnic groups are also living in this study area.

4.1 Socio-economic Characteristics of Respondents

There were altogether eighty-one (81) HIV-infectious who were taking antiretroviral treatment service from this hospital. Thus total population *of this study is* eighty-one which is regarded as the universe of this study. So, this study gives information only about eighty (81***)*** respondents supposing each and every one respondent is the unit of this investigation. The respondents are from different socio-economic backgrounds and therefore the different subject matters of the respondents such as gender, caste and ethnicity, income, occupation, marital status, education, age and religion are mentioned within this topic. They are discussed as below:

4.1.1 Sexual Division

Sex and gender are different attributes. Sex refers to the biological attributes of humans and animals and it is usually categorised as male and female whereas gender is social construction because it refers to the socially constructed roles, behaviours, expressions and identities of men, women, girls etc. NCASC (2020) in the national scenario of Nepal about HIV there are 37,596 ever reported cases but there are only 23,136 alive PLHIV in Nepal. There are 13,341 male, 9,572 female and 223 transgender mong the total number of cases. The status of study area is presented in table number 4.1.

Table 4.1: Sexual Division of Respondents

Gender	No. of Respondents	Percent
Male	35	43.2
Female	46	56.8
Total	81	100.0

Source: Field Survey, 2020

The data presented in table 4.1 shows that it is the frequency table of respondents of this research study which is about their sexual division in which there are only male and female respondents and none of the respondents were found to be belonging with transgender. Therefore it gives the information about only male and female respondents while reading the sexual division table in this investigation. As described in the table for there are eighty-one members in total. Among them thirty-five respondents are male members which occupies the 43.2 percentage space of the total population and rest of the others forty-six respondents are female members which covers 56.8 percentage from the total population. This finding displays that the number of female respondents are more than the male respondents in this investigation because of their spouse, labour migration, lack of awareness about precautions, illiteracy and sexual violation over them.

4.1.2 Caste and Ethnicity of people

In general caste is the ascribed status of people which is determined by birth but not by selection. There is social stratification and hierarchy in caste system. Similarly ethnicity is the state of belonging to a social or cultural tradition. Therefore ethnic groups are based on own lineage while case is a social status. NCASC (2020) the mean age of the women aged 15–49 years was 29 years. Most of them were Janajatis (35.8%) followed by Hill Brahmin/Chhetri (30%) and less than 20% were Dalit/muslim/other (17.7%) and Terai caste (16.5%). Similar to women, most of them were also Janajatis (38.1%) followed by Hill Brahmin/Chhetri (28.2%) in Nepal. The status of study area is presented in table number 4.2.

Table 4.2: Caste and Ethnicity of Individuals

Caste/Ethnicity	No. of People	Percent
Brahmin	26	32.1
Kshetri	6	7.4
Thakuri	4	4.9
Newar	4	4.9
Magar	22	27.2
Gurung	6	7.4
Bishwokarma	10	12.3
Sarki	3	3.7
Total	81	100.0

Source: Field Survey, 2020

The data presented in table 4.2 gives the information about the different eight types of caste and ethnicity of respondents in this study such as Brahmin, Kshetri, Thakuri, Newar, Magar, Gurung, Bishwokarma, and Sarki. As shown in the table among the total population of 81 respondents, the respondents belonging to Brahmin ethnicity are in largest number with the population of 26 respondents (32.1 percentage). The second and third highest population of respondents are from Magar and Bishowkarma having 22 respondents (27.2 percentage) and 10 respondents (12.3 percentage) respectively. There is tie in between population of Kshetri and Gurung having same number of population with 6 respondents (7.4 percentage). Similarly there areagain same number of population in ethnic groups like Thakuri and Newar with 4 respondents (4.9 percentage). The least number of population can be seen belonging to Sarki having 3 respondents (3.7 percentage). As shown in the table the majority of Brahmin are infected by HIV followed by Magar because Brahmin and Magar are living there in large numbers than the other caste groups.

4.1.3 Income Distribution of Respondents

The earnings or money received especially on a regular basis from work or through investment is known as income and it can be in the form of wages, salary, pension, return from investment etc. In Nepal about half (46.7%) of women out of the total HIV-infectious were engaged in agricultural activities as main occupation and more than two-fifth of men were engaged in manual labour. (NCASC, 2020). The status of study area is presented in table number 4.3.

Table 4.3: Income Distribution

Monthly Income	Frequency	Percent
Up-to 10,000	8	9.9
Below 10,000	17	21.0
Above 10,000	13	16.0
NO Income	43	53.1
Total	81	100.0

Source: Field Survey, 2020

The table 4.3 given below is prepared to give data information about the income per month of respondents which also shows the economic status of clients. For the study of economic status of the respondents they are divided into four different income groups according to their income level i. e. the respondents having monthly income up-to 10,000, below 10,000, above 10,000 and no income. There is variation in income level of respondents. According to this table among 81 respondents there is highest number of population with 43 respondents having no any income. The rest of the two groups such as below and above Rs. 10,000 have occupied the second and third highest population with 17 and 13 respondents respectively. There is the least number of population that is of 8 respondents in income group of up-to Rs. 10,000. Therefore the majority of respondents do not have any monthly income and surviving with extreme poverty.

4.1.4 Marital Status

The state of being married or not is considered as marital status and its examples are married, unmarried, single, divorced and widow. About two-third of the men were married and most of the women (76.8%) were married/living together out of the total clients (NCASC, 2020). The status of study area is presented in table number 4.4.

Table 4.4: Marital Status of HIV-infectious

Marital Status	No. of Persons	Percent
Married	59	72.8
Unmarried	14	17.3
Widow	8	9.9
Total	81	100.0

Source: Field Survey, 2020

According to the data information presented in table 4.4, among the 81 respondents, 59 respondents (72.8 percentage) are married, 14 respondents (17.3 percentage) are unmarried whereas rest of others 8 (9.9 percentage) are widow women. This is how the table shows that the highest number of respondents are married and the least number of respondents are widow who are surviving their lives as single women. The married clients are in large numbers but unmarried people are also infected with HIV due the transmission from mother by birth and through drug using equipment like syringe whereas in married people HIV is the consequence of labour migrant, sexual partner and sexual violence towards women.

4.1.5 Occupations of People

The job or work of people is known as the occupation generally. Farming, teaching, masonry, carpentry, doctor, driving, business etc. are the different examples of it. The respondents of this investigation are also engaged in different occupation and economic activities for the survival in their family and society. In Nepal about half (46.7%) of women out of the total HIV-infectious were engaged in agricultural activities as main occupation and more than two-fifth of men were engaged in manual labour. (NCASC, 2020). The status of study area is presented in table number 4.5.

Table 4.5: Occupational Distribution

Occupation of Respondents	Frequency	Percent
Housewife	25	30.9
Agriculture	28	34.6
Students	12	14.8
Masonry	9	11.1
Service	6	7.4
Wage labour	1	1.2
Total	81	100.0

Source: Field Survey, 2020

The data presented in table 4.5 argues about the occupations of respondents in this study. This table clearly shows that there is variation in the work and occupations and are founded to be involved in different six fields of occupations in total as their main economic activities for their survival and earning money as well for the family and selves and these economic activities of the

respondents are housewife, agriculture/farming, students, masonry, service in different sectors and wage labour. In the table the most frequent value is of 28 respondents (34.6 percentage) that is in the agricultural field. Thus the highest number of respondents are found to be engaged in agriculture. Then second and third highest number of respondents can be seen in the field of housewife with 25 number of respondents and in the sector of students there are 12 respondents which occupy 30.9 and 14.8 percentages respectively. Similarly there are 9 (11.1 percentage) respondents in masonry and 6 (7.4 percentage) respondents in service sectors. There is only one respondent is involved in wage labour which occupies the least number of respondents among the total population. In this way having no good income, occupation and education they are compelled to work as labour migrant and sex worker.

