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HIV WIDOWS - A STUDY IN ANANTAPURAMU DISTRICT OF ANDHRA PRADESH



K. Radhika

HIV/AIDS INTRODUCTION:

HIV/AIDS has been a major threat and a great challenge to the quality of life and humanity. The first cases of HIV/AIDS have come into open in the year 1981 in USA and the calamity has unfolded quickly and viciously across the world. It came to be one of the main concerns of the day. It awfully affects people, mostly in the prime of their lives, causing tremendous suffering and great sorrow to millions of people in the world. Today, the HIV epidemic continues to grow alarmingly and invisibly, and the number of people diagnosed with AIDS is increasing rapidly. More people have become infected in 2003 than ever before and more people have died of AIDS than ever

Abstract

Women have greater susceptibility than men to HIV infection due to social, cultural and physiological reasons, and are now being infected at a higher rate. Though the HIV epidemic initially affected mostly men, today substantial numbers of people living with HIV are women. Kofi Annan, the former Secretary General, UN, noticed the feminization of HIV/AIDS across the Globe and observed that "increasingly, the face of HIV/AIDS is a woman's face". According to HIV Estimations published by NACO in the year 2014, the National Adult (15-49 years) HIV prevalence is estimated at 0.27%; the actual number working out to 19.43 lakhs among Adults (15+) of which 61% and 39% are males and females respectively. Highest number of PLHA live in Andhra Pradesh, the number being 4.19 lakhs among Adults (15+) of which male and female percentage works out 0.32% and 0.22% respectively.

This paper is based on a study of 120 HIV Widows in Ananthapur district of Andhra Pradesh. The socio economic data pertaining to the respondents reveals that majority of them are in the age group of 26-45, socially backward, illiterate and from rural areas. Their awareness on HIV/AIDS before and after getting infected is minimal. Majority of the respondents suffer from HIV related opportunistic infections. More than 74% of the respondents are on ART and 60% of them have at least one child who is HIV infected. The HIV infection is adversely affecting their health and financial position and they face stigma and discrimination in the society. The respondents receive economic, nutritional, care and treatment and Life Skills support from different GOs and NGOs, yet not to their requirements.

Conclusion: The study concludes that the life of HIV infected Widows is a struggle for them. Widowed, mostly at a young age, left to fend their families with declining health and finance life is trauma, which they hope to cope with the help of different CBOs, GOs and NGOs.

Keywords : HIV Widows , social, cultural and physiological reasons.

Short Profile

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before. Joint United Nations Programme on HIV/AIDS (UNAIDS) has estimated that while 12.9 million people were living with HIV/AIDS in 1992, today we are having 35 million people living with HIV/AIDS in the world.

The year 2014 marks 33 years since the discovery of HIV. Within this short span of 33 years, 16 million women and another 35 million are living with HIV today. With around 2.1 million people becoming infected with HIV in 2014, there are now an estimated 35 million people around the world who are living with HIV. African countries are worst hit by this catastrophe and India is in league with them. With devastating effect on individual, family, community

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and society HIV and AIDS have become dreaded words for the mankind. (UNAIDS, 2014).

Women constitute more than half of all people living with HIV. For women in their reproductive years (ages 15-49), HIV/AIDS is the leading cause of death. Women are at least twice more likely to acquire HIV from men during sexual intercourse than vice versa. A study in South Africa found that young women who experienced intimate partner violence were 50% more likely to have acquired HIV than women who had not experienced violence. In 2014, 70% of pregnant women living with HIV received effective antiretroviral medicines to prevent vertical transmission to their children. In sub-Saharan Africa, women constitute 58% of all people living with HIV. In 2014, almost 60% of all new HIV infections among young people aged 15–24 occurred among adolescent girls and young women. That means the impact of AIDS will be much transmission of HIV more dangerous and severe than the impact of Second World War. This statistic makes the fact that 1.5 million people have already died of AIDS by 2014 since the epidemic, which of Worldwide. (UNAIDS Fact Sheet, 2014)

Human Immunodeficiency Virus (HIV)

HIV stands for human immunodeficiency virus. Unlike some other viruses, the human body cannot get rid of HIV. That means that once you have HIV, you have it for life. HIV belongs to a special class of viruses called retroviruses. Within this class, HIV is placed in the subgroup of lent viruses. Other lent viruses include SIV, FIV, Visna and CAEV, which cause diseases in monkeys, cats, sheep and goats. Almost all organisms, including most viruses, store their genetic material on long strands of DNA. Retroviruses are the exception because their genes are composed of RNA (Ribonucleic Acid). RNA has a very similar structure to DNA. However, small differences between the two molecules mean that HIV's replication process is a bit more complicated than that of most other

viruses. (Markus Hacker and Miriam Claeson 2010)

Unlike most bacteria, HIV particles are much too small to be seen through an ordinary microscope. However they can be seen clearly with an electron microscope. The viral core (or capsid) is usually bullet-shaped and is made from the protein p24. Inside the core are three enzymes required for HIV replication called reverse transcriptase, integrase and protease. Also held within the core is HIV's genetic material, which consists of two identical strands of RNA.

Unlike most bacteria, HIV particles are much too small to be seen through an ordinary microscope. However they can be seen clearly with an electron microscope. HIV particles surround themselves with a coat of fatty material known as the viral envelope (or membrane). Projecting from this are around 72 little spikes, which are formed from the proteins gp 120 and gp 41. Just below the viral envelope is a layer called the matrix, which is made from the protein p17. (Dr. G.C.Satpathy, 2003)



Fig 1.1 HIV under an electron microscope
 Prepared by: Centre for Disease Control and Prevention.

HIV can replicate (make new copies of itself) inside the human cells. The process typically begins when a virus bumps into a cell that carries on its surface a special protein called CD4. The spikes on the surface of the HIV particle stick to the CD4 and allow them to fuse. The contents of the HIV particle are then released into the cell. Once inside the cell, the HIV enzyme called reverse transcriptase converts the viral RNA into DNA. This DNA is

then transported to the cell's nucleus, where it is inserted into the human DNA by the HIV enzyme integrates. Once inserted, the HIV DNA is known as provirus. It is at this point that HIV affects the cell in such a way, that it begins to die - weakening the immune system.

Acquired Immunodeficiency Syndrome (AIDS)

The term AIDS (Acquired Immuno-deficiency Syndrome) applies to the most advanced stages of HIV infection. A person is diagnosed with AIDS when their immune system is too weak to fight off infections. AIDS is a medical condition. "AIDS is caused by infection with a virus called HIV" (CDC, 2003).

HIV is a virus that gradually attacks immune system cells. As HIV progressively damages these cells, the body becomes more vulnerable to infections, which it will have difficulty in fighting off. It is at the point of very advanced HIV infection that a person is said to have AIDS. If left untreated, it can take around ten years before HIV has damaged the immune system enough for AIDS to develop. (UNAIDS, 2013).

HIV epidemic in Andhra Pradesh

The otherwise prosperous Andhra Pradesh is one of the most severely affected states by the HIV epidemic. Contributing almost 20% of the total estimated PLHIV burden of the country, the state has been the epicentre of the epidemic in the country. Till recently Andhra Pradesh was number one in list of worst affected States in the country and as per the latest reports was replaced by Manipur to stand second in the list. However, available evidences on HIV epidemic in the state have shown a declining prevalence among general population. The declining trend in the State, as studies reveal is because of concerted efforts by government and civil society and also increase in awareness levels of its population. The increase in awareness levels is clearly evident in DLHS-3 study.

DLHS-3 and AIDS Awareness in Andhra Pradesh women

The District Level Household and Facility Survey is one of the largest ever demographic and health surveys carried out in India, with a sample size of about seven lakh households covering all the districts of the country. The Ministry of Health and Family Welfare (MoHFW), Government of India, initiated District Level Household Surveys (DLHS) in 1997 to provide district level estimates on health indicators. The District Level Household and Facility Survey (DLHS-3) in 2007-08 is the third in the series preceded by DLHS-1 in 1998-99 and DLHS-2 in 2002-04. DLHS-3, like two earlier rounds, is designed to provide estimates on maternal and child health, family planning and other reproductive health services. Unlike other two rounds in which currently married women age 15-44 years were interviewed, DLHS-3 interviewed ever-married women (age 15-49). In DLHS-3, along with ever-married women age 15-49, never married women (age 15-24) are also included as respondents. The DLHS-3 collected information about HIV/AIDS. The DLHS-3 data clearly indicates that the awareness level of women about HIV/AIDS in Andhra Pradesh is fairly high and it is more than 67%.