4.1.6 Age Distribution

Age is the time that a person has lived or existed so it is the lifetime of human. Age distribution is also called as age composition. The age of the respondents is analysed in the following table by categorized in different seven categories from up-to ten years to above sixty years. In this way to study about the respondents in terms of their ages they are grouped into different seven groups like the respondents up-to 10 years is kept in the first group and similarly the respondents from 10 to 20 years, from20 to 30 years, from 30 to 40 years, from 40 to 50 years, from 50 to 60 years and above 60 years are put in the second, third, fourth, fifth, sixth and seventh/last groups respectively. The status of study area is presented in table number 4.6.

Table 4.6: Age Distribution of HIV-infected people

Age of Respondents	Frequency	Percent
Upto-10 years	1	1.2
10-20 years	10	12.3
20-30 years	3	3.7
30-40 years	14	17.3
40-50 years	33	40.7
50-60 years	18	22.2
Above 60 years	2	2.5
Total	81	100.0

Source: Field Survey, 2020

The data presented in the table number 4.6 describes about the respondents of different age groups. As shown in the above table the age of the respondents in this study is divided into different seven groups. There is highest number of population with the number of 33 respondents (40.7 percentage) in age group from 40 to 50 years. Similarly there are 18 respondents (22.2 percentage) in age group from 50 to 60 years, 14 respondents (17.3 percentage) in age group from 30 to 40 years, 10 respondents in age group from 10 to 20 years. Likewise the age group from 20 to 30 years and the age group above 60 years include 3 respondents (3.7 percentage) and 2 respondents (2.5 percentage) respectively. The least number of population with only one respondents (1.2 percentage) is seen in the age group up-to 10 years.

4.1.7 Religious Diversity

Religion is the belief/faith and worship of super controlling power (god or goddess especially). People can follow the different religions like Hinduism, Budddhism, Christianity, Islam, Bon, Jainism, Sikkhism and so on.The given table 4.7 explains about the frequency of respondents in different two religions. The table below shows altogether two religions that are Hinduism and Buddhism which are followed by the respondents in this study. The status of study area is presented in table number 4.7.

Table 4.7: Religion of People with HIV

Religion	No. of People	Percent
Hinduism	80	98.8
Buddhism	1	1.2
Total	81	100.0

Source: Field Survey, 2020

According to the above table 4.7 the highest number of population is covered by the Hinduism religion with the number of 79 respondents (98.8 percentage) and Buddhism religion consists of only 1 respondent (1.2 percentage) among 80 respondents.

4.1.8 Education Level

Education is the process of receiving and giving systematic instruction of knowledge especially at school and universities. More than one-third (35.1%) of the women had secondary level

education whereas 33.3% did not have any formal education. Less than one-fifth (16.7%) had a primary education and 14.9% had higher education. Likewise about half of the men had higher education while about 10% did not have any formal education (NCASC, 2020). The status of study area is presented in table number 4.8.

Table 4.8: Level of Education

Education level	**No.**	**Percent**
Illiterate	24	29.6
Literate	3	3.7
Primary	40	49.4
Lower Secondary	5	6.2
Secondary	7	8.6
SEE	1	1.2
Above SEE	1	1.2
Total	81	100.0

Source: Field Survey, 2020

According to the data presented in the table 4.8**,** the level of education on the basis of education qualification of all the 81 respondents is categorized into different seven categories such as illiterate, literate, primary, lower secondary, secondary, SEE (Secondary Education Examination) and above SEE. In the above frequency table 4.8 the highest number of respondents have qualification of primary level of education with the number of 40 respondents (49.4 percentage), there are 24 respondents (29.6 percentage) illiterate having no any degree or qualification of school education and on the basis of this table the number of illiterate respondents occupies the second highest population out of the total. Similarly the respondents having secondary level of qualification are 7 persons (8.6 percentage), there are 5 respondents (6.2 percentage) who have got lower secondary education and only 3 respondents (3.7 percentage) are found to be literate who are able to read and write in general but do not have any school level qualification and certificate. Eventually there are equal number of respondents having least number of population with 1 person (1.2 percentage) in getting qualification of SEE and above SEE successfully out of the total 81 respondents. In this way such type of data shows that most of the clients are illiterate and there is lack of high education.

CHAPTER FIVE

IMPACT OF COVID-19 IN PEOPLE LIVING WITH HIV-AIDS

The different tables and figure are presented in this chapter to give information clearly about the impact and influence of COVID-19 in people living with HIV-AIDS.

5.1 Influence of COVID-19 pandemic in HIV-infectious

There are so many impacts of COVID-19 illness in people who are living with HIV-AIDS. Actually this disease badly affected in various aspects of both individual and social life and it is impossible to mention all these aspects here that's why some of them are discussed in this study like status of COVID-19 in respondents (it means to show whether they faced COVID-19 disease or not), whether they served other COVID positive patients or not, what safety measures they used as their safety measures, how they observe festivals and if they had to experience of any kinds of social stigma somewhere or not.

5.1.1 Status of COVID-19 on Respondents

Whether the person is being HIV positive or not is HIV status here whereas being affected with COVID-19 or not affected by it on the basis of appearance and disappearance of its symptoms on respondent is considered as status of COVID-19.The following table gives the answer of respondents to the researcher in her question "Did you go to hospital after symptoms appeared in you?" So, the data information given in this table below represents their answers. This table helps to know whether they infected by COVID-19 or not, similarly whether they went to hospital or not if they were infectious. The status of study area is presented in table number 5.1.

Table 5.1: Appearance of COVID-19 Symptoms

Symptoms of COVID-19	Frequency	Percent
No symptoms appeared	73	90.1
Symptoms appeared but didn't go to hospital	4	4.9
Stayed home taking warm water and steam after symptoms appeared in me	4	4.9
Total	81	100.0

Source: Field Survey, 2020

The data presented in the table 5.1 shows that COVID-19 status on respondents. Out of the total, 73 respondents (90.1 percentage) are found in the category in which no any symptoms of COVID-19 in them, the symptoms of COVID-19 appeared on 4 respondents (4.9 percentage) but they didn't go to hospital for their treatment, eventually 4 respondents (4.9 percentage) said that after appearing of symptoms of this disease on them they stayed at their own home by taking warm water and its steam. In this way from this table, it comes to know that respondents did not go to hospital for their treatment even after they were infected by COVID-19 disease due to lock down imposed by the government of Nepal, the fear of COVID-19 transmission, far distant from hospital and the fear of social stigma and discrimination in the society.

5.1.2 Safety Measures Used by Respondents for Prevention of COVID-19

Safety measures are the measures that are taken/used to increase safety and protection from any danger and transmission of diseases. Here this study gives information about the PPE (Personal Protective Equipment) and other safety measures that are used by the respondents during this COVID-19 pandemic time. The table shows that whether the respondents used safety measures and PPE or not as well as the table helps to find out and describe what kind of safety measures and PPE they used in this pandemic of COVID-19. The status of study area is presented in table number 5.2.