Awareness on HIV/AIDS in Andhra Pradesh - DLHS-3

Women and HIV/AIDS knowledge (%)	Rural	Urban	Total
Women who have heard of HIV/AIDS	68.1	87.6	73.0
Women who know place of testing of HIV/AIDS	64.1	76.5	67.9
Women underwent test for detecting HIV/AIDS	32.5	35.4	33.4
Unmarried women who have heard of HIV/AIDS	83.1	93.9	86.6
Unmarried women who know place of HIV/AIDS test	72.9	79.6	75.3
Unmarried women who underwent HIV/AIDS test	3.8	4.0	3.93

(Source: District Level Household Survey, 2007-08)

As per the study the main sources of knowledge for HIV/AIDS in Andhra Pradesh are television (63.9%), and relatives/ friends (58.3%). Thirty percent of women have heard

about it from their health personnel, 23.3% from print media, 21.5% from leaders/community meeting and 10.8% of women have heard it from their husbands.

HIV PREVALENCE IN THE DISTRICT

The PLHIV situation in the district indicates relatively low institutional. The HIV prevalence among the high risk general population in Ananthapuramu District is moderate at 2.68% (PPTCT, The less favorable WLHA situation coupled with several other influencing factors (trafficking, commercial sex workers, national highways, in and out migration, Basivini/ Jogini system, recurrent covariant risks affecting livelihoods etc., seems to have contributed to the spread of the epidemic in the district as could be seen from the data available from different sources. The HIV epidemiological data of the district is available from DAPCU data collected by the programme management unit at district level. The data pertains to ANC and also non ANC situation in the district.

Status of HIV/AIDS in Ananthapuramu District

S. No	Indicator		2002-2014
			(up to Nov 14)
1.	ANC (Pregnant Women)	Tested for HIV	432049
		Found HIV Positive	1609
2.	Non ANC (General Cases)	Tested for HIV	470914
		Found HIV Positive	22643
3.	Total (ANC + Non ANC)	Tested for HIV	902963
		Found HIV Positive	24252
4.	ART (2006 to Nov, 2014)	Tested for HIV	17750
		Found HIV Positive	9127
5.	DSRC (Designated STI/RTI Clinics)	Total no of Clinics Visited	61634
		No of STI episodes Treated	37385
6.	Blood Bank (Apr, 2010 to Nov, 2014)	Total no of Blood Units	89806
		Collected	

(Source: DAPCU)

Positivity Rates

The Ananthapuramu district has been identified by NACO as one of the vulnerable districts in the state. The WLHA situation in the district indicates relatively low institutional deliveries, high IMR and low condom use. The DAPCU data from 2002-14 suggest that HIV Positivity in ANC has gradually come down and stand at 0.37% and HIV Positivity in Non-ANC is

0.48%.

The prevalence of HIV among urban and rural antenatal women in the district indicates that the situation does not warrant any complacency. The fact that the incidence among urban ANCs is more than 1% is a clear indication that the epidemic is alarming in the district, although the situation in the rural sites is not as alarming as in other districts of AP such as East Godavari, Prakasam and Naziabad. The overall situation in the district could be termed as moderate.

Prevalence Rates among Widows

It is very difficult to identify the exact number of the HIV infected Widows in Ananthapuramu as there is no reliable, authentic and correct data base. One can count those Widows who are infected and also receiving ART in different centres, but there are a whole lot HIV infected Widows who are asymptomatic and also who are not yet on ART. Many NGO's and CBO's that work with the infected Widows, seldom share information. Whereas there is overestimation by some stake holders, multiple counting and duplication adversely affects deciding the number of infected Widows. The number of infected Widows very differently. CST provider in district ANP+, the Network of HIV positive widows in the district, 457.

The Response of the District

The government and the NGOs have not been oblivious of the emerging situation. Both have responded to meet the challenge, although the response falls short of the expectations. The responses particularly towards Widows Living with HIV/AIDS and Widows Affected by AIDS are discussed hereunder.

Health Services

The services provided by the government include facility based services for

testing and prevention, CD4 service, ART center, treatment of OIs in government facilities, STI clinics, CPT administration, promotion of institutional deliveries and intensive prevention campaigns. The NGO response, largely from the RDT, includes additional testing and prevention facilities (ICTCs, PPTCT, hospitals, CD4 screening, ART center), care and support facilities (drop-in-centers), prevention campaign (Avahan, PSH, anti-trafficking with UNIFEM, UNICEF & IKP support, STI clinics), care and support services (institutional care and support centers) and treatment of OIs (RDT).

Nutritional Support

The study concludes that the life of HIV infected Widows is a struggle for them. Widowed, mostly at a young age, left to fend their families with declining health and finance life is trauma, which they hope to cope with the help of different CBOs, GOs and NGOs. There is hardly any special scheme supporting HIV widow by National Aids Control Organization or the Indian government. In Andhra Pradesh, Government has offered a financial support for the HIV widows, in the form of a monthly pension of Rs.1000. The RDT monthly support to PLHIV, WLHAs and households was the largest and continuous in the district, with each household receiving 10 Kg of rice, 4 Kg of raagi, 2 Kg of red gram and 1 Kg of oil in addition to 1 Kg of nutramul and 1 tin of portioned to each WLHA. Equally significant was the RDT support of 4 tins of Lactogen-I and 5 tins of Lactogen-11 for HIV positive lactating mothers to prevent breast feeding. The other NGOs (PSS, KRUSHI, STHREE and HEADS) provide some small and discrete support to the PLHAs.

Psycho-Social Support

The only reliable and sustained source of psycho-social supports to the WLHA and comes from the caregivers, with outreach workers and ANP+ providing occasional support. The counselling support provided by the RDT at its

monthly ration distribution points appeared to be useful as it provided counseling on sanitation, personal hygiene, water hygiene, co-infections and precautionary care. The aid-in-distress program of RDT is a very useful support to the caregivers facing acute financial crisis.

Shelter and Alternate Care

There are no exclusive alternative care/shelter facilities for the WLHAs/ CAAs other than the Ananda Nilayams and Balika Sadans which did not claim to have provided any shelter to the WLHAs. However, the NGOs and the ANP+ have facilitated admission of CAAs in orphanages run outside the district.

Legal Support

The affected households do not have any special legal support system to facilitate early resolution of their problems. However, ANP+ has been articulating their legal issues with judicial and district officials.

Besides the above initiatives that were provided by government and non government organizations, under NACP-III, NACO and APSACS initiated specific prevention and care, support and treatment programmes for halting and reversing HIV epidemic in the district. The initiatives have resulted in the following specific programmes at district level.

Targeted intervention in the district

Under NACP – III, the programme aims to achieve saturated coverage among High Risk Groups (HRGs) like female sex workers (FSW), men who have sex with men (MSM) and Intravenous drug users (IDUs). The programme also addresses the needs of the bridge population groups like truckers and migrants. The approach of the TI programme is to saturate coverage of HRGs, through community led interventions and District-wide programming in its focused prevention interventions.

By implementing the district wide programming approach, state will adopt a

fundamental shift from a “project based” approach of focused intervention to “programme based” with district as the basic programme implementation unit as well as the impact measuring unit. This will have the development of common standards, optimizing utilization of resources and infrastructure and single framework for district level programming and monitoring of outcomes through collaboration with all projects as its major components.

The services provided under TI programme consist of (a) behaviour change communication, (b) enabling environment through advocacy, (c) STI services (through static and mobile clinics), (d) condom promotion and (e) referral to HIV services. In few interventions, the additional services for rehabilitation of HRGs through income generation programmes are also initiated. The TI programs in the state are implemented through NGOs and CBOs. During the initial stages of the program the implementation was exclusively done by NGOs while with introduction of NACP III the shift from NGO led intervention to CBO involvement for implementation is now emphasized.