Table 5.2: Safety Measures Used for Prevention of COVID-19

Safety Measures used	Frequency	Percent
Mask and sanitizer	8	9.9
Mask and frequently handwashing	44	54.3
Physical distance, mask and frequent hand washing	13	16.0
Stayed at home most of the time	6	7.4
Used mask while coming to market and hospital	10	12.3
Total	81	100.0

Source: Field Survey, 2020

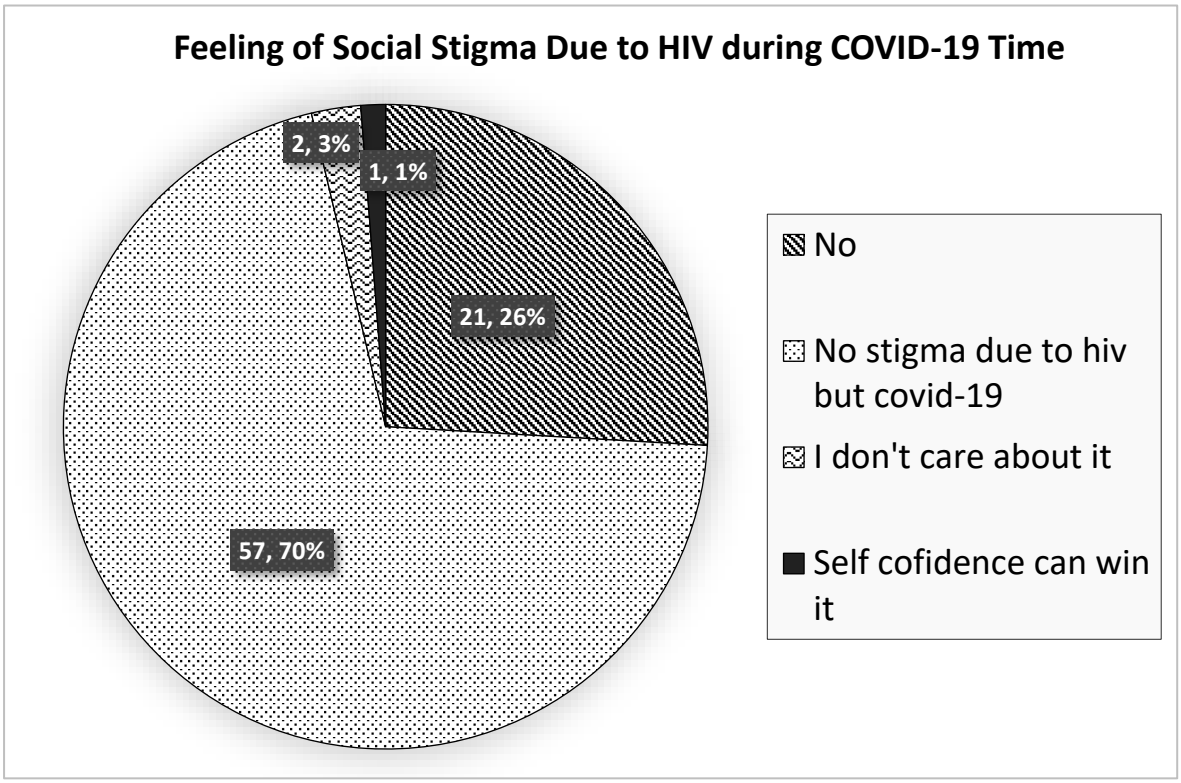
The data which are presented in the table 5.2 shows that out of the total 81 respondents, there are 8 respondents (9.9 percentage) who are mask and sanitizer users, the majority of the respondents with 44 population (54.3 percentage) are found to use mask and follow frequent handwashing rule, other 13 respondents (16 percentage) are found to maintain physical distance, use mask and

follow frequent handwashing rule during this pandemic time, there are 6 respondents (7.4 percentage) stayed at home for their safety and similarly rest of the 10 respondents (12.3 percentage) are found to use mask only when they go to market and hospital. According to this table most of the respondent used PPE and followed safety measures to help in the prevention and control of COVID-19 infection. It means respondents are compel to follow safety measures due to COVID-19 which added an extra burden of expenses on the head of individuals because they had to buy not only the things of daily needs but also mask, sanitizer etc. during this time.

5.1.3 Social Stigma in the time of COVID Pandemic

Social stigma means a strong feeling of disapproval that most people in the society have about something when there is unfair and differentiation in behaviour, speech, education, responsibility, duty, training and opportunity. The status of stigma, discrimination and marginalization by the other members of the family and society of study area during the COVID pandemic period is presented in figure number 5.1.

Figure 5.1: Feeling of Social Stigma Due to HIV during COVID-19 Time



Source: Field Survey, 2020

The data presented in this figure 5.1 shows the experience of clients about stigma. When respondents were asked the question by researcher like ‘do you have any feeling of social stigma due to HIV-AIDS during COVID-19 pandemic time’?, then among the total 81 respondents 21 respondents (26 percentage) answered by saying ‘’No’’, it means they didn’t feel social stigma in society due to HIV even in COVID time whereas according to answer of 57 (70 percentage) respondents who said that they felt stigma in their society due to COVID-19 but not because of HIV. Only 2 respondents (3 percentage) were found to be ignoring (not caring) the matter about social stigma. Finally 1 of the respondent (1 percentage) out of total 81 respondents said that self-confidence can win the feeling of social stigma because of COVID-19 disease rather than HIV/AIDS. This is how after reading this figure 5.1 it is found that the most of the respondents experienced stigma in their society because it is a kind of new disease having no any idea about proper medicine, vaccine and treatment and there was lack of enough awareness and knowledge and so that they used to be scared of its transmission and spread. People had fear in their mind that if they were infected by CIVID then they should be isolated from the family and society while the people are already aware of HIV, how it is transmitted from one person to another and they also know that how to protect oneself from HIV though it is also not easily accepted in the society. The case study-1 is presented to justify the data given in figure 5.1 more clearly.

Case study-1

I am Sanu Khadka (name changed). I live in Waling now a days. My religion is Hinduism. I am 45 years old, illiterate and single woman. Now I am a housewife only but till the COVID pandemic period I used to work in an INGO as a cleaner from where I was able to earn 5/6000 per month. I have a daughter and a grand-daughter too. They are not infected by HIV positive.

There were different behaviours in people due to fear of COVID-19 because the government of Nepal announced home stay order to the public by imposing lock down. Even in office all the staffs including with me had to wear mask and gloves, we had to wash hands frequently, maintain physical distance and apply sanitizer which was not necessary to do before COVID-19. While sneezing and coughing in this pandemic time we had to cover our mouth and nose.

I used my ART drug regularly even in the COVID pandemic to increase immunity power and live a long life as other normal people but it was not easy to get anti-retroviral pills in pandemic time because like other people I also locked into my house due to home stay order announced by the government in the country. I often become sick and now a days I am suffering from joint pain of legs too. I came to hospital myself and took my medicines from there even in this lock down but this time I couldn't take my pills easily without following safety measures as before COVID pandemic time. I don't earn sufficient money for my survival from my job and moreover I have to keep some money separately for purchasing the commodities of safety measures such as face-masks, sanitizer and so on. This is how COVID-19 has added more mental pain, economic burden and pressure about how to manage limited income with this expenditure.

Although there was lock down due to COVID-19 disease, I went to my village home from Waling on foot to visit my mother, daughter and grand-daughter and celebrate Teej festival. Later my relatives and neighbours scolded me for this stupid deed in the risky/dangerous time and suggested me not to do from next time. It was very hard to live without visiting family members in holiday. I really wanted to meet my mother, daughter and grand-daughter even in that pandemic time but COVID-19 made my mobility and survival harder. I couldn't move, communicate and work independently as before because I was surviving with HIV and there was high risk of COVID-19 to the people like me who were living with HIV infection.

I had lost my husband when my daughter was in class-2, he was died because of HIV-AIDS. But he did not tell me he had AIDS until right before his death. I have been infecting by HIV-AIDS for almost 20 years. Only my mother knew about my illness of HIV positive. I don't want to expose myself in front of others as HIV infectious because there is no any benefit of telling it to others. If I tell about it to others, I will get tag of social stigma and discrimination. So, when I have to come to hospital for taking my ART pills, I pretended to be another illness and come to hospital for my medicines. This is how I am hiding my illness and medication from others in the society. This COVID pandemic time was so hard for me because there was no situation to come out of home and reach hospital even for taking own drug due to prevention of transportation and mobility. I often depressed, became panic and forgot to do my some household chores due to fear of social stigma as well.

The above case study shows that COVID-19 has added problems and difficulties in the life of the people living with HIV and one of the example from this case study is the respondent went to her mother's house on foot to observe Teej festival though it was far away and no transportation. Like other people she also used safety measures during pandemic time but one of the chief point during this case study she said that she has not exposed in the society with her disease yet although she is suffering from HIV-AIDS since last 20 years because she doesn't want to be stigmatized, discriminated and marginalized. So, till this date only her mother knows about her illness. It means there are different point of view/looking glass of different people to see the disease and illness. Some of the people expose with their disease by expecting love, care and counselling whereas some others doesn't expose with their real illness having fear of social stigma, discrimination and marginalization.

5.1.4 Involvement of Persons in Service to COVID Patients

By nature humans prefer helping others mainly in time of trouble and need. This is not strange if this quality and nature is appeared in PWH. This study has also tried to find out whether any respondents in this study had ever served any patients at home or neighbourhood who were suffering from COVID Positive or not. The following data table helps us to give information about it. The status of study are is presented in table 5.3.

Table 5.3: People taking care of other COVID-19 Patients

Involvement in serving COVID-19 patients	Frequency	Percent
Involved to serve COVID patients	2	2.5
Not involved to serve COVID patients	79	97.5
Total	81	100.0

Source: Field Survey, 2020

After studying the data presented in table number 5.3, we are able to know that only 2.0 (2.5 percentage) respondents out of total 81 had served the people who were suffering from COVID-19 and rest 79 (97.5 percentage) respondents did not served any COVID-19 positive people. It means the majority of respondents didn't involve in serving COVID infectious with the fear of its spread and infection from one person to another but the respondents who engaged in serving

the member suffering with COVID positive were very carefully tackling the situation by applying safety measures like mask, gloves, sanitizer etc. though they are already living with HIV. Hence like in other sectors there was also fear of COVID-19 disease transmission in their mind so that majority of respondents who are already PLWHIV and didn't involve in serving COVID patients at home and family.

5.1.5 Influence of COVID-19 in tradition, culture and festivals

Influenced is defined as the impact or capacity to have an effect on the character, development and behaviour of someone or something. This study in this topic gives information about how COVID-19 influence in the traditional culture, social values and religious norms and how the respondents of this study celebrated their festivals such as Teej, Dashain and Tihar 2077 B.S. in the lock down time. Actually in data collection time the researcher asked the question to respondents, like "How did you celebrate Teej, Dashain and Tihar in this lock down time? And so, the answer given to the researcher by different respondents in this study were submitted in the table. So, the status of study area is presented in table number 5.4.

Table 5.4: Impact in traditional way of observing Teej, Dashain and Tihar

Way of Festival Celebration	No. of Respondents	Percent
Staying with family at home	61	75.3
Inviting relatives at home	3	3.7
Going to relative's home	1	1.2
Communicating with relatives from mobile phone	5	6.2
Watching television	8	9.9
Watching and posting photos on face book wall	1	1.2
Watching teej songs and dance in you tube	1	1.2
Doing no any shopping this time	1	1.2
Total	81	100.0

Source: Field Survey, 2020

The data presented in the table 5.4 shows that the majority of respondents with 61 (75.3 percentage) population out of the total 81 respondents observed their festival like Teej, Dashain and Tihar with their family members by staying at home. The other 3 (3.7 percentage) respondents said that they celebrated it by inviting their relatives at home. The 5 (6.2 percentage)

respondents celebrated their festivals this time by communicating with relatives from mobile phone. Likewise 8 (9,9 percentage) respondents observed these festivals by watching television and rest of the others have the same value of 1 (1.2 percentages) respondents who replied that they observed these festivals by going to relative's home, watching and posting photos in face book wall, watching teej songs and dance in you tube and doing no any shopping this time. Over all the table shows that respondents did not observe their festivals in traditional style as previous years due to COVID-19. For the more clear justification of the data in the table, case study-2 is presented.

Case study-2

I belong to Magar family. My permanent address is Kaligandaki Rural Municipality but we I live in Waling now a days. I follow Hinduism religion. I am 39 years old. I have passed SEE as well. I am also service holder and work in a office that works in favour of HIV-infectious), Waling. My monthly income is about RS. 14,000 from this job. I am single woman. I have a son as well in village home with his grandparents.

There were changing behaviours in people including me in pandemic time because we had to follow lock down rules as well as safety measures like mask, sanitizer, frequent handwashing, physical distance while speaking and behaving with others etc. furthermore I did not let anyone else outsider to enter my home and touch any things. Similarly other neighbours also did the same to me due to the fear of COVID transmission.

I have been suffering from HIV infection since2065 B.S. but I started my anti-retro viral treatment only from 2067 B.S. I haven't told anything to anyone in the society about my illness of HIV positive besides my family. Therefore I exposed myself with this disease only in my family. I exposed myself in the family in this way in search of love and care. My husband did not tell me anything about his illness of HIV though we live together in the same house. When my husband became seriously ill, he was admitted in the hospital for his treatment. In this treatment process his blood was tested and through his blood report I knew about his illness which he was hiding with me. After that I was also suggested by the doctor to test my blood sample but my blood report was also positive unfortunately.

Then I told everything about my illness to my husband's elder brother who brought me in this hospital for my treatment but my child is not living with HIV positive. The role of ART pills is great in my life because it is benefited me to increase my strength and immunity. More or less there is feeling of stigma and discrimination in my family regarding my illness of HIV though my husband is no more in this world. Thus besides my family members I hide everything from everyone about my illness and medication. I often used anti-retro viral pills and took my drug myself from the hospital even in lock down.

The life during pandemic time was not as so comfortable and easy as normal time for me because I did not test myself by coming to the hospital although the general symptoms of COVID positive appeared in me. Instead I stayed at home taking warm water and so on due to the fear of social stigma, discrimination and isolation. I was panic remembering my son and family because due to lock down I couldn't go to visit my son and I survive hiding pain within self. Similarly I faced difficulties in many ways such as in bringing things of daily needs from the market, in family gathering and social mobility etc. Similarly festivals like Teej, Dashain and Tihar celebrations were limited only within family due to lock down and fear of COVID spread.

COVID-19 affected a lot in our daily medication. Basically I had faced so many difficulties in fetching ART drug even though I used to live in my rented room nearby the hospital. It badly impacted to those more than me who had faced problems in coming hospital to take their ART pills due to transportation and far distant. The behaviours and verbal speech of health workers including ART Counsellor in this hospital during COVID-19 pandemic and lock down were so good. Thus I am very happy with the counselling and behaviour of my ART Counsellor too. But in spite of this while taking medicine and talking to them I had to use mask, sanitizer and maintain physical distance which things has given more tension and additional economic burden on me.

The above case study shows that life was not so comfortable during pandemic time of COVID-19 because it invited so many difficulties and problems that's why its impact was in many aspects of individual and social life such as interaction, behaviour, gathering and mobility including with tradition, culture and festivals. Therefore respondents observed their festivals and performed rites by staying at home but they were not able to celebrate their great festivals like in traditional ways due to COVID-19. This is how COVID-19 badly impacted in our culture, tradition and festivals. Similarly the gathering and crowd of people were totally avoided, there was difficulty even in going to market to purchase the daily using things of basic needs. One of the most important thing was they were compelled to increase their expenses in buying face masks, sanitizer etc.

In the conclusion, this overall chapter is related with the influence of COVID pandemic in the lives of people who are living with HIV-AIDS and taking ART service from the GPH. It analysed the status of COVID-19 in respondents, about the safety measures they used in pandemic time, whether they served others suffering from COVID positive or not and how this new disease impacted in their tradition, culture and festivals. According to the study of this chapter most of the respondents had negative impacts of COVID disease because it caused difficulty in movement and communication with each other, prevention in transportation of vehicles, lack of work, economic burden, tension of medication, increase of social stigma and physical distancing and prevention in family and social gathering. In this way this chapter shows that respondents were facing many problems and stigma in the family and society because they are already living with HIV. Moreover this disease causes additional stigma, tension and problems in the people existing with HIV.

CHAPTER SIX

IMPACT OF COVID-19 IN DAILY MEDICATION

This chapter gives the information about the respondents of this study regarding their daily medication and impact of COVID-19 in it. This can be discussed in this way by preparing the different sub-topics.