STATEMENT OF PROBLEM:

Hundreds of thousands of women across the world become infected with HIV every year. In addition, many more women who are not infected with HIV are indirectly affected by the epidemic, as a result of HIV related suffering, trauma and death in their families and their communities. Women are increasingly becoming vulnerable to HIV/AIDS. The latest data on HIV/AIDS conclude that 38% of the infected persons in India are women. This indicates the increasing feminization of HIV/AIDS in India. Ms. Sujatha Rao, the former NACO Director General has observed that marriage is the single largest reason for HIV/AIDS among women in India. According to her, the Indian woman in India in a very large number is being infected by her promiscuous husband. Ms. Sujatha Rao also noticed that high prevalence of HIV in Andhra

Pradesh is because of ‘one in every five men in Andhra Pradesh has multi partner sex’ and only 25 % of them use condoms. She also said that the surveys conducted by APSACS showed that of the youngsters who have been surveyed, 20-30% had premarital sex. The promiscuous husband indulging in multi partner sex is getting HIV infected in the first place and later on knowingly or unknowingly passing on the infection to their wives, who are in mono sexual relation with her husband. When both the spouse get infected, in majority cases, the Husband and the bread winner dies first of AIDS leaving his widow who is also infected and children who are infected and affected. HIV infected widows in substantial number is now a social reality, at least in Andhra Pradesh. It is a glaring yet a topical problem that has to be comprehended and probed in complete detail. The HIV widows suffer from different problems that are peculiar to them. Social exclusion, neglect, discrimination, stigma and ill-treatment of the HIV infected widows are common in the society. The HIV widows are double discriminated because they are widows and also HIV infected. Shunned by their families and communities, they are often placed in situations that only increase their risk. The list of challenges to HIV widows is indeed daunting: economic uncertainty, denial of property and inheritance rights, illiteracy, malnutrition, illness and physical and sexual abuse. As said earlier, though HIV infected women concerns have always been present within the great spectrum of needs associated with HIV infection, the problems peculiar to HIV widows have to some extent been overshadowed. Similarly, HIV/AIDS research is also inundated with problems of adults, more so with sexually active age group. Till date, no comprehensive study was made on HIV widows. Hence, the need for the present study. The proposed study is a comprehensive enquiry as to what is all about HIV widows in the study area.

OBJECTIVES OF THE STUDY

The overall aim of the present research topic is to make a study on HIV widows. The above being the general objective; following specific objectives were set for the present study:

- ★ To trace the history and prevalence of HIV/AIDS across the Globe and India in general and Andhra Pradesh in Particular;
- ★ To examine the prevalence of HIV/AIDS in Ananthapuramu district and to explore Care and Support available to PLHIV in the district.
- ★ To explain the incidence of HIV widows with special reference to the State and District
- ★ To describe the socio, economic and medical profile of the HIV widows and families in the study area;
- ★ To assess the Care, Support and Treatment available to the HIV widows and deficiencies therein.

METHODOLOGY

A.Hypothesis for the study

The proposed study is explorative in nature and as such the researcher does not propose any hypothesis for the study. The researcher wishes to go to field with an open mind and not with any predetermined postulations.

B.Research design

The present study adapted descriptive research design. It describes the sociological issues pertaining to impact of HIV/AIDS on the lives of HIV widows. The study examines socio, economic, medical and care and support issues pertinent to HIV widows. The study also traces the history and prevalence of HIV/AIDS in the study area.

C.Area of the study

The present study is conceived and designed to be a district wide study. Ananthapuramu district of Andhra Pradesh was

purposely selected for the study. Located in the rain shadow Rayalaseema region the district is most backward of the districts in Andhra Pradesh. Out of the estimated 7, 79,052 households in the district, 51% were reported to be poor and poorest of the poor. Poverty associated commercial sex and distress migration is clearly evident in the District. With 0.37% of HIV positivity among ANC and with 4.80% positivity among persons who were tested (22643 out of 470914), Ananthapuramu does not lag behind compared to other districts in the State, in terms HIV/AIDS. Besides the Government initiatives, the PLHIV in the district are ably supported by RDT a premier NGO in the State and ANP+, the best Networks of PLHIV in the State in the spheres of prevention and Care, Support and Treatment. Hence the district was chosen for the study.