6.1 Impact of COVID-19 in daily medication

The respondents who are suffering from HIV-AIDS have to use anti-retro viral drugs regularly for the good immunity power and long life span as other normal people. As we heard there is high risk of COVID-19 to the people living with HIV. Thus it is useful to discuss the subject matter such as whether the respondents (who are already living with HIV-AIDS and taking anti-retro viral treatment) took their medicines (ART pills) daily or not, whether they came to hospital themselves to take medicines or not, why they were/weren't able to come to hospital themselves for taking own ART pills and how they got their drug in lock down to know the impact of COVID-19 illness in the regular medication of the respondents in this investigation.

6.1.1 Self Presence of Respondents in hospital to fetch regular drug

There should be clear information in the study which helps to let the people know about how respondents were able to go to the hospital to get their medicine even in lock down and how many of them were unable to presents themselves in hospital to take their drugs during lock down. The status of study area is presented in table number 6.1.

Table 6.1: ART pills getting process

Process	Frequency	Percent
Self-presence	15	18.5
Friends	14	17.3
Relatives	2	2.5
Hospital itself	50	61.7
Total	81	100.0

Source: Field Survey, 2020

The data presented in the table 6.1 shows that among the total 81 respondents, there are 15 respondents (18.5 percentage) who were able to go to the hospital themselves to take their ART pills and 14 respondents (17.3 percentage) out of the total were unable to present themselves in the hospital to take their anti-retro viral pills so that their friends brought their medicines from hospital in their absence. There were 2 people (2.5 percentage) who got their drug through their relatives. Similarly hospital itself delivered anti-retroviral drug to 50 respondents (61.7 percentage) by coordinating with different social service motive organizations. In this way the above table helps to notify that the highest number of respondents couldn't go to the hospital to take their ART drugs due to fear of COVID-19 transmission, far distance and lock down.

6.1.2 Way of receiving anti-retro viral pills

The topic 'Way of receiving anti-retroviral pills' refers to the pattern of achieving anti-retroviral drug during lock down time. Here is the list of the answers given by the respondents when they were asked question ''how did you get your ART pills in lock down?", and it is the information including with the number of respondents and their percentage. The status of study area is presented in table number 6.2.

Table 6.2: Pattern to get anti-retroviral medicine

Medicine getting pattern	Frequency	Percent
Took by self from hospital	15	18.5
Delivered by family and relatives	14	17.3
Delivered by friends	2	2.5
Delivered by hospital itself	50	61.7
Total	81	100.0

Source: Field Survey, 2020

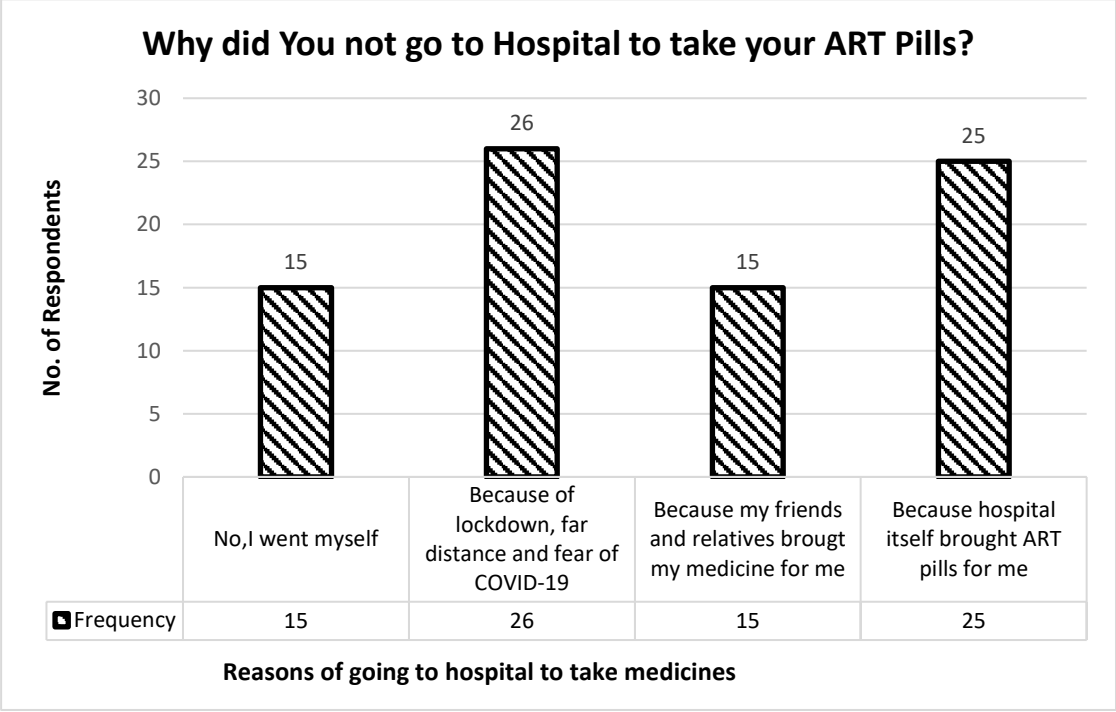
The data presented in the table 6.2 notifies that there were 15 respondents (18.5 percentage) who themselves went to the hospital and took their medicines because their residence was nearby the concerned hospital. There were 14 respondents (17.3 percentage) who did not go to the hospital to take their medicines because their family members and relatives took medicines from hospital. Only 2 respondents (2.5percentage) were the respondents who had got their medicines through their friends because they were unable to come to hospital and the hospital provided their pills through friends. And the hospital itself delivered medicines to 50 respondents (61.7 percentage)

because they were unable to come to the hospital for taking their medicines due to many reasons and problems such as lock down, transport and far distance. It means the ART department of the hospital made an arrangement of medicines and delivered it to the hand of concerned clients by co-ordinating with different governmental and non-governmental organizations.

6.1.3 Status of Accessibility for ART drug

The status of accessibility for ART drug is meant the quality of easy obtain or availability of anti-retro viral drug by the concerned respondents especially in lock down time in this study. Hence following figure supports to get information about why/ why didn't the respondents come to the hospital to take their ART drug because it includes the reasons of coming or not coming to the hospital for getting their own medicines which they should use daily for strength and good immunity power so that they work as other normal people. The status of study area is presented in figure 6.1 clearly.

Figure 6.1: Reasons of going to Hospital to take their ART Pills



Source: Field Survey, 2020

The data presented in the figure 6.1 shows that the different six types of answer in the question of ''why didn't you go to hospital to take your ART pills?'', for examples; when they were asked

the above question, there were same number with 15 respondents (18.5 percentage) who answered “No, I went to hospital myself to take my medicine even in lock down’’ and ‘’because my friends and relatives brought my medicines for me.’’ respectively. Altogether 26 respondents (32.5 percentage) responded the question with the answer that they couldn’t go to hospital to take their pills because of lock down, far distance and fear of COVID-19. Eventually 25 respondents (30.5 percentage) answered that the hospital itself delivered their medicines to them because they were unable to come to hospital due to long distance and unavailability of transportation facility in lock down time. This is how after reading the above figure 6.1 it comes to know that only 15 respondents out of the total 81 population were able to go to bring their ART drug and the majority of respondents (66 respondents among total 81 population) were unable to reach the hospital to take their own medicines during lock down time but they would not be deprived of using their medicines regularly due to co-operation of their friends, relatives and ART department of the hospital.

In this regards the ART Counsellor of ART department in this Garahun Primary Hospital, Waling-9, Syangja said *“ART is like life giver for the people living with HIV-AIDS and as an impact of COVID-19 clients had to face difficulty of transportation due to lock down hence it was impossible for them to fetch ART drugs from the hospital in self- presence. On the one hand most of the infectious of HIV in this hospital belong to lower class of economic status and they are compelled to work as wage labourers because of their poverty and moreover that time they were facing difficulty/problems in finding sufficient work for their survival. On the other hand they had feeling of fear and tension of COVID-19 risk and infection having already existing with HIV-AIDS. Moreover the majority of respondents hide their HIV-AIDS due to fear of family and social stigma, discrimination, domination and marginalization. Only few number of respondents tell to family and other members that he or she has HIV with the expectation of getting love, affection, care and advice regarding this disease. Furthermore almost all the clients used their ART drug daily besides in nominal cases because I along with hospital management team delivered their pills to them who were far away from this hospital even in lock down by co-ordinating with different social service organizations such as Sangkalpa Sahayog Samuha (INGO), Health Department of Waling Municipality, Epidemic Control (EpiC) Project Nepal, Nepal Police, health-workers and volunteers. But the clients who resided nearby the hospital came themselves to take their medicines. While talking about second pandemic time as well through telephone and mobile we suggested our clients to isolate, stay at home and take prescribed medicines if general symptoms of COVID positive appeared and the case was not*

serious. So, they came to hospital for treatment in case of serious illness. In this second phase of COVID pandemic most of the clients were infected by COVID-19 disease and fortunately no deaths of any clients occurred. Now all the clients above five years have vaccinated''.

Case study-3 is presented to support key informant answer or statement and justify the data given in figure 6.1 more clearly in the study.

Case study-3

I am Mrs. Kumari Thapa Magar (name changed). I follow Hinduism religion. By occupation I am a farmer and I do agricultural work for the survival so that I don't have any monthly income. I couldn't study above class-3 that's why I can write my name only. During COVID-19 pandemic and lock down I couldn't come to hospital to fetch my ART pills due far distance and I was worried regarding my medicine which I had to use daily. But fortunately ART Counsellor helped me that time by sending my medicines with my friends of the same village. Thus I was able to use my drug regularly. I followed the lock down rule placed by the government of Nepal as well as preventive measures such physical distance, face mask and frequent handwashing even in work place/field but did not leave to work.

I have been suffering from HIV-AIDS for 19 years. When my child became seriously ill, I took him to the hospital where his blood was tested and then mine. After that I called my spouse to the hospital for his blood test. This is how through that blood test report I knew that we are infected by HIV-AIDS. Actually this HIV was transmitted in me by my husband. So, medication was also started by him initially and I began my anti-retro viral treatment only after 3/4 years. I think the role of this ART pills in my life is very important because it helps us to make active and give longer life.

We told everything in the family and society about our HIV infection because with the expectation of getting love, care and counselling from them and we really wanted to aware them about it and we didn't hide our illness. After we exposed with HIV, there was stigma and marginalization in my family and society. Gradually they changed a little but more or less social stigma and differentiation appear in their verbal speech and activities. Actually stigma places limits in work, restrict travel and prevent participation in important festivals and ceremonies. Furthermore stigma reduces my self-esteem, self-worth and increase depression and in depression I sometimes forget to take my drug.

This kind of stigma was increased more and more in the COVID pandemic time as well though it's symptoms were seemed to each and everyone in the whole society and not only for us. In this pandemic time I know that I am not alone who is discriminated in the society but I am sure that I am discriminated and stigmatized more by other people due to COVID-19 disease because I am already living with my HIV-AIDS although almost all of my neighbours were suffering from common cold and general symptoms of COVID-19 was appeared in them as well.

I am fully satisfied with the counselling of ART counsellor in this hospital. The behaviours of the health persons of this hospital remained same as before COVID pandemic in other things but we had to maintained physical distance and use mask when we came to take our ART pills and while talking to them in the pandemic time.

Once my husband was sick and tested in nearby the health post. The test report came with COVID positive. In this way we knew that he was suffering from COVID-19. Thus I served him by isolating in a separate room until he recovered completely. Even in the pandemic time I was compelled to work out of the home with others because of my poverty but again it was not possible to get enough work easily due to COVID-19. I don't have money to go to good hospital for treatment when we are ill. This life is very hard and difficult for me. So, it badly affected in my life.

The above case study shows that it also supports the key informant's points strongly in this regards because above case study shows that the respondent was unable to present in the hospital to take her own medicine due to far distance and lock down but she and her husband should not be deprived of using their ART drug daily because ART counsellor contacted them through mobile phone and send their medicines with their friends who was from the same village. In this way medicines were delivered by co-ordinating with different social organisations and individuals during the lock down. According to the respondent in this case study there was changing behaviour in people because of COVID-19 so that everyone used to put on mask, apply sanitizer, maintain physical distance and wash hands frequently even in the work place like in field. According to her she used to face so much stigma in the beginning when she was exposed in family and society with HIV-AIDS and gradually it was decreased but still it is expressed through stigmatizing languages and behaviours. Similarly, initially there was social stigma, discrimination and marginalization regarding the matter of COVID-19 but later almost all of her neighbours were suffering from common cold and general symptoms of COVID-19 was appeared in them as well but this COVID-19 has increased social stigma and discriminations more than previous in the case of people who are already existing with HIV and they are highly risky group of COVID-19. The symptoms of COVID positive were also appeared in respondent's husband too who is already surviving with HIV but he was recovered after isolation of few days in separate room of the same house and the taking care of family members. This shows that a large number of respondents were infected by COVID-19 though they were unable to come to hospital for their treatment. But luckily no any respondents were found to be converted into deaths due to COVID-19 in this study.

In conclusion, there are impacts in the daily medication of the respondents during the time of lock down. According to them, they are badly affected by COVID-19 because this caused lock down in the country. In the lock down most of them were unable to come to hospital for taking their anti-retro viral drugs due to prevention of transportation, far distance and fear of this disease transmission because they already existing with HIV and were in the high risk group. This is how this chapter shows they have been surviving with HIV since some years/decades by facing so many problems and stigma in the family and society and besides these this new born disease added more risk, trouble, problems, difficulties, social stigma and tension in their lives. But ART department of this hospital has been helping and supporting continuously in the matter of medication of people living with HIV since the initiation so that even in the lock down in their absence hospital itself delivered their medicines in their home by co-ordinating with several

social service motive institutions, their relatives and friends. In this way no one would be deprived of using anti-retro viral drugs.

CHAPTER SEVEN

SUMMARY, MAJOR FINDING AND CONCLUSION

This chapter presents the overall summary of this study through the eagle eye perspective instead of frog eye angle in this analysis. Then the succeeding section presents the major findings and conclusion of the study where the complete outcome of the research work has been discussed as per requirement, the quantitative and qualitative data extracted from the fieldworks i.e. interview schedule, key informant interview and case studies are integrated.

6.1 Summary

This research study entitled with ‘ Impact of COVID-19 in People Living with HIV-AIDS’ has been conducted in Garahun Primary Hospital, Waling-9, Syangja by collecting the data from ART Counsellor of the ART department of this hospital as key informant and from the people living with HIV and taking ART service in this hospital till now as my respondents. The respondents are from five different municipalities and rural municipalities of Syangja district and these are Kaligandaki Rural Municipality, Waling Municipality, Chapakot Municipality, Bhirkot Municipality and Galyang Municipality As we know that COVID-19 is one of the burning issue for sociological analysis recently because it is not limited only within a local area but its impact is spread all over the world. The first case of this disease was found in Wuhan city of China in December 31, 2019 and then it is still affecting different countries and territories around the world though the large number of people are vaccinated now. Thus this investigation has tried to address the problems and difficulties of PWHIV as the main issues of this study and analyze about the influences of COVID-19 in people who are already existing with HIV-AIDS.

This investigation has been undertaken by putting two objectives mainly. One objective is to study the impact of COVID-19 in people living with HIV-AIDS and taking ART service and another objective is to analyse about the influences in daily medication of people living with HIV during lock down due to COVID-19. Therefore this research study has tried to address the main problems, difficulties and effects/influences of COVID-19 in the people living with HIV and in their daily medication such as anti-retro viral drug as the main issue of the study because the respondents have to use ART pills as possible as daily for the growth of their confidence,

activeness and immunity power to work as other persons and this drug is just like life-giver to the people who are living with HIV-AIDS.