D.Sample selection

Locating HIV widows is a difficult task. Fearing stigma and discrimination the PLHIV seldom share details with others. The Network, NGOs and CBOs that support the PLHIV maintain confidentiality about them. The Ananta Network Positives (ANP+) is the Implementing agency for VIHAAN initiative in Ananthapuramu district that works for the well being of the PLHIV. After elaborate rapport building with the Ananta Network of Positives (ANP+) and assurance about maintaining at most confidentiality of the PLHIV, the researcher could locate 457 HIV Widows across Ananthapuramu district, which constitute the universe for the study. Of the Universe 120 HIV widows were randomly selected and were approached for collection of data collection with the help of ANP+.

E.Pilot Study

A pilot study was undertaken to get firsthand information after selection of the research topic. Pilot study was done to ascertain suitability and adequacy of sample and quality

of data. The Interview Schedule for the study was prepared after completion of the pilot study.

F. Tools and techniques

The data pertaining to the study was collected from both from primary and secondary sources; more from primary source. In the present research study interview schedule was used to collect primary data. Editing and standardization of the schedule was done after the pilot study. Every care was taken to collect and record only reliable data pertaining to the objectives envisaged for the study. Personal observations were also recorded.

G. Data to be collected

The proposed study is based on primary as well as secondary data. Primary data will be collected from select HIV widows and also from different players involved in the interventions. Secondary data will be collected from different related organizations and agencies. A pretested standardized schedule shall be the tool of data collection.

H. Analysis and interpretation of data

Both quantitative and qualitative data were collected and analyzed by using the appropriate statistical and non statistical tools. Frequency and cross tables were generated and the results were interpreted through percentage analysis. While frequency tables were used to examine the socio economic and medical particulars of the HIV widows, cross tables were used to analyze other pertinent variables in the study.

I. Limitations:

1. Andhra Pradesh has highest number of PLHIV, but at the same time there is no correct and reliable data. Furthermore, a study on respondent who does not wish to reveal his identify and come out in the open is a formidable task.

The conclusions and the generalizations

drawn on the basis of the sample study are valid for the sample and may not hold good for the entire universe.

The Socio-economic status of HIV Widows of Ananthapuramu

Ananthapuramu district was purposively selected for conduct of the present study. Locating Women living with HIV/AIDS (WLHA) is a difficult task. Fearing stigma and discrimination the PLHIV and WLHA seldom share details with others. The Network, NGOs and CBOs that support the PLHIV and WLHA in the district reveal no information on the identity of the PLHIV/WLHA they work with and the data on them is confidential. The Ananta Network Positives (ANP+) is the Implementing agency for National Pediatric HIV/AIDS Initiative (NPHI) in Ananthapuramu district. After elaborate rapport building with the Ananta Network of Positives (ANP+) and assurance about maintaining at most confidentiality of the WLHA, the researcher could locate 120 HIV Widows across Ananthapuramu district and they constituted the universe for the study. Each one of these WLHA registered with Ananta Network of Positives (ANP+) was approached for collection of data collection. Hence the study is a census study of HIV WIDOWS registered with Ananta Network of Positives (ANP+) who live across the district. This was rounded up to 120 and data was presented for 120 HIV WIDOWS respondents only. The data was mostly collected by administering schedule prepared for the purpose and from interacting with the caretakers in their household. Additional data about the respondents were collected from the Network and also ART centres that the respondents attend for treatment.

The discussion hereunder presents the details of the respondents. The data is presented in the form of simple tables. The data pertain to respondents' socio- economic information that includes respondents' age, religion, caste, residential area; medical

information, which includes type of family, ownership of house, and educational information, which include respondents.

Table -1
Distribution of Respondents by Age

Age Group	No. of Respondents	Percentage
Less than 18	3	2.5
18-25	15	12.5
26-35	51	42.5
36-45	34	28.3
46-55	8	6.7
Above 56	9	7.5
Total	120	100.0

Table 1.explains the age distribution of the respondents. The statistics reveal that the majority of the HIV widows that is over 42% belong to one particular age group of 26-35. Another 15% of the respondents are even younger and are in less than 25 age group. Put together more than 57% of the respondents are young widows, and were between the ages of 18-35, and HIV infections have devastated their lives. All the HIV infected widows in the study were infected through their husbands and the HIV infection of the respondents was through sexual transmission.