This study is prepared with the support of data information that was taken from key informant and respondents themselves from the field by using the interview schedule, case study and key informant interview (KII). The ART depart of this Garahun Primary Hospital is taken as the field of research study by the researcher and from where the data and information about the related issues of COVID-19 and its impact in the people living with HIV and in their anti-retroviral medicines were successfully collected for this study.

6.2 The Major Findings

In this topic, the major findings of this study are presented pointwise below with multiple bullets that address the main objectives of this study.

- On the basis of first objective of this study it is found that respondents faced many problems and difficulties due COVID-19 because the first and direct impact of COVID-19 appeared as lock down. It was actually imposed to control the transmission of COVID-19 disease by the governments of different countries in different parts of the world. So, the people living with HIV-AIDS including with other healthy people also locked in to their home during this lock down time. This COVID-19 disease caused negative impact in the different aspects of lives in the people living with HIV according to the first objective of this investigation. For examples; their relationship and interaction limited within electrical devices mobile and online internet because the family and social gathering were totally avoided and they had to interact with each other by maintaining physical distance due to fear of COVID-19 transmission.

- They observed their festivals like Teej, Dashain and Tihar with the family members only by staying at own home rather than going to outside of the house due to lock down which caused change in the pattern of celebrating religious festivals. This is how this disease also showed the negative implication in the other aspects of individual and social life of people living with HIV such as in their family and social gathering, traditional values, religious norms and cultural festivals of the respondents.

- Physical education of students was also badly affected because most of them have no access of internet for virtual education as majority of respondents belong to rural area on the ground of facilities and development infrastructure.

- There was like stagnation in the market because there was restriction in the movement and transportation of people. They couldn't move here and there independently because they were locked in their own home due to home stay order given by government to control the spread of COVID-19 disease. There was lack of work to wage labourers. Though it was benefitted to the business like medicines, face mask, gloves, sanitizer, digital transaction, internet etc but as a whole it badly affected the economic and social mobility of respondents.

- Similarly in terms of second objective of this study the another impact of COVID1-19 fell down in the medication of the people who are living with the illness of HIV-AIDS previously which other people did not face normally. It means to say that COVID-19 added the tension and trouble in the life of respondents about how to get their own anti-retro viral drug (daily medication) including with other normal people have been facing recently because they are already living with the load of illness named by HIV-AIDS and who have high risk of COVID-19 transmission.

- Actually lockdowns and physical distancing mandates due to COVID-19 disease have made it extremely difficult to continue the face-to-face health encounters that have long been the backbone of HIV prevention, testing and treatment services. HIV prevention services have inevitably been disrupted, and supply chains for key prevention commodities, including antiretroviral and other medicines, have been impacted. In this way COVID-19 badly affected in the health and medication of PLWHIV.

- Majority of respondents had problems to go to hospital to bring their ART pills though it was taken for their good immunity power but they couldn't go to hospital to fetch their medicine due to lock down, restriction of transportation, fear of COVID-19 transmission and far distant from the hospital. Hence the hospital itself delivered their medicines to their home every month by coordinating with their friends, respondents and different social service organizations such as Nepal Police, health posts, Sangkalpa Sahayog

Samuha, EpiC Nepal Project etc. in this way COVID-19 impacted in the health and medication of people living with HIV/AIDS.

6.3 Conclusion

Due to COVID-19 disease and lockdown respondents including with other normal people were locked in their own home, they were not allowed to do gathering. There was like a stagnation in social and economic mobility, the family and social relationship, education and communication with relatives, friends and neighbours were limited within mobile phone and online system. People faced lots of problems like they could not perform their rites rituals and culture and observe their festivals as previous years in traditional ways by making crowd and gathering with relatives. Hence there was not positive impacts in family and social gathering with other people, social and economic mobility, traditional norms, values, culture and festivals. Furthermore respondents had to face one more problem regarding their anti-retro viral drug having already surviving with the burden of HIV disease because of COVID-19 and lock down that was imposed by the government of Nepal in 2077 B.S .

It was also a bitter truth that the bad culture of spending money unnecessarily by organising parties and doing unnecessary shopping to show up in the name of celebrating festivals was totally ruined in this year by COVID-19 And the reason behind it was mainly that they couldn't come out of their home due to lockdown and COVID-19 disease. More or less digital transections, internet and business of sanitizer, masks, medicines etc. are benefited whereas the people living with HIV are badly affected by COVID-19 in their social relationship, family gathering, social and economic mobility, education as well as in their medication. Eventually this study is concluded with the statement which insists that symbolic interactionism framework is still relevant, powerful and significant in the issue of Sociology of health to better understand how PLWHIV think and interact with each other about their health issues though symbolic interactionism approach and perspective was twentieth century theoretical approach and it has been already replaced by other new theories. In another word this symbolic interactionist theory is very influential even today to understand the thought, feeling, experience and problems of respondents about their individual health issue regarding their illness while interacting with them.

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APPENDIX I

Impact of COVID-19 in People Living with HIV/AIDS

Interview Schedule

Researcher: Ishwari Baniya

Commitment Assurance:

This is Ishwari Baniya. I am the student of Sociology at the Master's Level in Prithvi Narayan Campus, Pokhara. I am undertaking a research work on the above mentioned topic in partial fulfilment of the requirement for the degree in Master of Arts in Sociology. I kindly request for your cooperation by providing necessary information and giving answers of the given interview questions. I would make a commitment that I will abide all the ethics in research and will not reveal any personal information that will create any physical and emotional harm to the respondents. You have complete freedom to turn down my request and not tot fill the information below. And you even can skip the questions if you find it not comfortable to answer it.

Section [A]: Demographic questions for Respondents

1	Name	……..
2	Caste/Ethnicity	1) Brahmin 2) Kshetri 3) Thakuri 4) Newar 5) Magar 6) Gurung 7) Bishwokarma 8) Nepali
3	Sex	1) Male 2) Female
4	Marital Status	1) Married 2) Unmarried 3) Widow
5	Address	1) Waling Municipality 2) Chapakot Municipality 3)Bhirkot Municipality 4) Galyang Municipality 5) Kaligandaki Rural Municipality
6	Religion	1) Hinduism 2) Buddhism
7	Occupation	1) Housewife 2) Agriculturre 3) Students 4) Masonry 5) Service 6) Wage labour
8	Monthly Income	1) Up-to 10,000 2) Below 10,000 3) Above 10,000 4) No income
9	Age	1) Up-to 10 years 2) 10-20 years 3) 20-30 years 4) 30-40 years 5) 40-50 years 6) 50-60 years 7) Above 60 years
10	Level of education	1) Illiterate 2) Literate 3) Primary 4) Lower Secondary 5) Secondary 6) SEE 7) Above SEE

Section [B]: Topic related questions for Respondents (open-ended questions)

1. Do you know about COVID-19 disease?
   Yes [ ] Little bit [ ] Not well enough [ ]

2. Did you follow lockdown rule imposed by the government?
   Yes [ ] Not properly [ ] I don't say anything [ ]

3. Did participate in any festivals and social gathering during this pandemic time?
   Yes [ ] No [ ]

4. Do you maintain physical distancing with other people?
   Yes [ ] Worked together with neighbours [ ]
   No [ ] Played with friends [ ]

5. Which of the following protective equipment do you use in this COVID pandemic time?
   Face mask [ ] Face shield [ ] Both mask and face shield [ ]
   Mask, gloves and face shield [ ]
   Used mask only while coming to city and hospital [ ]

6. Do you follow the rule of frequently handwashing?
   I wash hands frequently [ ] I wash hands after finishing work [ ]
   I wash hands when it becomes dirty

7. Have you ever served any corona patients in family or society?
   Yes, I have served [ ] No, I haven't served [ ]

8. Did you take your regular medicines (ART pills) during lock down time?
   Yes [ ] No [ ]

9. Did you come to hospital your-self to take your medicines in lockdown time?
   Yes [ ] No [ ]

10. How did you get your regular medicines then?
    Tool by-self from hospital [ ] Delivered by family and relatives [ ]
    Delivered by friends [ ] Delivered by hospital itself [ ]