Table .2
Distribution of Respondents by Opportunistic Infections They Suffer From

Particulars	Number	Percentage
Suffered OI in last one year	68	56.7
Did not Suffered OI in last one year	52	43.3
Type of OI		
Bacterial Infection	13	19.2
Candidacies	11	16.2
Chronic diarrheic	10	14.8
Tuberculosis	8	11.7
CMV retinitis	5	7.4
MAC	4	5.8
Hates zoster	4	5.8
PCP	3	4.4
Meningitis	1	1.4
Others	9	13.2
Total	68	100.0

The HIV infected persons suffer from opportunistic infections that in turn depend on the CD4 count, viral load and general health of the PLHIV. Data was collected about the opportunistic infections suffered by the respondents in the last year. The respondents were also asked as to whether they suffered any opportunistic infections peculiar to HIV infection

in the last one year. The responses of the respondents were presented in table- 2. Out of the total 120 respondents. 68 respondents said that they suffered from some their or other opportunistic infections related to HIV and have to visit the doctor for treatment. As the table reveals, almost 19% of the respondents with opportunistic infection suffered from bacterial infections. Candidacies and diarrhea have been other two major opportunistic infections that affected more 16% of the respondents and 12% of the respondents suffered varied forms of tuberculosis. More than 9% of the respondents suffered from other opportunistic infections that varied from flu, fever, body and joint pains, anaemia etc. headache, common cold can be classified as common ailments and need not be necessarily considered opportunistic infections as reported by the respondents.

Table .3
Distribution of Respondents by Knowledge on HIV Transmission

Knowledge on routes of HIV/AIDS Transmission	Number	Percentage
Yes	81	67.5
No	39	32.5
Routes of HIV/AIDS transmission		
Sexual transmission	50	61.7
Mother to child	38	46.9
Blood transmission from infected people	17	20.9
Sharing needles	10	12.4
All the above	14	17.3
Total	81	100.0

The respondents were asked whether they knew what caused HIV/AIDS. The above table presents information regarding the knowledge of the routes of transmission of HIV/AIDS. 68% of the respondents said that they knew about the routes of HIV transmission. For More than 61.7% of HIV infection was through sexual transmission. More than 46% of the respondents know the HIV infection could be vertical; from mother to child. 20.9% of the respondents said blood transmission is the reason for HIV/AIDS. More than 12% of the respondents had given Sharing needles as the reason. 14 of the respondents know all the above as and other irrelevant answers that were not known to routes of HIV transmission.

FINDINGS OF THE STUDY:

- ✦ All the 120 WLHA in the study were infected through their husbands and the infection of among them is through sexual transmission.
- ✦ The HIV widow that is over 42% belongs to one particular age group of 26-35. Than 57% of the respondents are young widows, and were between the ages of 18-35, and HIV infections have devastated their lives.
- ✦ Majority of respondents (75.8%) are Hindus. The HIV infection does not have any religious bias as the proportion of the respondents are more or less equal to proportion of Muslim and Christians percentage in the district.
- ✦ Majority of the Christian respondents were Scheduled Castes on records and claim the benefits of meant for the Scheduled Castes.
- ✦ More than 47% of the respondents were from backward castes while 26% respondents were from Scheduled Castes, only 20% of the respondents belong to forward castes.
- ✦ The backwardness of respondents not only socially and economically but also in education. 25.8% of the respondents are literacy. Majority of the respondents are (74%) are illiterates.
- ✦ The highest level of education the respondents' could reach was intermediate and this works out to around 20%.
- ✦ More than 90% of the respondents are in small occupations that by and large involve physical labour. Less than 10% of the respondents are in government occupations which is Class IV occupations.
- ✦ 79% of the respondents get an income of less than Rs. 6000/- per month, which hardly sufficient to meet barely the family needs.
- ✦ Only around 10% of the respondents earn less Rs.9000.
- ✦ The average income of the respondents worked out to Rs. 4,852.
- ✦ More than 80% of the respondents have two or less than two children. Four is the maximum number of children in the respondents' household and less than six percent of the respondents have four children.
- ✦ A little more than 10% of the respondents have three children.
- ✦ Majority of the respondents, which works out to 42.5% are living in terraced houses. From the economic position of the families of the respondents' it is very clear that majority of them were returned as BPL category.
- ✦ Data reveals about 74% of the respondents live in rural area and only 26% of the respondents live in urban areas.
- ✦ Majority of the respondents (56.7%) were residing in their own houses and 43% of respondents were residing in rented houses.
- ✦ As the husband and male head of the household is dead, some of the respondent widows lived separately and supported their children and some others have taken support from different relatives and managed their families.
- ✦ Almost 50% of the respondents are on their own and support their children. Parents, parents-in-law and brothers are providing respondents' support.
- ✦ The data reveals, that as many as 28 (23.3%) of the respondents are living in joint families and all the respondents except two are from urban area. As the data reveals overwhelming percentage, around 77% of the respondents' families were reckoned as nuclear families only.
- ✦ The reveal 33 (27.5%) respondents own landed property and another 29% of respondent families have taken land for lease for the purpose of agriculture around 43% do not own any land.
- ✦ The data reveals more than 65% of the

houses have all the facilities. Further probe reveals that 96% of the houses owned by the respondent have at least 3 facilities and the houses that are on rent do not have adequate facilities.

- ✦ The above table is pertaining to the practice of any loan facility was provided to the respondents. It is clear from the table 51% of the loan facilities at widows.
- ✦ As the data reveals all the respondents do possess ration cards, a preponderant size about 93% white ration cards meant for BPL sections of population. More than 80 percent of the respondents do have voter cards and Aadhar card.
- ✦ More than 35% of the respondents have made use of SHG loans and many more are willing to take loans as more than 84 percent of the respondents are members of SHGs.

CONCLUSION

To summarize Ananthapuramu district, the research setting is well endowed with medical and health facilities. The district consists of considerable number of High Risk Groups (HRG), PLHIV and WLHA. The district boasts of a reputed district level net work for PLHIV, the name of Ananta Net of Positive (ANP+) and RDT, a very popular and reputed NGO for HIV/AIDS interventions. The district is poor, drought prone and backward in most of the development indices. Crop failures, distress migration, trafficking of women and girl child are common to the district. The interplay of the above advantages and disadvantages of the district make Ananthapuramu district a fertile research ground for conduct of a study in the nature of a contemporary social problem.

It sufficiently clear from the analysis of the data that the respondents, in general, are socially backward and economically poor. The respondents and their families were devastated by HIV infection. The infection has resulted in loss of husbands and lack of security for the widows.

The HIV infection played havoc on the lives of the respondent to let them down socially, physically and economically. The loss of stature of the respondents and their families as a result of HIV infection coupled with their low socio economic status has led to their 'status discount' in the community.

From the analysis of the data it is clear that the district initiatives pertaining to care, support and treatment needs of PLHIV/WLHA are being sufficiently addressed. All the care, support and treatment facilities, institutions, projects are sufficiently placed in the district in the form of ART centres, Link ART Centres and Community Care Centres. These facilities are providing not only medical care but also social, economical, livelihood and psychological support. All the respondents, according to the needs, have sufficiently accessed the medical facilities and also other support services will help to mitigate and relieve the sufferings of the respondents to an extent.

Stigma and discrimination is commonly associated with HIV/AIDS and the respondents in the field are no exception. The analysis of the data reveals that the respondents in substantial number suffered stigma and discrimination in all the contexts possible. Stigma and discrimination is clearly evident in family, social relations, relatives, community, health care setting. The negative attitudes associated with HIV/AIDS remained steadfast in the different institution of the community. Unless determined IEC strategies and efforts by the community and civil society are made to alter the mindset of the WLHA/PLHIV are bound to suffer.

The HIV vaccine is still elusive. The AIDS cure is still a remote hope. With their ignorance or indulgence, the HIV infected men have passed on the infection to their wives, who in course of time have become HIV widows. No amount of compassion or care and support by the community or civil society can reverse their plight. The WLHA in large number and their

doomed future is a stark reality in the study area. Having worked with the HIV Widows and a witness to their misery the researcher wishfully looks forward for an UNAIDS envisaged 'zero HIV infections, zero AIDS deaths and zero discrimination' society in reality, in the near future.

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