11. Did you have any travel history during corona time?
    Yes [ ] No [ ]

12. Have you ever felt any social stigma due to HIV AIDS in this COVID-19 pandemic?
    No [ ] No, stigma due to HIV but COVID-19 [ ]
    I don't care about it [ ] Self-confidence and counselling win it [ ]

13. Have you seen any changing behaviour of family and other people in this pandemic situation?
    Yes [ ] No [ ] I don't know [ ]

14. Did you become and insure of free health insurance provided by government of Nepal?
Yes [ ] No [ ]

15. How did you spend your days during COVID-19 pandemic and lockdown time?
    a. Staying at home with family
    b. Doing farming/agriculture in the village
    c. Working as a mason in the village
    d. Doing service/job
    e. Doing household work
    f. Watching TV, studying, playing with friends and grazing cattle
    g. Playing mobile and taking virtual class

16. Have you vaccinated against COVID-19 disease? Why?
    a. Yes
    b. No, vaccines are not available

17. Why didn't you go to hospital yourself to take your regular medicines?
    a. No, I went myself
    b. Because of lock down and far distance
    c. Because my friends brought my medicines for me
    d. Because my relatives brought ART pills for me
    e. Because hospital itself brought ART pills for me
    f. Due to lock down and fear of COVID-19

18. What problems are you facing due to COVID-19 disease?
    a. Problems in health, education and transportation
    b. Lack of money to feed family
    c. Difficulty in paying school fee of children
    d. Problems in getting work to generate money
    e. Not till now
    f. Problems in making social and religious gathering
    g. Problems in normal movement

19. How did COVID-19 disease affect on you?
    a. By imposing lock down
    b. By bringing physical distancing on social relationship
    c. By preventing family and social gathering
    d. By creating problems in social and economic mobility
    e. By closing school for physical education
    f. No effect has done yet

20. How you were transmitted by HIV positive?
    a. Through syringe/drug
    b. Through blood transmission
    c. Through spouse/sex partner
    d. Through parents/inherited by parents
    e. Skip the question

21. How is COVID-19 pandemic time different than that of normal time in your opinion?
    a. Cause we can't move and work freely as before
    b. We should use mask and sanitizer in COVID time
    c. We should maintain physical distancing in this pandemic
    d. We should pay attention in frequently handwashing now
    e. There is lack of work in this pandemic time
    f. We can't participate even in funeral rite of relatives and neighbours as normal
    g. We can't celebrate festivals together with relatives
    h. Because we can't perform our activities as our desire like before
    i. No idea

22. Which time is better for you? The time before/during COVID-19?
    a. Time before COVID-19
    b. COVID-19 pandemic time
    c. Same-same

23. How did you celebrate Teej, Dashain and Tihar festivals during this COVID-19 pandemic time?
    a. Staying with family members at home
    b. Inviting relatives at home
    c. Going to relative's home
    d. Communicating with relatives from mobile
    e. Watching and posting photos in face book
    f. Watching Teej songs and dance in you tube
    g. Doing no any shopping this time

24. Did you observe Teej festival of this year by making gathering with neighbours and relatives? Why?
    a. Yes, because we live in the same community
    b. No, because of fear of COVID-19
    c. No, because of far distance with relatives
    d. No, because of lock down and transport

25. What lesson do you get from COVID-19 pandemic situation?
    a. To maintain personal health and hygiene
    b. Not to go out unnecessarily
    c. To maintain physical distance and use mask while talking and behaving with others
    d. To wear mask and cover mouth while sneezing and coughing
    e. To help people by using safety measures
    f. No idea about it

26. What are the impact of COVID-19 in religious and cultural festivals?
    a. Teej,Dashain and Tihar limited within family at home
    b. Difficulty in transportation and shopping due to lock down
    c. Increased in expenses by buying mask and internet access
    d. Unable to perform Panchami Pooja in gathering
    e. Unable to go to marriage ceremony and funeral rites
    f. Difficulty in going hospital to bring ART pills
    g. Got free health insurance of one lakh in COVID pandemic time
    h. No, physical class in school

i. Observed festivals with relatives and neighbours with fear of COVID-19

27. What difficulties did you face as a HIV patient due to COVID-19?
    a. Difficulty in movement and gathering
    b. Difficulty in bringing regular medicine
    c. High risk of COVID-19 so it created tension
    d. Difficulty in getting work

28. What safety measures did you follow for the prevention of COVID-19 disease?
    a. Mask and sanitizer
    b. Mask and frequently hand washing
    c. Mask, physical distance and frequent hand washing
    d. Stayed at home by avoiding crowd of people
    e. Used mask while going to market and hospital

29. How did you communicate with your neighbours and relatives in lockdown time?
    a. Wearing mask
    b. Maintaining physical distance
    c. Through mobile phone
    d. Using mask and maintaining physical distance
    e. All of the above

30. Are you happy with the counselling and treatment services provide by your health personals?
    a. Yes, extremely happy
    b. Yes, happy
    c. Satisfied

31. Have you suffered from COVID-19?
    a. Yes
    b. No

32. Did any symptoms of COVID-19 appear in you?
    a. No
    b. General symptoms appeared

33. Did you go to hospital after symptoms of COVID-19 appear in you?
    a. No any symptoms appeared in me
    b. General symptoms appeared but didn't go to hospital
    c. Stayed at home by taking warm water, steam etc. after symptoms appeared

Thank you for your information

APPENDIX II

Impact of COVID-19 in People Living with HIV/AIDS

Check list for Key Informant (KI)

Ishwari Baniya

Research student

Department of Sociology

Prithvi Narayan Campus, Pokhara

Date of interview: 10 December 2020

Key Informant's Interview-KII (open ended questions)

Questions Key Informant

1. How many HIV positive people are treating in this hospital in total?
2. What are the influences of COVID-19 in people living with HIV AIDS in your opinion?
3. Did you see any changing behaviour on them in this COVID pandemic time?
4. Did they get their ART pills regularly?
5. How did you provide antiretroviral pills to them during this lockdown time?
6. What is the role of ART in them?
7. Do they want to be exposed in the society or not?
8. How many of them have been still treating but not exposing themselves?
9. Why don't they want to be exposed?
10. Which organisation arrange fund for their treatment and medicines?
11. Did anyone of them face COVID-19 disease?
12. Did you face any difficulties in your interaction with patients because of COVID-19?
13. Was there any problems and difficulties for you and your patients in social mobility?

Thank you for your information

Guideline for Case Study

Open ended questions for Case Study

1. What are the influences of COVID-19 in you in your opinion?
2. Did you follow lock down rules imposed by the government due to COVID-19 disease?
3. How did you interact and behave with others in society during this pandemic time?
4. What safety measures did you follow to help in preventing, controlling and minimizing the spread of COVID-19 epidemics in your society?
5. Did you see any changing behaviour of other people on you in this COVID pandemic time?
6. Did you take your ART pills regularly?
7. Did you come to hospital yourself to take your regular (ART) medicines during this lock down time?
8. How did you get antiretroviral pills during this lockdown time?
9. What is the role of ART in your life?
10. Do you want to be exposed in the society or not?
11. Why do/don't you want to be exposed in the society?
12. How did your health persons behave with you in this COVID-19 pandemic time?
13. Are you satisfied with the treatment service and counselling of this hospital and health person?
14. Did you face any difficulties in your interaction with health persons because of COVID-19 pandemic?
15. Have you ever faced with COVID-19 disease?
16. Did you feel any social stigma, discrimination and marginalization in your family and society due to subject of HIV and COVID-19?
17. Did you have any problems and difficulties in your social and economic mobility?
18. Did you have any experience about your family and social gathering?
19. How did you celebrate the festivals such as Teej, Dashain, Tihar and Chhath in this pandemic situation and lock down time?
20. Why did/didn't you observe your festivals by making gathering with relatives and neighbours?
21. Did you perform your work regarding your occupation in society going out of your home during this pandemic and lock down? Why or why not?

Thank you for your information